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Intersections of Mental Illness and Legislative Changes at Androscoggin County Jail

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Intersections of Mental Illness and Legislative Changes at Androscoggin County Jail

An Honors Thesis

Presented to

The Faculty of the Peace and Conflict Studies Program

Bates College

In partial fulfillment of the requirements for the

Degree of Bachelor of Arts

By

Katherine G. Stevenson

Lewiston, Maine

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Abstract

Since 2015, corrections officers and mental health providers in Androscoggin County, Maine have become increasingly concerned about the growing prevalence of mental illness among patients (inmates) at Androscoggin County Jail. These concerns have been exasperated by recent budget and policy changes within the County and throughout the State. In partnership with Androscoggin County Jail and Tri-County Mental Health Services, I analyzed a random sample of 686 patients' medical files from Androscoggin County Jail, reviewing 1,154 individual bookings dated from 2013 to 2017. Over 70% of patients since 2015 were found to have a substance use disorder and/or another mental illness. Mental illness and substance use disorders were highly correlated to having a greater number of bookings and a history of violent offense. A triangulation approach was used to analyze these findings within the context of recent and proposed changes pertaining to MaineCare and Androscoggin County Jail. These analyses indicate numerous problems with the provision of community-based mental health treatment in Androscoggin County. Primary issues include insurance coverage gaps, biased MaineCare eligibility policies, a lack of treatment availability within the jail, poor continuity of care across county agencies, and a fear of collaboration between county agencies and the state administration. Based on these findings, I have made a number of policy, practice, and research recommendations that would improve the accessibility of community-based mental health treatment at the jail, county, and state levels.

Chapter 1: Introduction

“We used to think least restrictive is best. People will fight to get out if you put them in a box. Now we put people in as tight of a box as we can.”
Anonymous Care Provider with Androscoggin County Jail

Driving along the streets of downtown Auburn, Maine most people do not notice the large beige and red brick building located in the city center. Architecturally, it is not very interesting. Its brick colors are muted and it has few structural elements that would catch the attention of the human eye. Tucked behind the county courthouse and a YMCA, the building just sort of sits, overlooked by passersby.

This building is Androscoggin County jail. On any given day, approximately 155 individuals are incarcerated here. This jail, like the individuals housed inside it, is not meant to be very noticeable. It is designed to be quiet and unobtrusive, staying out of the attention of the people walking by it, leading their normal lives.

I have lived in this community for three years and have driven, biked and run by this corner countless times. Yet, somehow I had never noticed that this building was there until my partnership with Androscoggin County Jail started in September, 2016. Since this project began, the idea of the jail sitting, ignored in the middle of the city, has not left my mind.

I became connected to Androscoggin County Jail (ACJ) through my senior, undergraduate thesis (which you are reading now). You see, jail populations across the country tend to have exceptionally high prevalence of mental illness in comparison to the entirety of the U.S. population (Kessler, 2007; James, 2006). ACJ is not an exception and, according to the corrections officers and administrators at the jail, the prevalence and severity of mental illness within the jail is only getting worse.

To me, the building that makes up Androscoggin County Jail serves as a beautiful metaphor for the relationship between mental illness and incarceration. The jail, like mental illness, sits at the center of our communities. You can literally walk up and touch it. It impacts many of us each day, whether it is through a loved one or our own direct experiences. And the jail, like mental illness, often goes completely unnoticed. Most importantly, mental illness, like the jail, supports the structure of incarceration.

Research has shown that 64% of individuals in jails have had symptoms or a history of a mental illness in the past year (James 2006, p.1). Lifetime prevalence rates are even higher. Since the decline of deinstitutionalization between the 1950s and 1990s, correctional facilities have increasingly become the default mental health facilities across the country. The national move towards deinstitutionalization was based in the idea that mental illness should be treated with the least restrictive care possible. This idea was great in theory. However, it was heavily dependent on the ability of community-based mental health treatment programs to take over the care provision that had previously been the responsibility of inpatient facilities (Frontline 2005).

When this did not occur, correctional settings across the country quickly became the default mental health facilities. This criminalization of the mentally ill occurred despite the fact that most correctional facilities, jails in particular, were not designed with the intent or the ability to provide mental health treatment. Furthermore, as research now shows, the incarceration and reintegration experiences amplify existing stressors of mental illness in individuals and communities alike (Turney 2012).

At Androscoggin County Jail (ACJ), mental illness takes a number of different shapes. It includes the person who goes through alcohol withdrawal twenty-four hours into their sentence and the person whose depression becomes more and more isolating over the course of a few

months. There are generalized anxiety disorders as well as schizophrenia spectrum disorders. In some cases the mental illness is never known by anyone beyond the individual themselves. In other cases, a patient has to be moved to their own cell in maximum security because their behavior is too upsetting to others in their unit.

Experiences like this last example have become increasingly common at ACJ over the past few years. In fact, it has become so bad that self-described “hardened” corrections officers have begun expressing their concern to jail administrators. In response, these administrators have begun working with a local mental health agency, Tri-County Mental Health Services (TCMHS) in an effort to understand what is going on and what can be done. Together, the agencies recognized that in order to create change, they needed more information about what exactly the mental health crisis at the jail looks like. My partnership with these agencies and the thesis you are reading now were born out of this need.

The purpose of this research is to create a base of information for understanding the interconnections between the prevalence of mental illness amongst individuals at Androscoggin County Jail and the mental health treatment systems available to them at the jail, county, and state levels. This purpose can be loosely broken down into three research questions. 1) What community and jail based mental health services are available to patients at Androscoggin County Jail and what structural barriers limit access to these services? 2) What are the prevalence rates of substance use disorders and other mental illnesses at the jail and what other factors can these rates be correlated to? 3) How do these prevalence rates inform our understanding of the mental health services at Androscoggin County Jail and vice versa?

When I came on board with the project, ACJ and TMCHS were in agreement that they were interested in having a student researcher conduct an evaluation of patient medical records.

Together, we worked to determine exactly what this data collection and analysis process would look like as well as how this research could be used once it was collected.

To create the data file component of this research, I pulled mental health information (such as diagnoses, referrals, and certain symptoms) from over six hundred medical files from Androscoggin County Jail. These medical files included a combination of screenings, care plans, and treatment notes. Most of these have been completed by medical providers, although some are conducted by corrections officers. These records spanned slightly more than four years, beginning in January 2013 and ending in January 2017. We chose this timeframe because the first quarter of both 2014 and 2016 were characterized by dramatic changes within Maine's Medicare eligibility, which cost thousands of individuals their health insurance. The 2013 starting point was chosen in the hopes of having a reference point for any prevalence rate changes that took place as the 2014 changes were implemented.

The other part of this research was based around creating a comprehensive picture of the mental health services that are available to individuals at or recently released from ACJ. For this component I read through legislative hearing transcripts, newspaper articles, MaineCare benefits manuals, legislative testimonies, commissioner letters, budget reports and more in an effort to create a thorough mapping of what services and gaps exist. The understanding I developed from these sources was bolstered (and confirmed) by the numerous conversations I had with representatives from various state and county agencies regarding these services.

Contextualizing the Research and the Researcher

Androscoggin County is located in the south-western portion of the state of Maine. It has a total population of approximately 107,000, and makes up about 8% of Maine's total

population. The county is approximately 470 square miles and is overwhelmingly white (92.7%). It has a 15.0% poverty rate, which is higher than both the Maine and U.S. poverty levels (13.4% and 13.5% respectively). In 2015, the median household income was \$47,537. In this same year, the median income was \$49,331 in the state of Maine and \$53,889 nationally. Androscoggin County also has higher rates of individuals under 65 who lack health insurance (12.0% versus 10.3% in Maine and 10.5% nationally). Within the county are a number of smaller towns and the “twin cities” of Lewiston and Auburn, which together comprise the second biggest metropolitan area in Maine. (US Census Bureau, 2016)

In the summer of 2016, ACJ and Tri-County Mental Health Services (TCMHS), the primary mental health agency serving Androscoggin County, engaged in a series of conversations surrounding perceptions of worsening rates of mental illness among the individuals at ACJ. As I mentioned, this resulted from reports from corrections officers, particularly from the few months preceding the beginning of this research, that the state of mental illness at ACJ was getting progressively worse. This observed phenomena at the Jail coincided with TCMHS’s concern that a number of patients they had recently been forced to drop from their services would be at a significant risk of incarceration as a result of losing their treatment.

Recent Maine Medicaid (MaineCare) policy changes have meant that mental health agencies across the state could no longer be reimbursed for providing intensive mental health treatment to many of their clients. Many of these patients had to switch to less intensive and comprehensive forms of mental health treatment while others lost services entirely. Since the summer of 2016, when conversations between TCMHS and ACJ began, TCMHS has become aware of a handful of patients who have been incarcerated since losing access to their treatment.

When the Sheriff of Androscoggin County Jail and the Director of Tri-County Mental Health reached out to Bates College to find a student researcher, I happened to be looking for a community partner to work with for my undergraduate honors thesis project. At the time, I did not have any prior experience working with or studying either incarceration or mental health. However, I did have practical background in restorative justice, and a significant amount of prior course work in the intersections of health and conflict both in the U.S. and international contexts. I have also worked as an EMT and for two different health care access organizations and have strong connection to the local Lewiston/Auburn community. When I heard that ACJ and TCMHS were looking for a student to do this research, my interest was immediately sparked.

My Positionality within this Research

Before I delve into any more details of this project, it is important that readers understand who I am and what perspective and positionality I am approaching this research through. One of the basic concepts of Community Based Research is the notion that no research is truly “objective”. A researcher's identity, their experiences, and the connections they make through the project shape the research project and its outcome. These personal factors are what drives most individuals to conduct their research in the first place. Because of this, it is important for readers to understand my positionality in this work and how that has shaped the conclusions I have drawn.

I am a senior at Bates College. I am white, female, and grew up in a middle class family in New Jersey. While I did not grow up in Androscoggin County, I have been heavily involved in the local community for the past four years and feel a strong connection to the lives and experiences of my neighbors and community members. While I may not have a “personal

connection” to ACJ or TCHMS in the sense that I have never worked or been a patient at either, I do feel a strong attachment to both resources because they are such central parts of the lives of so many people in this area.

I was not raised to have a particularly strong reverence for or fear of policing or the criminal justice system. I do not have any family or close friends who are police or corrections officers. I also have never been arrested nor have any of my close family members or friends. I am also privileged enough that I have never been personally affected by the institutional racism that is built into the criminal justice system in the United States.

Additionally, I do not have any strong direct connection to community-based mental health treatment. I have never been diagnosed with a mental illness and have not spent a significant amount of time working at, or in partnership with, a treatment program. That being said, I do have family members and friends to whom these services have been incredibly important. Finally, I am not and never have been, a recipient of Medicaid or an employee of the Maine Department of Health and Human Services.

However, like I said, I do have a fair bit of experience in working directly with patients. I have treated individuals in mental health crises and have watched as patients try to balance the importance of going to a hospital with concerns about the large cost of the ambulance ride that would get them there. I have tried to help clients sign up for Marketplace health insurance plans, but failed because it was too complicated to find a plan they felt they could afford. For part of the year prior to this research I lived and studied in another country and culture where, despite a booming healthcare industry, substance use was such a taboo topic that people were actually confused if you brought up substance use disorders in conversation.

Some of the patients I have worked with could not take their medications because they had no way to get themselves to a pharmacy. I have even worked with clients, who, between language barriers, cultural understandings of medicine, a low income, and other life responsibilities literally could not get to appointments on their own if their life depended on it. So, while I do not have any personal experiences with the challenges of MaineCare, mental illness, or incarceration, the effects of social inequalities on health are not foreign to me.

My own recent experiences as a patient have also shaped how I think about this research. In the middle of this conducting this project, I was concussed and could do little more than sit in a dark room for about three weeks. For close to a month and a half afterwards I had difficulty reading, writing, driving, and even watching other people walk around.

A concussion is not a mental illness and my two month experience pales in comparison to the long term difficulties many individuals face. However, this experience was a small, personal insight into how difficult it can be to try to operate within a system that is not designed to accommodate your specific health needs. Going into a pharmacy to pick up a prescription, talking on the phone with insurance companies, getting to appointments, and even just making it through the day were next to impossible to do on my own.

I am fortunate that between the huge amount of support I received from my school, doctors, insurance company, family, and friends, I was able to navigate all of these obstacles. I was also privileged enough to be in a financial position where taking a few months off of my part-time job did not severely impact my ability to get by. Even the simple ability to recognize that I needed medical care put me at an advantage. If this all had not been the case though; if I had not had access to a good insurance company, friends with time and resources to give me, and financial stability; I am certain that I would not have gotten to a place where I could complete

my semester at school, let alone finish this research. If my situation had been different; if I was dealing with a chronic mental illness rather than a concussion, if I was in jail rather than college, or trying to navigate Social Security and MaineCare rather than my athletic trainer's office, I can barely imagine how much more difficult everything would have been.

A Broken System - My Perspective on Sociological Inequalities and Their Impact on Health

Because I did not have any direct prior experience working with mental health agencies or correctional facilities, conducting this research did require a fairly steep learning curve and I am very appreciative of everyone who worked to help get me up to speed. While my knowledge of these systems has grown dramatically, there is certainly a lot I still do not, and probably never will, understand. While I think that the insights I have made in this project do offer a valuable perspective, I do not pretend that any of the recommendations I make are going to solve the problem of mental illness in correctional facilities or even just at ACJ. That being said, I do think that my involvement in this research offers a unique and important perspective on these issues. Because I have not been personally connected to any of these agencies previously, I am able to look at each of these agencies and the systems they are a part of without the biases (good and bad) that come with being a past or current employee. However, I will not pretend that I do not have my own biases.

To that end, the lens through which I have analyzed the data I have gathered is heavily influenced by the way I understand and interact with the forces at work within our world. My education has been a combination of "hard" and "social" sciences. While the thought process behind how I collect quantitative data may look more like one found in a STEM field, I tend to analyze data with an eye towards the structural and social factors at play. This combination

heavily influenced the multidisciplinary approach I took in conducting and analyzing this research, as I discuss in Chapter 5.

In general, the experiences that I mentioned above have convinced me that social hardships and inequalities are the result of socially constructed systems and institutional inequalities. While I maintain that we are each responsible for our own actions, I am convinced that negative life circumstances, such as substance use disorders, incarceration, and poverty are the results of these systems. They are not the result of lifestyle choices, laziness, inherent differences in capabilities, or deservingness of a positive and meaningful life. Furthermore, I feel that each of us has an obligation to use our privileges to better the lives of those without them. As part of this, I believe that social services that aim to empower and uplift (rather than burden, stigmatize, and punish) individuals through the use of community support systems are vital components of addressing social inequalities.

I am most drawn to the social factors that shape individual and community health. This includes topics such as how socioeconomics, geopolitics, and community relationships influence how and when individuals access health care and what that healthcare looks like. As an EMT and volunteer with various community health care access organizations, I have personally witnessed many of the ways that government policies, the accessibility of services, and social and cultural factors impact individual and community health.

My interests, experiences, and beliefs have shaped most, if not all, of the conclusions I have made in this research. Not only do they it shape my interpretation of my data, but they also likely led me to focus on certain elements that might seem less significant to others. In this way, my perspective brings a unique lens to this data, one which one may be less likely to come by when also trying to keep a jail, a mental health agency, or MaineCare running.

In addition to the specificities of my analytic approach, I do have one other significant things to offer to this data. I do not deny that TCMHS and DHHS have deeper understandings of MaineCare policy, that the corrections officers at ACJ have a better grasp on “corrections work”, that the medical and mental health teams at ACJ have a more nuanced understanding of illness at the jail, and that the individuals at ACJ have a far better understanding of effects of incarceration than I ever will.

However, to my knowledge, I am one of only a few who has had the opportunity to delve into patient records *and* legislative session transcripts. I am probably the only one who has read files where patients report that they are not medicated because they lost their insurance coverage hours after mapping out the MaineCare income eligibility changes implemented by DHHS in 2014. I have been lucky enough to meet with representatives of the Department of Health and Human Services, KEPRO, Tri-County Mental Health Services, and their ACT Team, and various departments at Androscoggin County Jail, including the Sheriff’s Office, Medical, Records, Archives, and Maintenance and then follow up these conversations by reading inmate/patient requests “to please see Kathy from mental health”. Therefore, while I certainly do not know everything there is to know about these topics, my analyses and conclusions are based on a collection of research and knowledge that, at least for the time being, only I have been able to access.

Use of the Term *Inmate* vs. *Patient*

This paper takes a unique approach to the way it refers to the subjects of this research. The dominant practice is to refer to incarcerated individuals as inmates. Instead, I have chosen to refer to these individuals as patients. The use of the term “inmate”, particularly by medical providers, presents a number of problems. It suggests that an individual’s incarceration status

holds more importance than the fact that they are receiving health care. For many individuals the label of “inmate” stays with them, even after release. This label carries stigmas. It alters individuals’ abilities to get and maintain steady employment. It impacts how they are recognized as citizens, impacting their rights to vote and receive social benefits. This stigma affects their ability to be valued by their communities as well as their own perceptions of self-worth. The effects of these stigmas have a direct and undeniable impact on the mental health of these individuals.

Like most, I’ve been socialized to refer to these individuals as inmates. Throughout my time conducting this research, however, I’ve come to realize that part of my role in combating the incarceration of individuals with and without mental illness is encouraging the recognition of these individuals, first and foremost, as fellow humans. When we fail to do this, it can be easy to ignore the injustices and the inequalities that are rampant throughout our justice system. We can forget that these individuals have a right to be loved, to feel joy, to be respected, and to be treated kindly. We can rationalize budget cuts and legislative actions even when we know they will have dramatic negative impacts on these individual. Our categorization of these individuals as “other” allows our society to excuse poor standards of living and mistreatment as “just desserts”. This is all while we fail to recognize that the social, psychological, physical, and economic harms being experienced by individuals in correctional facilities are no different than the actions they are being punished for.

The purpose of medicine is to help individuals heal. The purpose of our justice system, I believe should be the same. Rather than punishing individuals, we should be helping them heal; from their pasts, from their actions, and from the future that awaits them upon release. The term patient comes from the Latin word *pati*, meaning to suffer. This undoubtedly describes the

experiences of individuals in correctional facilities, which in the eyes of many, is the purpose of incarceration in the first place.

The purpose of this paper is to gain a greater understanding of the mental health of individuals at Androscoggin County Jail. Medical researchers in all other fields refer to the subjects of their work as patients. For the reasons mentioned above, I will do the same here.

Why Mental Illness in Jails Matters

Over the course of the past few months, it has been clear to me that the connection between mental illnesses, substance use disorders, and incarceration is not news to the majority of people I have spoken with. Most people are aware that these issues are deeply connected and only getting worse. If we are generally aware of these connections, why has more not been done to fix this problem? From my personal observations there are a handful of common thought processes that are primarily responsible for our inability to make real and meaningful improvements to this system.

Many people have deeply held beliefs about the value of a retributive justice system. In discussions I have had about restorative alternatives to incarceration, people often balk at the idea of people not being punished. I've heard things like: "We need to hold them accountable!" "How will they learn?" "What will deter others from doing the same thing?" and "Doesn't this let them off too easily?". From multiple corrections officers I have been told variations of, "No, that won't work, some of these people are just jerks. When you've been here as long as I have, you can tell." However, these concerns and beliefs are exasperated by societal propensities to arbitrarily ascribe the "need for punishment" based on societal factors such as income level, employment, use of social support services, and inalterable identities like race. Many use the false notions of the existence of the "worthy and unworthy poor" and "welfare leeches" to

legitimize argument for bolstering punitive policies while reducing access to social welfare services. These ideas are used to excuse individuals and communities of the moral obligation for compassion because those who are struggling are simply undeserving of that empathy.

Connected to this line of thinking is the belief that these unworthy individuals are better where they cannot be seen. The mentally ill, the homeless, and the criminally involved have historically been isolated and ostracized and still are. Where I worked this summer, the homeless were ushered off of busy business streets each day at 6am, before most employees made it to work. We hide away individuals awaiting trials on islands from Rikers to Guantanamo. Historically, we isolated individuals with mental illness in psychiatric hospitals. Since the push for deinstitutionalization began, we isolate them in correctional facilities instead.

Implementing meaningful change would require an acknowledgement that the United States, is and always has been, built on social inequalities. By identifying victims of social inequalities as “disruptive” and “dangerous” we validate our decisions to hide them away where their lifelong hardships cannot cloud the rosy view we have of this “land of opportunity”. Supposedly, what we don’t know won’t hurt us.

It is a privilege to be able to go through life not seeing social inequalities. For many individuals it can be difficult to understand the magnitude of the issues mental illness imposes. Without any insight into the worlds of mental illness and incarceration, it can be easy to become distanced to the issue. *I* am not connected to these individuals. This could never happen to someone *like me*. This does not impact *me* so *I* do not have an obligation to change this system. In reality, we are all connected to these issues. Adverse life events, altered brain chemistries, family crises, instances of “wrong place, wrong time” can happen to anyone; there is no way to guarantee that mental illness and incarceration will not touch us or the people we love.

If we can manage our way past these ideological barriers, we still find ourselves with one final obstacle. Once we recognize the moral and social importance of healing our mental health and criminal justice systems, we must still convince ourselves that these changes are economically and logistically feasible. It can be easy to convince ourselves that the cost of revolutionizing this system would outweigh its benefits: the problem is not large enough to warrant the energy and money it would take to correct it.

The research I have conducted aims to address a part of this final barrier. Unfortunately, a financial cost benefit analysis of improving mental health resources is outside the scope of this thesis. Instead, my project focuses on increasing our understanding of the extent of mental illness within Androscoggin County. Without robust, local data, it is difficult to truly comprehend the severity of the problem (Haneberg 2016, p. 1). And, without an understanding of current strengths and weaknesses within existing systems it is impossible to begin to imagine solutions. This research is not going to revolutionize the mental health and incarceration systems in Androscoggin County. However, my hope is that it will provide a base level of knowledge about the local problem, galvanize interagency dialogue, and act as a jumping off point for continued research.

Ethical Considerations for this Project

The methods I used for this research were approved by the Bates College Institutional Review Board, Tri-County Mental Health Services, Androscoggin County Sheriff's Office, and Correctional Health Partners LLC (the health care organization that provides medical care at ACJ). While I did not interview patients themselves, I was certified in conducting research with human subjects because of the nature of the data I was collecting. I made every effort to protect the privacy of the individuals whose experiences (and therefor medical files) informed this

research. In some cases throughout this paper I include examples of medical conditions and commentary from patients. However, none of these conditions or commentary are direct quotes from a single file or patients. Instead, I included details and quotes that I wrote, but felt were representative of the overall sample I was looking at.

While I believe that using the voices of these patients would have been more informative, honest, and powerful, doing so would have required the consent of each individual whose information I hoped to use. Not only was this logistically impractical, but it would also potentially put an undue burden on these individuals. Because this jail operates within the community in which I live, it would have been conceivable for me to have come across a file of someone I know. While this did not actually happen, I had planned to “return and replace” such a file rather than including it in my sample.

Thesis Outline

Chapter 2 provides an overview of current understandings of the relationship between mental illness and incarceration as well as a discussion of why addressing this relationship is important. In Chapter 3 I discuss the methods I used to conduct this research. This includes a detailed explanation of how I collected and analyzed data from patient medical records and the limitation that I faced in collecting that portion of the data. Woven into this chapter is also a discussion of the numerous conversations I had with representatives from organizations like Tri-County Mental Health Services, KEPRO, Androscoggin County Jail, and the Department of Health and Human Services. These conversations shaped, and were shaped, by the way I worked with and understood the medical files I looked at.

Chapters 4 and 5 are discussions of state, community, and agency structures that are responsible for shaping the delivery of community-based mental health services in Androscoggin

County. Chapter 4 takes an in-depth look at recently enacted MaineCare (Medicaid) policies surrounding income and diagnostic eligibility requirements. It also includes a discussion of proposed legislation and the impact it would have on the provision of mental health services. Chapter 5 is a discussion of policies and procedures within Androscoggin County Jail. This includes a discussion of themes including budget limitations, electronic medical records, the availability of mental health treatment options, and collaboration with other services.

Chapter 6 presents the prevalence rate data I gathered from the patient medical files. This section discusses prevalence rates of substance use disorders and other mental illnesses, among other things. It also discusses the correlations that were found between substance use disorders, mental illness, violent offenses, homelessness, and number of bookings. While these findings are significant on their own, I think that they are most important when they are understood in the context of the mental health systems that these patients are a part of (as discussed in Chapters 4 and 5).

Chapter 7 is dedicated to integrating the medical file data with the structure of the mental health systems within Androscoggin County. In this chapter, I outline the overarching problems that have become most apparent to me throughout this research. These problems fall into five themes: limited jail services, diagnostic ineligibilities, coverage gaps, continuity of care, and disproportionate punishments. While other problems certainly exist, my data (ranging from conversations with county administrators to medical file data) has pointed to the strong influence of these five problems.

Although the current state of mental health among ACJ's population seems bleak, I do think that opportunities for change are on the horizon. Even within the few months that I have been conducting this research I have seen steps taken, from interagency collaboration on grant

applications to conversations about new medical records, that encourage me about the future of these system. In an effort to help support these changes, I conclude this final chapter with a series of recommendations. These recommendations are aimed at both the state and agency levels with suggestions for new policies, improved services, and further research ideas.

To those of you reading this from an academic background, this thesis may not read like traditional research paper. That's great, I hope it doesn't. This research was not conducted to make it into an academic journal or as an opportunity to expound on my literary knowledge. I engaged in this research in the hopes of gathering information that would be valuable to the community that I work and live in. With that in mind, I have tried my best to write this thesis in a way that would be accessible to anyone in the community who would like to read it.

To any of you who do end up reading this thesis, thank you. I hope that you find this work engaging and thought provoking. Perhaps it will pull on your emotions or encourage you to view things from a new perspective. Maybe it will even make you motivated to participate in change. At a minimum, I hope this thesis begins conversations. Whether you agree or disagree, are hopeful or believe that any efforts will be useless, at least start talking. Do not let the issues of mental health and incarceration continue to be invisible. This system has caused so many individuals unnecessary suffering, the least we do can is recognize that it exists. Any other change we make has to start from there, so that is where we might as well begin.

Chapter 2: Literature Review

“I think that’s the idea behind the education, mental health, and substance abuse programs in facilities. It’s to get people on that track that maybe, when they get out, they keep going on it.”
Administrator at Androscoggin County Jail

In this chapter I present an overview of current research pertaining to mental illness within county jails. To begin this chapter I review current data on mental illness prevalence rates and correlations between mental illness and other factors including booking rates, homelessness, and history of violent offenses. I follow this section with an explanation of the factors that contribute to increased rates of mental illness within jails. This is combined with a discussion of the effects of incarceration on mental illness. This chapter concludes with an overview of literature on addressing mental health prevalence rates within jails. As I discussed in Chapter 1, I disagree with the use of the term inmate because of the phrases’ stigmatizing nature. However, I will be coopting the term for use in this chapter because it is the phrase most commonly used in research conducted on mental illness within the criminal justice system.

Prevalence of Mental Illness within County Jails

For years, sociology and criminology research has found that the prevalence of mental illness among criminally involved persons are greater than national rates. A 2006 report conducted by the Bureau of Justice Statistics found that the rates of twelve month histories or symptoms of mental illnesses in state and federal prisons is 56% and 45% respectively. The report found that prevalence rates among jail inmates are even greater, with 64% of jail inmates reporting mental illness symptoms, diagnoses, or treatment within the past year (Glaze 2006, 1). In comparison, a 2004 study conducted by the U.S. Centers for Disease Control and Prevention

found that only 25% of the general U.S. population report having a mental illness within the past year (Reeves 2011, p. 1).

As “short term” care facilities, jails are often working with smaller budgets and shorter time frames than prisons. Short sentences and frequent inmate rollover means limited opportunities for mental health evaluations, referrals, and treatments. Because these individuals are in and out more frequently, they have more contact with their communities than those incarcerated in prisons. Because mental illnesses are connected to community based risk factors, this increased contact may trigger or worsen mental illnesses, and is therefore reflected in higher prevalence rates among jail populations. As Greenberg and Rosenthal explain, jail inmates are “closer to the community” (2008, p 176). Because of this, the difficulties that jail inmates struggle with are likely to be more reflective of community problems than in other types of correctional facilities.

The Bureau of Justice and Statistics reports that 6.7 million individuals are currently under supervision by the criminal justice system (Kaeble 2016, p. 1). This includes individuals in jails and prisons, on work release programs, on parole, and in other community supervision programs. Approximately 728,000 of these individuals are incarcerated in local jails (p. 2). Only about 14% of jail inmates identify as female (Minton 2016, p. 4). However, women in the criminal justice system are particularly vulnerable to mental illness, particularly because our punitive system is designed for men (Colbert 2013, p. 409). In local jails, approximately 75% of females have mental illnesses as compared to 63% of males (James 2006, p. 1).

