STATE OF MAINE
120TH LEGISLATURE
FIRST REGULAR SESSION

Final Report of the COMMITTEE TO STUDY THE NEEDS OF PERSONS WITH MENTAL ILLNESS WHO ARE INCARCERATED

December 19, 2001

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Executive Summary

A significant percentage of the incarcerated population suffers some form of mental illness. This is the case not only in Maine but across the country. Nationally the Department of Justice estimates that over 16% of inmates in State prisons and local jails are mentally ill. In Maine at least 25% of inmates are reported to be in mental health therapy or counseling programs.

There are many reasons why persons with mental illness end up in the criminal justice system. Among the key reasons seem to be the high incidence of co-occurring substance abuse disorders among persons with mental illness, which can lead to drug-related offenses or to erratic, violent behavior, and the increased likelihood of impaired financial capacity leading to homelessness and minor offenses such as panhandling. In some cases jail may become a sort of housing of last resort: homeless mentally ill persons exposed to the elements booked for minor infractions and placed in jail because there is no other place to take them.

Once a person with mental illness comes in contact with the criminal justice system, there is a significant potential for a deterioration of the condition. A person who does not receive adequate treatment while incarcerated may well leave the institution in a worse condition than that in which he/she arrived. Without adequate planning for release, an inmate may leave the prison or jail with a deteriorated mental condition, no medical insurance, no job, no home and no financial resources. Under these circumstances, recidivism is likely and so the cycle repeats with perhaps a further deterioration of the person's mental condition. In addition to the effect on the person, this pattern also has negative impacts on society. A person whose mental illness is adequately treated, on the other hand, may become a productive and taxpaying citizen -- a much more desirable result for the individual and society.

This study committee, which consisted of the members of the Joint Standing Committee on Criminal Justice, was established by a Joint Order of the Legislature (see Appendix A) and directed to examine the needs of persons with mental illness who are incarcerated. The committee held 6 meetings. The committee received presentations from corrections officials, mental health officials and advocates for the mentally ill about the current status of the treatment of the mentally ill in the criminal justice system. It also hired Dr. Fred Osher, M.D., Associate Professor and Director, Center for Behavioral Health, Justice and Public Policies, University of Maryland School of Medicine to make a presentation to the committee on the study issues; Dr. Osher reviewed and commented on the preliminary findings and recommendations of the committee. Early in its work, the committee broke into 4 subcommittees that met with stakeholders on the topics of diversion, treatment in prisons, treatment in jails and aftercare. The subcommittees produced preliminary findings and recommendations that the full committee then reviewed, debated, refined, and, over the course of several meetings, turned into the findings and recommendations that appear in this report. On November 7th the committee requested an extension of its reporting deadline from December 5, 2001 to January 4, 2002; the Legislative Council reviewed the request during its November 13th meeting and approved an extension to December 19, 2001.

On December 10th a draft report was distributed to allow members and interested parties to make comments and suggestions. The committee, however, did not meet again to discuss the several comments received; under the direction of the chairs of the committee, the report was revised to incorporate or reference, as appropriate, those comments.

Due to the sheer magnitude of the study topic and the need to make manageable the task given time constraints, the committee focused its examination on the treatment of adults with mental illness and did not attempt to examine the special issues associated with the treatment of juveniles.

The committee's principal finding is that community mental health services, though very good, are, due to lack of resources, inadequate to meet the needs of persons with mental illness. This has resulted in some persons with mental illness falling through the treatment services net and into the criminal justice system. The lack of community mental health resources also impairs the ability of law enforcement, courts and corrections facilities to divert persons with mental illness away from the criminal justice system and into more appropriate treatment settings.[1] Clearly there are people with mental illness who, because of their behavior, require incarceration; there are others who would better be treated outside an incarcerated setting. In any case, the availability of adequate mental health resources to meet the needs of persons with mental illness in an appropriate setting is vital; the committee found these resources currently to be inadequate.

The following is a summary of the committee's findings and recommendations, a full listing and description of which may be found in Sections III and IV of this report.

The committee finds that county jails have inadequate resources to meet the needs of persons with mental illness. It finds there is a need for a more standardized assessment process in jails for assessing and addressing the needs of persons with mental illnesses and a need to improve treatment capacity and crisis response mechanisms and resources. It finds there is a need to improve discharge planning and aftercare. It finds there is a need to improve state-county partnerships to link jails with state services. It finds there is a need to divert persons with serious mental illness away from county jails into more appropriate care settings.

The committee finds that while the State prison system has made great strides in improving its capacity to meet the needs of persons with mental illness, there is a need to improve mental health screening and aftercare planning in State correctional facilities.

The committee finds that collaboration, communication and cross-training among and between criminal justice agencies and mental health service providers is vital to ensuring a seamless system to meet the needs of persons with mental illness. It finds there is a need to improve the sharing of mental health information between the Department of Behavioral and

[1] In commenting on a draft of this report, the Department of Behavioral and Developmental Services noted more generally that the current system and practices of service provision to criminal justice populations, which are the result of cultural norms, mores, state law, policies, historical funding and program development, together with limited community mental health resources have made it difficult to provide effective mental health care within the criminal justice system and to divert persons with mental illness into more appropriate treatment settings.

Developmental Services and correctional facilities to ensure adequate client care and treatment. It finds there is a need to ensure access to forensic hospital beds, especially for women, to handle transfers of persons with mental illness who require stabilization. It finds that there is a need to improve advocacy for inmates with mental illness in order to ensure adequate responses to treatment needs. It finds that there is a need to ensure adequate housing and transportation opportunities for persons released from prison or jail.

As these findings make clear, in order to address the needs of persons with mental illness who are or who may become incarcerated, significant efforts will need to be made at many levels of the criminal justice system. The committee recognizes that addressing these needs is not a one-time event but will require on-going efforts, examinations and re-evaluations. The committee's recommendations are designed to advance measurably the process of addressing these needs, to offer concrete proposals for further Legislative debate and refinement, and to lay the groundwork for future efforts. Proposed legislation implementing recommendations requiring statutory changes may be found in Appendix C.

Diversion

The committee makes recommendations relating to actions that may be taken to encourage, promote and cause the diversion, as appropriate, of persons with serious mental illness away from incarcerated settings into treatment settings. The committee is well aware that in order for diversion to be successful, adequate treatment outside of the incarcerated setting must be available. The committee expects that as its recommendations make their way through the legislative process more information will become available and decisions will need to be made as to the extent of resources that can and should be applied to address deficiencies in community mental health services. During the committee's discussions and also during the review of a draft of this report, questions were raised several times whether the Department of Behavioral and Developmental Services could within existing resources improve the services it provides to persons with mental illness within the criminal justice system, in particular those who are diverted from incarceration; it is a question that the Criminal Justice Committee expects to examine further as these recommendations make their way though the legislative process.

1. The committee recommends that the Department of Behavioral and Developmental Services be directed to examine the efficiency and effectiveness of the current police ride-along program. The committee also recommends that the Legislature consider expanding the ride-along program by funding 2 new Intensive Case Managers (ICMs) to provide ride-along services. Under current formulas a major portion of the costs of these ICMs would be eligible for Medicaid reimbursement.
2. The committee recommends that the Criminal Justice Academy continue its work to develop a training program to train Crisis Intervention Team (CIT) officers.
3. The committee recommends that the Maine Jail Association examine the success of Franklin County's collaborative model (described in Section II, D, 11) to determine whether it can be replicated in other areas of the state.[2] The committee notes, however,

[2] In its comments on the draft of this report, the Maine Jail Association expressed some concern about its capacity to do this. See Appendix I.

that each county has different needs and different resources and that no one model is likely to fit every jail.

4. The committee recommends that case managers be established within each of the 8 prosecutorial districts to work with prosecutors, defense attorneys, bail commissioners and others to develop treatment plans and sentencing options for persons with mental illness. Under current formulas a major portion of the costs of these ICMs would be eligible for Medicaid reimbursement.
5. The committee discussed the idea of developing mental health courts but did not arrive at a consensus. The committee believes that legislation on this subject currently before the Joint Standing Committee on Judiciary (LD 202) deserves further discussion and evaluation.
6. The committee recommends that mental illness awareness training should be expanded to encompass the judiciary, jail staff and others within the criminal justice system.
7. The committee recommends the creation of a position within the Department of Behavioral and Developmental Services to serve as criminal justice liaison to consult with county jails and the Department of Corrections on diversion issues and to improve coordination and communication between mental health service providers and the corrections system.

Treatment and Aftercare Planning in State Facilities

The following recommendations relate to actions that may be taken to improve the identification and treatment of persons with mental illness who are in the custody of the Department of Corrections (DOC).

1. The committee recommends that a position be created at each DOC intake facility to undertake mental health screening and to collect relevant mental health information upon intake.
2. The committee recommends that funding be provided to DOC for 1 psychiatrist and 1 psychiatric nurse to provide mental health treatment services to inmates in the State facilities.
3. The committee recommends that the DOC develop a training program to provide specialized forensic training to case management and community support providers and crisis and outpatient providers.
4. The committee recommends that the DOC be directed to work with the Department of Behavioral and Developmental Services to ensure its formulary includes the best medications for the treatment of inmates with mental illness and adopt policies to ensure that the most effective such medications are available and used and that clinical care needs, not cost, govern the use of medications.
5. The committee recommends that a person in each DOC facility be designated to make initial contacts with family and community services for persons with mental illness prior to their release from DOC facilities.
6. The committee did not have a chance to discuss at any length a proposal by NAMI Maine (see Appendix G) that the DOC, in consultation with the Department of Behavioral and Developmental Services, develop a grievance process, separate from other grievance

processes, for addressing complaints by persons with mental illness about their treatment. Some members of the committee, during the review of a draft of this report, expressed support for including this as a recommendation. The chairs of the committee determined that it should be included as a recommendation in order to encourage further discussion of the issue by the Criminal Justice Committee and the Legislature.

Treatment and Aftercare Planning in State and County Facilities

The following recommendations relate to actions that may be taken to improve the identification and treatment of persons with mental illness who are in the custody of the Department of Corrections (DOC) or county correctional facilities.

1. The committee recommends that the Department of Human Services establish procedures to ensure that a person receiving federally approved Medicaid services prior to incarceration does not lose Medicaid eligibility merely as a result of that incarceration, notwithstanding that Medicaid coverage may be limited or suspended during the period of incarceration.
2. The committee encourages jails to enter pre-release agreements with the local Social Security offices under which jail staff can acquire training on SSI rules in return for the jail's notification of the Social Security Administration of the release of inmates likely to meet SSI eligibility.
3. The committee recommends that the Department of Behavioral and Developmental Services be directed to work with the DOC and the county jail administrators to develop memoranda of agreement to improve access to forensic beds for transfers of inmates who require care in a State mental health institution.
4. The committee recommends that the Department of Behavioral and Developmental Services be directed to develop, in consultation with appropriate state and county correctional facility administrators, procedures to ensure that any inmate of a state or county facility that is hospitalized for treatment of mental illness has a written treatment plan describing the mental health treatment to be provided when the inmate is returned to the correctional facility for the remainder of the inmate's incarceration.[3]
5. The committee recommends that the Legislature consider amending current law to allow the Department of Behavioral and Developmental Services to share medical records with the DOC or county jail without the client's consent in cases in which the client suffers an acute deterioration such that the client cannot provide consent.[4] However, a number of committee members have concerns about altering the current law's protections of inmate medical records; the committee includes this recommendation for the purposes of allowing further legislative debate. The Department of Behavioral and Developmental Services has noted that even if this law is amended, there may be other limitations on the ability of the department to share information acquired from outside sources.

[3] The Department of Behavioral and Developmental Services and the Maine Jail Association (see Appendix I), in reviewing a draft of this report, expressed concerns about this recommendation. The Department of Behavioral and Developmental Services suggested that instead of requiring that persons be returned from the hospital with a treatment plan that they be returned to the correctional facility with a written recommendation for follow-up care.

[4] The Maine Jail Association has expressed a desire that this exception be expanded even further. See Appendix I.

6. The committee recommends that, in order to facilitate the sharing of information between the Department of Behavioral and Developmental Services and the DOC, the DOC should work with the Department of Behavioral and Developmental Services to develop a procedure to facilitate the identification of persons with a history of mental illness. (It is recognized that, with such procedures, only persons whose mental health histories are known to the Department of Behavioral and Developmental Services would be identified.)
7. The committee recommends that the DOC and the Maine Jail Association be directed to examine and develop ways of treating inmates with mental illness in the least restrictive setting possible that does not compromise security.
8. The committee recommends that, to the extent resources permit, the Offices of Advocacy in the DOC and in the Department of Behavioral and Developmental Services should make every effort to advocate diligently for those with mental illness who are incarcerated.
9. The committee recommends the creation of an independent Ombudsman for Mentally Ill Inmates.[5]

Treatment and Aftercare Planning in County Facilities

The following recommendations relate to actions that may be taken to improve the identification and treatment of persons with serious mental illness who are in the custody of the county correctional facilities. While each county facility is different and has its own unique circumstances and resources, every jail has inmates with mental illness whose needs must be addressed; the following recommendations are designed to assist jails in addressing those needs and to provide State resources for this purpose.

1. The committee recommends that the law governing furloughs from county jails be amended to make it clear that furloughs for longer than 3 days may be granted to provide treatment for mental conditions, including a substance abuse condition, as determined by a qualified medical professional.[6]
2. The committee recommends the creation of a pilot program to address the needs of persons with mental illness in county jails. The pilot program should include at least these four critical components: intake screening, a process to determine the appropriate mental health care, case management/treatment, and aftercare. The pilot program should involve at least 3 pilot locations (jails), at least one of which should be a jail in a rural area of the State.
3. The committee did not discuss a proposal by NAMI Maine (see Appendix G) that the Department of Behavioral and Developmental Services be directed to provide mental health staffing resources to county correctional facilities so that each county facility has at least 16 hours of facility-based mental health coverage each day. NAMI proposed that the facility-based staff be trained and qualified to address mental health and substance abuse issues and be familiar with inmate cultures and the criminal justice system. Some members of the committee, during the review of a draft of this report, expressed support for

[5] In its review of a draft of this report, the Maine Jail Association expressed opposition to this recommendation. See Appendix I.

[6] In its review of a draft of this report, the Maine Jail Association suggested that changing the furlough law will not be productive. See Appendix I.

including this as a recommendation. The chairs of the committee determined that it should be included as a recommendation in order to encourage further discussion of the issue by the Criminal Justice Committee and the Legislature.

I. INTRODUCTION

Incarceration rates across the country have more than tripled since 1980.[1] Currently over 3% of adult residents of the United States are behind bars or under correctional supervision.[2] During the 1990s the incarcerated population across the country grew an average of 5.7% annually; population growth nationally in State prisons and local jails during the 12-month period ending June 30, 1999 was about 3.1% for prisons and 2.3% for jails.[3]

A significant percentage of the growing incarcerated population suffers some form of mental illness and often suffers, in addition, a substance abuse disorder (co-occurring disorders). Nationally the Department of Justice (DOJ) estimates that over 16% of inmates in State prisons and local jails are mentally ill.[4] The DOJ estimates that on average across the country 10% of state inmates receive psychotropic medication; in Maine, the figure is closer to 20%, which is among the highest percentage in the nation.[5] In Maine at least 25% of inmates are reported to be in mental health therapy or counseling programs.[6] In Maine's county jails, the percentage of inmates receiving psychotropic medications ranges from 8% in the Oxford County facility to 50% in the Hancock County facility.[7] As such statistics clearly indicate, the treatment of the mentally ill in the criminal justice system is a significant issue all across the country and no less so in Maine.

There are, of course, many reasons why persons with mental illness end up in the criminal justice system. Among the key reasons seem to be the high incidence of co-occurring substance abuse disorders among persons with mental illness, which can lead to drug-related offenses or to erratic, violent behavior,[8] and the increased likelihood of impaired financial capacity leading to homelessness and minor offenses such as panhandling.[9] It has even been suggested that jail can become a sort of housing of last resort through so-called mercy bookings in which homeless persons exposed to the elements are booked for minor infractions and placed in jail because there is no other place to take them.

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[1] U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health Treatment in State Prisons, 2000, NCJ 188215, July 2001. Associated statistics may be found at http://www.ojp.usdoj.gov/bjs/correct.htm.
[2] .Id.
[3] Id.
[4] Id.
[5] Id.
[6] Id. This is a distinction the State shares with Louisiana, Nebraska and Wyoming.
[7] Maine Jail Association Mental Health Survey, draft report provided to the study committee on November 27, 2001, attached as Appendix I.
[8] According to a Department of Justice survey in 1998, more than a third of the mentally ill in state prisons or local jails showed signs of alcohol dependence. Nearly half of the mentally ill in state prisons indicated they were binge drinkers; 46 percent reported they had been in physical fights while drinking; 17 percent had lost a job due to drinking. U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.
[9] According to the 1998 Department of Justice survey, about 40 percent of mentally ill inmates were unemployed before their arrest. U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.

Once a person with mental illness comes in contact with the criminal justice system, there is a significant potential for a deterioration of the condition. Dr. Osher, an expert in the treatment of mentally ill persons within the criminal justice system with whom the committee consulted, noted that incarcerated environments, stressful and hypercritical, are pathogenic by nature. Incarceration can cause a person without a mental illness but vulnerable to mental illness to begin to exhibit symptoms of illness, and the symptoms of a person who already suffers from a mental illness can be much exacerbated.

A person who does not receive adequate treatment while incarcerated may well leave the institution in a worse condition than that in which he/she arrived. Without adequate planning for release, an inmate may leave the prison or jail with a deteriorated mental condition, no medical insurance, no job, no home and no financial resources. Under these circumstances, recidivism is likely and so the cycle repeats with perhaps a further deterioration of the person's mental condition.[10] In addition to the effect on the person, this pattern also has negative impacts on society. For instance, according the Department of Corrections, the average annual cost of housing an inmate at the Maine State Prison in 2000 was about $35,000; a person whose mental illness is adequately treated, on the other hand, may become a productive and taxpaying citizen -- a much more desirable result for the individual and society.

This study committee, which consisted of the members of the Joint Standing Committee on Criminal Justice, was established by a Joint Order of the Legislature and directed to examine the needs of persons with mental illness who are incarcerated. The study grew out of two bills presented to the Criminal Justice Committee during the 1st Regular Session of 120th Legislature: LD 1492, An Act to Improve Treatment of Persons with Mental Illness in Maine's Jails and Prisons and LD 1099, An Act to Permit Involuntary Medication of Mentally Ill Persons Residing in Department of Corrections Facilities. The former bill was carried over to the 2nd Regular Session. The latter was amended and passed under the title An Act Regarding the Care and Treatment of Persons With Mental Illness Who Are Incarcerated; it was enacted as PL 2001, Ch. 458. This law directs the Department of Corrections to consider mental health information prior to making a placement decision for a person committed to or transferred to the custody of the department, requires all adult correctional facilities and juvenile facilities to be accredited by a nationally recognized body by January 1, 2005, and specifies that persons in the custody of the department have a right to adequate mental health treatment. The Criminal Justice Committee's amendment to LD 1099 included a section that would have established this study; that portion of the amendment was eventually stripped from the bill and passed separately as a Joint Order in HP 1383 (attached to this report as Appendix A).

The committee held 6 meetings. At its first meeting on September 13, 2001 the committee received presentations from the Maine Jail Association, the Department of

[10] According to the 1998 Department of Justice survey, more than three-quarters of the mentally ill inmates had been sentenced to prison, jail or probation at least once prior to their current sentence. Half reported three or more prior
sentences. U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.

Corrections, the Department of Behavioral and Developmental Services and from NAMI Maine about the current status of the treatment of the mentally ill in the criminal justice system. At its second meeting on October 9th the committee broke into 4 subcommittees that met with stakeholders on the topics of diversion, treatment in prisons, treatment in jails and aftercare. The subcommittees produced some preliminary findings and recommendations. At the third meeting, which was held in South Portland on October 26th, the committee heard from Dr. Fred Osher, M.D., Associate Professor and Director, Center for Behavioral Health, Justice and Public Policies, University of Maryland School of Medicine. Dr. Osher was hired by the committee to provide expertise on the study issues; he also reviewed and commented on the subcommittees' preliminary findings and recommendations. At the fourth, fifth and sixth meetings (November 6th and 27th and December 5th respectively) the committee reviewed and assessed the subcommittees' preliminary recommendations and settled upon final recommendations. On November 7th the committee requested an extension of its reporting deadline from December 5, 2001 to January 4, 2002; the Legislative Council reviewed the request during its November 13th meeting and approved an extension to December 19, 2001.

On December 10th a draft report was distributed to allow members and interested parties to make comments and suggestions. The committee, however, did not meet again to discuss the several comments received; under the direction of the chairs of the committee, the report was revised to incorporate or reference, as appropriate, those comments.

During the committee's work, a recurring theme was the inadequacy of community mental health resources to meet the needs of people with mental illness. Because of the inadequacy of community resources, people with mental illness are falling through the treatment net into the criminal justice net, and correctional facilities, in particular county correctional facilities, are struggling to provide mental health services in settings ill-designed to provide such services.[11]

Clearly there are people with mental illness who, because of their behavior, require incarceration; there are others who would better be treated outside an incarcerated setting. In any case, the availability of adequate mental health resources to meet the needs of persons with mental illness in an appropriate setting is vital; the committee found these resources currently to be inadequate.

[11] Based on the testimony provided to the committee, it appears clear that county correctional facilities have, as a rule, very limited resources for dealing with persons with mental illness. In a survey conducted by the Maine Jail Association, every facility administrator answered "yes" to the following question: Do you support an alternative facility to house the mentally ill? Maine Jail Association Mental Health Survey, draft report provided to the study committee on November 27, 2001, attached as Appendix H.

II. BACKGROUND

A. Brief history of the treatment of persons with mental illness

The following brief history of the treatment of persons with mental illness is based on information provided to the committee by Dr. Osher, Associate Professor and Director, Center for Behavioral Health, Justice and Public Policies, University of Maryland School of Medicine.

In Colonial times and the early years of this country, persons with mental illness were likely to end up in prison. By the early nineteenth century, however, a reform was underway to provide what was termed "moral treatment." Asylums were established to provide such treatment and people with mental illness were moved into them and out of the prisons. The hope was that patients might be restored to mental health; in fact, the asylums largely failed in this respect. By the end of the nineteenth century the mental hygiene movement was underway: the deteriorating asylums began to be replaced by state psychopathic hospitals and treatment came to include outpatient care and early intervention. But again, the hopes of the new movement were not fulfilled: treatment was not leading to restored mental health and the hospitals began to overflow with long-term patients.

By the mid-twentieth century the community mental health movement was underway and the science of mental health treatment was making new strides, particularly in the area of new drugs. Community mental health led to deinstitutionalization; unfortunately the people released from the hospitals often didn't have the means to function in society (some hardly had clothes to wear). Lack of community-based services led to a wave of homelessness. The high incidence of co-occurring disorders resulted in significant numbers of mentally ill persons being arrested for violations of new drug laws.

Since the 1970s advocates have sought increases in community support systems for the mentally ill, including housing and income supports. At the same time the mental health profession has promoted the idea of recovery and the return to health for the mentally ill. More recently the idea of "in vivo" support has gained momentum, the concept of which is to focus support where the help is needed (e.g., if a person is having a problem with his/her job, provide support to the person at the job). Another movement, called Evidence Based Practice, is also gaining momentum, the principal idea of which is that resources should be focused on programs that have proven outcomes. The Practice also focuses on consumer need. New medications have continued to be developed and new advocacy voices have arisen: In 1979 the nonprofit National Alliance for the Mentally Ill (NAMI) was founded.

According to Dr. Osher, there is still a significant gap between what we know scientifically and what we are doing as a society to address the needs of the mentally ill. He noted that our society has somewhat ironically returned to Colonial-style institutionalism: seriously mentally ill persons are ending up once again in jails and prisons. Indeed, in 1998, the number of persons

with mental illness in prisons and jails was 4 times the number in state mental hospitals.[12] As Dr. Osher noted, the mental health system still has a long way to go.

B. Current approaches to meeting the needs of persons with mental illness; a brief overview.

Current approaches to addressing the needs of persons in the criminal justice system may be divided into three general categories: diversion programs, treatment programs in jails and prisons, and aftercare programs.

Diversion may broadly be defined as programs designed to "prevent incarceration or cut it [13] but is used here more specifically to refer to programs that result in an "immediate alternative to incarceration."[14] There are two basic types of diversion programs: pre-booking and post-booking, the former involving "access to psychiatric treatment…in lieu of arrest or criminal incarceration"[15] and the latter involving the diversion of persons with serious mental illness from the jail to a treatment environment. All diversion programs involve two basic components: "First is the diversion mechanism, or the means by which an individual is identified at some point in the arrest (or trial) process and diverted into mental health services. Second is the system of integrated mental health and substance abuse services to which the client is diverted."[16] Diversion programs typically involve one or more of the following: training of law enforcement and/or corrections staff in identification and understanding of mental illness; development and use of screening tools to assess persons coming into jail; mental illness training for judges; placement of mental health workers in court to help negotiate diversion outcomes; or the creation of mental health courts. The success of diversion programs depends upon the availability of appropriate mental health and substance abuse services to which persons can be diverted.

