RECOMMENDATIONS AND REPORT

OF THE

TASK FORCE ON PERSONS WITH MENTAL DISORDERS

INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM

Submitted to the
Maine State Legislature

by the
Maine Department of Mental Health and Mental Retardation

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INTRODUCTION

The relationship between the mental health and criminal justice systems, both corrections and law enforcement, has been an emerging area of concern both locally and nationally. The need to examine Maine's needs in this particular area and to set an agenda is of critical importance.

The Maine State Legislature shares this concern. In the Spring of 1992, the 115th legislature passed and the Governor signed LD 1911, "An ACT Related to the Planning and Delivery of Mental Health Services" (PL 1991, c.781). Part B of this law mandates a mental health project relating to persons accused or convicted of crimes:

> The Department of Mental Health and Mental Retardation shall initiate a concentrated planning effort to develop recommendations for a program aimed at a meaningful and effective mental health program for those accused and convicted of crimes.

To involve advice and assistance from consumers of mental health services, the Department of Corrections, the Department of Human Services, the Department of Public Safety, the Office of Substance Abuse, the courts, and the Office of the Attorney General, as specified by the legislation, the Department of Mental Health and Mental Retardation established a 14-member Task Force on Persons with Mental Disorders Involved with the Criminal Justice System. This report is the result of the work of these entities, as well as a number of resource people who supplied data, recommendations, and ideas to the Task Force.

The recommendations presented in the front of this report are primarily directed at those adults involved with the criminal justice system who have a serious mental illness or disorder. The recommendations are not intended to address all mental health needs of all persons involved with the criminal justice system.

A significant proportion of the inmate population manifests mental disorders, with a small subset of these having mental illnesses. Serious mental illness refers to major illnesses such as schizophrenia, bipolar disorders, and major depression. A serious mental disorder would include the more disabling forms of personality disorders or anxiety disorders. This does not include mental retardation, sexual disorders, sleep disorders, impulse control disorders, adjustment disorders or substance abuse disorders in and of themselves - only as secondary diagnoses. The definition of the priority population served by the Bureau of Mental Health is appended in the footnote section.

This report is organized so that the recommendations of the Task Force are presented first. Background information and a discussion of the situation and existing system in Maine follow.

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RECOMMENDATIONS

GOAL I: TO ASSURE APPROPRIATE MENTAL HEALTH SERVICES BY EXPANDING AND ENHANCING THE AVAILABILITY OF PROFESSIONALS WITH EXPERTISE IN WORKING WITH PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM.

Recommendation 1: Provide correctional (jails and other correctional facilities) and law enforcement officers (police, sheriffs, etc.) and mental health and other service personnel with adequate training for working with persons with serious mental illness or disorders who are involved with the criminal justice system.

A. Expand the curriculum at the Criminal Justice Academy to include specific, specialized training regarding mental illness and mental disorders for both law enforcement and correctional staff.

1) This training must include identification and strategies/techniques for dealing with individuals with mental disorders, and should include as trainers mental health professionals, family members, and consumers of mental health services.

2) Also included must be components on persons with mental disorders who also have other special needs, such as concurrent substance abuse.

B. Expand courses in the mandatory statewide mental health training/certification program, administered through the Department of Mental Health and Mental Retardation's Division of Public Education, re: criminal justice issues for both inpatient and community mental health personnel.

C. Require that State-supported training programs for mental health personnel to include a minimum of six hours in on-site training in jails and other correctional facilities.

D. Identify and make full use of existing personnel with specialized knowledge, such as forensic psychiatrists, psychiatric crisis staff, law enforcement personnel, substance abuse treatment specialists, etc., in cross-education and training efforts.

E. Expand the provision of cross-education and training opportunities related to individuals involved with the criminal justice system with multiple needs, such as, mental illness and substance abuse, deafness, psychogeriatric, and/or cultural diversity.

F. Assure training and technical assistance for judges, and court personnel, such as District Attorneys, in matters relating to mental health and serious mental disorders.

- Develop a benchbook (technical assistance manual), including a resource directory, which is kept current, outlining mental health protocols.

G. Recommend that State-funded mental health services require that individuals contracting with the State have criminal justice training/experience and, if not, that they obtain the training within a specified time period.

GOAL II: TO ESTABLISH A COMPREHENSIVE SYSTEM OF INTEGRATED MENTAL HEALTH SERVICES WHICH ARE ADEQUATE, ACCESSIBLE, AND APPROPRIATE FOR PERSONS WITH SERIOUS MENTAL ILLNESS OF DISORDER WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM.

Recommendation 2: Provide an assessment and diagnostic system and process for persons with serious mental illness or disorder involved with the criminal justice system.

A. Identify a central, local community point of contact available 24 hours/day to dispatchers, law enforcement officers and other criminal justice personnel to meet psychiatric needs/crises.

B. Develop Psychiatric Triage/Assessment Teams to

1) Assist law enforcement officers to assess and divert appropriate individuals from the criminal justice system ("nuisance" crimes such as trespassing, indecent exposure, etc.);

2) Conduct comprehensive assessments and make recommendations regarding individuals within the jails and other correctional facilities with psychiatric crisis/needs within 24 hours of admission and thereafter; and

3) Involve guardians, families, and other natural support system members in the comprehensive assessment process (as permitted by the individual or the guardian) throughout the criminal justice process.

Recommendation 3: Provide comprehensive mental health services for persons with serious mental illness or disorder involved with the criminal justice system.

A. Assure psychiatric crisis intervention capacity through the State-funded 24-hour psychiatric crisis stabilization programs and/or the proposed psychiatric assessment teams, as appropriate.

B. Reinforce Bureau of Mental Health (BMH) contractual language, which currently indicates that persons with mental illness will be served wherever they are, by adding a new general provision that BMH priority population members involved with the criminal justice system will be served, even if incarcerated.

C. Tie State funding to the provision of these mental health services, promoting continuity, in the jails and other correctional facilities, through use of performance indicators/outcome measures as measured in contract compliance.

D. Identify and assure the provision and integration of mental health services, requiring a specialized knowledge base and skills, for persons with serious mental disorders who have additional special needs, such as substance abuse.