While substance use disorders are a form of mental illness, they are often considered separate from other illnesses in research looking at rates of mental illnesses. While this is problematic in some ways, it helpful because of the high rates of co-occurring substance use

disorders with other mental illnesses and the unique forms of treatment these interacting illnesses require. Approximately 76% of inmates with a different mental illness also have a substance use disorder, which equates to 49% of total jail populations (James 2006, p. 6).

Inmates with mental illnesses have a greater likelihood of a number of social risk factors including higher rates of drug use, homelessness, and unemployment as compared to inmates without mental illness. Individuals who have been homeless within the past year make up 15.3% of the U.S. Jail population as compared to approximately 1.7% of the general population (Greenberg 2008, p. 170). The Bureau of Justice Statistics' Mental Illness study found that 17.2% of inmates with mental illness reported homelessness in the past year as compared to 8.8% without a mental illness (James 2006, p. 4). Individuals with mental illness are less likely to be able to cope with the stressors of homelessness, creating an endless feedback loop of mental illness, incarceration, and homelessness.

Inmates with mental illnesses are also nearly three times more likely to report a history of being physically or sexually abused (27% vs. 10%) than individuals without mental illnesses (James 2006, p. 5). The prevalence rates of past trauma are significantly greater for female inmates overall (44%) and nearly seven times greater for female inmates with a mental illness (68%). (James 2006, p. 10).

Individuals with mental illnesses are more likely to be repeat violent offenders (32% versus 22%) but are no more likely to have used a weapon during those offenses than those without a mental illness. They are also more likely to serve three or more sentences (42% versus 33%). While mentally ill prison inmates have longer average sentences than those without mental illnesses, the mean sentence of mentally ill jail inmates is five months shorter than those without mental illnesses. (James 2006, p. 7-8)

Between more frequent criminal involvement and potentially greater care needs, individuals with mental illness place a burden on the correctional system itself. Incarcerated persons with mental illness are more likely to be charged with breaking facility rules and with a physical or verbal assault on a corrections officer or other inmates (Glaze 2006, p. 10). Not only does this create safety concerns, but the follow up from such events requires additional resources from staff for de-escalation, documentation, and follow up.

As I conducted my literature review, I was surprised by the number of articles I came across that were specifically evaluating the relationship of schizophrenia spectrum disorders and other psychotic disorders rather than mental illness more generally. This focus was interesting because the same emphasis on schizophrenia has also appeared in Maine Medicaid treatment eligibility policies (Department of Health and Human Services 2016).

Other research in contrast, has shown that other mental illnesses including depression, and other mood disorders present a greater risk of incarceration than schizophrenia (Robertson 2014, p. 931; Schnittker 2012, p. 466). A risk analysis conducted with a veteran population found that neither schizophrenia nor antisocial personality disorder were independently correlated with incarceration (Erickson 2008, p. 178). This same study found that substance use disorders were the strongest predictors of incarceration, particularly among schizophrenia patients (Robertson 2014, p. 931). Further studies have also found correlations between homelessness and incarceration to be mediated by substance use disorders (Greenberg 2008, p. 170).

While these studies have all produced important findings about general links between mental illness and incarceration, few of them provide information about the interactions between *severity* of the illness and the adverse causes and effects of incarceration. Many researchers

currently focus on the prevalence of specific diagnoses, often described as “major psychiatric disorders”, “severe and persistent mental illnesses”, and “serious mental illnesses”. However, publications vary on whether they are referencing specific diagnoses, levels of functional impairment, or both.

In Maine these determinations of severity often rest heavily on specific diagnoses at the cost of providing individuals appropriate services for functional impairments (see Chapter 4 for more information). By categorizing certain illnesses as “severe” or “serious”, we encourage a system which stigmatizes certain diagnoses as incapacitating and others as illegitimate. Because of this, I have chosen not to give further credence to these rather arbitrary categorizations and will not be distinguishing “severity” or “seriousness” in any of the analysis I do in this research.

Causes and Effects of Mental Illness in Correctional Facilities

The causal direction of incarceration and mental illness is difficult to pin down. Does mental illness presuppose arrests or is a result of incarceration itself? The compounded social, emotional, and financial stressors of incarceration and reintegration increase patient’s risk of individual illness such as major depression (Turney 2012, p. 465-467). At the same time, life-course determinants, such as adverse childhood events, are correlated with both criminal justice involvement and mental illness (Schnittker 2012, p. 459). These sorts of risk factors could be resulting in an overrepresentation of individuals with mental illness in the corrections populations.

Research has found that mental illness plays a role in the way inmates experience incarceration. Inmates with mental illness are more likely to attribute their suffering to external factors and to discuss their incarcerations with greater hostility and persecutory ideations (Yang 2009, p. 302). At the same time, coping mechanisms adopted during incarceration may lead to

negative coping strategies that, after release, may leave patients vulnerable to mental illnesses (Turney 2012, p. 477).

When mental health treatment is accessible within correctional facilities (usually within the long term prison structure) individuals may find that their mental health improves (Harner 2013, p. 36). However, these improvements are heavily dependent on the accessibility of treatment and programming, which are less accessible in short term correctional settings. One study found that fewer than half of inmates who had been taking psychiatric medications at the time of their arrest had taken psychiatric medications since being incarcerated (Gates 2014).

Regardless of the quality of care received in a jail or prison, reintegrating into a community without the appropriate social supports in place can be just as detrimental to an individual as the incarceration experience itself. For example, former inmates are 12.7 times more likely to die within the two weeks following release than the average American is on a regular basis. Their risk of dying from a drug overdose, suicide, or homicide during this time is even larger. (Binswanger 2007, p. 157)

Poor access to substances use and mental health treatment following release is likely at play in this phenomena. In 2004, The Bureau of Justice Statistics report found that in 2002, 59% of inmates had a monthly income of less than \$1,000 (James 2004, p. 8). Lower income levels reduce inmates' abilities to afford private, or even subsidized insurance. The Inmate Exclusion Policy prevents inmates from maintaining active Medicaid coverage and from applying to Medicaid coverage while incarcerated. Lag time in the enrollment or re-enrollment process can take weeks and leaves eligible individuals with significant gaps in coverage during this distinctly vulnerable period.

Challenges of Release

Following release, mental health often worsens through a snowball like effect. *Stress proliferation theory* explains that primary stressors related to incarceration, such as losing a job or social service benefits often lead to second stressors such as difficulties in being able to financially provide for a child. As stressors cascade into one another, poor health (and mental illness specifically) is likely to worsen (Turney 2012, p. 467). Additionally, former inmates are frequently impacted in both employment and social settings due to the stigma associated with incarceration. This stigma, and the expectations of rejection that it creates, has mental health ramifications (Turney 2012, p. 469).

Incarceration puts stressors on relationships with family and friends, which exacerbates problems further as most individuals rely on these relationships for their support networks (Turney 2012, p. 478). Furthermore, inmates often face systemic obstacles that ultimately lead to a decline in mental health. For example, reintegrating individuals may have difficulty gaining access to public housing, which may be a result of exclusion from such social services as a result of having a criminal background. The inability to obtain stable housing puts individuals at mental, physical, and emotional risk and increases one's risk of recidivism.

Individuals with mental illness may have greater difficulty in navigating social services agencies, such as insurance enrolment and subsidized housing applications (Wakeman 2009). For inmates who do not have access to discharge services or Forensic Intensive Case Managers, the likelihood of going without these services grows dramatically, as does one's likelihood of recidivating. A 2013 study found that many female inmates express concern about losing health coverage (because of affordability) once they get a job and their wages increase following release (Colbert 2013, 415).

Because these systems coincide with gaps (or complete failures) in health care coverage, inmates are less likely to find positive ways to manage their mental illnesses. This increases their risks of recidivism as well as substance use disorders and homelessness, both of which also mediate recidivism. Poorly designed integration plans make it more likely that inmates will reenter communities where triggers of their mental health, substance use, or criminal behavior are still prevalent. If inmates are not able to increase their positive coping skills while incarcerated, the risk of relapsing grows substantially (Vulnerable Populations and Opportunities for Reducing Health Risks 2013, p. 18).

This system creates a positive feedback loop in which individuals with mental illnesses are at an increased risk of incarceration, experience worsening symptoms during and following incarceration, and are then re-incarcerated as a result of their mental illness and other obstacles related to reintegration. This system is referred to as the revolving prison door (Baillargeon, 2009) and is often modified with the inclusion of homelessness and psychiatric hospitalization into the cycle. Without effective discharge, reintegration, community support services, and mental health treatment to break the cycle, this revolving door does one of two things. If a person is lucky, the cycle simply continues uninterrupted. For unlucky individuals, the cycle spirals out of control until it finally results in a significant negative life event such as an a long term sentence or death from an suicide, homicide, overdose, or other chronically unmanaged illness.

The causes and effects of incarceration reach beyond the experience of the inmates themselves. Families are not immune to the social determinants (such as socio-economic pressures, familial substance use disorders, poor access to education and health care, high levels of community violence and drug use, and insecurity) that put someone at risk of incarceration. Regardless of the quality of care an inmate receives while incarcerated, these social risk factors

remain present for the inmate's family members, both during and after the incarceration period. (Vulnerable Populations and Opportunities for Reducing Health Risks 2013, p. 25)

Socioeconomic hardships, including lost work, difficulty finding employment due to criminal history, and paused or canceled social security insurance place a large burden on an inmate's dependents and may increase their own risk of mental illness and justice involvement, creating a generational revolving door.

Reducing Mental Illness in Jails

Stopping the revolving door of criminal justice involvement will look different for each individual, family, community, and state. It is dependent on the current regulations of state sponsored social services such as Medicaid and Social Security as well as the type, quality, and accessibility of local, community-based support networks. It will be dependent on the unique risk factors affecting a region (an opium epidemic, a lack of affordable housing, both, etc.) as well as the past and present cultures of the communities within them. While interventions should be designed to meet the needs and utilize the strengths of unique communities, there are a number of baseline approaches and initiatives that can act as a general backbone for communities to use.

Jails are not meant to be acting as mental health treatment providers, but the fact of the matter is that they are. Even if community based programs take off with wild success it will take some time for individuals with mental illness to truly be directed away from correctional facilities. Therefore, taking a multi-pronged approach that focuses on improving access to quality treatment and support services within correctional facilities and within communities is incredibly important.

As discussed previously, research has been steadily demonstrating that substance use disorders plays a very large role in the prevalence of mental illness in jails. As such, robust

programs that treat substance use disorders are a must have. (Vulnerable Populations and Opportunities for Reducing Health Risks 2013, p. 17; Erickson 2008, p. 183; Robertson 2014, p. 937) Improving other mental health services also plays a critical role in not only stabilizing individuals within facilities but in providing inmates with the emotional, social, and cognitive abilities to cope with their time in jail and their reintegration into communities.

Because rates of mental illness are known to vary between gender, races, and other identities, having care providers who are skilled in providing individualized treatment to patients with different identities is crucial. Other forms of specialized training, such as specific training in working with forensic patients or patients with co-occurring disorders is invaluable. Additionally, because the rates of physical and sexual trauma are so high for inmates with mental illness (particularly female inmates), the ability to provide trauma-informed care is incredibly important (Vulnerable Populations and Opportunities for Reducing Health Risks 2013, p. 23-25; Haner 2013, p. 41). As efforts are made to improve the care available in jails, it is important that equal and simultaneous efforts are made to ensure that accomplishments made through treatment on the “inside” can be furthered and built upon through treatment on the “outside”.

Because risk of relapse is so great, particularly when inmates are reentering the communities in which their criminal behavior was based, it is vital that systems are designed so that inmates continue receiving treatment when they are released. Inmates should be able to leave jail knowing that they will have the economic ability to continue to receive their treatment. This may come in the form of Medicaid, affordable subsidized insurance plans, or access to stable employment that provides access to their needed services. This coverage should be activated at the point of release, if not sooner, so that inmates are not stuck in a coverage gap as a result of approval windows and the like. Furthermore, this coverage should cover the actual care

that inmates need, not a paired down version of care that forces reintegrating individuals into a less comprehensive or less effective types of care (Vulnerable Populations and Opportunities for Reducing Health Risks 2013, p. 26).

As discussed above, socio-economic stressors, job security, and accessible housing play a large role in supporting released individuals in the reintegration process. It is important that discharge services and social support services work together to empower and assist reintegrating individuals in finding stable employment and safe housing. Mechanisms that help to mitigate the stressors of these efforts, such as providing temporary economic stability during these transitions, should play a part in these services (Erickson 2008, p. 183). Across the board, any services, programs, or interventions created should be designed as opportunities to not only empower released individuals but to also connect their families to necessary support services. This type of multi-level intervention aims to disrupt both the individual and generational cycles of mental illness and incarceration (Vulnerable Populations and Opportunities for Reducing Health Risks 2013, p. 26).

Chapter 3: Methods

“So what goes? What goes is substance abuse counseling. What goes is the mental health provider that might have been coming in a day or two a week because we’ve got to do the bare minimum requirements. And I think you’re seeing the same thing with all of these providers.”
Administrator at Androscoggin County Jail

The methods that drive community based research are often significantly different, and perhaps somewhat counterintuitive to most “traditional” academic work. Objectivity and personal connections are encouraged, while understandings of the researcher as the exclusive owner of knowledge, experience, and insight are known to be fallacies. In keeping with this unconventionality, this next section will be a different type of methods section than some readers may be used to. The quantitative and qualitative elements of this project have been deeply intertwined from the beginning of this work. To try to explain them as distinctly separate elements of this project would be inaccurate and fail to represent the importance of the interdisciplinary approach of this project. Furthermore, the limitations of the data collection process are just as informative as much of the data I was able to reliably analyze. They are a form of qualitative data on their own. Because of all of this, my discussion of my experience gathering, understanding, and analyzing this data will likely appear to be a somewhat overlapping and winding explanation as I explain the triangulation methods I used for this work.

I have broken this “methods” chapter into four sections. First, I begin with a discussion of the conversations and research that shaped my interactions with these medical files. Second is an explanation of the specific data I pulled from the files themselves. The third sections focuses on the limitations of the paper medical record system at the jail and difficulties inherent in gathering data from the various forms that have been used by the medical team over the past five years. This section and the previous one are accompanied by Appendix 2 which is an annotated version of a hypothetical patient’s medical record. I have primarily included this part of the appendix in

an effort to better convey my research process. I also hope that this “file” gives readers a small window into the world of the individuals whose experiences informed this research. The project would not have existed if it was not for their own personal difficulties and under no circumstances should these experiences be minimized. This section also includes a brief description of the electronic booking records I used to provide demographic and charge data for this sample. Finally, this chapter concludes with a discussion of the coding and analytic processes I used for this data.

A Trail of Conversations

My discussions with clinicians and administrators informed the design of my file analysis and my file analysis informed who I spoke with and what we spoke about. Knowing relatively little about criminal justice systems and community-based treatment and even less about the nuances of the services in Androscoggin County, this research began with a number of exploratory conversations. These were aimed at understanding what our current system looks like and the nuances of ACJ and TCMHS’s current concerns. Eventually, these conversations became more focused on confirming that my understanding of these structures, gaps, and policy timelines coincided with the understandings of my community partners.

These conversations were not interviews. While I often went into these dialogues with questions in mind, overall, they were informal and unstructured. Furthermore, these conversations were nothing more than someone might have while discussing the nuances of a friend’s job or inquiring into policy through a phone call to a local representative.

Each time I met with someone new, we would start by discussing how my research had come about and what we were hoping to gain from it. I would also explain how I had been connected with them and why I felt that their area of knowledge could help inform my research.

Encouragingly, all of the individuals I spoke with were excited about the research and appreciative for the opportunity to contribute to my understanding. The final version of this thesis has been shared with all of them.

These conversations started small as I worked with my community partners to develop a mental picture of the systems I was looking into. While we had previously discussed the concerns that were driving this project, I needed a better understanding of the systems I would be collecting data on. I worked with administrators from the jail and sheriff's office in an effort to understand the relevant procedures, protocols, and community relationships. Topics ranged from the booking procedures to the physical location of the jail to the impact of statewide budget cuts. These discussions were followed by conversations with the records administrator where we worked together to identify what relevant information was available from the jails electronic booking records system.

I met with members of the medical team who helped me understand the structure of medical care and medical records keeping at the jail. We spoke about the availability of mental health and substance use treatment at ACJ. We also discussed changes in health care management companies and formularies that created variability in the care that could be provided year to year.

Following these conversations, I began an initial review of the files, familiarizing myself with the health assessment and treatment forms. The methods I used for file analysis were approved by the Bates College Institutional Review Board, which is discussed more fully in the *Ethics* section of Chapter 1. The depth of information available in each medical file varied greatly. The average file contained a handful of forms including an inmate bookings record, a medical and mental health assessment, some health service requests, possibly a work clearance

form, perhaps a form referring patients to ACJ's health team, and a treatment plan when necessary.

Some files contained large discharge forms from local emergency departments and psychiatric hospitals. Many files contained booking after booking after booking. In some files, certain forms, such as a booking record or a health assessments were missing altogether. This was particularly common in files from 2013 because initial medical screenings were not conducted unless an individual disclosed a health concern in their pre-booking screening. I also spent time observing the booking process in an effort to more clearly understand the files that I was reading through. See the sections entitled *The Files* for an in-depth conversation of the structure of the files and the data I pulled from them.

These files, in combination with the initial conversations I had, led me to a series of questions regarding potential gaps within the mental health treatment systems available in Androscoggin County. To strengthen my understanding of these shortcomings, I spoke with a handful of individuals involved in the provision of mental health and substance abuse services through the Maine Department of Health and Human Services. Some of these individuals wished to remain anonymous because DHHS rules require public commentary to be handled through the department itself.

Through these conversations I aimed to strengthen my understanding of the web of available mental health resources. To this end, we discussed the role that each of their departments played within the mental health network as well as potential gaps they saw in the current system. With each of these individuals I also discussed my current understanding of treatment gaps in the hopes that they could shed light on services I had overlooked.

Unfortunately, but not surprisingly, they could not. Some individuals even confirmed that the gaps my community partners and I saw were gaps they noticed as well. These meetings led me to conversations with representatives from DHHS's Substance Use Department as well as a representative from KEPRO, the health management organization that coordinates the approval of MaineCare coverage for mental health treatment. I followed up these conversation with further discussions with providers and administrators at ACJ and TCMHS.

These conversations took place over four months. They helped to shape my understanding of our current mental health treatment system and its recent and proposed changes. Many of them confirmed the initial gaps that TCMHS had presented to me at the beginning of our partnership. Some conversations brought up new ones. The time I spent interacting with hundreds of paper medical files brought up others. These conversations also shaped the way I collected data and the files I paid attention to. Most importantly, they informed the way I analyzed the data and how we can understand the results I found.

In addition to the primary data collection I conducted through these conversations and the medical files, I also conducted research through secondary documents including legislative hearing transcript, newspaper articles, MaineCare benefits manuals, legislative testimonies, commissioner letters, and rate study reports among other sources. In Chapters 4 and 5 I discuss the data I gathered through my conversations and secondary documents. These chapters focus on the structural factors within the MaineCare and Androscoggin County Jail that impact the nature of mental health amongst patients at the jail. Chapter 6 is focused on the results of the medical file data analysis. In Chapter 7 I analyze these findings within the context of my results from Chapters 4 and 5.

The Files: A Help

Creating the Sample

The medical files at ACJ are stored in two different places. Files on current patients as well as patients incarcerated within the previous calendar year are stored in a file room adjacent to the medical office and treatment rooms. Each year, a member from the medical team relocates files from the previous year to the jail archives, which are held outside of the physical structure of the jail. Throughout the time I was collecting data, files labeled as 2015 were being relocated to the archives. When patients recidivate within a year, a new set of health records are added to the patient's pre-existing file, beginning with the booking record. Many individuals were incarcerated frequently enough that their files contained information from an upwards of fifteen separate stays at ACJ. For a handful of the individuals I sampled, there was enough time in between a patient's initial stay and a new booking that their initial file had been archived and a second, new file was created.

To create the time period from which I gathered my sample population, I spoke with administrators from TCMHS and AJC about specific budget and policy changes that they felt had a large impact on the mental illness prevalence at the jail and treatment availability within the community; see Chapter 4 for a discussion of these changes. I also asked them whether there were any particular years that felt especially concerning, even if they were not able to pinpoint specific legislation that would have caused changes. Through these conversations and my own research into legislative changes, I settled on collecting sample data from 2013 to the present. 2014 and 2016 marked significant MaineCare changes. 2014 also marked the start of the Maine State Board of Corrections. I chose to include 2013 data as a comparative year.

Since 2013, 8,231 different people have been incarcerated at ACJ. However, there are more than this many physical files for this time period, as many individuals had duplicate files as

I explained above. While sampling every file would have been ideal, this was impractical due to the large number of files and timeline available for this project. Instead, I initially chose to sample every fifth file from each year in the sample period in order to collect a strong sample size within the time constraints.

Each booking in each file was documented as a separate data set in the original data collection process. This data was later restructured to reflect information about an individual over the course of the sample time period as well as trends over six and twelve month time periods. I will discuss this process more later on.

Initially, I created my sample by alphabetizing all of the individuals booked since 2013 and pulling the file for every fifth person in my list. After assessing the files for 2016, it became clear that this process was inherently flawed as I was only able to locate one-half to one-third of the files in my random sample. I still have not been able to understand why so many files seemed to be missing. However, nothing has led me to believe that there is a systematic reason that could be impacting any of my results.

At this point I changed methods, going from hunting for every fifth person to pulling every fifth file that was physically filed in a records box. I used this method to pull samples from 2014 and 2015, which are stored in the archives room external to the jail. After sampling every fifth file from 2014 and 2015, it became apparent that sampling so frequently from 2013 and completely resampling from 2016 would be impractical. A concussion set me back two months in my data collection and taking significantly longer to expand data collection would not have been possible. However, because I was reviewing all of the bookings from each file, there had never been any guarantee that there would be an equal number of bookings analyzed each year, regardless of how many files I looked at. For example, many of the files from 2016 also

contained bookings for 2013, 2014, and 2015. So, sampling one-hundred files from 2016, 2015, 2014, and 2013 would inevitably led me to analyze more 2013 files than 2016.

After looking at my data to ensure that each sampling method would result in at least 200 bookings from each year, I chose to pull every tenth file from 2013, 2016, and 2017. The alternative would have been to ignore an entire year's worth of files, which would have logically meant dropping 2013. However, data from this year felt like an important tool for impact comparison for all of the MaineCare changes that took place since then. Because 2013 already had a disproportionate number of bookings examined and I had approximately one hundred booking data points from my initial review of 2016, I was comfortable with only evaluating every tenth file from both years.

Because this data was collected at the beginning of the calendar year, only one and one-half months' worth of 2017 files were available. They were either mixed into the 2016 files or stored separately if the file was "active" meaning it was for someone currently at ACJ. Because of the overlap and my timeline, I also looked at every tenth file active file. Overall, I analyzed 1154 bookings, representing 686 individuals. This sample included 204 files from 2013, 336 from 2014, 326 from 2015, 270 from 2016, and 18 from January, 2017. These bookings were spread across 686 unique individuals, with a range of one to sixteen bookings over the four years included in the sample.

Within the Files

Each section of a patient's file begins with a pre-booking screening that corresponds to a particular booking and stay at ACJ. For each file I pulled I would separately record the health history provided in the medical forms pertaining to each booking. In the majority of files, this screening was followed up with one (or multiple) health and mental health screenings. I

primarily relied on these forms to gather my data. Additional forms, such as health service requests, detox sheets, treatment plans, and referral information were also used when present. It was frequently the case that one or more relevant forms was not included in a patient's file. However, to the extent possible, I gathered extensive information from each booking section of each file. For an annotated sample medical file, see Appendix 2.

In planning out what data to collect, I aimed to gather information that would be clearly indicative of substance use or other mental illness. This information included whether the patient had a history of mental health treatment, had self-disclosed a mental illness, was referred to the mental health team, or was put on medical watch for detox. I will discuss the nuances of collecting these variables in later sections.

Pre-booking screenings are conducted by a corrections officer at intake. The pre-booking screening has multiple purposes which include assessing the patient's physical and mental health as well as making a determination about the patient's classification (minimum security, maximum security, etc.). This screening is used to determine whether the patient has any health conditions which the Corrections Officers need to be aware for the time between booking and the patient's initial medical screening. These include health conditions such seizure disorders, recently acquired injuries, communicable diseases, allergies, and other conditions which could pose a danger to the patient or other patients during their stay. The screening is also used to determine whether the individual is intoxicated upon arrival and whether they will likely be undergoing detox while at ACJ.

This screening is usually conducted in a section of the jail referred to as "Booking". Booking is located immediately inside the entrance through which police officers bring arrested individuals into the jail. The pre-booking is conducted at a large open desk which takes up the

majority of Booking. This desk offers little privacy beyond a few partitions along the desk. The information collected in these screenings is added to the patient's' permanent record file and is accessible by a variety of different corrections officers, health providers, and IT personal at ACJ.

A large portion of the screening aims to determine whether the patient is suicidal or homicidal at intake. If the patient is deemed to be experiencing homicidal or suicidal tendencies, they are refused at booking and instead transported to a local emergency department. The suicidality screening asks patients whether they have history of self-harm, suicidal ideations, or suicide attempts. The correction officer conducting the screening additionally makes an assessment of the individual's emotional state and looks at previous booking records to determine whether the patient has a prior history of self-harm. The screening program software combines the patient's responses and the correction officer's assessment to calculate the patient's suicide risk "score". Patients' scores are translated into a low, medium, high, or very high risk. Those with scores above a certain threshold must be cleared by a physician at the local emergency department before they can be incarcerated.

This screening is also used to determine whether the patient presents a threat to other patients or correctional officers. If a patient is deemed to be homicidal they are also refused at booking and taken to the hospital. In less severe instances, the patient may be put on a higher security clearance where they can be monitored more frequently or put in an observation cell until they no longer pose a threat to others.

This pre-booking screening was one of two primary tools used to gather data on a patient's history of mental illness. From the screening, I recorded information about patients' history of self-harm, suicidality, their suicide risk determination, and whether they were experiencing suicidal ideations upon intake. I also recorded whether the patient was intoxicated

upon intake and whether their bookings form acknowledged that they were seeking psychiatric care upon intake. I also recorded any mental illness a patient self-reported during the screening. Self-reported illnesses included, anxiety, depression, bipolar disorder, mania, schizophrenia, ADHD, OCD, Asperger's syndrome, sleep disorders, claustrophobia, stress disorders, agoraphobia, panic attacks, substance abuse or dependence disorders, mood disorder, anti-social personality disorder, oppositional defiance disorder, anorexia, and postpartum depression among others.

As I discussed in Chapter 2, categorizing a type of mental illnesses as “severe” or “serious” can be both misrepresentative and stigmatizing because it neglects to take an individual's level of impairment into account. Because there was no way for me to consistently determine patients' current or past level of impairment by only reading their medical file, I did not distinguish between “severe and persistent” mental illnesses and any other diagnoses in my data collection.

Within twenty-four hours of booking, a member of the medical team conducts an initial medical intake screening. These screenings are currently conducted for every patient booked at the jail. In 2013 and earlier, these screenings were only conducted for individuals who reported a mental illness or medication during their pre-booking screening.

ACJ has had contracts with at least three different healthcare management companies over the past five years. Each time the health management company changes, health assessment forms do as well. Some nuances in the different forms did make it difficult to gather the same data from each type of form. For example, questions about withdrawal were only asked on some forms. Other questions were worded in different ways which affected the reliability of data from these questions. Appendix 2 shows an annotated, sample version of these various forms. Each of

these forms asked patients whether they had a history of mental illness and mental health treatment and whether they were participating in any current mental health treatment. They also ask whether the patient uses drugs not prescribed by a physician or has ever received substance abuse treatment. I recorded whether patients responded positively to any of these questions. I noted any specific mental illnesses patients reported, as I did for the pre-booking screening. I also recorded any specific drugs the patient reported using. I chose not to record information about what type of mental health service a patient had or was receiving or when they had received it. I also did not record specifics about patient's substance abuse treatment, such as where and when they had been treated.

I chose not to record this data for three reasons. First, gathering data from paper medical files is an exceptionally involved process, one that takes far more time than running queries on the number of patients who report "X" in an electronic records system. Recording every possible data point from these files would have made the data collection process impractically long and likely would have led me to use a smaller sample size and subsequently have less robust data.

Second, I am not a doctor, a mental health practitioner, or substance abuse specialist. As such, I feel that even with extensive literary research I would not have adequate training to make any knowledgeable assessment or conclusions related to a patient's specific treatment history.

Third, the data varied greatly in the specificity of responses for history of mental health and substance abuse treatment. While some noted when and where the patient had been seen, others were simply marked with a "yes" or "patient could not recall where". By focusing more broadly on whether patients had a history of these medical services, I feel that I was able to gather information about mental illness prevalence that would be more valuable to my community

partners. Focusing on broader information about treatment use is also more in keeping with current research on the prevalence of mental illness in the U.S. correctional system.

