The Criminalization of People with Mental Illnesses in Maine

Report of the
Maine Advisory Committee to the
U.S. Commission on Civil Rights

May 2019

Advisory Committees to the U.S. Commission on Civil Rights

By law, the U.S. Commission on Civil Rights has established an advisory committee in each of the 50 states and the District of Columbia. The committees are composed of state citizens who serve without compensation. The committees advise the Commission of civil rights issues in their states that are within the Commission's jurisdiction. More specifically, they are authorized to advise the Commission in writing of any knowledge or information they have of any alleged deprivation of voting rights and alleged discrimination based on race, color, religion, sex, age, disability, national origin, or in the administration of justice; advise the Commission on matters of their state's concern in the preparation of Commission reports to the President and the Congress; receive reports, suggestions, and recommendations from individuals, public officials, and representatives of public and private organizations to committee inquiries; forward advice and recommendations to the Commission, as requested; and observe any open hearing or conference conducted by the Commission in their states.

Letter of Transmittal

Maine Advisory Committee to the
U.S. Commission on Civil Rights

Members of the Commission
Catherine E. Lhamon, *Chairperson*
Debo P. Adegbile
Gail Heriot
Peter N. Kirsanow
Davie Kladney
Karen K. Narasaki
Patricia Timmons-Goodson, *Vice Chair*
Michael Yaki

Mauro Morales, *Staff Director*

The Maine Advisory Committee, as part of its responsibility to advise the Commission on civil rights issues within the state, submits this report, "The Criminalization of People with Mental Illnesses in Maine." The report was unanimously adopted by the Advisory Committee.

Sincerely,

Diane Khiel, *Chairperson*
Maine Advisory Committee

Maine Advisory Committee

Diane A. Khiel, *Chair*
Orono

Akintoye Akinjiola
Portland

Maurice R. Gilbert
Auburn

Judith D. Jones
Hope

Muhidin Libah
Lewiston

Eric M. Mehnert
Orono

Paul S. Robinson
Lewiston

Rachel Talbot Ross
Portland

Carl M. Toney, *Vice Chair*
Scarborough

Acknowledgments

The Maine Advisory Committee thanks all of the participants in the June 2017 briefing for sharing their expertise. This report is made possible by the guidance and support of Barbara de La Viez, the designated federal official assigned to the Maine Advisory Committee. The Committee thanks Evelyn Bohor for her support of the Committee. Staff extends special appreciation to Maureen Rudolph and TinaLouise Martin.

In addition, the Committee extends a special thank you to Contract Attorney-Analyst Julie G. Bush. The Committee greatly appreciates her significant contributions and her tireless work to ensure the completion and publication of this report. She reviewed, revised, and supplemented a prior draft, strengthening the Committee's report.

Table of Contents

Executive Summary 1
I. Introduction 3
II. Summary of the Briefing 8
III. Background on Treatment of Persons with Mental Illnesses 10
Historic Treatment of Persons with Mental Illnesses 10
Deinstitutionalization Movement 11
Legal Context of Early Deinstitutionalization Movement 14
Passage of Americans with Disabilities Act: Olmstead Anti-Discrimination Cases 15
IV. Evidence of "Criminalization" Links Between Incarceration and Mental Illnesses 18
V. Decriminalizing Persons with Mental Illnesses in Maine: Criminal Justice System 21
Prevention of Entry to Criminal Justice System 23
Institutional Commitments and Arrests of Persons with Mental Illnesses 23
Correctional Seclusion and Restraint of Persons with Mental Illnesses 26
Criminal Justice Staff Training and Partnering with Mental Health Professionals 28
Health Services and Treatment of Incarcerated Persons with Mental Illnesses 31
Vulnerability of Persons with Mental Illnesses to Police Shootings and Inmate Violence 33
Incidents of Police Shooting Persons with Mental Illnesses 33
Vulnerability While Incarcerated 36
Discharge & Release Issues 37
V. Decriminalizing Mental Illnesses in Maine: Community-Based Services 40
First-Order Needs: Stable Housing, Continuous Treatment, and Adequate Funds 40
Treating Children with Mental Illnesses in Homes and Communities 43
Outside Criminal Justice System: Status of Psychiatric Hospitals? 45
Finding Funds: Expanding "MaineCare," Maine's version of Medicaid, a Partial Solution 46
Implementing Antidiscrimination Principles in Community Settings 47
Crisis System Relief 48
Intensive Case Supports 49
Integrated Supported Housing 50
Supported Employment and Rehabilitation Services 51
Additional Provisions 51

Diverting People with Mental Illnesses from Criminal Justice System and Incarceration 52
Stepping Up Initiative 52
Alternative Courts 53
Maine Pretrial Service Contracts 54
VI. Findings and Recommendations 56
VII. Best Practice Models which Decriminalize Mainers with Mentally Illnesses 62
Appendix A: Briefing Panels and Speakers 63
Appendix B: Transcript of June 14, 2017 Briefing 64

Executive Summary

People with mental illnesses are overrepresented in prisons and jails nationally and in Maine. For example, in 2005, the Bureau of Justice Statistics found that more than half of all prison and jail inmates had a mental health problem.[1] Individuals with mental illnesses are 4.5 times more likely to be arrested than those in the general population.[2] According to the National Alliance on Mental Illness (NAMI), 2 million people with mental illnesses are booked into jails each year.[3] This overrepresentation is found in both adult and juvenile corrections, and has been increasing over decades.[4] Incarcerated persons with mental illnesses serve longer than comparable persons without mental illnesses, and cost taxpayers more per day incarcerated than those without mental illnesses.[5] In Maine, there is not enough space to safely house persons with mental illnesses, nor are there adequate means to effectively treat and habilitate them.[6] In a very real sense, persons with mental illnesses have been "criminalized" in Maine.

The Maine Advisory Committee to the U.S. Commission on Civil Rights ("Advisory Committee" or "Committee") chose to examine the facilities, care, and resources provided to individuals with mental illnesses in Maine, particularly within the law enforcement and criminal justice system (which has become a sort of *de facto* mental health system). The Committee's primary concerns were whether deficiencies therein might be leading to the "criminalization" of persons with mental illnesses, and how best Maine could offer support, treatment, and care for individuals in the state with serious mental illnesses while appropriately respecting their civil and statutory rights.

Towards this end, the Advisory Committee convened a public briefing in Lewiston, Maine on June 14, 2017 ("Briefing") to gather information from local advocates, law enforcement, attorneys, legislators, judicial officials, family members, and the public regarding treatment and (de-)criminalization of persons with mental illnesses in Maine. This report draws on Briefing testimony and other research to convey that information, and makes recommendations for future improvements.

The Committee concluded that to decriminalize mental illnesses in Maine, two primary approaches are necessary. First, the Committee recommends using evidence-tested ways to protect and treat individuals with mental illnesses caught up throughout the criminal justice system, with the goal of stopping criminalization and enabling such individuals to thrive in Maine's communities. Second, the Advisory Committee recommends funding and building up

---

[1] Doris J. James and Lauren E. Glaze, U.S. Department of Justice, Bureau of Justice Statistics, *Mental Health Problems of Prison and Jail Inmates*, 2006, p. 1.

[2] Anisha Lewis, Center for Prisoner Health and Human Rights, "Backgrounder: Incarceration and Mental Health," https://www.prisonerhealth.org/educational-resources/factsheets-2/incarceration-and-mental-health/.

[3] National Alliance on Mental Illness (NAMI), "Jailing People With Mental Illness," https://www nami.org/learn-more/public-policy/jailing-people-with-mental-illness (last accessed Mar. 28, 2019).

[4] *See* report part V, *infra*.

[5] Ibid.

[6] Ibid.

expanded, appropriate community care systems consistent with evidence-based best practices, so that in time nearly all persons with mental illnesses will benefit from integrated care in their homes and communities.

I. Introduction

One in five American adults, and one in five children ages 13 to 18, has (or will have) a mental illness.[7] Of those people who experience mental illnesses, one in five (i.e., one in 25 people overall) has a "serious" mental illness, which substantially interferes with one or more major life activities.[8] In Maine, there are roughly 300,000 adults with a mental illnesses, of whom nearly 62,000 have serious mental illnesses.[9] And over 16 percent of Maine children ages 3 to 17, or roughly 34,000 children, received mental health treatment or counseling in the past year.[10]

This report concentrates on psychiatric illnesses, rather than intellectual/developmental disorders or substance abuse issues unaccompanied by psychiatric illnesses. As discussed in this report, a large number of these individuals will come into contact with the police and other members of the criminal justice system, some repeatedly.

From 1820 through 1970, individuals with moderate and serious mental illnesses in America were generally confined in state-run residential psychiatric hospitals (or "asylums").[11] Such institutions could deliver medical and therapeutic treatment and were designed to keep mentally ill persons both safe and secluded from the rest of society.[12]

---

[7] National Alliance on Mental Health ("NAMI"), *Mental Health By the Numbers*, 2015, https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers (last accessed Feb. 21, 2019). A mental illness is defined as "a mental, behavioral, or emotional disorder, [which] can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment," according to the National Institute for Mental Health ("NIMH"), "Mental Health Information: Statistics," *Mental Illness Definitions*, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (last accessed Feb. 21, 2019). Mental disorders are also described as "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD, 1999), at 5.

[8] NAMI, *Mental Health By the Numbers*, *supra* note 7, defining a serious mental illness as an illness that "substantially interferes with or limits one or more major life activities," citing to the NIMH definitions at NIMH, "Mental Health Information: Statistics," *Mental Illness Definitions*, *supra* note 7.

[9] Rachel N. Lipari, Struther L. Van Horn, Arthur Hughes, and Matthew Williams, Substance Abuse and Mental Health Services Administration (SAMHSA), *The CBHSQ Report* (July 20, 2017), Tables 1 and 2; Resources to Recover, Mental Health Resources in Maine, https://rtr.org/mental-health-maine (drawing on SAMHSA data) (last accessed Mar. 25, 2019). Figures were calculated by authors based on data in these sources.

[10] Maine Children's Alliance, *Maine Kids Count* (2019), https://mekids.org/2019-maine-kids-count-data-book.php. Maine has more than 65,000 children diagnosed with developmental, mental, or behavioral issues; many of these children may come to have, psychiatric mental illnesses. *Bangor Daily News*, Editorial, Jan. 12, 2019, paragraph 7. According to Maine local station WGME, a new study in JAMA Pediatrics found that Maine has a higher percentage of children with mental health disorders than any other state. *See* WGME, *Report: Maine Has the Highest Percentage of Children with Mental Health Disorders*, https://wgme.com/news/local/report-maine-has-the-highest-percentage-of-children-with-mental-health-disorders.

[11] *See, e.g.*, E. Fuller Torrey, Mary T. Zdanowicz, Aaron D. Kennard, H. Richard Lamb, Donald F. Eslinger, Michael C. Biasotti, and Doris A. Fuller, Treatment Advocacy Center and National Sheriffs' Association, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey* (April, 2014), TACReports.org/treatment-behind-bars (visit page and select this report), at 9-11 (hereinafter Treatment Advocacy Center, *State Survey*).

[12] *See, e.g.*, E. Fuller Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* (New York: John Wiley & Sons, 1997), Chapters 1, 3, and Appendix, as excerpted by PBS Frontline, "Deinstitutionalization: A

Starting in the 1960s, for a variety of reasons,[13] a different trend for treating people with mental illnesses emerged. This "deinstitutionalization" movement entailed releasing inpatients from the hospitals to reside in communities throughout the states, where they were intended to receive community-based and home-based supportive treatment. Psychiatric hospitals came to admit fewer patients, and most were down-sized or closed.[14]

The movement to deinstitutionalize people with mental illnesses was explicitly coupled with the promise to develop a network of community-based supports and treatments that would enable such individuals to thrive.[15] Due to underfunding and other issues, however, this community-based supportive network was largely not created in Maine nor in most United States communities.[16] With few treatment options available, the criminal justice system has swept up and processed many people with mental illnesses, most merely for expressing behaviors that result directly from their untreated illnesses. Today, Maine incarcerates more individuals with severe mental illnesses than it hospitalizes;[17] nationwide, ten times more people with severe mental illnesses are incarcerated than are hospitalized.[18] Because the criminal justice system was unprepared for the vast influx of individuals with mental illnesses, such persons often faced discrimination, misunderstanding, victimization, lack of treatment, and violations of their civil rights and liberties.

Psychiatric 'Titanic,'" May 10, 2005, https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt html (hereinafter Torrey, *Out of the Shadows*).

[13] *See* Discussion and Sources *infra*, at notes 26-42.

[14] *See, e.g.*, Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 9, Oct. 2012 ("By 2003, the number [of inpatients in U.S. public psychiatric hospitals] had decreased [from its height of nearly 560,000 in 1955] by more than 90 percent to just under 50,000."); Ronald W. Manderscheid, Joanne E. Atay & Raquel A. Crider, "Changing Trends in State Psychiatric Hospital Use From 2002 to 2005," 60 *Psychiatric Services* 29, 31 (January 2009) ("Between 2002 and 2005, the number of state psychiatric hospitals decreased from 220 to 204, and the bed capacity decreased 10.3 percent.").; E. Fuller Torrey, *Out of the Shadows*, *supra* note 12 ("*Deinstitutionalization* is the name given to the policy of moving severely mentally ill people out of large state institutions and then closing part or all of these institutions.")..

[15] *See, e.g.*, Bagenstos, *The Past and the Future*, *supra* note 14.

[16] *See, e.g.*, Jenna Mehnert, Executive Director of NAMI Maine, testimony, *Briefing on the Criminalization of the Mentally Ill before the Maine Advisory Committee to the U.S. Commission on Civil Rights*, *Lewiston, ME*, June 14, 2017, transcript, pp. 31, 43 (hereafter cited as *Briefing Transcript*), citing "[t]he lack of a community-based mental health crisis response system [in Maine]" and, for a person with mental illness creating a public disturbance, "[w]hat community-based service is there for them to go [to, instead of going to jail]? [] The challenge is[,] what are the other resources? What are the community-based mental health services where that individual could be going instead or redirected to instead, in some parts [of Maine]? [] And so the challenge is really about community-based resources and the lack of them."

[17] E. Fuller Torrey, Aaron D. Kennard, Don Eslinger, Richard Lamb, and James Pavle, Treatment Advocacy Center and National Sheriffs' Association, *More Mentally Ill Persons are in Jails and Prisons than in Hospitals: A Survey of the States*, 2010 (hereinafter Treatment Advocacy Center, *More Mentally Ill*).

[18] Treatment Advocacy Center, *State Survey*, *supra* note 11, at 6.

The Maine Advisory Committee to the U.S. Commission on Civil Rights ("Advisory Committee" or "Committee") chose to examine the facilities, care, and resources provided to individuals with mental illnesses in Maine, particularly within the law enforcement and criminal justice system (which has become a sort of *de facto* mental health system). The Committee's primary concerns were whether deficiencies therein might be leading to the "criminalization" of persons with mental illnesses, and how best Maine could offer support, treatment, and care for individuals in the state with serious mental illnesses while appropriately respecting their civil and statutory rights.

By "criminalization," the Advisory Committee means both treating persons with mental illnesses as if they were criminals, and imposing criminal charges on persons with mental illnesses. The word is used neutrally as to the motives of those who "criminalize" mentally ill persons (e.g., to deter "commotions" or "nuisance" behaviors in public places; to bring an ill person to a place where she might receive appropriate care and treatment). The term "criminalization" was introduced by jail psychiatrist Marc Abramson in 1972 to indicate that people with serious mental illnesses were being processed through the criminal justice system instead of the (then-disappearing) mental health system. [19] Advocates for individuals with mental illnesses sometimes use the term "decriminalization" to refer to nondiscriminatory, integrated treatment of persons with mental illnesses after and, particularly, wholly outside of the criminal justice system. The overarching goals of the Committee's work were to decriminalize and to eradicate discrimination against people with mental illnesses.[20]

Towards this end, the Advisory Committee convened a public briefing in Lewiston, Maine on June 14, 2017 ("Briefing") to gather information from local advocates, law enforcement, attorneys, legislators, judicial officials, family members, and the public regarding treatment and criminalization of persons with mental illnesses in Maine.[21] This report draws on briefing testimony and other research to convey that information, and makes recommendations for future improvements.

The Committee concluded that to decriminalize mental illnesses in Maine, two primary approaches are necessary. First, in light of the current situation, the Committee recommends ways to protect and treat individuals with mental illnesses caught up throughout the criminal

---

[19] *See*, *e.g.*, Arthur J. Lurigio, "Forty Years After Abramson: Beliefs about the Criminalization of People With Serious Mental Illnesses*," International Journal of Offender Therapy and Comparative Criminology*, vol. 57(7), 2013, 763, https://journals.sagepub.com/doi/full/10.1177/0306624X13490142.

[20] *See, e.g.,* Milton L. Mack, Jr., Conference of State Court Administrators ('COSCA), *Decriminalization of Mental Illness: Fixing a Broken System* (2017), https://cosca ncsc.org/~/media/Microsites/Files/COSCA/Policy%20Papers/2016-2017-Decriminalization-of-Mental-Illness-Fixing-a-Broken-System.ashx; National Alliance on Mental Illness (NAMI), Decriminalizing Mental Illness (2017), https://www.nami.org/getattachment/Get-Involved/NAMI-National-Convention/Convention-Program-Schedule/Hill-Day-2017/FINAL-Hill-Day-17-Leave-Behind- De-Criminalizing-Mental-Illness.pdf.

[21] *See generally* Transcript of Briefing Before the Maine State Advisory Committee to the U.S. Commission on Civil Rights, Lewiston, ME, June 14, 2017, transcript, p. 29 (hereafter cited as *Briefing Transcript*), *infra* Appendix B.

justice system, with the goal of diverting criminalization and enabling such individuals to thrive in Maine's communities. Next, at the same time, the Advisory Committee recommends funding and building up expanded, appropriate community care systems consistent with evidence-based best practices, so that in time nearly all persons with mental illnesses will benefit from integrated care in their homes and communities.

This report evaluates harms to people with mental illnesses throughout the criminal justice system, and reviews the current laws, procedures, and treatments available. Such problem areas include the failure to prevent and divert people with mental illnesses from ever entering the criminal justice system; ensuring the receipt of appropriate medical treatment to incarcerated persons with mental illnesses; preventing solitary confinement and other punitive measures directed at expressions of a person's mental disability; developing constructive pathways whereby mental health commitment does not become indefinite; and training front-line law enforcement officers about mental illnesses to prevent and divert unnecessary arrests and reduce police shootings of persons with mental illnesses. Approaches that have been tried and tested within Maine and in other locations can provide model best practices for Maine's communities.

Next, under the Fourteenth Amendment and the Americans with Disabilities Act (ADA), this report discusses working to prevent discrimination against people based on their disabilities and to ensure they are afforded procedural protections and substantive autonomy as are other people without mental illnesses. Because the ADA commands integrating people with mental illnesses among other people in the community who lack mental illnesses[22] and views the lack of integration as unlawful, disability-based discrimination,[23] this requires funding and creating services and supports within Maine's communities to treat mental illnesses and enable individuals with mental illnesses to thrive outside institutions in the criminal justice system and psychiatric hospital system. Here, too, best practices and evidence-based treatments can be applied to benefit people with mental illnesses in Maine.

Although most advocates for people with mental illnesses strive for a community-based and home-based network of care, some believe that psychiatric hospitals may still play an important role. A current running through the report examines whether such institutions, along with or in lieu of criminal justice system institutions, should be funded and appropriately used to assist people with mental illnesses in Maine.