E. Assure that persons found to be Not Guilty by Reason of Insanity (NGRI), who are in a State or other psychiatric inpatient facility, are not mingled with other individuals involved with the criminal justice system.

F. Develop alternative psychiatric inpatient/structured treatment resources for individuals with mental illness involved in the criminal justice system, such as in communities throughout the state, other than the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute (BMHI).

G. Work with mental health providers, as well as private practitioners, and professional organizations to ensure the availability of psychiatric professionals (psychiatrists, psychologists, social workers, psychiatric nurses) within the jails and other correctional facilities.

H. Assure that psychiatric medications are provided in jails and other correctional facilities as needed by individuals with mental illness involved with the criminal justice system.

Recommendation 4: Assure that incarcerated individuals with mental illness will not return to the community without prior planning for community living and treatment.

A. Develop formal and specific release procedures, specifying community living plan requirements (which include treatment, housing, employment/education) involving mental health professionals, which is agreed to by all relevant parties.

B. Increase and require guardian and inmate, and encourage family involvement in these release plans.

C. Work with the courts to identify and mandate follow-up psychiatric care, as needed, as a condition of probation when inmates with mental illness are released from jails and other correctional facilities.

Recommendation 5: Develop and increase local and statewide coordination among various components of the human service system.

A. Develop local coordination committees, at least one per county, relating to the county jails and sheriffs, which include representatives of families, consumers, law enforcement, jail staff, District Attorneys, judges, lawyers, Attorney General's Office, mental health providers, other service providers (entitlement programs, CAP agencies, community health agencies, substance abuse, voc. rehab., etc.) to share information and coordinate service planning and delivery for persons involved with multiple systems.

B. Develop formal linkages between agencies to develop integrated networks of services that can

1) Prevent or divert individuals from incarceration;
2) Follow them into the jails and other correctional facilities; and
3) Be available in the community to protect against relapse after release.

C. Establish a state-level coordination group which includes the Commissioners or heads of at least the following: the State departments of Corrections, MHMR, Human Services, Education, and Labor, as well as the Maine Sheriff's Association, Office of Substance Abuse, and the Maine Judicial Department. This group shall report semi-annually to the Governor.

D. Hold publicly funded mental health providers accountable through the contractual process for providing information, as appropriate, to jails and other correctional facilities, continued contact, and services upon release.

E. Coordinate and integrate mental health and criminal justice management information systems which have the capacity to identify individuals with mental illness in order to assure the provision of appropriate services,- while at the same time insuring confidentiality.

Recommendation 6: Examine current and potential resources to maximize limited available funds for this special population.

A. Examine State and Federal funding and human resources identifying duplicative and ineffective uses.

B. Redesign funding streams to direct mental health dollars from institutional to community treatment and rehabilitation options.

C. Reallocate State funds specifically for mental health services for persons with serious mental illnesses or disorders involved with the criminal justice system.

BACKGROUND

It is estimated there are about 10 million annual admissions nationally to the country's 3,300 county jails, not including state or federal prisons. Based on a 1991 study by Karen Abram and Linda Teplin of 728 randomly selected pre-trial arraignment inmates in the Cook County jail (Chicago), 6.4% of the inmates were mentally ill (schizophrenia, manic-depression, or major depression), manifesting some form of psychosis.[1] This would mean that nationally there were 657,041 admissions to U.S. jails in 1991 with mental illness and as many as 635,478 persons released to the community who were severely mentally ill upon admission. Based on Maine county jail statistics, this percentage would mean that there were 2,037 persons admitted to county jails in 1991 with mental illness and as many as 2,015 individuals released to the community who were mentally ill upon admission. A 1992 report from the National Alliance for the Mentally Ill places the percentage of inmates with mental illness at a higher percentage of 7.2%.[2]

Mental health rights groups and others have successfully sued for changes in commitment laws so that dangerousness to self or others, when based on mental illness, has become the general standard, although in some states, inability due to mental illness to care for oneself is also a criterion. In addition, treatment against an individual's wishes has been made more difficult.

A psychiatric inpatient facility does not have to admit anyone because of disruptive or unmanageable behavior or substance abuse when the individual is mentally ill unless the legal standard is met.

The police officer dealing with an individual with a mental disorder who may have committed a crime has few options. At the present time a law enforcement officer has two custody options: (1) arrest, or (2) protective custody (34-B M.R.S.A. 3862[1] involuntary commitment). The officer may charge the person with a minor offense to take him/her off the street and prevent their return to the crime scene as a form of protection. Many of these crimes are often described as "nuisance crimes": trespassing, vagrancy while sleeping on someone's property, disturbing the peace, disorderly conduct, menacing while panhandling, and shoplifting food. Another of Teplin's studies has shown that given the same crime, police arrest a person with mental illness more often than someone who has no disorder. Jail, in short, becomes the mental health facility of last resort. If the person is unmanageable in jail, s/he usually cannot be committed to a hospital unless s/he is in immediate danger to her/himself or others. If s/he is diverted in the jail, s/he is usually out in a short time, likely to repeat the entire episode again.

It must be noted that a good percentage of the individuals with mental illness in the criminal justice system should not be classified as mentally ill individuals unfairly swept up in the criminal justice system, but as criminals who are also mentally ill. In addition, there are also sizable numbers of individuals in the criminal justice system who show serious forms

of mental disorders, such as antisocial, borderline, paranoid, obsessive-compulsive, and other personality disorders.

Sociologist Henry Steadman states that "...there are serious mental health needs in American jails. How they got that way is not important. What is important is what we do about what is there."[3]

SITUATION IN MAINE

It has become apparent that the mental health needs of persons in Maine who have mental health disorders and are involved with the criminal justice system are not being met. Apart from inadequate funding, this has been due, in some measure, to several factors:

1. The, historically, understood practice that there is generally a primary agency responsible for certain population groups and services for them, so that, for example, an individual involved with the correctional system would be seen as "its" client and not that of any other system;

2. The frequently-held opinion in the correctional and law enforcement fields that mental health needs are the purview of the mental health system, that mental health services should be provided by the mental health system directly, and that correctional/law enforcement staff should not have to be mental health professionals;

3. The tendency by many not to differentiate between law enforcement and correctional issues and needs (including a differentiation between county/municipal jails and State correctional facilities).