While an older screening form only asked about general “substance use”, the most recent form asked patients about alcohol use, specifically what patients usually drink as well as how much and how often. While I noted when patients reported using other drugs, including heroin, cocaine, crack, Suboxone, and marijuana; I chose not to record specific information about patient’s alcohol use. I also did not record information about patient’s frequency of drug use. Again, I do not feel that my training qualifies me to use this information on individual’s substance use habits to determine whether they would qualify as a substance use disorder. Furthermore, as I will discuss further in the following section, there are numerous reasons why a patient would underreport their substance use. Therefore, any diagnosis gained from a record of someone’s self-reported use, may be wildly inaccurate.

Instead of this information, I focused on gathering information, such as history of withdrawal, being put on medical watch for detox, and history of substance abuse treatment as these factors more objectively show that a patient has experienced some form of substance dependence. I later used some of these variables to identify individuals whose health history was an indicator of a substance use disorder, which I will discuss more fully later on.

One company’s forms also asked patients whether they had any prior engagement with a mental health court. Another set recorded whether patients had a history of withdrawal after ceasing drug use. All of the forms asked patients questions about their history of self-harm, suicidal ideations, and suicide attempts. Information about how far in the past a patient’s self-harm or suicidality occurred was also recorded.

Many patients' files also contained a number of additional forms from which I collected data. These forms were particularly helpful when the pre-booking, medical, or mental health screenings were missing data or missing in their entirety (such as in 2013). Patients who were placed on medical watch for alcohol or opiate withdrawal have a medical watch form in their file. I recorded whether this form was present, as well as whether a patient was withdrawing from opiates or alcohol. The presence of forms related to suicide watch or suicide watch-clearance were used to document that the patient had suicidal ideations at some point during their stay.

I also recorded whether a patient was referred to a mental health provider at the jail. A referral was indicated through a pre-booking screening, medical or mental health assessment form, or in a separate mental health referral form. The presence of a mental health progress note would also indicate that the patient had been referred to the mental health team. A mental health provider at ACJ noted to me that the threshold for being referred to the mental health team was fairly low. Patients may also request to see a member of a mental health team through a written Health Service Request. These self-referrals were usually accompanied by a formal mental health referral form or a mental health assessment or progress form. I skimmed mental health evaluations and progress notes to determine whether the mental health practitioners at ACJ had diagnosed the patient with any mental illnesses (including substance use disorders).

Of all of the forms I looking through, these Health Service Request forms struck me the most. Unlike the rest of the forms that are either typed or handwritten by a corrections officer or medical team member, these request forms are hand written by the patient themselves. When I was buried in numbers and becoming tired of examining file after file, these health service requests would help center me to the purpose of this research. Some requests were carefully

written with beautifully articulated explanations of why the patient needed to see a provider but not be placed on suicide watch. Others were curt, expressing that the patient needed to “work out some shit”. Many were distressing, with scratchy letters and misspelled words explaining that the patient “was getting worse”, their “mind was racing”, and they “couldn’t make it stop”. All of them were deeply personal windows into the difficulties these individuals were facing.

I also reviewed any forms from outside organizations, such as St. Mary's Regional Medical Center, Tri-County Mental Health, or Riverview Psychiatric Center to determine whether the patient had been refused at booking or sent out for psychiatric treatment or evaluation. Files for individuals who were initially refused by the jail because of homicidal or suicidal ideations and later cleared by a hospital for incarceration usually included a discharge packet. These contained information on the assessment and treatment the patient received from the emergency department as well as any follow up that was needed. In some cases patients were released to the jail with a referral to Tri-County Mental Health Services or specifically to their Assertive Community Treatment Team. I included any diagnostic information provided in these forms in my documentation of patient mental health history. Many of these packets contained educational discharge sheets designed to provide patients with information about their condition.

These discharge sheets were the most baffling component of these files. The educational information and self-care recommendations included on these sheets were so incredibly impractical for anyone about to spend a significant amount of time in jail it was almost comical. Advice telling patients to do things that make them happy, spend time outside, or find ways to lower stress levels seemed insensitive advice to tell someone with depression or suicidal ideations who was about to go spend weeks or months in a maximum security cell. One doctor’s note advised a patient that if they were “in need of care and cannot connect to the outpatient

setting, the emergency department is the place to go”. This was probably sage advising seeing that many of these individuals cannot access comprehensive care because of health insurance barriers on the outside and funding barriers within ACJ.

The Files: A Hindrance

Collecting coherent data from these files presented a number of challenges, many of which are a result of issues inherent to using a paper, rather than electronic, file system. This sort of filing system not only makes it difficult to collect data, but it also makes it difficult to provide quality continuity of care over the course of an individual’s time in and out of ACJ. The disadvantages of a paper filing system have a strong impact on the way we understand the data I have collected. As I will discuss later, these limitations overwhelmingly suggest that the prevalence rates I found from my data are underestimates of the prevalence of mental illness at ACJ (see Chapter 6).

Appendix 2 shows an annotated version of the pre-booking screening and the mental health assessment used in past three years. I have filled out these forms with hypothetical data from an imaginary patient, Steven Katz. They are not meant to be representative of any individual patient, but are reflective of an average medical record. I have aimed to fill out these forms in a way that demonstrates the specific data I gathered from these forms as well as how I recorded data that was missing or contradictory. I would recommend reading through that section for a more detailed and concrete explanation of the way I collected data from these files.

Since these files were handwritten, some forms were illegible. This was a particular problem for mental health assessment forms and mental health progress notes. Because these forms require a large amount of clinician note taking, they were much more difficult to interpret than other forms that were mostly yes/no questions. In many instances, this difficult to read

handwriting hindered my ability to document any additional diagnoses made by the mental health staff. In these instances, this information was documented as “missing data” if it was completely impossible to identify whether a diagnosis had been made. If I was able to identify that an additional diagnosis had been made but could not determine the specific diagnosis, the data was just noted as a positive indicator of a diagnosis.

Completing files by hand, rather than through an electronic system which mandates data input for certain fields leaves room for questions to go unanswered. Occasionally, fields such as whether a patient had a history of withdrawal were left blank. This happened infrequently and is presumably an accident. However, because neither a positive or negative response was originally recorded for the patient, instances where this occurred were noted as “missing data”.

Some assessment questions were double barreled, making it difficult to ascertain what documented information actually meant. For example, in the 2015 forms patients were asked whether they have a “history of or current mental health treatment”. Unless the specific dates of treatment or “current” was written next to the question, it was difficult to determine when the patient had utilized the treatment. Patients who could be confirmed as receiving mental health treatment at the time of booking were recorded both as having a history of treatment and undergoing current treatment (since the latter necessarily implies the former). When it was difficult to determine whether the treatment was current, a history of mental health treatment was positively recorded while the current treatment was recorded as “missing data”.

The hand filed nature of the medical records also presented an occasional organizational problem. The medical files are organized alphabetically by year. Because they were organized and stored by hand, it was not unusual to find medical records filed in an incorrect alphabetical or year location. An “Fr” name might occasionally find its way to the “St” section while a 2013

file folder may end up in the 2015 archives. This may have been the result of two files accidentally being stuck together or simple human error that occasionally happens in busy work environments. There is nothing to suggest that these records were misfiled with any sort of pattern or with any other significance. Therefore, these misfiling do not introduce any sort of confounding variable into the random sampling used to select the files.

When a patient who has previously stayed at ACJ is booked again, their previous file is pulled and current information added. If records are misfiled, it could become difficult to locate and add new files, potentially leading the health team to create a new file which would then lack components of the patient's previous medical records. I frequently found files in which portions of the patient's medical record seemed to be missing. Refer to Chapter 5 for a discussion of how this impacts patient care. In many cases, health histories noted on one form, such as the pre-booking screening, were also noted elsewhere, such as in the initial medical assessment. Fortunately, this usually meant that if one forms was missing, I was able to gather the necessary data from another form in the patient's file. However, because some information was only recorded in one place this was not always possible. These instances were also noted as "missing data".

The ability to gather the same information from multiple points in a patient's file was exceptionally valuable. Mental illness (including substance abuse) is extremely stigmatizing. As such, many individuals chose not to disclose their mental health histories at various points throughout their stay at ACJ. Most commonly, patients would deny any history of mental illness during their pre-booking screening, but later report them to the medical and mental health staff. This is not unsurprising as these pre-booking screenings are conducted in a fairly public space by corrections officers rather than health care professionals. It should also be noted that because

many patients are booked while under the influence of alcohol and other drugs, their altered mental status may have been responsible for their lack of disclosure. By looking at a patient's entire file, I was able to "make up" for a portion of the missing files and gain a slightly more accurate measure of variable prevalence.

Despite this, I firmly believe that the data I gathered is an under representation of the prevalence of mental illness, substance abuse, and treatment histories amongst patients at ACJ. In addition to patients choosing not to disclose their histories, a number of patients do not have the opportunity to fully inform clinicians of their mental illnesses. For many, this may be because their stay at ACJ is too short to be given an opportunity to receive a full medical or mental health assessment. And in the case of mental illness and substance abuse disorders, many may not be disclosing a diagnosis because they have never previously had the opportunity to be seen by a clinician on the outside and are therefore unaware of having any actual diagnosable concerns. Others may be choosing not to disclose their histories for a whole host of other reasons.

During my few months at ACJ, I was occasionally told that some patients will report a mental illness or threaten suicide because it gains them access to certain attention or resources or because they think they will not be booked under certain circumstances. While I do not doubt the validity of this statement, I do not believe this represents a significant portion of the patients at ACJ. After reading through hundreds of mental health assessments, health histories, and health service requests, the impact that mental illness has on patients at ACJ is undeniable and well supported within each file. I believe that the extensive prevalence of mental illness greatly outweighs the problems of a select few individuals who may be falsely reporting an illness.

On average, files that only included a single booking and only contained the most basic health screening form took me approximately one minute to read through and record. Files that included numerous bookings or complicated discharge, referral, and treatment form could take an upwards of thirty minutes to read through and record. Overall, I spent at least seventy-five hours reading files.

In addition to the data I gathered from patient medical files, I also worked with data from the jail's booking records system. This is a computerized system which stores a whole range of information on patients' charges, their arrest, their security levels, and their cell mates as well as demographic information. This system is partially connected to the record system that operates throughout the state. To gather data from this system, I worked with the Records Administrator at ACJ to understand what information was available through this system. In the end, the Records Administrator was able to provide demographic information (age, "sex", "race", "ethnicity", homeless at time of bookings), charge data, sentence length, and segregation information, as well as a small amount of medical information, for each booking at ACJ since 2013.

Some of these demographic categories are in quotes because these fields are not consistently filled out based on answers from patients, some corrections officers may just fill them out on a hunch. The potential options for these categories (Male/Female/Unknown, "Black/White/Asian/Indian", "Hispanic/Non Hispanic") are fairly inaccurate and problematic categories from a sociological standpoint. My use of quotes is also used to recognize that someone else's determination of someone's gender, race or identity through these narrow categories does not provide much accurate data about the individual's actual identity.

We attempted to pull additional information about patient's suicide evaluations, however the system was back-coded in such a way that it was impossible to pull this information out of records system and into an analyzable database. We ran into similar types of coding problems a number of times. For example, charges are generally categorized as misdemeanors vs. felonies and as violent or nonviolent offenses. Because the jail's data base system records this data for use in determining a patient's security levels, it records it all in one category. Violent offense overrides the misdemeanor/felony designation. As a result, information about whether a charge was a misdemeanor or felony was not included for many individuals.

These records are not designed for easy analytics, they are designed to be useful in running a jail. Therefore, it is understandable that we ran into a number of problems trying to pull data in a way that would be usable for this research. However, should there ever be a change in what records system is used or even a purchase of an electronic medical records system, there would be value in investing in a system design that would make it feasible to run queries on all of the information that is recorded in patient's records. Obviously this would be dependent on there being available funds to do so. However, such a system has the potential to dramatically increase ACJ's ability to keep better track of trends in the population they work with and would likely be an asset in developing future jail programs or community partnerships. It could potentially even enable medical providers to identify patterns in an individual's medical history, such as whether they are consistently arrested while intoxicated and therefore need to be referred to a substance use specialist.

Crunching the Numbers

The data I gathered from patient medical files and the jail records system were initially stored in Excel files. Each patient was given a Patient ID number in the data set. This was used

to match multiple bookings for each individual and enabled me to remove any identifying information from each patient's records. The information was initially stored by booking. For example, if Steven Katz, the hypothetical patient use in Appendix 2, had been booked three times since 2013, he would have three sets of data associated with his Patient ID number. Each individual data set was identified by the booking date of the booking it referred to.

Because the medical files only contained a sample of the patients booked at ACJ since 2013, many of the data sets from the jail records system were not used. Those that did not correspond to an individual in my data set were removed from the sample.

The medical records, sentence, segregation, and demographic data were merged into a single comprehensive file using each individual booking as the unit of measure. This file was primarily used to analyze factors related to sentence length. It was also converted into files that organized the information by individual over the five year sample time as well as by individual over year and half-year intervals. For example, the Individual File would include information about every booking Steven Katz had since 2013. This file was used to analyze information such as the proportion of individuals that disclosed a mental illness at any point over the past five years. The Year and Half-Year files collated all of the information from all of the bookings an individual had in that span of time. For example, Steven was booked three times in the first half of 2013 and once in the second half. One data set would include the information for Steven from January to June of 2013 while another data set would include data from July through December.

Breaking up this data by six and twelve month time periods was intended to be used to analyze changes in prevalence rates and correlations between variables over time. Unfortunately, that data was not able to be analyzed in time to make it into this paper. However, it will be used

to gather further information about changes in the prevalence and nature of mental illness at Androscoggin County Jail over the past four years.

In each data file, multiple variables were combined to create a number of mental illness indicator variables. Specific self-disclosed diagnoses as well as new diagnoses made while the patient was at ACJ were combined into a “Disclosed/Diagnosis” variable. Patients were coded as either a 1 (for not having a disclosed or diagnosed mental illness) or a 2 (having a disclosed or diagnosed mental illness). This variable did not include any diagnoses or disclosures of substance use disorders and the reason for this will become clear momentarily. This variable was then combined with whether a patient had been sent out to another facility (a local emergency department or psychiatric hospital) for mental health treatment, reported a history of mental illness or mental health, or had any history of suicidality or self-harm. If a patient had answered “yes” to any of these variables or had a 2 for the Disclosed/Diagnosis variable, they were considered to have a positive “Mental Illness Indicator”.

A separate, but similar variable was created for individuals with substance use disorder. Anyone who disclosed or was diagnosed with a substance use disorder, reported a history of substance abuse treatment, or went through detox from alcohol while at ACJ was considered to have a “positive indicator of substance use disorder”. Detoxing from an opiate was not included in this criteria because there was no way to identify whether a patient was withdrawing from a prescribed drug or not. Formulary limitations within the jail limit individuals’ abilities to continue to take prescribed opiate medications while at ACJ, so some individuals do end up detoxing from non-abused prescription medications.

I created a separate variable that recorded whether the patient had reported using any illegal substance. I did not include this variable in the “Substance Use Disorder Indicator”

variable mentioned above because using recreational drugs, particularly marijuana, is not a direct indicator of a substance use disorder. I also did not include whether a patient was intoxicated upon arrival because being intoxicated and arrested once is not indicative of a substance use disorder.

The mental illness and substance use indicators were combined into a final, overarching “Total Mental Illness Indicator”. Substance use disorder is a mental illness. As such, I felt that it was important to include it in my correlation analyses of mental illness and other factors (such as sentence length, number of bookings, homelessness, and violent offense). However, resources for individuals with substance use disorders versus those with other mental illnesses are treated very differently under the MaineCare Benefits handbook. Because of this, I choose to analyze the two sets of disorders both together and separately. This enabled me to conduct additional analyses that looked at the rates of co-occurring disorders (substance use disorder along with another mental illnesses) as well as the relative contribution of substance use versus other mental illnesses to other factors such as sentence length and number of bookings.

An individual’s total number of bookings was calculated over six and twelve month unites of time as well as over the four year sample timeframe. Whether the patient had a violent offense as well as whether the patient was homeless at the point of booking in any of these timeframes was also calculated. Information about the specific diagnoses each patient had and the specific drugs each patient used were also combined to create a number of dummy variables. A separate variable was created for whether a patient had: PTSD, a separate trauma or stress disorder, a depressive disorder, bipolar disorder, a different mood disorder, an anxiety disorder, obsessive compulsive disorder, a schizophrenia spectrum disorder (which includes schizophrenia and schizoaffective disorder, which were also assessed individually), a personality disorder, an

adjustment disorder, a neurocognitive disorder (such as dementia), a neurodevelopmental disorder (such as ADD and ADHD), a disruptive/impulse/conduct disorder or another unspecified mental illness. Separate variables were also created to record individual's use of separate illicit substances such as heroin, Suboxone, opiates in general, cocaine, crack, hallucinogens, benzodiazepines, methamphetamines, marijuana, and other unspecified drugs.

I analyzed this data using the statistical analytics software, SPSS. I used crosstabs, which included Pearson's' Correlation tests, to identify correlations between rates of mental illness, substance use disorder, violent offenses, homelessness, and bookings at the individual level. I ran these same tests to determine correlations between gender and race and each of these variables. I also ran correlations between all seven of the above mentioned variables against a number of specific mental illnesses and drugs that were disclosed by patients as well as against general rates of drug use disclosure. Crosstabs were also run for the "half-year" and "year" data files, which collated reports of each variable by the six and twelve month intervals, rather than over the full four year sample period. These crosstabs looked at changes over time in mental illness, substance use disorder, violent offenses, homelessness, specific mental illnesses, and specific drug use.

Additionally, I ran multivariate regressions to analyze the ability of mental illness, substance use disorder, and homelessness to predict whether an individual had a history of violent offense or a greater number of bookings during the full sampled period. Results from this regressions and the other correlations I had run were used to create a path analysis for violent offense and number of bookings.

While age is generally considered an important variable in criminology studies, it was not practical for use here. Because these tests were run on data files that combined responses from multiple booking, determine which age to include in the analysis would have been a complicated

process. I could have averaged the age of each individual at each of their bookings and included that number in their regression. However, I felt that doing so would have introduced just as many confounding variables as it was eliminating. For example, MaineCare eligibility criteria are different for 18 year olds versus 19 and 20 year olds versus 22 year olds. Because of this, averages that altered which age came out in the data analysis might have misrepresented or masked certain policy effects.

Chapter 4: MaineCare

*“Do something... don’t just warehouse them.” “That’s hard to do without any money”
Administrators at Androscoggin County Jail*

In December 2012, the United Nations passed a resolution on universal health coverage, urging countries to take steps towards providing universal and equitable health care. Shortly thereafter, the World Health Report, the World Health Organization’s annual leading publication, was published with the title, *Research for Universal Health Coverage*. This publication had two aims. First, it served as an argument for universal care, emphasizing that this model provides high quality prevention and treatment to patients as well as financial risk protection to individuals, communities, and countries. Second, the publication pushed for the development of universal care systems through evidence based delivery systems, using established research to guide countries’ development of these models. (World Health Organization, 2013)

Despite this global push, Maine embarked on what has now been a five year journey in reducing, and often eliminating, health care coverage for thousands of Mainers, with little publically available research to back up these decisions. Particularly in the case of mental health treatment, these changes have led to a policy structure of reactionary care. Rather than providing preventative or stabilizing care, we have created a system which waits for individuals to be in crisis before providing services.

The purpose of my research is to analyze the relationship between systems like these and the prevalence of mental illness among patients at Androscoggin County Jail. In doing so, this thesis serves as a body of work that can be used to inform efforts to improve the provision of mental health treatment at the jail and in the county. The first of my three research questions ask, “What community and jail based mental health services are available to patients at Androscoggin County Jail and what structural barriers limit access to these services?”

This chapter, as well as Chapter 5, answer that question by taking an in-depth look at the systems within the state and across local agencies that provide mental health treatment. More specifically, these two chapters focus on the barriers to care that are built into this system. This chapter focuses specifically on MaineCare and the limitation it puts on an individual's ability to receive appropriate mental health treatment. Chapter 5 focuses on the services and obstacles within the Androscoggin County Jail and the local agencies it partners with. In Chapter 7, I will come back to these two chapters, using the information from them to interpret the data that was collected from the medical files I analyzed.

In this chapter, I focus on legislative changes in MaineCare that have been enacted since 2013. While an analysis of changes that took place earlier may be an interesting and worthwhile conversation as well, my community partners and I, Tri-County Mental Health Services and Androscoggin County Jail, agreed that 2013 marked a logical beginning to the most recent flood of MaineCare changes and so it made sense to begin this analysis there. However, I encourage anyone interested to dive deeper into the historical and political contexts that have been shaping these systems far longer.

This chapter is organized into three sections. The first is a discussion of general eligibility requirements for low cost health insurance in Maine and the numerous income eligibility changes that have taken place since 2013. The second is an in depth look at mental health diagnostic eligibility changes that were enacted in March, 2016. This chapter will conclude with a discussion of MaineCare budget and policy changes that have been proposed and are currently being discussed by the state legislature.

Before we dive into the details of these past five years, however, I would like us to keep three points in mind. First, Maine is not an outlier. We are not a sad, broken state with a

malevolent legislature. We are not even close. We are participants in a global system that, without careful thought and intersectional understanding, leads us to this place time and time again. What we are experiencing right now in Maine is something referred to as the Inverse Care Law. In short, this law explains that our current systems are ones in which a majority of healthcare resources are available or most easily accessible to those with the fewest health care needs. In contrast, those with the most need have the most difficult time accessing care. This phenomena is intimately linked to the reactionary care model our Maine Department of Health and Human Services has crafted and being able to pinpoint it as such increases our ability to recognize and work against these problems.

Second, Maine's current government has a strong affinity for the idea of "the worthy poor". This is the idea that some individuals who are struggling are more deserving of a helping hand than others. For example, Governor LePage's 2018-2019 budget proposal claims to "devote taxpayer resources to our neediest and most vulnerable" by cutting \$140 million from services that serve low-income individuals and legal non-citizens including asylum seekers and refugees (LePage, 2017; Maine Equal Justice Partners 2017). This culture, however, is not the sole result of the individuals working within the Maine government, but is enabled and upheld by us as voters and community members who have all played our own role in furthering these prejudiced ideas.

To that end, it is not enough to simply criticize inequitable budget proposals and unjust legislation. We must also look internally to see whether we are equally extending helping hands on smaller scales. Are we putting just as much hope and perseverance into stubborn and frustrating patients as those who are noncompliant with treatment? Do we extend just as much compassion to patients who say thank you as we do to those who do not? Are we as willing to

have listening dialogues with individuals from opposing political viewpoints as we are with our own? Changes in systems often mean changes in ourselves.

Third, my research has primarily been centered on access to mental health treatment provided by community-based mental health providers. I came to this focus through conversation with my community partners about what issues currently seem most urgent. However, access to these programs is by no means the only part of the mental health puzzle. Holistic physical, emotional, mental and spiritual health care, as well as healthy and sustaining food availability, affordable and safe housing, job security, community and family support, and access to the outdoors are all important components of an individual's mental health. This is in addition to childhood access to quality education, positive role models, and loving caregivers who can teach positive coping and interpersonal skills. All of these play a vital role in sustaining the mental health of individuals and communities and their importance should not be forgotten. As we move forward; as providers, corrections officers, community members, advocates, family members, and friends; it is important to think broadly and interdisciplinary. We must avoid developing a myopic view of reform, and instead to strive for a visionary understanding of what it would truly mean to change this system.

Income Eligibility Changes

Overview of Income Eligibility in Medicaid

In 1965, Medicaid was established to provide health insurance to low income individuals. The Children's Health Insurance Program (CHIP) was created in 1997 to provide health insurance to children whose parents' incomes are too high to qualify for Medicaid but too low to purchase private insurance. States individually manage their Medicaid and CHIP

programs and as such, they each independently determine exactly what constitutes “low income”. Generally, qualifying for Medicaid requires an individual or family to have a Modified Adjusted Gross Income at or below a certain percent of the Federal Poverty Levels (FPL). What percent each state designates as the benchmark income varies significantly. Table 1 shows the Federal Poverty Levels for 2017. In Maine alone, qualifying income levels have ranged between 250% and 105% of the FPL since 2005. (Maine Equal Justice Partners 2016a; MEJP 2016b; MEJP 2017)

Table 1. 2017 Guidelines for the 48 Contiguous States and The District of Columbia*

Person In Family/Household	Poverty Guideline
1	\$12,060
2	\$16,240
3	\$20,420
4	\$24,600
5	\$28,780
6	\$32,960
7	\$37,140
8	\$41,320

Families with households of more than 8 persons, add \$4,180 for each additional person.

* FPL for Hawaii and Alaska are slightly higher.

Some individuals earn too much to qualify for their state’s Medicaid program but do not have enough money to afford private insurance. These individuals fall into an uninsured status known as the “the coverage gap”. In 2014, the Affordable Care Act was implemented, in part, as a way to help reduce the number of individuals falling into this hole. It established the Health Insurance Marketplace, which provided lower cost, subsidized insurance to individuals who earned too much to qualify for their state's Medicaid program. Individuals with incomes between

100% and 400% of the FPL are eligible. In what manner these market place insurances will continue to exist in the upcoming months has yet to be seen. (Office of the Assistant Secretary for Planning and Evaluation, 2017; Centers for Medicare & Medicaid Services, 2017; Office of the Assistant Secretary for Planning and Evaluation, 2017).

As I mentioned, states independently administer their Medicaid and set the rules for who exactly their Medicaid program is designed to serve. In Maine, this is where things get messy. Between 2003 and 2013, all individuals in Maine who made 100% or less of the FPL qualified for Maine Medicaid, referred to as MaineCare. In MaineCare and in Medicaid formularies in other states, individuals who fit into certain categories (disabled, parents, pregnant individuals, HIV positive individuals, and children) often have different income eligibility criteria, which may be less than the baseline level set for the general population. For example, in 2005 individuals identified as “working disabled” who made up to 250% of the FPL qualified while parents of children over six needed earnings less than or equal 150% to qualify.

Changes in MaineCare Income Eligibility

In 2013, income eligibility requirements in Maine began to tighten dramatically. Eligibility for parents was reduced from 200% to 133% of the FLP in 2013 and again to 105% in 2015. This change caused 14,500 parents to lose their health insurance. Income eligibility requirements for parents have been this low since 2013 and have been proposed to drop as low as 40% in the 2018-2019 budget proposal (LePage, 2017). Table 2 shows all MaineCare income eligibility changes since 2005.

MaineCare Income Eligibility Requirements

Year	Disabled/ Elderly	HIV/AIDS	Working Disabled	Non-Categorical Adults	Parents of children >6	Parents of children <6	19&20 Year Olds	Pregnant Women
2003				Non-categorical Adults become eligible for MaineCare				
2005	100%	No data	250%	100%	1-19: 150%	<1: 200%		200%
2010	100%	No data	No data	100%	200%	200%	150%	200%
2013	100%	250%	No data	100% (some services reduced)	133%	133%	150%	200%
2015	100%	250%	250%	Ineligible	105%	105%	161%	214%
2016	100%	250%	250%	Ineligible	105%	105%	161%	214%
2018-2019 Proposed				Ineligible	Able-bodied adults: 40%	Able-bodied adults: 40%	Ineligible	

(Maine Equal Justice Partners 2016a; Maine Equal Justice Partners 2016b; Maine Equal Justice Partners 2017; MaineCare & Marketplace Income Eligibility Guidelines as of January 1, 2015, 2015)

To jump back in time briefly; in 2002 Maine received approval to expand Medicaid coverage to low income, childless adults. These individuals are frequently called “non-categoricals”, or “non-cats” because they do not fall into any other eligibility categories (disabled, pregnant, etc.). From 2005 to 2013, all non-categorical individuals who earned 100% or less of the federal poverty level were eligible for MaineCare. This expansion was an important step in ensuring health insurance for low income Mainers. Unfortunately, the expansion was short lived.

In 2014, *all* non-categorical adults lost their MaineCare eligibility. That is another 10,000 individuals in addition to the parents who had lost coverage in 2013. Between 2013 and 2014, a total of 24,500 individuals lost their MaineCare coverage. While this number is large on its own, it is also not representative of the large number of children who, as a result of this change, were now living with parents and caregivers who no had no health insurance. There is little question that adults who are better able to manage their own health are better able to manage the health of their children. This may be because they develop better health habits they can share, because they are healthier and able to be more involved and active in their children’s lives, or because they are able to avoid spending money on catastrophic health expenditures for emergency care.

As I alluded to earlier, the coverage gap refers to individuals who do not qualify for Medicaid and cannot obtain private health insurance. Of those 24,500 individuals, 14,500 of them lost their coverage because they earned slightly too much. For some, this may have been 110% rather than 105% if the Federal Poverty Line. For the other 10,000 individuals, this coverage gap emerged because they no longer met the state's arbitrary categorical requirements.

And no matter how significantly their income levels drop, they will not be able to receive coverage. That is, they will not receive coverage unless they become disabled, contract HIV, or have a child, none of which seem likely particularly healthy and stable life events for individuals operating at such low income levels to begin with.

