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

**December 19, 2001**

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## Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Diversion**

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

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

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

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

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

### **Treatment and Aftercare Planning in State Facilities**

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

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

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

### **Treatment and Aftercare Planning in State and County Facilities**

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

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

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

<sup>4</sup> The Maine Jail Association has expressed a desire that this exception be expanded even further. See Appendix I.

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

### **Treatment and Aftercare Planning in County Facilities**

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

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

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<sup>5</sup> In its review of a draft of this report, the Maine Jail Association expressed opposition to this recommendation. See Appendix I.

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



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

## I. INTRODUCTION

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

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

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

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<sup>1</sup> U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health Treatment in State Prisons, 2000, NCJ 188215, July 2001. Associated statistics may be found at <http://www.ojp.usdoj.gov/bjs/correct.htm>.

<sup>2</sup> Id.

<sup>3</sup> Id.

<sup>4</sup> Id.

<sup>5</sup> Id.

<sup>6</sup> Id. This is a distinction the State shares with Louisiana, Nebraska and Wyoming.

<sup>7</sup> Maine Jail Association Mental Health Survey, draft report provided to the study committee on November 27, 2001, attached as Appendix I.

<sup>8</sup> According to a Department of Justice survey in 1998, more than a third of the mentally ill in state prisons or local jails showed signs of alcohol dependence. Nearly half of the mentally ill in state prisons indicated they were binge drinkers; 46 percent reported they had been in physical fights while drinking; 17 percent had lost a job due to drinking. U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.

<sup>9</sup> According to the 1998 Department of Justice survey, about 40 percent of mentally ill inmates were unemployed before their arrest. U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.

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

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

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

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

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

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

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

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

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

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

## **II. BACKGROUND**

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

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

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

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

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

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

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

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

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

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

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

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<sup>12</sup> U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.

<sup>13</sup> Draine and Solomon, “Describing and Evaluating Jail Diversion Services for Persons with Serious Mental Illness,” *Psychiatric Services*, January 1999, vol. 50, No. 1, p.56.

<sup>14</sup> *Id.*

<sup>15</sup> *Id.* at 57.

<sup>16</sup> *Id.* at 56.

<sup>17</sup> Steadman, Deane, Borum and Morrissey, “Comparing Outcomes of Major Models of Police responses to Mental Health Emergencies,” *Psychiatric Services*, May 2000, Vol. 51, No. 5, p. 645.

<sup>18</sup> *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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<sup>20</sup> For a description of federal benefit rules governing suspension and termination of benefits while a person is incarcerated see booklet "For People with Serious Mental Illnesses: Finding the Key to Successful Transition from Jail to Community," Bazelon Center for Mental Health, Washington, D.C., March 2001.

<sup>21</sup> U.S. DOJ, Bureau of Justice Statistics Special Report, Mental Health and treatment of Inmates and Probationers, NCJ 174463, July 1999.



that “(o)ver three-quarters of mentally ill inmates had been sentenced to time in prison or jail or on probation at least once prior to the current sentence.”<sup>22</sup>

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

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

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

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

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

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<sup>22</sup> Id.

<sup>23</sup> U.S. DOJ, Bureau of Justice Statistics Special Report, *Mental Health Treatment in State Prisons, 2000*, NCJ 188215, July 2001.

<sup>24</sup> Id.

<sup>25</sup> Id.

<sup>26</sup> This information was supplied by the National GAINS Center for People with Co-Occurring Disorders in the Justice System, Delmar NY. The web site is [www.prainc.com/gains](http://www.prainc.com/gains).

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

#### **D. Summary of current laws and services in Maine**

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

##### **1. Department of Behavioral and Developmental Services diversion strategy.**

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

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<sup>27</sup> 34-B MRSA §1219.

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

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

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

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

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

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

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

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

### **3. Other ways of committing forensic patients to state mental health institutions.**

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

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

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

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

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<sup>30</sup> 15 MRSA §101-B(3).

<sup>31</sup> 15 MRSA §101-B(4).

<sup>32</sup> 15 MRSA §103.

