

**REPORT ON THE
STATUS OF SERVICES
FOR PERSONS
WITH MENTAL ILLNESS
IN MAINE'S JAILS
2000-2007**

What has changed?

NAMI MAINE

Author's Introduction

In 2000, NAMI Maine spoke with the family of James Thomas an 18 year old who had killed himself while “on loan” to the Maine State Prison from a local jail. That jail was not able to contain his mental illness or manage his suicide attempts, nor could they get help from the local mental health system. That was the beginning of NAMI Maine’s journey to fix all of the things that led to James’s death.

During the six years since I talked with James’ family, I have talked to:

- Fathers who have lost a young son to suicide in a Maine’s correctional facility;
- Mothers whose young daughters have been held in jail for months, so ill they are stripping off their clothes, talking to people who are not there, and untreated because they are too ill to consent to treatment;
- Correctional officers who have physically supported inmates who they found “hanging up”, dead or near dead, while shouting for someone to come and cut the inmate down;
- Sheriffs whose faces showed significant distress as they talked about their employees who are unable to sleep because, after the suicide of an inmate, they wake up and wonder, “If I had just been there sooner, could that suicide have been prevented. Would that man have lived? Could have saved him?”
- Correctional officers who told of having to put a football helmet on a newly admitted inmate to keep her from hurting herself when she repeatedly banged her head in the cell. “You could hear her hollering all night long across the entire jail. THAT was hard to take,” they told me.
- Former inmates who said, “they don’t give you toilet paper in there, you have to use your clothes. It’s really embarrassing.”

Six years into this journey 19 **jail** inmates have died from suicide or drug/alcohol related illness and there have been 4 suicides in the prison. In some ways, things are worse. I say this despite what I know are significant and ongoing efforts, not just at NAMI Maine, but by many impressive local and state leaders. My heartfelt thanks to Sheriffs Ross of Penobscot and Dion of Cumberland, Sharon Sprague and Debra Henderlong from the Department of Health and Human Services, Elizabeth Simoni from Maine Pre-Trial Services, Justice Nancy Mills and Hartwell Dowling from the Court system, Steve Sherrets and Denise Lord from the Department of Corrections, Sgts. Robin Gauvin from the Portland Police Department and Paul Edwards from the Bangor Police Department, former State Senator Mike McAlevey, Representative Ed Povich – and the rest of the people who have helped with diversion efforts.

This report, the third in a six year period, reviews what has been done to help people who have failed to receive treatment for their mental illness and substance abuse problems who end up in jail. Unfortunately, Maine's jails remain overcrowded, conditions inside are deteriorating, and correctional officers are still the largest providers of mental health and substance abuse services in the state.

Moreover, many policy-makers are not aware of the problems facing Maine's jails or the families of inmates with mental illness. Most taxpayers don't give much thought to our jails, are not aware of the jail's impact on their property tax bill, nor do they realize that jails serve as the primary provider of care for Mainers who have mental illness or co-occurring substance abuse problems. Worse still, the stigma about people with mental illness, and people who go to jail contributes significantly to this problem. Jails have faced double the number deaths that the Augusta Mental Health Institute did in late 1990s. Ten people with mental illness died in that state institution and 16 years of litigation and an arm load of laws and rules resulted. Paraphrasing Joseph T. Hallinan*, we call it "going up the river" when we incarcerate people because we send them away, and put them out of our minds. Hallinan tells the story of our prisons. Peter Earley tells the story of our jails in his 2006 book, Crazy. Those books are a call to action for the country. I hope this report is a call to action to Maine.

Carol Carothers, Executive Director, NAMI Maine

Executive Summary

Executive Summary

In 2000 and again in 2002, NAMI Maine released a report describing conditions for people with mental illness in Maine's jails and prisons. In December of 2006, two things prompted NAMI Maine to again take a look at conditions for people with mental illness in our jails. Both involved the release of reports designed to help jails. In September of 2006, the Bureau of Justice Statistics reported that 64% of jail inmates have mental illness (60% are actively symptomatic and 24% meet criteria for a psychotic disorder). In December of 2006, just three months later, the Maine Corrections Alternatives Commission released its findings and failed to mention, even once, the prevalence of mental illness in Maine's jails, a significant oversight.

Although NAMI Maine congratulates the members of the committee for their work *and* their report, we see failure to mention that over half of Maine's jail inmates are people with mental illness or co-occurring substance use problems as a significant omission.