This legislation sent an important message to Mainers. It suggested that even though you are struggling financially, because you do not have a child, because you are not elderly, and because you are not disabled in the narrow window of ways social security claims you can be, this administration does not have an interest in helping you lead a healthy life. This message has been repeated in a myriad of ways from policy changes to press releases since then.

The Affordable Care Act did attempt to address the categorical barriers within these types of coverage gaps. The notion of Medicaid expansion meant that individuals who make below 138% of the FPL would qualify for Medicaid solely based on their income. No other categorical requirements were necessary. In theory, this would have been great. Everyone earning between 0% and 400% of the FPL would have some form of affordable insurance, some through Medicaid, and others through Marketplace insurance plans.

In 2012, however, a Supreme Court decision ruled that states would be able to individually decide whether or not to expand Medicaid. In Maine, Governor LePage has vetoed Medicaid expansion six different times (Doyen, 2017). Of the 130,000 uninsured Mainers in 2014, 19% of them fell into the coverage gap because of categorical eligibility constraints (Kaiser Family Foundation, 2014).

There have been some minor improvements for certain populations' eligibility over the past five years. For example, between 2010 and 2016, eligibility for nineteen and twenty year

olds went from 150% to 161% of the FPL. However, this coverage disappears once those individuals turn twenty-one, so the positive effect are relatively short lived.

In short, 2013 began a series of income eligibility changes which have gradually chipped away at the proportion of low income Mainers who are able to access MaineCare. As we move into our discussion of diagnostic eligibility changes, this lack of coverage of non-categorical adults will be important to remember. This next section focuses on reduced resources for individuals who are eligible for MaineCare. So, for each person who loses care because of eligibility criteria, there are many other individuals who are not impacted by these rules because they have not been eligible since 2013 anyway. For the most part, individuals who do not currently fit those eligibility categories lost these resources back in 2014.

Diagnostic Eligibility Changes

Background on Service Specific Eligibility

Most Americans are familiar with the fact that insurance plans have regulations on what services and treatments they will and will not cover for their patients. Plans may specify which practitioners members may see, requiring patients to see “in network” providers. They may limit the number of treatments a patient may have in a given time, such as a limit of twenty-four, 30 minute outpatient counseling sessions a year. Companies may also require a referral from a physician before a patient can see a new type of health care provider. In some cases, insurance plans will simply not cover certain treatments or procedures (eye care often falls into this category). All of these policies and rules are designed as a mechanism for financial management, designed to balance how much money the insurance company receives and distributes per member.

In our discussion of MaineCare funded mental health services, understanding two regulatory mechanisms will be key; reimbursement rates and prior-authorization. Reimbursement rates determine how much insurance companies (MaineCare in this case) will reimburse providers for certain services. Rates can be determined and provided in a number of ways. Many MaineCare mental health services are currently reimbursed through a fee-for-service model. In this model, healthcare providers are reimbursed per patient, per service, at a set rate.

MaineCare's Rate Setting Unit claims that their "goal is to develop rates for services that will be cost effective and affordable as well as meeting the service delivery system's needs" (Division of Audit, 2017). It is not uncommon, however, for there to be incongruity between what providers and insurance companies believe reimbursement rates should be. As we will discuss in detail later, unreasonably low reimbursement rates can make it impossible for agencies to provide certain treatment and can even push certain services out of existence.

While reimbursement rates essentially deal with the administrative end of service provision, prior-authorization regulates treatment coverage on the patient side of things. Prior-authorization is a process many insurance companies use to determine whether certain services are "medically necessary" for certain patients. "Medical necessity" may be determined by a patient's level of functionality, their treatment compliance, and evidence that the treatment has been effective when used previously.

When a provider determines that a patient needs a treatment that requires prior-authorization, the provider submits the pertinent information regarding the patient's diagnosis and treatment plan to a utilization management system. KEPRO is the utilization management system contracted by Maine DHHS for the coordination of behavioral and mental health services. KEPRO compares the information sent by providers to eligibility criteria for the

services requested and makes a determination as to whether the particular services being requested are “medically necessary” for the patient’s condition. KEPRO’s decision determines whether the patient will be able to receive that treatment, thereby approving or denying the patient’s prior-authorization. (KEPRO, 2016)

My repeated use of quotes in the previous two paragraphs is important. As we will discuss shortly, providers and insurance companies often disagree on what exactly makes something medically necessary. I would like to believe that high quality collaboration between practitioners and rate setters could create a system where prior-authorization requirements were truly reflective of medical necessity. However, my research into the current state of prior-authorization in Maine makes me dubious of a system designed to have non-medical personal making, often life-altering decisions about what medical care a patient is eligible to receive.

When I refer to diagnostic eligibility changes, I am referring to recent changes in MaineCare policy which have dramatically restricted the types of mental health diagnoses that will be approved by prior-authorization. Policy changes enacted in March 2016 have shifted prior-authorizations away from determining eligibility based on a level of function (how well someone is able to get on leading a relatively healthy, normal life) to determinations based on a very slim selection of primary diagnoses. Most frustratingly perhaps, these changes have been enacted through claims of medical best practice without any actual evidence provided to service providers or community members to back them up.

Community-based Mental Health Treatment Services

To begin our discussion of these services, we are going to start with quick discussion of everyone’s favorite light read, the MaineCare Benefits Manual, produced by the Maine Department of Health and Human Services. The Benefits Manual outlines all of the services

covered by MaineCare and DHHS as well as all of the policies, rules, and regulations pertaining to those services. The manual is broken down by service, with each service category referred to as a “section”. These “sections” range in topics from hospice services to psychiatric hospital services to STD screening services.

Because this research is primarily based on access to community-based health resources, we are going to be focusing our attention on four sections of the benefits manual: Section 13, Targeted Case Management Services; Section 17, Community Support Services; Section 65, Behavioral Health Services; and Section 92, Behavioral Health Home Services. There are other sections of the Benefits Manual that are directly or tangentially related to the mental illness and other cognitive impairments. These include: Section 18, Home and Community-Based Services for Adults with Brain Injury; Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder; Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations; and Section 46, Psychiatric Hospital Services, among others. My research did not focus on these services and there were no trails which inadvertently led me to them. However, my decision not to focus on these services does not mean that there are not important structural matters related to these programs, their services delivery, their funding, or their relationship to other community and social support services.

Behavioral Health Services, Section 65

Behavioral Health Services, for the most part, are outpatient services and are what most individuals imagine as traditional counseling or therapy. These include individual and group outpatient therapy, intensive outpatient services, family psychoeducational treatment. These services also include resolution and crisis residential services, which are immediate and short

term services used as intervention and stabilization tools for individuals during acute emotional disturbances and psychiatric emergencies. Behavioral Health Services are the lowest tier of mental health treatment and do not include any form of case management. They also do not include medication management for medications other than methadone. (Department of Health and Human Services, Nov. 23, 2016).

Behavioral Health Home Services, Section 92 and Targeted Case Management, Section 13

Behavioral Health Home Services (BHH) is a new, relatively innovative, team-based approach to mental health care. BHH provides integrated care through teams which include a psychiatrist, a psychiatric nurse, a physician, a peer support specialist, a clinical team leader and a few other roles. The service aims to provide individual, family, and community support services, comprehensive care management, and improved continuity of care across providers and treatments. BHH provides a significantly more comprehensive form of care than Behavioral Health Services. The average patient accesses BHH services once per week. Targeted Case Management, Section 13, similarly provides case management and care coordination. However, this section lacks the integrated, team care model that BHH uses. (Department of Health and Human Services, 2014a; Department of Health and Human Services, 2014b).

Community Support Services, Section 17

Community Support Services are the most comprehensive and involved form of community-based mental health treatment. They are commonly referred to as Section 17 rather than Community Support Services, so I am going to use that language here. These services are aimed at helping individuals develop the skills and natural supports that promote an individual's recovery and integration into the community.

Depending on the particular services used, Section 17 treatment may include a range of case management services including coordination with patients' family and other support networks, face-to-face contact with patients' other caregivers and providers, medication management, housing assistance, and career exploration among others. A key difference between BHH and Section 17 services is that BHH patients do not have access to the same resources used to help patients integrate into their community and develop natural support systems that Section 17 patients do. Section 17 services include Assertive Community Treatment and Community Rehabilitative services, which work with patients three days and seven days a week respectively. These services are the most intensive form of outpatient treatments available. (Department of Health and Human Services, 2016a)

In relation to one another, these four services provide a spectrum of community-based treatment options. Behavioral Health Services and Section 17 services lie on opposite ends of the spectrum, with the former providing the least involved forms of treatment and the latter providing the most intensive and comprehensive form of care available outside of a residential program. BHH and Targeted Case Management lie somewhere in the middle, with BHH providing a collaborative form of care that would probably be useful to all patients, regardless of which service they receive.

2016 Changes to MaineCare Covered Services: Section 17

Mental illnesses similarly operate along a spectrum, with some individual's illnesses causing only occasional or short term disruptions and while others create serious and persistent disruptions to an individual's ability to function in everyday life. Logic seems to suggest then, that this spectrum of patients' needs could be mapped on to this spectrum of available services and everyone would be matched with the services that best suit their needs.

I refer to this model as functionality based care. Patients are matched with the level of intensity of care that is best suited to their level of function and independent recovery. We use this model to treat other medical needs all the time. If you develop a minor ankle sprain, someone wraps it in an ACE bandage and you use ice for a while. If it's bad, maybe you end up with a walking boot. Alternatively, if you shatter your ankle, you end up with metal plates, screws, and a lot of physical therapy. It would be ridiculous to treat a minor sprain with a metal plate. It would also be negligent to treat a shattered ankle exclusively with an ACE bandage and ice. Mental health treatment should work the same way.

Unfortunately, this is not how community-based mental health services work in Maine, at least not anymore. On February 29th, 2016, MaineCare recipients currently receiving Section 17 services received a notice from the Department of Health and Human Services that the eligibility criteria for these services would be changing on March 22, 2016 (Nadeau 2017). This letter was in reference to a dramatic change in the prior-authorization requirements that, for many, meant a complete loss in crucial services. Rather than using a functionality based care model to determine eligibility, Section 17 service eligibility now focus most of their eligibility determinations focus on diagnoses. These changes ended up affecting a significant portion of patients receiving intensive treatment. For example, TCMHS's Assertive Community Treatment team had to drop ten patients, or approximately one tenth of the individuals they work with, because they were no longer eligible for the services they had been receiving.

The minutia of who is currently eligible for which services is now relatively complex. However, the specificities of which services are available to whom are important for understanding the mental health crisis that is going on at Androscoggin County Jail. To organize these details, I am going to discuss services in the order of most to least intensive treatment

option. Within this discussion, it is important to remember that Section 17, BHH, Targeted Case Management, and parts of Behavioral Health services require prior-authorization, which means that each patient's diagnostic and treatment information must be submitted to and approved by KEPRO providers prior to the patient receiving the services. As such, official decisions about a patient's eligibility for these services is made by KEPRO.

To preface this section, I should note that while I am not a clinician or a legislator, my understanding of these service provisions comes from a number of conversations with a wide range of individuals connected to the delivery of these services. I have had extensive conversations about the availability of these services with staff at Tri-County Mental Health Services, the Department of Health and Human Services, and KEPRO in addition to reading large portions of the MaineCare benefits manual. I have made my best effort to ensure that I have not made any significant oversights in available services. As a result, I am confident in saying that the treatment gaps I discuss here are significant treatment gaps built into the structure of our current community-based treatment system.

Prior to the change that took place in 2016, Section 17 services were available to individuals with Axis I and II diagnoses (Department of Health and Human Services 2009). Axis I and II diagnoses essentially include any mental illness someone can think of: depression, PTSD, personality disorders, anxiety, schizophrenia, claustrophobia, OCD, eating disorders, kleptomania, bipolar disorders, and the list goes on. To receive these services, patients also had to have a LOCUS score of 17 (Department of Health and Human Services 2009). LOCUS refers to Level of Care Utilization System, which is an instrument developed by the American Association of Community Psychiatrist and used to determine an individual's service needs.

Generally, those with a higher score require more comprehensive or more intensive treatments. (LOCUS 2009)

By no means was this version of Section 17 eligibility all inclusive. Individuals with a primary diagnosis (what their clinician deemed to be their overarching illness) of a substance use disorders, an antisocial personality disorders, or an adjustment disorder were specifically ineligible for these services. As we continue to discuss different community-based services, we will see that the exclusion of these three services is a trend. Neurocognitive and Neurodevelopmental disorders are also excluded, however, they are separately covered under other sections of MaineCare that I will not be addressing here.

Despite these three exclusions, Section 17 services had been available to most who were deemed to need them. With the 2016 changes in place, this is no longer the case. Currently, there are only two ways to access these services. The first way is by having a diagnosis of Schizophrenia or Schizoaffective disorder and a LOCUS score greater than 17. Restricting eligibility to these two diagnoses means that this service went from being available to nearly all possible mental health diagnoses down to only two specific illnesses. (Department of Health and Human Services, 2016). The following is a portion of the Department of Health and Human Service's explanation of the Section changes,

Section 17 services are designed to serve those most in need of intensive support. The Department believes that some of the individuals currently receiving Section 17 services are more appropriately served under other sections of the MaineCare manual, such as Section 65 (Behavioral Health Services), or Section 21 (Home and Community Benefits for Members with Intellectual Disabilities or Autistic

Disorder), Section 29 (Support Services for Adults with Intellectual Disabilities or Autistic Disorder), or Section 92 (Behavioral Health Homes)...

The Department carefully evaluated the need for changes to Section 17 rule and spent nearly a year meeting with a group that included a psychiatrist and other clinicians. The Department spent a great deal of time reviewing and discussing clinical criteria for the appropriate treatment of individuals with severe mental illness and concluded that treating individuals with mild or moderate mental illness (individuals with conditions such as anxiety, mild or moderate depression, and PTSD) with the types of community supports provided in Section 17 is not clinically appropriate and can even be counter indicated. These individuals are better served with counseling and/or medication, and those services are available in Section 65, or through the holistic support provided in the Behavioral Health Home model, Section 92. Individuals with severe and persistent mental illness do benefit from intensive community supports, and they will remain eligible for these Section 17 services. The Department determined that it was in the best interest of the MaineCare population to make these changes to the eligibility criteria. As such, the Department tailored the eligibility criteria to meet the needs of the individuals for whom Section 17, is clinically appropriate. (Nadeau 2016a, p. 3-4)

DHHS states that these services are designed for those “most in need of intensive support”. This certainly applies to some individuals with schizophrenia or schizoaffective disorder. However, it does not apply to everyone with these diagnoses, as many patients are able to manage their illnesses through medication alone. Additionally, many individuals with other

mental illnesses, including the anxiety, depression, and post-traumatic stress disorder may require this intensive support, something which DHHS denies in the above quote. This new rule does not recognize the broad range of coping that is connected to these illnesses. By specifically identifying schizophrenia and schizoaffective disorder as criteria for eligibility, this rule suggests that a diagnosis means more about one's ability to manage their illness or their need for support than their own lived experience does. This delegitimizes the wide range of experiences individuals may have and institutionalized many of the stigmas that exist surrounding mental illness.

DHHS also asserts that Section 17 Services are “not clinically appropriate and can even be counter indicated” for individuals with illnesses such as anxiety, depression, and PTSD. If this is truly the case, few clinicians would argue to continue to provide these treatments. However, I have been unable to find any evidence based research connected to DHHS's claim. TCMHS requested copies of the research DHHS referred to, but never received any materials either. Until some sort of supporting evidence is provided, DHHS's rationale seems questionable at best.

As I said, these new Section 17 rules do include a secondary mechanism for eligibility. The second way that individuals can become eligible for these services is through proof that they will be in crisis (or already are) by not receiving care. Individuals who have just been discharged from a psychiatric hospital or residential mental health facility or who had two or more inpatient mental health treatment stays of greater than 72 hours within the past year automatically qualify. Those who have been committed by a court for psychiatric treatment (institutionalization) do as well. Those with a written opinion from a clinician that can prove that their patient has an imminent threat of homelessness or criminal justice involvement or is at a significant risk of being admitted to inpatient treatment for greater than 72 hours are also eligible.

However, according to representatives from Tri-County Mental Health and KEPRO, it can be very difficult to have this written opinion approved, particularly for individuals who have co-occurring disorders of a Substance Use Disorders and other mental illness. Similar to the previous version of this services, Section 17 services are still not available to individuals with a primary diagnosis of Antisocial Personality Disorder and Substance Use Disorders, even if their provider can demonstrate that these imminent or current crises exist. Providers whose patients suffer from these illnesses are often asked to re-submit authorization requests and are frequently denied altogether.

According to a KEPRO representative, the likelihood of treatment being approved following a clinician's written opinion is heavily dependent on how the provider presents their patient's current and past medical history. Providers must be sure to present co-occurring disorders in a manner that portrays their patient's substance use disorder as a secondary condition to the other mental illness. It must be highlighted that the other mental illness is responsible for the impending crisis, rather than a substance use disorder.

It is often difficult for providers to distinguish whether a substance use disorder is a cause or effect of another mental illness. However, with this current written opinion process, providers are essentially encouraged to claim a specific causal pathway in order to get their patient's treatment approved. Massaging patient health histories is ethically wrong. However, so is denying a patient treatment when they are on the verge of homelessness, hospitalization, or incarceration.

Spending time dancing around the particularities of this system also puts an excessive burden on providers. In addition to providing information about a patient's medical history, they also need to provide any additional information necessary to prove this patient's crisis state.

Particularly for a clinician who is not very knowledgeable about how best to present their patient's case in these applications, providing all of the necessary information in the right way can be exceptionally difficult to do. This is an inefficient use of time as it takes provider's' time away from actually treating patients. In addition to assessing, diagnosing, and treating incredibly complicated and often life-threatening mental illnesses, providers are now tasked with being put documentarians and storytellers for their patients as well.

Towards the beginning of this section, I mentioned that DHHS has created a reactionary model of care. This system is nowhere more evident than in the new eligibility criteria for Section 17. In their quest to provide help to the "neediest and most vulnerable" Mainers, the LePage administration is consequently creating a new group of vulnerable and needy individuals (LePage, 2017). When DHHS changed the policy for Section 17 Service eligibility, they included the sections which provide coverage to those in crisis. This section exists to mitigate the fact that by reducing the diagnostic eligibility, many people will inevitably end up in crisis. When we take away the support structures that help someone stabilize their life, it is only a matter of time until something goes wrong.

Thinking about this structure reminds me of Jenga, the tower game where you keep removing blocks until the tower becomes too unstable and falls down. Usually as it becomes unbalanced, someone compulsively reaches out to grab the tower pieces as they tumble to the ground. Each new cut to these services feels as though we are removing a block from the Jenga tower of mental health. These crisis eligibility stipulations feel like a desperate grasp to stop the tower from falling. Rather than trying to catch individuals who are falling, perhaps DHHS should recognizing that it is their removal of support structures that is leading people into crisis in the first place.

Perhaps the one redeeming quality of this eligibility structure is that, unlike most other services, portions of Section 17 services are available to low income individuals who do not qualify for MaineCare. This is one of a few instances where individuals who fall within the health insurance coverage gap in Maine are able to receive covered care. Community Integration, Assertive Community Treatment, and Daily Living Support Services are three specific programs included under Section 17. Mental Health providers who bill MaineCare for these three services are able to request grant funding to provide these three services to patients ineligible for MaineCare. These individuals must meet the same restrictive diagnostic criteria as MaineCare recipients in order to be eligible. (KEPRO 2016)

When DHHS contacted Section 17 recipients about the upcoming eligibility changes, they mentioned that patients may be able to transition to a Behavioral Health Home if they lost their Section 17 services. For patients of larger agencies that were able to establish BHH programs, this transition would enable a patient to continue to receive case management services, but not necessarily with the same frequency or intensity as they had been.

Because a BHH program requires a certain number of specific providers for each care team, provider availability and cost became prohibitive for agencies serving smaller populations or working in rural areas. For some individuals, finding an accessible BHH program was not an option and these individuals lost their services. For grant funded individuals, transitioning to a BHH was never an option as BHH, unlike parts of Section 17, does not qualify for grant funding. Neither do any other mental health services. This means that grant funded individuals who were deemed newly ineligible for Section 17 services lost all of their mental health treatment. All of it.

Not surprisingly, BHH is also not available to MaineCare eligible individuals with substance use disorders, antisocial personality disorders, or adjustment disorders. Individuals

with these diagnoses are only eligible for Behavioral Health Services. As discussed earlier, this is the least intensive type of mental health treatment available. These services do not include case management, medication management, transportation services, or any form of vocational or socialization services.

While outpatient and group treatments are obviously important services, Section 17 and BHH provide numerous other intensive supports that are vital components of many individuals' ability to recover or maintain a stable life. And despite their claims, DHHS has not provided any evidence to the contrary. For individuals who were dropped from Section 17 services and not able to access BHH, these services simply disappeared. These newly ineligible individuals are now added to the large number of individuals with substance use disorders and antisocial personality disorders, who were never eligible in the first place, no matter what level of crisis they were in.

Proposed Changes

The MaineCare eligibility changes that have been in effect since 2014 have had significant impacts on the accessibility of community-based mental health treatments across the state of Maine. Over 24,000 individuals have lost services and the numbers continue to rise. To the distress of patients, providers, and corrections officers alike, more policies like these are likely on their way. In this section I am going to specifically focus on three sets of proposals that, at the time of writing, are currently at various points of discussion within the state legislature and Commissioners' offices. These sets of proposals are: the Burns rate study changes, Commissioner Mayhew's Medicaid waiver proposal, and the State of Maine's 2018-2019 Biennial Budget Briefing.

In addition to these, there are number of addition proposals also on the docket for the 128th Legislature to discuss. These proposals are all important to the state of mental health treatment in Maine and Androscoggin County. However, in the interest of time, space, and readers' sanity, I will only be focusing on the three proposals mentioned above. I have chosen to discuss these specifically because I feel that they are the proposals most deeply connected to the specific issues that I have been discussing in this research.

The Burns rate study changes are proposed changes to MaineCare reimbursements for Section 17 services, Behavioral Health services, and a few other programs. In many places, if these changes take place, agencies will be forced to discontinue these services because the new reimbursement rates would not be financially sustainable for smaller organizations.

Commissioner Mayhew's Medicaid waiver proposal, would dramatically reshape the current structure of MaineCare, likely ostracizing many individuals from these services. Finally, the 2018-2019 Biennial Budget proposal threatens to cut thousands more from MaineCare and completely remove the general assistance program in Maine.

Burns Rate Study

In 2016, the 127th Maine Legislature passed a bill that required the Maine Department of Health and Human Services to conduct a rate study on the cost and utilization of Section 28 (Children's Habilitative Services) and Section 65 (Behavioral Health) services. DHHS chose to add evaluations of Section 13, Targeted Case Management, and Section 17, Community Integration Services to this study, which it contracted out to Burns & Associates, Inc., a health care consulting firm. This study was followed up by a new rates model, crafted by Burns & Associates based on their findings. These new rates made their way to the floor in the 127th Legislature but voting on them was halted when a moratorium was imposed to provide the

Legislature more time to review the proposed changes before voting. The proposal is back in working sessions at the legislature but is currently facing another moratorium.

The Burns rate model proposes numerous changes to reimbursement rates for a variety of mental health services. These rate changes include a 26.02% drop in reimbursement for Targeted Case Management, a 22.77% drop in the Community Integration component of Section 17, and a 40-44% drop in reimbursement rates for medication management for children and adults. (Tri-County Mental Health Services, 2016; Burns Review, 2017). According to Tri-County Mental Health Services, these rate changes will likely result in hundreds of individuals losing services, because the rates will simply be too low for it to be economically feasible for agencies to continue to provide them. This will be particularly impactful for smaller agencies in rural areas and may cause some to close their doors completely.

There are some rate increases that have been proposed with this legislation. However, these increases are for services that treat a significantly smaller percentage of the patient populations as compared to the services that would experience rate reductions. Furthermore, none of these increases are aimed at bolstering services that can act as alternatives for patients whose services will likely be cut. Most likely, individuals who lose their services will not have anywhere else to go. According to TCMHS, the changes in Community Integration services and Medication Management alone will impact approximately 11,000 individual's (Tri-County Mental Health Services 2016). What may be most concerning about this rate study and proposal is that, according to TCMHS, the study did not take the actual costs of service provision into consideration, hypothetical costs were used instead. Furthermore, changes were not made to the data when the inaccurate cost estimates received pushback from providers.

These rates changes represent yet another attack on community-based mental health services. In keeping with the establishment of the changes I discussed in the previous section, these changes were proposed with unsupported information and seemingly little concern for the impacts that this legislation could have on patients and their communities.

Waiver Proposal

At the same time that the Burns Rates Study was coming back into focus in the Legislature, Commissioner Mary Mayhew, the Commissioner of Maine Health and Human Services, sent a letter to Senator Tom Price (the then nominee - now current) U.S. Secretary of Health and Human Services. This letter outlined a number of MaineCare reforms that Commissioner Mayhew and the LePage administration were intending to pursue (Mayhew, 2017).

According to the Commissioner, these reforms will “help move Maine forward in the best interests of those who truly need to depend on the critical services and supports within the Medicaid program... They are vital to our continued success” (Mayhew, 2017). Exactly who the Commissioner believes “truly need to depend on these critical services” and what “continued success” she is referring to is rather unclear. Upon reading the remainder of the Commissioner's description of these proposed reforms, it is clear that the reforms she is proposing may result in critical services being stripped away from many of the most vulnerable individuals in Maine, such as those with mental illnesses.

Throughout this letter, Mayhew emphasizes that these policies are aimed towards “able-bodied adults”. When I asked Tri-County Mental Health Services what this meant, they were just as confused as I was. What qualifies as able-bodied? Would someone with a functionally impairing mental illness who is otherwise healthy be included in this category? Is this

exclusively based on physical criteria? Is able-bodied specifically a reference to individuals who do not qualify for disability insurance from Social Security?

While I would like to think that the LePage administration is taking a holistic approach to “able-bodiedness”, they do not have a good track record of taking holistic approaches to mental illness. TCMHS said they had previously asked for clarification from the Commissioner's office on this point, but had not received a response. Because of this lack of clarity, TCMHS and I have interpreted this letter with suspicion and concern. Hopefully we will find that our fears were unnecessary. Until that happens however, I will be interpreting these reforms from the cautious perspective that “able-bodied” refers to all individuals who do not qualify for disability insurance through the state.

These reforms intend to impose a number of restrictions on “able-bodied” individuals. For example, the letter proposes a work or education requirement for “able-bodied” adults on Medicaid. It also seeks to impose a five year, lifetime limit on MaineCare eligibility for these individuals. Let me say that again... a *lifetime* limit. Additionally, these reforms intend to put more stringent requirements on the covered use of non-emergency transportation (NET) services such as LogistiCare, which currently provides free transportation for all MaineCare recipients. This includes making “able-bodied” adults ineligible for NET services.

The commissioner explains that this changes is intended for members to make better use of other available low cost transportation services, such as public transportation and “natural supports” (rides from family, friends, and community members). While this is a nice idea in theory, for individuals who are struggling to manage illness such as severe and disabling anxiety and who have few strong social ties, public transportations and “natural supports” may not be feasible options. If a patient such as this had previously been relying on LogistiCare to get to

their psychiatry appointments, it is fairly likely that these patients will not be able to get to there. Personally, I would not have been able to get to a doctor's appointment on public transportation while I had my concussion. For many individuals, a mental illness is equally, if not more debilitating and public transportation is not a feasible option.

The reforms also propose a change in MaineCare's missed appointment policy. In the letter, the Commissioner explained that they are hoping to require MaineCare members to pay a fee for missed appointments. Even if these fees are small, for individuals who are living on a limited income, these fees may be a significant amount of money. The policy also suggests the implementation of premiums, which will present the same (if not more substantial) issue.

Finally, the Commissioner is looking to end retroactive coverage of MaineCare services. MaineCare can currently be backdated to cover required services that were received prior to MaineCare enrollment (or reactivation in the case of some patients released from ACJ). Backdating plays a very important role in ensuring that patients from Androscoggin County Jail are able to receive care immediately upon release. Because it may take days, weeks, or months for released patients to enroll in or reactivate MaineCare, retroactive coverage is a key way to ensure that they can receive care. Backdating is also used to reimburse agencies like TCMHS services for Section 17 services, like Assertive Community Treatments, that were initially covered by grant funds. When grant funded patients are enrolled in MaineCare, their services can be retroactively covered by MaineCare, freeing up those grant funds to be used to treat other patients. Just like with the rest of these reforms, TCMHS has not been able to receive clarification on whether any sort of exemptions will be made to mitigate the impact of this change.

It would be wonderful to find out that TCMHS and myself have misinterpreted these proposed reforms. If we have not however, these changes are unlikely to ensure the state's continued success and lead "Maine back from the brink" and as Mayhew claims in her letter. If anything, I believe it has a higher likelihood of leading individuals (particularly those who have been released from ACJ with a mental illness and have to wait ninety-days for their MaineCare to activate) towards any number of "brinks" rather than away from them.