Throughout, the report explores the criminalization of people with mental illnesses in Maine, and makes findings and recommendations for how best to decriminalize and prevent discrimination against such persons in the future. Ultimately, success in decriminalization—i.e., coming to separate and divert people with mental illnesses from ubiquitous treatment by the criminal justice

[22] *See* 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities," which is defined in 28 C.F.R. pt. 35 app. A as "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.") (the "integration mandate" of the ADA).

[23] *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999); *see also* Exec. Order No. 13,217, 66 Fed. Reg. 33,155 (June 18, 2001).

system—will require the simultaneous funding, creation, and evolution of integrated networks providing treatment and supports within Maine's communities.

II. Summary of the Briefing

The Advisory Committee designed the Briefing to address (i) the frequency and ways that individuals with mental illnesses interact with Maine's criminal justice system, and (ii) the treatments and interventions that are or can be provided to people with mental illnesses both within and without the criminal justice system's confines. The Committee invited local and national advocates, law enforcement agents, attorneys, legislators, judicial officials, family members, and the public to speak and present information. Each panel of speakers touched on important issues of criminal justice, law, and policy for people with mental illnesses in Maine.

The first panel featured organizational and family advocates for persons with mental illnesses in Maine, including such persons' interactions with the criminal justice system and the impacts of those interactions on the individuals' care, treatment, and prognosis. Speakers included Tonya DiMillo, the Board of Visitors chair of the Long Creek Youth Development Center; Jenna Mehnert, the executive director of the Maine chapter of the National Alliance on Mental Illness (or "NAMI-Maine"); and Bob Reed, a parent and advocate who serves as the board president of NAMI-Maine.

The second panel included several experts among Maine's law enforcement personnel. Speakers included Darrell Crandall, the sheriff of Aroostook County; Jason Madore, commander of the state's police Crisis Negotiation Team; Michael Sauschuck, the police chief of Portland; and Tyler Stevenson, commander of the state's police Tactical Team.[24] Panelists discussed their experiences with and protocols for interacting with persons who have mental illnesses in their official law enforcement capacities.

The third panel generally addressed legal rights and obstacles for individuals with mental illnesses. Topics included such issues within the criminal justice system, including alternative court programs; voluntary and involuntary institutionalization in connection with mental illnesses; and living as supported or unsupported outpatients within Maine's communities. Speakers included Maeghan Maloney, the district attorney of Kennebec and Somerset Counties; Troy Morton, the sheriff of Penobscot County (which formally employs the "Stepping Up" initiative); Kevin Voyvodich, the managing attorney of advocacy group Disability Rights Maine; and Tim Zerillo, a criminal defense attorney and partner at Hallett, Zerillo & Whipple, P.A.

The fourth panel looked toward improving, and "decriminalizing," the treatment provided to persons in Maine with mental illnesses. Speakers included Daniel Wathen, the court master overseeing the Maine Mental Health Consent Decree who is also retired chief justice of the Maine Supreme Court; Maine state representative and co-chair of the Criminal Justice and Public Safety Committee Charlotte Warren of Hallowell; and Maine state representative and co-chair of the Health and Human Services Committee Dr. Patty Hymanson of York. Panelists explored potential legal and policy methods of better treating and caring for Maine's mentally ill residents,

[24] This is also referred to as a "SWAT" team, meaning a "Special Weapons and Tactical" team.

whether through new psychiatric residential facilities, improved mental health provider partnerships with law enforcement and jail/prison personnel, state investment in community housing and treatment resources, or other proposals.

The briefing concluded with questions and comments from members of the public, illustrating the real issues faced day-to-day by the loved ones of individuals with mental illnesses. Cumulatively, the Briefing explored treating and addressing Maine's mentally ill population with multidisciplinary methods in a variety of settings.

A list of speakers is provided in the Appendix.

III. Background on Treatment of Persons with Mental Illnesses

Historic Treatment of Persons with Mental Illnesses

From 1770 to 1820 in the United States, mentally ill individuals were frequently found in America's jails and prisons. Their surroundings were often grossly unsanitary and unhealthy, sometimes lacking basic comforts such as heating in wintertime, and which could otherwise be described as "inhumane" and "degrading" conditions.[25] Although such conditions were applicable to incarcerated persons in many jails and prisons on the whole at the time, influential persons found them especially offensive in the case of mentally ill persons.[26]

Two such influential persons were the Reverend Louis Dwight and social reformer Dorothea Dix. Dwight, who founded the Boston Prison Discipline Society in 1825, publically advocated for improved prison and jail conditions in general and hospitals for mentally ill prisoners in particular.[27] This prompted the Massachusetts legislature in 1827 to investigate conditions in the state's jails, ultimately recommending that all mentally ill inmates of jails and prisons be transferred to the Massachusetts General Hospital and that confinement of mentally ill persons in the state's jails be made illegal.[28] In 1841, Dorothea Dix observed that mentally ill persons in a jail near Boston had no heat in their cells because, as the jailer told her, "the insane need no heat."[29] After visiting many other jails and almshouses, Dix reported to the state legislature that numerous Massachusetts "Insane Persons" were confined "in cages, closets, cellars, stalls, [and] pens: [c]hained, naked, beaten with rods, and lashed into obedience."[30] There and in other locations, Dix shed light on how mentally ill persons were being treated, and successfully urged states to build public psychiatric hospitals where such persons could humanely receive treatment.[31]

Over time, state-run psychiatric hospitals were employed throughout the country. The year 1955 marked the peak use of residential psychiatric institutionalization, when nearly 560,000 individuals with mental illnesses resided at year-end in some 352 psychiatric hospitals.[32]

---

[25] *See generally* E. Fuller Torrey, *Out of the Shadows*, *supra* note 12; Treatment Advocacy Center, *State Survey*, *supra* note 11, at 9-11.

[26] Torrey, *Out of the Shadows*, *supra* note 12.

[27] Ibid., Ch. 3; Treatment Advocacy Center, *State Survey*, *supra* note 11, at 9-11.

[28] Torrey, *Out of the Shadows*, *supra* note 12, Ch. 3. The state then created the 120-patient State Lunatic Asylum at Worcester, more than half of the initial patients of which came from jails, almshouses, and prisons.

[29] Torrey, *Out of the Shadows*, *supra* note 12, Ch. 3; Treatment Advocacy Center, *State Survey*, *supra* note 11.

[30] Torrey, *Out of the Shadows*, *supra* note 12, Ch. 3; Treatment Advocacy Center, *State Survey, supra* note 11.

[31] Torrey, *Out of the Shadows*, *supra* note 12, Ch. 3; Treatment Advocacy Center, *State Survey*, *supra* note 11.

[32] Manderscheid, et al., Changing Trends, *supra* note 14, 29.

Deinstitutionalization Movement

In the middle and late twentieth century, a different trend for treating people with mental illnesses emerged. This "deinstitutionalization" movement entailed releasing inpatients from the hospitals to reside in communities throughout the states, where they were intended to receive newly-created, well-funded supportive treatment. Psychiatric hospitals admitted fewer patients, and most were down-sized or closed.[33]

Several factors in the late 1950's and 1960's led to deinstitutionalization. Some major catalysts included (i) the invention and successful implementation of anti-psychotic medications (starting with chlorpromazine or "Thorazine" in the mid-1950's[34]), which allowed patients to leave facilities and receive treatment as outpatients; (ii) investigative reports revealed the inhumane and disturbing living conditions of some state facilities, changing the public perception of state hospitals;[35] and (iii) a broad, active civil rights movement emerged in America, including civil libertarians who viewed involuntary commitment of blameless individuals suffering from mental illnesses as a form of incarceration, denying liberty and discriminating against people with mental illnesses, and further failing to apply appropriate due process protections.[36] Many deinstitutionalization proponents expressly aimed to replace the state psychiatric institutions with a new system of care, involving a network of supports and treatments accessible to people who lived in homes integrated within communities. They aimed, in other words, "to develop an array of services and supports in the community that would enable people with psychiatric disabilities . . . to flourish."[37] Fiscal conservatives, who favor small, low-spending governments

---

[33] *See, e.g.*, Bagenstos, *The Past and the Future*, *supra* note 14, 9 ("By 2003, the number [of inpatients in U.S. public psychiatric hospitals] had decreased [from its height of nearly 560,000 in 1955] by more than 90 percent to just under 50,000."); Manderscheid, et al., Changing Trends, *supra* note 14, 31 ("Between 2002 and 2005, the number of state psychiatric hospitals decreased from 220 to 204, and the bed capacity decreased 10.3 percent."); Torrey, *Out of the Shadows*, *supra* note 12 ("*Deinstitutionalization* is the name given to the policy of moving severely mentally ill people out of large state institutions and then closing part or all of these institutions.").

[34] *See, e.g.*, Torrey, *Out of the Shadows*, *supra* note 12; Manderscheid et al., Changing Trends, *supra* note 14, 29; Deanna Pan, "TIMELINE: Deinstitutionalization and Its Consequences," *Mother Jones*, Apr. 29, 2013, https://www.motherjones.com/politics/2013/04/timeline-mental-health-america/.

[35] *See, e.g.*, Bagenstos, *The Past and the Future*, *supra* note 14, 16, note 60; Unite for Sight, "Module 2: A Brief History of Mental Illness and the U.S. Mental Health Care System, https://www.uniteforsight.org/mental-health/module2#_ftnref10 ("the institutional care system drew harsh criticism following a number of high-profile reports of poor living conditions and human rights violations [by the mid-1950s]") ; Deanna Pan, "TIMELINE: Deinstitutionalization and Its Consequences," *Mother Jones*, Apr. 29, 2013, https://www.motherjones.com/politics/2013/04/timeline-mental-health-america/ (psychiatric hospital abuses were portrayed in Ken Kesey's *One Flew Over the Cuckoo's Nest*, which was drawn on Kesey's personal experience as a nurse's aide in a psychiatric hospital).

[36] Bagenstos, *The Past and Future*, *supra* note 14, 14-15; Torrey, *Out of the Shadows*, *supra* note 12.

[37] Bagenstos, *The Past and Future*, *supra* note 14, 16. In one litigation to remove mentally ill persons from hospitals to live in communities, the plaintiffs' attorney said the "ultimate goal" was to promote "community-based alternatives (including halfway houses, hostels, group homes, community education and training programs, etc.) so that [psychiatric institutions] can be promptly and completely phased out of existence." Ibid. *See also* Manderscheid, et al., Changing Trends, *supra* note 14, 33 (deinstitutionalization stemmed in part from "the development of a liberating, humane policy that served as an alternative to restrictive institutionalized care," yet researchers and

and low taxes, became allies, supporting deinstitutionalization under the notion that states could save money by reducing the already underfunded residential institutions and replacing them with community-based treatment programs.[38]

These societal conditions and catalysts taken together yielded the closing of hundreds of state institutions, leaving patients and their families to seek residence and support elsewhere. Whereas the peak number of residents in psychiatric hospitals in 1955 was 559 thousand, by 2003 that number decreased to just 47 thousand.[39] The total number of such facilities and the average length of stay also decreased significantly during the past few decades.[40] However, the most important promises of the deinstitutionalization movement did not materialize. True, people with mental illnesses were no longer hidden away and theoretically came to have more autonomy; likewise, states came to spend far less supporting psychiatric hospitals. Yet the network of community-based supports and treatments was not sufficiently funded and did not blossom as originally proposed. As homelessness rates increased, most of the public (and many mental health advocates) viewed, by the 1990s, that the deinstitutionalization movement had failed.[41]

---

policy analysts often spoke with "concerns about the effects of deinstitutionalization in the absence of parallel efforts to build strong community services.").

[38] *See* Bagenstos, *The Past and Future*, *supra* note 14, at 20-21.

[39] Manderscheid, et al., Changing Trends, *supra* note 14, at 29.

[40] *See* Bagenstos, *The Past and Future*, *supra* note 14, at 9.

[41] *See, e.g.*, Richard D. Lyons, "How Release of Mental Patients Began," New York Times, p. C1 (Oct. 30, 1984) ("The policy that led to the release of most of the nation's mentally ill patients from the hospital to the community is now widely regarded as a major failure.), https://www nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html; Bagenstos, *The Past and Future*, *supra* note 14 (asserting that the major reason many hold the (in his view, false) belief that deinstitutionalization was a total failure "is the belief that deinstitutionalization caused an epidemic of 'homeless mentally ill [persons],'" citing to Am. Psychiatric Ass'n, The Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association (H. Richard Lamb ed., 1984) and E. Fuller Torey, Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill (1988)); Torrey, *Out of the Shadows*, *supra* note 12 (same). Others criticize the movement for the failures in developing its intended counterpart, namely, an adequately-funded, rich network of home and community-based supports and treatments. *See* Bagenstos, *The Past and the Future*, *supra* note 14, at 11-13.

Although conventional wisdom dictates that deinstitutionalization was unsuccessful, leading to the abandonment of persons with mental illnesses and an increase in the nation's homeless population, the reality of deinstitutionalization's wake is more complicated. *See* Bagenstos, *The Past and the Future*, *supra* note 14, at 2-4. Some argue that cuts to social welfare programs in the 1980s, not deinstitutionalization, were the main cause of the growth in rates of homelessness of the mentally ill. Ibid., 4, 10-11. The community-based services promised during the deinstitutionalization movement, they argue, were never broadly implemented due to lack of funding and support from the fiscal conservatives who helped promote deinstitutionalization for cost-cutting reasons. See Ibid., 20-21, 43. For example, during the Carter administration, a statute was passed to restructure and improve services for community-based mental health care, the Mental Health Systems Act, PUB. L. 96-398, Oct. 7, 1980, codified at 42 U.S.C. § 9401 et seq. Funding was soon cut, however, under Reagan's Omnibus Budget Reconciliation Act of 1981, PUB. L. 97035 (Aug. 13, 1981), Title IX, § 902(e)(1).

Though funding was cut in the early 1980s, the spike in incarceration rates for people with mental illnesses did not occur until the 1990s. One plausible theory for the delayed increase in mentally ill prisoners is the ruling in the 1990 Supreme Court case *Washington v. Harper*, 494 U.S. 210 (1990), holding that prisoners could be treated against their will with antipsychotic drugs under certain conditions. This decision arguably made it cheaper for prisons to treat mentally ill patients by reducing the procedural barriers to doing so. *See* Frederick E. Vars & Shelby B.

While deinstitutionalization was coupled with the promise of extensive supports and treatments, far fewer such community-based resources were created and funded than were needed to support the many persons with mental illnesses who were released from the psychiatric institutions. As discussed below,[42] this ultimately resulted in people with mental illnesses getting swept up in the criminal justice system. There was a rapid growth in the number of individuals with severe mental illnesses living in the community, some lacking funds, home-based caregivers, medications, and so forth. Many of them exhibited behaviors, caused by their illnesses, that violated social norms and disturbed or frightened other community members. Since there were insufficient community treatments available and the psychiatric institutional options had largely dried up and vanished, people with mental illnesses came to be identified and processed in the criminal justice system.

By the 1970s, it was apparent that more people with mental illnesses were participants in the criminal justice system.[43] In 1972, prison psychiatrist Marc Abramson coined the term "criminalization" of mental illness, indicating the large number of individuals with mental illnesses who were caught up in the criminal justice system.[44] The progressive increase of mental illnesses in the criminal justice system was yet more clear in the 1980s.[45] By 1998, research revealed that at least 16 percent of those in jails and prisons were people with mental illnesses.[46]

Prisons and jails were not created to serve as mental health facilities, yet that has become one of their primary functions in recent years.[47] Most are ill-equipped to provide the mental health

---

Calambokidis, Essay, From Hospitals to Prisons: A New Explanation, 102 CORNELL L. REV. ONLINE 101, 103-04, 113-15 (2017) (citing *Washington v. Harper*, 494 U.S. 210, 227 (1990)).

Among the often-overlooked benefits of deinstitutionalization, according to Bagenstos, are a loss of stigma of mental illness and the integration of those with intellectual and developmental disabilities into many aspects of everyday life (*See* Bagenstos, *The Past and the Future*, *supra* note 14, at 4, 8; Harold Pollack, What happened to U.S. mental health care after deinstitutionalization?, WASH. POST (June 12, 2013), https://www.washingtonpost.com/news/wonk/wp/2013/06/12/what-happened-to-u-s-mental-health-care-after-deinstitutionalization/?noredirect=on&utm_term=.d85edf9c7546.) — not to mention the successful home and community-based treatments and supports that succeeded in being built and funded. However, there are real issues with the nation's current treatment of those with mental illnesses, including a lack of funding for community services to support people with mental illnesses without resorting to institutionalization, and the subsequent deflection of many of these people into jails and prisons or private institutions such as nursing homes. Ibid., 11-12.

The focus of current deinstitutionalization efforts is on the needed accessibility of community-based services for those with mental illnesses who are not institutionalized. See Bagenstos, *The Past and the Future*, *supra* note 14, at 6. However, budget concerns remain due to the high upfront costs of creating community programs. Ibid., 6, 43-44.

[42] *See* Sources and Discussion at Section IV, *infra*.

[43] Treatment Advocacy Center, *State Survey*, *supra* note 11, at 12.

[44] Ibid.

[45] Ibid.

[46] Ibid., 13.

[47] DiMillo, *Briefing Testimony*, p. 26 ("Long Creek is not medically equipped to deal with the delicate needs of youth in acute mental health crisis . . . . [and] Long Creek Youth Development Center is not a mental health

interventions and treatment that mentally ill prisoners tend to require. Nonetheless, the lack of sufficient, more suitable, therapeutic alternatives nationwide and in Maine renders prisons and jails the recurring and long-term "homes" for many people with mental illnesses.[48]

Once individuals with mental illnesses have been processed by all areas of the criminal justice system – the subjects and objects of calls to state police; often arrested and detained; sometimes detained in jails for long periods awaiting psychiatric evaluations; often tried and found guilty of misdemeanors or, in some cases, felony assaults or other felonies, and correspondingly imprisoned; sometimes found incapable to stand trial or not criminally responsible due to mental illnesses and correspondingly incarcerated indefinitely (ostensibly for mental health treatment); – they can encounter severe discrimination, and their civil rights and liberties are frequently violated along the way.

Legal Context of Early Deinstitutionalization Movement

From a civil rights perspective, long-term hospitalizing of people with mental illnesses, especially where involuntary, denied them liberty and autonomy, failed to confer sufficient procedural due process protections, and otherwise discriminated against such individuals. The deinstitutionalization movement served to increase autonomy and procedurally protect people with mental illnesses. A parallel goal, according to many historians, was "to develop an array of services and supports in the community that would enable people with psychiatric disabilities . . . to flourish."[49] In other words, as free, autonomous members of the integrated community, people with mental illnesses could avail themselves of supportive institutions and live intermixed with and as closely as possible to people without mental illnesses.

Deinstitutionalization law and advocacy originally relied primarily upon the Due Process clause of the Fourteenth Amendment,[50] which provides that no state may "deprive any person of life, liberty, or property, without due process of law."[51] Involuntary institutional confinement clearly

---

facility"); Morton, *Briefing Testimony*, p. 134 ("We [Penobscot County Jail] have become the largest mental health detoxification center in northern Maine. And that is not what the county jail was designed for."); Zerillo, Briefing Testimony, p.152 (describing a client who "spent at least four years in jail while significantly mentally ill without staff or an actual doctor to help him. Aroostook [County Jail] does not have a psychiatrist or even a psychologist on staff, and Matt was cycled back and forth between jails for much of the time I represented him because the jails don't have the staff or the funding to deal with people who have his level of [mental health] issues."). *See also* Manderscheid, et al., Changing Trends, *supra* note 14, 33 (January 2009) (State psychiatric hospital admissions increased somewhat between 2002 and 2005; "staff attributed the increases principally to one factor—the increase in the number of forensic [i.e., crime or law enforcement related] admissions and residents.").

[48] Torrey, *Out of the Shadows*, *supra* note 12; Manderscheid, et al., Changing Trends, *supra* note 14, at 33.