We responded by (1) reviewing the findings and recommendations of multiple recent studies about mental illness in Maine's jails and the current status of their recommendations, and (2) surveying Maine's 15 jails about their experience between 2002 and 2006 with inmates with mental illness. Nine Maine jails (60%) responded and here's what we found:

"In September of 2006, the Bureau of Justice Statistics reported that 64% of jail inmates have mental illness. In December of 2006, just three months later, the Maine Corrections Alternatives Commission released its findings and failed to mention, even once, the prevalence of mental illness in Maine's jails, a significant oversight."

- More deaths. 19 jail inmates have died in Maine's jails since 2000 either from suicide or from drug/alcohol overdose or withdrawal. Most of those deaths were clustered in 2002-03 (ten) and 2006 (six).
- Recommendations not carried out. Most of the recommendations from two lengthy legislative studies carried out between 2002 and 2006 about how to reduce the number of jail inmates with mental illness have not been implemented.
- Limited action/limited funding. The state (the Department of Health and Human Services, the Department of Corrections, and the Courts) have each taken limited action, because of limited funding, to address the needs of inmates with mental illness.
- Sustainability of local advances is questionable. Most concrete and specific assistance to Maine's jails has come from local leaders, who have joined together with NAMI Maine to generate private and federal grant dollars to help inmates and to divert people to treatment. What will happen to these projects once grant dollars end is unknown.

- Jails largest provider of care. Maine’s jails, like those in the rest of the nation, continue to be the largest providers of mental health services at increasing cost in terms of jail medical and overtime budgets as well as construction of new jails (Two Bridges jail opened in Wiscasset in 2006; new jails/jail expansions are planned in Somerset, Penobscot, Kennebec, and Waldo Counties. Here are the facts from the 9 jails who responded to the survey:
 - o All of the jails reported multiple suicide attempts since 2000, with a high of 45 and a low of 18. The average number was 27.
 - o All jails reported suicidal inmates and constant observation for suicidal inmates as a routine part of the jail week. The average number of inmates on suicide watch per month was 21.75, the maximum 107.
 - o Jails sent inmates to psychiatric hospitals 87 times between 2004 and 2006, but most report difficulty accessing beds when they need them. One jail reported being able to access a hospital bed just 69% of the time. All had to staff inmates in local emergency rooms while waiting for a hospital bed, some for as long as 6.9 days. In 2006 alone, jails held inmates in the jail on constant observation 19 times while waiting for a hospital bed (a violation of federal law).
 - o All jails report providing psychiatric medications to inmates. The low was 29% of inmates taking mental health medications, the high 75%; the average 51%.
 - o Two larger jails, Cumberland and Penobscot, have significantly increased the availability of mental health services and can therefore document the amount of care provided to inmates with mental illness. In 2006, Penobscot County Jail provided 539 substance abuse interventions, 637 mental health interventions, 1,353 co-occurring disorders interventions to inmates to the inmates passing through 173 beds. Cumberland County Jail reported 8,231 mental health intakes, which resulted in 14 hospitalizations, 656 mental health interventions, 749 follow-up interventions, 372 evaluations, 1,357 self referrals seen by mental health workers, 323 seen by the psychiatrist, 536 seen by the nurse – for a total of 5,621 psychiatric encounters in 2006.

“In 2006, the Penobscot County Jail provided 539 substance abuse interventions, 637 mental health interventions, and 1,353 co-occurring interventions to the inmates passing through 173 beds.”

Full Report

Introduction

In the fall of 2000 and again in September 2002, NAMI Maine released a report on conditions for people with mental illness and/or substance abuse in Maine's jails and prisons. Those reports raised serious concerns about inmate suicide, inadequate or unavailable mental health services, and the use of segregation as a common practice for handling psychotic or highly symptomatic inmates with mental illness. The facts were startling:

- Over 40,000 people passing through Maine's jails each year, 35% of Maine's jail inmates were taking medications for mental illness.
- 50% of Maine's jails reported they could not access psychiatric hospital beds even when inmates had been medically determined to need one between
- Most Maine's jails reported inadequate or no mental health resources.
- Ten jail inmates committed suicide, one died of a drug overdose, and one died from alcohol withdrawal.
- Seven Maine jails were deemed over crowded, one was deemed unsafe. A riot in one jail was blamed on overcrowding. On the day of the riot, 116 inmates were housed in a jail designed for 58.