Pre-booking diversion programs focus on "innovative training and practices to avoid detaining people in need of emergency mental health and substance abuse services in local jails by arranging for community based mental health and substance abuse services as alternatives."[17] "Another key element in many pre-booking diversion programs is a designated mental health triage or drop-off center where police can transport all persons thought to be in need of emergency mental health services, usually under a no-refusal policy for police cases."[18] Memphis, Tennessee has developed what many feel is a model pre-booking diversion program that involves a so-called Crisis Intervention Team made up of officers trained in psychiatric diagnosis and de-escalation techniques; these officers provide on-the-scene expertise in responding to crisis

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[12] U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.
[13] Draine and Solomon, "Describing and Evaluating Jail Diversion Services for Persons with Serious Mental Illness," Psychiatric Services, January 1999, vol. 50, No. 1, p.56.
[14] Id.
[15] Id. at 57.
[16] Id. at 56.
[17] Steadman, Deane, Borum and Morrissey, "Comparing Outcomes of Major Models of Police responses to Mental Health Emergencies," Psychiatric Services, May 2000, Vol. 51, No. 5, p. 645.
[18] Id.

situations. The program also involves an emergency psychiatric service available at the University of Tennessee that accepts all police referrals on a no-refusal basis.

Post-booking diversion programs can be jail-based and/or court-based and can result in a variety of outcomes including transfer of the client to secure emergency inpatient care treatment, conditional release of the client to receive mental health treatment, the reduction or dropping of charges, or alternative sentencing. Jail-based programs typically involve the training of corrections staff in mental illness awareness and the development of a screening process to identify persons to be diverted. Court-based diversion involves court officers assessing the mental illness of a defendant and making decisions about the effect it should have on the outcome of the prosecution of the case.

A recent development in court-based diversion is the emergence of mental health courts. The Department of Justice in 2000 undertook an examination of the four pioneering mental health court initiatives (Broward County, Florida; King County, Washington; Anchorage, Alaska; and San Bernardino, California) and described their common features as including the following: the objective of the court is to divert persons who are mentally ill to appropriate services and support in the community; the defendant must consent to participation; only persons with demonstrable mental illness may participate; a high priority is given to concerns for public safety in arranging for the care of mentally ill offenders in the community; the court seeks to expedite early intervention through timely identification of candidates (screening and referral of defendants takes place within a maximum of 3 weeks after the defendant's arrest); the court uses "a dedicated team approach, relying on representatives of the relevant justice and treatment agencies to form a cooperative and multidisciplinary working relationship with expertise in mental health issues;" the court provides supervision of participants with an emphasis on accountability and monitoring of the participant's performance; and the programs all emphasize "creating a new and more effective working relationship with mental health providers and support systems, the absence of which in part accounts for the presence of mentally ill offenders in the court and jail systems."[19]

Treatment programs in an incarcerated setting involve providing adequate care to persons inside the facility and depend upon the resources within that setting. Such resources can range from non-existent to large mental health units staffed by psychiatrists. Among the issues that arise in the incarcerated setting include:

- the availability and use of physical and staffing resources;
- the use of medications, including formulary policies and forced medications;
- managing the tension between security and treatment needs, including use of restraints; and
- access to information about a person's mental health history.

Aftercare programs are programs designed to transition persons back to the community in a manner that supports their mental health needs. Such programs typically involve pre-release

[19] See Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage, USDOJ, Office of Justice Programs Monograph, April 2000.

planning and case management that links the person to community services. Issues that arise in terms of aftercare include:

- ensuring basic food, clothing and shelter needs are met;
- arranging for mental health services; and
- ensuring that income-support and health care benefits that may be lost during incarceration, such as SSI, SSDI, Medicaid and Medicare, are reinstated in a timely fashion.[20]

C. Some context: a brief survey of initiatives and studies around country

The issues surrounding the needs of persons with mental illness who are incarcerated are important, complex, often vexing and not limited to any one state or region of the country. Consequently, the issues have been and continue to be examined around the country. The following is a brief survey of some of those activities.

Two years ago the Council of State Governments, the Police Executive Research Forum, the Pretrial Services Resource Center, the Association of State Correctional Administrators and the National Association of State Mental Health Directors partnered to create the Criminal Justice/Mental Health Consensus Project. The goal of the project is to develop a bipartisan consensus among criminal justice and mental health policymakers concerning the treatment of persons with mental illness in the criminal justice system. The project has involved the creation 4 advisory groups (law enforcement, courts, corrections and mental health) whose membership includes policymakers from around the country. Senator McAlevey, co-chair of this study committee, is Vice-Chair of the board of the Project. The final report of the Project, which is expected to be issued in March or April of 2002, will include recommendations on how policymakers in federal, state and local governments may improve the criminal justice and mental health systems' response to individuals with mental illness.

The Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (BJS) has issued 2 special reports in the last few years on mental health treatment in the criminal justice system. In July 1999, the BJS issued the special report, "Mental Health and Treatment of Inmates and Probationers" which analyzed data from a 1997 Survey of Inmates in State or Federal Correctional Facilities, the 1996 Survey of Inmates in Local Jails, and the 1995 Survey of Adults on Probation. Among the findings of the report: State prison inmates with a mental condition "were more likely than other inmates to be under the influence of alcohol or drugs at the time of the current offense (59% compared to 51%); and more than twice as likely as other inmates to have been homeless in the 12 months prior to their arrest (20% compared to 9%)."[21] It also finds

[20] For a description of federal benefit rules governing suspension and termination of benefits while a person is incarcerated see booklet "For People with Serious Mental Illnesses: Finding the Key to Successful Transition from Jail to Community," Bazelon Center for Mental Health, Washington, D.C., March 2001.
[21] U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.

that "(o)ver three-quarters of mentally ill inmates had been sentenced to time in prison or jail or on probation at least once prior to the current sentence."[22]

In July 2000, the BJS issued the special report, Mental Health Treatment in State Prisons, 2000 that analyzed data from the 2000 Census of State and Federal Adult Correctional Facilities. According to the BJS, this was the first census that included items related to facility policies on mental health screening and treatment.[23] Among the findings of the report: "The 2000 prison census findings reveal a great diversity in the amount and type of treatment being provided among State correctional facilities."[24] It also finds that mental health screening and treatment is more frequent in maximum/high security facilities than in minimum/low security facilities, and the most common form of treatment is the use of psychotropic medications and the provision of therapy and counseling.[25]

The Center for Behavioral Health, Justice and Public Policy at the University of Maryland School of Medicine has received a grant to develop a standardized assessment tool for testing serious mental illness in jails and prisons. Currently there is no standard assessment tool. The creation of such a tool should help correctional facilities identify and treat persons with mental illness, divert them to treatment facilities or plan for their treatment within the facility, and plan for their care after release.

According to the Council of State Governments, the following states, in addition to Maine, currently have study committees or task forces examining the issues associated with the treatment of the mentally ill: Colorado, Connecticut, Florida, Illinois, Indiana, Montana, Nebraska, Oregon, Rhode Island, Tennessee, Texas, Virginia and West Virginia.

The following is a sampling of the programs tried or underway across the country to address issues associated with the treatment of the mentally ill in the criminal justice system.[26]

- Two counties in Arizona (Pima County and Phoenix), have diversion programs which include the following options: release from jail with special conditions; deferred prosecution with treatment/intervention conditions which, if met, result in charges being dropped; and summary probation with special conditions which allows the defendant to avoid incarceration.
- Several counties in Connecticut have a court-based diversion program involving mental health staff based in court who develop plans for diversion, coordinate the plans with the bail commissioner and the public defender and present the plan to the court.

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[22] Id.
[23] U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health Treatment in State Prisons, 2000, NCJ 188215, July 2001.
[24] Id.
[25] Id.
[26] This information was supplied by the National GAINS Center for People with Co-Occurring Disorders in the Justice System, Delmar NY. The web site is www.prainc.com/gains.

- Honolulu has a program in which inmates are interviewed in jail prior to arraignment to determine whether diversion is appropriate; staff of the program help link the diverted individuals to community mental health services.
- In Wicomico County, Maryland there is a pre-booking diversion program called the "Phoenix Project" that focuses on dually diagnosed women and their children. The program involves a Mobil Crisis Unit, an intensive mental illness/substance abuse outpatient treatment program, case management services, secure crisis housing and transitional housing.
- New York City has a program called NYC-Link that provides diversion, discharge planning and transitional services. The program includes intake assessment, Linkage Planners who develop comprehensive discharge plans, Transition Management Teams who oversee the transition back to the community, and counselors who advocate on behalf of clients in the community and in court and who provide intensive case management services including assistance in obtaining medication and entitlements.
- Lane County, Oregon has a jail-based diversion program which involves a specialist who interviews inmates in jail and negotiates diversion outcomes with the District Attorney. Several hospitals and a number of residential and community-based organizations are available to receive persons who are diverted.
- Multnomah County, Oregon has a diversion program in which persons with co-occurring disorders are diverted prior to arrest to a special Crisis Triage Center. The Center works with community-based organizations to develop after-treatment plans.
- Two counties in Pennsylvania have pre-booking, post-booking and "coterminous jail diversion" programs. Under the latter program, an individual may be taken directly to psychiatric treatment and also have charges filed against him/her. After treatment charges may be dropped or the client may be prosecuted. All of these diversion programs involve police training, 24-hour crisis response teams, inpatient treatment and case managers.
- As described elsewhere in this report, Broward County, Florida, King County, Washington, Anchorage, Alaska, and San Bernardino, California all have developed mental health courts designed to handle the special circumstances of cases involving persons with mental illness.

D. Summary of current laws and services in Maine

There are currently a number of programs and provisions of law designed to address issues associated with persons with mental illness in the criminal justice system. The following is a brief summary of the principal laws, programs and services.

1. Department of Behavioral and Developmental Services diversion strategy. Current law[27] requires the Department of Behavioral and Developmental Services to develop a diversion strategy, defined as a comprehensive strategy for preventing the inappropriate incarceration of seriously mentally ill individuals and for diverting those individuals away from the criminal justice system. The Department of Behavioral and Developmental Services is required to work in collaboration with the Department of

[27] 34-B MRSA §1219.

Human Services, the Department of Corrections, law enforcement, community providers and advocates.

In response to this law, the Department of Behavioral and Developmental Services has entered into contracts with community agencies to provide crisis services statewide, including emergency assessments and consultations on care. The department has also assigned Intensive Case Managers (ICMs) in Augusta, Waterville, Lewiston and Bangor and, through contracts with community providers, crisis workers in Portland and Biddeford to provide "ride-along" services to police; these ICMs and crisis workers accompany officers and provide mental health expertise on the scene. The department also provides crisis services, including crisis residential services, through ICMs throughout the state. These ICMs are responsible for assisting mentally ill persons access needed mental health services in the community. There are also ICMs in each BDS service region[28] whose primary responsibility is to provide case management services to clients in jails and State correctional facilities; case management services include coordinating mental health services in preparation for an inmate's release. In Region II, the department is developing a telehealth network with the Kennebec County Correctional Facility, the Maine State Prison System and AMHI to provide links to psychiatric expertise; the system will be linked to 14 other sites that specialize in mental health and psychiatry.

The department has indicated that it is continuing to monitor, explore and develop methods to address issues in each region of the state with regard to the treatment of the mentally ill in the criminal justice system.

2. Transfers of inmates to hospitals from MDOC facilities and from jails. Inmates with mental illness under certain circumstances can be transferred to a mental health institute for treatment (either a State mental health institute such as AMHI or a non-state mental health institution). Different provisions of law govern transfers from jails and from state correctional facilities, through the standards for admission are essentially the same.[29]

An inmate may seek voluntary admission to a mental hospital if, in the case of an inmate in a county or local correctional facility, hospitalization is recommended by a licensed physician or psychologist, or, in the case of inmate in a State correctional facility, the chief administrative officer of the facility authorizes the application. Admission is subject to the availability of suitable accommodations at the hospital and a finding by the chief administrative officer of the hospital that the person is suitable for admission, care and treatment at that hospital.

[28] The Department of Behavioral and Developmental Services has three regional offices that serve the following regions: Region I serves Cumberland and York counties; Region II serves Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset and Waldo counties; Region III serves Aroostook, Hancock, Penobscot, Piscataquis and Washington counties.

[29] Transfers from county facilities are governed by 15 MRSA Ch. 309 (§2211-A et seq.) and 34-B MRSA Ch. 3, Sub-ch. IV (§3801 et seq.); transfers from state prisons are governed by 34-A MRSA §3069 and 34-B MRSA Ch. 3, Sub-ch. IV (§3801 et seq.).

A jail or state correctional institution may also apply to a mental hospital to admit an inmate on an involuntary basis. The application must include a certificate of a licensed physician, physician's assistant, certified psychiatric clinical nurse specialist, nurse practitioner or a licensed clinical psychologist, stating the person is mentally ill and, because of that illness, poses a "likelihood of serious harm," which is defined as posing a substantial risk of physical harm to him/herself or to others or a reasonable certainty that severe physical or mental impairment or injury will result to the person, if not admitted, after consideration of less restrictive treatment settings and a determination that community resources for his care and treatment are unavailable. The application and certificate must also be reviewed and endorsed by a judge or justice of the peace.

3. Other ways of committing forensic patients to state mental health institutions. In addition to transfers from jails and state correctional facilities, there are 3 additional ways in which a person with mental illness within the criminal justice system may be placed in a mental health institution.

Stage III evaluations:[30] A court may order a defendant examined to determine the defendant's mental condition with reference to competency, criminal responsibility, etc. If the Department of Behavioral and Developmental Services determines that admission to an appropriate institution for the mentally ill is necessary for complete examination, the court may order the defendant committed to the custody of the department, placed in an appropriate institution and detained and observed for a period of time not to exceed 60 days, for the purpose of ascertaining the mental condition of the defendant.

Incompetence to stand trail:[31] If a court finds a defendant incompetent to stand trial, it must continue the case until such time as the defendant is deemed by the court to be competent to stand trial and may either: commit the defendant to the custody of the Department of Behavioral and Developmental Services to be placed in an appropriate institution for the mentally ill for observation, care and treatment; or order that the defendant undergo observation at a state mental hospital or mental health facility approved by the department or by arrangement with a private psychiatrist or licensed clinical psychologist and treatment deemed appropriate by the State Forensic Service. If the court determines there does not exist a substantial probability that the defendant can be competent to stand trial in the foreseeable future, the court must dismiss all charges against the defendant and either order the Department of Behavioral and Developmental Services to commence involuntary commitment proceedings or (in the case of certain offenses) notify the appropriate authorities who may institute civil commitment procedures for the individual.

Not criminally responsible:[32] When a defendant is found not criminally responsible by reason of mental disease or mental defect the court must order the person committed to the custody of the Department of Behavioral and Developmental Services to be placed in

[30] 15 MRSA §101-B(3).
[31] 15 MRSA §101-B(4).
[32] 15 MRSA §103.

an appropriate institution for the mentally ill or the mentally retarded for care and treatment.

4. Availability of beds. Presently at the Augusta Mental Health Institute (AMHI) there are only 27 forensic beds, most of which are occupied by patients found not criminally responsible or incompetent to stand trial.[33] Consequently, forensic bed space is limited for transfers of inmates from jails or state correctional facilities. In addition, AMHI forensic beds currently only serve male forensic patients; female forensic patients are served only within the civil units.

The new Psychiatric Treatment Center, expected to be in operation in 2003, will have 44 forensic beds, 24 of which will be within an Intermediate Care Forensic Unit that will be able to take male or female patients. The number of beds is designed to meet needs as projected out to 2010. The projections assume a need for 2 beds for prison transfers and 12-16 beds for jail transfers.[34]

The Bangor Mental Health Institute (BHMI) does not have any forensic beds but does house several not-criminally-responsible patients, occasionally admits persons judged incompetent to stand trial, and provides short-term stabilization for inmates transferred from jails in Aroostook, Hancock, Penobscot and Washington Counties.

5. Conditions of probation. Current law[35] allows a court to attach conditions of probation, including requiring the person to undergo inpatient or outpatient psychiatric treatment or mental health counseling. Such conditions can be used to help ensure a person gets the treatment he/she needs and avoid the creation of crisis situations that can lead to criminal behavior and arrest.

The Department of Behavioral and Developmental Services is required to designate 7 liaisons to the courts and MDOC to assist in the administration of the conditions of probation;[36] the liaisons duties include obtaining mental health evaluations and assessing the availability of mental health services necessary to meet conditions of probation and assisting the person in obtaining the mental health services. The department, however, has not provided these 7 liaisons. Commissioner Duby stated to the committee that these mental health services "are being provided through liaisons which include primarily the State Forensic Service and on a case-by-case basis by case managers of specific clients. This approach meets the same intent of the statute of providing a liaison to the courts although it does not provide for seven regional liaisons, which the Department feels would

[33] For instance, on Nov. 9, 1999, there were 24 forensic patients at AMHI, 12 of whom were not criminally responsible, 5 incompetent to stand trial, 1 was pending evaluation and 6 were jail transfers. See report, Maine Inpatient Treatment Initiative: Civil and Forensic, Pulitzer/Bogard & Associates, L.L.C., February 29, 2000, Table 9, p. 15.
[34] See report, Maine Inpatient Treatment Initiative: Civil and Forensic, Pulitzer/Bogard & Associates, L.L.C., February 29, 2000, Table 13, p. 21.
[35] 17-A MRSA §1204.
[36] 34-A MRSA §1220.

together by the department, the University of Maine Center for Inclusion, and the Disability Rights Center provided a training session at the MCJA with respect to dealing with mentally ill persons as victims, witnesses and perpetrators of crimes. The department also provided mental illness treatment, intervention and medication training in 1998-99 at the Maine Correctional Institution (Supermax) in Warren.

At the invitation of the Department of Corrections, NAMI Maine has provided mental illness awareness training to corrections staff at the prison in Thomaston and the Maine Correctional Center at Windham.

The Portland Police Department is participating in a pilot program funded by the Margaret Burnham Charitable Trust and the Simmons Foundation to train a Crisis Intervention Team (CIT) within the department. The model being used is the program developed in Memphis, Tennessee in which officers receive specialized training in psychiatric diagnosis, substance abuse issues, de-escalation techniques, empathy training, and legal training in mental health and substance abuse. In operation, the CIT program involves crisis response and referrals. The CIT approach is similar to the ride-along programs offered through the Department of Behavioral and Developmental Services in that it provides resources to assist law enforcement in de-escalating crises and diverting persons with mental illness away from the criminal justice system to appropriate treatment.

7. Protective custody. Under current law[38] a law enforcement officer may take a person into protective custody if there are reasonable grounds to believe, based upon probable cause, that a person may be mentally ill and that due to that condition the person presents a threat of imminent and substantial physical harm to that person or to other persons, or if a law enforcement officer knows that a person has an advance health care directive authorizing mental health treatment and the officer has reasonable grounds to believe, based upon probable cause, that the person lacks capacity. If the law enforcement officer does take the person into protective custody the officer must deliver the person immediately for examination for emergency admittance to a mental hospital or, if the person has an advance health care directive authorizing mental health treatment, for examination to determine the individual's capacity and the existence of conditions specified in the advance health care directive for the directive to be effective. The examination may

[37] Letter to the committee from Commissioner Duby dated Nov. 5, 2001.
[38] 34-B MRSA 3862.

occur in a hospital emergency room; if it occurs outside an emergency room it must be done by a licensed physician or licensed clinical psychologist.

8. The new State Prison. As of the writing of this report, the new Maine State Prison nears completion on the grounds of the existing Maine Correctional Institution (Supermax) in Warren. The new facility will replace both the existing prison in Thomaston and the Supermax and will house special management, close security and medium security prisoners. A portion of the existing Supermax will be turned into a 50-bed Mental Health Unit which will include, in addition to the 50 cells, a day room with games, exercise equipment, television, telephones and vending machines, an interview room and showers. The prison will also include a 50 bed High Risk Management Unit and a 32-bed Administrative Segregation and Disciplinary Segregation Unit. The new prison includes a gymnasium, weight room, chapel, library, computer lab, music room and shops for industries. The prison will have a total capacity of 916 beds and is constructed to allow for future expansion.

The new prison is designed to facilitate the implementation of a new Unit Management Model in which unit clinicians and corrections staff do not rotate through units but are assigned to the unit and work as an interdisciplinary service team.

9. MDOC accreditation. The Department of Corrections has been working toward meeting the standards of the American Correctional Association (ACA) with the goal of receiving accreditation of all of its facilities. In the 1st Regular Session of the 120th Legislature a bill was enacted which directs that Department of Correction adult correctional facilities and juvenile facilities must be accredited by a nationally recognized body by January 1, 2005.[39]

While accreditation in itself may not ensure adequate treatment of persons with mental illness who are incarcerated in State facilities, it will at least ensure that a certain level of critical review of that treatment has occurred and will continue periodically to occur. As part of the accreditation process a committee from the ACA will visit the facility to be accredited and conduct an audit to review documentation regarding the meeting of ACA standards, interview staff and residents and evaluate the conditions of confinement.

10. Advocacy offices. There are currently 2 advocate offices that have statutory authority to advocate on behalf of persons who are mentally ill within the criminal justice system: the Office of Advocacy within the Department of Corrections and the Office of Advocacy within the Department of Behavioral and Developmental Services.

The Office of Advocacy within the Department of Corrections (DOC) is statutorily required to investigate the claims and grievances of persons in the custody of the DOC, to investigate, in conjunction with the Department of Human Services, allegations of abuse or neglect in correctional facilities and detention facilities and to advocate for compliance

[39] Public Law 2001, Ch. 458, codified at 34-A MRSA 1214.

by the department, any correctional facility, any detention facility or any contract agency with all laws, administrative rules and institutional and other policies relating to the rights and dignity of persons in the custody of the DOC. The Office consists of 2½ advocate positions: the Chief Advocate, one full time facility advocate and one half-time facility advocate. The full-time facility advocate is currently assigned to the Maine State Prison, the Maine Correctional Institute, and the Bolduc Unit; when the new Maine State Prison comes on line, this advocate will cover the new facility and the Bolduc Unit. The half-time facility advocate is currently assigned to the Long Creek Youth Development facility in South Portland. The Chief Advocate handles the rest of the State's facilities, including the new Mountain View Youth Development facility in Charleston.

The Office of Advocacy within the Department of Behavioral and Developmental Services is required to investigate the claims and grievances of clients of that department, to investigate with the Department of Human Services all allegations of abuse in state institutions and to advocate on behalf of clients for compliance by any institution, other facility or agency administered, licensed or funded by the department, including mental health institutions, with all laws, administrative rules and institutional and other policies relating to the rights and dignity of clients. The Office's current advocacy resources consist of an advocate at AMHI, an advocate at BMHI, 8 persons assigned to advocate for persons with mental retardation, a children's advocate and the Chief Advocate who oversees the office. There are currently no resources within the office specifically to advocate for persons with mental illness who are incarcerated.

11. Some activities at the local level: The evidence reviewed by the committee points to the conclusion that resources at the county level to address the needs of persons with mental illness are very limited. For instance, only 4 facilities offer any services of a psychologist; the 4 that do, offer the services only a few hours per month.[40] All the counties work with outside vendors to provide mental health services and some efforts to divert persons with mental illness to appropriate treatment settings are occurring.

The committee heard particularly positive comments about a collaborative approach to addressing the needs of persons with mental illness in Franklin County.[41] As described to the committee, jail staff, the sheriff's department, town police departments, county commissioners, the University of Maine, Farmington, Kennebec Valley Technical College, SAD#9 Adult Basic Education, the Department of Behavioral and Developmental Services, judges, prosecutors, local mental health providers, and other interested parties have worked in a collaborative effort to quickly identify and divert to appropriate treatment people with mental illness who have been arrested and brought to the county

[40] See Maine Jail Association Mental Health Survey, draft report provided to the study committee on November 27, 2001, attached as Appendix H.

[41] For further description and analysis of the community-collaborative approach and of what has been developed in Franklin County see Tanner, William S., "Community Organizing for a Purpose: the Answer to the Social Issues of the Twenty-First Century" (2001). Ann Arbor, Michigan, UMI Company, Bell & Howell. Library of Congress/Copyright - TX5-404-231.

jail. The collaborative effort has been funded with money from the Community Corrections Act.

The Cumberland County Jail is currently in the process of seeking ACA accreditation and expects to receive accreditation by mid-January 2002. The Cumberland County facility has a mental health counselor who attends the facility 40 hours/week and a psychiatrist who is available 4 hours/week. According to the facility, there is usually a long list of inmates on the psychiatrist's waiting list. There is also a long waiting list for the supervised bail program. According to the jail administrator, diversion will not become a viable option until community mental health services have the capacity to meet the demand.

12. The Plan Development Work Group for Community-Based Living. In response to a 1999 U.S. Supreme Court decision interpreting the Americans with Disabilities Act (ADA),[42] the Department of Human Services joined with the Department of Behavioral and Developmental Services, the Department of Education, the Department of Labor, and the Department of Corrections to establish the Plan Development Work Group for Community-Based Living to develop a comprehensive approach for providing community-based services for persons with disabilities. The Work Group includes representatives of a wide range of consumer advocates, including the Disability Rights Center, the Maine Association for Mental Health Services, Maine Association of Substance Abuse Programs, and the National Alliance for the Mentally Ill, Maine Chapter. The Work Group is charged with examining the following questions: how to eliminate unnecessary institutionalization of persons with disabilities (in both state and private institutions); how to ensure sustainable community living for persons receiving publicly funded services in the community; and how to identify and address the needs of persons at risk of unnecessary institutionalization who are not currently receiving services. The Work Group expects to produce a draft plan by the end of March 2002. Public comment is scheduled for May and a final plan to be produced in July 2002.