4. The attendant tendency to look primarily to State agencies so that all expectations related to criminal justice tend to focus on the Department of Corrections;

5. The lack of comprehensive assessments and the general attribution of "mental illness" to a wide variety of conditions, including aggressive behaviors, so that appropriate responses may not be taken and/or services provided or developed;

6. The stated opinion by some that persons in jails/prisons are not mentally ill for if they truly have mental illness, they would not be in jail/prison but in a treatment facility instead; and

7. The reported reluctance of community mental health providers to provide mental health services in jail and prison settings.

Jail and correctional personnel are neither trained nor hired to address the mental health needs of inmates. Training for Correctional Officers, guards, and support staff who

have daily contact with prisoners who have mental health issues is virtually non-existent except for training at the Maine Criminal Justice Academy's basic corrections course. There are a large number of individuals with personality disorders and poly-substance abuse problems in the jail population. Nonetheless, there is no provision of specific space for treatment, and no place where disruptive behavior may be managed. A large number of inmates are in direct need of, and appropriate for, on-site psychiatric services but do not qualify for inpatient hospital treatment.

There is a great unevenness and diversity in the services offered by the county sheriffs and jails. Even so, it is not surprising that county jail systems are seen by some as being able to be more innovative and creative than the State correctional system.

MENTAL HEALTH SERVICE NEEDS - ADULTS INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM

The inmate population in Maine includes those incarcerated in county jails and State correctional facilities, as well as those under the supervision of the Department of Corrections' Division of Probation and Parole. According to the Department of Corrections, approximately 1,600 adults are housed in State correctional facilities with 52 of them being female. On average, there are between 220 and 250 juveniles in the State's only juvenile correctional facility; about 25 of them are female. In 1992, there was an average of 942.3 adults (883.1 males; 59.2 females) and 21.5 juveniles (19 males: 2.5 females) held in county jails. As of November 1992, the Division of Probation and Parole was supervising over 11,000 people: 8,785 adults and 2,335 juveniles. Approximately 15% of this group is female.

While the exact number of jail inmates in Maine who have a serious mental illness is not known, the estimated 6 to 7 percent of jail inmates having schizophrenia, bipolar disorder, major depression, or other severe mental disorders places an added burden on county jails, as well as prisons, in budgets for psychiatric care and additional or constant supervision.

In identifying the mental health needs of adult mentally ill offenders, it became clear that greater precision about the different needs of various groups within the correctional population was necessary. These groups and their associated needs can be described as follows:

A. Offenders with mental illness, primarily the more severe and prolonged conditions, include those with diagnoses of schizophrenia and other psychoses, depression, bi-polar disorders. In the 1991 County Jail Survey this number was conservatively estimated to be about 6%.[4] This group may require the following:

1. Treatment within a correctional facility, including medications, individual and group therapies;

2. Occasional, time-limited inpatient care at AMHI/BMHI (rarely, long-term inpatient care); and
3. Community aftercare post-release services.

B. Offenders who have no pre-existing mental illness, but who are in acute crisis because of overwhelming situational stressors. This group may require:

1. Evaluation and triage;
2. On-going treatment, usually time-limited;
3. Referrals for inpatient evaluation and treatment, as needed; and
4. Measures to ensure physical protection.

C. Offenders with long histories of disordered behaviors, including anti-social behaviors, impulsivity, and manipulativeness, usually brought to mental health attention because of self-abuse, threats, and assaultiveness. This group requires:

1. Evaluation and triage to rule out mental illness or a crisis due to other causes;
2. Containment of behaviors and/or high level of security observation at the correctional facility to prevent dangerous behavior;
3. Inpatient evaluation may be indicated if there is doubt about the accuracy of the correctional site evaluation. Ongoing psychiatric inpatient treatment is not appropriate for individuals who do not have mental illness, and problem behaviors may be reinforced by gaining a transfer from the correctional system; and
4. Periodic brief assessment and treatment contacts, as needed.

D. Offenders who present themselves electively, asking for help in understanding their problems and changing their behaviors. This group may require group and individual therapies within the facility and in the community. Specialized needs frequently relate to issues of sexual, physical, and emotional victimization. Also, many have issues related to unresolved grief or loss.

E. Offenders whose primary problem is substance abuse. This group may require:

1. Inpatient substance abuse treatment;
2. Long-term substance abuse counseling at the correctional facility and in the community, and
3. Residential substance abuse programs.

F. Sex offenders who may have a "Sexual Disorder" diagnosis from DSM III-R. This group may require:

1. Long-term therapies within correctional facilities, as well as in the community; and
2. In some cases, medical treatment with Depoprovera.

G. Offenders with mental retardation and mental health disorders.

Most inmates need some type of human service, including vocational/employment, education, health, substance abuse, and child care services. Although specific information about needs is not available, we know that a large number of inmates need mental health services. A relatively small portion require acute psychiatric treatment. According to the Department of Correction, thirty percent (30%) of the offender population incarcerated in State correctional facilities are sex offenders with about three times that percentage being incarcerated adults who have a history of substance abuse.

A majority of persons with mental illness who break the law have already been in and out of the mental health system prior to incarceration. Most of those in prison or jail who are identified as mentally ill will still have that condition upon discharge. Most of them, when released, will never be hospitalized when living in the community but will still require mental health services of some sort.

There is a need for a variety of programs, involving the various service systems, to serve offenders with mental illness in the community. The released offender with mental illness should not be caught between total incarceration/institutionalization (with few or no services) and total "freedom" (with few or no services). The stabilization of individuals in the community is imperative and will require considerable and collaborative efforts, as well as the awareness that many face additional problems of poverty, inadequate education or special learning needs, inadequate/inappropriate vocational skills for the job market -- and their ramifications.

Mental health system providers have not been trained to work in jails and prisons. Some work with mentally ill people in the community. The combination of insufficient funding for mental health staff and appropriate services as well as inadequate training results in a chronic shortage of mental health services for the criminal justice population.