Multiple efforts were made to address those issues including:

- A 2000-01 Legislative study recommended spending \$9 million to establish diversion programs, address gaps in mental health services, and create in-jail programming. \$65,000 was appropriated for one pilot project (eventually started in the Knox, Waldo, and Lincoln county jails). L.D. 2068, legislation resulting from that study, became Public Law Chapter 659 in April of 2002. That law required:
 - The Department of Health and Human Services to establish procedures to ensure that inmates who were receiving Medicaid services prior to incarceration did not lose their eligibility as a result of that incarceration, if possible;
 - That the Department of Health and Human Services develop agreements with the Department of Corrections and county jail administrators to improve access to inpatient psychiatric beds for inmates. (In 2005, Riverview Psychiatric Center established a 72 hour observation bed for Maine's jails and jails who signed an agreement to accept the inmate back at the jail within that time frame now have access to that bed.
 - That inmates returning to correctional settings from psychiatric hospitals must have written treatment plans telling the jail how to maintain the inmate's mental health.
 - That the Department of Corrections and the Maine Jail Association work together to examine ways to treat people who are incarcerated who have mental illness in the least restrictive setting possible and to report back by January 30, 2003 regarding their actions and recommendations.
 - That the jails report back to the legislature about the use of furloughs to assist with meeting their psychiatric or medical needs.
 - That the Department of Corrections adopt the same formulary as that at the state's psychiatric hospitals and (those formularies are now the same and some jails now

take advantage of joint purchasing of medications through the Department of Corrections.),

- That the Department of Corrections establish separate grievance processes for inmates with medical or mental health treatment complaints.
- That the Department of Health and Human Services evaluate the effectiveness of its Ride Along program and report back to the legislature with recommendations (this report was released in 2003).

During that same time, the Cumberland County jail became the first jail in Maine to meet national accreditation standards and two memorandum's of agreement were signed between local jails and the Department of Behavioral and Developmental Services – one with the Kennebec County Jail and one with the Penobscot County Jail. These were designed to link these jails more closely to intensive case managers and psychiatry available through the state. In 2002 NAMI Maine started a nationally recognized pre-booking jail diversion program, CIT, in Portland, Maine. And Maine's Department of Behavioral and Developmental Services provided Intensive Case Managers to some Maine's jails, required the mobile crisis system to carry out mental health assessments in Maine's jails, and continued police ride-along programs to assist correctional and law enforcement officers to cope with the needs of people with mental illness.

2003 – 2006 More Studies

Despite two-years of legislative study and multiple recommendations by the Joint Standing Committee on Criminal Justice in 2002, jails continued to experience increased numbers of inmates with mental illness/substance use problems and rapidly increasing medical budgets. The cost of corrections in Maine continued to climb and Maine's budget could not keep pace. Faced with decreasing state revenue and increased correctional costs, in 2003, the Legislature asked the Commission to Improve the Sentencing, Supervision, Management and Incarceration of Prisoners (the Sentencing Commission) to identify solutions, including responding to the growing number of inmates with mental illness. That group issued two reports. The first, in 2004, recommended a number of changes in Maine's sentencing laws, some of which were enacted. The Commission's 22 recommendations about diversion, however, were deferred for a second year of study and discussion and the DOC and DHHS were asked issue a joint action plan for diversion and re-entry. In June 2005, the Commission's second report was released, and it included the state's joint action plan.

The commission's final report concluded: "The commission recognizes that these are difficult financial times for the state; also that some solutions require new money or a reallocation of existing money. As one Commission member noted 'If we could intervene successfully in domestic violence, substance abuse, and mental illness we would permanently reduce the prison, jail and probation overcrowding problem in this state.'" Despite this acknowledgement, and 22 recommendations designed to "intervene successfully", the only concrete diversion effort to result from that study was the state's joint action plan, attached as an appendix.

"If we could successfully intervene in domestic violence, substance abuse and mental illness we would permanently reduce the orison, jail and probation overcrowding problem in this state."

In 2006, as the cost of corrections continued to rise (jails were still over crowded and the prison, designed to have room to spare through 2010 was full) another study was commissioned. The Corrections Alternatives Advisory Committee was asked to examine ways to address the problem. In November of 2006, the group issued a report including 22 recommendations designed to encourage jails, the courts, and the state to reduce the number of people going to jail. Despite a September 2006 report from the Bureau of Justice Statistics* which found 64% of jail inmates nation-wide have serious mental illness, and a fall news conference held by the Sheriff in charge of Maine's largest jail, which said that almost 100% of the inmates in the Cumberland County jail were taking medications for a mental health problem, the new committee failed to make a single recommendation related to the issue of mental illness/substance abuse.

It is important to note that both the Sentencing Commission and the Corrections Alternatives Commission were charged with addressing a growing list of problems in Maine's corrections system, problems that extend beyond the needs of inmates with mental illness or substance use problems. In fact, all of the studies that have been undertaken have collected and analyzed important data and made valuable suggestions. Unfortunately, the majority of recommendations about how to solve the problems associated with mental illness/substance use in our criminal justice system have not been implemented.