[49] Bagenstos, *The Past and Future*, *supra* note 14, at 16.

[50] Ibid., 1, Abstract: "[D]einstitutionalization advocates have moved from the due process theories on which they relied in the 1970s and 1980s to an anti-discrimination theory relying on the ADA," which "imposes a powerful incentive on states to create and fund adequate community services."

[51] U.S. CONST. amend. XIV, § 1.

denies some liberty and autonomy to the persons confined, and advocates worked to assert and establish procedural rights for persons who might be committed to asylums (such as affording a hearing, providing an attorney, applying evidentiary rules, and even a "privilege against self-incrimination").[52] Standards were established in litigation, including finding "beyond a reasonable doubt" that a person is mentally ill, dangerous to self or others, and that all other "less drastic" alternatives to commitment have been investigated and found unsuitable.[53]

In addition to procedural advocacy, litigation was also undertaken in a substantive due process vein, seeking to prove that involuntarily committed persons had a constitutional right to treatment as well as liberty from undue restraint.[54] In *Youngberg v. Romeo*, the Supreme Court upheld a qualified right to treatment based on the decision of a mental health professional, taking state funds allocation into account.[55] This line of cases aimed to improve the treatment of people with mental illnesses inside psychiatric hospitals, but (by definition) could not further the interests of people with mental illnesses obtaining community-based treatments.

Passage of Americans with Disabilities Act: Olmstead *Anti-Discrimination Cases*

In 1990, Congress enacted the Americans with Disabilities Act (ADA), a comprehensive civil rights statute to protect persons with disabilities from discrimination.[56] Title II of the ADA, which deals with government accommodations, requires that no "qualified" individual with a disability shall, "by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[57] The "integration mandate" regulation to Title II provides that a public entity shall "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[58] Beginning in the 1990s, deinstitutionalization lawyers and advocates have successfully brought public and private legal actions asserting that to keep individuals with mental illnesses disabilities in a psychiatric hospital unlawfully discriminates against such individuals by segregating them from people without mental illnesses and denying them the opportunity to integrate with the broader community.

---

[52] *Lessard v. Schmidt*, 379 F. Supp. 1376 (E.D. Wis. 1974); *see generally* Bagenstos, *The Past and Future*, *supra* note 14, section 1C ("Due Process and the Old Law of Deinstitutionalization"), pp. 22-25.

[53] *Id*.

[54] *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971); *Wyatt ex rel. Rawlins v. Sawyer*, 219 F.R.D. 529 (M.D. Ala. 2004). *See generally* Bagenstos, *The Past and Future*, *supra* note 14, section 1C, pp. 25-29.

[55] *Youngberg*, 457 U.S. 307, at 319, 322-23.

[56] Americans with Disabilities Act (ADA), Pub. L. 101-336 (1990), as amended, codified at 42 U.S.C. § 12101 et seq.

[57] 42 U.S.C. § 12132.

[58] 28 C.F.R. § 35.130(d).

The seminal case, decided by the U.S. Supreme Court in 1999, is *Olmstead v. L.C. ex rel. Zimring*.[59] The case was brought by two mentally disabled women, each of whom had mental illnesses as well as developmental disabilities, who were in psychiatric hospitals but wished to be treated in community-based settings. The professionals treating both individuals suggested they could be treated appropriately in community-based settings. Plaintiffs alleged that the state's denial to accommodate such transfers constituted unnecessary segregation that discriminated against them on the basis of their disabilities.[60]

The Supreme Court agreed, holding that "unjustified institutional isolation" was discrimination based on disability.[61] It further held that the state is obligated under the ADA's anti-discrimination mandate to provide community-based treatment for qualified people with mental illnesses where (i) reasonable treatment professionals find it appropriate; (ii) the individuals do not oppose it; and (iii) the placement can be reasonably accommodated, in light of the state's resources and the needs of others with similar disabilities.[62] Only where the state shows that appropriate modifications would "fundamentally alter"[63] the nature of the services, program, or activity may the state may fail to accommodate the individuals with disabilities in the integrated program.[64]

After *Olmstead* was decided, many public and private actors brought deinstitutionalization actions on the premise that segregating individuals with mental illnesses is discriminatory and violates Title II of the ADA. President G.W. Bush issued an Executive Order in 2001 to foster "swift implementation of the *Olmstead* decision" by the states in conjunction with federal assistance, stating that the nation "seeks to ensure that America's community-based programs effectively foster independence and participation in the community for Americans with disabilities," underscoring that "unjustified isolation or segregation of qualified individuals with disabilities is a form of disability based discrimination" prohibited by the ADA and that "states must avoid disability-based discrimination unless doing so would fundamentally alter the nature of the service, program, or activity provided by the state."[65] It stated that the nation "is

---

[59] *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

[60] *Id.* at 593-94. The court elaborated on the discriminatory nature of unjustified isolation, stating that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id*., at 600. Further, it said that institutionalization "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id*., at 601.

[61] *Id.* at 597.

[62] *Id.* at 607.

[63] 28 C.F.R. § 35.130(b)(7)(i) provides that a public entity need not make reasonable modifications to avoid discrimination on the basis of disability if "the public entity can demonstrate that making the modifications would *fundamentally alter* the nature of the service, program, or activity" (emphasis added).

[64] *Olmstead*, 527 U.S. at 603-607.

[65] Exec. Order No. 13,217, 66 FED. REG. 33,155 (June 18, 2001).

committed to community-based alternatives for individuals with disabilities and recognizes that such services advance the best interest of Americans."[66] The Department of Justice has brought deinstitutionalization actions involving people with mental health disabilities in many states, generally obtaining settlement agreements setting timetables for, governing the quality of, monitoring, and requiring states to provide specified integrated, community-based services in areas such as supported housing, treatments (including case management), crisis services, and supported employment.[67]

[66] *Id*.

[67] *See, e.g*., Settlement Agreement, *United States v. Delaware*, No. 11-CV-591 (D. Del. July 6, 2011) (hereinafter "*Delaware Settlement*"); Settlement Agreement, *United States v. Georgia*, Civil Action No. 1:10-CV-249-CAP (N.D. Ga. Oct. 19, 2010) (hereinafter "*Georgia Settlement*"). *See also* Bagenstos, *The Past and the Future*, *supra* note 14, at 35-36.

IV. Evidence of "Criminalization" Links Between Incarceration and Mental Illnesses

As discussed above, people with mental illnesses are overrepresented in prisons and jails nationally. For example, in 2005, the Bureau of Justice Statistics found that more than half of all prison and jail inmates had a mental health problem: 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates.[68] Individuals with mental illnesses are 4.5 times more likely to be arrested than those in the general population.[69] According to the National Alliance on Mental Illness (NAMI), 2 million people with mental illnesses are booked into jails each year.[70] Nearly 15 percent of men and 30 percent of women booked into U.S. jails have a serious mental health condition. In state prisons, the prevalence of serious mental illnesses is 2 to 4 times higher than in the community.[71] The juvenile justice system, too, over-represents youth with mental illnesses; according to NAMI, 70 percent of youth in juvenile justice systems have at least one mental health condition, and at least 20 percent live with a serious mental illness.[72]

The overrepresentation rate of mental disorders in prisons and jails has increased over the decades since deinstitutionalization began; the sheriff of Cook County, Illinois, Tom Dart, recently stated that the rate of persons in jail with mental illnesses had risen from 1 in 15 in 1990 to roughly 1 in 3 by 2015. Similarly, while the average daily population dropped 12 percent from 2005 to 2012 in Rikers Island, the prevalence of mental illnesses rose 32 percent during the same period.[73] By 2014, the number of individuals with serious mental illnesses in prisons and jails exceeded the number in state psychiatric hospitals tenfold.[74] Today, over half of all police calls statewide in Maine are reportedly related to individuals with mental illnesses.[75]

Briefing speaker Jenna Mehnert of NAMI-Maine stated that a person with a mental illness arrested for a misdemeanor will on average serve three times as long as a person without a mental illness.[76] Such a stay is more costly than that of a person without a mental illness not just because of its length, but because the average cost per day is greater due to the institution's

---

[68] James and Glaze, *Mental Health Problems of Prison and Jail Inmates*, *supra* note 1, 1.

[69] Anisha Lewis, Center for Prisoner Health and Human Rights, "Backgrounder: Incarceration and Mental Health," https://www.prisonerhealth.org/educational-resources/factsheets-2/incarceration-and-mental-health/.

[70] National Alliance on Mental Illness (NAMI), "Jailing People With Mental Illness," https://www.nami.org/learn-more/public-policy/jailing-people-with-mental-illness (last accessed Mar. 28, 2019).

[71] David Cloud, Vera Institute of Justice, *On Life Support: Public Health in the Age of Mass Incarceration*, November 2014, at 7

[72] NAMI, Mental Health By the Numbers, *supra* note 7. *See also* DiMillo Testimony, *Briefing Transcript*, pp. 24-25, on data about Maine's juvenile correctional population (e.g., "[a]lmost 85 percent arrived at Long Creek with three or more mental health diagnoses.").

[73] Council of State Governments Justice Center, unpublished data, 2013, cited by Seth J. Prins, "Why Determine the Prevalence of Mental Illnesses in Jails and Prisons?", *Psychiatric Services*, 65(8), Aug. 2014, p. 1074.

[74] Treatment Advocacy Center, *State Survey*, *supra* note 11, p. 6.

[75] Mehnert Testimony, *Briefing Transcript*, p. 30.

[76] Mehnert, testimony, *Briefing Transcript*, p. 29.

obligation to provide mental health treatment and supervision.[77] Jails are reported to spend two to three times more on people with mental illnesses than they do on people without these needs, straining taxpayer budgets.[78]

Maine has too few psychiatric beds for people with mental illnesses involved with the criminal justice system.[79] The wait times for placements, mental health evaluations, and temporary higher-level care for people with mental illnesses in prison and jails tend to be exceedingly long; when prisoners or individuals in jails receive stepped-up psychiatric care and are then returned, frequently another cycle of acute psychiatric need results.[80] At Maine's youth correctional institution, Long Creek, nearly 85 percent of youth enter with three or more mental health diagnoses.[81] Overall, most people with mental illnesses are charged or incarcerated for misdemeanors rather than felonies, and present little threat to public safety.[82]

Youth in the state of Maine have the highest rate in the country of anxiety, and the third highest rate of depression.[83] Maine also has a noteworthy teen suicide rate.[84] Of Maine's 369 youth per 10,000 children in residential treatment, 54 children, or nearly 15 percent, are housed out of state.[85]

---

[77] Stepping Up Summit press release, *Unprecedented National Summit Gathers Teams from 50 Counties to Reduce the Number of People with Mental Illnesses in Jails*, Apr. 18, 2016 (on file with authors); *see also* Treatment Advocacy Center, *State Survey*, *supra* note 11, p. 14 (over a 2-year period, treatment of individuals involved in the criminal justice systems with schizophrenia and bipolar disorder cost Connecticut taxpayers twice as much as treating individuals with the same serious disorders who were not involved in the criminal justice system).

[78] Stepping Up Summit press release, *Unprecedented National Summit Gathers Teams from 50 Counties to Reduce the Number of People with Mental Illnesses in Jails*, Apr. 18, 2016 (on file with authors).

[79] Reed Testimony, *Briefing Transcript*, pp. 14-18 (Reed's son is now housed in a South Carolina psychiatric correctional facility, a thousand miles away from his family and community). For Maine's lack of sufficient beds, *see also* Crandall Testimony, *Briefing Transcript*, pp. 64-65, 69, 100, 102; Morton Testimony, *Briefing Transcript*, p. 160; Sauschuck Testimony, *Briefing Transcript*, pp. 79, 116; Wathen Testimony, *Briefing Transcript*, pp. 174, 177, 179; Zerillo Testimony, *Briefing Transcript*, pp. 149-50, 153.

[80] Crandall Testimony, *Briefing Transcript*, pp. 64-65, 69; Madore Testimony, *Briefing Transcript*, pp. 109-10; Maloney Testimony, *Briefing Transcript*, p. 142; Morton Testimony, *Briefing Transcript*, pp. 134, 160; Reed Testimony, pp. 14-18; Sauschuck Testimony, *Briefing Transcript*, p. 116; Voyvodich Testimony, *Briefing Transcript*, p. 125; Wathen Testimony, *Briefing Transcript*, pp. 176-19, 196; Zerillo Testimony, *Briefing Transcript*, pp. 147-50.

[81] DiMillo Testimony, *Briefing Transcript*, p. 25. Note, too, that 82 percent of the Long Creek youth at intake used drugs.

[82] For example, at Long Creek, the only residential youth detention facility for young people from all 16 counties in Maine, 75 percent of the juveniles were incarcerated on misdemeanor charges rather than more serious crimes; 50 percent had previously been in a psychiatric facility, and nearly 85 percent arrived there with at least three mental health diagnoses. *See* DiMillo Testimony, *Briefing Transcript*, p. 25; Tim Zerillo letter to Ivy Davis, U.S. Commission on Civil Rights, June 13, 2017, p. 2; Long Creek Youth Development Center *Board of Visitors Report*, 2017/2018.

[83] Maine Children's Alliance, *Maine Kids Count*, *supra* note 10.

[84] Ibid.

[85] Ibid.

V. Decriminalizing Persons with Mental Illnesses in Maine: Criminal Justice System

People with mental health problems can enter the criminal justice system either as a result of criminalizing behaviors related to their illnesses or standard criminal justice processing.[86] Criminalization occurs when an arrest results directly from the symptoms of a mental illness; common examples include public-order offenses such as public nuisance for shouting outside of a store, trespassing/loitering, or public intoxication.[87] But people with mental illnesses are also incarcerated for more traditional criminal justice reasons such as assaults, robberies, or drug violations, which may or may not be related to their mental illnesses.[88] The criminal justice system is the only system that "can't say no."[89] However, this places a heavy burden on police forces to make medical decisions and directs certain police resources towards addressing mental health issues and away from more traditional policing tasks of patrolling and responding to 911 calls.

Law enforcement officers and others with power in the criminal justice system sometimes arrest and charge people with mental illnesses because they want to help and see no other viable alternatives; with no available hospital beds or community programs, they instead resort to "mercy bookings" for the chance that the person's mental illness(es) will be treated in jail or prison.[90] District Attorney Maeghan Maloney testified about her own use of a "mercy booking":

> I have had a woman who kept being charged with indecent exposure and engaging in prostitution. And my initial impression was to just not charge her, [] but then I dug in deeper to what was going on and realized that if I didn't do something, nobody was doing anything. And so [] I actually brought a charge just to get her into a group home in Skowhegan and then I dismissed the charge when she had a placement so that she would be safe because I didn't want to read that she had been killed on the front page of my newspaper. So [] it becomes the only way to get someone services, which is completely wrong, but it's all we have.[91]

---

[86] Arthur J. Lurigio, *Forty Years After Abramson: Beliefs About the Criminalization of People with Serious Mental Illnesses*, 57(7) INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 763, 763 (2013), http://journals.sagepub.com/doi/pdf/10.1177/0306624x13490142.

[87] Ibid., 763; Crandall Testimony, *Briefing Transcript*, p. 101.

[88] Maeghan Maloney Testimony, *Briefing Transcript*, 142-43 (describing of a woman in her 60s who shot her husband in the back (at 142), and a man in his early 30s who could not fill his medication prescriptions and, mental health deteriorating, brutally raped a 73-year-old woman in the middle of the night (at 142-43)).

[89] Slate, *supra* note 86, at 349; Kevin Johnson, *Mental illness cases swamp criminal justice system*, USA TODAY (July 21, 2014), https://www.usatoday.com/story/news/nation/2014/07/21/mental-illness-law-enforcement-cost-of-not-caring/9951239/.

[90] *See* Risdon N. Slate, *Deinstitutionalization, Criminalization of Mental Illness, and the Principle of Therapeutic Jurisprudence,* 26 S. CAL. INTERDISC. L.J. 341, 348 (2017); Reed Testimony, *Briefing Transcript*, p. 16.

[91] Maloney Testimony, *Briefing Transcript*, pp. 157-58.

Although such arrests and charges may lead some people with mental illnesses to treatment and recovery, for others it may be a gateway into temporary or ongoing criminal justice system institutionalization.

Prevention of Entry to Criminal Justice System

The vast majority of people with mental illnesses do not act violently.[92] According to a comprehensive report on mental health by the U.S. Surgeon General, "[T]he overall contribution of mental disorders to the total level of violence in society is exceptionally small."[93] The best outcome for non-violent people whose mental illnesses causes socially problematic symptoms is to undergo treatment and receive medical and non-medical needed services in their homes, within the community.[94] Preventing interaction with the criminal justice systems can often be handled with the assistance of family caregivers, case managers, mental health workers, medications, peer support, and other community-based methods.[95] In particular, community-based crisis management services that do not involve law enforcement unless the person exhibits violence or dangerous propensities can help link an individual with mental illness to services and treatments that likely prevent criminal justice system involvement.[96]

Issues of preventing or diverting entry of people with mental illnesses to the criminal justice system are discussed in greater detail later in the report, as community-based initiatives.

Institutional Commitments and Arrests of Persons with Mental Illnesses

A person suffering from mental illness(es) can become involved with the criminal justice system, or with civil care denying the person full autonomy, through various methods and for numerous reasons.

---

[92] *See, e.g.*, Johns Hopkins Bloomberg School of Public Health, *Study: News Stories Often Link Violence With Mental Health Illness, Even Though People With Mental Health Illness Are Rarely Violent*, June 6, 2016 (citing Emma E. McGinity, Alene Kennedy-Hendricks, Seema Choksy and Colleen Barry, "Trends in News Media Coverage of Mental Illness in the United States: 1995-2014," *Health Affairs*, June 2016), https://www.jhsph.edu/news/news-releases/2016/study-news-stories-often-link-violence-with-mental-health-llness-even-though-people-with-mental-health-illness-are-rarely-violent html. *See also* Crandall Testimony, *Briefing Transcript*, p. 61 (stating people with mental illness are "commonly arrested by local law enforcement because they commit petty crimes" related to their illnesses).

[93] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD, 1999), at 7 (internal citations omitted).

[94] *See, e.g.*, 28 C.F.R. § 35.130(d) (integration mandate of ADA); Exec. Order No. 13,217, 66 FED. REG. 33, 144 (June 18, 2001).

[95] *See, e.g.*, section (VI)(2) of the Memorandum of Understanding of Stepping Up Penobscot (undated) (a collaborative agreement among diverse county leaders to divert and prevent people with mental illness from being sent to jails and prisons): "The partners agree to collaborate and provide planning to divert individuals with mental illness from jail, to utilize a screening/assessment tool selection identifying mental health/substance use and trauma related needs/history, to develop a meaningful database, to regularly review community-based resources, to impact county and state policy change efforts[,] and to perform other tasks pursuant to the program . . . ." (on file with authors). *See also* other ways to divert criminal justice involvement, such as use of alternative courts, Maine Pretrial Service Contracts, and other programs that are largely community-based and involve collaborative partnerships among multiple stakeholders.

[96] Mehnert Testimony, *Briefing Transcript*, p. 31 (calling for a statewide mobile crisis system that would only alert law enforcement where there is a "violent element").

In general, individuals possess a constitutional right to liberty, and may not be confined without personally choosing to do so.[97] Mental illnesses, in and of themselves, do not suffice to abridge that right. In *O'Connor v. Donaldson*, the U.S. Supreme Court held that a state "cannot constitutionally confine[,] without more[,] a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[98] States can, nonetheless, confine certain persons with mental illnesses who present dangers.