COMMUNITY RESOURCES

Most persons with mental illness who have been involved with the criminal justice system are in or return to their communities, either on probation or after serving a sentence. These individuals require mental health services which they may not be able to access. Many community agencies are overwhelmed and have long waiting lists for services. This can mean that persons mandated to receive treatment as a condition of probation may be

unable to fulfill required conditions. Individuals may have to travel up to 100 miles to receive such services and may not have medical insurance, Medicaid, or sufficient income to pay for these services.

There is little coordination between mental health agencies and Probation and Parole. Individuals with mental illness released to the community on probation, with treatment as a condition of probation, cannot be adequately monitored by probation officers who have high caseloads and are not trained to work with or supervise offenders with mental illness. Community caseworkers, trained in working with this population, are needed to work in conjunction with Probation and Parole.

More community crisis stabilization resources are also needed. Police personnel are typically tied up for several hours when they bring a person with mental illness to the community hospital emergency room rather than arresting them (e.g., bizarre behavior in the street). If the police elect to arrest the person, county jail personnel are tied up for several hours when they bring the person to the emergency room. Current involuntary commitment laws restricting who may or may not be admitted to State psychiatric hospitals may increase demands placed on community resources and increase the numbers of mentally ill individuals who become involved with the criminal justice system.

There is little, if any, coordination of services for individuals with mental illness when they leave jails or correctional facilities. An individual who requires medication and treatment may have no resources (Medicaid is suspended during incarceration) and no referrals. Probation and Parole, Medicaid, Social Security, community mental health agencies, the State psychiatric hospitals, substance abuse treatment centers, etc. need to be integrated in order to deliver a more coordinated system of services and in a manner which does not confuse and overwhelm individuals trying to obtain services.

EXISTING MAINE SYSTEMS

I. Department of Corrections

The Department of Corrections offers some psychological/psychiatric services to prisoners at all its major facilities. Depending on the site, psychiatrists and psychologists are retained on either a full-time or contractual basis. In addition, caseworkers and other staff are employed for a variety of therapeutic and evaluative needs.

Because of an increasing population and limited staff resources, the Department of Corrections' mental health services cannot meet the needs of its population. Psychiatrists, psychologists, and social workers find themselves in situations of crisis management, where relatively little time is devoted to ongoing therapeutic, diagnostic, and evaluative services, and where more time is, by necessity, devoted to meeting with and evaluating prisoners who have immediate and often extreme psychological needs. Consequently, the mental health

staff in all facilities spend the majority of their time dealing with immediate, rather than ongoing and follow-up therapy.

Due to budget constraints, there are no longer any sex offender treatment programs in the adult-serving correctional facilities, except at the Downeast Correctional Facility.

As of May 1993, substance abuse counselor positions with the Department of Corrections will be eliminated unless financial assistance is received from federally-funded grants. This will effect the entire Department of Corrections system.

A. Maine State Prison (MSP) - Ongoing mental health services are provided by seven full-time correctional caseworkers at MSP, 1 full-time caseworker at Bolduc Correctional Facility (BCF), and 1 full-time caseworker on loan from the Maine Correctional Institution (MCI) - Maximum security facility in Warren who shares his time between MCI and BCF. One full-time caseworker position is frozen until July of '93 for BCF and two positions are slated for MCI. The person who is currently sharing his time at BCF will assume one of the two positions when BCF's frozen position is reactivated. Two full-time psychologists, and a part-time psychiatrist for eight hours/week at MSP and four hours/week which is shared by BCF and MCI-Warren for a total of 12 hours/week of psychiatric services. The caseworkers, responsible for almost 600 prisoners, including the Bolduc Unit and MCI, have a caseload ratio of 1:85 and are able to see approximately 40 clients each week, for a total of 280 prisoners. The 39 contract hours/week per caseworker do not include necessary administrative and report writing time. The caseworkers have extensive waiting lists.

The two full-time psychologists provide both individual and group therapy sessions. Together, the psychologists see a total of 45 prisoners per week. Again, these contact hours do not include administrative time. There is an extensive waiting list for individual and group counseling.

The contract psychiatrist is at MSP only eight hours per week, plus four hours/week shared between BCF and MCI-Warren, and may review up to 20 cases per week. The greatest mental health need at MSP, BCF, and MCI-Warren is for more psychiatric time in order to reduce the extensive waiting list.

B. Maine Correctional Center (MCC) - With a current population of 580 prisoners, mental health services here include one casework supervisor and six full-time correctional caseworkers, one contractual psychiatrist for about 8 hours/ week. The current ratio of caseworkers to prisoners is 1:105, with an extensive waiting list. The contractual psychiatrist is responsible for the care and treatment of all MCC prisoners. The current provider ratio for both psychiatrists and psychologists is totally inadequate and additional services are desperately needed in all areas. Prior to the current biennium year, MCC was staffed with two full-time psychologists and 12 hours of contracted psychological services. In addition, a psychiatrist was available in the MCC 8 hours per week.

Currently, psychological services have been reduced from 96 hours per week to 12 hours per week. Both full-time positions are vacant through deappropriation or employment freeze. The entire psychological component at the present time consists of the 12 contracted hours. Psychiatric services continue at 8 hours per week.

Psychiatric Services

The psychiatrist is at MCC for a full day (8 hours) each Wednesday under contract with Prison Health Services. He sees prisoners on an individual basis, consults with staff at MCC, and prescribes medication for prisoners through the medical department.

During the past five months, the psychiatrist's prisoner contact was as follows:

June - 58 prisoners
July - 53 prisoners
August - 68 prisoners
September - 78 prisoners
October - 87 prisoners

An estimated breakdown by area for the prisoners seen by the psychiatrist is as follows:

1. 20% - Major depressive episode with suicidal feelings at times.
2. 10% - Psychotic, schizophrenia, manic depressive, brief psychotic reaction.
3. 30% - Post-traumatic stress disorder.
4. 10-20% - Adjustive disorder with insomnia.
5. 50-60% - Have substance abuse history.
6. 10% - Acute withdrawal symptoms from substance abuse.
7. 5-10% - Disassociative disorder, i.e., multiple personality.
8. 10% - Behavioral problem, anger.
9. 10% - Anxiety disorder (panic disorder, obsessive compulsive disorder.