2018-2019 Maine State Budget Proposal

In keeping with the themes present in Commissioner Mayhew's letter, the 2018-2019 budget proposal is aimed at providing for the "neediest and most vulnerable individuals", as I reference earlier in this chapter. This phrasing appears in LePage's budget proposal as well as in the explanation that DHHS provided to explain the Section 17 Changes (LePage, 2017; Nadeau, 2016). In his budget proposal, LePage identifies these individuals as children, parents, the elderly and the disabled. In administrative terms, disabilities refer to those disabilities that Social Security deems to be qualifying for disability benefits.

Those not included in LePage's definition of "needy and vulnerable" are individuals with mental illnesses, the criminally involved, refugees, and asylum seekers; all individuals who are identified through sociological standards as being vulnerable populations because they are most susceptible to being impacted by the inequitable nature of our social structures. Starting with this linguistic variation on the concept of "the worthy poor", there are many concerning components of this budget. However, I am going to stick to just those that seem especially relevant to the provision of community-based mental health services (although all of them are related to mental health in some direct or indirect way).

First, this budget plans intends to cut nearly \$140 million from the DHHS budget. A large portion of these saving are based on lowering the MaineCare eligibility criteria for “able-bodied” parents (there’s that phrase again). Under this proposal, only those parents who make 40% or less of the FPL will be eligible for MaineCare. The current eligibility criteria for this population is 105%. Maine Equal Justice Partners estimate that 20,000 parents will lose their health insurance through this budget proposal (2017). And, as I have mentioned earlier, the loss of health insurance can have incredibly large impacts on the wellbeing of children (and other individuals) who are dependents of those individuals that would will lose their coverage. The budget also proposes cutting eligibility for nineteen and twenty year olds entirely (LePage, 2017). This will impact approximately 5,800 individuals.

Additionally, these reforms include a reduction in Temporary Assistance for Needy Families (TANF), time limits, and the elimination of the state’s General Assistance program all together. It is important to note that while these policies have significant ramifications for individuals with mental illness, they are also likely to have a large detrimental impact on all of the individuals who rely on these services to survive.

Summary of Findings

The purpose of this chapter was to discuss recent and proposed MaineCare policy changes of particular importance to the relationship between community-based mental health services in Androscoggin County and the state of mental illness at Androscoggin County Jail. While understanding the nuances of these systems is important for eventually designing reforms and implementing meaningful changes, it is only as valuable as our ability to step back and see the bigger picture. Below I have included a list of the main takeaways from this chapter. I will

return to these points in Chapter 7 when I use them to contextualize the medical data I collected from the jail.

- 24,500 individuals lost MaineCare between 2013 and 2014. Another 28,500 individuals (parents and nineteen and twenty year-olds) could lose coverage if the current 2018-2019 budget proposal is passed.
- Section 17 eligibility criteria limit intensive mental health treatment to a very specific group of individuals: those with diagnoses of schizophrenia and schizoaffective disorder and those with recent hospitalizations or institutionalizations.
- Written exceptions for Section 17 services are difficult to come by because substance use disorders and antisocial personalities are not eligible for these services.
- MaineCare recipients who lost Section 17 services *may* have been able to transition to BHH services however:
 - These services are not as intensive as Section 17 services and may not be accessible through smaller or rural agencies.
- Grant recipients who lost their Section 17 service eligibility lost all forms of mental health treatment because grant funding is only available for Section 17 services.
- The Burns rate model threatens to reduce reimbursements enough that agencies will have to stop providing these services (with few comparable available alternatives) or close altogether, causing more individuals to lose services.
- Proposed MaineCare reforms will put a substantial financial burden on MaineCare recipients (missed appointment fees and premiums) and will create obstacles to care (time limits, more stringent limitations on NET services, and ending retroactive coverage).
- The 2018-2019 Budget proposal, if passed, will cut approximately \$140 million in programs that provide vital services to vulnerable populations throughout Maine.

Chapter 5: Jail Care

*“We joke about the word ‘corrections’. Nothing is being corrected here, we’re babysitters.”
A Staff Member from the ACJ’s Maintenance Department*

Many nonprofit organizations and social service agencies talk about the goal of working themselves out of a job. The idea is that their work aims to address social problems so that someday their services are only needed minimally, if at all. In theory, the term “corrections” could imply this sort of work. It could imply that criminal justice aims to address harmful behavior, ultimately aiming to reduce rates of violence and the “need” for incarceration at all.

Realistically, the structure of the criminal justice system in the United State is about the farthest thing from this idyllic world. It is no secret that the U.S. justice system is based on a punitive and isolation based understanding of harm response, rather than one based on development and growth. The slow implementation of restorative justice responses, diversion programs, drug and mental health courts, and community reintegration services across the country suggest that a possibility for alternatives exist. However, as of now, these programs are the exception, not the rule.

The quote at the beginning of this chapter refers to jails as babysitters. I heard variations on this sentiment expressed by a number of different people at Androscoggin County Jail over the course of my research there. While I understand their sentiment, I think this is too forgiving of our criminal justice system. I think that this fails to recognize that the nature of incarceration in the U.S. does very real harm to individuals and communities. If they are babysitters, they are ones that punish rather than heal or teach. These babysitters trap individuals in cycles of poverty, homelessness, and substance use and create environments that exacerbate mental illnesses. And despite all of this, we seem to keep hiring them.

Unfortunately, incarceration is not going away anytime soon. However, a system which resembles actual “corrections” may be a lot closer than we think and presents realistic opportunities for those involved in the criminal justice system to help lessen the negative impact this system is having.

Like Chapter 4, this chapter focuses on the systems that bear particular importance to the relationship between community-based mental health services in Androscoggin County and the state of mental illness at Androscoggin County Jail. However, instead of focusing on state level policies, this chapter take a more local perspective. It focuses specifically on the policies and procedures that operate within Androscoggin County Jail (ACJ). This chapter also looks at some of the systems operating between the jail and partner agencies, which include Tri-County Mental Health Services, Riverview Psychiatric Center, the local office of the Department of Health and Human Services, and local emergency departments. Like the previous MaineCare chapter, I use the systems discussed here to contextualize the data that was gathered from my analysis of medical files at ACJ

Because this research aims to create a *usable* knowledge base for addressing the mental health epidemic at ACJ, I have tried to focus this chapter on those factors which seem to have both a large contribution to mental illness crisis and present reasonable potential for change. With that, I have specifically chosen not to focus on more theoretical factors that, while undeniably important, would require a difficult culture shift within at least the jail and the community, if not across state and the country. These factors include things such as the investigating the purpose of incarceration, the structure of relationships between corrections officers and patients and the negative power dynamics these create, the implications of the of

constant surveillance and the revocation of autonomy. While I am not discussing these factors here, some of them do make a brief appearance in the Recommendations section of Chapter 7.

In addition to these theoretical factors, there are a few more concrete issues that also have not made their way into this chapter. These topics include patients' limited access to educational programs, recreation time, and positive spaces with trees and other things that are not made of cement walls. Another is the relationship between mental illness and the tools used to determine patients' security levels (referred to as 'inmate classification systems'). I hypothesize that these tools may be designed in a way that correlates factors resulting from mental illness as risk factors of violent, disruptive, or deviant behavior, leading to more individuals with mental illnesses ending up in with higher security levels (and less autonomy and social interaction) as a result. Because I did not have a much exposure or involvement with either recreation or the patient classification system at ACJ, I do not feel that I have enough knowledge to make any substantiated arguments about either of these topics and will not be delving into them further in this thesis.

Through my conversations with health providers, corrections officers, and jail administrators as well as my own observations, five specific elements have stuck out to me as the most salient factors pertaining to the purpose of this research. These are: budget limitations, the structure of the medical team, access to discharge services, work programs, and connections to outside services.

Budget Limitations

Before reading this, section, I want readers to understand that this is not meant to be an exhaustive explanation of budgetary changes at ACJ or within the Maine State Correctional

System. That could easily take up a chapter unto itself, if not an entire thesis. Instead, this section is meant to be a small window into the budgetary barriers that are preventing Androscoggin County Jail from improving the services they are able to.

Police killings, mass incarceration, the injustices of for profit prisons: the list of horrors inflicted by our criminal justice system go on and on and only seem to be gaining national attention. And, because we find these problems so distressing, it often can be easy to jump to a place of blame, even when it is not justified. It is very important to me that readers understand how desperately every person that I spoke with at ACJ wished that their jail had the means to be doing better. Obviously no one is perfect and there are surely personal efforts the staff members at ACJ could be making to improve the state of things. However, that is true for those of us who do not work at ACJ either. My hope with this section is that readers come away understanding that most of the problems present at ACJ are not there because the staff at ACJ do not care. They are there because, like just like the patients, staff have been limited by policies and procedures; stuck between a rock and a hard place. Hopefully this small glimpse into the effects of Board of Corrections and current funding models helps to make that point clear.

In 2008, the Maine state legislature voted to establish a State Board of Corrections (BOC), which was tasked with the primary responsibility of overseeing correctional operations across the state. By 2014, the BOC was implemented as a mechanism for managing fiscal responsibility in corrections facilities statewide. (Maine Department of Corrections, 2017). This “management” mechanism included pooling and redistributing all of the money use for county facilities across the state. In essence, the BOC took jail management out of the hands of individual counties.

From conversations I had with various jail administrators, these funding changes left many local jails in the lurch. Those that were already underfunded, like Androscoggin County Jail, found their budgets shrinking even more. These cuts forced ACJ to reallocate money from programs such as public works, education, and treatment to cover other non-negotiable costs. For a wide range of reasons that are outside of the scope of this thesis, the BOC was disbanded in 2015 and county jails were put back under the exclusive financial control of individual counties. As often happens with negotiations, agreements were made. While jails were returned to county control, ACJ and other jails ended up with budgets lower than what they had prior to and during BOC operation. Since then, ACJ has been struggling to operate under a significant budget deficit. Jail administrators estimate that it will take at least ten years to make up for the money lost as a result of these changes.

The lowered budgets initiated by the BOC have been further exacerbated by recent revenue lost at the jail. ACJ receives money from the state government for every bed that is filled each night someone stays at ACJ. In other words, if someone is at ACJ for ten days, ACJ receives ten “bed days” worth of funds for that individual. In recent years, ACJ has made a concerted effort to implement programming that would help reduce recidivism rates within their population. Impressively, ACJ has managed to reduce their headcount over the past few years.

While reducing headcounts is wonderful on a number of levels, it has had a negative budgetary impact on ACJ. Because of this “bed day” funding model, every person who is not incarcerated is a unit of revenue that the jail does not receive. While a lower head count may mean that the jail has to provide a few less lunches and rolls of toilet paper, it does not have much impact on overhead costs. Reduced numbers do not change how much money is needed to

heat or light the facility. It also does not enable the jail to close entire units and so it has little effect on staffing numbers.

As a following section on the medical team will show, the services ACJ is currently able to provide are meager. However, nearly every time I have had a conversation at the jail about improving mental health services, the problem of budget limitations has come up. While the corrections officers and jail administrators would like to provide any number of services that would improve the wellbeing of the individuals they work with, the jail is barely getting by as it is. And in cases like this, programs are only as valuable as they are financially sustainable. As I will reiterate in Chapter 7, as Androscoggin County and the agencies within it think towards reforming these system, it is important to be thoughtful about the best ways to navigate the financial limitations of the agencies impacted by these changes.

Electronic Medical Records

While ACJ does use an electronic booking systems, they still rely on paper medical records. In Chapter 3, I gave a detailed discussion about how the use of paper medical records impacted my data collection process. This section expands on those limitations, focuses on the limitations that paper medical records put on patient care by making it difficult to maintain comprehensive health histories. By the nature of using paper files, patients' records are occasionally misplaced. Some are accidentally tucked into someone else's file or put away in the wrong cabinet. When this happens, the medical team has to create a new file if the patient returns to ACJ. For a relatively healthy patient, this might not be a problem. Even for a very ill patient, it is probably not a large concern as long as medical staff stay at ACJ long enough that there is institutional knowledge of this patient's health history (although, obviously that is not a guarantee).

For other patients however, those with mental illnesses that are significant but not impactful enough that they lead to erratic behavior or severe suicidality or something else memorable, this may present more of a problem. Particularly for these patients who are booked frequently but never stay very long, it is already difficult to establish any clear picture of the patient's health. When those files go missing, this becomes even more difficult. In situations such as this, it is less likely that the health team will be able to identify patterns that may be indicative of underlying issues.

For example, if a patient ends up with a mental health referral because of "racing thoughts" within a week of each of their five most recent bookings, perhaps they would benefit from accessing a mental health provider when they are released. When a file goes missing (or even is just a complicated collection of somewhat illegible handwriting), it can be difficult to make those connections. Electronic medical records help to alleviate these problems by ensuring that files do not go missing, are legible, and are consistently filled out (it was not unusual for questions to be left unanswered in medical and mental health screenings). An electronic file system should also allow providers to read through files in a more organized, efficient manner, making it easier for them to look for and identify health histories that would raise red flags.

At the end of each year, files from the previous year are removed from the medical office and relocated to the archives room. This room is separate from the jail and files in it are really never accessed by the medical staff. For some patients who are at ACJ frequently enough, their files are added to one another and kept in the medical office over time. This is not always the case, however, and it is not unusual for a patient's past medical files to be tucked away in the archives, never to be looked at again, even if they do recidivate. For individuals with low health literacy, conveying important components of their health history may not come naturally, and

important information may not be provided to the medical team. Electronic records ensure that patients' records are kept together in a usable format, rather than locked away in different obscure parts of an adjacent building.

When I talked to one jail employee about how I see the paper medical records as a poorly designed system, he explained that the majority of the medical care provided at the jail is reactionary care. His perception was that medical services at the jail are not currently designed to consider or evaluate someone's overall health history or to take a holistic view of a patient's wellbeing, so comprehensive past records are not as important. Instead, the records system is designed so that medical staff can respond to things that are problems now, particularly those that might become serious problems for the patient, other patients, or the jail staff. Seeing how low the jail is on funding sources, it is not shocking that the system is working this way. Interestingly enough, this reactionary system is not very different from the very reactionary and crisis-based system that MaineCare currently operates through. Fittingly, it is this MaineCare system (and its failure to provide accessible coverage) that leads many of these patients to the jail in the first place.

Medical and Mental Health Services

As I explained, the medical services that ACJ is able to provide are highly contingent on the budget they have to work with. Budget changes associated with the Board of Corrections, in combinations with increases in wages and the cost of employee health insurance among other things, have required ACJ to reallocate some of their medical spending towards other areas.

The medical team is coordinated by a health services administrator who works 40 hours a week Monday through Fridays. At the beginning of my time at ACJ, this position was filled by a registered nurse (RN). By the end of this research process, the RN had left and ACJ was looking

for someone new to fill the position. In addition to the RN there are two or three licensed practice nurses (LPN) and one or two medical technicians who work various shifts to provide seven days' worth of daytime coverage. Prior to the BOC changes, ACJ had been able to pay for enough staffing to provide coverage until midnight, providing about sixteen hours of coverage per day. Sixteen hours enabled the medical staff to provide three medical rounds (times when the LPNs or medical technicians distribute prescription medications to patients who take them) throughout the day. Now, budget changes have limited the staff to approximately twelve hours of coverage, which only allows them to provide two medical rounds. While the medical team is able to make "things work", not being able to provide three medication rounds potentially means that patient treatment is being modified to accommodate budgetary needs, rather than the other way around.

In addition to these staff members, there is a nurse practitioner or physician's assistant (depending on who is currently under contract) who comes in for five hours, twice a week for "sick call". During sick call, this provider sees any patients who needs to be seen because of an injury or illness. In addition, all patient are required to have a physical within fourteen days of incarceration. Since the average stay at ACJ is less than two days, there are generally not huge numbers of individuals needing these physicals each week. However, ten total hours is not very much time for seeing every sick patient and conducting physicals.

At night, when there are no medical staff on call, ACJ relies on the first aid training of its corrections officers and the discretion of the RN over the phone in determining whether a patient needs to be taken to a hospital. Medical services at ACJ are run by a for profit company, Correctional Health Partners (CHP). CHP runs medical services at a number of other correctional facilities in Maine. Overall, jail administrators seemed to hold a fairly positive opinion of CHP.

CHP does have physicians on call for questions that the RN cannot answer. However, CHP is based out of Colorado and so their on-call physicians will mostly likely never had any in-person interactions with the patients that they could be making care recommendations for. Again, this is an option that makes the budget limitations work, but in many ways is a compromise on quality of care.

In addition to the medical staff mentioned above, ACJ has two Licensed Clinical Social Workers (LCSWs) who each work part time at ACJ on weekdays. There is also a psychiatric nurse practitioner on contract with the jail who is able to prescribe psychiatric medications to patients. However, the nurse practitioner is only able to provide up to two hours of services at the jail each week. LCSWs have a master's degree in social work and are qualified to provide various forms of counseling to patients. However, according to jail administrators, the LCSWs provide more of a triage and screening role at ACJ. Their time is primarily spent evaluating individuals who are on suicide watch and referring patients to the psychiatric NP. While the LCSWs do make an effort to provide stabilizing support when possible, they do not really have the capacity to actually provide any sort of counseling or treatment to patients, despite being trained to do so. These limitations include an inability to provide any sort of substance use treatment.

Patients who are suffering from substance use disorders are limited to two sources of "support" at ACJ. Those who are withdrawing from alcohol or drug use are put on medical watch and provided medications to ensure a safe detoxification process. There are also Alcoholics Anonymous and Narcotics Anonymous groups that patients are able to attend. Besides these two services, however, there are no forms of durable substance use treatment at ACJ.

As I have already mentioned, many of the obstacles that patients experience at ACJ (such as a lack of mental health treatment options) are consequences of circumstances rather than intention. The barriers to care are not simply a result of a lack of want or a lack of thought, but are the results of funding limitations that are outside of ACJ's control.

Work Programs

ACJ currently has opportunities for certain patients to participate in work programs, primarily within the jail, but outside of the jail as well. Work programs within the jail include work in the laundry, kitchen, and janitorial services. Participation in work program is available to individuals who are not fugitives and are not sentenced for or pending sentencing for class A or B crimes. ACJ also has a limited public works projects and work release programs that is available to sentenced, minimum security patients with no violent, class A or B history. There are about 5 to 10 individuals participating in this program at ACJ at any time, depending on what jobs are currently available.

While conducting my research, I asked various jail staff what changes they thought would make the most difference in providing positive support to patients at ACJ. Multiple people mentioned that increasing access to work programs would have a significant effect. However, they noted, this is not currently possible because of budget and personnel limitations.

As mentioned above, individuals are precluded from participating in public works program if they have a violent charge history or are not housed in minimum security. Data from national research and that I collected from medical files at ACJ shows that individuals with mental illnesses are more likely to have a violent charge (James 2006, p. 7). Furthermore, when patients' are classified at booking, those with violent charges are put on higher levels of security classifications.

This suggests that individuals with mental illness are less likely to be able to access public works projects or work release programs because violent offenses and higher security lives are more likely to make them ineligible. Consequently, individuals with mental illness are less likely to be involved in these programs that could give them a sense of motivation and purpose while they are incarcerated. Because such a large percentage of patients within correctional facilities have a mental illness (see Chapter 6), the proportion of individuals who may ultimately be ineligible for participation in public works projects or work release is likely to be disproportionately large.

Discharge Services

Forensic Intensive Case Managers (ICMs) work with incarcerated and released individuals who have substance use disorders and severe mental illness. According to the Department of Health and Human Services, “an ICM helps a person return to his community by working with them... to identify needed services and entitlements, such as health care, psychiatry and medication management, counseling for mental illness and/or substance abuse, applying for Social Security Income, MaineCare, Food Stamps, housing subsidies and vocational supports” (Maine Substance Abuse and Mental Health Services, 2015). Some may refer to the work of Forensic ICMs as “discharge services” because their core role is helping patients navigate the transition between incarceration and reintegration into communities.

From my own observations and conversations with jail staff and administrators, the Forensic ICM who works at ACJ is one of the most important resources available to patients there. Patients can be referred to the ICM through any number of ways, including through the medical and mental health providers, corrections officers, and family members. The ICM at ACJ currently works with anywhere between thirty and sixty-six individuals at a time, which is

approximately one-fifth to one-third of the patients at ACJ. Currently, the singular ICM working at ACJ coordinates all of the substantive elements of discharge support at ACJ.

As anyone who has ever had to call any sort of state office can attest, making calls to agencies such as the Office of Social Security and the Department of Health and Human Services is usually not a simple or straight forward process. These hurdles are amplified for individuals who have just been released, are also trying to find housing, and are managing a mental illness. Barriers to accessing these types of services are fairly common for formerly incarcerated individuals and place a heavy burden on the ICM who helps facilitate access to these resources. For example, to help someone reactive their MaineCare, the ICM must first escort them to the Social Security Office and then assist them in calling MaineCare, a process which could take a few hours. These few hours are time that the ICM is not spending working with other patients.

Approximately two years ago, two ICMs worked at ACJ. One position was cut by DHHS, leaving behind one ICM with an additional individual who would do administrative work once per week. This has since dwindled down to a single ICM working at ACJ. In the past, the ICM had been able to compare current patients with a list of MaineCare beneficiaries to identify individuals who would need assistance in reactivating MaineCare. However, as the gradual reduction in the number of ICMs working with ACJ has diminished and the responsibilities on the singular ICM have grown, it is difficult for the ICM to have any time to look at these types of lists. Instead, the ICM must hope that the individuals who need a case manager are referred. Additionally, because the average stay at ACJ is so short and because the ICM can only work with so many patients at one time, there is no guarantee that the ICM will be able to work with everyone who needs their assistance.

Having access to health care, particularly mental health treatment, is incredibly important for recently released individuals. Researchers have found that risk of death, particularly from a drug overdose, suicide, or homicide is greatly elevated for individuals in the two weeks following release (Binswanger, 2007).

I have personally worked in a setting where I have been tasked with assisting clients with accessing Medicaid or other subsidized insurance. As a well-educated, health literate employee working in an office filled with trained professionals, I struggled. I cannot imagine how someone dealing with the stressors of reintegration in addition to a mental illness could manage to do this without the assistance of an intensive case manager.

Based on the number of individuals the current ICM works with, the number of services the ICM provides, and the time consuming nature of those services, increasing access to ICM services, rather than cutting them would be of incredible value to the individuals at ACJ. By helping individuals remain stable, housed, and employed after release, (and through that working to reduce recidivism), ICMs offer an important cost reduction service for the state. However, similar to other prevention services, ICMs seems to be viewed as a financial burden rather than a vital and underfunded benefit to the state.

Outside Services

A prominent theme throughout my research has been the lack of communication and service integration throughout care provision between ACJ, local hospitals, and mental health agencies. This limits providers' ability to ensure that patients are receiving high quality, continuous care between hospitalization, incarceration, and release. While the issues within this system are numerous, I am going to specifically focus on four that seem to be especially important shortcomings within this system. They are: the discharge and referral process from

local emergency departments, the lack of a forensic ACT team, poor coordination between with the current ACT team and the jail, and long wait times for admission to inpatient psychiatric care.

Local Emergency Departments

Individuals who are suicidal or homicidal when arrested are refused from ACJ and sent to a local hospital emergency department for evaluation. When the emergency department deems that the patient is stable enough to be released to the jail, they are generally released with two things: a referral to Tri-County Mental Health or their Assertive Community Treatment team and an educational information sheet related to their mental health. I will discuss the problems with these referrals in the next section. Here I will focus on the informational sheets the hospitals are providing.

Generally, the same information sheets are given out to patients with the same diagnoses. This is problematic because the environment that emergency patients will be released to are very different, even for patients suffering from the same illness. For example, patients at ACJ who have depression are provided the same information sheet that is given local college student with depression. The fact that the latter is being released to their families, friends, and a very supportive college environment, while the other is released to a cell, seems striking.

These packets encourage patients to find ways to reduce stress by doing things like spending time outside, doing things that make them happy, etc. Advice like this seems oblivious to the fact these patients are being taken directly from the hospital to a correctional facility where “doing things that make them happy” is mostly likely going to be rather difficult to achieve. Furthermore, these forms do not seem to take into consideration the potential mental health ramifications that the environment of a correctional facility often produced. Overall, these

information sheets seem to be fairly insensitive to the unique situations of their incarcerated patients.

Coordination with ACT

While patients are usually released to ACJ with a referral form to TCMHS and their ACT team, my conversations with TCMHS staff suggest that there are number of barriers to patients actually becoming connected to these services. When a patient is referred to the ACT team, it may be impossible to connect with them for a number of reasons. Currently, the ACT team does not have the ability to send a provider to ACJ at a moment's notice. As a result, a patient may make bail and be released before the ACT team is able to connect with them. Particularly for patients who are homeless, sending ACT team members out to hunt for patients after they are released is not a particularly safe or effective use of the ACT team's time.

For those individuals that the ACT team is able to contact, recent eligibility changes in Section 17 Services have placed dramatic new limitations on who can qualify for ACT services. New diagnostic criteria has made it increasingly difficult for providers to successfully refer new patients to the ACT team. Tri-County Mental Health Services' ACT team has recently noticed a decrease in ACT referrals from probation officers and other sources. They believe this may be a result of having to turn so many of their referrals away because they are not eligible for these services. Chapter 4 provides more information about these new policies.

While referrals often mean that the ACT team learns about a patient they cannot help, the opposite case is also a regular occurrence. Patients of the ACT team regularly end up hospitalized or incarcerated without their case managers every being aware. Seeing as the case manager's role is to help their clients navigate these situations and the resources that are

available to them, it is very important that the case manager finds out when their patients have been institutionalized.

Currently, there are no mechanisms in place for the ACT team to find out that one of their patient's has been arrested. While the pre-booking screening asks patients if they have a history of mental health treatment, no one is specifically asked whether they are working with a mental health case manager. For any number of reasons, including a lack of privacy, intoxication, and not realizing they could connect with their case manager, many incarcerated individuals are not independently self-reporting that they work with someone in this capacity. And, while the ACT team can call to ask whether their patient is at the jail, privacy laws prevent them from doing much more than that. As a result, connecting to an ACT team is heavily reliant on the mental health team and the ICM making direct referrals to the ACT team. The ACT team faces similar barriers to finding out that their patients have been hospitalized.

Forensic ACT Team

Tri-County Mental Health Services's ACT team does not currently have any form of specialized treatment teams. When I met with their director, he specifically mentioned that the ability to have a specialized forensic ACT could help to address many of the current barriers he sees in the provision of Assertive Community Treatment to patients at ACJ. *Forensic* is the clinical word used to identify individuals and services associated with incarceration. As the ACT director explained, this would be a team that could combine assertive community treatment with intensive outpatient programs for individuals with dual diagnoses of substance use disorder and other mental illnesses.

A team such as this could help take loads off of local crisis intervention teams because the forensic team could respond to their own patients in crisis situations, eliminating some of the

burden on these other resources. Because of limits on reimbursement and the subsequent low referral rates, the ACT providers have been unable to treat enough forensic patients to demonstrate the potential value of a specialized forensic act team.

Admission to Psychiatric Hospitals

Because this thesis is focused on community-based resources, I am not going to discuss much more than the specific commentary I heard about the process of being referred and admitted to a local psychiatric hospital. The history and current state of psychiatric hospitals in Maine is long and complicated and outside of the scope of this resources. However, I encourage readers to look into this history on their own as it is are connected to the overall state of mental health treatment across the state.

According to providers and administrators at ACJ, successfully transferring patients from ACJ to these psychiatric hospitals is incredibly difficult. According to these hospitals, there are not enough inpatient forensic beds to accommodate all of the patients who need one. As a result, patients are often forced to wait for a bed to become available. I have heard reports of patients waiting at ACJ for up to nine months before a space becomes available for them.

Since inpatient treatment is a level of intensive treatment beyond that provided by any outpatient program, those patients being sent to psychiatric hospitals are those in the most critical need of care. Instead of receiving it however, they often end up waiting at ACJ where they have exceptionally limited access to mental health treatment. While individuals are waiting at ACJ, it is not uncommon for their mental illnesses to become so disruptive or dangerous to themselves, other patients, and corrections officers that these patients have to be moved to maximum security. Waiting at ACJ without treatment, particularly in a harsh and isolating environment like maximum is unlikely to do anything other than worsen the patient's mental illness.

Some individuals who have the option to receive inpatient treatment at one of these facilities as a part of their sentence end up rejecting this offer for a plea bargain because spending so much time incarcerated at ACJ while they wait for a forensic bed offsets the beneficial prospects of receiving treatment.

I have heard from multiple sources that it is likely insufficient forensic staffing that is partially responsible for the forensic bed shortage. ACJ itself has a difficult time finding providers who are interested (and capable) of working in a correctional setting. It would make sense for these psychiatric hospitals to be experiencing similar problems.

Summary of Findings

As I mentioned at the outset of this chapter, this is not an exhaustive list of all of the policies, procedures, and structures that shape the mental health treatment system at Androscoggin County Jail. Of those factors that were not included here, some were outside of the theoretical scope of this research, while time constraints prevented me from fully investigating others. Some, factors have simply never made their way into my consciousness, and as a result, have not made their way into this paper. However, those that are included play an important role in our ability to understand the nature of mental illness at ACJ.