A Maine police officer can take a person who has not committed a crime into protective custody if the officer has "probable cause" to believe that the individual may have a mental illness *and* that the individual poses a danger to themselves or others as a result of their suspected mental illness.[99] Once in protective custody, the person must be "immediately" escorted via the least restrictive manner and mode of transportation to a medical practitioner who will conduct an evaluation to confirm the police officer's findings.[100] Note that law enforcement speakers testified that this process is often quite far from "immediate," involving lengthy hours or days of waiting by officers who must keep the individuals in their custody.[101] In addition, before admitting that person to a psychiatric hospital, the medical practitioner must certify that there are no available community resources.[102] An individual waiting for an examination may not be held in a jail or local detention or correctional facility.[103] The law officer may, however, formally transfer protective custody of the person to a health officer or health facility representative when a signed, written agreement specifies such arrangement. [104] An application for admission to a psychiatric hospital, complete with the medical practitioner's certification of evaluation, must also pass judicial review prior to the individual's admission to a psychiatric hospital.[105] Generally, the patient cannot be held against his or her will for more than 24 hours, though exceptions allow additional holding time for patients that post a serious risk of harm when a psychiatric bed or "other appropriate alternative" is not currently available.[106]

The U.S. Supreme Court has found that the standard to civilly commit someone, to meet substantive due process requirements, must be more than a mere preponderance of the evidence

---

[97] U.S. CONST., AMEND. XIV, § 1 (No state may "deprive any person of [] liberty [] without due process of law.").

[98] *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975). "A finding of 'mental illness' alone cannot justify a state's locking up a person against his will and keeping him indefinitely in simple custodial confinement. . . . [T]here is [] no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom." *Id*., at 575.

[99] ME. REV. STAT. ANN. 34-B, § 3862(1) (the person "presents a threat of imminent and substantial physical harm to that person or to other persons.").

[100] *Id*. at §§ 3862(1), (4).

[101] Darrell Crandall Testimony, *Briefing Transcript*, pp. 63-64.

[102] ME. REV. STAT. ANN. 34-B, § 3863(2)(C).

[103] *Id.* at § 3863(2-A). *See* Darrell Crandall Testimony, *Briefing Transcript*, pp. 63-64.

[104] ME. REV. STAT. ANN. 34-B, § 3863(2-A).

[105] *Id.* at § 3863(3).

[106] *Id.* at §§ 3863(3)(C), (3)(D) (additional 48 hours), and (3)(E) (another additional 48 hours).

(i.e., it is more likely than not).[107] In Maine, a clear and convincing evidence standard of proof is applied (i.e., it is highly probable or reasonably certain).[108]

For a person to be committed to a psychiatric hospital for a longer period (up to 4 months in the first instance, and up to 1 year in all subsequent instances),[109] a hearing is held by the district court up to 14 days from the date of application (or up to 21 additional days based on a motion for good cause).[110] The individual is entitled to counsel.[111] The applicant must show not only that the individual is mentally ill, but that (1) the person poses a likelihood of serious harm; and (2) "after full consideration of less restrictive treatment settings and modalities, inpatient hospitalization is the best available means for the treatment of the person."[112] The court must find, by clear and convincing evidence, that the person has a mental illness, that the illness poses a likelihood of serious harm, and that the proposed treatment plan is the best available way to treat the patient and is satisfactory.[113]

Individuals with mental illnesses may also voluntarily admit themselves to psychiatric hospitals, or persons under guardianship may be admitted with the consent of the guardian; however, the state's treatment of the person depends on the availability of suitable accommodations.[114]

The police can arrest a person suffering from mental health issues if there is probable cause to believe a crime has been committed and that the person committed the crime. If a defendant is found not criminally responsible by reason of insanity or the court accepts a negotiated plea of the same, the defendant is committed to the care of the Commissioner of Health and Human Services "to be placed in an appropriate institution for the care and treatment of persons with mental illnesses . . . ."[115] Such commitment can potentially continue indefinitely.[116] The court may also find a defendant incompetent to stand trial or otherwise proceed, after applying appropriate procedures including forensically examining the defendant for such competency.[117] Where the defendant is found incompetent, the court must continue the case (i.e., hold it in

[107] *Addington v. Texas*, 441 U.S. 418, 430-32 (1979).

[108] ME. REV. STAT. ANN. 34-B, § 3864(6)(A)(1).

[109] *Id.* at § 3864(7).

[110] *Id.* at § 3864(5)(A).

[111] *Id.* at § 3864(5)(D).

[112] *Id.* at § 3864(5)(E).

[113] *Id.* at § 3864(6).

[114] *Id.* at § 3831.

[115] ME. REV. STAT. ANN. 15, § 103.

[116] *See, e.g.*, Kevin Voyvodich, Testimony, *Briefing Transcript*, pp. 125—6; Tim Zerillo Testimony, *Briefing Transcript*, pp. 162-63. *See also* Daniel Wathen Testimony, *Briefing Transcript*, p. 200 ("When they emptied out [the predecessor to Riverview Hospital], there was a guy in there who had been in for 30 years on a theft [] charge which he'd been found NCR [not criminally responsible] on. It was a misdemeanor charge and he'd been there 30 years. Didn't want to leave when they turned him out.").

[117] *See generally* ME. REV. STAT. ANN. 15, § 101-D, parts 1, 5.

abeyance)[118] and either commit the defendant for appropriate placement, or issue a bail order with or without further requiring the defendant to undergo observation or other appropriate treatment program.[119]

If the government interest in prosecuting the crime is very strong and it believes that medically appropriate drug treatment is significantly likely and necessary to render the defendant competent to proceed without creating undue side effects likely to interfere with fairness, the government may seek to involuntarily medicate the defendant so as to restore competency for trial.[120] The court may allow involuntarily medication for these purposes if the situation meets the requirements set forth in *Sell v. United States* and codified in Maine statutory law.[121] If an adult defendant is found incompetent to stand trial in a criminal case and there is no substantial probability that he will attain competency in the foreseeable future, the government must conduct a civil commitment proceeding or release the defendant, because holding the defendant indefinitely without substantial probability of competency to participate in a trial would constitute a violation of the defendant's rights to equal protection and due process.[122] If a juvenile defendant is found incompetent to stand trial and there is no substantial probability that he or she will be competent to stand trial in the foreseeable future, the state can turn over custody of the child to the Commissioner of Health and Human Services or order the Commissioner to evaluate the appropriateness of providing mental health and behavioral support services to the juvenile.[123]

Correctional Seclusion and Restraint of Persons with Mental Illnesses

Solitary confinement of individuals with mental illnesses is a dangerous practice that many researchers believe can exacerbate illnesses and prevent the administration of medication or treatment.[124] Mentally ill prisoners are disproportionately represented in solitary confinement.[125] There are two common types of solitary confinement. The first type is disciplinary segregation, which is used to punish inmates for breaking rules within the prison.[126] The second type is

[118] The continuance only lasts "until such time as the defendant is determined by the court to be competent to stand trial." *Id.* at § 101-D(5).

[119] *Id.* at § 101-D, parts (5)(A) and (5)(B).

[120] *Sell v. United States*, 539 U.S. 166, 180-82 (2003); holdings codified under 15 ME. REV. STAT. ANN. § 106.

[121] *Sell*, 539 U.S. at 180-82; 15 ME. REV. STAT. ANN. § 106(3)(B).

[122] *Jackson v. Indiana*, 406 U.S. 715, at 1854-55, -58 (1972).

[123] 15 ME. REV. STAT. ANN. §§ 3318-B, 3314.

[124] *See, e.g.*, Kirsten Weir, "Alone, in 'the hole,'" *A.P.A. Monitor*, vol. 43, no. 5, 54 (2012), https://www.apa.org/monitor/2012/05/solitary; American Academy of Psychiatry and the Law, "AAPL Practice Resource for Prescribing in Corrections," *J. Am. Academy of Psychiatry and the Law Online*, vol. 46, No. 2 Supp., June 1, 2018, at § 6.1.1, http://jaapl.org/content/46/2_Supplement.

[125] Kirsten Weir, "Alone, in 'the hole,'" *A.P.A. Monitor*, vol. 43, no. 5, 54 (2012), https://www.apa.org/monitor/2012/05/solitary.

[126] Ibid.

administrative segregation, which is used when an inmate is deemed a danger to other inmates or the prison staff.[127]

In Maine, a prisoner may be placed into administrative segregation for one of four reasons:

1. The prisoner constitutes an escape risk in a less restrictive status;
2. The prisoner may pose a threat to the safety of others if in a less restrictive status;
3. The prisoner may pose a threat to his/her own safety if in a less restrictive status; or
4. There may be a threat to the safety of the prisoner if in a less restrictive status.[128]

Individuals left in solitary confinement who have serious mental illnesses are affected even more than those without mental illnesses by the detrimental effects of solitary.[129] The increased stress, lack of routine, and lack of social connections can exacerbate their symptoms.[130] In addition, mental health professionals are limited in their ability to treat inmates in solitary. Treatment plans may become limited to providing medication, asking the prisoner how they are doing, and sometimes a meeting with the clinician.[131] Due to confinement in their cells, these prisoners may be otherwise unable to attend other therapies which may be vital to their improvement.[132]

In Maine, disciplinary segregation is limited by time, to a maximum of 30 days.[133] Note that the current state code for disciplinary hearings requires that:

> Facility mental health staff shall make available . . . a list of those prisoners whose mental health needs may need to be considered in determining appropriate disciplinary dispositions. If a prisoner on the list has been found guilty of a disciplinary violation, the disciplinary hearing officer shall consult with the appropriate mental health staff prior to determining the disposition.[134]

---

[127] Ibid.

[128] 03-201 C.M.R. ch. 15, § 15.1, Procedure A(1), Procedure C(3). *See also, e.g.*, *Burr v. Bouffard*, 2015 WL 1757106 (Me. Super.) (Trial Order), Order on Respondents' Motion to Dismiss, No. AP-14-57 (Mar. 23, 2015), *5.

[129] *See* American Academy of Psychiatry and the Law, "AAPL Practice Resource for Prescribing in Corrections," *J. Am. Academy of Psychiatry and the Law Online*, vol. 46, No. 2 Supp., June 1, 2018, at § 6.1.1, http://jaapl.org/content/46/2_Supplement.

[130] Ibid.; Abstract to Metzner & Fellner, "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics" *J Am Acad Psychiatry Law*, 38:104–08 (2010). See Reed Testimony, *Briefing Transcript*, p. 15.

[131] American Academy of Psychiatry and the Law, "AAPL Practice Resource for Prescribing in Corrections," *J. Am. Academy of Psychiatry and the Law Online*, vol. 46, No. 2 Supp., June 1, 2018, at § 6.1.1, http://jaapl.org/content/46/2_Supplement.

[132] Ibid.

[133] 03-201 C.M.R. ch. 10, subs. 20.1, § VI, Procedure D, no. 2 (compare Classes A, B, C, and D).

[134] 03-201 C.M.R. ch. 10, subs. 20.1, § IV, Procedure C, no. 14. Note also that the Professional Standards provide there shall be "consultation between the facility and program administrator [] and the responsible health care practitioner [] prior to taking any action regarding . . . seriously mentally ill [] offenders in . . . disciplinary measures." 03-201 C.M.R. ch. 10, subs. 20.1, § VII, ACI - 4-4399.

For "safety reasons," the corrections staff may take other actions "not in the nature of punishment"; it is unclear whether such "other actions" could include extending a period of disciplinary segregation longer than 30 days. This is concerning if the original segregation of the individual stems from behaviors or vulnerabilities that are a direct result of his or her mental illness(es). Although some federal courts have ruled specific instances of solitary confinement for individuals with mental illnesses, e.g., without medical treatment, with deliberate cruelty on the part of corrections staff, or without the opportunity to exercise, constituted cruel and unusual punishment in violation of the Eighth Amendment, there is no general bar on segregated individual confinement of mentally ill persons in Maine.[135]

Criminal Justice Staff Training and Partnering with Mental Health Professionals

Many criminal justice system officers lack the training necessary to interact with people with mental illnesses in a safe and supportive way, and may misinterpret the individuals' behaviors or may stigmatize them.

The Committee heard testimony that over half of the calls to police departments in Maine involved mental health issues.[136] Many of these involved no criminal element, but the people calling may have nowhere else to turn.[137] Police generally attempt to lead persons with mental illnesses to treatment prior to arresting them but because of the lack of available treatment services, they often resort to arrest. This is usually for petty crimes, including disorderly conduct, trespass, loitering, and theft of subsistence items.[138] These calls and the related duties, including waiting at the hospital, identifying options, and transporting people to mental health facilities, remove officers from their traditional duties for hours at a time when Maine is already suffering a shortage of police officers.[139]

---

[135] *See, e.g.*, *Chavis v. Rowe*, 643 F.2d 1281 (7th Cir.) (1980); *Spain v. Procunier*, 600 F.2d 189 (9th Cir.) (1979); Porter v. Clarke, 290 F. Supp. 3d 518 (E.D. Va.) (2018); *Abila v. Funk*, 220 F. Supp. 3d 1121 (D. N.M.) (2016); *Platt v. Brockenborough*, 476 F. Supp. 2d 467 (E.D. Pa.) (2007); *Burnette v. Bureau of Prisons* (unpub.), 277 Fed. Appx. 329 (5th Cir.) (2007); *Wallace v. Hamrick* (unpub.), 229 Fed. Appx. 827 (11th Cir.) (2007).

[136] Mehnert Testimony, *Briefing Transcript*, p. 30. In Portland the number of calls primarily labeled mental health calls is about 1,250 out of a total of approximately 85,000 calls during the year. However, until recently the system only allowed for one disposition per call, so a burglary call would be characterized as that even where the underlying issue was a mental health one. Coding procedures in Portland have been changed to include a secondary disposition, permitting greater and more reliable data collection on the role of mental illness in calls to police. Sauschuck Testimony, *Briefing Transcript*, p. 71.

[137] Mehnert Testimony, *Briefing Transcript*, p. 31; Warren Testimony, *Briefing Transcript*, p. 185.

[138] Crandall Testimony, *Briefing Transcript*, p. 61.

[139] Crandall Testimony, *Briefing Transcript*, pp. 65-66; Jason Madore, Testimony, *Briefing Transcript*, p. 111; Editorial, *Investments in mental health and addiction treatment can help police shortage*, BANGOR DAILY NEWS (Mar. 27, 2018), http://bangordailynews.com/2018/03/27/opinion/editorials/investments-in-mental-health-and-addiction-treatment-can-help-police-shortage/.

A relatively new training model, Crisis Intervention Team training, provides officers with the knowledge and resources to address mental illnesses with greater understanding and sensitivity.[140] It is a 40-hour (i.e., one full week) training program, provided by NAMI Maine members and featuring local community resource providers, that teaches officers about mental health issues, the resources available to deal with them, and de-escalation practices, and is endorsed by the Bureau of Justice Assistance and the International Association of Chiefs of Police.[141] It is "designed to encourage the day-to-day collaboration between police officers and mental health experts," incorporating "a team approach to engagement with persons affected by mental illness[es]." [142] This is an example of law enforcement and criminal justice system officers working in concert or in partnership with mental health professionals and service providers.

Another form of training related to mental illness is "Mental Health First Aid" training.[143] This course takes only 8 hours, or 1 day instead of 5. The course teaches "how to help someone who may be experiencing a mental health or substance use challenge," and is geared towards first responders.[144] According to "Mental Health First Aid USA," it helps trainees "identify, understand and respond to signs of addictions and mental illnesses."[145] Complementing Crisis Intervention Team training, this training is more affordable in time and resources for small and rural law enforcement organizations in Maine, though it does not substitute for the full training on deescalating crises and identifying local resources that is found in Crisis Intervention Team training. The International Association of Chiefs of Police recommends in its One Mind campaign that, at minimum, 20 percent of all sworn law enforcement officers receive Crisis Intervention Team training, and 100 percent of sworn officers receive Mental Health First Aid training.[146]

Many misunderstandings, biases, and even shootings of people with mental illnesses by law enforcement officers might be prevented by providing them with crisis intervention training. Some of Maine's larger cities, such as Portland, embrace Crisis Intervention Team training and

---

[140] International Association of Chiefs of Police, *Improving Police Response to Persons Affected by Mental Illness*, March 2016, report from International Association of Chiefs of Police symposium, p. 19, https://www.theiacp.org/sites/default/files/2018-08/ImprovingPoliceResponsetoPersonswithMentalIllnessSymposiumReport.pdf (hereinafter International Association of Chiefs of Police, *Improving Police Response*); NAMI, *Crisis Intervention Team (CIT) Programs*, https://www.nami.org/Get-Involved/Crisis-Intervention-Team-(CIT)-Programs. *See also* Crandall Testimony, *Briefing Transcript*, pp. 67-69; Mehnert Testimony, *Briefing Transcript*, pp. 30, 52-54; Sauschuck Testimony, *Briefing Transcript*, pp. 72-75.

[141] Mehnert Testimony, *Briefing Transcript*, pp. 52-54.

[142] International Association of Chiefs of Police, *Improving Police Response*, *supra* note 140.

[143] Ibid.

[144] Home page, Mental Health First Aid USA, https://www mentalhealthfirstaid.org/.

[145] Mental Health First Aid USA, "Find a Mental Health First Aid Course," https://www.mentalhealthfirstaid.org/take-a-course/find-a-course/.

[146] International Association of Chiefs of Police, *Improving Police Response*, *supra* note 140, pp. 18-20.

certify all their officers within a year of entering the force.[147] Many of Maine's rural areas do not have the same resources and consequently have not certified many of their officers, although a firm commitment to the training by individual agency leadership appears to lead to certification. For example, seventy percent of officers in the rural Aroostook County Sheriff's Department have completed Crisis Intervention Team training, but none of the ten local agencies in Aroostook County have sent any officers to the Crisis Intervention Team training.[148] In 2015, the Maine Criminal Justice Academy instituted a model policy providing that 20 percent of all full-time officers would receive at least eight hours of mental health training by January 2018.[149] However, eight hours of training for only 20 percent of officers is insufficient.[150]

The Maine State Police fields at least two specialized teams: a crisis negotiation team and a tactical team. Sergeant Jason Madore commands the 13-member crisis negotiation team, for which all members have undergone Crisis Intervention Team and Mental Health First Aid training, as well as specialized training covering negotiation and other skills. The crisis negotiation team handles 20 to 50 calls annually, consisting of barricaded persons, suicidal threats, hostage situations, and the service of high-risk Maine drug enforcement search warrants. Seeking to persuade the person or persons in crisis to change their current direction in an effort to influence a safe resolution, they aim to preserve life and to mitigate the risk to tactical assets and the general public.[151]

The police tactical team handles situations in which a person in crisis has put others at risk. Sergeant Tyler Stevenson commands this 23-member squad, which includes medics and canine handlers among its ranks. The tactical team responds to high-risk incidents statewide, including incidents involving the use or threatened use of deadly force by one person against another; high risk search warrant service and execution; major civil disorders; searches for missing or wanted people; bomb threats; terrorist or sniper incidents; suicidal subjects armed with a dangerous weapon; and calls from the crisis negotiation team for incident assistance. All tactical team members have training in mental health first aid and specialized topics (including "encounters with persons exhibiting behavior indicative of mental illness"); some, but not all, have taken Crisis Intervention Team training.[152]

---

[147] Crandall Testimony, *Briefing Transcript*, p. 69; Sauschuck Testimony, *Briefing Transcript*, p. 73.

[148] Crandall Testimony, *Briefing Transcript*, p. 67.

[149] Ibid., pp. 67-68. Note that a national campaign put forth by the International Association of Chiefs of Police, the "One Mind" campaign, recommends that "a minimum of 20 percent of all sworn officers (and selected non-sworn staff, such as dispatchers) are trained and certified in CIT (Crisis Intervention Teams)."

[150] Ibid., p. 68.