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

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

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

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

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

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

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<sup>33</sup> For instance, on Nov. 9, 1999, there were 24 forensic patients at AMHI, 12 of whom were not criminally responsible, 5 incompetent to stand trial, 1 was pending evaluation and 6 were jail transfers. See report, Maine Inpatient Treatment Initiative: Civil and Forensic, Pulitzer/Bogard & Associates, L.L.C., February 29, 2000, Table 9, p. 15.

<sup>34</sup> See report, Maine Inpatient Treatment Initiative: Civil and Forensic, Pulitzer/Bogard & Associates, L.L.C., February 29, 2000, Table 13, p. 21.

<sup>35</sup> 17-A MRSA §1204.

<sup>36</sup> 34-A MRSA §1220.

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

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

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

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

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<sup>37</sup> Letter to the committee from Commissioner Duby dated Nov. 5, 2001.

<sup>38</sup> 34-B MRSA 3862.

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

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

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

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

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

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

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

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<sup>39</sup> Public Law 2001, Ch. 458, codified at 34-A MRS 1214.

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

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

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

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

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

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



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

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

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

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

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

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

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

### **III. FINDINGS**

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

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

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

#### **Findings on diversion**

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

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

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

### **Findings on treatment of inmates in State facilities**

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

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

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

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

The committee finds the following:

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

#### **Findings on treatment of inmates in county jails**

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

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

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

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

#### **IV. RECOMMENDATIONS**

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

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

##### **Diversion**

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

## 1. Law enforcement programs.

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

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

## 3. Diversion in the courts.

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

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

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

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

## **Treatment and Aftercare Planning in State Facilities**

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

- 1. Improve mental health screening.** The committee recommends that a position be created at each DOC intake facility (Maine State Prison and Maine Correctional Center) to undertake mental health screening and to collect relevant mental health information upon intake. These should be psychologist-level positions. Currently such screening consists of a brief self-report by inmates. The addition of these positions will allow for a comprehensive interview process that will then guide case management and treatment services. Intake screening should also be coordinated with aftercare planning (see aftercare recommendation, below). Proposed legislation implementing this recommendation may be found in Appendix C.
- 2. Meet accreditation requirements.** The committee recommends that funding be provided to DOC for 1 psychiatrist and 1 psychiatric nurse to provide mental health treatment services to inmates in the State facilities. Currently the DOC has only one psychiatrist on staff. Current law directs that the DOC meet ACA accreditation standards by 2005. The addition of these positions will provide greater treatment resources to meet the needs of persons with mental illness who are incarcerated and will allow the DOC to satisfy ACA accreditation standards. Proposed legislation implementing this recommendation may be found in Appendix C.
- 3. Improve cross training.** The committee recommends that the DOC develop a training program to provide specialized forensic training to case management and community support providers and crisis and outpatient providers. This training will help ensure that mental health service providers understand the forensic issues associated with the treatment of persons with mental illness who are incarcerated. This training is the necessary counterpart to the training that has occurred and that the committee recommends be expanded within the criminal justice system with regard to understanding mental health issues; cross training helps to span the boundaries and bridge the gaps in order to create a more seamless system to meet the needs of persons with mental illness. Proposed legislation implementing this recommendation may be found in Appendix C.
- 4. Ensure appropriate use of medications.** The committee recommends that the DOC work with the Department of Behavioral and Developmental Services to ensure its formulary includes the best medications for the treatment of inmates with mental illness and adopt policies to ensure that the most effective such medications are available and used and that clinical care needs, not cost, govern the use of medications. The committee recommends the DOC be directed to report to the joint standing committee of the



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

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

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

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

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

### **Treatment and Aftercare Planning in State and County Facilities**

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

#### **1. Preserving Federal benefits**

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

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

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

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

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

#### **4. Improve access to information.**

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

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

<sup>48</sup> See 34-B MRSA §1207.

<sup>49</sup> The Maine Jail Association has suggested expanding this exception even further. See Appendix I.

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

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

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

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

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

## **Treatment and Aftercare Planning in County Facilities**

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

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

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

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

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

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

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

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

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

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

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