In addition to illuminating systems that I will later use to contextualize the data I gathered from medical files, I hope that this chapter helps to set the stage for further conversations about the relationship between jail policies and practices and mental health. Ideally, this chapter can act as an example of the types of systems that need to be examined in order to gather enough information to implement meaningful reforms. It is not enough that we know that there is a global mental health problem at ACJ, we need to understand how it got there and what is keeping

it going. Similar to Chapter 4, below is a list of overarching takeaways of my investigation into these systems.

- ACJ's budget shortfalls dramatically limit the jail's ability to provide mental health treatment services or other programs that would have a positive impact on mental health.
- ACJ is working within a budgetary structure that financially punishes the jail for efforts that reduce incarceration rates.
- Paper medical records make it difficult to maintain comprehensive health records, potentially limiting providers' abilities to identify health patterns in individual patients and across the patients they work with.
- Budget limitations prevent ACJ from providing full time access to medical and mental health providers, making it difficult for patients to access elevated levels of care (physicians).
- Staffing limitations drive the focus of health care at ACJ towards reactionary, rather than preventative care.
- Patients with mental illnesses may be less able to access work programs that provide positive interaction, autonomy, and skill development because they are more likely to have a violent offense and to be housed at a higher security level.
- The Forensic Intensive Case Manager (ICM) provides incredibly important support services to patients as they are released from ACJ and reintegrate into their communities.
- The ICM is limited in the services they are able to provide by nature of being the only person providing these services within ACJ and because of structural barriers within the services the ICM is helping patients access.
- Effective systems that ensure that patients receive high quality, personalized, continuous care between hospitalizations, incarceration, and released do not exist.
- Systems to ensure that patients are connected to current or new case managers during hospitalization, incarceration, and release are not present.
- Current ACT teams are limited in their ability to provide effective care because of policy limitations and their lack of having a specialized forensic unit.
- Long wait times for access to forensic beds leaves patients waiting at ACJ with minimal mental health treatment, potentially allowing their symptoms to worsen.

Chapter 6: Results from the Analysis of Medical Files

“They’re not trying to live off the system, they don’t know how not to.”
Administrator at Androscoggin County Jail

One of the barriers to reforming the community-based mental health system is the lack of concrete data about what mental illness at Androscoggin County Jail actually looks like. By having reliable data, reform efforts can be shaped to maximize impact and can be used to monitor the effects of new policies and programs. In this vein, this chapter answers my second research question: What are the prevalence rates of substance use disorders and other mental illnesses at the jail and what other factors are these rates correlated to?

To answer this question, I analyzed data from a sample of medical files from Androscoggin County Jail. These files represented 636 unique patients and included 1,154 bookings from January 1st, 2013 to January 27, 2017. Because I analyzed entire files rather than individual bookings, the number of bookings in the sample from each year varied. The sample included 204 files from 2013, 336 from 2014, 326 from 2015, 270 from 2016, and 18 from January, 2017. The average number of bookings per patient was 1.68 within the sample period, with 16 bookings being the maximum.

In terms of racial demographics, 593 (86.4%) of the individuals included in the sample were identified as white in their pre-booking screening, 93 individual (13.6%) were people of color. During the booking process, corrections officers record patients’ races and ethnicities based on a predetermined list of identities that include White, Black, Asian, Indian, and a few others. Sometimes corrections officers ask patients what their race and ethnicity are, other times the officer just writes down their own assumption. These assumptions are incredibly subjective and might not reflect the patient’s own identity or the identity that society imposes on them as. Because of this, I did not attempt to identify individuals beyond being white or being people of

color. My results about correlations between race and mental health prevalence rates should be interpreted with caution because of the subjectivity in the documentation of race and ethnicity.

The gender break down in the sample is 524 (76.4%) individuals who were identified as male and 162 (23.6%) who were identified as female. Transgender patients are housed at ACJ based on their gender identity and so should be represented in this sample in the same manner. There was no way to identify how many individuals in the sample identify as transgender. Female patients make up a greater percent of the population at ACJ than in the national jail population, where they only make up about 14% (Minton 2016, p. 4). Individuals ranged from 18 to 77 years old at the time of arrest. The average age at arrest was 34.33 years.

Only 398 (34.4%) of the bookings were for an individual serving a sentence. Sentences ranged from 1 day to a year. The average sentence length was 50.16 days but the most common sentence was two days. Forty individuals (5.8%) reported being homeless at least once at the time of arrest. This is much lower than the national prevalence of homelessness in jail populations, which is 15.3%. However, it is greater than the general prevalence of homelessness in the U.S., which is 1.7% (Greenberg 2008, p. 170). Together, these individuals reported being homeless in 48 (4.2%) of the bookings in the sample.

Mental Illness

Mental illness was extremely prevalent within the sample with 401 (58.5%) of individuals having an indicator of a past or current non-substance use related mental illness in their medical files. Initial medical screening were not done for all patients during 2013 and so, total prevalence rates are likely artificially low because many diagnoses were not recorded in patients' files. In comparison, average prevalence rates between 2014 and 2016 were 71.23%.

The Bureau of Justice Statistics reports mental illness rates to be 64% nationally (James 2006, p. 1).

For this research, I identified individuals with indicators of current or past mental illnesses as anyone who reported a history of a mental health diagnosis, was diagnosed with a mental illness at ACJ, had a history of suicidality or self-harm, reported a history of or current mental health treatment, or was sent out or referred to an outside agency (a psychiatric hospital, local emergency department, or mental health agency) for care. 319 (46.5%) of individuals reported a specific diagnosis or were diagnosed at ACJ. Because of inconsistencies in the way mental health histories were recorded in patient files, it was not feasible to distinguish between current mental illnesses prevalence and lifetime mental illness prevalence rates. Chapter 5 provides further information on the inconsistencies in patient medical records.

Women were found to have a significantly greater prevalence of mental illness than men, (70.4% vs. 54.8%), (Table 1, Figure 1). Considering that both numbers are likely underestimates (as mentioned above), this is in line with national data that has found that 75% of female and 63% of male jail patients have a mental illnesses (James 2006, p. 10). My data also showed that white patients were significantly more likely than patients of color to have a mental illness indicator (Table 1, Figure 1). This difference is also consistent with national data (James 2006, p. 4). However, it could indicate a difference in levels of reporting and diagnoses rather than morbidity levels.

Table 1. Mental Illness and Substance Use Disorder Frequencies and Correlations By Gender and Race

	Female (N,%)	Male (N,%)	Correlation (Pearson's R)	White (N,%)	People of Color (N,%)	Correlation (Pearson's R)
Mental Illness	114 (70.4%)	286 (54.8%)	.13***	265 (44.7%)	265 (26.9%)	-.12**
Substance Use Disorder	79 (48.8%)	211 (40.3%)	.07	362 (61.0%)	39 (41.9%)	-.13***
Mental Illness or Substance Use Disorder	123 (75.9%)	240 (64.9%)	.10**	414 (69.8%)	49 (52.7%)	-.13**
Illicit Drug Use	51 (31.5%)	178 (34.0%)	-.02	193 (32.5%)	36 (38.7%)	.05
Number of Bookings	-	-	.01	-	-	-.05
Violent Offense	52 (32.1%)	187 (35.7%)	-.03	206 (34.7%)	33 (35.5%)	.01
Homeless	9 (5.6%)	31 (5.9%)	-.01	36 (6.1%)	4 (4.3%)	-.03

Positive Pearson's correlation values correlate to increased prevalence of dependent variable for females and people of color individuals, negative values indicated increased prevalence in men and white individuals.

*correlation is significant at the 0.05 level (2-tailed)

**correlation is significant at the 0.01 level (2-tailed)

***correlation is significant at the 0.001 level (2-tailed)

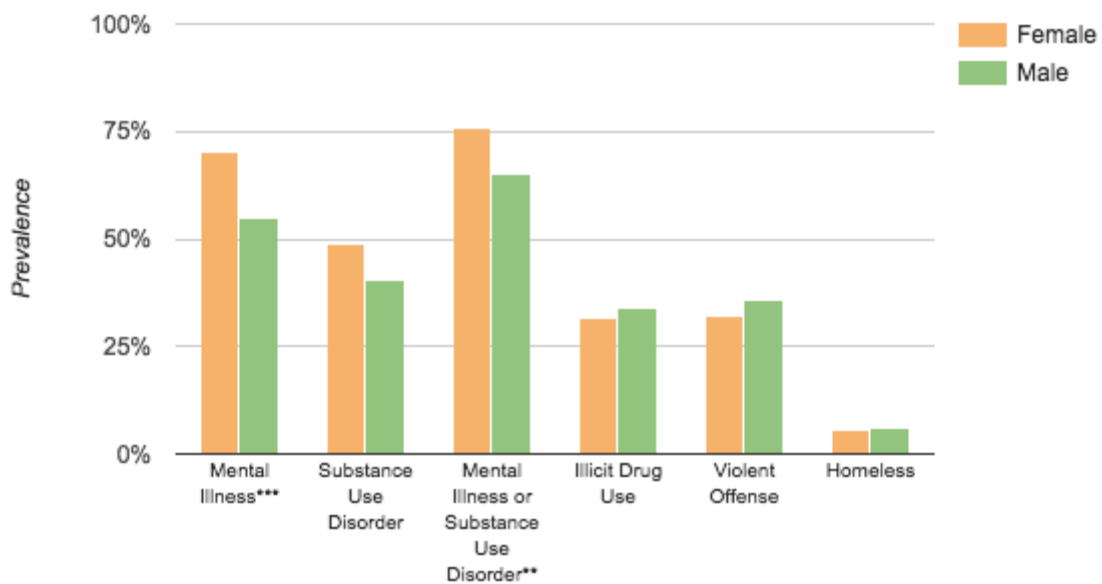


Fig. 1 Prevalence difference between male and female patients.

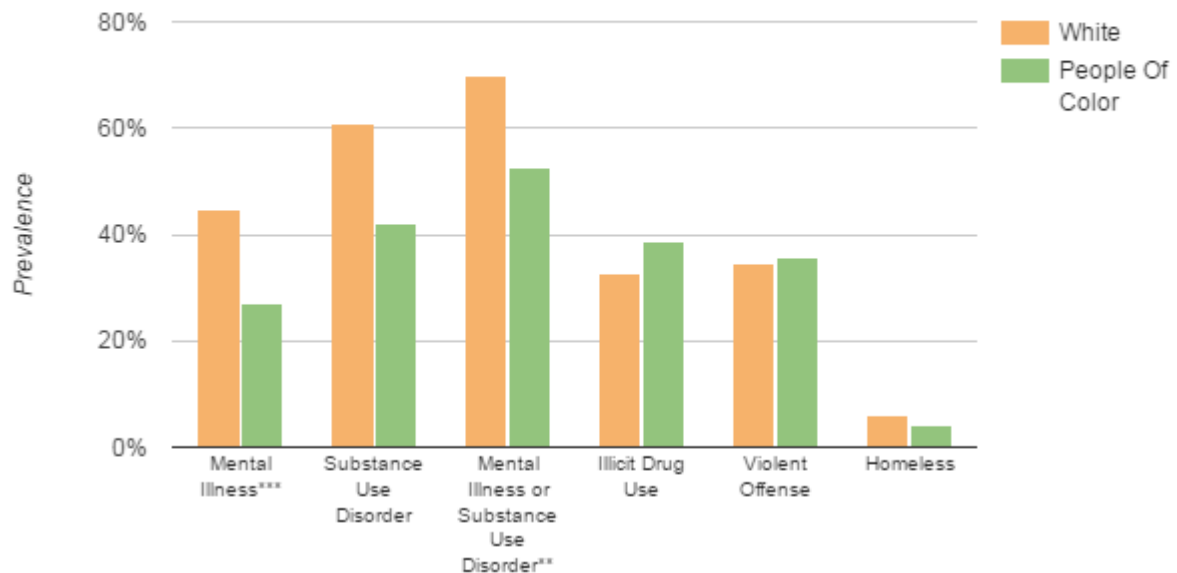


Fig. 2 Prevalence differences between white patients and patients of color.

This data also shows a significant correlation between having a mental illness and having a greater number of bookings (Table 2). This confirms that individuals with mental illnesses are arrested more often. However, this data was not able to provide additional information about whether individuals with mental illnesses are more likely to be sentenced, have longer sentences, or recidivate more quickly.

Mental Illness was not found to be directly correlated to homelessness (Table 2). However, only 5.8% of the sample population reported being homeless at the time of arrest during the four year period. It is likely that the sample size was too small to reflect any significant correlation as national research is fairly conclusive about there being correlations between homelessness and mental illness in incarcerated populations (Greenberg 2008, p. 170). For example, The Bureau of Justice Statistic Mental Illness study found that 17.2% of patients with mental illness reported homelessness in the past year as compared to 8.8% without a mental illness (James 2006, p. 4).

Furthermore, as I will address in the next section, substance use disorders and other mental illnesses were found to be significantly correlated with one another and substance use disorders were significantly correlated to homeless (Table 2). This data suggests that mental illness and homelessness are indirectly related through substance use, even if we cannot identify a direct relationship through this data (Figure 8). The section on *Path Analysis* explains how these indirect relationships are identified.

Overall, mental illness was found to be highly correlated to having a greater number of bookings, having a violent offense, and reporting illicit drug use (Table 2), which corresponds with national data (James, 2006, p. 8). As I discuss more fully in Chapters 5 and 7, this has ramifications for individuals with mental illness being able to participate in work programs at ACJ. Mental illness is most highly correlated to having a substance use disorder. 228 (33.2%) of patients had both a substance use disorder and another co-occurring mental illness (Table 2). This is lower than national data on co-occurrence (James 2006, p. 6). However, these prevalence rates are heavily influenced by inconsistencies in patients screening forms. Drug smuggling into ACJ is also fairly common. It is likely that some patients were not disclosing substance use disorders or were not detoxing because of their involvement with the provision or use of contraband within the jail. This could limit their likelihood of self-reporting or being diagnosed due to withdrawal symptoms and so substances use disorder rates may be even greater underestimates than mental illness rates.

Table 2. Mental Illness and Substance Use Disorder Correlations (Pearson's R)

	Mental Illness	Substance Use Disorder	Number of Bookings	Violent Offense	Homelessness	Illicit Drug Use
Mental Illness		.35***	.25***	.15***	-.01	.22***
Substance Use Disorder			.30***	.20***	.08*	.27***
Number of Bookings				.38***	.156***	.31***
Violent Offense					.11**	.22***
Homelessness						.03

*correlation is significant at the 0.05 level (2-tailed)

**correlation is significant at the 0.01 level (2-tailed)

***correlation is significant at the 0.001 level (2-tailed)

Mental illness was also found to be significantly correlated to illicit substance use and specifically correlated to marijuana, heroin, Suboxone, crack, cocaine, and benzodiazepine usage (Table 3). There were no correlations to the use of hallucinogens, other prescriptions opioids, or amphetamines. However, the number of individuals reporting use of these drugs was three, thirty-four, and three, respectively, and may have been too small to show significance.

Table 3. Frequencies and correlations of specific drug use with Mental Illness, Violent Offenses, and Homelessness

Illicit Drug	Frequencies (N,%)	Indicator of Mental Illness	Violent Offense	Homeless (at least once) at point of arrest
Substance Use Disorder	108 15.7%	.35***	.18***	.08*
Marijuana	126 18.4%	.13**	.12**	-.01
Heroin	49 7.1%	.10*	.09*	.17***
Suboxone	30 4.4%	.08*	.14***	.01
Other Opioid Painkillers	24 5.0%	.06	.14***	.03
Crack	10 1.5%	.10**	.14***	-.03
Cocaine	33 4.8%	.13**	.14***	.06
Hallucinogens	3 0.4%	.01	.04	-.02
Benzodiazepines	14 2.0%	.10**	.07	0.01
Amphetamines	3 0.4%	-.03	-.00	-.02

*correlation is significant at the 0.05 level (2-tailed)

**correlation is significant at the 0.01 level (2-tailed)

***correlation is significant at the 0.001 level (2-tailed)

Substance Use Disorder

While substance use disorders are mental illnesses, I chose to analyze substance use disorders and other mental illnesses separately. Substance use disorders have been found to be highly correlated to other mental illnesses (James 2006, p. 6). Patients with substance use disorders are also specifically excluded from receiving many MaineCare mental health services. Reference Chapter 4 for further information about these exclusions. Because of these factors I

felt that understanding the rates of substance use disorders separate from other mental illnesses was important.

Like mental illness prevalence rates, I suspect that the rates of substance use disorder found in this data are underestimates. In the four year sample, 290 (42.3%) of individuals reported (or were recorded as having) a substance use disorder at least once. Individuals who were detoxing from alcohol while at ACJ were considered to have a substance use disorder and are included in this percentage. Substance use disorders were highly correlated with having a violent offense (Table 2), with 55.6% (N=133) of individuals with one violent offense also having a substance use disorder.

Substance use disorders were highly correlated (even more so than mental illness) to having a greater number of bookings and having a violent offense. My data shows that substance use disorders are significantly correlated to a history of being arrested while homeless (Table 2). Substance use was also found to be correlated with race, with white individuals having higher rates of a substance use disorder (Table 1, Figure 2). There was no significant correlation between gender and substance use disorders (Table 1, Figure 1). .

Substance use disorder was most highly correlated with a diagnosis of a personality disorder. It was also independently correlated with depressive disorders, anxiety disorders, bipolar disorder, PTSD, suicidality/self-harm, and adjustment disorders (Table 4).

Table 4. Frequencies and Correlations of Specific Mental Illnesses with Substance Use Disorders, Substance Use, Violent Offense, and Homelessness

	Frequencies (N, %)	Substance Use Disorder (R)	Substance Use (R)	Violent Offense (R)	Homeless at least once during arrest (R)
Substance Use Disorder	108 15.7%	n/a	n/a	.180***	.077*
Depressive Disorder	194 28.3%	.190***	.166***	0.037	.023
Anxiety Disorder	184 26.8%	.181***	.171***	0.089*	-.010
Bipolar Disorder	94 13.7%	.165**	.113**	.118**	.027
PTSD	77 11.2%	.144***	.130***	0.089*	0.030
Neurodevelopmental Disorders	54 7.9%	.122***	.160***	.093*	-.066
Personality Disorder	43 6.3%	.217***	.136***	.051	.038
Other Mood Disorder	29 4.2%	.070	.066	.059	.010
Schizophrenia Spectrum Disorders	19 2.8%	.071	.031	-.030	.034
OCD	10 1.5%	.068	.043	-.012	-.030
Disruptive/Impulse/Conduct Disorder	8 1.2%	-.010	.038	.006	.089*
Suicidality/Self-Harm	5 0.7%	.100**	.085*	-.027	.125***
Neurocognitive Disorders	4 0.6%	.012	-.014	.024	-.019

*correlation is significant at the 0.05 level (2-tailed)

**correlation is significant at the 0.01 level (2-tailed)

***correlation is significant at the 0.001 level (2-tailed)

Overall, 462 (67.5%) of the patients in the sample had a current or reported history of substance use disorder, indicators of a past or current non-substance related mental illness, or both at some point in the sample period.

Drug Use

One-third of patients reported currently using illicit drugs (N=229, 33.4%). Reported drugs includes marijuana, heroin, Suboxone, various other opium based prescription painkillers, crack, cocaine, a variety of benzodiazepines, a few different hallucinogens, and a collection of different amphetamines. Marijuana, was the most commonly reported drug, followed by heroin, Suboxone, other opioid painkillers, and cocaine (see Table 3).

Violent Offense, Number of Bookings

In the four year sample period, 239 (34.8%) individuals had at least one violent offense. Overall, 368 (31.9%) of the bookings in the sample included a violent offense. Mental Illness, substance use disorders, and illicit drug use were all found to be strongly correlated to having a violent offense in this time (see Table 2). Having at least one violent offense was found to be significantly correlated to the use of a number of drugs (see Table 3).

Path Analysis

I used the above correlations, as well as multivariate regressions to conduct a path analyses on the effects of substance use disorder, mental illness, homelessness, race, and gender on violent offence and number of bookings. Path analyses are used to identify direct and indirect partial correlations between variables. While path models identify correlations through unidirectional arrows, it is important to remember that the correlational direction of the model has been assigned by the researcher.

For my models, this is most significant as we think about the correlation between mental illness/substance use/homelessness and number of bookings/violent offense. As I discussed in

Chapter 2 and have alluded to in Chapter 4, incarceration is both a cause and effect of mental illness. An individual may be arrested because of the behavior induced by their mental illness. Their mental illness may also be worsened by their time in a correctional facility. The relationship between homelessness and mental illness are similarly understood in this bidirectional manner.

Because this research is most prominently focused on the large number of individuals with mental illness who end up in jail, I decided to conduct this analysis with mental illness, substance use disorder, and homelessness as contributors to, rather than results of incarceration. Each arrows indicates a statistically significant relationship between two variables. These relationships can be followed through the model in the direction of the arrows. For example, there is no arrow between gender and violent offense, and thus no statistically significant direct relationship. However, there are arrows between gender and mental illness and between mental illness and violent offense. This indicates that gender is indirectly related to violent offense through mental illness.

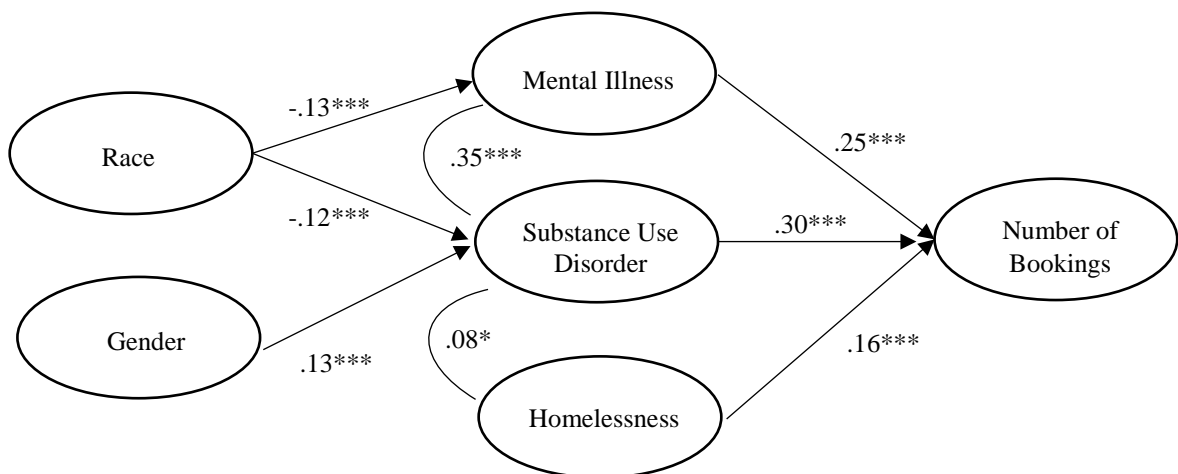


Fig. 8 Path analysis of race, gender, mental illness, substance use disorders and homelessness on number of bookings. Negative correlations with race indicate higher prevalence rates for white patients. Positive correlations indicate higher prevalence rates for female patients.

*correlation is significant at the 0.05 level (2-tailed)
 **correlation is significant at the 0.01 level (2-tailed)
 ***correlation is significant at the 0.001 level (2-tailed)

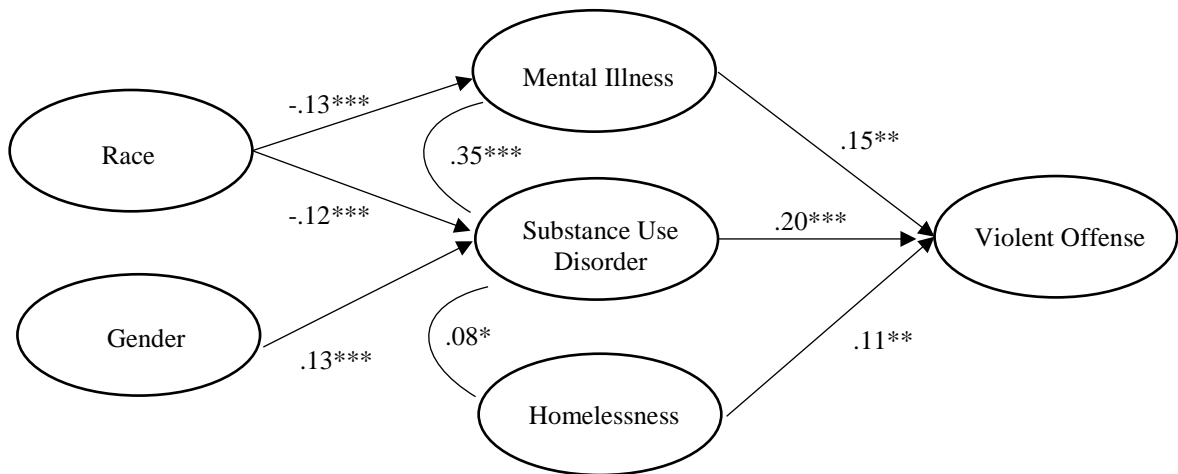


Fig. 9 Path analysis of race, gender, mental illness, substance use disorders and homelessness on violent offense. Negative correlations with race indicate higher prevalence rates for white patients. Positive correlations indicate higher prevalence rates for female patients.

*correlation is significant at the 0.05 level (2-tailed)
 **correlation is significant at the 0.01 level (2-tailed)
 ***correlation is significant at the 0.001 level (2-tailed)

These path analyses shows that there are strong endogenous relationships between number of bookings and mental illness, substance use disorders, and homelessness (Figure 8). Furthermore, there is a strong correlation between other mental illness and substance use disorders. This relationship indicates that there is an indirect relationship between mental illness and homelessness because substance use disorders and homelessness are correlated.

Correlations to mental illness and substance use disorder indicated higher prevalence rates for white patients. This suggests that white patients, as a result of indirect correlations via mental illness and substance use disorders, are likely to have a greater number of bookings. Similarly, this path analysis indicates that gender is indirectly correlated to number of bookings, with female patients being more likely to have a greater number.

The same endogenous relationships are present between violent offenses and mental illness, substance use disorders, and homelessness (Figure 9). However, they are not quite as strong as their partial correlations to number of bookings. Although it is not shown in the path

model, analysis showed extremely high correlation between number of bookings and violent offense ($R = 0.38$, $p=0.000$) (Table 2).

Changes over Time

Anecdotal data from corrections officers and administrators at ACJ suggested that the state of mental illness at ACJ had been worsening in recent years. Because of this, in addition to analyzing prevalence rates for individuals over the four year sample period, I also conducted analyses to look at prevalence rate changes over time. Crosstab analyses were used to determine whether the prevalence of mental illness, substance use, illicit drug use, homelessness, violent offense, and number of bookings changed over the sample time period. Initial medical evaluations were not offered to all patients in 2013, which could have created artificially low prevalence rates for 2013. 2017 also included a very small number of data sets because it only the month of January had been included in the data.

Because both 2013 and 2017 could skew trends, neither were included in the change-over-time analyses. The crosstab results for mental illnesses and drug use with $N>30$ occurrences between 2014 and 2016 are shown in Table 5 and Figure 5. The timewise analysis of prevalence data is unable to conclusively confirm or deny ACJ's corrections officers' observations as no overarching trends were observable across the four year period.

Table 5. Changes in Prevalence Rates in 6 month Increments between 2014 and 2016

	Total occurrences between 2014 and 2016	2014 Jan.- June	2014 July- Dec.	2015 Jan.- June	2015 July- Dec.	2016 Jan.- June	2016 July- Dec.	Pearson's R Correlation
Substance Use Disorder & Other Mental Illnesses		79.5%	85.2%	73.8%	72.2%	72.2%	73.0%	-.01
Mental Illness		71.2%	76.8%	66.4%	71.4%	69.9%	72.0%	-.02
Substance Use Disorder		50.8%	54.9%	51.7%	42.1%	41.4%	44.0%	-.08*
Homeless		1.5%	4.9%	6.0%	5.6%	3.0%	8.0%	.05
Drug Use		22.7%	40.8%	37.6%	34.9%	27.1%	29.0%	-.01
Two or More Bookings		15.2%	21.1%	18.8%	11.9%	12.0%	9.0%	-.09*
PTSD	79	5.3%	10.6%	10.1%	8.7%	12.8%	14.0%	.075*
Bipolar Disorder	92	12.1%	8.5%	13.4%	11.9%	14.3%	10.0%	.01
Depressive Disorder	205	20.5%	24.6%	28.2%	31.0%	27.1%	26.0%	.04
Personality Disorder	36	8.3%	7.0%	5.4%	0.0%	0.8%	6.0%	-.09**
Anxiety Disorder	195	19.7%	21.8%	30.9%	27.0%	27.1%	22.0%	.03
Neuro-Developmental Disorder	55	6.1%	7.7%	5.4%	5.6%	9.0%	9.0%	.03
Marijuana	136	11.4	23.9%	18.8%	22.2%	12.8%	14.0%	-.02
All Opiates	107	10.6%	13.4%	18.1%	15.9%	10.5%	13.0%	.00
Cocaine	34	3.8%	7.0%	3.4%	4.0%	3.0%	5.0%	-.02

Illnesses with fewer than twenty occurrences were not included in this tables as sample sizes were deemed too small to demonstrate statistical significance. There were no significant changes in rates of heroin, Suboxone, and other opioids painkiller use, so they were combined into a single row.