[151] Madore Testimony, *Briefing Transcript*, pp. 80-87.

[152] Stevenson Testimony, *Briefing Transcript*, pp. 87-92.

Sometimes law enforcement officers work alongside mental health experts directly. Chief Sauschuck of Portland has been engaged in a "co-responder" model since the late 1990's.[153] His police squad has a full-time mental health liaison, who answers calls related to mental health issues accompanied by a law enforcement officer. The liaison comes to work at the police office building every day, with a personal police radio, call sign, and unmarked car. Mental health expertise is fully incorporated into staff team decisions. Chief Sauschuck describes the model:

> When we're responding to these mental health calls we respond in a co-responder model; [] we're going through the door in partnership. You have a uniformed police officer and you have a trained mental health professional that are walking through the door together as a team to try to work through whatever situation we may have.[154]

Portland's co-responder program has grown over the years; it now includes mental health interns, a substance abuse liaison, and administrative support.

Health Services and Treatment of Incarcerated Persons with Mental Illnesses

Although the state has a constitutional duty to provide health care to prisoners[155] and to those in jail,[156] failure to provide health care tends only to impose liability when the government shows "deliberate indifference to serious medical needs" of confined persons.[157] In short, the required standard of care is very low.

Once in prison, inmates with mental health issues may not receive sufficient mental health care. In the DOJ Bureau of Justice Statistics study by James and Glaze, for example, only about a third of state prisoners with a mental health problem had been treated for it since admission, under a quarter of comparable federal prisoners received treatment, and the rate was only 17 percent for local jail inmates.[158]

---

[153] Sauschuck Testimony, *Briefing Transcript*, pp. 72-78.

[154] Ibid., p. 72.

[155] *Estelle v. Gamble*, 429 U.S. 97 (1976) (the government has an "obligation to provide medical care for those whom it is punishing by incarceration" because an inmate "must rely on prison authorities to treat his medical needs." The Eighth Amendment bars "cruel and unusual punishments," which are "'incompatible with 'the evolving standards of decency that mark the progress of a maturing society.'").

[156] Substantive due process under the Fourteenth Amendment makes it unconstitutional for the government to disregard the health and safety of detained persons. *See Youngberg v. Romeo*, 457 U.S. 307 (1982); *DeShaney v. Winnebago Cty. Dep't of Soc. Serv's*, 489 U.S. 189, 198-200 (2017).

[157] *See Estelle*, 429 U.S. at 104.

[158] James and Glaze, *Mental Health Problems of Prison and Jail Inmates*, *supra* note 1, 9. *See also* HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 94-125 (2003), https://www.hrw.org/reports/2003/usa1003/usa1003.pdf.

In addition to the lack of treatment available, the prison environment often exacerbates mental health issues, especially when solitary confinement is involved. Prisoners with mental health issues have a higher risk of suicide and have a tendency to violate prison rules because of their mental illnesses, leading to further discipline.[159]

Because Maine has insufficient community-based and institutional mental health services, many persons suffering from mental illnesses end up in Maine's jails and prisons as a last resort, and those facilities are ill-equipped to provide mental health treatment. A substantial number also end up being sent to out-of-state facilities.[160] Additionally, Maine incarcerates more individuals with severe mental illnesses than it hospitalizes.[161]

On the other hand, because so few people in the community with mental illnesses receive treatment, some people with mental illnesses may actually benefit from newly receiving treatment while in prison or jail in Maine. This is the logic behind "mercy bookings" and incorporating a stepped-up mental health medical treatment facility in the Maine state prison.

By its nature, data involving the mental health status of incarcerated individuals are sparse and often unavailable due to privacy laws. Law enforcement personnel in Maine's jails and prisons are usually not equipped or trained to identify mental illnesses or to properly refer inmates for treatment, nor are they privy to inmates' mental health records.

According to data from the Maine Department of Corrections' contracted medical provider, Correct Care Solutions, about 48 percent of juveniles and 34 percent of adult inmates were prescribed psychiatric medications in 2015.[162] The numbers are much higher in some county jails, according to a survey conducted by the Bangor Daily News, as its 2015 survey found that 61 percent of inmates at the York County Jail were receiving such medications.[163]

---

[159] Megan Testa, *Imprisonment of the Mentally Ill: A Call for Diversion to the Community Mental Health System*, 8 ALB. GOV'T L. REV. 405, 417-21 (2015); HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS (2003) at 53-70, 178-81, https://www.hrw.org/reports/2003/usa1003/usa1003.pdf.

[160] DiMillo Testimony, *Briefing Transcript*, pp. 45-46 (stating she believes "a number of youth" are being sent out of state for mental health issues); Reed Testimony, *Briefing Transcript*, p. 17; Wathen Testimony, *Briefing Transcript*, p. 192 ("Maine has two [adult] people in South Carolina that [Riverview] could not handle. . . .").

[161] Treatment Advocacy Center, *More Mentally Ill Persons are in Jails and Prisons than in Hospitals: A Survey of the States*, 2010.

[162] Editorial, *Investments in mental health and addiction treatment can help police shortage*, BANGOR DAILY NEWS (Mar. 27, 2018), http://bangordailynews.com/2018/03/27/opinion/editorials/investments-in-mental-health-and-addiction-treatment-can-help-police-shortage/.

[163] Ibid.; *see also*, Nok-Noi Ricker, *From hospitals to jails: How Maine's mentally ill are still institutionalized*, BANGOR DAILY NEWS (Feb. 20, 2016).

Many advocates have called for the construction of additional beds in new psychiatric hospitals to treat those suffering from imminent mental health crises,[164] but this approach takes for granted the current number of confined persons with serious mental illnesses. "Front-end," preventative care and treatment is demanded by many advocates for mentally ill persons. Adequate in-home and community-based services for treatment of mental illnesses, long before crises arise and at the earliest possible age, could prevent the need for institutionalization as the first and only treatment. Currently, the criminalization of persons with mental illnesses in Maine is greatly exacerbated by its long-term neglect of adequate funding for in-home and community-based delivery of mental health services.[165]

Vulnerability of Persons with Mental Illnesses to Police Shootings and Inmate Violence

Professor E. Lea Johnston defines "offender vulnerability" as "a term . . . to include both substantial risks of serious harm and a need for treatment or protection."[166] She advocates factoring offender vulnerability into judicial sentencing length and conditions of confinement for individuals with serious mental illnesses.[167] Data show individuals with mental illnesses are vulnerable to adverse events not only when incarcerated, but when in the community, as discussed below.

Incidents of Police Shooting Persons with Mental Illnesses

Due to the dearth of consistent mental health services, illnesses that are manageable are often exacerbated and become full-blown crises, and in turn, law enforcement is the first responder to interact with persons experiencing mental health crises; when the situation involves a weapon, officers must quickly evaluate the danger to themselves and others without regard for the person's mental health status, often leading to use of deadly force.

Nationally, quantification of the numbers of persons with mental illnesses who are killed by police has been extremely difficult due to lack of comprehensive reporting of incidents by local police departments to the Federal Bureau of Investigation.[168] As of 2016, fewer than half of the nation's 18,000 police departments reported their incidents to the Federal Bureau of Investigation. The FBI indicated in October, 2015 that it "is overhauling how it tracks violent

---

[164] Treatment Advocacy Center, *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*, 2016, https://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf.

[165] Crandall Testimony, *Briefing Transcript*, p. 64 (Maine did not and does not "actually make sure adequate community-based services exist in all areas of the state to take care of the folks who need it most.").

[166] E. Lea Johnston, *Conditions of Confinement at Sentencing: The Case of Seriously Disordered Offenders*, 63 CATH. U. L. REV. 625, 627.

[167] *Id*. at 627-630.

[168] Kelley Bouchard, *Across the nation, unsettling acceptance when mentally ill in crisis are killed*, PORTLAND PRESS HERALD (Dec. 9, 2012), http://www.pressherald.com/2012/12/09/shoot-across-nation-a-grim-acceptance-when-mentally-ill-shot-down/.

police encounters, calling it 'the highest priority.'"[169] Although the agency has upgraded its database on police use of force, reporting by local police departments remains voluntary, so its information will still not be comprehensive.[170]

In lieu of reliable governmental data, the International Association of Chiefs of Police cites various studies by advocacy groups, mental health providers and investigative journalists in its March 2016 report titled *Improving Police Response to Persons Affected by Mental Illness*,[171] in an attempt to define the scope of police shootings of persons with mental illnesses. The report cited the following:

- A Washington Post study of officer-involved shootings in 2015 finding that victims who were mentally ill or experiencing an emotional crisis accounted for one-fourth of those killed;[172]
- A Treatment Advocacy Center finding that persons with severe mental illnesses are at least 16 times more likely to be killed by police than other civilians; [173] and
- An in-depth study by the American Psychiatric Association finding that at least 11 percent of officer-involved shootings in a ten-year period in a large urban police department were classified as "suicide-by-cop," which means that "a suicidal individual engages in life-threatening behavior with a lethal weapon, or with what appears to be a lethal weapon, toward law enforcement officers or civilians specifically to provoke officers to fire at the suicidal individual in self-defense or to protect civilians."[174]

In Maine, persons with mental illnesses also have been shot by police disproportionately. In 2011, for example, Maine police shot nine people; five of the shootings involved people with mental illnesses, and all five were killed.[175] Likewise, according to a Portland Press Herald analysis of reports by the Maine Attorney General's Office, 42 percent of people shot by police

---

[169] Kimberly Kindy, Marc Fisher, Julie Tate, and Jennifer Jenkins, "A year of reckoning: Police fatally shoot nearly 1,000," WASH. POST, Dec. 26, 2015 (sidebar to story), https://www.washingtonpost.com/sf/investigative/2015/12/26/a-year-of-reckoning-police-fatally-shoot-nearly-1000/?utm_term=.69da202898d5.

[170] Lisa Marie Pane, AP, "FBI Database to Track Deadly Encounters with Police," Nov. 30, 2018.

[171] International Association of Chiefs of Police, *Improving Police Response*, *supra* note 140.

[172] Ibid. (citing Kimberly Kindy, et al., "A Year of Reckoning: Police Fatally Shoot Nearly 1,000, http://www.washingtonpost.com/sf/investigative/2015/12/26/a-year-of-reckoning-police-fatally-shoot-nearly-1000).

[173] Ibid. (citing Doris A. Fuller, H. Richard Lamb, Michael Biasotti, and John Snook, Treatment Advocacy Center, *Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters*, December 2015, at 12, https://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf).

[174] Ibid. (citing H. Richard Lamb, Linda E. Weinberger, and Walter J. CeCuir, Jr., "The Police and Mental Health," PSYCHIATRIC SERVICES vol. 53 no. 10, 1266, at 1269).

[175] Tux Turkel, PORTLAND PRESS HERALD, "Maine Police Make Spotty Use of Crisis Training," Dec. 10, 2012; *see also* archived Maine Attorney General reports, https://www.maine.gov/ag/news/shooting_reports_archive.shtml.

in the state and 58 percent of those killed in police shootings from 2000 to 2012 were people with mental health problems.[176]

The Maine Attorney General's Office routinely investigates each incident when a police officer uses "deadly force," shooting someone, to determine whether the officer was justified under the circumstances.[177] In addition, the Attorney General's office has periodically convened task forces to study and report in depth on trends in and best practices to avoid police shooting: Attorney General Steven Rowe called for a report, issued in December 2008, on law enforcement shootings of individuals in crisis related to "serious mental illness, severe emotional distress, or suicidal ideation" and how to reduce such incidents;[178] the task force found "no consistent deficit in training, procedures, or knowledge" of law enforcement that "if addressed, would have led to a different outcome." In December 2017, then-Attorney General Janet Mills (who became Governor in January 2019) called for another task force to study patterns and recommend how to reduce police shooting incidents.

The report, issued in January 2019, examined Maine police shooting incidents between 2015 and 2016.[179] Eight of the ten incidents involved subjects with "mental health challenges."[180] Among other predictive factors were being male, substance use, criminal and domestic violence histories, and having suffered a recent loss.[181] Nine of the ten task force proactive recommendations for reducing future incidents of police officers shooting community members invoked mental health services, treatments, training, and related issues.[182]

The 2019 report strongly advocated using court-ordered Progressive Treatment Programs for individuals who suffer severe and persistent mental illnesses that pose some risk of harm to self or others but do not rise to the level requiring involuntary commitment. Progressive Treatment Programs involve intensive treatment and regular supervision, and contain specific requirements and restrictions. When an individual under a Progressive Treatment Program is out of compliance, the plan may be enforced; the individual also may immediately be placed in a psychiatric facility.[183]

---

[176] Kelly Bouchard, PORTLAND PRESS HERALD, "Across the Nation, Unsettling Acceptance when Mentally Ill in Crisis are Killed" (Dec. 9, 2012).

[177] Maine Attorney General web site, https://www maine.gov/ag/news/shooting_reports.shtml.

[178] Maine Attorney General Rowe Ad Hoc Task Force, *Report of the Ad Hoc Task Force on the Use of Deadly Force by Law Enforcement Officers Against Individuals Suffering From Mental Illness*, Dec. 4, 2008, at 1 (on file with authors).

[179] Maine Attorney General Mills Task Force, *Report of the Attorney General's Task Force to Review Deadly Force Incidents by Police*, Jan. 28, 2019, at 1 https://www mcedv.org/wp-content/uploads/2019/02/Report-of-the-Attorney-Generals-Task-Force-to-Review-Deadly-Force-Incidents-by-Police.pdf.

[180] Ibid., 3.

[181] Ibid., 2-3.

[182] Ibid., 4-7.

[183] Ibid., 5.

While some Maine police precincts have implemented some training regarding mental illnesses, some may have no training at all. The U.S. Supreme Court has held that a municipality may be held liable under a § 1983 civil rights claim for failing to train its law enforcement officers if "the failure to train amounts to *deliberate indifference* to the rights of persons with whom the police come into contact" (emphasis added).[184] The Court holds that the subjective deliberate indifference standard is stringent, requiring proof that "a municipal actor disregarded a *known* or *obvious* consequence of his action" (emphasis added).[185] Thus, it would be difficult, although indeed possible, to make out a civil rights violation against a local municipality for failure to train its officers about the rights of persons with mental illnesses.

The U.S. Supreme Court has held that restraining a person's freedom to walk away, i.e., "apprehend[ding]" him "by the use of deadly force," constitutes a "seizure" subject to the Fourth Amendment's restriction on "unreasonable [] seizures."[186] The use of deadly force has been found an unreasonable "seizure" under the Fourth Amendment's balancing test where the circumstances involve a suspect who "poses no immediate threat to the officer and no threat to others" – "the harm resulting from failing to apprehend him does not justify the use of deadly force to do so."[187] In all of the ten incidents examined by the 2019 Maine task force in its report, however, the subject of the shooting had a weapon.

Vulnerability While Incarcerated

Individuals with mental illnesses are at risk when incarcerated, as violence among inmates is common and often used to enforce codes of behavior.[188] Their symptoms may cause inmates with mental illnesses to engage in repetitive, disruptive outbursts, noises, or other behaviors that may upset or disturb neighboring inmates; moreover, inmates taking psychiatric medications may be more vulnerable to physical assault due to sedation or cognitive slowing.[189] Sexual abuse is not uncommon in prisons; according to the Treatment Advocacy Center and the National Sheriffs' Association, a 2007 prison survey showed that "approximately one in 12 inmates with a mental disorder reported at least one incident of sexual victimization by another inmate over a six-month period, compared with one in 33 males [*sic*] inmates without a mental disorder."[190]

---

[184] *City of Canton v. Harris*, 489 U.S. 378, 388 (1989).

[185] *Connick v. Thompson*, 563 U.S. 51, 61 (2011).

[186] *Tennessee v. Garner*, 471 U.S. 1, 7 (1985).

[187] *Id.* at 1, 11.

[188] Megan Testa, *Imprisonment of the Mentally Ill*, *supra* note 159, 417-18; Treatment Advocacy Center, *State Survey*, *supra* note 11, p. 15.

[189] Megan Testa, *Imprisonment of the Mentally Ill*, *supra* note 159, 417-18.

[190] Treatment Advocacy Center, *State Survey*, *supra* note 11, p. 15. *See also* Congressional findings supporting the Prison Rape Elimination Act of 2003, PUB. L. 108-79, 117 Stat. 972 (Sept. 4, 2003), now codified at 34 U.S.C. § 30301 et seq., as amended, which include the following: "Inmates with mental illness are at increased risk of sexual victimization. America's jails and prisons house more mentally ill individuals than all of the Nation's

"Among female mentally ill inmates," they continued, "this difference was three times higher than among male mentally ill inmates."[191] Thus, incarcerated persons who are mentally ill are exceedingly vulnerable to attack while incarcerated.

The data on violence and abuse of incarcerated individuals with mental illnesses are staggering. Megan Testa chronicles, for example, that:

> Inmates with severe mental illness are up to eight times more likely to be physically abused in correctional settings than are other inmates, and they experience sexual abuse at a higher rate as well. Research has shown a positive association between the severity of psychiatric symptoms and abuse. Assaults are under-reported because inmates are ashamed, struggle with guilt about the assault, and worry that correctional staff (or administration in the event of staff on inmate violence) may not believe them or that perpetrators may retaliate if they are reported.
>
> Mortality among individuals with mental illness who are incarcerated is high, both during the time they are imprisoned and after their release. Suicide, defined as "death caused by self-directed harmful behavior with the intent to die as a result of the behavior[,]" is a leading cause of death among those imprisoned in correctional settings. Of deaths that occur in prison, suicide is the number one cause; it accounts for half of lives lost. (internal cites omitted) [192]

Discharge & Release Issues

Many people with mental illnesses have been institutionalized, either in a hospital, a residential correctional jail or prison, or some other institutional setting. When entering or re-entering community living, such people with mental illnesses may (initially, or over a longer period) have difficulty faring for themselves. They may not have had adequate support finding and retaining housing, food, money, medications, therapeutic opportunities, peer and community relationships, case management, and other necessities.[193] Certain behaviors stemming from their mental illnesses, even when harmless, may disturb other community members, or cause neighbors or onlookers to fear them.[194] They may not have been adequately prepared or supported when greater autonomy and liberty suddenly became available to them. At times, their reactions may have created dangers to other people or to themselves.[195] Ill-equipped to live autonomously, without work and general coping skills, certain individuals with serious mental illnesses may

---

psychiatric hospitals combined. As many as 16 percent of inmates in State prisons and jails, and 7 percent of Federal inmates, suffer from mental illness."

[191] Treatment Advocacy Center, *State Survey*, *supra* note 11, p. 15.

[192] Megan Testa, *Imprisonment of the Mentally Ill*, *supra* note 159, 418.

[193] Voyvodich Testimony, *Briefing Transcript*, p. 123.

[194] Ibid., 122.

[195] Reed Testimony, *Briefing Transcript*, pp. 13, 15.

have acted unconventionally, inappropriately, or even overtly violently or otherwise criminally.[196]

A number of aspects of treatment and support – such as housing, caregiving or case management, treatment, medication, funding, jobs or activities, and social supports – must be available in the community for a person with a mental illness to flourish, and are discussed more extensively in Chapter VI on community-based care, below.

It is important to point out here that the criminal justice system personnel may make little to no plan for how an individual's needs will be met once released to the community. Chief Sauschuck, for example, mentioned being informed about three upcoming "discharge plans" that only involved releasing people from Riverview and sending them to a Portland shelter.[197] Such a "plan" does not assure long-term housing, treatment, medication, and other necessary medical and social supports for a newly released person with a mental illness. It is probable that a person without a more fulsome release plan and with no known caregivers will encounter difficulties meeting needs, and may get caught in the "revolving door" phenomenon of recurring criminalization.