“During this same time frame over \$43,000,000 was cut from Maine's mental health system.*

During this same time frame, over \$43,000,000 was cut from Maine's mental health system.

The Joint Action Plan

As noted earlier, the Legislature required the State to issue a plan of action to address the needs of inmates with mental illness. That draft action plan, dated February 2006, and marked “This draft is for discussion purposes only. It does not necessarily reflect the position of the Baldacci Administration” includes five goals:

1. diverting people with mental illness from the criminal justice system,
2. improving mental health services for people with mental illness who are involved in the criminal justice system,
3. improved transition re-entry planning,
4. fostering mutual responsibility for meeting the needs of people with mental illness while ensuring public safety, and
5. ensuring that there are consistent, effective mental health services for the mutual clients of Riverview and DOC.

Implementation of the plan began in March 2006 when the state hosted stakeholder forums in each county to unveil the plan, solicit input, and brainstorm local needs. In October, the state also hosted a summit to release their findings and encourage additional discussion among county stakeholders. Many of the issues identified in their draft report are the same as those raised by NAMI and listed in earlier studies, including:

- The need for pre- and post booking diversion programs such as Crisis Intervention

- Teams (CIT) and boundary spanners*;
- The need for more community based treatment options to keep people out of jail, including Assertive Community Treatment teams;
 - The need to reduce long waits in emergency rooms and improve jail's ability to obtain hospital care for inmates in need;
 - The need improve community based services so that jails aren't defacto mental hospitals;
 - The need to assure that inmates can receive needed psychiatric medications while in jail.

The concluding statement in the report is: "Another summit is scheduled in 2007 which will call upon the work done in regional collaboratives to make policy recommendations which may be necessary to implement the diversion and re-entry action steps outlined in the joint plan of action.*"

Corrections at a Crossroads: A report to Cumberland County, Maine.

In 2002, Cumberland County received Maine's first federal jail diversion grant, becoming one of the nation's first jail diversion programs funded under the targeted capacity expansion program of the Substance Abuse Mental Health Services Administration, Center for Mental Health Services. In August 2006, with funding from the Maine Health Access Foundation, the Muskie Institute released a cost-benefit review of that program, Project Divert Offenders to Treatment (DOT), as well as a discussion of the needs of jails overall. That report, "Corrections at a Crossroads", analyzes the costs of operating Maine's largest jail, the impact of state policy on all Maine jails, and the impact of diversion programs. Her report includes the following statistics about the growth in jail spending:

- There has been a 50% increase in the number of jail inmates since 1995 and a 4.2% increase in probation caseloads.
- The Department of Corrections budget has grown by 46.7% more than expected, with a \$20.7 million increase for state prisons alone in 2007.
- The 2007 budget for community correctional programming sought just \$101,522 over 2004 spending levels, for an average increase for Maine's 16 counties of just \$6,344 over three years.
- Although the Department of Health and Human Services budget has grown by 75.4%, the Department of Behavioral and Developmental Services (now part of DHHS) has grown by 32.2% and the Judicial Department by just 12.9%.
- The average cost for a jail bed is \$107/day.
- Cumberland County Jail's average daily population grew by 108 between 1997 and 2004 – an increase of 80%;
- Statewide spending on jails increased by 108% between 1997 and 2004.
- In 2004, all counties combined spent \$5,215,000 for medical care for inmates;

"Between 1997 and 2004 spending on jails grew by 108%."

In addition, the report notes:

- Sheriffs across the country who have implemented diversion programs continue to see their jail budgets grow. Nonetheless, the benefits of a diversion program are many.
- The costs of state and local corrections have been rising rapidly and will be propelled to a whole new level with two new jails coming on line over the next few years.
- Cost savings occur in the short term in the form of reductions in overtime payments and wages for part time workers. In the longer term, costs savings come in the form of averted spending: not needing to expand a facility or build a new jail.
- When a jail is full, reducing the population by even a few people can change the environment from risky to manageable. The benefits may be even greater if the population reduction occurs through the diversion of people with mental illness and addictions, who are more difficult to manage, more likely to be victimized, are more at risk for suicide. Corrections officers rate having people with mental illness in jails and prisons as the second most serious workplace problem, after overcrowding.
- Overcrowding often leads to the decision to build a new facility, moving the entire cost structure to a new plateau. Crowding has been associated with an increase in use of sick and other paid leave time and more injuries of officers on the job. Next to police officers, corrections officers have the second highest rate of non-fatal incidents. Inmates are at greater risk in crowded conditions for injuries, homicide and suicide. Hospital visits, psychiatric assessments, medication expense and other variable costs also increase rapidly.
- Aggressive diversion programs and efforts aimed at reducing use of a jail can make the difference between getting by with the existing facility and needing to move ahead with expansion plans.