Psychological Services

The psychologist on contract is currently at MCC on Tuesdays and Thursdays for a total of 12 hours per week. He attends the Program Staff Briefing on Tuesdays, and is the chairperson for the Behavior Management Team which meets each Thursday. He sees approximately 10 prisoners each week on a one-to-one basis. These individuals are generally in acute crisis and are showing high risk of self harm or suicide attempt. He consults with other staff members and coordinates treatment, management, etc., with Security, Social Services, Classification and other areas as needed.

For the six-month period from July 1, 1992 to November 30, 1992, the psychologist saw approximately 99 prisoners*. An estimated breakdown by area for the prisoners seen is as follows (99 = 100 for estimate of percentages):

1. Number of psychotic prisoners - 8%
2. Significant mental health problems including substance abuse - 59%
3. Number of inmates with suicidal concerns - 26%
4. Number of inmates showing aggressive behaviors - 13%
5. Number of inmates for whom significant staff consultation was provided after seeing the inmate - 76%
6. Number of inmates for which staff consultation was provided without seeing the prisoner - 4% **

* Underestimates the total slightly; some of these prisoners were seen once, some were seen more frequently, some as many as 6 to 10 times.

** Significantly underestimated, this number does not include prisoners discussed at staff briefing, Behavior Management Team etc., for which consultation to the staff was provided, but direct intervention by the psychologist was not conducted.

As can be seen from this information, the mental health services with MCC have been reduced drastically. The institution has lost any proactive capability to teach, train, counsel and assist inmates in learning to handle their depression, anger, aggression, or mental illness. Now, every effort is made to react to a mental health emergency as opposed to proactively intervening based on evaluation, case management, and proactive care.

C. Downeast Correctional Facility (DCF) - This facility, with a population of 135 prisoners, has one full-time caseworker, one part-time (eight hours/week) psychologist, and one part-time (12 hours/week) MSW clinician, with a psychiatrist available on an emergency basis only. The caseworker sees between 25 and 30 prisoners/week, while the psychologist and clinician each sees approximately 16 prisoners per week. When a prisoner needs a psychiatrist, he must be transported 70 miles to Ellsworth, since the psychiatrist will not travel to the facility. The psychiatrist's insurance company will not insure him if he works in a correctional facility. Consequently, one of the facility's pressing needs is for psychiatric services at the facility. An additional 20 hours per week of psychological services are also required. Contracted substance abuse services are provided involving individual/group counseling, education, and referral for follow-up treatment.

D. Charleston Correctional Facility (CCF) - The Charleston Correctional Facility's (CCF) current population of 187 prisoners is provided with one full-time caseworker, one full-time and one half-time contractual substance abuse counselor, and one part-time contractual psychologist. No psychiatric services are available. At the present time, it is not financial feasible to continue the psychological services, which were provided for 44 hours/week under the federal drug grant; the one-to-one counseling provided by this position is no longer available. The part-time psychologist provides six hours per week of assessments, evaluations, and individual counseling/therapy. He sees approximately six clients per week and currently has 29 more on a waiting list. Any prisoner in need of more

extensive psychological or psychiatric services must be transferred to a facility where these services are available. Virtually no specialized sex-offender treatment can be provided. As the facility has grown, the needs of the population have changed, requiring more extensive mental health services. CCF desperately needs another caseworker and a full-time psychologist in order to reduce the extensive waiting lists and more appropriately respond to the mental health needs of the prisoners. Contracted substance abuse counseling services are provided 55 hours/week.

E. Bangor Pre-Release Center BPRC) - The Bangor Pre-Release Center's (BPRC) population of 53 has no caseworkers or in-house psychological services provided. Any prisoner in need of psychological services is referred to an institution where these services are available. At present, 20 hours per week of contracted substance abuse evaluations and counseling services are provided. In order to meet present and anticipated needs of the facility, a caseworker, as well as access to psychological services, is necessary. If CCF were to acquire a full-time psychologist, part of that person's time could be shared with BPRC.

F. Central Maine Pre-Release Center - This facility with a current population of 65 has no in-house mental health services. Psychiatric emergencies are referred to the Maine Correctional Center.

G. Bolduc Correctional Facility (BCF) - the Bolduc Unit with a current population of 119 has no mental health services on-site. Psychological and psychiatric services are provided by the Maine State Prison on an as-needed basis. Prisoners in need of these services are returned to MSP. The Bolduc Unit should have an on-site caseworker.

H. Maine Correctional Institution (MCI) - Maximum Security Facility in Warren - This is a new unit which recently began receiving inmates. The current population is 30 with no mental health services on site. Services are provided through the MSP in a manner similar to that of Bolduc.

I. Probation and Parole - Probation officers and Juvenile Caseworkers refer probationers to local community services, including mental health services. Medicaid and private insurance fund some of these needed services. Six private practitioners also contract with the Department of Corrections to provide mental health services, usually on an individual basis. The Department has allocated $20,000 to each of the six (6) district offices for mental health services i.e., sex offender treatment, crisis counseling etc. As of July 1, 1993, there will be no monies available for any probationer in need of mental health services.

J. Veterans - Veterans who require mental health services, as a rule, are not admitted to a VA Hospital during incarceration because of security reasons. However, at times, when a security issue(s) is not a major concern (for example, Community Custody Level), the Department does participate with a VA Hospital to allow the incarcerated individual the opportunity to receive mental health services on an as-needed basis.

II. County Jails

• Androscoggin County Jail - Special Forensic Team. Tri-County Mental Health Services provides outpatient substance abuse counseling services.

• Aroostook County Jail - Aroostook Mental Health Center provides services.

• Cumberland County Jail - One social worker and a substance abuse counselor. However, in the event the type or extent of counseling required cannot be provided by the jail counseling staff, the jail would contract out for these services with appropriate vendors.

• Franklin County Jail - Limited services are provided from Tri-County Mental Health Services on a transport basis. The full-time substance abuse counselor from the Kennebec Valley Regional Health Agency has been cut back to part-time. However, that agency still provides a full range of contracted substance abuse services.

• Hancock County Jail - Blue Hill Memorial Hospital provides occasional services. Crisis Response counselors provide counseling services and mental health evaluations at the jail. On-call services are also provided by a local psychiatrist.