The "revolving door" metaphor represents a pattern of repeated entries and exits from arrest, jail, prison, or hospitalization. Numerous briefing panelists referenced this pattern, and how costly it could be both for law enforcement and mental health service provider resources, and for the individual with a mental illness who desired to get on with his or her life successfully in the community.[198] Without stable housing on release, for example, a person with a mental illness might be unable to establish routines to get therapy, medication, and food, and might instead

---

[196] Crandall Testimony, *Briefing Transcript*, p. 101; Mehnert Testimony, *Briefing Transcript*, pp. 42-43; Reed Testimony, *Briefing Transcript*, p. 13.

[197] Sauschuck Testimony, *Briefing Transcript*, p. 79.

[198] Crandall Testimony, *Briefing Transcript*, p. 64 (because Maine lacks sufficient community-based networks throughout the state, individuals return "at a crossroads of going to jail, being forced into mental health evaluation, or in some cases much worse."); Madore Testimony, *Briefing Transcript*, pp. 108-09 (failing to arrest a person with mental illness likely means spending more resources in the future to answer another call about the person); Maloney Testimony, *Briefing Transcript*, pp. 157-158 (Eventually brings charges against "a woman who kept being charged with indecent exposure and engaging in prostitution" in order "to get her into a group home . . . and then I dismissed the charged when she had a placement so that she would be safe."); Morton Testimony, *Briefing Transcript*, p. 137 (To stop the revolving door, community needs to involve the "critical stakeholders," or else "folks are only going to continue to come back into jail."); Sauschuck Testimony, *Briefing Transcript*, pp. 94-95 ("There are instances [] that we know that this person doesn't belong in jail but [] this is a 3rd, 4th, 5th time, we've reached out to all of our providers in the area, we've tried to develop a plan. And even as a group, the decision is this person has to go to jail and then we'll get them stabilized in some kind of location so that we can try to mandate some kind of assistance down the road."); Stevenson Testimony, *Briefing Transcript*, pp. 108-09 ("Our options are none. We have one option. You're either going to the hospital or you're not going to the hospital. [] So you go to the scene, you determine is this person a danger to themselves or others, or potentially property? If they're not and they don't want to go to the hospital, then you leave them. You can't force them to go."); Voyvodich Testimony, *Briefing Transcript*, p. 119 (On revolving door that clients go through: "[W]e are seeing individuals sometimes multiple times, sometimes from the jail to the hospital back into the community residential program . . ."); member of public, Jean Gore, *Briefing Transcript*, pp. 207-08 ("And then along about his 34th hospitalization, he had become a revolving door, just in and out of the hospital because they'd treat him, they'd send him on his merry way, he'd stop taking his medication, he'd get sick again, and he'd be back. And he was homeless. He'd been in jail twice.").

reach a crisis leading to jail or the hospital emergency department.[199] Likewise, a person who creates noises or loiters in a way disturbing to others in her surroundings may be the subject of a series of complaint calls, without actually being arrested or taken for mental health evaluation. "[T]he issue with leaving the person there" in such a situation, according to panelist Jason Madore, "is you know you're going [to go] back, which is going to increase your calls for service, [and] increase [the] resources that you need."[200] Even if a person is relatively stable upon release, having a criminal record, especially for a felony crime, can restrict future access to jobs, leases, public benefits, various job-related licenses, or certain mental health care benefits, and lead to a decrease in stability whereby the person lacks needed resources and must somehow return to the criminal justice system and its institutions. [201]

Thus, careful, resource-rich discharge or release planning is important because people with mental illnesses are frequently arrested, charged, or imprisoned just for exhibiting signs of their mental illnesses; then their treatment in jail or prison (or other parts of the criminal justice system) aggravates their illnesses, increasing the chance of them ending up in the criminal justice system again. Likewise, releasing a person without an appropriate treatment and case management plan can contribute to the revolving door. A person who responds well to treatment while incarcerated may have difficulty obtaining care or accessing identical medications afterwards. The person might also have difficulty adjusting to home and community life if he or she suffers from anosognosia,[202] which is the neurologically-based "lack of insight" and mistaken belief that he or she is fine and not affected by a mental illness. Such a person may then decompensate and suffer more acute symptoms of the mental illness while in the community. Symptomatic behaviors may lead to another arrest, especially if the person robs or otherwise assaults a community member.[203]

---

[199] *See, e.g.*, NAMI Maine, *Mental Health System Reform* (2018), p. 17, https://cdn.ymaws.com/www.namimaine.org/resource/resmgr/advocacy/final_web_version.pdf.

[200] Madore Testimony, *Briefing Transcript*, pp. 108-09.

[201] *See generally* U.S. Commission on Civil Rights, *Collateral Consequences: The Crossroads of Punishment, Redemption, and the Effects on Communities* (forthcoming report) (search on https://www.usccr.gov/).

[202] Treatment Advocacy Center, "Serious Mental Illness and Anosognosia," June 2016, https://www.treatmentadvocacycenter.org/key-issues/anosognosia/3628-serious-mental-illness-and-anosognosia; Jean Gore (public) Testimony, *Briefing Transcript*, p. 207.

[203] For example, Bob Reed's son, Anthony, was arrested during a manic episode for assaulting someone who would not give him a cigarette, leading to his "bouncing in and out of prison with his mental health deteriorating with each incarceration." Reed Testimony, *Briefing Transcript*, p. 13.

V. Decriminalizing Mental Illnesses in Maine: Community-Based Services

When transitioning from an institution to community living, people with mental illnesses may make substantial adjustments and changes. This report section discusses how the individuals and the community may prepare for and address such adjustments and needs.

First-Order Needs: Stable Housing, Continuous Treatment, and Adequate Funds

Many briefing panelists testified about the immediate needs of people upon entering community living. The "Housing First" model seems promising: initially "getting [people with mental illnesses] housed and bringing services in to them."[204] Without stable housing, it can be extremely difficult to deal with medication, therapy, social support, and other basic issues of community living.

NAMI Maine stressed the importance of safe, accessible, and government-funded housing in its 2018 proposed "Mental Health System Reform[s]" for Maine:

> Portland has been fostering the Housing First model with the development of Logan Place and Florence House. The Housing First model delivers a real solution to the struggles associated with homelessness. Logan place 'provides efficiency apartments and 24 on-site support for 30 adults who had previously been homeless.' This model allows individuals to succeed in their recovery by providing a safe place where they have the ability to engage in mental health care and form social connection with other individuals. [205]

NAMI-Maine recommends implementing the Housing First model statewide "with designated state funding at a level that would allow for a measurable increase in availability for housing in Portland, Augusta, Waterville, Bangor, and Houlton."[206] They also recommend that a "homeless liaison" be developed for law enforcement, and that "working partnerships" be developed among landlords, advocates, and service providers "to obtain, maintain, and sustain safe, long-term housing."[207]

Panelist Kevin Voyvodich of Disability Rights Maine recently surveyed his consumers with mental illnesses about their needs. Among the needs mentioned were

> [A]dequate crisis services, medication services, access to housing, employment and peer services within the community such as peer respite [] as an alternative to hospitalization, going to the emergency department.[208]

---

[204] Voyvodich Testimony, *Briefing Transcript*, p. 120.

[205] NAMI Maine, *Mental Health System Reform*, *supra* note 198, at 17.

[206] Ibid.

[207] Ibid.

[208] Voyvodich Testimony, *Briefing Transcript*, p. 123.

Voyvodich spoke briefly about how Disability Rights Maine addresses such needs:

> We're preventative, working on issues such as getting a mental health service system that has adequate crisis services, which we've already heard a lot about, but that is an extremely important part of the system as far as reducing those interactions with law enforcement, access to medication as far as adequate medication services in the community so that if someone wants medication even in a rural area, they can get it, and they can get appointments in a reasonable [] area within where they live and where they reside, as part of community treatment teams that help people with severe and persistent mental illness navigate the community systems. And adequate housing as far as getting individuals housed with mental illness and not necessarily having that attached to a particular service model but getting them housed and bringing services in to them.[209]

Several panelists spoke about the lack of adequate community-based crisis services for people with mental illnesses to use voluntarily. The Police's Crisis Services Team requires one to risk commitment, arrest, and other interaction with law enforcement that an individual in crisis might not desire. Moreover, Maine has an existing system of crisis stabilization units that is "currently inaccessible to law enforcement" and for which funding was deeply cut in 2017.[210] Jenna Mehnert, Executive Director of NAMI Maine, articulated key problems with how crisis services are provided in Maine:

> Maine's current funding structure prevents the existence of a dynamic statewide mobile crisis response system that would allow law enforcement's involvement to be reserved only for calls where there is a violent element. The lack of a community-based mental health crisis response system results in the criminalization of mental illness because individuals are often forced to interact with law enforcement when their actions have no criminal component.[211]

The demands on those in Maine attending to mental health crises may be impacted by the restructuring of the Maine Crisis Network.[212] Previously, callers to the statewide crisis hotline were answered regionally; if a face-to-face meeting was required, someone from the same region would meet the caller in person. Since the restructuring, however, all mental health calls are channeled through a single provider first so as to ensure consistent service and resolve as many calls as possible by phone. The reimbursement system for crisis providers has been overhauled as well: now, local providers are only reimbursed for face-to-face services provided, not for the day-to-day activities involved in ensuring their 24/7 availability. This funding change puts many regional mental health crisis services at risk, as local providers determine how to continue

---

[209] Ibid., 120.

[210] NAMI Maine, *Mental Health System Reform*, *supra* note 198, p. 8.

[211] Mehnert Testimony, *Briefing Transcript*, p. 31.

[212] Matthew Stone, *DHHS quietly overhauls aid for children, adults in crisis*, BANGOR DAILY NEWS (June 4, 2018), https://bangordailynews.com/2018/05/30/mainefocus/dhhs-quietly-overhauls-aid-for-children-adults-in-crisis/.

operating with many of their costs now ineligible for reimbursement.[213] Logically, if Maine's crisis services are reduced due to this restructuring, the police departments, hospital emergency rooms, and county jails that refer callers to the hotline will be forced to handle even more crises.

Another general, high-priority issue concerns funding for other community-based treatment and service programs and providers. As discussed below,[214] although expansion of MaineCare (Maine's Medicaid program) became available to many single adults in the U.S. years ago and was supported by Maine's state legislature and its voters, the expansion was not made available in Maine until February, 2019.[215] Without insurance, it is difficult for many people with mental illnesses to obtain even basis therapeutic treatment, let alone paying for medications and obtaining other needed supports.

Of particular concern for the network of community-based services to grow in Maine is the low rate of pay, through MaineCare and even private funders, for professional mental health care providers.[216] Many such professionals have advanced degrees and substantial training, yet end up leaving the state because the wage level is low compared with other states.[217] This is especially true in rural areas, which can have difficulty attracting and maintaining psychiatrists, psychologists, and other mental illness treatment and service professionals.[218]

Of course, to live in the community rather than a hospital or prison, a person must be able to obtain food, clothing, and fulfill other basic physical needs. Some newly released people with mental illnesses may be able to work for pay; job-training and job-seeking supports would greatly benefit them. Others may need to apply for disability funds, for which experienced, supportive assistance is likely needed.

---

[213] Ibid.

[214] *See infra* § VII, Findings and Recommendations section I.

[215] Patient Protection and Affordable Care Act (ACA), PUB. L. 111-148 (Mar. 23, 2010); Me. Exec. Order No. 1 (Jan. 3, 2019), https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/Executive%20Order%201_0.pdf.

[216] NAMI Maine, *Mental Health System Reform*, *supra* note 198, p. 5 (Responding to the state's "increasing [specialized] workforce shortage within the mental health field," NAMI Maine advises that "[e]nsuring adequate reimbursement rates will attract more specially trained professionals who have the skills and training necessary to meet the [mental health] needs of Mainers.").

[217] Wathen Testimony, *Briefing Transcript*, p. 203 (On specialist turnover: "One of the long-time [forensic] residents of Riverview [] told me that he had 22 [successive] psychiatrists [within] four or five years.").

[218] *See infra* Discussion and Sources at § VII, Findings and Recommendations, Finding 1-B, including LD 3 (at note 288), a legislative proposal to repay substantial student loan debt for skilled professionals who provide mental health services in underserved parts of Maine for at least five years.

Treating Children with Mental Illnesses in Homes and Communities

In 1997, state officials, service providers, parents and advocates developed "a strategic plan for building up the range of services for children with mental health challenges that they could access without having to check into a hospital or be committed to an institution."[219] At that time, the legislature responded to the proposed strategic plan, as well as to lawsuits against the state, by devoting funding, enacting statutory and regulatory guidance and creating a comprehensive mental health delivery system for its youth. However, the system has long since been neglected: funding levels were not sustained for MaineCare, the state's Medicaid program, which pays the same rate today for many behavioral health services for children as it did over a decade ago.[220]

As the Bangor Daily News described the predicament in an editorial:

> Since costs have risen [since 1997], that means fewer and fewer providers have been able to afford to provide specialized services such as medication management, in-home behavioral health services, assertive community treatment for children (which helps children return to home life after a psychiatric hospitalization), and multisystemic therapy (an intervention aimed at reducing criminal behavior and aggression). The LePage administration even tried to cut funding for some of these services in 2015.
>
> With so little investment in a system of behavioral health services for children, and no current plan for sustaining the state's available resources and services, is it any wonder that psychiatric hospitals and the state's youth prison are common destinations for so many Maine youth with mental illness? The result is a system that's overwhelmed and ill equipped to address their difficult needs − many of which could be addressed sooner with less intensive services, if only they were available. There often appears to be little aside from the most intensive − and expensive − levels of attention.[221]

Historically, multisystemic therapy has been a highly successful home and community-based treatment used for Maine youth.[222] The program involves intensive therapy, delivered by a team in the child's home several times a week for up to six months. What sets this treatment plan apart from others is the involvement of family members and others regularly involved in the child's life, sometimes including neighbors, friends, teachers, and probation officers. Multisystemic therapy has been proven to reduce violence, aggression, and out-of-home placements of children with behavioral problems such as conduct disorder, both within Maine and across the country. It has also been endorsed by the Maine Department of Corrections. However, the MaineCare

[219] Editorial, *Maine's failed to keep at-risk youth safe. No wonder Long Creek is overwhelmed*, BANGOR DAILY NEWS (July 4, 2018), https://bangordailynews.com/2018/07/04/opinion/editorials/maines-failed-to-keep-at-risk-youth-safe-no-wonder-long-creek-is-overwhelmed/.

[220] Ibid.

[221] Ibid.

[222] Ibid.; Erin Rhoda, *A mother's struggle to help her violent son*, BANGOR DAILY NEWS (June 11, 2018), https://bangordailynews.com/2018/06/11/mainefocus/a-mothers-struggle-to-help-her-violent-son/.

reimbursement rate for the program has consistently failed to meet the actual costs incurred by providers, leading to a decrease in the number of providers in Maine, from eleven to four and a half. This drastic reduction in services, resulting from the providers' sustained six-figure losses, has led to areas of the state without any access to multisystemic therapy, and long waiting lists for others. A similar program, called functional family therapy, is offered by only two providers in the state and is reimbursed at the lowest rate across the nation.[223]

Maine's only juvenile correctional facility, Long Creek Youth Development Center (located in South Portland), has itself become a *de facto* treatment facility for youth with acute care needs, even though it is not designed, equipped or intended to be a mental health treatment facility. One Long Creek resident committed suicide in 2016, and another made a suicide attempt soon after. According to Long Creek board of visitors chair Tonya DiMillo, "[s]everal youth continue to self-harm, have attempted or made threats to harm themselves, and require unsustainable levels of constant observation."[224] Although such residents have acute care psychiatric needs, Long Creek is not equipped to treat them; it can "merely [] manag[e]" such youth "for their safety."[225] A Department of Corrections review of Long Creek in 2016 showed that 67 percent of its residents had received special education services and almost 85 percent had three or more mental health diagnoses upon entering the facility.[226] In its most recent report, the Long Creek Board of Visitors called for a review of the contract with the care provider at Long Creek, and overseeing committee members that possess mental health background.[227] This follows a 2017 independent report that found that Long Creek was "understaffed and ill-equipped to handle the serious mental health needs of young residents."[228] Though the staff are capable, they are not trained to deal with mental health issues and are often forced to work double shifts.[229]

Some advocates have called for the closing of Long Creek so that the state can move youth into home and community-based facilities that allow for more specialized attention from staff. [230] They argue that recent, government-promulgated data shows that home and community-based

---

[223] Erin Rhoda, *A mother's struggle to help her violent son*, BANGOR DAILY NEWS (June 11, 2018), https://bangordailynews.com/2018/06/11/mainefocus/a-mothers-struggle-to-help-her-violent-son/.

[224] Tonya DiMillo Testimony, *Briefing Transcript*, p. 23.

[225] Ibid.

[226] DiMillo Testimony, *Briefing Transcript*, pp. 24-25.

[227] Long Creek Youth Development Center, *Board of Visitors 2017/2018 Report*; Jake Bleiberg, *Youth prison watchdog calls for audit of medical contractor*, BANGOR DAILY NEWS (May 29, 2018), https://bangordailynews.com/2018/05/27/news/portland/youth-prison-watchdog-calls-for-audit-of-medical-contractor/?_ga=2.210653461.1850325411.1528829658-1771776550.1528466769.

[228] Matt Byrne, *Review finds Long Creek is understaffed and ill-equipped to meet youths' mental health needs*, PORTLAND PRESS HERALD (Dec. 15, 2017), https://www.pressherald.com/2017/12/14/review-finds-maines-youth-correctional-center-under-staffed-ill-equipped-to-help-many-in-its-care/.

[229] Ibid.

[230] Ibid.; Peter M. Rice, *Maine is moving backward on children's behavioral health*, BANGOR DAILY NEWS (June 5, 2018), https://bangordailynews.com/2018/06/05/opinion/contributors/maine-is-moving-backward-on-childrens-behavioral-health/.

services lead to improved outcomes on many measures, such as lower suicide rates and improved school attendance and performance, at a lower cost.[231] Others have suggested creating smaller residential facilities tailored to specific populations.[232] Another approach, recently suggested by the Board of Visitors, involves removing Long Creek out from under the umbrella of the adult corrections program and perhaps shifting it to the child welfare or public health departments.[233]

Outside Criminal Justice System: Status of Psychiatric Hospitals?

Maine's state psychiatric hospital capacity has also been highly controversial in recent years, both in terms of the level, type and quality of care provided by the existing hospitals and the debate around the building of a new facility, the level and type of care to be provided by a new facility and even the geographic location of a new facility. In the meantime, persons with mental illnesses are shifted between hospital and correctional facility, and often to out-of-state treatment facilities.[234]

There are currently two state psychiatric hospitals under the Maine State Department of Health and Human Services. The Dorothea Dix Psychiatric Center (formerly known as Bangor Mental Health Institute) is a 51-bed inpatient hospital with forensic bed capacity as of early 2017.[235] Located in Bangor, Maine; it also provides outpatient services. Riverview Psychiatric Center is a 92-bed inpatient psychiatric hospital which serves both civil and forensic patients, who are those committed relating to criminal charges. It has 44 forensic beds and 48 civil beds.[236] In 2013, Riverview was decertified by the U.S. Centers for Medicare and Medicaid Services for issues concerning medication errors, improper restraint use, and the use of stun guns and pepper spray.[237] It was not recertified until February 22, 2019.[238]

Maine is also planning to append an additional 20 beds to Dorothea Dix in Bangor, which Governor Mills says should add generally to Maine's mental health bed count, including people

---

[231] Joint CMCS and SAMHSA Informational Bulletin, May 7, 2013, at 2, https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf.