13. A note on Medicaid. Medicaid is a joint federal and state program that provides healthcare coverage to persons who meet qualifications of disability, age, or poverty. In Maine, qualification for Supplemental Security Income results in automatic Medicaid coverage. However, under the federal Social Security Act, Medicaid reimbursement ceases while a person is incarcerated, with the exception that if an inmate is transferred to a hospital for acute care, the hospital can claim reimbursement for the service.[43] Thus, the costs of providing mental health services to any person eligible for Medicaid coverage

[42] The Supreme Court in *Olmstead v. L.C.* 527 US 581, 119 S.Ct 2176 (1999), found that states are required to place persons with mental disabilities in community settings rather than in institutions when the state's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

[43] For a useful overview of federal benefits and how they are effected by a person's incarceration, see For People with Serious Mental Illness: Finding the Key to Successful Transition From Jail to Community, Bazelon Center for Medical Health Law, Washington, D.C., March 2001.

who is incarcerated fall to the State or county facility in which the person is incarcerated. Though federal reimbursement does not cover care in an incarcerated setting, federal rules do not require a person's Medicaid eligibility automatically to terminate upon the person's incarceration. Maintenance of eligibility can assist in ensuring that an inmate has Medicaid coverage immediately upon release, avoiding a coverage gap that could otherwise occur during reapplication for coverage.

III. FINDINGS

The committee, in order better to organize its examination of the issues of its study, divided the study topic into 4 subtopics: diversion, treatment in State facilities, treatment in county jails, and aftercare. Due to the sheer magnitude of the study topic and the need to make manageable its task given time constraints, the committee focused its examination on the treatment of adults with mental illness and did not attempt to examine the special issues associated with the treatment of juveniles.

The committee's principal finding is that community mental health services, though very good are, due to lack of resources, inadequate to meet the needs of persons with mental illness. This has resulted in persons with mental illness falling through the treatment services net and into the criminal justice system. The lack of community mental health resources also impairs the ability of law enforcement, courts and corrections facilities to divert persons with mental illness away from the criminal justice system and into more appropriate treatment settings.[44]

The committee made the following particular findings in each of the 4 sub-topic areas.

Findings on diversion

1. County jails are not well designed to provide treatment to persons with mental illness; consequently, there is a need to divert persons who need treatment into more appropriate care settings;
2. There needs to be as much collaboration, communication and training as possible among the various criminal justice agencies and mental health service providers to ensure that people throughout the system are sensitized to and understand the criminal justice and mental health aspects of treating and handling persons with mental illness who have been arrested or sentenced;
3. Resource limitations are a significant obstacle to adequately addressing needs of persons with mental illness in the corrections system;

[44] In commenting on a draft of this report, the Department of Behavioral and Developmental Services noted more generally that the current system and practices of service provision to criminal justice populations, which are the result of cultural norms, mores, state law, policies, historical funding and program development, together with limited community mental health resources have made it difficult to provide effective mental health care within the criminal justice system and to divert persons with mental illness into more appropriate treatment settings.

4. Available funding should be targeted to meet specific goals. The appropriate outcome for a diversion program should be a reduced population of people with mental illness in jails and prisons.
5. Currently the Maine Criminal Justice Academy trains police officers in understanding issues related to mental illness. There is also training available for corrections staff. Such training should be expanded to ensure all segments of the criminal justice system have a basic understanding of mental illness issues.
6. The criminal justice system needs to be designed to ensure that people with mental illness are not taken to jail for non-violent offenses due to lack of other viable options and merely out of concern for their well being. These individuals should have access to a community system of care.
7. Franklin County's collaborative effort in diverting persons with mental illness away from incarceration to more appropriate settings is an effort that bears further examination at the local level for possible replication in other counties. The committee notes, however, that each county has different needs and different resources and that no one model is likely to fit every jail.

Findings on treatment of inmates in State facilities

The committee notes the following as current strengths of the Maine Department of Corrections (DOC) in meeting the needs of persons with mental illness:[45]

- The change to unit management approach under which unit clinicians and guards are assigned to the unit and work as a treatment team;
- The increase in mental health training of staff;
- DOC's collaborative efforts with a diversity of providers and advocacy groups including its own Office of Advocacy, the Department of Behavioral and Developmental Services, NAMI Maine, the Disability Rights Center and the Maine Civil Liberties Union;
- The introduction and expansion of telemedicine capacity at DOC facilities, including links to Maine Medical Center and AMHI which increases access to psychiatric services and expertise;
- The physical plant of the new Maine State Prison in Warren, which is well designed for handling, treating and caring for persons with mental illness;
- New women's unit at the Maine Correctional Center in Windham that will utilize a treatment approach to handling women with mental illness and substance abuse problems; and
- The existence of the Clinical Director of Behavioral Health position, which demonstrates a commitment by DOC to addressing mental health issues.

[45] The Department of Behavioral and Developmental Services noted, during its review of a draft of this report, the following as among its own strengths in meeting the needs of persons with mental illness who are incarcerated:

- The planned increase of 17 forensic beds at the new psychiatric treatment center;
- The assignment of full-time Intensive Case Managers in the larger county jail facilities;
- The police ride-along programs currently operating in 6 local police departments; and
- The current collaborative efforts with DOC with regard to restraint policies, shared information and use of formularies.

The committee finds the following:

1. There is a need for a mental health screening at intake that is it more comprehensive and that results in a carefully-developed individual case management plan;
2. DOC should be provided sufficient resources to meet national accreditation standards;
3. There is a need to improve the transition process for release to the community by improving discharge planning and linking clients to families (see aftercare);
4. There is a need to improve cross training between DOC and the mental health system;
5. There is a need to expand and ensure access to forensic hospital beds, especially for women, to handle transfers of persons with mental illness who require stabilization;
6. There is a need for greater information sharing between the Department of Behavioral and Developmental Services and DOC to ensure adequate client care and treatment; and
7. There is a need to improve inmate advocacy and the grievance process in order to ensure adequate response to treatment needs.

Findings on treatment of inmates in county jails

1. There are persons with mental illness who should be diverted away from jails to more appropriate facilities or community treatment programs;
2. There is a need for greater information sharing between the Department of Behavioral and Developmental Services and jails to ensure adequate client care and treatment;
3. There is a need for a more standardized assessment process in jails for assessing and addressing the needs of persons with mental illnesses;
4. There is a need to improve crisis response mechanisms and resources and provide or develop greater resources to meet needs in jails;
5. There is a need to increase access by county jails to beds in appropriate hospitals to manage crisis situations;
6. There is a need to improve state-county partnerships and link jails with state services; and
7. The law governing furlough should be clarified in order to allow furloughs for the purpose of providing treatment for mental illness.

Findings on aftercare of inmates released from county jails or state facilities

1. No one with mental illness should leave jail/prison without a plan for transitioning back into the community;
2. State Medicaid practices should be designed to facilitate an inmate's immediate recovery of Medicaid benefits upon release from jail or prison in order to avoid a gap in coverage that would hinder a person with mental illness receiving necessary treatment for the illness;
3. Planning for aftercare should begin at intake; there should be an assessment of mental illness/substance abuse issues at intake and the development of an individual plan that includes a plan for aftercare. Case management should involve caseworkers that follow the client so that relationships are maintained throughout the system; and
4. There is a need to ensure adequate housing and transportation opportunities for persons released from prison/jail.

Finally, the committee finds that there is a need for improved collaboration among jails, the Department of Corrections, the Department of Behavioral and Developmental Services and community based providers so that there is a seamless system throughout the state to meet the needs of persons with mental illness.

IV. RECOMMENDATIONS

The committee makes recommendations in all 4 of the topic areas (diversion, treatment in county jails, treatment in state facilities and aftercare). However, since some recommendations relate to both county jails and State correctional facilities and since aftercare planning must be handled by facilities pre-release, the recommendations have been organized under the following headings: Diversion; Treatment and Aftercare Planning in State Facilities; Treatment and Aftercare Planning in State and County Facilities; and Treatment and Aftercare Planning in County Facilities

As the previous findings make clear, in order to address the needs of persons with mental illness who are or who may become incarcerated, significant efforts will need to be made at many levels of the criminal justice system. The committee recognizes that addressing these needs is not a one-time event but will require on-going efforts, examinations and re-evaluations. The committee's recommendations are designed to advance measurably the process of addressing these needs, to offer concrete proposals for further Legislative debate and refinement, and to lay the groundwork for future efforts.

Diversion

The following recommendations relate to actions that may be taken to encourage, promote and cause the diversion, as appropriate, of persons with serious mental illness away from incarcerated settings into treatment settings. The committee is well aware that in order for diversion to be successful, adequate treatment outside of the incarcerated setting must be available. As noted earlier, the committee finds that community mental health services are currently inadequate to meet the needs of the mentally ill. The Plan Development Work Group for Community-Based Living, mentioned earlier in this report (see Section II, D, 10), may be developing proposals that will help solve this problem. The committee expects that as its recommendations make their way through the Legislative process more information will become available and decisions will need to be made as to the extent of resources that can and should be applied to address deficiencies in community mental health services. During the committee's discussions and also during the review of a draft of this report, questions were several times raised whether the Department of Behavioral and Developmental Services could within existing resources improve the services it provides to persons with mental illness within the criminal justice system, in particular those who are diverted from incarceration; it is a question that the Criminal Justice Committee expects to examine further as these recommendations make their way though the legislative process.

1. Law enforcement programs.

- The committee has not had the time or resources closely to evaluate whether police ride-along program currently operating in Portland, Biddeford, Augusta, Waterville, Lewiston and Bangor are the most effective use of resources; it believes that the program should be subject to further evaluation (see next bullet below). However, the committee has received anecdotal information suggesting that the program can assist law enforcement personnel in responding to the needs of persons with mental illness. Consequently, the committee recommends that the Legislature consider expanding the ride-along programs and proposes for further legislative discussion the funding of 2 new Intensive Case Managers (ICMs) to provide ride-along services. Under current formulas, 77.8% of the costs of these ICMs would be eligible for Medicaid reimbursement at the reimbursement rate of $66.465%; thus, more than half of the costs would receive federal Medicaid reimbursement. Proposed legislation implementing this recommendation may be found in Appendix C.
- The committee recommends that the Department of Behavioral and Developmental Services be directed to examine the efficiency and effectiveness of the current ride-along program to determine whether this program is the best use of resources and to attempt to quantify the results of the programs. The examination should identify the goals of the program and whether the program is meeting those goals. The committee recommends that the department be directed to report back to the Joint Standing Committee on Criminal Justice by January 30, 2003 the results of its examination. Proposed legislation implementing this recommendation may be found in Appendix C.
- The committee understands that the Criminal Justice Academy has begun to develop a training program to train Crisis Intervention Team (CIT) officers, including training in psychiatric diagnosis, substance abuse issues, de-escalation techniques, empathy training and legal training in the areas of mental health and substance abuse. The committee commends the Academy for undertaking this project recommends that program go forward. The CIT model was developed in Memphis, Tennessee and is briefly described earlier in this report (see Section II, B). The Portland Police Department has already undertaken a pilot CIT program, which is briefly described in Section II, D, 6 of this report.

2. Local collaboration. The committee recommends that the Maine Jail Association examine the success of Franklin County's collaborative model (described in Section II, D, 11) to see if it can be replicated in other areas of the State.[46] The committee believes that county-based approach to diversion is desirable as it allows for local control in the meeting of local needs. The committee notes that each county has different needs and different resources and that no one model is likely to fit every jail.

3. Diversion in the courts.

[46] In its comments on the draft of this report, the Maine Jail Association expressed some concern about its capacity to do this. See Appendix I.

- The committee recommends that case managers be established within the trial court system to work with prosecutors, defense attorneys, bail commissioners and others to develop treatment plans and sentencing options for persons with mental illness. For this purpose, the committee recommends that Intensive Case Manager (ICM) positions, together with supporting staff positions, be established by the Department of Behavioral and Developmental Services within each of the 8 prosecutorial districts. Under current formulas, 77.8% of the costs of these ICMs would be eligible for Medicaid reimbursement at the reimbursement rate of $66.465%; thus, more than half of the costs would receive federal Medicaid reimbursement. Proposed legislation implementing this recommendation may be found in Appendix C.
- The committee discussed the idea of developing mental health courts based on the model described earlier in this report (see Section II, B). Legislation proposing to authorize the creation of such courts is currently before the Joint Standing Committee on Judiciary (LD 202) and this committee reviewed that legislation. However, the committee was not able to reach consensus on whether mental health courts should be created. The committee believes the legislation before Judiciary deserves further discussion and evaluation.

4. Training - criminal justice system. As described earlier in this report (see Section II, D, 6) mental illness awareness training is being provided by the Criminal Justice Academy to police officers and by NAMI to staff within DOC facilities. The committee believes that such training is vital to ensuing the needs of persons with mental illness who come into contact with the criminal justice system are met. The committee believes that such training should be expanded to encompass the judiciary, jail staff and others within the criminal justice system. Therefore the committee recommends that the Department of Behavioral and Developmental Services be directed to develop programs to provide mental illness awareness training to judges, jail staff and to others within the criminal justice system who do not currently receive such training. Proposed legislation implementing this recommendation may be found in Appendix C.

5. State mental health and corrections coordination - criminal justice liaison. The committee recommends the creation of a position within the Department of Behavioral and Developmental Services to serve as criminal justice liaison to consult with county jails and the Department of Corrections on diversion issues, to improve coordination and communication between mental health service providers and the corrections system, and generally to span boundaries and bridge gaps in order to create a more seamless system to meet the needs of persons with mental illness who are incarcerated. Proposed legislation implementing this recommendation may be found in Appendix C.

Treatment and Aftercare Planning in State Facilities

The following recommendations relate to actions that may be taken to improve the identification and treatment of persons with serious mental illness who are in the custody of the Department of Corrections (DOC).

1. Improve mental health screening. The committee recommends that a position be created at each DOC intake facility (Maine State Prison and Maine Correctional Center) to undertake mental health screening and to collect relevant mental health information upon intake. These should be psychologist-level positions. Currently such screening consists of a brief self-report by inmates. The addition of these positions will allow for a comprehensive interview process that will then guide case management and treatment services. Intake screening should also be coordinated with aftercare planning (see aftercare recommendation, below). Proposed legislation implementing this recommendation may be found in Appendix C.

2. Meet accreditation requirements. The committee recommends that funding be provided to DOC for 1 psychiatrist and 1 psychiatric nurse to provide mental health treatment services to inmates in the State facilities. Currently the DOC has only one psychiatrist on staff. Current law directs that the DOC meet ACA accreditation standards by 2005. The addition of these positions will provide greater treatment resources to meet the needs of persons with mental illness who are incarcerated and will allow the DOC to satisfy ACA accreditation standards. Proposed legislation implementing this recommendation may be found in Appendix C.

3. Improve cross training. The committee recommends that the DOC develop a training program to provide specialized forensic training to case management and community support providers and crisis and outpatient providers. This training will help ensure that mental health service providers understand the forensic issues associated with the treatment of persons with mental illness who are incarcerated. This training is the necessary counterpart to the training that has occurred and that the committee recommends be expanded within the criminal justice system with regard to understanding mental health issues; cross training helps to span the boundaries and bridge the gaps in order to create a more seamless system to meet the needs of persons with mental illness. Proposed legislation implementing this recommendation may be found in Appendix C.

4. Ensure appropriate use of medications. The committee recommends that the DOC work with the Department of Behavioral and Developmental Services to ensure its formulary includes the best medications for the treatment of inmates with mental illness and adopt policies to ensure that the most effective such medications are available and used and that clinical care needs, not cost, govern the use of medications. The committee recommends the DOC be directed to report to the joint standing committee of the

Legislature having jurisdiction over criminal justice matters no later than January 30, 2003 on its review of its formulary. Proposed legislation implementing this recommendation may be found in Appendix C.

5. Aftercare planning in DOC facilities. The committee recommends that a person in each DOC facility be designated to make initial contacts with family and community services for persons with mental illness prior to their release from DOC facilities. Aftercare planning should begin well before release and include a process for ensuring clients' applications for SSDI, SSI, Medicaid and Medicare are filed in a timely fashion. This should also be integrated with the improved screening process recommended above.

During the committee's discussions about aftercare planning it was noted that involvement of community service providers in the process well before release (in order to help prepare the inmate for the transition back to the community) is desirable; the committee did not have an opportunity to evaluate whether additional resources might be necessary to allow this; further consideration of this matter is left to the Criminal Justice Committee in its processing of the legislation implementing this recommendation.

Proposed legislation implementing this recommendation may be found in Appendix C.

6. Separate grievance process. The committee did not have a chance to discuss at any length a proposal by NAMI Maine (see Appendix G) that the DOC, in consultation with the Department of Behavioral and Developmental Services, develop a grievance process, separate from other grievance processes, for addressing complaints by persons with mental illness about their treatment. Some members of the committee, during the review of a draft of this report, expressed support for including this as a recommendation. The chairs of the committee determined that it should be included as a recommendation in order to encourage further discussion of the issue by the Criminal Justice Committee and the Legislature. Proposed legislation implementing this recommendation may be found in Appendix C.

Treatment and Aftercare Planning in State and County Facilities

The following recommendations relate to actions that may be taken to improve the identification and treatment of persons with serious mental illness who are in the custody of the Department of Corrections (DOC) or county correctional facilities.

1. Preserving Federal benefits

- The committee recommends that the Department of Human Services establish procedures to ensure that a person receiving federally approved Medicaid services prior to incarceration does not lose Medicaid eligibility merely as a result of that incarceration, notwithstanding that Medicaid coverage may be limited or suspended during the period of incarceration. Doing this will help ensure that a person does not experience a gap in coverage after release from incarceration while an application for

re-instatement of coverage is processed. Such coverage can mean the difference between a receiving and not receiving needed mental illness treatment. Proposed legislation implementing this recommendation may be found in Appendix C.

- The committee encourages jails to enter pre-release agreements with the local Social Security offices under which jail staff can acquire training on SSI rules in return for the jail's notification of the Social Security Administration of the release of inmates likely to meet SSI eligibility. The committee understands that a number of jails already have entered such agreements; the committee encourages all jails to take advantage of such agreements.

2. Ensure access to forensic beds. The committee recommends that the Department of Behavioral and Developmental Services be directed to work with the DOC and the county jail administrators to develop memoranda of agreement to improve access to forensic beds for transfers of inmates who require care in a State mental health institution. Proposed legislation implementing this recommendation may be found in Appendix C.

3. Treatment plans – inmates returned from hospitalization. The committee recommends that the Department of Behavioral and Developmental Services be directed to develop, in consultation with appropriate state and county correctional facility administrators, procedures to ensure that any inmate of a state or county facility that is hospitalized for treatment of mental illness has a written treatment plan describing the mental health treatment to be provided when the inmate is returned to the correctional facility for the remainder of the inmate's incarceration.[47] Proposed legislation implementing this recommendation may be found in Appendix C.

4. Improve access to information.

- Currently the Department of Behavioral and Developmental Services can share mental health records of an inmate with a jail administrator or the DOC only if the client or client's legal guardian provides written consent or if necessary to carry out hospitalization of the inmate.[48] The committee has examined the current law and believes the Legislature should consider amending the law to allow the Department of Behavioral and Developmental Services to share medical records with the DOC or county jail without the client's consent in cases in which the client suffers an acute deterioration such that the client cannot provide consent.[49] However, a number of committee members have concerns about altering the current law's protections of inmate medical records; the committee includes this recommendation for the purposes of allowing further legislative debate. The Department of Behavioral and Developmental Services has noted that even if this law is amended, there may be other

[47] The Department of Behavioral and Developmental Services and the Maine Jail Association, in reviewing a draft of this report, expressed concerns about this proposal. The Department of Behavioral and Developmental Services suggested that instead of requiring that persons be returned from the hospital with a treatment plan that they be returned to the correctional facility with a written recommendation for follow-up care.

[48] See 34-B MRSA §1207.

[49] The Maine Jail Association has suggested expanding this exception even further. See Appendix I.

limitations on the ability of the department to share information acquired from outside sources. Proposed legislation implementing this recommendation may be found in Appendix C.

- The committee recommends that, in order to facilitate the sharing of information between the Department of Behavioral and Developmental Services and the DOC, the DOC should work with the Department of Behavioral and Developmental Services to develop a procedure by which DOC provides to the Department of Behavioral and Developmental Services a list of inmates and the Department of Behavioral and Developmental Services then contacts those that it knows to have a history of mental illness. In this way, the Department of Behavioral and Developmental Services could seek the inmate's consent to the release of mental health information to care providers in the facility. (It is recognized that, even with such procedures, only persons whose mental health histories are known to the Department of Behavioral and Developmental Services will be identified.)

5. Address security/treatment tension. The committee recommends that the DOC and the Maine Jail Association be directed to examine and develop ways of treating inmates with mental illness in the least restrictive setting possible that does not compromise security. The committee recommends that the department and Maine Jail Association report the results of this examination and any actions taken together with any recommendations to the joint standing committee of the Legislature having jurisdiction over criminal justice matters no later than January 30, 2003. Proposed legislation implementing this recommendation may be found in Appendix C.

6. Ensure effective advocacy for mental health needs. As described earlier in this report (Section II, D, 10), there are currently 2 offices of advocacy with authority to advocate on behalf of persons with mental illness who are incarcerated: the DOC Office of Advocacy and the Department of Behavioral and Developmental Services Office of Advocacy. However, these offices have limited resources to devote to advocacy for the mentally ill within the corrections system. Nevertheless, the committee recommends that, to the extent resources permit, these offices should make every effort to advocate diligently for those with mental illness who are incarcerated. The committee also believes that an independent advocacy office specifically charged to advocate for persons with mental illness who are incarcerated would complement the current departmental advocacy offices and bring a needed focus to the needs of the mentally ill in the state and county correctional facilities. The committee therefore recommends the creation of an independent Ombudsman for Mentally Ill Inmates.[50] Proposed legislation implementing this recommendation may be found in Appendix C.

[50] In its review of a draft of this report, the Maine Jail Association expressed opposition to the creation of an Ombudsman. See Appendix I.

Treatment and Aftercare Planning in County Facilities

The following recommendations relate to actions that may be taken to improve the identification and treatment of persons with serious mental illness who are in the custody of the county correctional facilities. While each county facility is different and has its own unique circumstances and resources, every jail has inmates with mental illness whose needs must be addressed; the following recommendations are designed to assist jails in addressing those needs and to provide State resources for this purpose.

1. Provide more options for county jails – the furlough law. The committee recommends that the law governing furloughs from county jails be amended to make it clear that furloughs for longer than 3 days may be granted to provide treatment for mental conditions, including a substance abuse condition, as determined by a qualified medical professional. Currently the law allows such furloughs when "medically required", which may be interpreted not to encompass treatment for mental conditions. Clarifying the law will provide more options for county facilities to use in meeting the needs of persons with mental illness.[51] Proposed legislation implementing this recommendation may be found in Appendix C.

2. Pilot program to address the needs of persons with mental illness in county jails. The committee recommends the creation of a pilot program to address the needs of persons with mental illness who are incarcerated in country correctional facilities. The pilot program should include at least four critical components: intake screening, a process to determine the appropriate mental health care, case management/treatment, and aftercare. The purpose of piloting the program is to test its ability to meet the needs of persons with mental illness and to determine whether or not the recourses provided under the program are adequate to meet the needs. The committee recommends the creation of 3 pilot locations, one in each of the three Department of Behavioral and Developmental Services (BDS) service regions and coordinated with the existing Mental Health Clinics located in Bangor, Augusta and Portland. At least one of the 3 pilot locations should be a jail in a rural area of the State. The pilot program should include the following:

- *Intake*: Each pilot location should be provided with a trained in-house mental health "crisis" worker contracted by the Department of Behavioral and Developmental Services and stationed fulltime within the county jail. These workers should provide screening and, together with mental health caseworkers and contracted professional psychiatric services discussed below, case management, treatment and aftercare planning services within the jails. The Department of Behavioral and Developmental Services should provide ongoing clinical supervision for these crisis workers.
- *Triage*: The program should involve a triage system to ensure that inmates identified with mental illness are given appropriate care. Professional psychiatric services must

[51] In its review of a draft of this report, the Maine Jail Association suggested that changing the furlough law may not be productive. See Appendix I.

be made available to the pilot locations to ensure that appropriate care is identified and provided. To ensure at least a minimal level of such services (20 hours per week) to each pilot location, the pilot program should include funding for at least 1.5 FTE psychiatrists.