“The benefits may be even greater if the population reduction occurs through the diversion of people with mental illness and addictions, who are more difficult to manage, more likely to be victimized, are more at risk for suicide...Aggressive diversion programs and efforts aimed at reducing use of a jail can make the difference between getting by with the existing facility and needing to move ahead with expansion plans.”

Ms. LaPlante reaches the following conclusions:

- The pursuit of funding for state incarceration facilities has been crowding out reasonable and necessary increases in aid to jails, despite the transfer of responsibility for a fair share of sentenced offenders from state to county facilities.
- The Community Corrections Act of 1997 caused financial harm to county jails, which has increased over time. ‘This block grant approach set the jails adrift, to fend for themselves, fiscally speaking, and freed the state from the responsibility for addressing the cost impacts of rapidly rising inmate populations’. The law locked into place indefinitely a percentage share of total funding based on the experience in

1997 and ‘created a funding distribution system that is isolated completely from actual jail spending.’ Previous laws which transferred significant new responsibility for housing increasingly difficult sentenced populations exacerbated the problem.

- The bias toward incarceration and away from diversion is evident when spending requests are examined. In 2007, \$1.3 million was requested for juvenile *community* programs, while increases for juvenile incarceration facilities topped \$5.5 million.
- “The state has balanced its own budget on the backs of counties by repeatedly shifting responsibility to the jails” directing offenders from the prison system to the jails and “neglecting to invest adequately in community treatment for persons with severe mental illness or to respond assertively to the identified high level of substance abuse problems among Maine’s teens and young adults... While crying poverty to every commission and committee that has tried to look at corrections, the state has pumped millions upon millions of dollars into state facilities for the incarceration of adults and children”.
- “The presence of so many persons with untreated mental illnesses and addictions in Maine’s jails and prisons reflects a failure of the state’s mental health system. The presence of diversion programs in some counties but not others means that where one is arrested is a strong predictor of the course of their case”.

“The presence of so many persons with untreated mental illnesses and addictions in Maine’s jails and prisons reflects a failure of the state’s mental health system.”

Summary of Local Diversion Efforts since 2000

While state-wide studies have been underway, local efforts to address the needs of Maine’s jails have sprung up independently, including the following:

- Penobscot, Somerset, Cumberland, Kennebec, Piscataquis, Somerset, and Hancock Counties formed jail diversion collaboratives and initiated local improvements. Cumberland secured substantial three year federal grants to start Project DOT in Cumberland and Kennebec secured federal funding to start Maine’s first Co-occurring Court. Hancock secured private funding to start a local drug court and Somerset secured private funding to establish a partnership between medical and behavioral health care in the jail. How these programs will be sustained post grant funding remains to be seen.
- NAMI Maine obtained private funding to initiate the nation’s premier evidence-based pre-booking jail diversion program, Crisis Intervention Teams (CIT), across Maine, including piloting a first-in-the-nation jail-based CIT program. By the end of FY 2007, 24 communities and 8 jails will have CIT programs. Sustaining Maine’s CIT programs post grant is the subject of legislation introduced in 2007.
- The Department of Health and Human Services assigned Intensive Case managers to each of Maine’s 15 jails to help class members who are in jail.* The state’s commitment to continuing to deploy these case managers in Maine’s jails is now in question, with the 2008-09 budget calling to transfer 30 of them to other jobs.

- The Court System and DHHS have hired diversion coordinators to assist in the development of diversion programs.
- Volunteers of America and Maine Pre-trial Services have expanded their contracts with jails and are offering limited community corrections alternatives.

December 2006 Jail Survey

A December 2006 survey of Maine's jails completes the picture. (Appendix A shows their responses). Each jail was asked the following questions:

- Bed capacity vs. average number of inmates
- Number of suicides in the jail since 2000
- Number of crisis interventions in the jail in the last year
- Number of inmates hospitalized for psychiatric reasons in the last two years
- Cost of medical services in the jail
- Number of inmates taking mental health medications on average
- Percent of time the jail is able to obtain a psychiatric hospital bed when a blue paper has been signed.
- Number of times the jail has staffed an inmate in the emergency room in the last year for psychiatric reasons and the time before a bed could be obtained.
- Number of times the jail has staffed an inmate one on one in the jail while waiting for a psychiatric hospital bed in the last year.
- Number of inmates on average on suicide watch per month
- Other comments

Nine of Maine's 15 jails responded to the survey, including the four largest (Androscoggin 144 beds, Kennebec 132 beds, Penobscot 136 beds, Cumberland 500 beds) The results are shown on the attached chart and summarized below.