[232] Jenna Mehnert, *Closing Long Creek is not the solution to helping Maine children*, BANGOR DAILY NEWS (June 2, 2018), https://bangordailynews.com/2018/06/02/opinion/contributors/closing-long-creek-is-not-the-solution-to-helping-maine-children/.

[233] Long Creek Youth Development Center, *Board of Visitors 2017/2018 Report*.

[234] Speaker Bob Reed's son Anthony, for example, was placed out of state at a facility in South Carolina, "a regional psychiatric hospital under the control of South Carolina Department of Corrections. . . . a thousand miles away from his home [and] family." Reed Testimony, *Briefing Transcript*, p. 17.

[235] Wathen Testimony, *Briefing Transcript*, p. 177.

[236] Ibid., 174.

[237] Lawlor, J., *U.S. demands return of $51 million in federal funds that Maine spent at Riverview,* PORTLAND PRESS HERALD (June 8, 2017). Retrieved from http://www.pressherald.com/2017/06/08/feds-taking-back-51-million-in-federal-money-maine-spent-at-riverview-psychiatric-center/.

[238] Michael Shepherd, "Maine Stands to Gain $20M Per Year After Feds Recertify Riverview Psychiatric Center," BANGOR DAILY NEWS, Feb. 22, 2019.

who have been deemed incompetent to stand trial and jail transfers.[239] Despite this planned addition, individuals in crisis have few places to go in Maine; the county jail is one of them.

As discussed above, though many law enforcement officers and families of people with mental illnesses have sought for the state to provide additional short-term or long-term crisis beds, other advocates seek increased funding for community-based programs as an alternative to increasing Maine's institutional capacity. Such home and community programs, promised during the deinstitutionalization movement but never created or maintained, promote independent living while also providing important mental health care services, consistent with the ADA's integration mandate as expressed in *Olmstead* actions.[240] An increase in community programs arguably would also allow those who are currently ready for community placement to exit institutional care, freeing up beds for those in crisis.[241]

Finding Funds: Expanding "MaineCare," Maine's version of Medicaid, a Partial Solution

Lastly, the discussants addressed the legislature's and voter referendum efforts to expand MaineCare[242] to over 70,000 people potentially eligible through the federal Affordable Care Act, which efforts had been continually thwarted by Maine's Governor LePage. Increasing eligibility of individuals with mental illnesses to the state's Medicaid program would grant insurance and greater treatment access to Mainers suffering from mental illnesses, substance abuse disorders and co-occurring disorders; create healthier lives and communities; and alleviate pressure on law enforcement officers and correctional facilities to provide mental health treatment and reentry preparation.[243]

During his tenure beginning in 2011, Governor Paul LePage vetoed the legislature's bills for MaineCare expansion on five occasions.[244] A citizen-initiated referendum was held to decide on expansion on November 7, 2017, wherein expansion was approved and the referendum passed by 59 percent of voters.[245] New applicants were by law to begin signing up on July 2, 2018, but

---

[239] Michael Shepherd, "Mills Will Open Bangor Psychiatric Facility for which LePage Signed $11.3M Lease," BANGOR DAILY NEWS, Feb. 27, 2019.

[240] *See* Sources and Discussion at notes 56-67, above (report part III-d, Passage of ADA).

[241] Monica E. Oss, *You Have To Take Something Out, To Put Something In*, OPEN MINDS (Oct. 28, 2014), https://www.openminds.com/market-intelligence/executive-briefings/take-something-put-something/.

[242] Maine's Medicaid program is known as MaineCare.

[243] *See*, *e.g.*, Sauschuck Testimony, *Briefing Transcript*, p. 28; Maloney Testimony , *Briefing Transcript*, pp. 140-43 (expressing desire to "put services at the front end" to prevent criminal issues from ever occurring, and decrying how medical prescriptions are just "pieces of paper" to a mentally ill person without money or insurance).

[244] ML Strategies, *A Rundown of Recent State Action Relating to Medicaid Expansion*, June 4, 2018, https://www.mlstrategies.com/insights-center/viewpoints/2018-06-rundown-recent-state-action-relating-medicaid-expansion

[245] Ibid.; Scott Thistle, LEWISTON SUN JOURNAL, "Judge Orders LePage Administration to Expand MaineCare" (Nov. 21, 2018).

Governor LePage challenged the funding source for Maine's share of the expansion and failed to timely file an expansion plan with the federal government.[246] In January 2019, when Governor Janet Mills began her term, she signed an executive order on her first day in office to quickly implement MaineCare expansion.[247]

Expansion under the ACA will allow Maine to accept federal funding covering roughly 90 percent of the health care costs of an estimated 70,000 Mainers who were not previously eligible for MaineCare, including many low-income people with mental illnesses.[248] Mills instructed state officials to seek coverage retroactive to July 2018, the date the ballot initiative would have taken effect, where possible.[249] Nearly 17,000 newly eligible Mainers have been granted coverage under MaineCare in January through March 2019, and the state continues its outreach efforts to inform all newly eligible state residents of this opportunity for coverage.[250]

With MaineCare insurance, many more people with mental illnesses in the state can benefit from affordable, accessible mental health treatment.

Implementing Antidiscrimination Principles in Community Settings

Under the Supreme Court's interpretation of the ADA in *Olmstead*, the unnecessary segregation of individuals with disabilities in institutions is discriminatory.[251] Applying the ADA in *Olmstead* litigation, the federal Department of Health and Human Services' Office for Civil Rights (OCR) and the Department of Justice (DOJ) have obtained settlement agreements in many states to end discrimination against persons with mental illnesses.[252]

---

[246] Louise Norris, health insurance .org, *Maine and the ACA's Medicaid Expansion*, https://www.healthinsurance.org/maine-medicaid/#expand.

[247] Me. Exec. Order No. 1 (Jan. 3, 2019), https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/Executive%20Order%201_0.pdf; *See also* Joe Lawlor, "With 16,000 more Mainers already covered, feds approve state's Medicaid expansion," PORTLAND PRESS HERALD, Apr. 3, 2019.

[248] Sauschuck Testimony, *Briefing Transcript*, pp. 78-79 ("We have to own the fact that my clients (Portland residents), the people that we're dealing with, do not have insurance, okay? They do not have insurance. And [so we] can't get them into a [behavioral health] program because they can't pay for it."); *see also* Joe Lawlor, "With 16,000 more Mainers already covered, feds approve state's Medicaid expansion," PORTLAND PRESS HERALD, Apr. 3, 2019.

[249] Me. Exec. Order No. 1 (Jan. 3, 2019), https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/Executive%20Order%201_0.pdf; *See also* Joe Lawlor, "With 16,000 more Mainers already covered, feds approve state's Medicaid expansion," PORTLAND PRESS HERALD, Apr. 3, 2019.

[250] Maine Department of Health and Human Services, "MaineCare Expansion," Update: March 29, 2019, https://www.maine.gov/dhhs/expansion.shtml (accessed April 5, 2019); Joe Lawlor, "With 16,000 more Mainers already covered, feds approve state's Medicaid expansion," PORTLAND PRESS HERALD, Apr. 3, 2019. *See also* Alex Acquisto, "Maine to Open Temporary Call Center as Medicaid Expansion Enrollment Nears 9,000," BANGOR DAILY NEWS, Mar. 4, 2019 (On funds for 6 months' operation of a new call center that Governor Mills claims "will allow us to enroll people in MaineCare and offer temporary employment to people in western Maine at the same time.").

[251] *Olmstead v. L.C. by Zimring*, 527 U.S. 581, 597 (1999).

[252] Bagenstos, *The Past and the Future*, *supra* note 14, at 5.

Maine courts, including the First Circuit Court of Appeals, have held that the failure of law enforcement officials to make reasonable accommodations for or otherwise provide services or benefits for qualified mentally ill persons, where such failure is "by reason of [the individual's] disability," violates Title II of the Americans with Disabilities Act.[253]

The Obama administration brought or participated in *Olmstead* cases in twenty-one states, obtaining settlements that prohibit unnecessary institutionalization.[254] Advocates can use *Olmstead* to advocate for community services and challenge placement even in private institutions such as nursing homes, because the decision's broad protection encompasses state inaction and funding decisions that lead to unnecessary institutionalization.[255]

Recent *Olmstead* suits against states for segregation and discriminating against people with mental illnesses have promoted some evidence-based best practices in settlement agreements. Four community-based solutions frequently promoted by mental health advocates and found in *Olmstead* settlement agreements for persons with mental illnesses are: (i) community-based crisis services; (ii) intensive community-based treatment (incorporating case management to the degree needed); (iii) integrated supported housing; and (iv) integrated, supported employment.[256] They aim to provide treatments and supports enabling people with mental illnesses to integrate and thrive within their communities. The links among these solutions focus not on *where* people with disabilities live, but *how* they live; a small group home can still share certain negative qualities of an institution, so advocates have shifted from prioritizing the size of a living arrangement to the level of autonomy it provides.[257]

Crisis System Relief

Olmstead agreements often provide a variety of modalities to serve persons in crisis. These might include walk-in clinics; statewide toll-free hotlines; mobile crisis teams to respond to people at home or in other community settings; short-term inpatient bed locations to stabilize persons in acute difficulty (length of stay generally limited to 14 days); peer-supported crisis

[253] *Buchanan v. Maine*, 469 F.3d 158, 173 (1st Cir. 2006) (Although no Title II violation was found in this case, the First Circuit Court of Appeals stated how to find a violation where the facts of the case merit such a finding. The court declined to address whether Title II requires a county law enforcement department to draft policies and train officers on the needs of the mentally ill public.).

[254] Bagenstos, *The Past and the Future*, *supra* note 14, at 5.

[255] *See, e.g.*, Settlement Agreement, United States v. New York, No. 13-CV-4165 (E.D.N.Y. Jul. 23, 2013) (hereinafter "*New York Settlement*"), which permits persons with disabilities from 23 large, privately owned "adult homes" in New York City to transition to living in homes in the integrated community. Note that the New York Settlement has been amended twice, and a "Supplement to Second Amended Settlement Agreement" was signed as recently as Mar. 16, 2018, and approved by the Court on Sept. 6, 2018. *See also id*. at 33.

[256] *See, e.g.*, *Delaware Settlement*, *supra* note 67; *Georgia Settlement*, *supra* note 67; *New York Settlement*, *Id. See also* Bagenstos at 35.

The material in the following subsections is drawn from the state *Olmstead* settlements referenced in this note.

[257] Bagenstos, *The Past and the Future*, *supra* note 8, at 49.

apartments within the community (length of stay generally limited to 7 days).[258] Crisis services are usually staffed 24 hours daily, 7 days a week, and are designed to address persons in crisis through de-escalation, stabilization, and support as alternatives to hospitalization.[259] Law enforcement and advocates can direct and bring individuals with mental illnesses who are in crisis to crisis service resources.

The crisis services model aims to provide options for those experiencing (sudden, unexpected) trouble, so as to avoid jail time or other institutionalization.

Intensive Case Supports

Assertive Community Treatment teams, or ACT teams, frequently deliver intensive case support services to persons with mental illnesses. According to the settlement agreement in *United States v. Georgia*, ACT is:

> a service that delivers comprehensive, individualized, and flexible treatment, support, and rehabilitation to individuals where they live and work. ACT is provided through a multidisciplinary team that shall include a psychiatrist, nurse, psychologist, social worker, substance abuse specialist, vocational rehabilitation specialist, and peer specialist. Services are highly individualized and customized, and address the constantly changing needs of the individual over time. Among the services that ACT teams provide are: case management, initial and ongoing assessments, psychiatric services, assistance with employment and housing, family support and education, substance abuse services, crisis services, and other services and supports critical to an individual's ability to live successfully in the community.[260]

ACT is an evidence-based practice, and settlements specify that ACT teams must operate with fidelity to the Dartmouth Assertive Community Treatment model. The number of individuals that any ACT team member may serve is limited to 10 in the Georgia settlement agreement.[261]

Intensive case management also includes coordination of treatment and support services for individuals with severe, persistent mental illnesses, delivered by a mental health professional. Case managers help individuals with mental illnesses to access community resources and may deliver ongoing support to help them maintain services and supports already in place.[262]

---

[258] *See*, *e.g.*, *Delaware Settlement*, *supra* note 67; *Georgia Settlement*, *supra* note 67; *New York Settlement*, *supra* note 254.

[259] *See*, *e.g.*, *Delaware Settlement*, *supra* note 67; *Georgia Settlement*, *supra* note 67; *New York Settlement*, *supra* note 254.

[260] *Georgia Settlement*, *supra* note 67, at 12.

[261] *Id.* at 13.

[262] *Id.* at 12-15.

Integrated Supported Housing

Supported housing, which includes scattered-site housing as well as (or in lieu of) apartments clustered in a single building, must be safe, affordable, and linked with community-based services. Settlement agreements frequently include provisions to assist individuals with mental illnesses in obtaining and maintaining supported housing, and to support their integration into the community. They also specify the types of services and supports that should accompany such housing.

The original *Olmstead* settlement in *United States v. New York* defined both "supported housing" and "community services" as follows:

> "Supported Housing" means "scattered-site apartments" associated with "rental assistance and a minimum level of housing-related support services from the housing provider for individuals with Serious Mental Illness. These housing-related support services include assisting the resident in managing tenant/landlord relations and with transitioning to the new housing unit. In situations where a resident needs ongoing additional support to manage his or her symptoms, or assistance with living skills such as shopping, maintaining his or her living environment, medication management, and/or personal care services, the supported housing provider may assist in linking the resident with the entities that directly provide these additional services in coordination with the resident's care manager. . . . *These additional support services may include the "Community Services"* listed [] below. (emphasis added)
>
> "Community Services" means services and supports provided in New York State that assist persons with Serious Mental Illness to live in the community. Such services and supports include, but are not limited to, Assertive Community Treatment ("ACT"), care coordination, employment services, outpatient services, Intensive Psychiatric Rehabilitation Treatment, medical services, Personalized Recovery Oriented Services ("PROS"), crisis services, assistance with taking medication (including through prompting), Medicaid benefits for which the [person] is eligible, including but not limited to home and community based services ("HCBS") waivers, clinic services, certified home health care, personal care assistance, nursing and rehabilitative services.[263]

As these definitions suggest, *Olmstead* cases aim to provide housing in community settings with enough illness-specific and homeownership-related supports and services so that individuals with mental illnesses will be able to retain their homes and manage their mental health treatment successfully. The supports built in to the housing, as well as the "community supports"

[263] *New York Settlement*, *supra* note 254, 5-6.

accompanying it, are designed to assist a person with a mental illness in remaining there. The housing is usually "scattered-site," or spread throughout various parts of the community, in harmony with the goal of integrating people with mental illnesses alongside people without mental disabilities. Transitions from institutional to integrated supported housing may also include "bridge funding," defined in the Georgia settlement as "the provision of deposits, household necessities, living expenses, and other supports during the time needed for a person to become eligible and a recipient of federal disability or other supplemental income."[264]

Supported Employment and Rehabilitation Services

Olmstead settlements may also provide supports for people to obtain employment and/or disability income. The Delaware settlement commits to "develop options for people to work or access education and rehabilitation services." Supported employment:

> Is a service through which individuals receive assistance in preparing for, identifying, attaining, and maintaining integrated, paid, competitive employment. Among the services that a provider may offer is [*sic*] job coaching, transportation, assistive technology, specialized job training, and individually tailored supervision.[265]

Delaware further provides that supportive employment providers must "adhere to an evidence-based model for supporting people in their pursuit of and maintenance of work opportunities."[266]

In addition to education and substance abuse treatment, rehabilitation services may include "volunteer work, [] recreational activities, and other opportunities to develop and enhance social, functional[,] and academic skills in integrated settings."[267]

For job preparation services to meet the integration mandate, they must be spread throughout the types and locations of work in a community – as opposed to working in a location and field filled entirely by people with mental illnesses.

Additional Provisions

Other substantive provisions in *Olmstead* settlement agreements might include, e.g., peer support services, family support services, discharge planning protocols for people in institutions, or programs of outreach to persons with mental illnesses who might choose to take advantage of the community integration services described above.

---

[264] *Georgia Settlement*, *supra* note 67, 19.

[265] *Delaware Settlement*, *supra* note 67, 6.

[266] *Id*.

[267] *Id*. at 7.

Diverting People with Mental Illnesses from Criminal Justice System and Incarceration

People who commit bad acts deserve punishment, in order to deter crime. Sick people who cannot control their illnesses, on the other hand, deserve treatment and sympathy. The many discussions throughout this report depict people with mental illnesses as the blameless sick, as opposed to the blameworthy bad.

Lumping people with mental illnesses in with volitional criminals in Maine's jails and prisons strikes many stakeholders as inappropriate and wrong. To avoid such criminalization of people with mental illnesses, there must be methods of diverting them from the arrest to charge to jail to prison track, and steering them toward a treatment and support path to liberty and community integration.

Stepping Up Initiative

Many such efforts are reflected in the national Stepping Up initiative, a broad partnership to divert people with mental illnesses from jails and into treatment.[268] The initiative was founded in 2015 by the Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation, intended to "rally local, state, and national leaders to address the crisis of mental illnesses in jails."[269] Its partners today also include NAMI, over 425 counties, and numerous law enforcement associations, mental health organizations, and substance abuse organizations.[270]

In early phases, Stepping Up encouraged stakeholders at the county level to create shared definitions, formal resolutions or memoranda of understanding, and concrete goals to measurably reduce the number of people with mental illnesses and substance use disorders in jail.[271] Research, innovations, and models were shared among the coalition's growing membership. Today, "Stepping Up asks communities to come together to develop an action plan that can be used to achieve measurable impact in local criminal justice systems of all sizes across the country,"[272] including collecting data by establishing a locally-shared definition of "serious mental illnesses," employing a validated mental health screening tool on every person booked into the jail, referring people who screen positive for symptoms of serious mental illnesses to follow-up clinical assessments, and regularly recording and reporting on clinical assessment results to local stakeholders.[273]

---

[268] NAMI, *The Stepping Up Initiative*, https://nami.org/About-NAMI/National-Partners/The-Stepping-Up-Initiative.

[269] The Stepping Up initiative, *The Next Step: Collecting Data to Drive Change*, https://stepuptogether.org/wp-content/uploads/Next-Phase-Two-Pager_FINAL.pdf.

[270] Ibid.

[271] National Association of Counties (NACo), *The Stepping Up initiative: Overview*, https://www.naco.org/resources/signature-projects/stepping-initiative.

[272] The Stepping Up initiative, https://stepuptogether.org/.

[273] The Stepping Up initiative, *The Next Step: Collecting Data to Drive Change*, https://stepuptogether.org/wp-content/uploads/Next-Phase-Two-Pager_FINAL.pdf. *See also* Rise Haneberg, Tony Fabelo, Fred Osher, and Michael Thompson, Stepping Up initiative, *Reducing the Number of People with Mental Illnesses in Jail: Six*

In Maine, Penobscot is the first and only county to join the Stepping Up initiative.[274] County stakeholders adopted a formal memorandum of understanding, agreeing:

> to collaborate and provide planning to divert individuals with mental illness from jail, to utilize a screening/assessment tool selection identifying mental health/substance abuse and trauma related needs/history, to develop a meaningful database, to regularly review community-based resources, to impact county and state policy change efforts[,] and to perform other tasks pursuant to the program narrative of the grant application attached to this agreement.[275]

Other Maine counties, though not formal members of Stepping Up, are also employing diversion tactics and attempting to measurably decrease persons with mental illnesses in the criminal justice system. In that spirit, two of the most promising diversion methods in Maine—"alternative" courts and Pretrial Service contracts—are discussed below.