- *Case Management/Short Term Treatment***:** Each pilot location should also have an internal capacity to provide professional counseling, testing, referral and other ongoing mental health care while inmates are within the jail system. Consequently, each pilot location should be provided with a masters-level mental health clinician and/or a licensed psychologist under the clinical supervision of the Department of Behavioral and Developmental Services. This will enable the jail to provide stabilization services, sound mental health care/short term treatment, and develop appropriate discharge planning options. The position would also have the primary responsibility for identifying discharge planning needs and connecting the inmate with the existing community case management system. Discharge planning should include helping to arrange for basic needs (food, clothing, shelter) after release and ensuring that an inmate's applications for SSDI, SSI, Medicare and Medicaid are filed well before release.
- *Discharge***:** Under the pilot program, inmates with mental health needs should be quickly connected to community systems of care and follow-up/ongoing services should be monitored. While it will be the responsibility of the county jail mental health professional to develop initial discharge plans, the community system must provide for the inmate's ongoing community care. Therefore the pilot program should include funding for a full-time community support worker (Intensive Case Manager) to address the needs of persons with mental illness discharged from each pilot site. During the committee's discussions about aftercare planning it was noted that the involvement of community service providers well before an inmate's release (in order to help prepare the inmate for the transition back to the community) is desirable; the committee did not have an opportunity to evaluate whether additional resources might be necessary to allow this; further consideration of this matter is left to the Criminal Justice Committee in its processing of the legislation implementing this recommendation.

Proposed legislation implementing this recommendation may be found in Appendix C.

3. Mental health staff coverage. The committee did not discuss a proposal by NAMI Maine (see Appendix G) that the Department of Behavioral and Developmental Services be directed to provide mental health staffing resources to county correctional facilities so that each county facility has at least 16 hours of facility-based mental health coverage each day. NAMI proposed that the facility-based staff be trained and qualified to address mental health and substance abuse issues and be familiar with inmate cultures and the criminal justice system. Some members of the committee, during the review of the draft of this report, expressed support for including it as a recommendation. The chairs of the committee determined that it should be included as a recommendation in order to encourage further discussion of the issue by the Criminal Justice Committee and the

Legislature. Proposed legislation implementing this recommendation may be found in Appendix C.

APPENDIX A

Authorizing Joint Order

HP1383

STATE OF MAINE

In House June 20, 2001

WHEREAS, the joint study order establishes the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated; and

WHEREAS, persons with mental illness who are incarcerated in the county jails and state prisons need proper care and treatment that is safe and humane; and

WHEREAS, corrections officers and others in the jails and prisons who are responsible for persons with mental illness who are in their custody require proper training to care for these inmates; and

WHEREAS, the current corrections system does not provide adequate care for incarcerated persons with mental illness, nor does it provide those responsible for the care with the tools and training necessary to provide care; and

WHEREAS, the Legislature would benefit from a study of the needs of persons with mental illness who are incarcerated in Maine; now, therefore, be it

ORDERED, the Senate concurring, that the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated is established as follows.

1. Committee established. The Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated, referred to in this order as the "committee," is established.

2. Committee membership. The committee consists of the 13 members of the Joint Standing Committee on Criminal Justice.

3. Chairs. The Senate chair and the House chair of the Joint Standing Committee on Criminal Justice shall serve as the chairs of the committee.

4. Meetings; public hearings. The chairs of the committee shall call and convene the first meeting of the committee no later than 45 days after passage of this order. The committee may hold up to 6 meetings, 3 of which may be public hearings held in locations throughout the State.

5. Duties. The committee shall invite the participation of experts and interested parties, gather information and request necessary data from public and private entities in order to:

A. Evaluate the availability and appropriateness of current mental health services for persons incarcerated in Department of Corrections facilities and in county jails, including but not limited to: access to forensic beds for prisoners in need of that level of mental health intervention; the provision of mental health services within the institutions provided by or in partnership with the Department of Mental Health, Mental Retardation and Substance Abuse Services; and involuntary medication of prisoners with mental illness;

B. Identify what additional mental health services are needed for incarcerated persons and how those services may best be implemented, provided and funded;

C. Identify what mental health training is required for law enforcement and corrections officers who work in corrections facilities and jails and how that training may best be implemented, provided and funded; and

D. Identify steps necessary for county jails to seek and achieve accreditation.

The experts and interested parties with whom the committee may consult include but are not limited to the following: representatives from the Department of Corrections and the Department of Mental Health, Mental Retardation and Substance Abuse Services; representatives from state, county and municipal law enforcement; persons with mental illness who were formerly incarcerated in a Department of Corrections facility or a county jail; parents or guardians of persons with mental illness who are or were formerly incarcerated in a Department of Corrections facility or a county jail; representatives from advocacy groups for persons with mental illness; and representatives from community mental health agencies. The committee also may consult with other interested parties who may provide additional information.

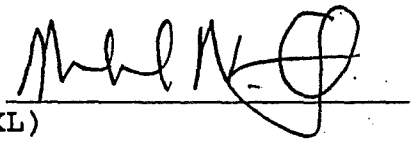
6. Staff assistance. Upon approval of the Legislative Council, the Office of Policy and Legal Analysis shall provide necessary staffing services to the committee.

7. Compensation. The members of the committee are entitled to the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for necessary

expenses incurred for their attendance at authorized meetings of the committee.

8. Report. The committee shall submit its report, together with any necessary implementing legislation, to the Legislature no later than December 5, 2001. If the committee requires a limited extension of time to conclude its work, it may apply to the Legislative Council, which may grant the extension.

9. Budget. The chairs of the committee, with assistance from the committee staff, shall administer the committee's budget. Within 10 days after its first meeting, the committee shall present a work plan and proposed budget to the Legislative Council for approval. The committee may not incur expenses that would result in the committee's exceeding its approved budget. Upon request from the committee, the Executive Director of the Legislative Council shall promptly provide the committee chairs and staff with a status report on the committee's budget, expenditures incurred and paid and available funds.

SPONSORED BY: 
(Speaker SAXL)

TOWN: Portland

HP 1383

HOUSE OF REPRESENTATIVES

June 20,2001

READ AND PASSED.

SENT FOR CONCURRENCE ORDERED SENT FORTHWITH.

Millicent M. MacFarland

CLERK

IN THE SENATE CHAMBER

June 21,2001

READ AND PASSED IN CONCURRENCE

Joy J O'Brien

SECRETARY OF THE SENATE

APPENDIX B

Membership list,
Committee to Study the Needs of Persons With Mental Illness Who Are Incarcerated

COMMITTEE TO STUDY THE NEEDS OF PERSONS WITH MENTAL ILLNESS WHO ARE INCARCERATED

Joint Order, H.P. 1383

As Of Wednesday, December 26, 2001

Sen. Michael J. McAlevey Chair
P.O. Box 340
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Sen. Paul T. Davis, Sr.
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Rep. James H. Tobin, Jr.
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(207)-924-5521

Rep. Edgar Wheeler
P.O. Box 207
Bridgewater, ME 04735
(207)-429-9108

APPENDIX C
Proposed legislation (4 draft bills)

Drafter: JC
LR: 3344(1)
Doc. Name: G:\OPLALHS\LHSSTUD\Mental Illness\report -legislation-save.doc(11/29/01 4:29 PM)
Date: Wednesday, December 19, 2001

DRAFT LEGISLATION ON DIVERSION
Submitted by
Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated pursuant to Jt Order HP 1383, Sec. 8

An ACT to Implement the Recommendations of the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated Relating to Diversion from Jails and Prisons

PART A

law enforcement programs

Sec. A-1. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
BEHAVIORAL AND DEVELOPMENTAL SERVICES, DEPARTMENT OF	
Mental Health Services - Community	
Positions – Legislative Count	(2.000)
Personal Services	$ 87,820
Provides funds for 2 Intensive Case Manager positions to ride with police officers to help in dealing with crisis situations involving persons with mental illness. This request will generate $35,082 in General Fund revenue in fiscal year 2002-03.	
TOTAL	$ 87,820

	2002-03
Regional Operations	

All Other	$ 20,000
Provides funds for the overhead costs for 2 Intensive Case Manager positions to ride with police officers to help in dealing with crisis situations involving persons with mental illness.	
TOTAL	$ 20,000

Sec. A-2. Examination of ride-along programs. The Department of Behavioral and Developmental Services shall examine the efficiency and effectiveness of its so-called ride-along program in which specially trained Intensive Case Managers ride along with police officers to assist in dealing with crisis situations involving persons with mental illness. The Department of Behavioral and Developmental Services shall attempt to quantify the results of the program and determine whether the expenditures on this program are the most effective use of resources in addressing the needs of persons with mental illness in their interaction with law enforcement. The examination must clearly identify the goals of the program and assess whether the program is meeting those goals. The department shall report the results of its examination together with any recommendations to the joint standing committee of the Legislature having jurisdiction over criminal justice matters no later than January 30, 2003.

PART B

division in the courts

Sec. B-1. 34-B MRSA §1219, sub-§3 is enacted to read:

3. Court-based diversion program. The department shall develop a program to facilitate the diversion of persons with mental illness away from incarceration. The department shall designate at least 1 liaison to the District Courts within each of the prosecutorial districts established under title 30-A, section 254 to work with district attorneys, defense attorney, judges, bail commissioners and others to help develop and design plans for meeting the needs of persons with mental illness and diverting them away from incarceration.

By January 30th of each year, beginning in 2003, the department shall report to the joint standing committee of the Legislature having jurisdiction over criminal justice matters on its implementation of the diversion program developed pursuant to this subsection.

Sec. B-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
BEHAVIORAL AND DEVELOPMENTAL SERVICES, DEPARTMENT OF	
Mental Health Services - Community	
Positions – Legislative Count	(16.000)
Personal Services	$606,493
Provides funds for 8 Intensive Case Manager positions and 8 Clerk III positions to aid District Courts in diverting persons with mental illness away from incarceration and to appropriate mental health services. This request will generate $242,282 in General Fund revenue in fiscal year 2002-03.	
TOTAL	$606,493

	2002-03
Regional Operations	
All Other	$160,000
Provides funds for the overhead costs for 8 Intensive Case Manager positions and 8 Clerk III positions to aid District Courts in diverting persons with mental illness away from incarceration and to appropriate mental health services.	
TOTAL	$160,000

Sec. B-3. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
BEHAVIORAL AND DEVELOPMENTAL	

SERVICES, DEPARTMENT OF

Mental Health Services - Community

All Other $1,262,563

Provides funds for community mental services for diverted individuals.

Mental Health Services – Community Medicaid

All Other $1,495,999

Provides funds for community mental services for diverted individuals.

Mental Health Services - Community

All Other $ 453,721

Provides funds for psychiatric inpatient treatment for diverted individuals.

Mental Health Services – Community Medicaid

All Other $ 537,610

Provides funds for psychiatric inpatient treatment for diverted individuals.

DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES TOTAL APPROPRIATION $3,749,893

Sec. B-4. Allocation. The following funds are allocated from Federal Expenditures Fund to carry out the purposes of this Part.

2002-03

BEHAVIORAL AND DEVELOPMENTAL SERVICES, DEPARTMENT OF

Mental Health Services – Community Medicaid

All Other	$2,980,360
Allocates federal matching funds for community mental services for diverted individuals.	

Mental Health Services – Community Medicaid

All Other	$1,071,037
Allocates federal matching funds for psychiatric inpatient treatment for diverted individuals.	

DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES TOTAL ALLOCATION	$4,051,397

PART C

training – criminal justice system

Sec. C-1. Mental illness training for judiciary, jails staff and others. The Department of Behavioral and Developmental Services shall establish a research-based training program designed to increase awareness of the needs of persons with mental illness within the criminal justice system. The training shall be made available to trial judges, jail staff and others within the criminal justice system who don't currently receive such training. The department shall, no later than January 30, 2003, provide a report to the joint standing committee of the Legislature having jurisdiction over criminal justice matters on the development and implementation of the training program.

Sec. C-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
BEHAVIORAL AND DEVELOPMENTAL SERVICES, DEPARTMENT OF	
Mental Health Services - Community	
All Other	$50,000

Provides funds to establish training programs regarding mental illness awareness and understanding within the criminal justice system	
TOTAL	$50,000

PART D

State mental health and corrections coordination – criminal justice liaison

Sec. D-1. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
BEHAVIORAL AND DEVELOPMENTAL SERVICES, DEPARTMENT OF	
Mental Health Services - Community	
Positions – Legislative Count	(1.000)
Personal Services	$43,910
All Other	10,000
Provides funds for 1 Intensive Case Manager position to serve as a criminal justice liaison to consult with jails and the Department of Corrections on issues relating to the diversion of persons with mental illness away from an incarcerated setting. This request will generate $17,452 in General Fund revenue in fiscal year 2002-03.	
TOTAL	$53,910

SUMMARY

This bill implements the recommendations of the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated relating to diversion from prisons and jails.

Drafter: JC
LR: 3368(1)
Doc. Name: G:\OPLALHS\LHSSTUD\Mental Illness\report -legislation.prisons-jails.doc(12/17/01 10:59 AM)
Date: Wednesday, December 19, 2001

DRAFT LEGISLATION ON
TREATMENT IN STATE AND COUNTY FACILITIES
Submitted by
Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated pursuant to Jt Order HP 1383, Sec. 8

An ACT to Implement the Recommendations of the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated Relating to Treatment and Aftercare Planning in Prisons and Jails

PART A

preserving federal benefits

Sec. A-1. 22 MRSA § 3174-Z is enacted to read:

§3174-Z. Medicaid eligibility during incarceration.

The department shall establish procedures to ensure that a person receiving federally approved Medicaid services prior to incarceration does not lose Medicaid eligibility merely as a result of that incarceration, notwithstanding that Medicaid coverage may be limited or suspended during the period of incarceration. Nothing in this section requires or permits the department to maintain an incarcerated person's Medicaid eligibility if the person no longer meets eligibility requirements or refuses coverage.

PART B

ensure access to forensic beds

Sec. B-1. The Commissioner of the Department of Behavioral and Developmental Services shall develop memoranda of agreement with the Department of Corrections and county jail administrators to establish procedures and policies that improve access to inpatient beds at a State mental health institution for people with mental illness transferred from the Department of Corrections or county jails.

PART C

treatment plans – inmates returned from hospitalization

Sec. C-1. 34-A MRSA §3069, sub-§3 is enacted to read:

3. Re-incarceration planning. For each person hospitalized pursuant to this section, the Department of Behavioral and Developmental Services shall, in consultation with the chief administrative officer of the correctional or detention facility and before the person is transferred back to the correctional or detention facility, develop a written treatment plan describing the treatment to be provided to the person during the remainder of the person's incarceration.

Sec.C-2. 15 MRSA §2211-A, sub-§10 is enacted to read:

10. Re-incarceration planning. For each person hospitalized pursuant to this section, the Department of Behavioral and Developmental Services shall, in consultation with the sheriff or other person responsible for the local or county correctional facility and before the person is transferred back to the correctional facility, develop a written treatment plan describing the treatment to be provided to the person during the remainder of the person's incarceration.

PART D

improve access to information

Sec. D-1. 34-B MRSA §1207, sub-§1, ¶¶B-3 and B-4 are enacted to read:

B-3. Information may be disclosed to the Department of Corrections if the client is in the custody of the Department of Corrections, the client is suffering an acute mental deterioration such that the client is not capable of granting informed written consent, and the information is necessary in order for the Department of Corrections to carry out its statutory functions;

B-4. Information may be disclosed to a Sheriff responsible for a county detention facility if the client is in the custody of that facility, the client is suffering an acute mental deterioration such that the client is not capable of granting informed written consent, and the information is necessary in order for the facility to carry out its statutory functions;

PART E

address security/treatment tension

Sec. E-1. Examination of treatment of mentally ill persons incarcerated in prison. The Department of Corrections and the Maine Jail Association shall examine

and develop ways of treating persons with mental illness who are incarcerated in the least restrictive setting possible that does not compromise security. The department and Maine Jail Association shall report the results of this examination and any actions taken together with any recommendations to the joint standing committee of the Legislature having jurisdiction over criminal justice matters no later than January 30, 2003.

PART F

ensure effective advocacy for mental health needs

Sec. F-1. 34-B MRSA Ch. 16 is enacted to read:

Chapter 16
Ombudsman for Mentally Ill Inmates

§17001. Ombudsman program

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

A. "Ombudsman" means the director of the program and persons employed or volunteering to perform the work of the program.

B. "Program" means the ombudsman program established under this section.

2. Program established. The ombudsman program is established as an independent program within the Executive Department to provide ombudsman services to persons with mental illness who are in the custody of the Department of Corrections or a county correctional facility. The program shall consider and promote the best interests of persons with mental illness who are incarcerated, answer inquiries and investigate, advise and work toward resolution of complaints of infringement of the rights or interests of persons with mental illness who are incarcerated. The program must be staffed, under contract, by an attorney or a master's level social worker who must have experience in advocacy for persons with mental illness, and support staff as determined to be necessary. The program shall function through the staff of the program and volunteers recruited and trained to assist in the duties of the program.

3. Contracted services. The program shall operate by contract with a nonprofit organization that the Executive Department determines to be free of potential conflict of interest and best able to provide the services on a statewide basis. The ombudsman may not be actively involved in state-level political party activities or publicly endorse, solicit funds for or make contributions to political parties on the state level or candidates for statewide elective office. The ombudsman may not be a candidate for or hold any statewide elective or appointive public office.

4. Services. The program shall provide services directly or under contract and may set priorities for service among the types of inquiries and complaints. The program may:

A. Provide information to the public about the services of the program through a comprehensive outreach program. The ombudsman shall provide information through a toll-free telephone number or numbers;

B. Answer inquiries, investigate and work toward resolution of complaints regarding the performance and services of the Department of Corrections, the Department of Behavioral and Developmental Services, or any county correctional facility;

C. Participate in conferences, meetings and studies that may improve the performance and services of the Department of Corrections, the Department of Behavioral and Developmental Services, or any county correctional facility;

D. Provide services to persons with mental illness who are incarcerated to assist them in protecting their rights;

E. Inform persons of the means of obtaining services from the Department of Behavioral and Developmental Services, the Department of Corrections, the county correctional facility or other entity which may offer services;

F. Provide information and referral services;

G. Analyze and provide opinions and recommendations to agencies, the Governor and the Legislature on state programs, rules, policies and laws;

H. Determine what types of complaints and inquiries will be accepted for action by the program and adopt policies and procedures regarding communication with persons making inquiries or complaints and appropriate agencies and facility administrators and staff;

I. Apply for and utilize grants, gifts and funds for the purpose of performing the duties of the program; and

J. Collect and analyze records and data relevant to the duties and activities of the program and make reports as required by law or determined to be appropriate.

5. Access to persons, files and records. As necessary for the duties of the program, the ombudsman has access to the files and records of the Department of Corrections, the Department of Behavioral and Developmental Services and any county

correctional facility, without fee, and to the personnel of the departments and facilities for the purposes of investigation of an inquiry or complaint. The ombudsman may also enter the premises of any state or county correctional facility for the purposes of investigation of an inquiry or complaint without prior notice. The program shall maintain the confidentiality of all information or records obtained under this subsection.

6. Confidentiality of records. Information or records maintained by the program relating to a complaint or inquiry are confidential and may not be disclosed unless the disclosure is permitted by law and consented to by the ombudsman or ordered by court. Records maintained by the program are not public records as defined in Title 1, chapter 13.

7. Liability. Any person who in good faith submits a complaint or inquiry to the program pursuant to this section is immune from any civil or criminal liability for that act. For the purpose of any civil or criminal proceedings, there is a rebuttable presumption that any person acting pursuant to this section did so in good faith. The ombudsman and employees and volunteers in the program are employees of the State for the purposes of the Maine Tort Claims Act.

8. Penalties. A person who intentionally obstructs or hinders the lawful performance of the ombudsman's duties commits a Class E crime. A person who penalizes or imposes a restriction on a person who makes a complaint or inquiry to the ombudsman as a result of that complaint or inquiry commits a Class E crime. The Attorney General shall enforce this subsection under Title 5, section 191.

9. Information. Beginning January 1, 2003, information about the services of the program and any applicable grievance and appeal procedures must be provided to all inmates in the custody of the Department of Corrections or a county correctional facility.

10. Report. The program shall report to the Governor, the department and the Legislature before January 1st each year on the activities and services of the program, priorities among types of inquiries and complaints that may have been set by the program, waiting lists for services, the provision of outreach services and recommendations for changes in policy, rule or law to improve the provision of services.

11. Oversight. The joint standing committee of the Legislature having jurisdiction over criminal justice matters shall review the operations of the program and may make recommendations to the Governor regarding the contract for services under this section. The committee may submit legislation that it determines necessary to amend or repeal this section.

Sec. F-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
EXECUTIVE DEPARTMENT	
All Other	133,815
Provides funds to contract with a nonprofit organization to operate an ombudsman program. Funding is included for one Ombudsman position and one support staff position, operating costs and one-time start-up costs.	
TOTAL	$133,815

SUMMARY

This bill implements the recommendations of the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated relating treatment and aftercare planning in state prisons and county jails.

Drafter: JC
LR: 3367(1)
Doc. Name: G:\OPLALHS\LHSSTUD\Mental Illness\report -legislation.prisons.doc(12/17/01 10:58 AM)
Date: Wednesday, December 19, 2001

DRAFT LEGISLATION ON TREATMENT IN PRISONS
Submitted by
Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated pursuant to Jt Order HP 1383, Sec. 8

An ACT to Implement the Recommendations of the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated Relating to Treatment and Aftercare Planning in Prisons

PART A

improve mental health screening

Sec. A-1. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
CORRECTIONS, DEPARTMENT OF	
Maine State Prison	
Positions – Legislative Count	(1.000)
Personal Services	35,870
All Other	83,799
Provides funds for one records clerk and contracted psychologist services to undertake mental health screening at the Maine State Prison	
TOTAL	$119,669

Maine Correctional Center

Positions – Legislative Count	(1.000)
Personal Services	35,870
All Other	83,799

Provides funds for one records clerk and contracted psychologist services to undertake mental health screening at the Maine Correctional Center

TOTAL	$119,669

PART B

meet accreditation requirements

Sec. B-1. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
CORRECTIONS, DEPARTMENT OF	
Correctional Medical Services Fund	
All Other	275,000

Provides funding for added contracted psychiatric and nursing services to provide mental health services in the department's correctional facilities in order to ensure the department can meet national accreditation standards.

TOTAL	$275,000

PART C

improve cross training

Sec. C-1. Forensic training for mental health workers. The Department of Corrections shall establish a training program designed to provide specialized forensic training to case management and community support providers and crisis and outpatient providers of mental health services in order to increase awareness of the criminal justice issues associated with the treatment of persons with mental illness who are incarcerated. The department shall, no later than January 30, 2003, provide a report to the joint standing committee of the Legislature having jurisdiction over criminal justice matters on the development and implementation of the training program.

Sec. C-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
CORRECTIONS, DEPARTMENT OF	
Correctional Medical Services Fund	
All Other	10,000
Provides funding for specialized forensic training to case management and community support providers and crisis and outpatient providers	
TOTAL	$10,000

PART D

ensure appropriate use of medications

Sec. D-1. Use of medications to treat mentally ill inmates. The Department of Corrections shall, in consultation with the Department of Behavioral and Developmental Services, review its formulary to ensure that it includes the best medications for the treatment of inmates with mental illness and shall adopt policies to ensure that the most effective such medications are available and used and that clinical care needs, not cost, govern the use of medications. The department shall, no later than January 30, 2003, provide a report to the joint standing committee of the Legislature having jurisdiction over criminal justice matters of its actions pursuant to this section.

PART E

aftercare planning in DOC facilities

Sec. E-1. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
CORRECTIONS, DEPARTMENT OF	
Adult Community Corrections	
Positions – Legislative Count	(2.000)
Personal Services	94,925
All Other	22,860

Provides funding for 2 caseworkers to provide aftercare planning services for persons with mental illness to be released from state prison facilities	
TOTAL	$117,785

PART F

separate grievance process

Sec. F-1. 34-A MRSA §1402, sub-§5 is amended to read:

5. Grievance procedures. The commissioner shall establish procedures for hearing grievances of clients as described in section 1203. The commissioner, in consultation with the Department of Behavioral and Developmental Services, shall establish a separate grievance process for addressing complaints by clients with mental illness about their treatment, which must include a means by which a client may obtain a second opinion about mental health treatment from an independent mental health professional.

SUMMARY

This bill implements the recommendations of the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated relating to treatment and aftercare planning in state prisons.

Drafter: JC
LR: 3369(1)
Doc. Name: G:\OPLALHS\LHSSTUD\Mental Illness\report -legislation.jails.doc(12/17/01 11:00 AM)
Date: Wednesday, December 19, 2001

DRAFT LEGISLATION ON TREATMENT IN JAILS
Submitted by
Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated pursuant to Jt Order HP 1383, Sec. 8

An ACT to Implement the Recommendations of the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated Relating to Treatment and Aftercare Planning in Jails

PART A

provide more options for county jails-the furlough law

Sec. A-1. 30-A MRSA §1556, sub-§1 is amended to read:

1. Furlough authorized. The sheriff may establish rules for and permit a prisoner under the final sentence of a court a furlough from the county jail in which the prisoner is confined. Furlough may be granted for not more than 3 days at one time in order to permit the prisoner to visit a dying relative, to obtain medical services or for any other reason consistent with the rehabilitation of an inmate or prisoner which is consistent with the laws or rules of the sheriff's department. Furlough may be granted for a period longer than 3 days if ~~medically~~ required to provide treatment for a physical or mental condition of the prisoner, including a substance abuse condition, as determined by a qualified medical professional.