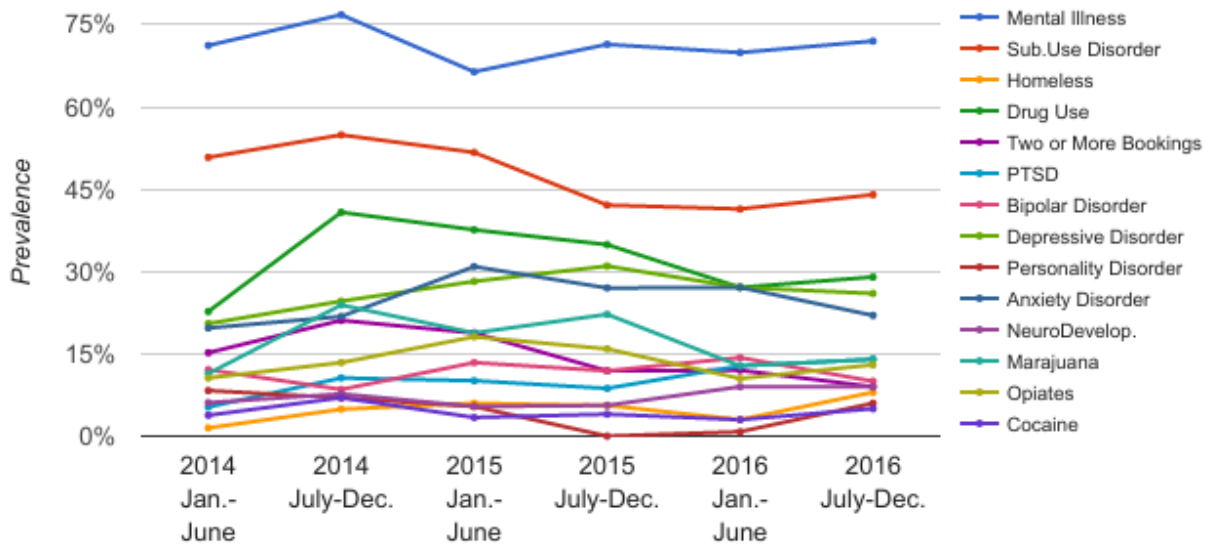


Figure 5. This graph represents prevalence rates for mental illness substance use disorders, homelessness, drug use, number of bookings, and number of specific mental illnesses and drug uses.

Statistically significant changes in prevalence over time were found for substance use disorders, number of bookings, PTSD, and personality disorders (Fig. 5). Substance use disorders and the prevalence of two or more bookings were both most common between July and December of 2014, although these prevalence rates were not significantly different from rates during any other time frame. Illicit drug use was also most prevalent at this time. These five variables were also found to have a slight downward trend in between the second half of 2014 and the second half of 2015 (Figure 6). Overall, during the second half of 2014, 85.2% of patients at ACJ had a substance use disorder, another mental illness, or both (Table 5).

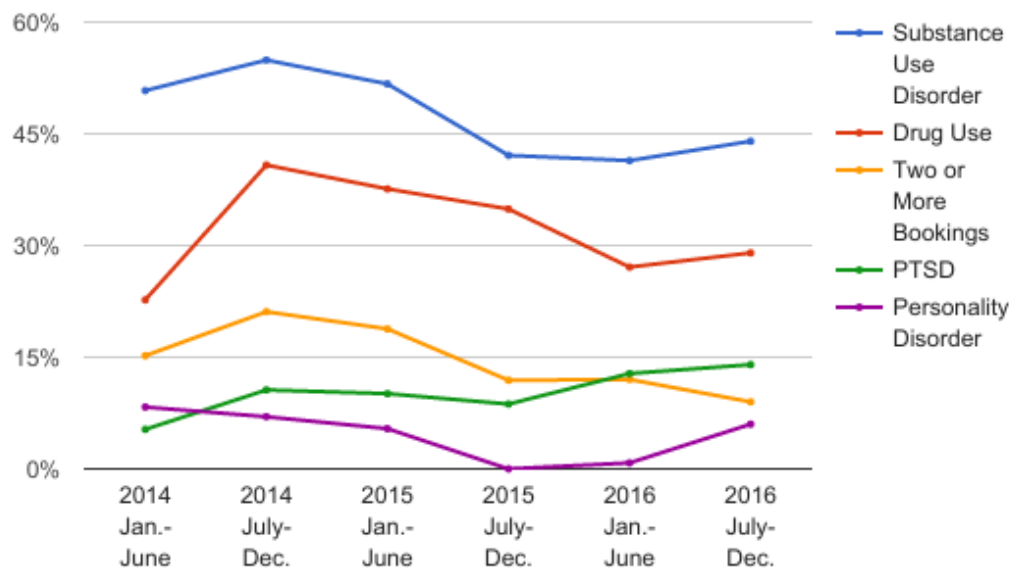


Figure 6. This graph shows the prevalence rates for five factors that showed peak prevalence rates during 2014, followed by a decrease in prevalence rates until the second half of 2015.

These five variables, in addition to neurodevelopmental disorders, marijuana, cocaine, and opiate use as well as overall mental illness all rose in prevalence during 2016 (Fig. 7). Having two or more bookings was the only variable of this group that did not experience this 2016 rise. Again, while these patterns are apparent on visual inspection, they were not found to be statistically significant. However, the fact that these are clear patterns between a number of the variables suggests that there is some, still unidentified, time change phenomena occurring. Continued research should be done on prevalence rates in 2017 and beyond to see whether trends continue.

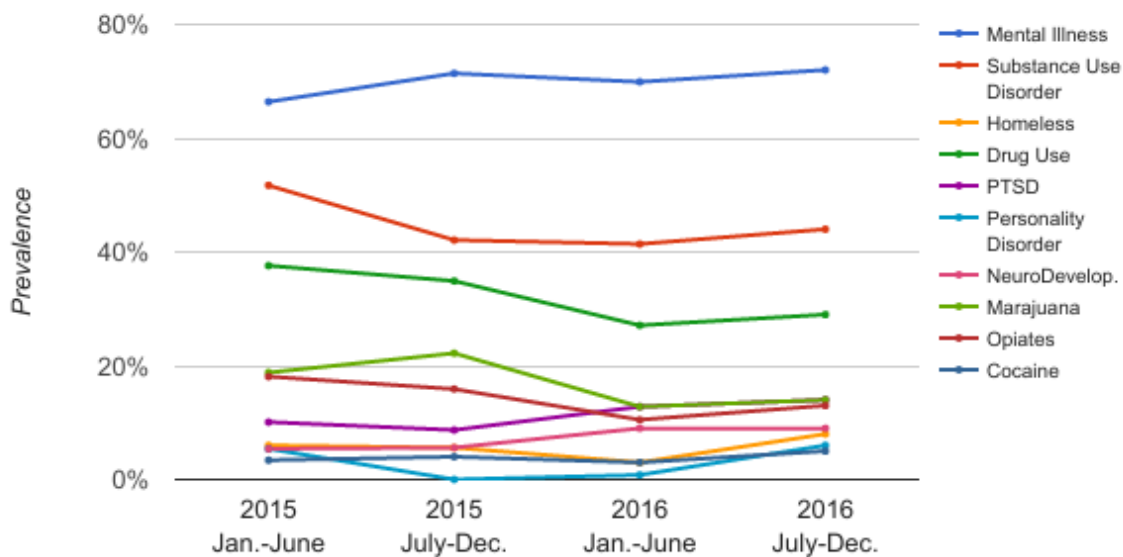


Figure 7. This graph shows the prevalence rates for a number of factors between the beginning of 2015 and the end of 2016. The slightly increased prevalence rates across these factor is observable between the beginning and end of 2016.

Insufficient sample sizes may have been at play in a number of the insignificant findings. For example, mental illnesses like OCD and schizophrenia spectrum disorders have very low prevalence rates. Correlating nine occurrences of schizophrenia spectrum disorders to a likelihood of having a violent offense is not statistically sound and any findings would carry little meaning. The unreliability of small sample sizes in demonstrating statistical significance is particularly important to understand when considering the lack of significant findings in changes of prevalence rates over time.

Summary of Findings

Analyses of the medical file data presented a number of important findings. The most important ones are summarized below. In the following chapter, these findings will be interpreted within the context of the structural findings discussed in Chapters 4 and 5.

- 59% to 71% of individuals at ACJ between 2013 and 2017 had a mental illness besides a substance use disorder. Rates were at approximately 70% in 2016.
- At least 42% of patients at ACJ has a substance use disorder.
- Substance use disorders and overall mental illness rates peaked in the second half of 2014.
- Mental illness and substance use disorders are highly correlated. At least one third of patients at ACJ suffer from co-occurring disorders (substance use disorders and another mental illness).
- Higher rates of mental illness were correlated with being female and being white.
- Higher rates of substance use disorder were correlated with white patients.
- Mental illnesses and substance use disorders were strongly correlated to a history of violent offense and a greater number of bookings.
- Mental illness was significantly correlated to illicit drug use.
- Substance use disorders were significantly correlated to homelessness.
- Race and gender were indirectly correlated to number of bookings and a history of violent offense.
- Depressive disorders, PTSD, bipolar disorders, and anxiety disorders were the most prevalent mental illnesses after substance use disorders.
- Some pattern exists in prevalence changes over time. A number of variables, including total prevalence substance use disorders and certain mental illnesses reached peak prevalence in the second half of 2014. Prevalence rates for even more variables dropped at the beginning half of 2016, and began to rise during the second half of the year.
- Substance use disorders were independently correlated with all of the variables that reached their peak prevalence in the second half of 2014. Substance use disorder rates also peaked during these years.

Chapter 7: The Big Picture

“You never know, it might just be that one interaction... All of a sudden something clicks... you don’t know what it will be... You are part of a system that is trying to provide something for people... so when they’re released they can function.”

Administrator at ACJ

In Chapters 4 and 5, I detailed many components of mental health treatment services that operate within (and without) Androscoggin County Jail. In these sections I noted numerous barriers that exist to accessing low cost, intensive community-based mental health treatment. This included obstacles built into the MaineCare and the Department of Health and Human Services Grant coverage. I outlined numerous points at which continuity of care breaks down, both in referral processes and in transitions between hospitalization, incarceration, and release. My analysis of barriers to community-based treatments included a strong criticism of the reactionary nature of Maine’s mental health system. In these sections I also discussed budget and staffing limitations that impede ACJ’s ability to provide more programming, comprehensive treatment services, or guaranteed discharge services. These chapters also included a discussion of the limitations caused by the jail’s reliance on paper medical records.

There is no doubt that the data I gathered from patient medical files and discussed in Chapter 6 is alarming. However, in reality, these numbers mean very little if they are not understood in a broader contexts of Chapters 4 and 5. It is one thing to know that nearly three-fourths of patients at ACJ suffer from substance abuse or mental illness. It is another to understand that many of them will have zero access to mental health treatment once they are released. Or that even though substance abuse disorders are highly correlated to a greater number of bookings, individuals with this illness are ineligible for intensive care. Moreover, these numbers become very scary when we recognize that Maine’s 2018-2019 Budget proposal threatens another series of cuts to MaineCare (LePage, 2017).

In this chapter I contextualize my findings from Chapter 6 within the current nature of jail and community-based mental health treatment. Because the findings are too extensive to list here individually, readers should consult Appendix 3 for a summary of the important findings from Chapters 4, 5, and 6. For a more detailed explanation of any of the programs and policies referenced in this section, see Chapters 4 and 5.

In the hopes of not leaving readers with a feeling of desperation, I conclude this chapter, and my thesis, with a discussion of next steps. These includes recommendations for changes in policy and procedure at the state, county, and jail level. I also put forward a number of potential areas of research that I believe could greatly improve progress on this issue.

The Big Picture

In the interest of not letting any single point be overshadowed, I have decided to split this part of the chapter into six sub-sections. Each sub-section discusses a different “big picture” issue that I have identified through this research. I have not organized these sections based on any order of significance. These problems are dependent on one another. To pretend that any one is more or less significant than another would be missing the point that these problems are the results of overarching systemic failures in the design and execution of our mental health system.

Furthermore, while these are the “big picture” problems that I have noticed, I highly doubt that these are the only ones that exist. Others are likely to find additional problems that I have overlooked and I sincerely hope they do. The purpose of this research is to act as a catalyst for intentional, change-driven dialogue, so any conversations that emerge from it indicate the effectiveness of this effort.

Limited Jail Services

ACJ averages a patient population of approximately 155 individuals. This means that at any given time approximately 108 individuals at ACJ will have a history or symptoms of a substance use disorder or other mental illness. Not every one of these individuals will want to receive treatment at the jail and not all of them will need to. However, these individuals are all especially vulnerable to the stressors of incarceration and have an increased likelihood of requiring mental health services. These are 108 individuals who, upon their release, will be at an increased risk of substance use relapse, homelessness, hospitalization, re-incarceration and just generally difficult reintegration. Furthermore, these are 108 individuals who are dependent on only two half-time licensed clinical social workers, a single one-day-a-week psychiatrist, and a single forensic intensive case manager for managing their care during incarceration and release.

At least 42% of individuals at ACJ have an indicator of substance use disorder. Many of these individuals are intoxicated at the point of arrest and are even smuggling drugs into the jail. Many of them will be released into environments that trigger their substance use. These triggers may range from friends with substance use disorders to the pressure of looking for stable housing to the stressors of rebuilding relationships with families and friends.

The Alcoholics Anonymous and Narcotics Anonymous programs at the jail are certainly helpful for some. However, the fact is that AA and NA, in combination with medical watch for those actively detoxing, are not enough to help the majority of individuals begin to recover from their illness or to develop the coping skills required to manage their health problem following release. These individuals' suffering should be enough to persuade us that this type of system is not acceptable. However, it is also significant that the decline of patient mental health puts an additional financial and emotional toll on ACJ and its staff.

Diagnostic Ineligibilities

The prevalence of substance use disorders and other illnesses, as well as their high rates of co-occurrence, are also significant beyond the walls of ACJ. Current MaineCare policies dramatically prioritize schizophrenia and schizoaffective disorders over other mental illnesses. For those without either of these diagnoses, accessing intensive services, such as community integration services, is exceptionally challenging. This data shows, however, that mental illnesses such as depression, anxiety, bipolar disorder, PTSD, and personality disorders are far more prevalent than any schizophrenia spectrum disorders. Many of these illnesses are also correlated to substance use disorders, substance use generally, and to an increased likelihood of having a violent offense. Schizophrenia spectrum disorders are not correlated to any of these.

Governor LePage's administration frequently claims that their policies are designed to help "our neediest and most vulnerable" (LePage 2017, p. 20). In fact, this exact language is used in the Department of Health and Human Service's official explanation of the 2016 policy changes that limited Section 17 (Community Support Services) to individuals with schizophrenia and schizoaffective disorder (Nadeau 2016). In this explanation, DHHS even specifically cited depression, anxiety, and PTSD as mental illnesses that did not necessitate these sorts of intensive services. However, as this data shows, these illnesses are clearly connected to incarceration within the county. And as the literature shows, incarceration itself perpetuates vulnerability and neediness in individuals who have been released.

For patients who do have schizophrenia or schizoaffective disorder, eligibility may be obtained if a clinician can demonstrate through a written opinion that their patient is on the verge of a significant adverse experience (homelessness, incarceration, hospitalization). However, individuals with primary diagnoses of substance use disorders are an exception to the rule. Of the approximately 42 % of patients at ACJ who are likely to have a substance use disorder, a vast

majority of them would be ineligible for these intensive services. And for those who would need access to these services but would be ineligible, there is a high risk of recidivism, relapse, homelessness, and general mental health decline.

Coverage Gaps

Section 17 services are grant funded. This means that individuals who do qualify for these services are able to receive them, even if they are not eligible for MaineCare. However, for those who are not eligible for Section 17, less intense versions of community-based treatment are not available. Because Behavioral Health Services and Behavioral Health Homes are not grant funded, many of the tens of thousands of individuals who fall within the health insurance coverage gap have no access to mental health treatment. It is highly likely that the majority of individuals at ACJ who would be disqualified from Section 17 would also be disqualified from MaineCare.

Even for those who do qualify for MaineCare, accessing coverage may be difficult. As I described in Chapter 4, the process of reactivating MaineCare following incarceration is time-intensive and confusing, posing an additional burden on those who are attempting to navigate release and mental illness simultaneously. For those individuals who did not have health insurance when they were arrested, the enrollment process is even more cumbersome and can be drawn out far beyond those critical first few weeks following incarceration.

While the Intensive Case Manager (ICM) at ACJ is able to help many patients navigate these obstacles, there is only so much a single person can do. Furthermore, because so many individuals are bailed out or released before the ICM has a chance to connect with them, many individuals have no opportunity to engage in this service, leaving them with yet another coverage gap.

Continuity of Care

The insufficient number of ICMs and the obstacles built into the Medicaid enrollment process speak to the poor continuity of care that seems to characterize incarceration within Androscoggin County. For those who are able to find a meaningful level of stability at ACJ, limited access to health insurance, mental health treatment, and substance use treatment after release makes it difficult to maintain this stability following release. Insufficient continuity of care is also evident in the mediocre integration between ACJ and Tri-County Mental Health's Assertive Community Treatment team. For example, there is no reliable way for ACJ (and the local hospitals) to know whether their patient already has a case manager. The poor referral process and quick turn over at the jail, as well as the lack of a forensic ACT team, often impedes the ACT team's ability to connect with referred patients. The mostly irrelevant educational sheets that are distributed to patients when they are sent from the hospital to the jail also reveal a lack of thoughtful transitions of care among services providers across the county.

Disproportionate Punishments

Finally, this research shows that patients with mental illnesses, including substance use disorders, are significantly more likely to have a greater number of bookings than individuals without these illnesses. Patients with mental illness are also significantly more likely to have a violent offense, which increases patients' security classifications and makes them ineligible for the public works programs that ACJ offers.

Together, these factors mean that patients with mental illnesses are more likely to be in jail more often, with higher security classifications, and with less access to services that promote positive coping and external interactions. In other words, this system is disproportionately

punishing individuals with mental illnesses by making justice involvement something that is distinctly more likely to induce or worsen a mental illness.

Recommendations

There are many issues with the availability of appropriate mental health treatment in Androscoggin County, probably more than I just mentioned above. As someone who believes that comprehensive solutions are often the only real solutions, the extent of these problems can easily be seen as insurmountable. However, this is Maine. And if there is one thing Maine is good at, it is digging down and persevering. It's just like shoveling out a car: bit by bit, slow and steady, until it's done.

This final section is a collection of recommendations that I have developed as a result of conducting this research. As I write, some of what I propose here is actively being considered through grants, agency budget allocations, and state legislation. My recommendations are organized into three parts. The first section, *Policy*, discusses policies on the state level. The section on *Practice* includes programs and ways of thinking that can be implemented in organizations and agencies including ACJ, Tri-County Mental Health Services, the Department of Health and Human Services, and local emergency departments. Finally, *Research* discusses further research that could be conducted within Androscoggin County to strengthen our ability to address these issues.

Policy

The Maine Legislature is currently engaged in working sessions on a bill that would make dramatic changes to reimbursement rates for health care providers (as discussed in Chapter 4). The nature of these rate changes would impact current services so severely that many types of

services will be removed entirely. Governor LePage's 2018-2019 Bi-annual budget plan would cut \$140 million from welfare services across the board and would dramatically reduce income eligibility levels for MaineCare (LePage 2017). Commissioner Mayhew's letter to the Secretary of Health and Human Services similarly proposes a set of changes that would only further the coverage and treatment gaps that already exist (Mayhew 2017). I implore state representatives and voters alike to consider the far-reaching impact of these types of policy changes and to vote against them.

Beyond rejecting these proposed changes, I am a strong advocate of any insurance program that expands coverage to the thousands of Mainers who currently fall into the coverage gap. Furthermore, the repeal of stigmatizing and restricting policies, such as the new Section 17 changes, are important first steps to improving care. And, in the future, politicians that hope to reduce spending or streamline care, should more deeply consider how their policies would impact patients, particularly in unjust or biased ways. Finally, any steps that move Maine towards a preventive, rather than crisis intervention, model of care are an important step in pushing Maine to catch up with the rest of the world.

In Practice

Below are a series of program and procedurally based recommendations that I believe could make significant changes in the provision of mental health treatment within Androscoggin County. Because this section runs the risk of providing a near endless conversation of potential services, I have broken it down by association to the stakeholders most closely connected to the recommended change. However, as I mentioned before, it is important to remember that different components of treatment provision are all connected. Services in the jail are connected to services in the community, which are intrinsically linked to government policies and programs,

all of which are informed by community perceptions of mental illness and incarceration. Therefore, it is somewhat misrepresentative to characterize these recommendations the way I have.

Androscoggin County Jail

Androscoggin County Jail could desperately use an improvement in the type and amount of mental health services they are able to provide. Because of budget limitations, ACJ is not currently able to provide much more than two part-time clinicians to an overwhelming number of patients, which impedes their ability to provide intensive treatment. In addition to increasing the sheer number of providers at ACJ, efforts should be made to ensure that these providers are specifically trained in serving this population. For example, training in trauma-informed care and in working with individuals with co-occurring disorders are no-brainers based on the sheer number of incarcerated individuals who are dealing with one or both of these issues.

In addition to increased provider accessibility and ability, ACJ's population would benefit from access to any clinician-provided substance use treatment. While Alcoholics Anonymous, Narcotics Anonymous, and medical watch are important, they are not the same thing as working with a substance use counselor. Increased access to group treatment and more comprehensive counseling and case management type services are important improvements that should be made.

All patients at ACJ are likely to experience mental health benefits from increased access to programs that encourage positive forms of coping, relationship building, autonomy, and personal growth. These services may include increased access to recreational time, educational classes, and public work programs, among many others.

Part of improving access to mental health services in ACJ is dependent on connecting patients with outside resources. For example, some counties have systems that enable booking officers or medical staff to look up whether a patient is working with a case manager or other mental health providers through their local Medicaid services. Even more simply, bookings officers could make sure to simply *ask* patients whether they work with a provider. A fairly simple system could be put in place to enable the jail or the patients to contact the case manager, ensuring that continuity of care is maintained during the transitions into and out of the correctional facility.

For those individuals who do not already have a case manager or provider or are referred to one by a local emergency department, a system should be established to ensure that patients can be connected to those services. This system should be designed to connect patients to these services, even if they are released before any contact can be made at the jail. Finally, increasing the power of Forensic Intensive Case Managers (ICMs) within ACJ is incredibly important. The current ICM does an incredible job of helping patients, despite being the only one working with such a large number while trying to navigate so many structural barriers. Improving both the number of ICMs available at each jail and working to remove many of the barriers that limit their effectiveness could go a long way in improving patients' transitions out of the jail.

After spending nearly seventy-five hours reading through hundreds of paper medical files, I desperately hope that ACJ can transition to an electronic medical records system. In particular, I hope that ACJ is able to work with a system that would enable them to more easily conduct further research using these electronic records. The system should be designed so that ACJ can keep track of mental illness prevalence rates and monitor patients' use of their mental health treatment services. Like any medical service, the ability to conduct efficient and accurate

quality improvement/quality assurance reviews is important to improving the level of care provided. And, if new treatment programs are to be implemented at ACJ, it will be important to be able to monitor their impact on the patient population.

As importantly, electronic medical records will improve jail providers' ability to recognize concerning health trends and make appropriate referrals for individual patients. For example, if a patient is at ACJ every few months, but only for a night or two, it may be difficult for providers to recognize that this patient consistently arrives intoxicated with suicidal ideations. This is particularly challenging when staff members rotate or are only employed part time at ACJ. Electronic records will ensure that files do not get lost, misplaced, or hidden in the archives room. This will help to maintain more robust medical histories for each patient and will enable providers to more easily identify trends or warning signs in a patient's history.

Implementing these suggestions would incur varying costs. Therefore, a key component to implementing any changes at ACJ is addressing the severe budget shortcomings that ACJ has been desperately trying to navigate around.

Finally, with all of these recommendations, I also believe that both ACJ and the Androscoggin community at large would do well to think about the purpose of incarceration. What is it trying to accomplish? Does incarceration achieve the outcome the community would like it to? Do the policies and practices operating within Androscoggin County and Androscoggin County Jail reflect these goals? If we hope that incarceration does provide some sort of "corrections," are we setting patients up for growth and success or merely engaging them in a system that will perpetuate negative mental health consequences? If the latter is the case, perhaps we need to think more deeply about how some of the most basic components of

incarceration (limited autonomy, regimented scheduling, power dynamics, security classifications, etc.) are contributing to this mental health crisis.

Tri-County Mental Health Services and Other Mental Health Agencies

In my conversations with representatives from TCMHS, it was very clear that the creation of specialized Assertive Community Treatment teams is one of the biggest dreams of TCMHS' current ACT team. A forensic ACT team would be specially trained to work with patients with co-occurring illnesses and would have the ability to more adeptly navigate the corrections systems. Part of the success of such a system would heavily rely on improved referral and screening programs to ensure that patients are being connected to their current (or new) case managers when they are hospitalized or incarcerated.

Emergency Departments

It appears that there is little intentional thought in the design of the referral and release processes from local emergency departments to ACJ. Dramatic improvements could (and should) be made through a purposeful analysis and redesign of this process. The development of other programs, such as the establishment of a forensic ACT team or inclusion of a case manager question during booking should be an integral part of how these changes should be conceptualized.

Furthermore, emergency departments can improve the care they provide their patients by recognizing and responding to the unique conditions that their patients are being released into. Rather than giving education sheets that recommend "getting outdoors" and "doing things that make you happy", local emergency departments could instead provide information about accessing psychiatric services and case management at ACJ. Or, they could provide information

about incarceration-specific coping strategies such as “find things that give you autonomy and purpose; try to join a work program or get involved in the educational classes”

Additionally, there is a large resource gap in the accessibility of forensic, inpatient mental health treatment across Maine. Speculation suggests that forensic units in these facilities are largely understaffed and as a result, patients at ACJ may wait in jail for as long as nine months while waiting for a bed to open up. While preventative care will hopefully mitigate the need for such intensive care, improvements must be made so that this care is accessible if and when it is needed.

Other Social Support Services (including DHHS and the criminal justice system)

Ensuring access to other social services plays an integral role in ensuring that released patients, and ACJ itself, are set up for success. Increasing access to diversion programs such as Drug Court, can help to mitigate the negative effects of incarceration by avoiding it altogether. Guaranteed immediate and long term access to health insurance, ideally through health care expansion, is vital for protecting individuals in those most vulnerable weeks following release. More importantly perhaps, ensuring preventive physical and mental health care, before and after incarceration, is central to reducing the ever-rising rates of mental illness within the community.

Furthermore, access to support services, such as subsidized housing, food vouchers, job training, and other forms of general assistance, play an incredibly important role in helping individuals remain stable during difficult periods of life transitions. It is important that these programs are maintained and enhanced in ways that enable and empower individuals to find stability and outgrow their need for these assistance programs. Ensuring this stability is likely to dramatically reduce rates of incarceration, recidivism, and homelessness within the county.

Coordination

The poorly functioning referral system, the lack of communication about case managers, and the impractical educational sheets provided by local emergency departments speaks to the lack of coordination that seems to exist among agencies throughout Androscoggin County. However, my conversations and observation over the past few months indicate that coordination failures go much deeper than poorly designed care provisions and practices.

My impression is that there is a level of mistrust that exists between many agencies toward one another and toward government bodies. Instead of collaborating, I have observed agencies second guess whether to share new program initiatives with one another out of fear that the information would be used against them. Agencies seem hesitant to collectively organize around their mutual frustrations because of concerns that they will be punished through policies and other actions for doing so. Despite having the same jobs, some providers have not spoken to their statewide counterparts in years.

Of all the failures of the network of mental health treatment across this state, this lack of coordination makes me the most upset. If agencies, providers, and state representatives cannot find ways to work together, then any steps taken to improve this system will not get very far. It is impossible for a single group (be it a mental health agency, the jail, or the government) to enact meaningful changes without the cooperation of these other actors. Even if it does accomplish its main goal, unitary action will inevitably have unintended consequences, such as furthering partisan disagreements and eliciting criticism and resentment from stakeholders that should be aiming to strengthen, not undermine, their ability to collaborate.

With all of this in mind, I believe that now is the time for a new culture to develop among these stakeholders. As of now, each stakeholder primarily operates within an isolated

understanding of their own goals, frustrations, and fears. Prior to Tri-County Mental Health Services and Androscoggin County jail coming together to conduct this research, there were few efforts to bring these isolated agencies into the same space. Now, this research provides a baseline set of information for stakeholders to organize around. If any significant changes are to be made, stakeholders must be willing to come to the table openly, with honest intentions to listen and understand. Without this collaboration, all of these other recommendations mean next to nothing.