Alternative Courts

Maine's court system includes certain "specialty dockets," or courts that deal with topics rather than all civil or criminal issues. There are "Drug Treatment Courts" in several locations including Augusta, and also in Augusta are "Co-Occurring Disorders Court" and "Veterans' Court."[276] Skowhegen has a "Community Drug Court" created by the community without the services of a judge ("because the judiciary is just strapped too thin").[277] In such courts, defendants make pleas, and agree to undergo a period of mental health treatment and substance abuse treatment supervised by the court. Such supervised periods, in which participants are strictly accountable to the court, may last for 12 months, 16 months, 23 months, or some other relatively long period of time. Drug testing is used. Treatment services are not merely offered, but required during the period of supervision. For those who successfully complete their programs, the charges can be erased at the end.[278]

Questions County Leaders Need to Ask, Jan. 2017, https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf.

[274] Stepping Up Summit press release, *Unprecedented National Summit Gathers Teams from 50 Counties to Reduce the Number of People with Mental Illnesses in Jails*, Apr. 18, 2016 (on file with authors); *see also* The Stepping Up initiative, The Counties, https://stepuptogether.org/what-you-can-do.

[275] Memorandum of Understanding of Stepping Up Penobscot (undated, unsigned) (on file with authors). Partner agencies include the Penobscot County Sheriff's Office, NAMI Maine, Community Health and Counseling Services, along with Penobscot County Commissioners Peter Baldacci and Laura Sanborn, the District Attorney's Office for Penobscot County, Bangor Department of Public Health and Community Services, and individual members of the partnership agencies.

[276] Maloney Testimony, *Briefing Transcript*, p. 139; Maine Courts, Maine's Drug Treatment Courts, https://www.courts.maine.gov/maine_courts/drug/index.html.

[277] Maloney Testimony, *Briefing Transcript*, p. 139.

[278] *See generally* Maine Courts, *Drug Treatment Court Frequently Asked Questions*, https://www.courts.maine.gov/maine_courts/drug/faq.html; Maine Co-Occurring Disorders and Veterans Court, https://www.courts.maine.gov/maine_courts/drug/codvc.html; Maine's Adult Drug Treatment Courts,

According to district attorney Maeghan Maloney, the "graduates" of the Veterans' Court and the Community Drug Court in here region have recidivism rates of absolutely zero.[279] And the Co-Occurring Disorders Court graduates have had zero recidivism since 2014.[280] By providing individualized treatments coupled with court supervision, such alternative courts have been highly successful in enabling people with mental illnesses and co-occurring substance abuse to re-enter the community instead of falling prey to the criminal justice system's institutions.[281]

Maine Pretrial Service Contracts

Maine Pretrial Services is a private, non-profit agency "committed to providing pretrial services, post conviction alternatives, and diversion options throughout the state of Maine."[282] One function is to sign a "pretrial contract" in lieu of posting bail. As Maeghan Maloney describes it, Maine Pretrial Services "enables people to sign a contract agreeing that they'll go to all their court dates and then be released from jail without having to put up any money."[283] She stated that more than 130 people in Kennebec County were out of jail on Maine Pretrial Services Contracts at the time of the Briefing – an amount roughly equal to the number of persons staying in the jail at that time.[284]

Maine Pretrial Services also offers "alternative sentencing programs," under which a participant (who has been sentenced by a judge to attend) attends a camp or school in custody and under supervision, and performs community service work along with attending educational programs.[285] Maine Pretrial Services further offers forensic case managers who screen and assist with the Maine Co-Occurring Disorders Court,[286] and who assist as case managers in Drug Treatment Courts in parts of the state by "meet[ing] frequently with clients, test[ing] for drugs

---

https://www.courts.maine.gov/maine_courts/drug/adults.html. Note that the drug court FAQ suggests that although Maine once had judicially-operated drug treatment courts for juveniles, the state no longer has them.

[279] Maloney Testimony, *Briefing Transcript*, p. 140.

[280] Ibid.

[281] Note that in court with an ordinary criminal docket, it is sometimes possible to get a "deferred disposition," whereby a defendant must satisfy a condition, such as obtaining a psychiatric evaluation or attending a treatment program, after the completion of which the prosecution may have all charges dismissed. Maloney Testimony, *Briefing Transcript*, pp. 141-42. The defendant must initially plead guilty, with sentencing suspended during the period to satisfy the condition. Afterwards, the defendant is sentenced to a lesser charge or the entire charge is dismissed. *See*, *e.g.*, Chris Nielsen, *Options to Resolve your Criminal Case in Maine* (Oct. 25, 2013), http://www.nielsengrouplaw.com/resolve-your-criminal-case/.

[282] Maine Pretrial Services home page, http://mainepretrial.org/programs.asp.

[283] Maloney Testimony, *Briefing Transcript*, p. 156.

[284] Ibid.

[285] *See* "Alternative Sentencing Programs" link at Maine Pretrial Services home page, http://mainepretrial.org/programs.asp.

[286] *See* "Co-Occurring Disorders Court" link at Maine Pretrial Services home page, http://mainepretrial.org/programs.asp.

and alcohol, monitor[ing] and report[ing] progress to the court, and assist[ing] in accessing services."[287]

Thus, Maine Pretrial Services' programs operate to keep people integrated in their communities rather than deeply caught up in the criminal justice system.

[287] *See* "Adult Treatment Drug Court" link at Maine Pretrial Services home page, http://mainepretrial.org/programs.asp.

VI. Findings and Recommendations

Finding 1: The lack of adequate home- and community-based care networks in Maine for people with mental illnesses has deprived them of adequate mental health treatment and services and denied them community integration and autonomy.

Overarching Recommendation: Maine should fund, create, and expand networks of home and community-based care in the following ways:

A. Medicaid Expansion Outreach

Under the 2010 federal Affordable Care Act (ACA),[288] states were newly permitted to provide Medicaid to many low-income, non-elderly individuals under "Medicaid expansion." During the June 14, 2017 Briefing, many speakers decried the state's failure to implement Medicaid expansion in Maine, despite the passage of a 2017 state referendum overwhelmingly favoring expansion of the state's program, called "MaineCare," by July 2018. The MaineCare expansion, they argued, would make care, treatment, and services accessible to many Maine residents with mental illnesses who were otherwise not covered by health insurance.

When Governor Mills entered office in January 2019, she immediately ordered steps be taken to implement Medicaid expansion in Maine by February 1, 2019.[289] The MaineCare expansion was expected to cover up to 70,000 additional Maine residents, including many people with mental illnesses.[290]

As of March 29, 2019, nearly 17 thousand people in Maine had been enrolled in MaineCare coverage.[291]

Recommendation 1.1:

> The Maine Department of Health and Human Services, together with state advocates for persons with mental illnesses and individuals with mental illnesses who have already enrolled in MaineCare, should strategize on how best to conduct outreach to potentially eligible persons with mental illnesses and should actively carry out such efforts expeditiously.

When compared to institutionalization, home and community-based services provide a higher quality of care with more individualized attention, and allow those in treatment to live and work

---

[288] Patient Protection and Affordable Care Act (ACA), PUB. L. 111-148 (Mar. 23, 2010). State Medicaid programs are funded by a combination of federal and state contributions.

[289] Me. Exec. Order No. 1 (Jan. 3, 2019), https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/Executive%20Order%201_0.pdf.

[290] Louise Norris, health insurance.org, *Maine and the ACA's Medicaid Expansion*, https://www.healthinsurance.org/maine-medicaid/#expand.

[291] Maine Department of Health and Human Services, "MaineCare Expansion," Update: March 29, 2019, https://www.maine.gov/dhhs/expansion.shtml (accessed April 5, 2019).

in their communities.[292] Community-based programs can decrease the stigma attached to mental illnesses,[293] and allow families and communities to be involved in continued care and treatment. This style of treatment also seeks to prevent behavioral issues before they arise; community-based services, such as multisystemic therapy, can help address underlying issues and prevent further interactions with law enforcement due to the person's mental health problems.[294]

Such programs, however, have been *consistently underfunded* since deinstitutionalization, leading to a lack of accessible options for people with mental illnesses in Maine. This lack of options has contributed to an increase in the proportion of people with mental illnesses who enter Maine's criminal justice system. Even those programs that do exist experience funding problems, specifically including the recent restructuring of the MaineCare reimbursement rates for community-based programs.

Finding 1-A: Preventative treatment of mental illnesses through in-home and community-based services provides a higher quality of care and is more cost-effective than institutionalization (either in hospitals or in the criminal justice system). [295]

Recommendation 1.2:

> Implement and fund start-up costs for evidence-based, cost-effective home- and community-based treatments and services for persons with mental illnesses.

This could include such things as supportive housing and Housing First, multisystemic and related therapies for youth with mental illnesses, peer support groups for persons with mental illnesses, case managers who monitor whether people with mental illnesses obtain and take medications, and other proven effective treatments and services.

Recommendation 1.3:

> Study and recalculate MaineCare reimbursement rates for community programs such as multisystemic therapy and functional family therapy to reflect and cover the actual costs incurred by such programs.

---

[292] Testa, *Imprisonment of the Mentally Ill*, *supra* note 159, on prebooking and postbooking diversion and systemic reforms, pp. 429-39.

[293] Laura Greenstein, NAMI, 9 Ways to Fight Mental Health Stigma (Oct. 11, 2017), https://www.nami.org/blogs/nami-blog/october-2017/9-ways-to-fight-mental-health-stigma; NAMI, What is Stigma? Why is it a Problem?, https://www.nami.org/stigmafree; *see also* Michael L. Perlin and Alison J. Lynch, *"Mr. Bad Example": Why Lawyers Need to Embrace Therapeutic Jurisprudence to Root Out Sanism in the Representation of Persons With Mental Disabilities*, 16 WYO. L. REV. 299 (2016).

[294] *See*, *e.g.*, Erin Rhoda, *A mother's struggle to help her violent son*, BANGOR DAILY NEWS (June 11, 2018), https://bangordailynews.com/2018/06/11/mainefocus/a-mothers-struggle-to-help-her-violent-son/.

[295] According to District Attorney Maloney, it costs taxpayers $45,000 per year to incarcerate a person in the Maine State Prison. Maloney Testimony, *Briefing Transcript*, p. 143.

Recommendation 1.4:

> Study carefully the recommendations of the comprehensive evaluation of Maine's system for serving children with mental illnesses,[296] and undertake a comprehensive evaluation of Maine's system for serving adults with mental illnesses. Using that information, develop a strategic plan to serve persons in Maine with mental illnesses, ensuring adequate funding and statutory and regulatory flexibility to implement the plan on a long-term basis.

Finding 1-B: Maine does not compensate mental health treatment providers adequately, especially in rural parts of the state.

Recommendation 1.5:

> Access state, local, and federal funding streams in order to attract and retain skilled mental health providers, leading to greater continuity of care for Maine residents with mental illnesses.

Recommendation 1.6:

> The Legislature should pass emergency bill LD 3,[297] which would repay substantial student loan debt for skilled professionals who provide mental health services in underserved parts of Maine for at least five years.

When individuals with mental health illnesses are in crisis, they or a family member often turn to the police, who in turn rely on crisis service providers. However, these trained, skilled providers lack adequate funding to meet the demand for their services. A recent change to the Maine Crisis Network reimbursement policy means that crisis service providers only get reimbursed for the time spent performing a service, i.e., the billed amount that they submit. Such reimbursement does not cover their operating costs, which require service providers to be available twenty-four hours a day, seven days a week, to satisfy police officers and the public need. The funding decrease has the potential to lead to closures of some programs, and the narrowing of the geographic scope of others.

Recommendation 1.7

> Increase statewide funding for community-based crisis services.

Recommendation 1.8

---

[296] *See* Maine Department of Health and Human Services, Office of Child and Family Services, *Children's Behavioral Health Services Assessment Final Report* (Dec. 15, 2018) (assessment conducted by Public Consulting Group), https://www.maine.gov/dhhs/ocfs/cbhs/documents/ME-OCFS-CBHS-Assessment-Final-Report.pdf.

[297] Legis. Doc. 3 (emergency), 129th Leg, 1st Reg. Sess. (Me. 2019). *See also Bangor Daily News*, "Keep Mental Health Workers in Maine," Apr. 3, 2019.

Restructure the Maine Crisis Network reimbursement system so that crisis providers are paid based on all the hours they are available to provide services. This would lead to more efficient response time by more providers over a greater geographic area.

Finding 1-C: Maine does not offer sufficient rehabilitative treatments and paths to community reentry for persons with mental illnesses adjudicated not criminally responsible or incapable of standing trial for criminal charges.

Caring for such individuals in psychiatric or criminal justice institutions is costly, and the individuals are discriminatorily deprived of full, community-based lives and relationships.

Recommendation 1.9:

Study effective models of community-based treatment and services for persons with mental illnesses found not criminally responsible or incapable to stand trial in the criminal justice system. Wherever possible, implement best practices to return such persons to integrated community settings.

Finding 2: Many individuals with mental illnesses in Maine are involved with the criminal justice system based on symptoms of their illnesses, and are thereby facing discrimination, stigma, and segregation. Civil rights law requires we decriminalize them, by making every effort to provide them community-based treatment and help them recover from their illnesses.

Overarching Recommendation: Maine should fund, create, research, and expand trainings on mental health issues and information-sharing partnerships with mental health professionals for personnel involved in law enforcement and the criminal justice system.

When citizens are experiencing trouble due to mental illnesses, they often turn to the police for assistance, even when there has been no crime. Police officers are often first responders when dealing with people suffering from mental illnesses and crises, including people contemplating suicide. A large portion of police officers' daily duties involves interacting with mentally ill people, but these duties are not covered sufficiently in their academy training. Crisis Intervention Teams (CIT) training provides officers with training about how to navigate these interactions in ways that minimize potential dangers to those with mental illnesses, through increased sensitivity, information, and de-escalation techniques, helping those interactions produce more positive solutions. Though many officers in Maine have completed the 40-hour Crisis Intervention Team training program, there are areas, especially in rural Maine, where few or no officers have been adequately trained in mental health issues. This poses a risk in such areas that a preventable situation involving a person with a mental illness will get out of hand because of an insufficiently trained or biased officer, leading to personal injury, unnecessary jailing or imprisonment, or even legal liability for a police department.

Recommendation 2.1

Provide financial resources for all officers to receive Crisis Intervention Team training and Mental Health First Aid training, especially in rural areas.

Recommendation 2.2

Expand the integration of mental health professionals into the criminal justice system. This can include enhancement of diversionary programs in courts, ride-along programs, mental health liaisons within police or sheriff departments, or other innovative ways of partnerships between law enforcement officers and mental health professionals so as to prevent those with mental illnesses being arrested, jailed, imprisoned, or otherwise removed from the community without need.

Recommendation 2.3

Improve and increase consistent data collection on police shootings and police interactions in the community with those with mental illnesses. Use Police Chief Sauschuck's "secondary coding" system as a model.

Recommendation 2.4

Implement and train personnel in the use of a uniform and consistent screening tool, such as one promoted by the Stepping Up Initiative, to be used in all Maine county jails. This would allow law enforcement staff to roughly screen inmates for mental health diagnoses. Create a protocol for law enforcement to refer arrestees or inmates to appropriate mental health services or to divert them to specialized courts or programs. Increase anonymous or otherwise privacy-protective data collection in correctional facilities on inmates' mental health diagnoses, psychiatric prescription usage, and final disposition of criminal charges using Stepping Up resources or another evidence-based tool.

Finding 2-A: Alternative courts, such as mental health courts, veterans' courts, and co-occurring disorders courts, have been shown to help divert low-level offenders and non-criminal behavioral norm-violators from the criminal justice system. So, too, with Maine Pretrial Services Contracts. They can effectively substitute treatment and services for punishment and criminalization.

In alternative courts, criminal charges can be adjourned when a defendant agrees to adhere to a community-based treatment plan, and are ultimately dismissed if the defendant fulfills the treatment obligations for a specified period. Likewise, Maine Pretrial Services Contracts contain treatment requirements, drug testing, and case management as conditions of bail, during which time an individual has not yet been tried, convicted, or released. If a person with a mental illness

complies with the Pretrial Services Contract, she can significantly improve her mental health condition and symptomatic behaviors before ever coming before the court to resolve case charges. Such contracts may divert further involvement with the criminal justice system.

Because prisoner care is expensive, providing people with mental health treatment in prison is expensive, and mentally ill prisoners tend to remain in prison much longer than those without mental illnesses, diversionary programs that provide community-based treatment are cost-effective as well as non-discriminatory approaches for those with mental illnesses.

Recommendation 2.5:

> Encourage and expand state-wide the use and availability of alternative court systems, Maine Pretrial Services Contracts, Stepping Up initiative partnerships, and other tools to divert people with mental illnesses from entering the criminal justice system.

Finding 3: Although it is unlawful discrimination to segregate people with mental illnesses in psychiatric institutions when they wish to be in the community, there remains some need for psychiatric inpatient treatment on a short-term or long-term basis. Maine currently lacks sufficient inpatient treatment beds to support that need, especially given the numerous persons with mental illnesses involved with the criminal justice system who may need acute care, evaluation, or longer-term housing.

Recommendation 3:

> At least for the time being, more psychiatric treatment beds in state or community-based institutions are needed. Provide funding and mechanisms to increase the number of adult beds, and create a therapeutic residential facility for mentally ill youth as an alternative to Long Creek.

VII. Best Practice Models which Decriminalize Mainers with Mentally Illnesses

- More therapeutic psychiatric beds for adults (and for youth with mental illnesses)
- Therapeutic facilities for youth with acute mental health issues
- Funding for *universal CIT* among police & sheriff staff, prioritizing rural areas first
- MaineCare expansion (insurance for low-income people), and other funding increases
- Better funding for crisis mental health workers and for specialists in state
- Enhanced pay to attract, retain specialized mental health staff, especially to *rural* areas
- *Front-end* (preventative, or at least diversionary) programs (e.g., MST, community crisis services, peer support) to prevent eventual court involvement
- Access to medications without interruption, including on release or after hospital
- *Pre-release* preparation addressing housing needs, medications, psychotherapy, psychiatry, care management, community resources, peer support, funding for food & bed, job training and activities, etc.
- For behavior that is *medically* (not criminally) caused, better tools to screen, identify, and treat such behavior
- Fund expansion of the *courts*, especially alternative, diversion-oriented courts; expand scope (geographic, past crimes) of co-occurring disorders court
    - Maine Pre-Trial Contracts
    - Deferred dispositions (e.g., Veterans' Court model)
- *ACT* (Assertive Community Treatment) Teams
- *Housing First* model
- Model programs employed in state *Olmstead* settlements
- *Step-Down* programs for people doing better
- *Step-Up* programs (like the IMHU) for people needing more intensive treatment

Appendix A: Briefing Panels and Speakers

Panel One

Bob Reed, *Parent, Advocate, and NAMI Maine Board President*

Tonya DiMillo, *Board of Visitors Chair of the Long Creek Youth Development Center*

Jenna Mehnert, *Executive Director, Maine chapter of the National Alliance on Mental Illness*

Panel Two

Darrell Crandall, *Aroostook County Sheriff*

Michael Sauschuck, *Portland police chief*

Jason Madore, *Commander of Police Crisis Negotiation Team*

Tyler Stevenson, *Commander of Police Tactical Team*

Panel Three

Kevin Voyvodich, *Disability Rights Maine Managing Attorney*

Troy Morton, *Penobscot County Sheriff*

Maeghan Maloney, *District Attorney, Kennebec and Somerset Counties*

Tim Zerillo, *Private Defense Attorney at Hallet, Zerillo & Whipple, P.A.*

Panel Four

Daniel Wathen, *Court Master, Maine Mental Health Consent Decree*

Charlotte Warren, *Maine State Representative, Criminal Justice and Public Safety Committee Co-Chair*

Patty Hymanson, *Maine State Representative, Criminal Justice and Public Safety Committee Co-Chair*

Appendix B: Transcript of June 14, 2017 Briefing