PART B

pilot program to address the needs of persons with mental illness in county jails

Sec. B-1. 34-B MRSA §1222 is enacted to read:

§1222. County jail mental illness treatment pilot program.

The department shall establish a county jail mental illness treatment pilot program, referred to in this section as the pilot program, to provide adequate mental health services to persons with mental illness in county correctional facilities. The pilot program must include a process to screen inmates for mental illness upon entry,

procedures to determine the appropriate mental health care and case management, treatment, and aftercare services.

The department shall chose at least 3 county correctional facilities to pilot the program, one in each of the three service delivery regions established under section 1201-A and shall coordinate the program with existing Mental Health Clinics. At least one of the 3 pilot locations must be a county correctional facility located in a rural portion of the State.

1. Program elements. Under the pilot program:

A. Each participating correctional facility must be provided with adequate mental health resources to undertake intake screening to identify persons with mental illness;

B. Each participating correctional facility must be provided with adequate mental health resources to ensure that inmates identified with mental illness are given appropriate treatment, including professional counseling, testing, referral and other ongoing mental health care;

C. Each participating correctional facility must be provided with adequate mental health resources to undertake discharge planning for inmates with mental illness, including identifying treatment needs, connecting the inmate with the community mental health system, helping to arrange for basic needs, and ensuring that an inmate's applications for any benefits such as Medicare or Medicaid for which the inmate may be eligible are filed in a timely manner prior to release; and

D. Adequate community mental health services must be provided to meet the mental health needs of inmates who are discharged to the community under the pilot program.

2. Report. By January 30th of each year, beginning in 2003, the department shall report to the joint standing committee of the Legislature having jurisdiction over criminal justice matters on its implementation of the pilot program developed pursuant to this subsection and recommendations for continuation of and changes to the program.

Sec. B-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

2002-03

BEHAVIORAL AND DEVELOPMENTAL SERVICES, DEPARTMENT OF

Mental Health Services - Community

Positions – Legislative Count	(7.500)
Personal Services	470,783
All Other	135,000

Provides funds for the county jail mental illness treatment pilot program to fund 3 caseworker positions, 1.5 psychiatrist positions, and 3 psychologist positions and to contract for 3 community support worker positions to provide mental health services to persons with mental illness in 3 county correctional facilities. This request will generate $188,068 in General Fund revenue in fiscal year 2002-03.

TOTAL	$605,783

2002-03

Regional Operations

All Other	$105,000

Provides funds for the overhead costs for 3 caseworker positions, 1.5 psychiatrist positions and 3 psychologist positions to provide mental health services to persons with mental illness in 3 county correctional facilities as part of the county jail mental illness treatment pilot program.

TOTAL	$105,000

PART C

mental health staff coverage

Sec. C-1. 34-B MRSA §1223 is enacted to read:

§1223. County jail mental illness staff coverage.

The department shall provide mental health staffing resources to county correctional facilities so that each county facility has at least 16 hours of facility-based

mental health coverage each day. The facility-based staff must be trained and qualified to address mental health and substance abuse issues and be familiar with inmate cultures and the criminal justice system.

Sec. C-2. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	2002-03
BEHAVIORAL AND DEVELOPMENTAL SERVICES, DEPARTMENT OF	
Mental Health Services – Community	
Positions – Legislative Count	(36.000)
Personal Services	$1,475,076
Provides funds for 36 MH & MR Caseworker positions to provide 16-hour/day mental health services to persons with mental illness in county correctional facilities. This request will generate $586,874 in General Fund revenue in fiscal year 2002-03.	
Regional Operations	
All Other	$ 360,000
Provides funds for the overhead costs for 36 MH & MR Caseworker positions to provide 16-hour/day mental health services to persons with mental illness in county correctional facilities.	
DEPARTMENT OF BEHAVIORAL AND DEVELOPMENTAL SERVICES TOTAL	$1,835,076

SUMMARY

This bill implements recommendations of the Committee to Study the Needs of Persons with Mental Illness Who Are Incarcerated relating to treatment and aftercare planning in county jails.

APPENDIX D

Overview of services provided by the Department of Behavioral and Developmental Services to persons with mental illness who are incarcerated (provided by BDS)

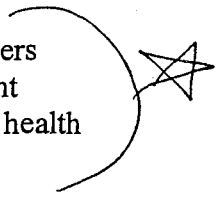
Department of Behavioral and Developmental Services

Overview of relationship with DOC; services that the Department of Behavioral and Developmental Services (BDS) can/does provide to incarcerated persons; roles BDS can play in the care and treatment of persons with mental illness who are incarcerated, who are on probation or who are returning to the community; update on the current forensic program.

Summary of Services Provided to Incarcerated Populations

Mental Health Services

- Department of Behavioral and Developmental Services has Intensive Case Managers (ICMs) in each regional office with a primary focus on providing case management services to clients in jails and correctional facilities. The ICMs coordinate mental health services in preparation for individual's release from correctional facilities.



- BDS contracts with community agencies to ensure the availability of crisis services statewide on a 24-hour a day basis. Crisis clinicians provide emergency assessments and consultation on appropriate level of care.

Adult Mental Health Special Initiatives

Region I

- A team of two Intensive Case Managers and their supervisor work as part of the "ICM Corrections Team" with the focus of providing case management services to Cumberland County and York County mental health consumers who are either currently incarcerated or who have been released from jails and correctional facilities in the Region.

- Region I contracts with mental health agencies in York and Cumberland counties to provide crisis services. Each of these crisis services has a staff member assigned to work with local police departments. This includes a liaison to the Portland and Biddeford police departments. These individuals "ride along" with police to provide crisis mental health services and linkages with mental health providers and hospitals.

- The Multi-Cultural Affairs Specialist for the Region works closely with local police departments in helping them understand cultural and refugee issues impacting mental health clients. This staff person also provides training to local sheriff and police departments about the mental health service system and how to access services for refugees.

- A contract with one of the primary outpatient counseling agencies in Cumberland County includes funding for a full-time clinician to work with mental health clients incarcerated at the Windham Correctional Center. This individual works as part of the WCC mental health team and receives consultation/supervision as well from Community Counseling Center.

Region II

- Region II currently operates three (3) ride along programs in Augusta, Waterville, and Lewiston. These have been critical positions within our Department which allows mental health workers to accompany patrolman in police cars and make mental health expertise available to the officers. The "ride along" workers provide emergency and routine services to people who might have previously only been served by the criminal justice system and may have never been served by the mental health system.

- The Region participates in the Androscoggin and Franklin County Criminal Justice/Behavioral Health Collaboratives. These are organized opportunities for mental health, criminal justice, and municipalities to come together to problem solve, identify issues, provide training, and find better ways to resolve issues.

- We have ICM's assigned to each County Correctional Facility in Region II. They routinely meet with prisoners who have psychiatric diagnoses or are class members. They assess current levels of functioning and also examine their needs for housing, income, and medications upon discharge and determine whether the individual has or will need case management. The ICM's attempt to link people with services in preparation for their release from correctional facilities.

- The Regional Office has a close relationship with the Maine State Prison and Maine Correctional Institute (Supermax). We work collaboratively on issues that face inmates who have mental illness. We have, at times, deployed BDS staff to the facility to assist with challenging inmates. We also work closely at an administrative level to resolve larger, systemic barriers in the delivery of mental health services.

- The Regional Medical Director provides psychiatric consultation to the County and State Correctional facilities across the entire Region.

- The Region is developing a telehealth network with the Kennebec County Correctional Facility, the Maine State Prison System, and AMHI in an attempt to bring prompt psychiatric care to the facilities in a way that reduces inmate security and excessive staff overtime. In addition, the sites will be linked electronically with fourteen others across the Region that specialize in mental health and psychiatry, with a goal of enhancing the clinical integrity and timeliness of service delivery.

Region III

- The Intensive Case Manager (ICM) Ride Along Position is a fulltime position dedicated to the Bangor Police Department. The ICM accompanies police officers to homes and various community sites to assist people with mental health issues who become involved with law enforcement. The ICM also links with probation officers, the courts, attorneys and other mental health service providers regarding client needs. This person also consults with the Acadia Consultation Service that operates within the Penobscot County Jail.

- The ICM Outreach position also has a significant amount of involvement with the legal system. The ICM frequently coordinates services with the legal system and the Ride along ICM.

- All ICM's link with The Department of Probation, the Courts and jails throughout the five county area of Region III.

- The Substance Abuse Coordinator provides consultations to the staff of Corrections regarding substance abuse issues and is available for training.

Mental Retardation Services

- Mental Retardation Crisis Teams provide training to police and jail personnel to help ensure appropriate care to clients with cognitive deficits.

- Mental Retardation Individual Support Counselors interact with all components of the legal system on behalf of their clients.

Substance Abuse Services

- Substance Abuse Coordinators are available to consult with all regional staff regarding departmental clients who are involved in the legal system and who have substance abuse issues.

- The Office of Substance Abuse (OSA) funds a therapeutic community at the Windham Correctional Facility for males with substance abuse treatment needs. OSA is currently working on a women's therapeutic community proposal.

Children's Services

- There are four BDS Mental Health Program Coordinators operating out of the Department of Corrections, Juvenile Justice field offices. These coordinators screen all the field correctional caseworkers case leads to identify youth in need of mental health services. The Coordinators also provide "flex funding" for mental health evaluations and support services.

- There is one Mental Health Coordinator that is housed in Department of Corrections only facility for committed youth. This Coordinator is part of the assessment/orientation team that assesses all committed youth entering the facility. The Coordinator works to identify all youth in need of mental health services upon entering and while they reside at the facility. The coordinator then refers the residents to the appropriate service within the faculty (psychiatric, psychotherapy, and substance abuse treatment).

- A Psychiatric Social Worker who works exclusively with the male detention unit in the southern Maine facility has provided 281 hours of mental health treatment/consultation/education to an average of 35 residents a month in the past six months.

Augusta Mental Health Institute - Inpatient Forensic Services

The Augusta Mental Health Institute (AMHI) provides inpatient services for several classifications of forensic patients. A team of mental health professionals serves all of these patients, with representation from the following disciplines: psychiatry, psychology, nursing, social work, and therapeutic recreation. Additional professional staff are available to meet other, more specific treatment needs, including a chaplain, dual diagnosis clinician (substance abuse/mental illness), and medical internists.

The treatment needs of forensic patients at AMHI are addressed on an individualized basis. However, the treatment and discharge planning process also varies with the particular forensic subpopulation being served. Forensic patients at AMHI generally fall into one of the following categories:

1. **Not Criminally Responsible (NCR)**: These patients enter the legal system after behaving in a way that would usually result in a criminal conviction (e.g., assault, arson, homicide). However, through the court process they have been found not responsible for the act(s) because that behavior was found to be the result of an acute episode of mental illness. These patients have been committed to the custody of the commissioner of BDS for treatment.

    a. Treatment: The focus of treatment is on reducing or eliminating acute symptoms of the illness, developing a comprehensive understanding on the part of both the patient and the treatment team of the patient's behavior leading to the NCR ruling, and the development of a relapse prevention program that will ensure the safety of both the patient and the community.
    b. Discharge: NCR patients must petition the court in order to obtain increasing levels of autonomy. Depending on individual needs, patients may be transitioned through an on-grounds forensic halfway house or discharged directly to the community.

2. **Incompetent to Stand Trial**: These patients are committed to AMHI after a legal determination that their current impaired mental status would prevent them from participating effectively in the adjudication process. For example, an IST patient may be

acutely psychotic or may not understand the court process for a variety of reasons related to mental illness. IST patients are committed to the custody of the commissioner of BDS for the restoration of competency.

a. Treatment: The focus of treatment is on restoring the patient's competency so that they can participate in the court process. For acutely psychotic patients, treatment usually involves antipsychotic medication and psychosocial rehabilitation that addresses their ability to tolerate the legal process. For patients who additionally lack an understanding of the court process, there is a greater focus on education regarding that process.
b. Discharge: Once competency is restored, the patient returns to jail (or the community, if on bail) to complete the adjudication process. If the court determines that competency is not likely to be restored in the foreseeable future, the patient is assessed and treated using the same standards used for any non-forensic AMHI patients. If further hospitalization is found to be warranted, involuntary transfer to a non-forensic unit is initiated as soon as possible.

3. **Stage III Evaluations**: These patients are committed to AMHI when their competency to stand trial is called into question in court, and the court is interested in additional assessment prior to making a final decision regarding competency.

a. Treatment: The scope of treatment may be dictated to a certain extent by the content of the court-authored commitment order. Unless specifically prohibited by the order, AMHI assesses and treats these patients as other non-forensic patients are treated. They are often in the acute phase of a mental illness and in need of stabilization. However, the primary focus of the admission is an evaluation by the State Forensic Service to determine competency. This usually occurs within 60 days of admission.
b. Discharge: Once the State Forensic Service evaluation has been completed, the patient usually returns to jail to complete the court process. If found competent to stand trial, the patient completes the adjudication process. If found incompetent, the patient returns to AMHI under IST status (see above).

4. **Jail/Prison Transfers**: These patients are admitted directly from jails and prisons throughout the state for acute stabilization of mental illness. Generally, these patients are clinically very similar to the patients admitted to the non-forensic units at AMHI, and meet medical necessity criteria for inpatient psychiatric care: i.e., acutely suicidal, homicidal, or unable to care for themselves in a correctional setting because of a mental illness. These patients may be admitted to AMHI either on a voluntary status or under civil commitment. However, there are also additional legal restrictions on their ability to leave AMHI: e.g., a voluntary jail/prison transfer who wants to leave AMHI but does not meet civil commitment criteria is returned to the custody of the referring facility rather than discharged directly to the community.

a. Treatment: Treatment mirrors the treatment offered to non-forensic acutely ill patients. The goal is to assist the patient in returning to a level of functioning that allows for a safe return to the referring facility.
b. Discharge: In the short term, most of these patients return to the referring facility. However, especially in the case of jail transfers, patients may also be returning shortly to the community. AMHI staff (particularly social workers, whose primary function is discharge planning) provide discharge planning services that are very similar to those provided on the non-forensic units; e.g., arranging for community case management, mental health and medical follow-up, appropriate living arrangements, financial support, etc.

Bangor Mental Health Institute

1. **Not Criminally Responsible (NCR):** BMHI has a few NCR inpatients and follows a small number as outpatients.
2. **Incompetent to Stand Trial:** Occasionally admitted to BMHI pending bed at AMHI.
3. **Stage III Evaluation:** BMHI admits, later to transfer to AMHI when bed is available.
4. **Jail/Prison Transfers:** Most of BMHI admissions in Forensic Services are from this area. Treatment and discharge the same as AMHI.

Communication with jails and prison services are through the Admissions Office. The jails either use Crisis Services or designated mental health liaison to interface with BMHI. Local jail administrators communicate with BMHI regarding issues involving treatment and referral with admissions and hospital administration as needed or in scheduled meetings.

APPENDIX E

Response from the Department of Behavioral and Developmental Services to questions posed by the study committee

STATE OF MAINE
DEPARTMENT OF
BEHAVIORAL AND DEVELOPMENTAL SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

LYNN F. DUBY
COMMISSIONER

November 27, 2001

Honorable Senator Michael J. McAlevey, Chair
Honorable Representative Edward J. Povich, Chair
Members of the Committee to Study the Needs of Persons with Mental Illness who are Incarcerated
State House
Augusta, ME 04330

Dear Senator McAlevey, Representative Povich, and Members of the Committee:

The information provided in this letter and attachment are in response to questions and requests for information by the Committee to Study the Needs of Persons with Mental Illness who are Incarcerated at its November 6, 2001 meeting.

1) Information on the results expected from ride-along program.
The police mental health ride-along programs have been extremely well received by communities and by the host police departments. Attached please find testimonials from police department officials as to the effectiveness of this program. In addition, current program statistics are provided below:

Region I			
Portland	1 FTE	1/10/01-7/27/01	229 interventions*
Biddeford	1 FTE	No statistics available, although worker sees 1-5 clients daily.	
Region II			
Augusta/Lewiston	2 FTE	1/01-9/01	419 interventions*
Region III			
Bangor	1 FTE	1/01-9/01	626 contacts (calls and interventions*)

* interventions include face-to-face assessment, evaluation, supportive counseling, referral, case management, and other mental health related services.

2) Re: persons included under AMHI consent decree: # of interactions with criminal justice system over last year and # now in jail.
The total number of active AMHI class members in the state is 3,164. There are 533 active AMHI class members residing outside of the State of Maine. Currently, 90 (2.8%) AMHI class members are in Maine Department of Corrections facilities. Eleven AMHI class members are in corrections facilities outside of Maine. There currently is not a system in place for tracking class member interactions with the criminal justice system other than through the Department of Corrections without conducting individual case record audits. The Department's experience has been that criminality among the AMHI class population does not differ greatly from that of the general population.

3) Check on the figure given for avg. cost for community mental health services for diverted individuals ($11,347/person/year).
As was noted in the BDS 11/05/01 response to previous questions of the committee, this estimate does not include any medication expenses. Additionally, it does not reflect transportation or security costs. The detailed breakout of the average statewide yearly cost of adult mental health services based on data extracted from MMDSS for Medicaid claims paid in calendar 2000 is:

Cost/Person for Mental Health Services =	$1,530.77
Cost/Person for Psychological Services =	$563.97
Cost/Person for Out Patient Services =	$1,034,73
Average yearly cost per person =	$3,129.47

Community Support Worker Services average annual cost estimate based on our '02 Contract with HealthReach:

CSW cost per person per hour =	$89.76
Average number of hours per person =	91.56
Average cost per person per year =	$8,218
Total: =	$11,347

4) Could BDS use any of the existing AMHI consent decree caseworkers to provide services to DA offices (Diversion recommendation)? BDS estimate of cost of providing ICMs to the 8 DA offices, with consideration of any AMHI consent decree caseworkers that could be redeployed to provide this service.
Consent decree coordinators are by decree restricted to the role they are able to carry out which is specific to the tracking of AMHI class members and service coordination in the community. Mental health case workers working in the community currently have full case loads and is unlikely that they could be freed up to perform an alternative function.
However, in September of 2001 there were 35 vacancies among community mental health caseworker positions statewide. If all positions were filled, capacity may exist for reassignment of some positions.

Cost estimate for providing ICM's to the 8 DA offices:

Staff:	8 ICM's @ $50,000 per	=$400,000
	8 support staff @ $35,000 per	=$280,000
	Total staff	=$680,000

Note: it is our understanding from committee staff that the counties currently pay for office space of DA's and would likely expect reimbursement for any additional expense.

Office Space: Class A category office space at approximately $12 per sq. foot., 2 offices per DA location of dimensions 12x15 totaling 360 sq. ft. of office space excluding reception area with other overhead and utilities to be negotiated)

$51,840 per location x 8 locations	=$622,080
Total staff & space	=$1,302,080

5) Can BDS find an existing position to serve the criminal justice liaison function (Diversion recommendation concerning improving state coordination)?
This role involving consultation with jails and the DOC on diversion issues would require, as outlined in the 11/05/01 response to Committee questions, one full-time Intensive Case Manager (ICM) at a cost of about $50,000 per year. The department does not see that such capacity currently exists. There are limited

staff lines to perform this function and current reductions in revenues faced by the State limit BDS's capacity to fill any vacancies.

6) Proposal from BDS/MDOC/jails regarding jail diversion strategy (Mike McAlevey's suggested considering come mechanism to divert to a more appropriate facility any person not stabilized within 72 hours.)
See attached Proposal for Mental Health Pilot Program in Maine County Jails.

7) Information on the evaluation done on the Portland Drug courts.
This pilot project in Portland was federally funded and was not affiliated with the Office of Substance Abuse (OSA) of BDS and it is our understanding that the funding has been discontinued. OSA has worked with personnel from this project to derive insight from important lessons learned for use in developing the structure of the drug court model it is currently funding.

OSA is now working with the judicial system in implementing a research based model funded by OSA at $750,000 per year, with total cost including client fees at approximately $1 million, for drug courts in six Maine courts (Biddeford/Alfred, Portland, Rumford, Portland, Bangor, and Calais/Machias). These became functional in June of 2001 and the Office of Substance Abuse and the judicial system are working to evaluate this initiative but results are not yet available. The basic premise of these courts is that people entering the criminal justice system are screened by a substance abuse liaison to the courts to identify possible substance abuse issues. A clinical diagnosis is then made and if the individual fits criteria for outpatient treatment and the nature of their crime is within a certain range of severity, the judge may order them into the drug court as their sentence. Participants undergo outpatient treatment and are assigned a case manager for the period of one year. During that year, the participant works to address their substance abuse problem and meets weekly with the judge, together with other drug court participants, and case managers to receive feedback from the judge on their progress including sanctions and rewards for progress and adherence. If the program is successfully completed the participant has completed their sentence.

Please contact my office if there is further information with which we can provide you. It has been our pleasure to assist with the Committee's work.

Sincerely,

Lynn F. Duby
Commissioner

Cc: Sue Bell, Office of the Governor

Portland Police Department
Michael J. Chitwood
Chief of Police

CITY OF PORTLAND

A Nationally Accredited Department of Excellence

November 26, 2001

Hon. Michael J. McAlevey
Maine Senate
2 State House Station
Augusta, ME 04330

Dear Senator McAlevey:

The Mental Health Liaison has become a critical component of the Portland Police Department. Over the course of three years, the Mental Health Liaison has provided support to officers on calls for service when an individual is threatening suicide, conducted mental health assessments in crisis situations, and critical incident interventions at crime scenes.

The Department's first mental health liaison, Scott Hutcheson, an LCPC, and his supervisor, Sgt. Robin Gauvin, have worked very hard to integrate the liaison program, and Ingraham into the Portland Police Department's 911 response. Through their dedication and hard work, the program now provides assistance and support to both law enforcement and the community. The client population served includes adolescents, adults and the elderly. The Liaison's response to these populations results in partnership with Sweetser, DHS-child and adult services, Maine Medical Center, Shalom, SMAAA (Southern Maine Area Agency on Aging), and inter-department services to include community policing and the victim/witness advocate program. The Liaison has also partnered with a number of mental health agencies to intervene with regards to clients/consumers who utilize emergency response services on a regular basis.

The benefits from these partnerships are tremendous. The patrol officer's time is utilized more effectively. Referrals and resources are provided in a more efficient manner to families and individuals. Clients and agencies partner with an effective advocate. Community policing neighborhoods can utilize a trained professional to intervene when a community member's mental health is compromised.

Please contact my office if you need further information.

Sincerely,

Michael J. Chitwood
Chief of Police

Police Department
William E. Welch
Chief of Police

Lewiston Maine
Setting the Pace

November 19, 2001

Holly Stover, Regional Director
Department of Behavioral and Developmental Services

The Intensive Case Manager utilized by the Lewiston Police Department in conjunction with the Department of Behavioral and Developmental Services has proven to be an invaluable service.

The main goal of the Intensive Case Manager (ICM) is to intervene as early as possible with behavioral problems encountered by the police. The ICM is then able to assist in evaluating and coordinating with social service agencies to help provide on-going or follow-up services.

The ICM has worked beyond our initial expectations and has proven to be a valuable asset, not only to the Lewiston Police Department but also in helping the community. By having the ICM position in place, it has saved time and manpower to both our agencies in helping to expedite the care in cases.

Andrew D'Eramo
Deputy Chief

171 Park Street ♣ Lewiston, Maine ♣ 04240 ♣ Tel. 207-795-9010 ♣ Fax 207-783-3373

AUGUSTA POLICE DEPARTMENT
33 Union Street
Augusta, Maine
04330

WAYNE M. MCCAMISH
Police Chief

ROBERT C. GREGOIRE
Deputy Chief

Holly Stover, Regional Director
Department of Behavioral and Developmental Services

November 20, 2001

The Intensive Case Manager (ICM) that works in conjunction with the Augusta Police Department has proven to be an invaluable asset to the Department and to the Augusta community.

When working with the Police Department, the ICM has the opportunity to observe and assist the Police with behavioral problems encountered within the community. The ICM also works as a liaison with other social service agencies to assist the Police and involved clients.

The ICM has exceeded all expectations for service to the Police and the Augusta community. Having an ICM in place with the Police Department has allowed the Police and the ICM to provide a better and more expedient service to the Community and any involved clients.

Major Robert C. Gregoire

Waterville Police Department

1 Common Street
Waterville, Maine 04901-6699

John E. Morris
Chief

Joseph P. Massey
Deputy Chief

November 20, 2001

Fax: 287-4052
Holly Stover

To Whom It May Concern:

This letter is to strongly advocate for and support the continuance of the Waterville Police Crisis Intervention Program. This program came into existence immediately following the murder of two nuns in Waterville by a man suffering from mental illness who was in a period of crisis.

I can state unequivocally that this is one of the best things that we do for the community. I know that this program in Waterville has saved lives and prevented other long-term damage to the community. The residents of Waterville and the surrounding communities are very aware and also supportive of this program.

Waterville is still healing from the murder of the nuns in their convent. If the Waterville Police Department was to loose this ability to deal with crisis intervention, the community would be uncomfortable, angry and I fear that all we have done to educate concerning mental illness will be quickly gone.

Once again, I cannot tell you how important and vital this program is for health and well being of both the community and those who suffer from mental illness.