• Kennebec County Jail - Psychiatric nurse with forensic experience on a part-time and on-call basis; substance abuse counselor. Also, part-time in-house mental health counseling is available to inmates.

• Knox County Jail - Substance abuse counselor on staff for assessment and referral. Mid-Coast Mental Health Center is utilized for emergency evaluation and committal.

• Lincoln County Jail - Provides a licensed psychologist for routine and emergency services.

• Oxford County Jail - Full-time substance abuse counselor has been cut back in hours. These outpatient counseling substance abuse services are provided by Tri-County Mental Health Services. The jail administrator described the availability of services as "limited".

• Penobscot County Jail - Services provided by a licensed psychologist 5 hours per week, and a Master of Social Work/Substance Abuse Counselor for 80 hours per month.

• Piscataquis County Jail - Referral by the facility to Community Health and Counseling Services on a per diem basis.

• Sagadahoc County Holding Area - Full-time adult substance abuse counselor; full-time juvenile substance abuse counselor.

• Somerset County Jail - Full-time substance abuse counselor; crisis services from Crisis and Counseling.

• Waldo County Jail - Mid-Coast Mental Health Center provides counseling to inmates on a per diem basis. Emergency mental health care services are provided by Mid-Coast Mental Health Center at Waldo County General Hospital.

• Washington County Jail - In-house counseling, substance abuse and emotional counseling by a contract counselor who is licensed for substance abuse and employment counseling. Emergency mental health counseling services are provided by Down East Community Health and Counseling.

• York County Jail - Provides a licensed social worker 10 hours per week. Emergency mental health care services are provided by Southern Maine Medical Hospital.

A special program funded with Justice Assistance funds and administered by the Kennebec Valley Regional Health Agency, provides counseling, case management, and drug and alcohol monitoring services to all offenders leaving a county jail or State correctional facility in a seven-county area. This area includes Franklin, Kennebec, Knox, Lincoln, Penobscot, Sagadahoc, and Somerset counties.

III. Mental Health Institutions

A. Augusta Mental Health Institute (AMHI) - The Augusta Mental Health Institute forensic treatment unit is divided into two separate areas: (1) the maximum-security unit for dangerous AMHI patients and for the acute treatment of jail and prison inmates (six beds), and (2) the medium-security unit (21 beds), primarily for Not Guilty by Reason of Insanity (NGRI) acquittees and individuals found to be incompetent to stand trial. While admission rates are relatively low for this unit, release rates are even lower.

B. Bangor Mental Health Institute (BMHI) - A total of 18 beds are available for the treatment of NGRI, county jail, and civil patients believed to be dangerous.

GAPS:
- Additional mental health workers are needed, including those trained to conduct group therapy,
- Day hospital/community programs,
- Mentally ill offender residential program.

C. State Forensic Service (SFS) - The State Forensic Service, established in 1986, functions primarily in an evaluative and educative capacity for the State. It is the State's first independent forensic service with the entire State as its catchment area. The majority of the case work performed by the State Forensic Service, located on the grounds of the Augusta Mental Health Institute, involves pretrial and presentence evaluations. These evaluations determine if either mental disease or defect affects competency to stand trial and/or criminal responsibility with respect to alleged offense(s).

The Service is mandated to perform the following examinations: pretrial, presentence, pre-release, post-conviction review, bindover, or any other examination, at the request of the Commissioner, which is related to forensic issues. The pretrial evaluations are of three levels of examination which become progressively comprehensive in content and structure. On occasion, SFS assistance is requested in Federal cases where forensic concerns are at issue with the State.

In 1992, the State Forensic Service received 309 scheduled court orders. With 25 refusals or no shows, the completed evaluations equalled 284. Of these, 39.4% were completed by SFS staff and the remaining 60.6% by contracted mental health professionals. With only a small staff of its own, the State Forensic Service contracts with private sector mental health professionals to perform presentence evaluations and the first level pretrial examinations.

The SFS reports directly to the Commissioner of the Department of Mental Health and Mental Retardation. It is, however, a separate and distinct service with no treatment responsibilities or administrative linkage to any State treatment facility. This separation allows a high degree of autonomy and objectivity which otherwise would not exist.

IV. Community Resources

Most persons with mental illness who have been involved with the criminal justice system are in or return to their communities, either on probation or after serving a sentence. They find that there is no system of services in the community specifically to meet their needs. The community mental health system is available to them as it is to anyone else. Many do not have medical insurance, Medicaid, or sufficient income to pay for these services. In addition, many community agencies are overwhelmed and have long waiting lists for services.

There is little coordination between community mental health agencies and Probation and Parole or the jail and correctional systems. Community caseworkers, trained in working with this population, are needed to work in conjunction with Probation and Parole.

In addition, more community psychiatric crisis stabilization resources are needed. There is little, if any, coordination of services for individuals with mental illness when they

leave jails or correctional facilities. An individual who requires medication and treatment may have no resources (Medicaid is suspended during incarceration) and no referral.

V. Special Needs

Services to Women - Women with mental health disorders who are involved with the criminal justice system are generally eligible for the same mental health services as men. Women are incarcerated at the various county jails and at the Maine Correctional Center (MCC). Girls are incarcerated at the Maine Youth Center and also at the various county jails where appropriate.

Women designated as "Legal Hold" patients are housed on the locked, inpatient psychiatric units at the State psychiatric institutions (typically the Admissions unit). Women court committed as "Not Guilty by Reason of Insanity" (NGRI) have been housed on civil inpatient psychiatric units at AMHI and BMHI. There is no forensic treatment unit for women. The number of women in Maine, at any given time, who are designated as "Legal Hold" or NGRI is small.

The majority of female offenders are being incarcerated for the first time, a factor which may increase stress levels for these women. In March, 1990, a new, self-help group for 12 female inmates began to deal with women's issues of self-esteem and physical and sexual abuse. Because of staff shortages, this program has been discontinued. There are no sex-offender programs specifically for women.

Helping Incarcerated Parents (HIP), a federally-funded program to assist incarcerated parents to deal with their children more effectively, is available to both men and women.

Medical staff at MCC state that major medical problems for females include psychiatric problems, sleep disorders, and specific female medical problems. In some cases, the stress of incarceration appeared to provoke medical problems for female offenders, which might be better treated psychiatrically. These types of problems are found in two-thirds of the female population.