- Maine's jails remain over crowded. Eight of the 9 jails who responded report routine overcrowding. The average number of inmates over bed capacity was 23, the maximum was 37 the minimum 14.5. Many of the jails have been granted a temporary variance to accommodate more inmates than they were originally designed to hold.
- Inmates continue to commit suicide in Maine's jails. Six of nine jails report in-jail suicides since 2000, for a total of 11 deaths. (19 inmates have died in total, the other mental health/substance abuse related cause was alcohol/drug overdose or withdrawal.) Two jails had two suicides; one jail had 4 suicides, and three jails had one suicide. Of the jails reporting, two had no suicides.

- Suicide attempts are a routine part of jail life. All of the jails reported multiple suicide attempts since 2000, with a high of 45 and a low of 18. The average number was 27. All jails reported suicidal inmates and providing constant observation for suicidal inmates as a routine part of jail events. The average number of inmates on suicide watch per month was 21.75, the maximum was 107, the minimum .25.
- Jails continue to seek hospitalization for inmates with psychiatric problems. Jails sent an inmate to the hospital 87 times between 2004 and 2006. Two were always able to get a hospital bed within 3 days. One was able to obtain a hospital bed 25% of the time; one 69% of the time. All jails had to staff inmates in local emergency rooms while waiting for a hospital bed, waiting for as long as 6.9 days, one for only 3 hours. Nineteen times last year, Maine jails held inmates in the jail on constant observation while waiting for a hospital bed (a violation of federal law). Two jails refuse to hold an inmate in the jail while waiting for a hospital bed to surface.
- Jails continue to house many inmates with mental illness. All jails report providing psychiatric medications to inmates (the usual way that jails measure the number of inmates with mental illness). The low was 29% of inmates taking mental health medications, the high 75%; the average was 51%.
- Larger jails have been forced by need to fund in-jail services. Two larger jails have significantly increased the availability of mental health services. One reported providing 539 substance abuse interventions, 637 mental health interventions, 1,353 co-occurring disorders interventions in 2006 for the 173 inmates in the jail. The other reported 8,231 mental health intakes, 14 hospitalizations, 656 mental health interventions, 749 follow-up interventions, 372 evaluations, 1,357 self referrals seen by mental health workers, 323 seen by the psychiatrist, 536 seen by the nurse – for a total of 5,621 psychiatric encounters in 2006.
- Jails express frustration. Jails expressed frustration with having to cope with addicted inmates who will do anything to get the medications they want, with the lack of security in local hospitals so that officers have to remain in emergency rooms with inmates for long periods of time, delays in obtaining hospital beds, including the “rapid assessment bed” at Riverview, difficulties with jail providers who refuse to prescribe needed medications and the behaviors that are a result.

Conclusions

It is clear that Maine’s jails are housing large numbers of inmates with mental illness and struggling to manage their mental health needs. Legislators, state officials, the Governor’s office, advocates, and families all acknowledge the problem. Studies have been ordered *and funded* to tell us what needs to be done. Numerous good recommendations have been made and are based on expert advice, evidence-based practice, research, and hard data about Maine. There is considerable agreement amongst diverse stakeholders about what needs to be done including, as so eloquently stated by a member of the Sentencing Commission, the need to address mental illness, substance abuse and domestic violence as the key. Nonetheless, during the last six years, the state has slashed spending for community mental health treatment programs, spent more on institutional state-run correctional programs, and funding for jails has remained stagnant or declined,

while jail populations have risen by 80%. We know what must be done, but we have failed to do it. Nineteen inmates have died from suicide or drug related medical problems while we have been studying the issue.

There is some improvement. Both the Court system and DHHS/DOC have created and filled a jail diversion position. DHHS has assigned Intensive Case Managers (ICMs) to many Maine jails and required local crisis service providers and case management agencies to provide service to inmates, a first step in helping inmates negotiate the court process and offering limited re-entry assistance. Local communities have initiated improvements on their own. Nonetheless, we foresee the following difficulties:

- Questionable sustainability. Concrete programmatic actions that keep people with mental illness out of jail by diverting them to treatment have been funded primarily by private, one-time grant dollars, and through the efforts of local leaders. (Even the state's own *prison* re-entry program is grant funded). Sustainability of what has been accomplished is questionable. Unfortunately, the trend to spend our dollars on institutional programs appears likely to continue without a shift in policy *and* practice.
- Shifting costs to the property tax. The problems of Maine's county jails, the citizens they serve, and people with mental illness who are shifted to their care will continue as shrinking access to behavioral health services continues and local property tax payers pick up the cost. Promises to freeze property taxes and the proposed \$90,000,000 cut to mental health services will exacerbate the problem.
- Continued overcrowding and construction of new jails. Budget deficits, differences in system philosophies and training, stigma and public distaste for criminal offenders may continue to mean additional numbers of people with mental illness in Maine's jails. Because the problem crosses legislative committee jurisdictions (Judiciary, Health and Human Services, and Criminal Justice) as well as Departments of government (Public Safety, Corrections, DHHS), and levels of government (County, City, State) a lack of action and continued study may continue to impede the implementation of recommended solutions.
- More spending on corrections. During the 1990s state spending for mental health services grew 33 percent, total state spending grew 56%, and spending on corrections grew 68%. As a result, the share of state spending devoted to mental health is dropping – by 15% from 1990 to 1997 (shrinking from 2.12% of state spending to 1.81% of state spending). * If Josie LaPlante's report is valid, this same trend has been documented in Maine. Spending on institutional correctional programming will subsume spending on less expensive and more effective evidence-based community treatment alternatives. If this trend continues, Maine's jails will continue to be the primary residential program for people with mental illness at enormous cost to the state, the county, city government, Maine's property taxpayers, and to inmates and their families.

A Call To Action

NAMI Maine makes the following recommendations:

1. As originally enacted in 1995, Title 34-B, section 1219, and re-enacted by the 2003 Sentencing Commission, the state must implement a comprehensive strategy for preventing the inappropriate incarceration of seriously mentally ill individuals and for diverting those individuals away from the criminal justice system. In times of budget deficits, it is important to recognize that the cost of incarceration (\$50,000 for a supermax bed; between \$24,000 and \$40,000/year for a jail bed)* far exceeds the cost of community treatment (\$10,000/person for an ACT team). We call upon the Governor to take the lead.
2. Review all recommendations made by earlier study commissions, assess what has been implemented what still needs to be done, and amend the state's Joint Action Plan to implement those recommendations and establish a timeline for their implementation.
3. Carry out the recommendations made by the 1999 Maine Inpatient Treatment Initiative Report. These recommendations involve improved community services for people with mental illness – noting that the new AMHI will be too small if these improvements are not made.
4. Establish a data repository that will provide consistent measurable information about jail inmates and their mental health and substance abuse needs. Establish uniform data collection tools for Maine's jails so that DOC has accurate information about the number of inmates with mental illness/substance use problems, suicide attempts and successful suicides, available in-jail services, and jail's ability to access hospital beds for inmates. Use this information to provide an annual report to the legislative committee of jurisdiction on Maine's jail's ability to treat and care for inmates. Use this report to guide annual updates of the Joint Action Plan.
5. Assure that correctional officers and law enforcement officers receive required training about serious mental illness, suicide, and appropriate interventions. Require that these facilities report to DOC documenting that required training has occurred. Fund the police, jails, and prisons so that they can afford to train their staff. Require training for the courts regarding alternative sentencing options for people with mental illness/substance use problems.
6. Require DHHS to complete an annual assessment of service gaps that lead to incarceration, report that assessment to the committees of jurisdiction and use the joint action plan to address those gaps. Require the DHHS and DOC to jointly develop an inventory of existing services and make that information available to people who are working to keep inmates out of jail or to help them get out of jail. There are services available, but many don't know where to find them.
7. Insure that inmates who have been "blue-papered" or those who have been "determined to need a hospital bed but have not been blue papered in order to avoid an EMTALA complaint" actually are admitted to a psychiatric bed, not held in seclusion in the jail. Develop partnerships between the Department of Corrections and community psychiatric hospitals to provide inpatient treatment for forensic patients including adolescents
8. Change the Community Corrections Act from a subsidy to a proportional reimbursement to county jails. Base the amount provided to each jail on the number of inmates and the cost of bed-days. Provide an incentive for jails which implement evidence-based diversion, re-entry, or rehabilitative programs to receive more of these funds.
9. Assure that jail inmates can obtain the medications they need to remain stable during their incarceration, including requiring policies that govern the use of methodone, seboxone for those who are stabilized in their addiction on these drugs.