Sincerely,

John Morris
Chief of Police

JM/ke

Winslow, Donald
From: Winslow, Donald
Sent: Wednesday, November 21, 2001 10:58 AM
To: 'katherine.bubar@state.me.us'
Subject: ICM Ridealong Program

Kathy,

Here are some of my thoughts regarding the Intensive Case Manager ride along program. As you know, we don't collect hard data (I'm not sure what we would collect) but I can assure you the program is worth its weight in gold. I have received only positive feedback from my officers. That in itself should say a lot because police officers can be a very cynical. I think one particular reason the program is favored here at Bangor PD is because of the personality of the ICM assigned to us. Dave Tremble has a great personality, knows his business, and has become a respected member of our agency.

Anyway, here's why I think it works:

- We channel all information concerning contact with mental health clients to the ICM. It gives him a broader picture of what is happening to an individual whose mental health may be deteriorating and therefore increasing the risk of harm.

- The ICM has access to medical history information that enables him to get a client in need of assistance reconnected with their service provider much faster than an officer can. In most cases the ICM knows the client.

- The program saves us time. The ICM can relieve an officer and deal with non-violent clients in crisis. He makes the calls, does the listening, and makes a more educated assessment of the client's needs. His presence frees officers up to do other law enforcement functions.

- The program has helped enhance the departments relationship with mental health consumers in our community. I think the ICM working alongside a police officer sends the message that we are concerned about their well being. I recently attended an open house with the ICM and was impressed with warmth I received from consumers.

- The program has helped give our officers a better understanding of the mental health system of care.

- The ICM is able to look into cases that have not become criminal (and really not a law enforcement functions) but do need attention. As you might expect, we receive a number of letters or calls coming from people who obviously have "issues". These cases are referred to the ICM who evaluates the correspondence, and in many cases will make contact with the individual and arrange for any service that may be needed.

- The ICM has opened doors for us that we have had difficulty opening before. For example, serving court orders (i.e. protection from abuse orders, subpoenas, etc.) at institutions has become much easier.

There are probably other benefits as well, but the ones listed readily come mind. I hope you find this information helpful; don't hesitate to call me should you have any questions.

Have a nice holiday.

Don

Proposal for
Mental Health Pilot Program in Maine County Jails

Introduction:
The following is a description of a possible program approach to providing needed mental health services to the Maine county jail population. This description represents an amalgamation of the thoughtful discussions in legislative work sessions held over the past several weeks by the Criminal Justice Legislative Standing Committee. This program approach was written and submitted by a small group of state and community stakeholders, identified in this proposal as the subcommittee, and was done at the specific request of the Criminal Justice Legislative committee. It was clear during the Committee hearings and work sessions that five principles were guiding the deliberations and these serve as the foundation of the proposal below. The principles are:

1. The mental health needs of the county jails are not adequately being met by existing recourses.

2. Any strategy for improvement will need to increase the internal mental health treatment capacity of the specific county jail.

3. A "one size fits all" approach will not work. Programs need to be adjusted to recognize the uniqueness of each specific county jail.

4. The mental health and county jail systems need to develop ways to better connect with each other for a more efficient use of existing and scarce resources.

5. Because the existing county jail system has such significant needs, and the existing mental health system is already strained, any substantial increase in services to this underserved population will require additional resources.

Proposal:
This proposal builds on the current strategies in place by BDS to address needs within the criminal justice population and puts forth that there are at least four critical opportunities for providing effective mental health needs to the county jail populations. The proposal also recognizes that these four opportunities are so interrelated that they all need to be in place and integrated if they are to be truly effective. Although any one of these program components could stand alone, they need to be connected to and build upon each other in order to be truly successful.

The proposal also provides for an incremental implementation or " piloting" of this approach in order to test its ability to meet the needs of the county jails and whether or not the additional recourses identified as necessary are adequate. The pilot programs could be located within each of the three Department of Behavioral and Developmental Services (BDS) regional offices and coordinated with the existing Mental Health Clinics operated by BDS located in Bangor, Augusta, and Portland.

It was also the view subcommittee that a rural jail would need to be part of the testing. The four identified areas that are key to effective mental health interventions and strategies are intake, triage, case management, and discharge, as outlined below:

I. Intake

The first critical juncture in intervention is when the inmate first presents at the county jail. It is here, within the first 24 hours, that the jail intake personnel will conduct the initial health screening. Contained within the general health screening are a series of questions designed to identify mental health histories, current medications, suicide ideation, and general mental health status. A national search was conducted by BDS and the Department of Corrections (DOC) to determine whether a universal, easily administered, understandable and reliable mental health assessment tool was available for the criminal justice population that could further identify specific mental illnesses. None was discovered. A subsequent discussion with representatives of county jails and a review of a few of the existing screening tools used by the county jails led the subcommittee to believe that the existing screening tools were adequate to identify gross mental health indicators that would require further assessment.

Although the screening tools are indeed felt to be adequate, the capacity for the county jails to each respond to the identified immediate mental health need is not. An existing system of mental health crisis response exists across the state through agencies under contract with BDS. Linkages between county jails and this system are inconsistent. Absent immediate, short-term mental health interventions, inmates can frequently digress and decompensate and become significant behavioral problems for the jail personnel. Interventions at this point would need to be provided by a trained in-house and immediately available mental health "crisis " worker. It is also felt by subcommittee members that this position needed be part of and understand the specific county jail environment and therefore needed to be a county jail employee or at least a contracted agency whose staff person is stationed fulltime within the county jail. It is also important that the jail have available (via contract), immediate access to advanced practitioners or psychiatric services for medication review, management and prescription. A cautionary note is that independent crisis workers without good sound clinical supervision can quickly become isolated and less effective. If this position is to be an employee of the county jail, particular attention needs to be placed on the need for the individual to receive ongoing clinical supervision.

Additional resources....3 FTE Crisis Workers...@ approx. $40,000 each.....**$120,000**

II. Triage

After an individual is identified through the above described intake process as needing immediate mental health care, the next 72 hours are critical in determining whether the inmate will respond to that care. If they do, then the crisis worker can determine, together with the mental health caseworker, which will be described later in this proposal, the exact course of ongoing mental health care while at the county jail, as well as discharge planning options. If the inmate does not respond, then the jails would need immediate access to additional mental health consultation and care. At this point the services of a psychiatrist to provide clinical case plan review, development and possible referral is needed. An additional advantage of a consulting psychiatrist is their ability to identify needed inpatient care and to possibly facilitate access that care. It should be noted, however, that community hospitals believe that additional capacity is

not available and that issues of risk, security, and potential for violence complicate any possible role of community inpatient care for county jail populations. Regarding the role of the State psychiatric hospital capacity, an extensive study was conducted in 2000 relative to the needs of county jails for access to State inpatient psychiatric beds. The need for an additional 17 forensic beds was identified and will be provided for in the new psychiatric treatment facility to be built in Augusta. An option for the provision of psychiatric consultation service could be through an expansion of the BDS's regional clinical services located at Bangor, Augusta and Portland. However, these clinics currently have only limited (.20 FTE) psychiatric services and could not handle the expected increased caseload. Expansion of this service could be as minimal as 1.5 FTE Psychiatrists statewide, which would provide each pilot county jail program 20 hours per week of psychiatric intervention/consultation.

Additional needed resources: 1.5 FTE Psychiatric Services
@ approx. $60,000 for 3 jails.....**$180,000**

III. Case Management/Short Term Treatment

Each county jail expressed the need to have an internal capacity to provide counseling, testing, referral and other ongoing mental health care while inmates are within the jail system. This service primarily needs to be provided by a Masters level mental health clinician and/or preferably licensed psychologists. This enables the jail to provide stabilization services, sound mental health care/short term treatment, develop appropriate discharge planning options, and enable the inmate a more successful move from the county jail to the community when the sentence is served and as well as possibly reduce recidivism. This position will draw upon the knowledge, interventions and testing by the crisis worker and will increase the continuity of care within the jail setting. This position will also have the primary responsibility for identifying discharge planning needs and connecting the inmate with the existing community case management system. Since there is a responsibility of the county jails to provide mental health care to its populations, these services are not intended to supplant any existing capacity of county jails to meet these needs, but are instead meant to enhance the current services available. Again, county jail personnel thought it important that this person be part of the county jail environment and part of the county jail staff/team. As in the case of crisis workers, it is important that these mental health clinicians receive sound clinical supervision in order to be effective which would need to be somehow accommodated by the county jails.

Additional resources...3 MSW/Psychologists @ $60,000 each.....**$180,000**

IV. Discharge

All county jail inmates eventually return to the community, most within a very short period of time. Inmates with mental health needs should be quickly connected to community systems of care and follow-up/ongoing services monitored. While it will be the responsibility of the county jail mental health professional to provide initial care and develop initial discharge plans, the community system must be involved and accept the responsibility for the inmate's ongoing community care. Currently the mental health system provides that service in two ways; from the network of community support workers funded by BDS and contracted through the private mental health provider network, and if individual needs are particularly problematic, BDS has a cadre of trained Intensive Case Managers statewide. Both systems are necessary to provide this

service. It is believed that most of the population of inmates who have mental health needs could benefit from community support services, specifically case management services. This service can assist inmates with connecting with ongoing mental health systems of care. The existing caseloads of case managers preclude their ability to pick up any significant increase in caseload size and would therefore require additional resources. There are some inmates who present particular challenges and for this population BDS already assigns several Intensive Case Managers to provide ongoing care and discharge planning to the county jails. The needs of the county jails are, however, greater than the ability of BDS to respond in all cases. BDS will continue to commit this service to its greatest ability to the county jails. The advantage of having this next system of care external to the county jail is that the inmate needs to assimilate back into the community and this system is already present and familiar with the individual prior to release. As is the case with other services, the current system is at capacity and this pilot would require a full time staff person for each pilot site (larger jails report 5-10,000 admissions/discharges a year).

Additional resources.....3 Community Support Workers.....@ $40,000 each..... **$120,000**

Totals	**3 Crisis Workers (jails staff).....**	**$120,000**
	1.5 Psychiatric consult (contract).....	**$180,000**
	3 Psychologists (jail staff).....	**$180,000**
	3 ICM's (contract or BDS).....	**$120,000**
		$600,000

APPENDIX F

Response from the Department of Corrections to questions posed by the study committee

October 9, 2001

DOC

MAINE DEPARTMENT OF CORRECTIONS INFORMATIONAL RESPONSE TO LEGISLATIVE QUESTIONS

1) Describe the services provided to persons with mental illness who are incarcerated within the MDOC.

Mental health services involve a combination of modalities including:

- Individual counseling
- Group counseling
- The utilization of psychiatric medication
  Intensive treatment on the mental health unit
  Inpatient psychiatric hospitalization

The providers of the mental health services come from a variety of different sources:

- 9.0 FTE MDOC state employees
- 3.7 FTE MDOC contract with Prison Health Services
- 3.0 FTE MDOC contract with Mid Coast Mental Health (unsecured funding)
- 1.5 FTE funded by Dept. Behavioral and Developmental Services
- .5 FTE MDOC contract with Cathance Mental Health Services

*Please refer to the attached sheet for a breakdown of service providers by professional discipline and the MDOC institution served by each individual.

The cost involved in the provision of mental health services is as follows:

MDOC state employees = 531,308.
PHS contracted services = 405,358.
Mid Coast Mental Health = 191,948.
Dept. Beh and Dev Serv = 72,868.
Cathance Serv contract = 41,361

Total Cost of Mental Health Services: 1,242,843.

Examples of Collaboration with the Dept. of Behavioral and Developmental Services are:

- Joint release planning meetings with BDS regional offices
- Utilization of state mental health inpatient beds for male prisoners
- BDS provides a crisis worker for class members at the Maine State Prison
- BDS provides a clinical social work position at Maine Correctional Center
- Significant collaboration around the release of "high profile" prisoners with mental health needs.

Mental Health Training received by facility staff in the MDOC:

- The MDOC currently uses a 2 day (16 hour) training offered by the National Alliance for the Mentally Ill of Maine
  *(please refer to the attached NAMI training curriculum).

- This training is the primary training currently being used for MDOC facility staff and it is supplemented by inservice workshops conducted by MDOC mental health providers.

2) Identify necessary increases in services, training, and staff in order to meet current mental health needs of the MDOC incarcerated population:

The MDOC needs to expand and strengthen certain areas of mental health treatment in order to meet growing demands within the system. There is a need for increased mental health assessment capacity at the time a person enters the MDOC. There is a current need for increased psychiatric services, particularly at the time of intake and on the mental health unit.

With regard to training, the current 2 day NAMI training provides a good basic understanding of how to work with prisoners with mental health needs and more extensive training does not seem to be indicated at this time.

The Department is beginning to implement telemedicine technology. This technology will be used for psychiatric and mental health purposes. Training in its use will be provided through a contract with Maine Telemedicine.

Greater collaboration and professional interaction between the MDOC's and Department of Behavioral and Developmental Services' mental health and psychiatric providers will enhance our ability to provide inpatient services and transition to community aftercare.

3) Provide specific accreditation requirements for mental health services and training:

Please refer to the American Correctional Association standards and the National Commission on Correctional Health Care standards which have been provided as part of this informational response packet.

4) Will MDOC require additional resources for mental health programs to meet accreditation?

The MDOC will need to increase psychiatry services and/or use physician assistants or nurse practioners in order to maximize psychiatric coverage and service. An expansion of systemic mental health assessment and a common psychometric tool will be necessary improvements.

5) Recommendations for legislative or policy changes to improve mental health system for prisoners:

One area of difficulty is that the MDOC has the ability (due to existing legislation) to share mental health information with other relevant state agencies or departments in the best interest and care of a prisoner with mental health needs; however, the Dept. of Behavioral and Developmental Services does not have the same ability to share relevant mental health information with the MDOC. Perhaps legislation allowing a more reciprocal ability to share mental health information would enhance treatment planning and service for the incarcerated person with mental illness.

Another area of concern is the issue of access to inpatient psychiatric beds when necessary. Although the male prisoner population has had access to inpatient state forensic beds the female prisoners are often times sent out of state to accommodate their inpatient mental health needs. The MDOC estimates a need to have ready access to 2 male and 2 female forensic inpatient psychiatric beds in the new state psychiatric hospital. This would allow for improved mental health treatment for incarcerated persons with severe mental illness.

CURRENT MENTAL HEALTH SERVICES IN MDOC (10-09-01)

Discipline	Quantity (FTE)
Psychiatry (MD)	1.2
Psychologist (PhD)	2.1
Psychologist (MA)	1.5
Social Worker (LCSW)	6.5
Social Worker (LMSW)	1.0
Social Worker (LSW)	1.0
Clinical Counselor (LCPC)	1.0
RN (psychiatric)	1.0
RN (generalist)	1.0
Activity Specialist	1.0
Crisis Worker (BA)	0.5

MDOC Mental Health Services Facility and Funding Breakdown

MSP/MCI/Bolduc

PhD	(1)	(state MDOC)
LCSW	(3)	(state MDOC)
LMSW	(1)	(state MDOC)
LSW	(1)	(state MDOC)
MA Psy	(1)	(Mid Coast contract)
RN	(1)	(Mid Coast contract)
Psy RN	(1)	(PHS contract)
Activity Rx	(1)	(Mid Coast contract)
ICM	(.5)	(state DMH)

MCC

PhD	(1)	(state MDOC)
LCSW	(2)	(state MDOC)
MA Psy	(.5)	(PHS contract)
LCPC	(1)	(PHS contract)
LCSW	(1)	(DMH/Community Counseling contract)

DCF

PhD	4Hrs/wk	(Cathance contract)
LCSW	18Hrs/wk	(Cathance contract)

APPENDIX G

Letter and attachment from NAMI Maine to study committee offering some recommendations and background information

NAMI Maine

(Formerly The Alliance for the Mentally Ill of Maine)

December 3, 2001

Senator Michael McAlevey
Representative Edward Povich
Members of the Committee to Study the Needs of Persons with
Mental Illness who are Incarcerated
State House
Augusta, Maine 04333

Dear Senator McAlevey, Rep. Povich and Members of the Committee:

On behalf of NAMI Maine we commend you for all of the work that has been accomplished to date. We write to make several suggestions based on the decisions that have been made and are still pending.

1. **Evidence-based programming**. You have received a number of proposals for new pilot programs and for additional positions for existing programs. Dr. Osher stressed the importance of getting the "bang for the buck" by funding programs that have proven results, and we agree. We hope the Committee will recommend funding for programs that can demonstrate success in keeping people with mental illness out of jail and/or prison. There are models that have been proved to be successful (i.e., Project LINC, a Rochester, New York program involving an ACT team and supported housing, CIT officers, the Memphis, Tennessee community policing model,) and eight pilot programs are currently being studied by SAMHSA. Existing research[1] suggests that two core elements are necessary for successful diversion: aggressive linking to an array of community services especially for people with co-occurring mental health and substance abuse disorders and non-traditional case managers (educational level has no impact. Rather success comes from hiring case managers who are familiar with the criminal justice system and the local culture(s) of the inmates.) In short, NAMI Maine recommends funding evidence-based models. One CIT program costs $5,033. Project Link cost $681,455 per year (Project Link services are Medicaid reimbursable).

2. **Jails.** The Bazelon Center for Mental Health Law[2] indicates that in-jail mental health staff, inmate retention of Medicaid and Social Security benefits, discharge planning, and training for jail staff (especially in social security, Medicaid, and Medicare)

[1] Assessing the Effectiveness of Jail Diversion Programs for mentally Ill Persons, Steadman etal. 12-99.
[2] Finding the Key to successful transition from jail to community for people with serious mental illnesses. 3-01.

P.O. Box 5120, Augusta, ME 04332
(207) 622-5767/1-800-464-5767 Fax (207) 621-8430 Both telephone numbers are TTY accessible.
E-mail: NAMI-ME@nami.org Web Site: www.nami.org/about/namime/index.html

are needed. NAMI Maine recommends funding sufficient jail-based mental health staff to provide coverage 16 hours a day. Rather than fund 2 full-time positions for each jail (i.e., 30 in-jail case managers) we believe that smaller jails in adjoining counties could share workers. One case manager should cost in the $30,000 to $35,000 salary range. It is imperative that these case managers be dually licensed/certified – able to respond to mental health and/or substance abuse issues and that they be "non-traditional" – i.e., familiar with inmate cultures and the criminal justice system. The Steadman research cited earlier also indicates that "boundary spanners" are helpful – i.e., people who will talk to all of the systems involved (judiciary, probation and parole, mental health, substance abuse, criminal justice). These case managers must perform this function.

3. **Mandates.** We believe that some statutory mandates should occur – (l) a mandate for inmate screening and assessment[3], in jails and in prison (2) a mandate for jails and prisons to assist inmates to retain their disability benefits for as long as federal laws allow and for reinstatement of those benefits prior to release, (3) a mandate that inmates entering jail or prison be given their medications until such time as an assessment can be completed, (4) a mandate that jails and prisons have contracts with local mental health service providers (and vice versa*) including hospitals.* (Note that current law does mandate mental health providers to serve jails – Title 34-B, section 3604, paragraph 4.), and (5) a mandate that all inmates who have been hospitalized due to mental illness return to the jail/prison with a written treatment plan which describes the treatment to be provided during the remainder of their incarceration, (6) a mandate that DOC establish a separate grievance process for medical complaints.

4. **Hospitalization**. When inmates are acutely mentally ill and need hospital services (ie., a mental health evaluation has resulted in a recommendation for hospital care) they should be admitted to the psychiatric hospital with whom the facility has a contract. Note that ACA standards currently include such a requirement. Rather than create a correctional psychiatric hospital, the current forensic hospital (AMHI) must be required to accept inmates who are in need of hospitalization as the safety net placement – i.e., when no other community hospital beds are available. This may mean expanding the number of beds included in the soon to be constructed new state facility.

5. **Oversight**. Currently, DOC has just 1.5 advocates to respond to the informal and formal complaints of over 1,700 inmates. There is no advocacy entity for jail inmates. NAMI Maine believes this is inadequate. We also believe that *external* advocacy is needed. Although we don't recommend moving the DOC's current 1.5 positions out, leaving them with no internal monitoring capacity, we do advocate for the creation of an ombudsman or the establishment of additional advocates (3) specifically designated to handle correctional issues – and that these positions go out to bid. Two ombudsman models are available in Maine: the Long Term Care Ombudsman, a standing non-profit agency and the Children's Ombudsman, which was created last session and is currently

[3] A review of correctional program outcomes (i.e., in reducing recidivism) shows that effective programs are those that start by assessing inmate risk factors and building programming around those identified needs. Latessa, University of Cincinatti. Presentation 11-01.

out to bid. The Children's Ombudsman is an independent program with in the Executive Department and was funded for two positions and start up costs at $106,000.

6. **Formulary.** We recommend that the DOC and Maine's jails adopt current Medicaid formulary protocols and that the Department of Human Services work with DOC and the jails to identify a mechanism for the Medicaid rate for prescription purchases to apply to Maine's jails and prisons.

Thank you again for your thoughtful attention to these issues.

Sincerely,

Carol Carothers
Executive Director

Barbara Merrill
Attorney

JAIL DIVERSION PROGRAMS FOR PEOPLE WITH MENTAL ILLNESS AND THOSE WITH MENTAL ILLNESS AND SUBSTANCE ABUSE

NAMI MAINE

2000

Introduction

There is growing evidence that the nationwide policy of treating people with mental illness in the community and downsizing the number of mental hospital beds is resulting in higher rates of arrest and incarceration for persons with mental illness. Although research shows that most people with mental illness are not more violent than the rest of the population, the failure to build adequate community service systems is resulting in "trans-institutionalization" – the movement of people with mental illness from one institution to another. It is estimated that approximately 685,000 inmates with serious mental illnesses are admitted to U.S. jails each year. This is approximately eight times the number of patients admitted to state mental hospitals. In some cases, they are held in jail because of a serious offense and they need treatment while inside. In other cases they have been arrested for non-violent crimes such as vagrancy, disturbing the peace, or trespassing and could be diverted to treatment. In other cases, they may be held in jail because there is no other safe place for them in the community

Nationally, and in Maine, we are incarcerating people at alarming rates. We built the Cumberland County jail in the early 1990s. This jail is now on the brink of being overcrowded. We built the Kennebec County jail during the same timeframe. This jail is now holding more people than it was designed to hold. We built a new prison in Maine in 1992. We are currently funding the expansion of our prison system by hundreds of cells. In fact, four new correctional facilities open every month in this country. In 1972 our prison population was 330,000; by mid-1998, it exceeded 2 million. This trend is exacerbated by the fact that 63% of all prisoners return to jail/prison within 3 years of release; if mental illness is a factor, the recidivism rate rises to 80%.

Even though the criminal justice system has become the largest provider of institutional care for people with mental illness, services inside our jails and prisons are woefully inadequate. Of Maine's 16 jails, nine have no psychiatric coverage, 6 have no social work or psychological coverage; 10 have no nursing coverage. A survey of jail administrators by the National Institute of Justice in 1994 indicated that administrators described their mental health programs as grossly understaffed and in urgent need of program development and of intervention by mental health organizations. 64% of jail administrators indicated the need for improved medical services for offenders with mental illness; 82% of probation and parole agency directors indicated the need for better access to mental health professionals.[1]

Why Jail Diversion

Appropriate diversion of offenders with mental illness from the criminal justice system helps promote smooth jail operations.

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[1] Mental Illness in U.S. Jails: Diverting the nonviolent, low-level offender. Research Brief, 11/96. The Center on Crime, Communities, and Culture.

Jails are critical places to address mental health issues because of the sheer number of mentally persons behind bars on any given day. Jails serve as the first point of entry into the criminal justice system for nearly 10 million individuals arrested each year, as many as 13% of whom suffer from severe mental disabilities. A study of the Cook County jail in 1996 found that 6.1% of males and 15% of females had an acute and serious mental illness, compared to 5% of the general population. In addition, 75% of female and 72% of male detainees with serious mental illnesses have co-occurring substance abuse disorders. Because of these facts some states are developing mechanisms to divert low-level, nonviolent offenders with mental illness to treatment programs in the community as an alternative to detention in dangerously overcrowded and understaffed jails. This type of cooperation between the criminal justice system and the larger mental health care system is proving to be an effective means of dealing with people with mental illness.[2]

When it is mental illness and not criminal intent that underlies a petty criminal act, treatment in mental health programs is demonstrably more effective at reducing recidivism than a jail sentence. It is also an effective tool for reducing overcrowding and disruption in jails and for reducing the victimization often suffered by inmates with mental illness. It is also important to note that although suicide is one of the 10 leading causes of death in this country, it is the leading cause of death in jails. And, the vast majority of jail suicides occur in the population of offenders with mental illness.[3]

Jails are designed to focus on a person's offense and to emphasize detainment and conformity to correctional rules rather than treatment. This approach can be detrimental to offenders with psychiatric disorders. Sheriffs call for diversion so that jails will be free to perform their primary function: protection of society.[4] Some statistics highlight the problems being faced by jail staff and administrators. While the national number of people living in state mental institutions fell from 634,000 to 221,400 between 1955 and 1985, the number of people with psychiatric disabilities in jails rose from 185,780 to 481,393.[5] People with psychiatric disabilities seem to be more at risk for arrest and re-arrest than others. A 1989 report shows a 52% lifetime arrest rate among people with psychiatric disabilities, but only 19% of these are ever convicted of a crime. Over half of the time, arrest is preceded by a failed attempt at commitment and jail provides a temporary sanctuary for people with no housing or other supports. A 1998 study in Missouri, showed that 38% of arrestees with psychiatric disabilities had been arrested more than once, with 23% of the charges involving family members who were attempting to facilitate a protective environment when all other efforts had failed.[6] Factors which have been shown to contribute to increased rates of incarceration include closing of mental institutions, lack of needed community supports, difficulty with access to community programs, and negative attitudes of some law enforcement officers.