The findings of the Task Force on Female Offenders specifically recommended for MCC the following:[5]

- Psychiatric services should be expanded to assist in diagnosing physical problems of female inmates which may be related to stress;

- The use of volunteers to lead the women's issues group, to include topics of self-esteem, victimization, and stress management, should be explored;

• Training regarding the specific needs of female offenders and appropriate ways to manage female offenders should be provided by qualified persons to all correctional staff, not just correctional officers. Topics for training might include:

- The historical treatment of women in custody and community supervision;
- Myths and early theories about female offenders;
- Current attitudes and sexual stereotyping;
- Benefits and challenges of cross-gender supervision;
- Sensitivity to the special needs of female offenders;
- Resources for working with female offenders;
- Legal issues and key court decisions;
- Communication skills for working with female offenders; and
- Techniques to deal with stress related to working with female offenders.

VI. The Courts

The court system looks to the mental health system for assistance in three general areas:

1) Pretrial evaluations to determine if an individual is competent to stand trial and if any mental disease existed which would render the individual not criminally responsible (NGRI).

2) Presentence forensic evaluations to determine mental health needs so that sentences can be fashioned to respond to needs identified.

3) Services, provided either in institutions or in the community, designed to foster rehabilitation and control criminal behavior.

Protocols already exist to provide for pretrial determinations of competence and criminal responsibility. While scarce resources frequently contribute to undesirable delays in these evaluations, the procedural mechanisms are adequate.

There is a serious lack of presentence mental health evaluations for convicted offenders. While a cooperative agreement between the courts and the State Forensic Service provides for presentence evaluations in serious child-sexual abuse cases, these services are seldom available in other cases. Such evaluations are costly and beyond the means of the current Judicial Department budget.

As has already been documented, there is a critical lack of mental health services for convicted offenders, both in our prisons and in the community. While difficult to quantify, this lack of treatment resources contributes, no doubt, to problems of recidivism.

At the present time there are limited communications between the courts and county jails. This communications needs to be strengthened so that courts may take into consideration county jail personnel's knowledge of inmates and their needs.

VII. Substance Abuse Issues/Dual Diagnosis

Based on analysis and study, the Committee for Atypical Syndromes (CATS) in April 1990, determined that "the multiply diagnosed patient was not 'atypical', but rather represented a very large number of the spectrum of patients presenting to mental health and substance abuse systems".[6] The CATS report also noted "that many individuals in the criminal justice system, particularly at the county jail level, were people who warranted a multiple diagnosis and needed services well beyond the purview of correctional facilities (particularly county jails)."

The report went on to say that: "although...getting accurate data relative to the 'real' number of multiply diagnosed patients presenting to human service systems is often compromised by our failure to allocate adequate resources to the task of good data collection, it is not unreasonable to assume that the number of such patients probably lies between 60 to 75% of all those presenting, in extremis, to human service systems".

Coupling this study with the data noted earlier in this report that eighty-five to ninety percent (85-90%) of the incarcerated adults have a history of substance abuse and forty to eighty-five percent (40-85%) of juvenile offenders are substance abusers reinforces the magnitude of the issues which need to be faced while working with incarcerated offenders within Maine's county jail and prison system.

It is important, therefore, that not only do mental health providers need to be cross-trained or experienced in substance abuse but that substance abuse providers need to be cross-trained or experienced in mental health, especially those working with individuals involved with the criminal justice system.

In State FY 1992, nearly 14,000 individuals, including affected other individuals and co-dependent persons, received treatment through Office of Substance Abuse-funded agencies and Driver Education and Evaluation Program providers. Not counting shelter and detox client, of the 6,834 substance abuse clients, 11.4% had a concurrent psychiatric disorder and 9.9% had a correctional facility listed as their primary residence on acceptance for substance abuse services. Correctional facilities and county jail systems were shown as the source of referral for 7.5% and .4% respectively.[7]

VIII. Adult Protective

Under 18-A Probate Code, The Department of Human Services' Bureau of Elder and Adult Service's Adult Protective Services has responsibility for incapacitated adults, other than those individuals with mental retardation who are the responsibility of the Bureau of Mental Retardation. DHS may assume responsibility for those individuals with mental illness, physical illness or disability, only if no private person can assume responsibility. In these situations Adult Protective Services may seek guardianship and/or conservatorship of adults who are unable to make decisions for themselves and who have no family or friend able to make these decisions for them.

Guardianship and/or conservatorship provides protection and care for incapacitated adults. Only a Probate Court can declare an adult to be incapacitated and appoint a guardian or conservator. The court uses the opinion of a licensed physician or psychologist in making this decision.

At present, DHS-APS is public guardian for about 500 individuals; 83 of these are AMHI consent decree class members (some with diagnoses other than mental illness, but most have mental illness), and, of these, 3 are offenders with mental illness, who are incarcerated. It is unknown how many mentally ill offenders are incapacitated and have a court appointed private guardian. Also unknown is the number of mentally ill offenders who are incapacitated and unable to give informed consent and have no guardian.

It is important to understand that

1. most persons with mental illness are not incapacitated;
2. incapacitated adults' behaviors may not be purposeful or manipulative;
3. decision-making has been assigned to another because the incapacitated adult is unable to make those decisions;
4. a guardian has legal responsibilities on behalf of the ward; and
5. treaters and service staff must include the guardian when making decisions or planning for the incapacitated mentally ill offender.

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APPENDICES

County Jail Survey - April 1991

In April 1991, the Subcommittee on Mental Health Services to Persons with Mental Disorders Who Are Involved in the Criminal Justice System surveyed all the Maine county jails regarding individuals with a history of serious mental illness. The data was collected on 732 county jail inmates who were in the system on April 1, 1991. Information was collected on the gender, status (sentenced/not), class of charges, length of stay from booking until 4/1/91, history of psychiatric hospitalization, medications, presence of guardian/case manager/social worker, and disability benefits.