Citations

- Page 2: Going Up the River: Travels in a Prison Nation. J. Hallinan. Random House. 2001
- Page 2: Crazy: A Father's Search Through America's Mental Health Madness. P. Earley. G. P. Putnam's Sons. 2006.
- Page 9: Bureau of Justice Statistics Special Report: Mental Health Problems of Prison and Jail Inmates. September 2006. Page 1.
- Page 9: Flyer produced by the Maine Association of Mental Health Services summarizing FY 2006-2007 funding cuts, including state, general fund, and federal dollars.
- Page 10: CIT is the nation's premier program for diverting people from arrest and into treatment. CIT trains law enforcement officers to de-escalate people who are in psychiatric crisis and establishes special protocols that allows them to easily take people to the emergency room instead of jail. Boundary spanners are specialized case managers who help people negotiate both the behavioral health care system and the criminal justice system.
- Page 10: DRAFT Report on Regional Diversion/Re-Entry Team Meetings. October 2006. pg. 23.
- Page 10: Ibid. Pg. 6
- Page 12: ICMs are deployed inconsistently. While some sheriffs report receiving significant and notable assistance from ICMs, others report they only come to the jail if AMHI class members are there. One sheriff said: "they have responded less than half a dozen times to our facility."
- Page 15. Bazelon's Disintegrating Systems Report. Pg. 15
- Page 16: Skyrocketing costs are described in Community Corrections in America. National Coalition for Mental and Substance Abuse Health Care in the Justice System. CSAT No. 5-H87-T10029. 1996. "Costs of the correctional system are escalating faster than any other costs of government, including the even now infamous costs of health care. Punishment costs are one fourth of Alabama's entire state budget." pg. 13

Appendix A

Jail Survey

Jail	bed capacity	over capacity issues	suicides 00-06	suicides at-tempts since 2000	crisis interv 2006	psyc hospital 2004-2006	medical budget	inmates psyc meds	% of time able to secure hospital bed with blue pap	Times staffed ER and LOS	1x1 in jail while waiting for psyc bed/2006	inmates suicide watch/ mo 2006	comments
Waldo	32	14.5/day	2	34	1089 27 CIT	17	45000	0.62	0.69	4/166 hrs	9	12	
Somerset	55	15-20 over	1	18	24	4	50000	0.49	0.25	2/7 days each	3	25/mo/3/yr	
Androscoggin	134	155	0	40-45	35	18	30,000-50,000	0.59	5-6 hrs	3-4 hrs.	0	5-7/mo.	
Penobscot	136	173	4	33	35	12	317000	0.75	n/a	6/1-2 days each	don't accept	107	frustration is diversion of mh meds and inmates on high levels of narcotics when admitted. Med seeking inmates. Acadia in-jail provider had 539 sa interventions, 637 mi interventions, 1,353 co-occur. Interventions in PCJ in 2006
Oxford	27/44 conting.		0	24	18	10	20000	10%*	1	12-3 times 12-24 hrs	2-3 times; long wait for psyc assessment	1/mo	much frustration that local hosp. Doesn't have security, so cop has long wait at hospital. Not enough forensic beds Delays in getting a rapid assessment bed can stretch over 24 hours. Current med. provider will not prescribe for "behavioral" issues or sleep meds. Sleep deprivation can cause emotional instability and the jail has to deal with emotional outbursts, assaults, and vandalism as a result.

Jail	bed capacity	over capacity issues	suicides 00-06	suicide at-tempts since 2000	crisis interv 2006	psyc hospi-tal 2004-2006	medical budget	inmates psyc meds	inmates psyc meds	% of time able to secure hospital bed	Times staffed ER and LOS	1x1 in jail while waiting for psyc bed/2006	inmates suicide watch/ mo 2006	comments
Kennebec	variance 32-38 over		2	20 16 cit 60 C&C	16 279,820/mi	50/day - 90 mi=137,680 12-15,000/mo.	5 times 6-8 hrs	3	25					
Cumberland	500		1			meds plus 2-10,000 10,000 samples								1,222/2006 alone: 8,231 mh intakes, 14 psyc hospitalizations, 656 mh initial visits, 749 f-up visits, 372 mh assessments, 1357 self-referrals seen, 323 psychiatrist visits, 536 nurse pract. Mh visits, 1,222 suicide watches, 5,621 psychiatric encounters in 2006.
Knox	55 day over	1-25/ over	1	20	30	10 128,700 total medical&mh	3.5 hrs	1	2			2		
Franklin	over 29 93% of time		0	6 5 for 2006	5	75000	0	0.6	1	0	0	0 1 or less		Very difficult for inmates to get some medications inside due to no regular prescriber. Lengthy wait to secure hospital bed for stabilization. Access to psychiatric care is available 24-7 and some on-site care too. Medical and psyc. Providers communicate well.

Appendix B

Information from Other States