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[2] Ibid.
[3] Ibid.
[4] Jail Diversion for People with Psychiatric Disabilities: The Sheriffs' Perspective. Walsh & Holt. Psychiatric Rehabilitation Journal. Fall, 99, vol. 23, no. 2. pg. 154.
[5] Ibid.
[6] Ibid. pg. 155

Additional studies show that neither cellmates nor jail personnel are able to deal effectively with alcohol and drug withdrawal, suicidal episodes, aggression, or psychotic behaviors. Though there is recognition that diversion is needed, a 1994 review of 1,263 jails with a population of 50 or more found that only 52 jails had active diversion programs.

Potential Cost Savings of Diversion

A study in New York in 1996 found that the cost of incarcerating one person in the New York City jail system for one year was approximately $64,000. State prison in New York cost $32,000. Of course, people with mental illness cost more, as they require additional jail and prison resources in the form of treatment, suicide prevention observation, and crisis intervention. New York City alone pays $115 million a year to provide health and mental health services to jail inmates.[7] Add to these costs, the cost of processing the case in the court system, and the cost of jailing people with mental illness climbs even higher. Although it is difficult to calculate the cost of treating mental illness, a 1997 Wisconsin study found that the average total expenditure for inpatient and outpatient mental health services per client was $10,995. Supportive housing in New York City costs approximately $12,000 per year.[8] New York City ACT teams are estimated to cost $10,000 per person per year.

What does the Research Show about Jail Diversion?

A number of studies have been carried out to assess the efficacy of diverting people with mental illness from jails and additional study is underway. A variety of approaches are also in place across the country to help keep people with mental illness out of jail and to reduce recidivism. Some of these studies are reviewed below.

Comparing Outcomes for Diverted and Nondiverted Jail Detainees with Mental Illnesses. Law and Human Behavior, Vol. 23, No. 65, 1999.

This study focused on identifying the characteristics of persons diverted through a court-based program in the mid-west and includes some background information about jail diversion. Notable is the fact that calls for jail diversion programs are not new – the National Coalition for Jail Reform called for more diversion programs in the 1970s and 1980s; NAMI national made jail diversion programming a cornerstone of their call for action in 1992. And, many larger communities have implemented formal police-based or jail-based diversion programs. Slightly less than half of police departments in communities with a population of 100,000 or more have access to some specialized response for dealing with mentally ill persons. Thirty percent of departments have agreements solely with mental health mobile crisis teams, 12% employ special mental health officers, and 3% have police officers with special mental health training.

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[7] Prisons and Jails: Hospitals of Last Resort. The Need for diversion and discharge planning for incarcerated people with mental illness in New York. Barr, H. Correctional Association of New York and the Urban Justice Center. 1999.

[8] Ibid.

However, formal diversion programs are more limited. Less than 50 mental health diversion programs are estimated to exist nationally in jails with a capacity of 50 or more.[9]

The diversion program reviewed in this study was funded by the State Department of Mental Health to provide prearraignment diversion. The program averages 20-25 cases per month. Eighty percent of referrals to the court come from public defenders who seek an evaluation of clients who appear to have a mental illness; 20% of the referrals come from pretrial services and involve people screened at the jail who appear to be mentally ill. The court liaison, who is also a mental health evaluator, evaluates 5-6 inmates a day and appears at the arraignment of each detainee who is determined to be eligible for diversion. The liaison makes recommendations to the judge. Results are as follows: the judge goes along with the evaluator's recommendation, the judge places the offender on probation and he/she is assigned to specially trained mental health probation officers, the sentence is mitigated, the person goes to jail for public safety reasons, or, the person is held in jail until appropriate services are arranged. When a person is jailed, the community mental health system is notified so that appropriate treatment is provided in jail and post release treatment planning is assured.

The population involved in this study had an average of 17 prior arrests with over half of the prior arrests for crimes against persons; 95% had been hospitalized in a psychiatric facility at some time in the past; 86% had received community-based case management; half had lived in specialized mental health housing and 75% had received inpatient alcohol treatment. Over 90% had participated in AA, NA, or other self-help groups at some time in the past. Eighty people participated in the study. Thirty-five were diverted and 45 were not diverted. The outcomes were as follows:

- The diverted subjects were not rehospitalized (0% vs. 20%);
- The rearrest rates were no different, though no one was rearrested for a violent offense against a person.
- Older, female subjects were more likely to be diverted by the courts.
- There were few major outcome differences between diverted and nondiverted subjects.

A SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons. Steadman, etal. PSYCHIATRIC SERVICES vol. 50, no 12; 12/1999.

When the major diversion programs in the country were examined, five key elements were associated with the programs that were perceived to be most successful:

- All relevant mental health, substance abuse, and criminal justice agencies were involved in program development from the start.

[9] Comparing Outcomes for Diverted and non-diverted Jail Detainees with Mental Illness. Stedman, etal. 1999. pg. 616

- Regular meetings between key personnel from the various agencies were held.
- Integration of services was encouraged through the efforts of a liaison person or boundary spanner between the corrections, mental health, and judicial staff.
- The programs had strong leadership.
- Nontraditional case management approaches were used. These approaches relied on staff hired less for academic credentials and more for experience across the criminal justice, mental health, and substance abuse systems. Success depended on building new system linkages, viewing detainees as citizens, and holding the community responsible for the full array of services needed by the detainees.

Three modest outcome studies have been undertaken:

- Lamb, etal. Studied prebooking diversion utilizing emergency outreach teams composed of police officers and mental health professionals who made disposition decisions and were able to refer mentally ill offenders to specialized outreach teams. The results were that only 2 of 69 subjects were jailed and the subjects' access to mental health services was increased.
- Borum, etal. Studied two prebooking programs in Alabama. Three different approaches were studied including a Crisis Intervention Team (specially trained police officers), a community service officer program (in-house social workers at the police station), and a traditional mental health emergency team. All three programs showed great promise in diverting people from jail, keeping them in the community, and facilitating access to treatment. Across all three sites, only 6.7% of the mental disturbance calls resulted in arrest. The CIT program had an arrest rate of 2%. The most effective program was the Memphis CIT program which had access to a 24-hour, no refusal crisis drop-off center.
- Lamb, etal. Reviewed outcomes from a postbooking diversion program in Los Angeles County that provided mental health consultation to a municipal court. In this program, 54% of those diverted had poor outcomes (hospitalization, arrest, physical violence against others, homelessness). However, those diverted to judicially monitored treatment had good outcomes compared with subjects who were not mandated to receive monitored treatment.

In an attempt to better understand the effectiveness of jail diversion, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded a three-year study in 1997. The goal of this program is to better understand ways to improve treatment. Nine sites were selected for review including three major types of jail diversion – prebooking programs, court-based postbooking programs, and jail-based postbooking programs. Five prebooking programs are included; 11 post booking programs are included; and several jail-based postbooking

programs are part of this review. Results have yet to be published. Project descriptions are attached to this report.

What do we know about Mental Health Courts?

Emerging Judicial Strategies for the Mentally Ill in the Criminal Case Load: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage. April, 2000. Bureau of Justice Assistance.

There are approximately 500 drug courts across the United States. This approach has also been tried with domestic violence and is now being tried as a judicial approach for people with mental illness. The four mental health courts evaluated here, have common attributes: they are voluntary and the defendant must consent to participation before being placed into the court program; the person must have a mental illness to participate; and the objective is to prevent the jailing of the person with mental illness and/or to secure their release from jail to appropriate services and community supports. Finally, each court gives a high priority to concerns for public safety when arranging for the care of offenders with mental illness in the community. This emphasis on public safety explains the focus on misdemeanor and other low-level offenders and the careful screening or complete exclusion of offenders with histories of violence. Nonetheless, the King County Court is open to defendants with a history of violent offenses that have been triggered by mental illness who are then provided with a level of supervision sufficient to protect the public. The four courts described here are also designed to focus on early intervention and identification using screening and referral timeframes ranging from immediately after arrest to a maximum of three weeks after arrest. Each court uses a team approach that forms a multidisciplinary working relationship between providers, the court, and the jails. Each court provides supervision of the participant that is more intensive than would otherwise be available with an emphasis on accountability and monitoring of the participant's performance. [10]

The four courts also have significant differences. Broward County's mental health court places eligible participants into treatment prior to disposition of their charges, which are held in abeyance pending successful program completion. In King County defendants who request a trial are free to return to treatment court should they be found guilty, but may also waive their right to a trial in return for admission to the mental health court. Deferred sentencing and prosecution is also possible. Response to non-compliance differs. In Broward and Anchorage, jail confinement is less likely to occur as a response to noncompliance, more likely to occur in King County, and relatively commonplace in San Bernardino. The difference is based both on different philosophies and to the type of offender admitted.

Common difficulties also affect each of the four courts. Balancing speed of identification and assessment with the need for a quality assessment is a challenge. In addition informed consent, competence, confidentiality, and acquiring information about

[10] Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts, Bureau of Justice Assistance. 4/2000. pg. 6

a person's criminal justice and mental health background can be complicated. There is also a concern about "coerced treatment" – i.e., is participation truly voluntary when jail is the alternative? Is coerced treatment effective? An additional challenge involves the inherent conflict between the criminal justice system goals and the mental health system goals. Finally, the length of treatment and the expectation of "cure" are difficult. With drug courts, abstinence for 12 months could be measured. In mental health, achievable milestones are more complex and the measure for "graduation" may be more difficult. Finally, because mental health courts must rely on the very system that has failed the offender with mental illness in the past, the risk is that the courts will identify a large population of people in need of significant treatment resources in systems where these very resources are nonexistent.

Often the offender with mental illness is already well know in the community and has serious problems such as alcohol or drug abuse, housing, employment and physical health problems. Each of the four courts reviewed began with a primary focus on defendants entering the criminal process shortly after arrest, but eventually expanded to accept referrals from other courts, attorneys, police, friends, relatives, or other community contacts. The goal of all four courts is to consolidate justice procedures to identify and enroll candidates in treatment. Each court builds the proper treatment around court supervision-- linking participant cooperation with needed services.

Broward County Mental Health Court (Florida) was the first in the nation. Although designed to handle minor offenses by people with mental illness who return frequently to the criminal justice system, they also accept candidates with violent crimes who express genuine desire to participate. Only Axis I, head injured, or developmentally disabled persons are accepted. Between 1997 and 1999, 882 cases were placed under the mental health court's jurisdiction. The court's goal is pre-adjudication diversion based on the belief that involvement of persons with mental illness in the criminal justice system will likely exacerbate their conditions and contribute to their recycling in and out of criminal court. Broward County uses advanced degree students from the local University as well as its own clinical staff to evaluate defendants prior to the first probable cause hearing. All jail admits who have visible mental health conditions are housed in the jail's mental health unit and are fully assessed by a consulting jail psychiatrist. These individuals are referred to the mental health court. Offenders who are acutely ill during their first appearance are sent to treatment for stabilization and once stable, returned to court. The mental health court has access to a wide range of community services – and makes referrals to those services. The court also has its own, dedicated transitional housing program capable of housing program participants for up to 5 months until more permanent living arrangements are available. Vocational, medication, substance abuse, and primary health care services are provided at that setting.

The King County Mental Health Court (Washington State) opened in February of 1999, following a year of task force activity to identify diversion options. The court handles misdemeanor offenses committed by people whose crimes appear related to mental illness, who have been referred for competency evaluation, whose medical histories include a major mental illness or organic brain impairment, or who are

determined by court clinicians to need mental health treatment. Participants may have past arrests for violent crimes and still be accepted into the program. Program participation is voluntary and many participants, who are successful with treatment, have the original charges withdrawn. Candidates are identified principally at post-arrest by jail medical staff, although referrals may come from other courts, justice officials, or family. The court has received 199 referrals since February of 1999. A court monitor meets with the person referred, collects information on mental health history and treatment, and prepares a treatment plan to go into effect upon participation in the mental health court. The plan includes living arrangements and provisions for supervision and treatment. Defendants who are lacking capacity and acutely mentally ill are hospitalized or treated in another setting designed to restore stability prior to participating in the mental health court.

Defendants who opt for the mental health court supervised treatment are placed in that treatment for several weeks, and then returned to court to make a final decision. Opting out means their case becomes part of the regular adjudication process. Generally, participants are placed on probation in the mental health court for one-two years. In general, successful completion of the court program results in dismissal of the charges. Once a participant in the mental health court, a probation officer is assigned and he/she works closely with the mental health service provider. Participants are assigned to treatment programs.

The Anchorage (Alaska) mental health court began operations in July of 1998. Specially trained judges link mentally ill offenders with services. To avoid the special stigma associated with mental health courts, the Anchorage program is called the court coordinated research project (CCRP). Referrals come from jails, courts, family, attorneys, and others. The CCRP program is closely linked to the Jail Alternative Services (JAS) program – an alternative mental health program which places mentally ill inmates into community treatment. Participation in either program is voluntary and the person must be competent to make the decision. A guilty or no contest plea is required for participation. A treatment plan is developed and a reliable third party agrees to provide community supervision. There is no court monitor and the burden of lining up treatment falls upon the defense attorney. Due to shortages in funding, this program offers less services and supervision than the other mental health courts.

The San Bernardino (California) mental health court receives referrals from the West Valley Detention Center's mental health staff. These staff also serve as case managers for the diversion program. A guilty plea is needed to qualify for the program and the participant must sign a treatment plan. Once the treatment is complete, the charges against the participant may be dismissed. Most participants are released into a court-run residential treatment facility. Some may live in other settings, i.e., with supportive family. Status hearings are held every 3-4 weeks to track compliance with treatment. Failure to comply generally results in a return to traditional court and the use of jail as a sanction. Most participants also participate in the Pegasus program – a day program lasting between 8:30 am and 1:00 pm.

Discussion

Jail diversion, originally part of states' attempts to address the growing numbers of persons with substance abuse in jail and prison, has expanded to include mechanisms for keeping people with mental illness out of the criminal justice system. A variety of approaches are being utilized including use of specially trained police teams who divert persons with mental illness to treatment without considering arrest or incarceration and post-arrest options designed to insure as well as supervise treatment for an extended period of time.

Diversion programs have their own controversies including confidentiality, coerced treatment, forced guilty pleas, and community supervision and probation which may be considered by the person with mental illness to be excessive, intrusive, and lengthy. Although drug courts have been active for many years, mental health courts are new. There has not been sufficient time for good outcome studies to inform us about the long term impact of diversion programs. And, there are continuing controversies about their impact on individual rights and liberties. A 1999 article in The Oregonian entitled "Mentally ill suspects may get separate court" quotes some advocates who believe mental health courts are "band-aids for years of neglecting to pay for treatment on a large scale. They also describe them as problematic because they segregate the mentally ill, force suspects into pleading guilty, and then coerce them into taking psychotropic drugs to comply with the terms of their release, which could violate civil liberties. They see this kind of effort as the "chemical crusade approach which drives people from help.[11]

Nonetheless, there are outcomes from diversion programs that offer hope of success, including:

- The development of new partnerships and working relationships between courts, criminal justice systems, and mental health services.
- Improved understanding of mental illness within the court system.
- Increased options for judges and courts when considering how to adjudicate defendants with mental illness.
- Increased attention to the link between community supports and reductions in criminal justice system convictions of persons with mental illness, especially to the need for expanded services for persons who have co-occurring disorders.
- Expanded role of judges, attorneys, and the criminal justice system staff in understanding the need for and calling for increased community mental health services.
- Increased attempts to identify and implement successful ways to keep people with mental illness out of jail.
- The early outcome studies of prebooking programs indicate a trend toward improved treatment of offenders with mental illness and decreased arrest rates.

[11] The Oregonian. 10-22-99.

APPENDIX H

Draft of Maine Jail Association Mental Health Survey results

To: Maine Jail Association
From: Michael Vitiello
Subject: Mental Health Survey
Date: October 2, 2001

Please collect the following information from your facility (to the best of your ability) for presentation to the Legislature's Criminal Justice Committee. I would appreciate having you e-mail me the info as soon as possible, but not later than next Monday morning. I will work to compile the data for our meeting on Tuesday.

1. Number of inmates in your jail taking medication for a mental health condition.
2. Percentage of entire inmate population who take mental health meds.
3. What services do you currently provide?
   a. Number of hours for a mental health worker
   b. Number of hours for a social worker
   c. Number of hours for substance abuse (for dual diagnosis patients only)
   d. Number of hours for mental health medication review
   e. Number of hours for suicide prevention or crisis intervention
   f. Number of hours of intervention by a nurse for a mental health issue
   g. OTHERS (list other services provided)
4. Average number of times per week a community crisis provider is called to the jail after hours or on weekends to evaluate an inmate.
5. What organization or vendor provides the services listed in numeral 3 above?
6. What is the cost of medical care to the mentally ill in your facility? Provide a breakdown of the costs for services listed in numeral 3 above.
7. Of the number of inmates with mental health issues in your jail, what percentage is on probation with DOC?
8. Can you cite examples where your facility collaborates with a division of state government (i.e. dept. of mental health, or dept. of corrections) to provide services for the mentally ill?
9. What is the wish list for mental health in your jail? Be as specific as possible.
10. Do you support an alternative facility to house the mentally ill?
11. How many hours of mental health training does your staff receive annually?
12. What are the topics for the training (i.e. suicide prevention, management of aggressive behavior, etc...)?
13. What is the cost for this training?
14. What would it cost to provide all of your staff with 3 hours of mental health training annually?
15. Do you have any recommendations for legislative or policy changes to improve care for the mentally ill in your jail?
16. Is there something that you wish to discuss which is not addressed in this survey?

Maine Jail Association
Mental Health Survey

MJA Q #	Question	Androscoggin	Aroostook	Cumberland	Franklin
1	Number of inmates taking M/H meds.	23	21	94	6
2	Percentage of population on M/H meds.	16%	28%	25%	23%
3	*Current Services Provided:*				
	Hours of mental health worker	0	3	20-40	40 +
	Hours of social worker	15	0	0	10
	Hours for Substance Abuse (M/H clients)	7	2	not tracked	not tracked
	Hours for M/H medication review	5	0	3	
	Hours for suicide prevention / crisis intervention	4	on-call	not tracked	40 +
	Hours of intervention by a nurse for M/H issue	8	1	18 incidents/month	0
	Hours of a LCPC (counselor)	8	0	0	0
	Hours for a psychologist	1.5	0	0	0
	Other	n/a	0	5 legitimate suicide	2 hours/week anger
				attempts per month	mngmt. group
4	After hours calls per week to community M/H provider	1.5	1.5	2.5	2
5	Organization(s) / Vendor(s) who provide services	ARCH Medical	Aroostook	Primecare Medical	ARCH Medical
			Mental Health		Comm. Corr. Altern.
6	Cost breakdown for medical care to M/H inmates	no data	0	1.4 million (all costs)	@$62,500 (all costs)
7	Of M/H inmates, number that are on state probation	no data	75%	not tracked	70%
8	Who does facility collaborate with ?	DMHMR-OSA	crisis service	crisis service	DMH
9	Wish list for mental health issues in county jails	see attached sheet			
10	Support an alternative facility to house M/H inmates ?	yes	yes	yes	yes
11	Number of staff training hours for M/H issues	no data	1	2-4	4-6
12	List topics of training	no data	suicide prevention	suicide prevention / identification	suicide prevention, behavior mgmt
				how to deal with M/H inmates	documentation of behavior
13	What is the cost of this training ?	no data	$1,000	$5,000 - $6,000	$600 + replacmnts.
14	What would 3 training hours per officer cost ?	no data	$2,000	$7,000 - $10,000	$1,000+ instructor
15	Recommendations for legislative/policy changes	see attached sheet			
16	Addition discussion topic not covered by survey ?	no data	no	no	see attached sheet

Revised 11/26/01

Maine Jail Association
Mental Health Survey

MJA Q #	Question	Hancock	Kennebec	Knox	Lincoln
1	Number of inmates taking M/H meds.	25	61	13	4
2	Percentage of population on M/H meds.	50%	39%	28%	17%
3	*Current Services Provided:*				
	Hours of mental health worker	1	20	0	3
	Hours of social worker	0	4	0	1
	Hours for Substance Abuse (M/H clients)	1	20 (all inmates)	22 (all inmates)	4
	Hours for M/H medication review	1	4/month	5/month	4.5
	Hours for suicide prevention / crisis intervention	3	10	10/month	4
	Hours of intervention by a nurse for M/H issue	0	20	0	0
	Hours of a LCPC (counselor)	0	6	0	0
	Hours for a psychologist	0	4/month	0	0
	Other				pastoral cnslng.
4	After hours calls per week to community M/H provider	5	2	9	1
5	Organization(s) / Vendor(s) who provide services	Comm. Health	ARCH Medical	ARCH Medical	Sweetser
				Mid-Coast M/H	Mid-Coast M/H
6	Cost breakdown for medical care to M/H inmates	$200/hour	$36,600	$32,900	$53,000
7	Of M/H inmates, number that are on state probation	12	81%	82%	50%
8	Who does facility collaborate with ?	no one	DMH, Kennebec Valley	BMR	DMHMR
9	Wish list for mental health issues in county jails	see attached sheet			
10	Support an alternative facility to house M/H inmates ?	yes	yes	yes	yes
11	Number of staff training hours for M/H issues	3	4	4	not tracked
12	List topics of training	suicide prevention	suicide prevention	suicide prevention	suicide prevention
		anger/behavior mgmt	M/H behavior, meds.	anger/behavior mgmt	
13	What is the cost of this training ?	$1,500	$3,900	$2,352	not tracked
14	What would 3 training hours per officer cost ?	$1,500	$2,925	$12,650	$1,000
15	Recommendations for legislative/policy changes				
16	Addition discussion topic not covered by survey ?	no	see attached sheet	see attached sheet	no

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Maine Jail Association
Mental Health Survey

MJA Q #	Question	Oxford	Pennobscott	Piscataquis	Somerset
1	Number of inmates taking M/H meds.	3	50	5	30
2	Percentage of population on M/H meds.	8%	37%	16%	44%
3	*Current Services Provided:*				
	Hours of mental health worker	2	25	1.5	0
	Hours of social worker	0	20	1	5
	Hours for Substance Abuse (M/H clients)	as needed	108 contacts/month	2	3
	Hours for M/H medication review	as needed	3	1	3
	Hours for suicide prevention / crisis intervention	4 hours/month	5	as needed	4
	Hours of intervention by a nurse for M/H issue	0	0	0	5
	Hours of a LCPC (counselor)	0	0	0	5
	Hours for a psychologist	0	0	0	1.5
	Other	0	16	transport as	
				needed	
4	After hours calls per week to community M/H provider	1/month	2/month	<1 hour	2/month
5	Organization(s) / Vendor(s) who provide services	Tri-County MH	ARCH Medical	Chrltte White Cntr	ARCH Medical
		Oxford Crisis	Acadia M/H		
6	Cost breakdown for medical care to M/H inmates	$15,600	$75,600	$16,000	no data
7	Of M/H inmates, number that are on state probation	0	no data	0	50%
8	Who does facility collaborate with ?	DMHMR	DMHMR	no one	DMHMR
9	Wish list for mental health issues in county jails		no data	see attached sheet	
10	Support an alternative facility to house M/H inmates ?	yes	yes	yes	yes
11	Number of staff training hours for M/H issues	2	3	1.5	8
12	List topics of training	suicide prevention	suicide prevention	symptom recog.	suicide training
			MOAB	behvr. mngmt.	detecting the mentally ill
13	What is the cost of this training ?	$0	$6,000	$5,000+	$2,500
14	What would 3 training hours per officer cost ?	0	$6,000	$5,000+	$1,200
15	Recommendations for legislative/policy changes				
16	Addition discussion topic not covered by survey ?	see attached	no	no	

Revised 11/21/01

Maine Jail Association
Mental Health Survey

MJA Q #	Question	Waldo	Washington	York
1	Number of inmates taking M/H meds.	5	10	42
2	Percentage of population on M/H meds.	14%	20%	33%
3	*Current Services Provided:*			
	Hours of mental health worker	on call	4	0
	Hours of social worker	on call	2	15
	Hours for Substance Abuse (M/H clients)	0	0	6
	Hours for M/H medication review	4	1.5	5/month
	Hours for suicide prevention / crisis intervention	as needed	1	6
	Hours of intervention by a nurse for M/H issue	on call	0	7
	Hours of a LCPC (counselor)	as needed	0	7
	Hours for a psychologist	0	0	3/month
	Other	5	0	
4	After hours calls per week to community M/H provider	2	1.5	2.5/month
5	Organization(s) / Vendor(s) who provide services	Coastal Cnslg.	Northeast Crisis	ARCH Medical
		Midcoast MH		
6	Cost breakdown for medical care to M/H inmates	0	$3,600	$375,000 (all costs)
7	Of M/H inmates, number that are on state probation	60%	20	not tracked
8	Who does facility collaborate with ?	crisis service	DMHMR	DMHMR
9	Wish list for mental health issues in county jails			
10	Support an alternative facility to house M/H inmates ?	yes	yes	yes
11	Number of staff training hours for M/H issues	4	3	4
12	List topics of training	suicide prevention	suicide prevention	suicide prevention
		anger awareness	behavior mgmt.	behavior mgmt.
13	What is the cost of this training ?	$960	$1,300	$3,500
14	What would 3 training hours per officer cost ?	$770	$1,300	$,2625
15	Recommendations for legislative/policy changes	none		
16	Addition discussion topic not covered by survey ?	none	no	no

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Maine Jail Association

Mental Health Survey

Response to questions # 9 & #15, by county (responses to these questions have been combined due to their similarity):

#9 What is the wish list for mental health in your jail. Be as specific as possible.
#15 Do you have any recommendations for legislative or policy changes to improve care for the mentally ill in your jail?