Data collection was based on a conservative definition of serious mental illness: multiple and/or two or more week psychiatric hospitalization. Even so, interesting information emerged. Individuals who had multiple or two-week or longer psychiatric hospitalizations (n=42) had a much longer length of stay in jail than people who did not have such a history. For them, the length of stay to date was an average of 75 days compared to 44 days. Individuals who were receiving antipsychotic medications (n=10) had a somewhat higher percentage of felony charges than average. Seventy percent (70%) of the inmates on antipsychotic medications had felony charges compared to fifty-eight (58%) of the whole group. The length of stay was also much longer (112 days from date of booking).

LENGTH OF STAY FROM BOOKING TO 4/1/91

Psychiatric History	# Inmates	% Inmates	LOS Days
No psychiatric hospitalization (or less than two weeks)	690	94.3%	44
History of psychiatric hospitalization (multiple and/or more than 2 weeks)	42	5.7%	75
TOTAL	732	100.0%	
Individuals on antipsychotic medication	10	1.4%	112

The percentage of the jail population receiving antipsychotic medications (1.4%) was similar to the median estimate of individuals with psychosis in the community (1.7%). Only

four of the jail inmates who were receiving antipsychotic medications reported having a case manager in the community (0.55%).

It should be noted that the survey was a very preliminary and basic one, and represents a snapshot rather than a comprehensive look at the jail population. In addition, as noted above, the definition used for mental illness was very narrow. This has implications for the survey outcomes since the State mental health institutions have for some time restricted entrance to involuntary admissions and the growing trend for length of stay is increasingly less than two weeks.

County Jail Survey - 1992

In a survey conducted by Meuse and Welch for the University of Maine HRD 610 class, an overview, based on face-to-face interviews with jail officials in 15 counties in Maine (Sagadahoc does not have a jail), was obtained of the situation of inmates with mental illness in these facilities.

The survey found that the statewide cumulative average of inmates that appear to have a mental illness is 9.8% vs. the national average of 7.2% found by NAMI, although the basis for this percentage is not defined (impression, statistics based on actual diagnosis, etc.). Similarly, 80% of respondents noted seeing some form of an increase of inmates with mental illness, with 40% of the respondents seeing persons with mental illnesses far more in their jails than ever before. In the opinion of the jail administrators, the three most common offenses for which inmates with mental illness were arrested were a) criminal trespassing, b) assault, and c) disorderly conduct.

In addition, they stated that inmates with mental illness are the cause of many special problems in the jails, such as requiring additional attention from jail staff, disrupting normal jail activities, requiring more close attention for possible suicide; increasing the potential for outbreaks of violence, and being abused by other inmates.

In over four-fifths of the jails, personnel have had no special training for identifying persons with mental illness, with only minimal initial training about mental illness. The Booking Officer is the one who completes the medical and psychological screenings. All medications are confiscated prior to incarceration and confirmed before administration by jail personnel (75% of the time) or a nurse (25%), and, in any event, most noted there was a problem of refusals of psychiatric medication by inmates with mental illness. Over half of the inmates with diagnosed mental illness receive no therapy while in jail, the balance most frequently receiving crisis intervention. 27% are housed apart from the jail's general population. Most stated that services required by these inmates was taking a greater percentage of their budget and that they did not feel that their staff or facilities were equipped for working with inmates with mental illness. Over half stated they did not see a positive correlation between inmates with mental illness and increased recidivism.in handling inmates with mental illness.

Priority Population Definition

For the purpose of planning and service system assessment, persons eighteen years and older with severe and prolonged mental illness shall be defined as individuals meeting 1) DSM III-R, Axis I criteria for mental disorders* (with the exception of mental retardation, substance abuse disorders, adjustment disorders, and V codes) and 2) Axis V criteria indicating serious functional impairment when 3) combined with the presence of the following characteristics:

A. General Characteristics: (One of the following must apply.)

1. All persons currently receiving active discharge planning while in a State hospital or who have been discharged in the last six months.

2. All persons with psychiatrically related diagnoses receiving active discharge planning from other inpatient units or residential facilities or who have been discharged in the last six months.

3. Persons with hospitalization or residential treatment care of at least six months in the last eighteen months.

4. Two or more periods of hospitalization in the last six months.

5. Four or more psychiatric emergency face-to-face incidents in the last twelve months.

6. Other persons with a history of hospitalization who are currently receiving psychotropic medication(s), who have a diagnostic history of major mental illness, and/or whose functioning ability is such that community support, day treatment/rehabilitation is needed.

B. Functional Characteristics:

(Signs or symptoms of mental or emotional disorder must be of sufficient severity to cause a disturbance in role performance or functional abilities as evidenced by the presence of one or more of the following characteristics.)

1. The person is homeless or at risk of losing his/her current residence.

2. The person is unable to work, has experienced behaviorally observable deterioration in social support or vocational performance, or is facing imminent extrusion from job or family.
3. The person's ability to carry out usual roles and functions in the community is grossly impaired due to psychiatric symptoms or antisocial behaviors.

4. The person has become socially isolated, has no social support system, and has lost or failed to acquire the capacity to develop such a system.

5. The person is unable to support him/herself or manage his/her finances without assistance.

6. The person is causing disturbances in the community because of poor judgment or antisocial, bizarre, or intrusive behavior.

7. The person exhibits behaviorally observable deteriorating clinical symptoms, as determined by a qualified mental health professional, which will lead to hospitalization, psychiatric emergencies, difficulties with the criminal justice system, or the need for other restrictive forms of care.

8. The person lacks service support systems which are adequate to restore his/her previous level of functioning in the absence of services.

* Special Diagnostic Criteria:

Persons meeting DSM III-R, Axis II diagnostic criteria will also be defined as persons with severe mental illness when at least one of the following psychiatric signs or symptoms is present:

1. Attempts or threats of suicide.

2. Confusion, disorientation, memory loss, and lack of judgment which impair behavioral functioning.

3. Hallucinations, which are active and distracting to the individual, impair behavioral functioning.

4. Delusional or disorganized thoughts which impair behavioral functioning.

5. Grossly bizarre behavior with severe disturbances of mood or affect.

6. Severe psychomotor retardation, agitation or hyperactivity.

7. Grossly inappropriate or grossly blunted affect.

8. Inability to care for self which by failure to receive treatment will result in severe deterioration of medical condition(s) or will create life or limb threatening condition(s).