Aroostook –

- Require DMHMR to provide follow-on care for their people who come in and are currently being treated
- Require DMHMR to provide after care

Cumberland –

- Legitimate access to community mental health without a long waiting list
- Diversion programs with housing for pre and post booking of mentally ill inmates
- Cost control for psychiatric medications (possible Medicaid funding)
- Streamlined process to have incarcerated individuals evaluated at AMHI/BMHI
- Outpatient commitment law in Maine

Franklin –

- Need funding for psychiatric, brain trauma & MR services
- Discuss restructuring service delivery to include state-administered funding, but county-delivered services
- Creation of safe, self-contained cell & have someone from DMHMR available to watch an inmate when constant observation is required
- Non-medication intervention
- A positive response from community mental health providers to service clients while they are in jail

Hancock –

- More hours for a mental health caseworker
- Social workers to help with release planning
- Provide funding for the services and medications required for the mentally ill as requested by the mental health provider

Kennebec –

- Full-time substance abuse counselor
- Full-time social worker
- Minimum of 15 hours per week of psychiatric services
- Full-time mental health nurse

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Knox –

- Mechanism to invoice the DMHMR for all expenses related to the treatment of the mentally ill in a county jail

Lincoln –

- Diversion of the mentally ill from county jails

Oxford –

- We would like to have a psychologist easily available to us who can medically evaluate inmates to determine if or what medication they may need. At present, an appointment has to be made with Tri-County Mental Health with at least a six-week waiting period.
- We would also support the idea of having an alternative facility to house the dysfunctional mentally ill
- We would like to have better accessibility to "in-house" counseling by licensed clinical therapists (or similar credentials)

Additional topic: We would like to have more advocacy for legal issues by representatives from the mental health field.

Pennobscott –

- To have more community providers continue to provide services to their clients when they enter jail (although this would put a strain financially on agencies)
- To have a place other than holding, where an inmate is placed in isolation, for an inmate to be placed when they are suicidal
- Give jails more funding so they can provide needed mental health services

Piscataquis –

- Provision of 2-4 hours of coverage for mental health workers
- Provision of cost coverage for mental health services

Somerset –

- To be able to get inmates into AMHI or another hospital that can provide proper care and security of inmates
- The state should provide for a full-time mental health worker in all of the county jails at their cost and not the counties', or provide a facility for the mentally ill.

Additional topic: Inmates who violate probation should go to the state to be housed or have the state pay for each person housed in the county jail.

Waldo –

- Case managers to coordinate programs and services for inmates with MH issues

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Washington –

- Relocate the mentally ill to facilities whose mission is actually addressing their needs
- Jails are security oriented and the staff can not be expected to stop and consider if there might be some underlying social issue that is contributing to a security violation

York –

- Access to mental health beds at state hospitals
- Legislation requiring community mental health providers to follow their clients into the jail to provide service
- Legislation requiring community mental health providers to create an "aftercare" plan prior to the release of their client from a county jail, to include the immediate renewal of services
- State funding for mental health treatment, to include staff, medication, and supplies
- Alternative facility for mentally ill (pre-trial and sentenced)
- Enforcement of existing laws, and contract obligations for medical care facilities to ensure appropriate care for patients in crisis (i.e. a hospital can not send a patient who is at risk of suicide back to a county jail on "suicide watch". Instead they must provide treatment/care until the person is no longer in crisis)
- Introduction of specific language in the State DMHMR's entire contracts with vendors to provide community crisis services, which specifically list a jail as covered under the contract. Current contracts specify a school or a hospital, but not a jail. This has left the contract open to "interpretation"
- Policy change from State DOC, requiring them to case manage probationers who are mentally ill and take steps at diversion prior to sending clients to jail
- Legislation/Policy change allowing counties to receive (at the state's expense) a second opinion of a person denied entrance by AMHI/BMHI
- Legislation/Policy change allowing counties to receive an independent evaluation of a client returning from AMHI/BMHI to determine the appropriateness of the release back to a county jail
- Legislation/Policy change allowing a second opinion when AMHI/BMHI returns a patient because the patient is deemed not mentally ill, but rather their actions are deemed "behavioral"

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APPENDIX I

Letter from Maine Jail Association commenting on draft report

MJA

December 13, 2001

Senator Michael J. McAlevey, Chair
Representative Edward J. Povich, Chair
211A State Office Building
Augusta, Maine 04330

RE: Final Report (Committee to Study the needs of Persons with Mental Illness who are Incarcerated)

Dear Senator McAlevey & Representative Povich:

The membership of the Maine Jail Association (MJA) greatly appreciates the opportunity to have been included in the study of persons with mental illness that are incarcerated in the state and county facilities across Maine. As you are aware, this is one of the most pressing issues that the county correctional system is facing. The number of inmates with mental illness is well above the national average and the cost to address their mental health needs is taxing the county tax rate. The membership has had an opportunity to review the draft report and has identified several areas of concern:

- **Page ii, second paragraph** – "The committee's principal finding is that the community mental health services, due to lack of resources, are inadequate to meet the needs of persons with mental illness." The MJA wholeheartedly supports this finding. However, the subsequent committee recommendations, in general, do not directly address increasing the community capacity to provide service to meet the needs of persons with mental illness. The MJA strongly feels that resources must be dedicated to increase services within the community or the goal of diverting inmates with mental health needs from the criminal justice system will be next to impossible. The current system is not robust enough to serve the already identified clients.

- **Page iii, Diversion** – The MJA supports all seven recommendations. However, the MJA does have a concern for the requirement to examine the success of the Franklin County collaborative model. It was reported anecdotally that several counties have attempted to implement similar programs with marginal success. The MJA does not have a capacity to examine the technical success of this program. Developing similar programs will require a collaborative effort from the full range of service organizations within each community.

- **Page iv, Treatment and Aftercare Planning in State and County Facilities** -

  Recommendation 4: The MJA is very concerned that the requirement to develop procedures for written treatment plans for inmates returning to jail from a hospital stay.

Clearly, jails need to know what is medically required. However, the security needs of the jail need to be considered when developing these treatment plans. As an example: the requirement to return an individual to the hospital every 10 days for a follow-up assessment will be cost prohibitive for all counties and difficult for the more rural counties to accomplish due to the distances that may need to be traveled.

Recommendation 5: The MJA is very concerned that the language change designed to allow better access to records of the mentally ill is not broad enough. The goal should be to address a growing deterioration of an individual before the event becomes a crisis.

Recommendation 9: The MJA is very concerned that the creation of an independent Ombudsman for the Mentally Ill is redundant and problematic. The Maine Department of Corrections Detention and Correctional Standards for Counties and Municipalities already outlines a process for inmates to a file grievance through the jail administration all the way to the DOC. Additionally, the Bureau of Developmental Services also has a grievance process for an individual to file a complaint if that individual is dissatisfied with the service they are receiving. The creation of a separate office for an Ombudsman will only create another layer of bureaucracy.

- **Page v, Treatment and Aftercare Planning in County Facilities** – The MJA does not feel that the recommended changes to the statute governing furloughs from the county jail will be productive. Only sentenced inmates would be eligible and the recommended language changes do not absolve the Sheriff from his/her statutory custody and control responsibilities. If a furloughed inmate walks away from a treatment program and commits a crime the Sheriff can be sued for the consequences of the crime.

Again, the Maine Jail Association appreciates the opportunity to be part of this study. There are many recommendations outlined in the draft final report that will serve to provide much needed relief to the county correctional system and ensure better service to the mentally ill. The MJA looks forward to working collaboratively with the Joint Standing Committee on Criminal Justice, the Maine Department of Corrections, the Bureau of Developmental Services, and the advocacy organizations for the mentally ill in Maine in developing solutions that meet the needs of the clients we all serve.

Very truly yours,

James Foss
President, Maine Jail Association

cc: Sheriff Mark N. Dion, President, Maine Sheriff's Association
Executive Director Maine Sheriff's Association
File

APPENDIX J

Summary of subcommittee preliminary findings and recommendations with summary of comments by Dr. Osher

COMMITTEE TO STUDY THE NEEDS OF PERSONS WITH MENTAL ILLNESS WHO ARE INCARCERATED

PRELIMINARY RECOMMENDATIONS

(For organizational purposes some recommendations have been moved or modified)

Supplemented by comments from Dr. Osher

DIVERSION

1. **Examine/expand law enforcement programs (ride-along):**
   a. Someone (*BDS*?) should examine the efficiency and effectiveness of the current BDS police liaison positions and the ride-along programs to determine whether these are the best use of resources. The examination should look at the goals of the programs and whether the programs are meeting the goals.
      i. Cost: BDS estimate = no cost.
   b. Expand law enforcement programs: Provide more state funding (*amount*?) for local police programs (e.g., ride along) that help in diversion; expand the ride along program.
      i. Cost: BDS estimate = current funding for existing Intensive Case Managers is about $60K/ICM).
   c. Dr. Osher: Another model similar to the ride-a-long: Crisis Intervention Team (CIT). These are law enforcement officers who have had specialized training in psychiatric diagnosis, substance abuse issues, de-escalation techniques, empathy training and legal training in the areas of mental health and substance abuse. In Memphis TN this is combined with a crisis triage center at a U. of TN medical facility where the police can drop off persons in crisis.
2. **Improve local collaboration**:
   a. Someone (*Maine Jail Association*?) should examine the success of Franklin County's collaborative model to see if it can be replicated in other areas.
      i. Dr. Osher: county approach is good model; decentralization; local control meeting local needs
3. **Address diversion in the courts:**
   a. Create positions within the court system or positions available to courts (*BDS positions or contracted through BDS*?) to assist courts in linking people to appropriate mental health services.
      i. Details:
      ii. Cost: BDS estimate = $50K/Intensive Case Manager and $35K/support staff. 49 courts. Avg. cost for community health services for diverted individuals = $11,347/person/yr.
   b. Consider the Mental Health Court model?
      i. LD 202 (carried over by the Judiciary Committee – fiscal impact not yet determined) proposes to authorize the Judicial Department to establish mental health treatment programs in the Superior and District Courts, possibility in conjunction with the drug courts.

ii. *Cost: MDOC estimate = $546,295 for 4 MH workers and 4 probation officers. Jud. Dept. cost not included.*

c. Establish mental illness awareness training programs for the judiciary (similar to training now available to police and corrections officers) -- *BDS contract with NAMI to provide?*

i. *Cost: BDS estimate (BDS contract with NAMI) = $50K (includes improved training of jail staff as well – see Jail recommendation 1)*

4. Improve state coordination - criminal justice liaison:

a. Create a position at the Department of Behavioral and Developmental Services (BDS) to serve as criminal justice liaison to consult with jails and DOC on diversion issues.

b. Cost: BDS estimate = $50K for 1 Intensive Case Manager

c. Dr. Osher: Such a liaison can help span boundaries and bridge gaps in the system – gaps where problems can be created or exacerbated.

Existing laws to be aware of:

1. 34-B § 1219 requires BDS to develop a **diversion strategy** (defined as a comprehensive strategy for preventing the inappropriate incarceration of seriously mentally ill individuals and for diverting those individuals away from the criminal justice system). DBS is to work in collaboration with DHS, DOC, law enforcement, community providers and advocates.
    - BDS will provide written description of how it is implementing this law.
2. 17-A § 1261 et seq. allows a court to sentence a person to the **Intensive Supervision Program** (a split sentence of imprisonment, the initial unsuspended portion of which is served in whole or in part with intensive supervision, followed by probation) if certain conditions are met. 17-A § 1204 allows a court to attach **conditions of probation**, including requiring the person to undergo in-patient or out-patient psychiatric treatment or mental health counseling. 34-A § 1220 requires DBS to designate 7 liaisons to the courts and MDOC in the administration of probation and the Intensive Supervision Program; the liaisons duties include obtaining mental health evaluations and assessing the availability of mental health services necessary to meet conditions of probation and assisting the person in obtaining the mental health services. BDS will provide written description of how it is implementing this law.
    - BDS will provide written description of how it is implementing this law.

MDOC

Preliminary recommendations

1. **Improve mental health screening**:
    a. Designate a person at each MDOC facility to do mental health screening and to collect relevant information. Probably a psychologist-level position. Other staff positions needed? *what? how many?* Coordinate with aftercare planning.

b. *Cost:* MDOC estimate = $239,338 for 2 psychologists and 2 clerks. BDS cost estimate (if staffed up each facility) = $679,000 for 7 psychologists and 7 clerks.
c. Improve sharing of information between DOC, BDS, DHS and families -- *see item 5, below.*
d. If community service providers are involved in this -- concerns about liability for community service providers who attend persons in facilities? (*See discussion under jails*)

2. **Meet accreditation requirements**:
   a. Fund more psychiatric-level staff and/or physician assistants or nurse practitioners in order to satisfy accreditation standards
   b. Cost: MDOC estimate = $227,905 for 1 psychiatrist and 1 psychiatric nurse.
   c. Dr. Osher: accreditation is a useful intermediate step, but is not necessarily sufficient to meet the needs of the mentally ill.
3. **Improve cross training**:
   a. Provide specialized forensic training to case management and community support providers and crisis and outpatient providers -- *training by MDOC?*
   b. Cost: MDOC estimate = $10K
   c. Dr. Osher: Cross training is important: mental health providers understanding criminal justice needs; criminal justice staff understanding mental health needs; bridging the gaps.
4. **Ensure access to forensic beds:**
   a. Set aside certain of the inpatient forensic beds at AMHI for MDOC transfers? *How many beds?* MDOC suggests need for "ready access" to 2 male and 2 female beds. *Beds empty when not used by MDOC*?
5. **Improve access to information:**
   a. Allow BDS (*and entities that contract with BDS to provide services?)* to share medical records regarding mental health with MDOC without client's consent when necessary for MDOC to carry out its responsibilities?
      i. Currently (under 34-B MRSA § 1207) BDS can share records with MDOC only if
         1. the client or client's legal guardian provides written consent or
         2. if necessary to carry out hospitalization.
      ii. Health care practitioners with which BDS contracts would appear to be subject to 22 MRSA § 1711-C:
         1. prohibits release of health care information without authorization from the client or, if the client is unable, from an authorized 3rd party (mainly relatives);
         2. there is an exception which allows disclosure "to appropriate persons" in cases where the client poses a direct threat of imminent harm to any individual (similar to the "likelihood of serious harm" standard governing involuntary transfers of clients from jail/prison to hospital);
         3. the law also allows a practitioner to provide a "brief confirmation of general health status" to corrections facilities.

- Dr. Osher: eliminating client consent is likely to create controversy and become a major sticking point. A way to achieve the same end and avoid the controversy may be to have DOC provide BDS a list of clients; BDS can then contact those that it knows have a history of mental illness and ask them to grant consent to release of mental health information to care providers in the facility.
- *Cost BDS estimate = no cost.*

6. **Address security/treatment tension:**
   a. MDOC should monitor, examine and develop expanded ways of dealing with requirements for security/restraint while providing for treatment needs (e.g., addressing issues associated with self harm.)
   b. Cost: MDOC estimate = no cost.
7. **Ensure advocacy offices can effectively advocate for mental health needs**:
   a. Modify MDOC (*or BDS*?) Office of Advocacy functions as defined in statute? (*MDOC Office of Advocacy established by 34-A MRSA § 1203; DBS Office of Advocacy established by 34-B MRSA § 1205*)
8. **Ensure appropriate use of medications**:
   a. MDOC should expand formularies to include newer medications and adopt policies to ensure that the most effective medications are available and used and that clinical care needs, not cost, govern the use of medications.
   b. Cost: ?
   c. Dr. Osher: this is an important step, but cost can be high.
9. **Ensure MDOC has adequate authority; forced medication:**
   a. Grant authority to MDOC to administer medications and treatment to clients without client's consent under certain circumstances (e.g., treatment is medically appropriate and, considering less intrusive alternatives, essential to client's safety or safety of others) with process consistent with Due Process.
   b. Dr. Osher: This is a value question; the research doesn't yet demonstrate benefits from forced medications. A majority of states don't force medications. If allow, need to be careful that there is adequate process and that staff aren't doing things that are provoking the need for forced medications.
   c. Rely on guardianship powers or advance directives?
   d. Consider BDS emergency treatment procedure in inpatient psychiatric units? (According to BDS rules "Rights of Recipients of Mental Health Services," Part B, section V, sub-section H emergency treatment may be given for up to 72 hours without client's consent if a physician "declares" an emergency -- defined as a situation where there exists a risk of imminent bodily injury to the recipient or to others --, a recognized form of treatment is required immediately to ensure safety, no one legally authorized to consent on client's behalf is available, and reasonable person would consent under the circumstances.) *Due process issues are clearly raised if this were done in a criminal justice setting.*

JAILS

Preliminary recommendations:

1. **Create a "standard assessment process"** in jails for assessing and addressing the needs of persons with mental illnesses.
    a. Goal: some level of comparability across the State while respecting local community expectations and needs.
    b. Process should address stabilization and administration of medication -- involuntary medication issues? *see recommendation #9 under DOC*
    - *Cost: MDOC estimate = $20K for MDOC to create standard assessment (as part of jail standards MDOC issues for jails).*
      BDS estimate = no cost if an existing assessment tool is used.
    c. Include access to hospitals and agencies under contract with BDS for crisis management services and beds?
        i. *Cost: BDS estimate = crisis management mobile services about $30K/jail; avg. annual cost for psychiatric inpatient treatment about $15,672/individual.*
    d. Dr. Osher: there is no standard assessment tool available (his Center has received a grant to develop one) but it is an important thing to develop; CO directed its jails to come up with a model and bring it back to the Legislature. Once developed, existing jail staff can administer (it simply involves a series of well-thought-out questions the answers to which allow for an initial screening).
    e. Include improved training of jail staff (*NAMI training through BDS contract?*).
        i. *Cost:* BDS estimate = $50K (includes training of judiciary as well, see Diversion recommendation 3)
2. **Create a jail "walk along" program**
    a. To help jail staff recognize and respond to mental health needs. *Provided by community agencies under contract with BDS?*
        i. *Cost: BDS estimate = $630,000 for 15 caseworkers (1 for each of the 15 jails) – these caseworkers could do the intake and aftercare planning as well (see Aftercare recommendation 1)*
    b. Dr. Osher: Seems like a very good idea; the question is cost.
3. **Increase jail staff resources** to administer medications and manage/treat persons with mental illness
    a. Provided by community agencies under contract with BDS?
        i. *Cost: BDS estimate = $811,200 for psychiatrist consultation services 8hrs/wk/jail.*
    b. Dr. Osher: NYC trains inmates to be observers to look out for inmates with signs of mental illness (e.g., depression) – consider ways of using in-house resources
    c. Concerns about liability for community service providers who attend persons in facilities?

i. Fact that providers are working in jail shouldn't alter liability exposure.
ii. Liability insurance to cover exposure?
iii. If consider grant of immunity, 34-A MRSA § 1213 may serve as model: grants to medical providers contracting to provide services in MDOC facilities "employee" status under the Tort Claims Act.
iv. Dr. Osher: does not require specialized clinical training to provide services in jail, does require training w/re working in jail environment

d. Need to change confidentiality laws/policies with respect to access by community service providers to mental health information?
   i. Dr. Osher: changing confidentiality laws raises civil liberties issues; may be better to rely on consent of the client.
   ii. Include as part of any changes to the law to allow MDOC access to the information? – *see recommendation 5 under DOC.*

4. Improve information flow:

a. Establish a process whereby jails can send a list of clients to BDS to identify those persons who have a history of mental illness and their treatment needs -- confidentiality issue again; *see recommendation 5 under DOC.*
   - Dr. Osher: eliminating client consent is likely to create controversy and become a major sticking point. A way to achieve the same end and avoid the controversy may be to have jails provide BDS a list of clients; BDS can then follow up by contacting those that it knows have a history of mental illness and ask them to grant consent to release of mental health information to care providers in the facility.
   - *Cost: BDS estimate = no cost.*

AFTERCARE

Preliminary recommendations

1. **Case managers in jail**

a. Place in each jail case manager(s) (community service providers under contract with BDS) responsible for inmate intake and aftercare. Case managers should assess mental illness/substance abuse issues at intake and develop an individual plan that includes a plan for aftercare. Case management should involve caseworkers who follow the client through the system so that relationships are maintained and who are responsible for helping arrange for basic needs (food, clothing, shelter) after release.

b. *Cost: BDS estimate = $630,000 for 15 caseworkers (1 for each jail) (these case managers could do jail walk-along as well, see Jail recommendation 2)*
   - Dr. Osher: having community service providers offer mental health services in jail can improve continuity between in-jail services and aftercare. Maryland accessed federal Byrne money (($341,000) to fund contract persons in each jail (to provide substance abuse treatment). (The Byrne Memorial Grant Fund Program was created

by the federal Anti-Drug Abuse Act of 1988; funding is generally aimed at dealing with violent and drug-related crime).

- Dr. Osher: include in planning a process for ensuring that the client's applications for SSDI, SSI, Medicare and Medicaid are filed well before release.

c. Concerns about liability for community service providers who attend persons in facilities? (*See liability discussion under jails.*)

d. Confidentiality issues with respect to access by community service providers to mental health information?

i. *See recommendation 5 under DOC*

ii. Dr. Osher: changing confidentiality laws may raise civil liberties issues; may be better to rely on consent of the client.

2. **Mechanisms to encourage a person to take necessary medications after release**?

a. *Probation sanctions? incentives?*

b. Dr. Osher: CA has created a specialized staff to provide community based supervision of persons with mental illness on probation. Resource issue.

- **Note**: 17-A § 1204 allows a court to attach **conditions of probation**, including requiring the person to undergo in-patient or out-patient psychiatric treatment or mental health counseling or "any other conditions reasonably related to the rehabilitation of the convicted person or the public safety or security." Failure to comply with a condition related to psychiatric treatment is a violation of probation but may not, in itself, authorize involuntary treatment or hospitalization. 34-A § 1220 requires DBS to designate 7 liaisons to the courts and MDOC in the administration of probation (and the Intensive Supervision Program); the liaisons duties include obtaining mental health evaluations, assessing the availability of mental health services necessary to meet conditions of probation and assisting the person in obtaining the mental health services.
  - BDS to provide written description of how it is implementing the liaison law.

3. **Designate a person in each MDOC facility to make initial contacts** with family and community services for persons about to be released.

a. Integrate with the improved screening process.

b. *Cost: MDOC estimate $117,784 for 2 caseworkers.*
BDS estimate (if have caseworker in each facility) = $294,000 for 7 caseworkers. ($42,000/caseworker)

i. Dr. Osher: include in aftercare planning a process for ensuring that the client's applications for SSDI, SSI, Medicaid, Medicare, are filed well before release.

4. **Amend medical furlough law** (30-A MRSA 1556) to make it clear that furloughs may be granted for treatment of mental illness (outside a hospital setting?)?

a. Dr. Osher: as a general matter, allowing furloughs to facilitate access to behavioral health care seems useful.

b. **Note**: current law provides for transfers from jails to mental health hospitals on a voluntary basis or on an involuntary basis (when a client poses a

"likelihood of serious harm") (15 MRSA § 2211-A(2)(9) and 34-B MRSA § 3801 et seq.)

c. 30-A MRSA § 1556 (1): The sheriff may establish rules for and permit a prisoner under the final sentence of a court a furlough from the county jail in which the prisoner is confined. Furlough may be granted for not more than 3 days at one time in order to permit the prisoner to visit a dying relative, to obtain medical services or for any other reason consistent with the rehabilitation of an inmate or prisoner which is consistent with the laws or rules of the sheriff's department. Furlough may be granted for a period longer than 3 days if *medically* required.

5. Examine federal benefits issues?

a. Dr. Osher: Examine State Medicaid policy; consider permitting inmates in jail or prison to keep Medicaid eligibility open during incarceration (avoid delay in reinstatement of benefits after release).

   i. According to DHS, there would be an administrative cost to keeping eligibility open: there must be an annual review of eligibility and a monthly issuance of a new card. DHS indicates that incarceration does not automatically result in eligibility termination; someone incarcerated for a short time would not typically have eligibility terminated.

b. With regard to SSI: Possibility of jails entering pre-release agreements between with the local Social Security office; jail staff would get training with regard to SSI rules in return for jail notification of SSA of inmates likely to meet eligibility and of their release. (This is described in the Bazelon booklet provided by Dr. Osher)