Further Research

Over the course of this research, every conclusion I drew sparked another question that my research could not answer. Some of these questions require new statistical analyses that are outside the scope of this project, while others require further engagement with corrections officers and current and recently released patients. Addressing some of these questions is dependent upon improving data collection methods within ACJ.

A shortcoming of this research is its inability to determine the severity of mental illness among patients at the jail, which would have helped to explain the observations (and subsequent concerns) of corrections officers within the jail. Gathering this information will require deeper conversation with correctional officers. If possible, further research should also include conversation with patients, asking about their experiences with the mental health system in ACJ and in their community.

In general, including the perspectives of patients is a necessary component to any future research. Both the mentally ill and incarcerated are vulnerable populations, which makes it difficult to conduct ethical research that does not put an undue burden on these groups. However, by not involving these individuals in research about their own experiences, we run the risk of

overlooking significant parts of their experiences. Moreover, by not including them in this research, we are further silencing voices that are already suppressed because of their positions in these systems.

Patients of correctional facilities can probably impart valuable information about the ways that incarceration interacts with current mental illness. Does it trigger mental illness? Does it make it worse? How do factors such as security classifications and access to work programs influence patients' experiences, particularly their mental health and behavior at the jail?

My data was unable to provide any concrete information about health insurance amongst patients. Asking additional questions of the patients, such as whether or not they have health insurance, could easily provide some of this data. Tri-County Mental Health is aware of a number of individuals who have been incarcerated since being dropped from their services following the 2016 eligibility changes. Research designed to follow up with individuals who have been dropped could provide a plethora of information about the causal relationships between insurance coverage and incarceration.

Much of my research was limited by the constraints of the data available at ACJ. For example, the format of the data I gathered from the jails' bookings record system prevented me from looking into the relationships between mental illness and factors such as recidivism and likelihood of being sentenced. A switch to electronic mental health records could also make it feasible and significantly less time-consuming to look at prevalence rates and patterns amongst patients. Electronic records would also enable the creation of larger sample data sets, potentially shedding light on the insignificant findings that were present within this research. Additional analytic abilities, in combination with electronic records and larger sample sizes, should also provide clearer information about what changes have taken place over time.

In Conclusion

Some people will probably read this chapter and think “Is she kidding? She knows there isn’t any way we can get all this done, right?” If this resonates with you, I invite you to go back to Chapter 1 and read the section on why we have not made more progress at this point. I suggest you give it some thought, and try to understand where you fall within these lines of thinking.

What exactly is stopping you from believing in a true investment in revolutionizing this system? Why are these issues, and the lives they touch, not worth the work?

If you remain skeptical, I hope that, at a minimum, you keep these recommendations in your mind. And, moving through your life, interacting with these systems however you will, I hope you remember what has been said here. Think about the way MaineCare privileges some illnesses over other. Think about the disproportionate punishment those with mental illness face within the criminal justice system. Think about the ways our social and political structures have actively produced, rather than alleviated, these problems. Think about all of the people struggling to get through every day because of correlations between social structures and some combination of mental illness, substance use disorder, incarceration, and homelessness. And, when the time comes that you decide that this system is worth changing, remember that it is within our power as employees, community members, voters, activists, and friends to make those changes happen.

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Appendix 1: Abbreviations and Terms

Abbreviations

AA - Alcoholics Anonymous

ACJ - Androscoggin County Jail

DHHS - Department of Health and Human Services (Maine)

FPL - Federal Poverty Level

ICM - Forensic Intensive Case Manager

LCSW - Licensed Clinical Social Worker

LPN - Licensed Practice Nurse

NA - Narcotics Anonymous

NP - Nurse Practitioner

RN - Registered Nurse

TCMHS - Tri-County Mental Health Services

Jail Terms

Amphetamines - drugs including methamphetamine, Adderall, and Ritalin.

Benzodiazepines - psychoactive drug used for management of anxiety and other illnesses (ex. Xanax, Valium)

Booking - process of admitting an arrested individual to a correctional facility. Conducted by corrections officers. Includes gathering information from the individual (identifying information, medical history, etc.), from the arresting officer (charges, concerns about behavior while incarcerated), and from criminal records databases (criminal record, past charges). Also includes exchanging personal items for facility issued clothing, fingerprinting, a search, and security level and suicide risk determination.

Corrections Officers - responsible for overseeing all patients at the jail, including maintaining the safety of patients and other officers.

Detoxification - process the body goes through to rid itself from toxins once a person has stopped using a drug.

Pre-booking Screening - Brief medical screening conducted by corrections officers during booking.

Public Works Programs - opportunities for incarcerated individuals to work under the supervision of a correctional facility, but usually outside the boundaries of that facility, on projects for the public interest.

Medical Team - health services administrator (usually a registered nurse), two to three licensed practice nurses, one to two medical technicians (who coordinate medication delivery), and mental health team.

Mental Health Team - comprised of two, part time licensed clinical social workers and a two hour a week psychiatric nurse practitioner.

Medical rounds - delivery of prescribed medications to patients

Opiates - include prescription medications used for pain management (Codeine, Morphine, Oxycodone) and treatment of opioid addiction (Suboxone), as well as illegal drugs (Heroin).

Withdrawal - symptoms associated with drug and alcohol detoxification, may be life threatening.

Work Programs - work opportunities within correctional facility; at ACJ these jobs are within facilities, laundry, and food services.

MaineCare Terms

Behavioral Health Homes (BHH), Section 92 - integrated mental health treatment provided through a team of providers including a psychiatrist, a psychiatric nurse, a physician, a peer support specialist, a clinical team leader, and others.

Behavioral Health Services: Section 65 - lowest intensity of mental health treatment; includes counseling and various individual and group therapies; appointments are most commonly every other week or once a month.

Burns Rates Study - service use and cost evaluation and corresponding reimbursement rate recommendations for Section 13, 17, and 65 services.

Children's Habilitative Services, Section 28 - not discussed in this thesis but included in Burns Rate Study.

Community Support Services, Section 17 - highest intensity of mental health treatment. Patients and providers interact three times per week to every day. Includes face-to-face contact with patient's other caregivers and providers, medication management, housing assistance, career exploration, in addition to traditional forms of counseling and treatment.

MaineCare - Medicaid program in Maine, run by the Department of Health and Human Services.

Targeted Case Management: Section 13 - case manager assists patient in managing care and services.

Appendix 2: Annotated Medical File

The following appendix pages includes an annotated medical file for Steven Katz. I created this part of the appendix as a way to provide readers with a deeper understanding of my experience with the medical files I reviewed. Steven Katz is not a real person. However, the medical history depicted in this file is representative of the average file I looked at for my data. This appendix is easiest to read with the file form on one's left hand side and the accompanying commentary (the page following the form) on one's right.

Some of the forms included here are actual forms currently used at ACJ. Others are mock versions of older forms that are no longer in circulation. When replicating these forms, I chose to remove many of the questions that did not pertain to the research I was doing, questions about things like tuberculosis and high blood pressure. These files also do not include a copy of a pre-bookings screening, which are printed as part of the booking record. In a single file, each booking is separated by one of these booking records. Not all of the forms included here will appear under each booking in an individual's file. However, because there are no booking records to separate these forms, readers should reference the date printed on the forms to identify which forms correspond with one another for each of Steven Katz's hypothetical bookings.

At the beginning and end of each booking record is a picture of the patient. Reading through records for hours every day, it was easy for patients' experiences to quickly become little more than a series of check marks and medical terms that I was inputting into my computer. Similar to the health service request forms that I discussed in Chapter 3, these pictures played a large role in my ability to remember that each of these files was a representation of the experience of a real person; someone with a life, family, friends, and most likely, a series of struggles that led them to ACJ. When I found myself getting frustrated with the data collection

process, I would try to spend a bit more time looking at each individual's picture before I read their medical file. I would try to imagine little bits of what their experience might be like, how their medical and mental health histories were interacting with their time at ACJ, and what this meant when they were released.

Since there is no photograph in this appendix, as you read through this section, I ask you to imagine a face that you can connect to this medical file. Picture someone you care about. Try not to picture that criminal from your favorite crime drama, because in reality, that is not who these individuals are. Try to picture a family member or a friend, or maybe just that neighbor who always waves to you or the cashier who brightens your day. Each person who stays at ACJ is all of those things and more to someone else who knows them.

MEDICAL INTAKE POST SECURITY SCREENING

1

Last Name		<u>Steven</u>		First Name		<u>Katz</u>		MI	
ID #				Booking ID #					
Date		<u>Sept 8, 2016</u>		Time		<u>10:00am</u>		DOB	
						<u>09/18/94</u>		Gender	
								<u>Male</u>	
Medical issues identified by security booking/intake screening process? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Describe/list									
Vital Signs:		BP		P		RR		T	
								SPO2	
								HT	
								W	
Are you allergic to any medications, food, seasonal or others? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> List allergies & reactions:									
Do you have any chronic illnesses? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> List									
Do you have any acute illnesses or injuries? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> List									
Have you been diagnosed with an infectious disease including STDs? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Diagnosis:									
Have you ever had a positive TB test? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> When? Tx/CXR									
Any head trauma with loss of conscience in the past 24-48 hours? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Describe									
Recent hospitalization? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Where?									
Are you in pain?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Pain level between 1 & 10:			Location of pain:		
Describe pain:									
History of mental health treatment or illness? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Describe <u>PTSD</u>									
Have you ever attempted suicide? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> When? How?									
Are you suicidal now?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Do you have a plan?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Describe <u>hx cutting</u>		
Are you taking any prescription medications? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> List medications:									
Are you taking any medications not prescribed to you by a doctor? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> List medications:									
Doctor or Clinic Name				Phone				Location	
Pharmacy Name				Phone				Location	
History of withdrawal symptoms? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Shakes? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Seizures? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Hospitalization? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
Describe symptoms <u>"Dope sick"</u>									
Do you drink alcohol?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Beverage of choice		<u>Twisted Tea</u>		Quantity	
When was last drink?								Frequency	
Do you use drugs?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		List:				Blood Alcohol Level (if available)	
								Time	
Any additional complaints or concerns at this time? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Describe:									
Females only									
Are you pregnant?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		LMP				Urine Pregnancy Test?	
If yes, prenatal care?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Estimated due date				Positive <input type="checkbox"/> Negative <input checked="" type="checkbox"/>	
Additional Relevant Information									
Disposition									
Medically cleared for general population				Suicide Watch				Lower level	
Referral to Medical Provider								Lower Bunk	
Referral to Mental Health									
Signature & Title					Date		Time		
<u>[Signature]</u>					<u>Sept 8, 2016</u>		<u>10:00 am</u>		

2

3

4

5

1. This is the medical intake form currently used at ACJ. Medical intake screenings are conducted within twenty-four hours of booking.
2. This question was very difficult to collect data from because of its double-barreled nature. For the majority of patients, answers to this question left it unclear whether the patient had a history of illness *and* treatment or just a history of illness. I would record any diagnoses that were listed here, but unless specific information was provided about treatment, I did not document anything else from this question. If this was the only place in a booking where history of treatment was asked about, I would record the information as missing. Occasionally that information would be disclosed on another form from that booking and I could make up for the missing data there.
3. If a patient answered a “yes” to any of these questions, they were considered to have a history of withdrawal in my data.
4. Responses about how much a patient consumed ranged from “every once in a while” to “two to three a week” to “a lot”. There was no way to tell exactly what these responses meant or even whether they were reliable (it would not be surprising for someone to misreport their substance use). I am not a substance use specialist and so it would have been questionable for me to attempt to make any speculations about an individual’s substance use from these reports. Because of this, I chose not to record any information about alcohol consumption. I did, however, note more specific things in other forms that directly indicated a substance use disorder. This included phrases such as “substance abuse disorder”, “alcoholism”, and “heroin dependence”.
5. I recorded any current illicit drug use that patients reported. Marijuana was not legal in Maine until the final week of this data collection process and therefor was considered an illegal substance for nearly the entirety of the sample period. It is important to note that using a banned substance is not indicative of a substance use disorder. However, substance use is known to be correlated to mental illness, so I chose to include it in my data.

Staff Referral Form

6

Type: Urgent Routine

Medical

- Physician
- Mid-level Provider
- Nurse
- Chronic Care
 - Asthma
 - Hypertension
 - COPD/Pulmonary
 - HIV / AIDS

Dental

- Dentist
- Cardiac
- Pregnancy

Mental Health

- Psychiatric Provider
- MH Professional
- MH Nurse
- Diabetic
- Seizures
- NID Diabetic
- Other (noted below)

Other _____

Reason for Referral: Inmate expressing bizarre thoughts

Additional Information (including interim actions taken):

Inmate states that "his mind is racing" and he "can't think when it's like this. I feel like I'm going to explode"

7

Referred By:

Katie Stevenson Katie Stevenson 9/10/16
Printed Name Signature Date

8

Appointment Date: _____

Date Seen: _____

Seen By:

Printed Name Signature Date

Patient Name	ID#	DOB	Date
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6. Corrections officers use this form to refer patients to the medical and mental health staff. I kept a record of whether patients were referred to mental health or not. This form was one indication that they had been. Referrals from the medical team at ACJ or from an outside agency (such as a hospital) were also recorded.
7. This *Additional Information* is a fairly typical description of why a corrections officer would be referring a patient to mental health.
8. This referral does not have any sort of mental health assessment form following it up. This occasionally occurred and is likely the result of individuals making bail before the mental health team is able to meet with them. Obviously, for someone whose “mind is racing” and who feel as though their mind is “going to explode”, not being able to access a clinician is an issue. For those who leave the jail and do not have access to a mental health practitioner on the outside (because of their lack of insurance, transportation, or general knowledge or willingness to go to one) not making this connection in ACJ can be create a long term problem. Not having a mental health clinician available every day, let alone 24/7 makes it difficult to prevent this from occasionally occurring. This additionally may make it difficult for the forensic case manager from DHHS to be connected with the patient, which prevents them from providing the patient with any sort of discharge services.

Receiving Screening⁹

Inmate Questionnaire:

Have you or are you currently being treated for any other illness or health problem not listed above? If yes, explain: _____ ¹⁰	Y	<input checked="" type="radio"/> N
Do you use drugs not prescribed by a physician? If yes, what kind? <u>Marijuana</u> ¹¹ Mode of use? _____ How much? _____ How Often? _____ Last Use? <u>Jan 1st</u>	<input checked="" type="radio"/> Y	<input type="radio"/> N
Do you use alcohol? If yes, what kind? <u>Beer</u> How much? <u>"a lot"</u> How Often? <u>3-4x/week</u> Last Use? _____	<input checked="" type="radio"/> Y	<input type="radio"/> N
Do you have a history of withdrawal after you stopped using alcohol or drugs? If yes, please describe: _____	<input checked="" type="radio"/> Y	<input type="radio"/> N
Have you ever received treatment for substance or alcohol abuse? If yes, where? <u>St. Mary's</u> When? <u>Current</u> ¹²	<input checked="" type="radio"/> Y	<input type="radio"/> N

Remarks: _____¹³

9. I found this screening in files from 2013 to 2015. In earlier files (mostly from 2014), this Receiving Screening and the Initial Mental Health Evaluation would appear together. For much of 2015, this screening was usually found on its own. The actual screening includes additional medical questions that I did not include here. In 2013 medical intake screenings were only conducted for individuals who reported a condition/illness or medications at booking. As a result, many of the 2013 files did not include any sort of medical screening.
10. A mental illness may be reported in a variety of places throughout this questionnaire. Here is the first place. For each of these sections I would document that the patient had a history of a mental illness and would record the specific illness(es) mentioned.
11. It may have been possible to ascertain whether an individual was currently on psychotropic medications. However, this would have required an extensive amount of time and research into the wide list prescription drugs patients were using, and did not feel like a worthwhile allocation of time. Also, not being a clinician, I likely would not be able to tell why drugs were prescribed if they are used to treat a variety of conditions. This also made it difficult to know whether a patient was detoxing from an appropriately used prescription drug (generally an opioid), and abused prescription drug, or an illicit substance.
12. Any time a patient noted that they were currently undergoing substance abuse treatment I recorded them as currently receiving mental health treatment, even if they otherwise noted they were not receiving mental health treatment.
13. This was the second place on this form that a mental illness may be noted.

(Receiving Screening cont.)

Suicide Potential Screening

1. Arresting or Transporting Officer Believes Subject may be a suicide risk.	YES	<input checked="" type="radio"/> NO
2. Lacks close family/friends in community.	YES	<input checked="" type="radio"/> NO
3. Worries about major problems other than legal situation (terminal illness):	YES	<input checked="" type="radio"/> NO
4. Family member or significant other has attempted or committed suicide (spouse/parentsiblingclose friend/lover).	YES	<input checked="" type="radio"/> NO
5. Has psychiatric history: <i>Depression</i>	<input checked="" type="radio"/> YES	<input type="radio"/> NO
6. Holds position of respect in community (professional/public official) and/or alleged crime is shocking in nature. Expresses feelings of embarrassment/shame: <i>Carpenter</i>	<input checked="" type="radio"/> YES	<input type="radio"/> NO
7. Expresses thoughts about killing self: ¹⁴	YES	<input checked="" type="radio"/> NO
8. Has a suicide plan and/or suicide instrument in possession ¹⁴	YES	<input checked="" type="radio"/> NO
9. Has previous suicide attempt: <i>Long time ago</i>	<input checked="" type="radio"/> YES	<input type="radio"/> NO
10. Expresses feelings there is nothing to look forward to in the future (feelings of helplessness and hopelessness):	YES	<input checked="" type="radio"/> NO
11. Shows signs of depression (crying or emotional flatness):	YES	<input checked="" type="radio"/> NO
12. Appears overly anxious, afraid or angry:	YES	<input checked="" type="radio"/> NO
13. Appears to feel unusually embarrassed or ashamed:	YES	<input checked="" type="radio"/> NO
14. Is acting and/or talking in a strange manner. (cannot focus attention.hearing or seeing things not there):	YES	<input checked="" type="radio"/> NO
15. Is apparently under the influence of alcohol or drugs:	YES	<input checked="" type="radio"/> NO
16. If YES to #15, is individual incoherent or showing signs of withdrawal or mental illness?: ¹⁵	YES	<input checked="" type="radio"/> NO
17. Is this individual's first arrest?	YES	<input checked="" type="radio"/> NO
18. Detainee's charges include: Murder, Kidnapping and/or Sexual Offense: Unknown	YES	<input checked="" type="radio"/> NO

Immediate Action: A "YES" from shaded area, or a total of 8 or more "YES" responses, shall result in notification of Shift Commander and immediate referral to MH evaluation. If after hours, initiate suicide watch immediately until MH can evaluate.

Routine Referral: Notify MH of any positive responses to suicide screen that did not meet above criteria for immediate referral.

14. A “Yes” from questions 7 or 8 was recorded as an indicators of suicidality and was recorded.
15. I did not record any information from this question as I did not feel that it provided concrete enough information about what the patient was experiencing. If a “yes” ultimately led to a mental health evaluation, it would have eventually been recorded through other means.

(Receiving Screening cont.)

16

Psychiatric Screening

1. History of or current psychotropic meds? List: <u>Wellbutrin 300mg/day</u>	<input checked="" type="radio"/> Y	<input type="radio"/> N
2. History of psychiatric hospitalization? When? _____ Where? _____	<input type="radio"/> Y	<input checked="" type="radio"/> N
3. History of outpatient mental health treatment? ¹⁶ When? _____ Where? _____	<input checked="" type="radio"/> Y	<input type="radio"/> N

Name: Katherine Stevenson

Date: 1/15/14

Provider Signature: [Signature]

16. This double barreled question was often difficult to gather data from. A “YES” was always marked down as a history of mental health treatment. When “current” was written next to medications, I documented the response as current mental health treatment. I did not record any information about the particular medication a patient was taking.

PATIENT HEALTH SERVICES REQUEST FORM - WITH CO-PAY

Name/Nombre Steven Katz Date of Birth/Fecha de Nacimiento 08/18/44

Book in # _____ Housing Unit/Unidad _____ Cell/Celda _____

Check only one box per slip

Sick Call: Describe Problem/Especifique el Problema Dental Treatment/Tratamiento Dental Mental Health/Tratamiento

I would like to speak to someone about my mental issues. Since I've been in here my anxiety has gotten worse, and I think it will continue. Thanks for your consideration.

I understand and agree that a clinic fee may be charged to my account for this visit

[Signature] 2/13/14 3:40 PM
Patient Signature/Firma Date/Fecha Time/Hora AM/PM

Health Care Staff Triage

Referral to provider					
Urgent, called provider	Date		Time		See Detailed Disposition
Next provider sick call					
Referral to next nurse sick call					
Referral to dentist					
Referral to mental health					
Other					
If no referral, why?					

Detailed disposition or comments

Health Care Staff Signature & Title Date Received Time

17. This form was the most moving part of any file I looked at. On some forms patients were clear and eloquent in their description of why they needed treatment. Other forms were written with scratchy lettering and poor grammar. Some forms gave the impression that completing the form was a difficult and exhausting process for the patient. In some cases the various health service requests in a patient's file ran the gamut of all three.

18. A mental health request or referral leads a patient to a mental health assessment with one of the two LCSWs that work part time at ACJ.

Initial Mental Health Evaluation (CCS) ¹⁹

Past History

Prior MH Treatment Outpt Inpt Provider? _____ 20
ROI Completed Yes No 21

Prior MH Medication Yes No If yes, list: _____

Prior MH Court Services Yes No If Yes, list: _____

Past Self Harm Yes No If Yes, detail: _____ 22

Past Substance Abuse Treatment Yes No If Yes, detail: Heroin, Suboxone, Etch 23, 24

Current Status

Currently in MH Treatment Yes No Specify: _____
ROI Completed Yes No

Currently taking MH meds Yes No Provider: _____ 25
Dose/Frequency/Date Last Taken: _____

Current Self Harm Thoughts Yes No Specify: _____ 26

Substance Use Yes No What kind? um _____ 27
Last Use? _____
Amount? _____

Current MH Issues:

Patient reports depressive symptoms and anxiety. Patient reports hx of PTSD. Pt reports that his thoughts are racing and states "I can't think like this." 28

Plan ²⁹

- Refer to MH Special Needs
- Initiate Self-Harm/MH Obs Watch
- Refer to Psychiatry
- Follow up by MH on _____ (date)
- Refer to Discharge Planner
- MH follow-up PRN, inmate educated on how to request services

Kurt [Signature]

2/14/14

19. This Mental Health Evaluation was seen fairly frequently in files from 2013-2015, but was not seen in every file. This made it difficult to get all pertinent information from each unique patient over the course of a patient's different stays at ACJ. Prior mental health court services were found on this form but not on others, while history of withdrawal and current treatment were not found on this one at all.
20. Sometimes a box would not be checked, but the provider would be filled out. I recorded this as a history of mental health treatment.
21. I also considered it a positive response when "ROI completed" was filled out but "Prior MH Treatment" was not.
22. A "YES" was recorded as a history of self-harm or suicidality.
23. In some cases, this question was marked as "YES" in this evaluation but had been marked as "NO" on the Receiving Screening. If the information was marked with a positive response on any screening, I recorded it as a positive response in my own data collection. This was part of the value of looking at multiple types of forms. I was able to catch diagnoses that were only disclosed at a certain screening or to a specific clinician. Additionally, if a clinician has misnoted a patient's response on one form, I could often catch the correct response on another. That being said, there is always the chance that a provider accidentally marked "YES" on a form as well.
24. Again, the boxes might not have been filled out, but detail was given, so I recorded the response as a history of substance abuse treatment.
25. As noted above, I recorded whether the patient was currently receiving treatment (aka, receiving treatment at the time of arrest), but not any specific information about the treatment the individual was receiving.
26. This was recorded as current suicidality or self-harm.
27. This question was illegible a disproportionate percent of the time in comparison to other questions. However, when it was legible, if a drug other than alcohol was reported, I did document what they reported using. Because I was not documenting when patients reported alcohol use, a "YES" without any information about what the patient used was recorded as missing data rather than as "YES" because I had no way of knowing which it was referring to.
28. A patient's reported mental health history was often recorded here. Sometimes it was illegible. When that was the case, I noted that the patient reported a history, but that the diagnostic information was missing. Other times I was able to gather specific information about a patient's diagnostic or treatment history from this question.
29. A check mark next to the first four of these was documented as a referral to the mental health team.

Mental Health Services Treatment Plan (CCS) ^{30, 31}

Diagnosis: Axis I: Anxiety; Substance induced ³²
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

30. This form frequently accompanied the Initial Mental Health Screening form, particularly if one of the first four “Plan” steps was checked off at the end of that form.
31. The original form includes more information such as treatment plan and patient goals. Because I did not gather any data from these sections I did not replicate these questions here. However due to the limited availability of treatment options at ACJ due to financial and personnel restraints, providers’ treatment plans were often limited to things like “assist patient in reaching stability goals” or “follow up in three days” rather than “refer patient to weekly substance use support group” or “prescribed 1.0 mg of clonazepam once daily” that would likely be seen in treatment plan notes written by a provider on the outside.
32. I used this document to collect data on diagnoses that ACJ’s mental health team made for patients. In some instances, ACJ’s diagnoses were the same as those self-reported by the patient. Other times they were different. In some instances, the patient was diagnosed by ACJ but had not self-reported any diagnosis.

Appendix 3: Summary of Findings

Chapter 4: MaineCare

- 24,500 individuals lost MaineCare between 2013 and 2014. Another 28,500 individuals (parents and nineteen and twenty year-olds) could lose coverage if the current 2018-2019 budget proposal is passed.
- Section 17 eligibility criteria limit intensive mental health treatment to a very specific group of individuals: those with diagnoses of schizophrenia and schizoaffective disorder and those with recent hospitalizations or institutionalizations.
- Written exceptions for Section 17 services are difficult to come by because substance use disorders and antisocial personalities are not eligible for these services.
- MaineCare recipients who lost Section 17 services *may* have been able to transition to BHH services however:
 - These services are not as intensive as Section 17 services and may not be accessible through smaller or rural agencies.
- Grant recipients who lost their Section 17 service eligibility lost all forms of mental health treatment because grant funding is only available for Section 17 services.
- The Burns rate model threatens to reduce reimbursements enough that agencies will have to stop providing these services (with few comparable available alternatives) or close altogether, causing more individuals to lose services.
- Proposed MaineCare reforms will put a substantial financial burden on MaineCare recipients (missed appointment fees and premiums) and will create obstacles to care (time limits, more stringent limitations on NET services, and ending retroactive coverage).
- The 2018-2019 Budget proposal, if passed, will cut approximately \$140 million in programs that provide vital services to vulnerable populations throughout Maine.

Chapter 5: Jail Care

- ACJ's budget shortfalls dramatically limit the jail's ability to provide mental health treatment services or other programs that would have a positive impact on mental health.
- ACJ is working within a budgetary structure that financially punishes the jail for efforts that reduce incarceration rates.
- Paper medical records make it difficult to maintain comprehensive health records, potentially limiting providers' abilities to identify health patterns in individual patients and across the patients they work with.

- Budget limitations prevent ACJ from providing full time access to medical and mental health providers, making it difficult for patients to access elevated levels of care (physicians).
- Staffing limitations drive the focus of health care at ACJ towards reactionary, rather than preventative care.
- Patients with mental illnesses may be less able to access work programs that provide positive interaction, autonomy, and skill development because they are more likely to have a violent offense and to be housed at a higher security level.
- The Forensic Intensive Case Manager (ICM) provides incredibly important support services to patients as they are released from ACJ and reintegrate into their communities.
- The ICM is limited in the services they are able to provide by nature of being the only person providing these services within ACJ and because of structural barriers within the services the ICM is helping patients access.
- Effective systems that ensure that patients receive high quality, personalized, continuous care between hospitalizations, incarceration, and released do not exist.
- Systems to ensure that patients are connected to current or new case managers during hospitalization, incarceration, and release are not present.
- Current ACT teams are limited in their ability to provide effective care because of policy limitations and their lack of having a specialized forensic unit.
- Long wait times for access to forensic beds leaves patients waiting at ACJ with minimal mental health treatment, potentially allowing their symptoms to worsen.

Chapter 6: Data Files

- 59% to 71% of individuals at ACJ between 2013 and 2017 had a mental illness besides a substance use disorder. Rates were at approximately 70% in 2016.
- At least 42% of patients at ACJ has a substance use disorder.
- Substance use disorders and overall mental illness rates peaked in the second half of 2014.
- Mental illness and substance use disorders are highly correlated. At least one third of patients at ACJ suffer from co-occurring disorders (substance use disorders and another mental illness).
- Higher rates of mental illness were correlated with being female and being white.
- Higher rates of substance use disorder were correlated with white patients.

- Mental illnesses and substance use disorders were strongly correlated to a history of violent offense and a greater number of bookings.
- Mental illness was significantly correlated to illicit drug use.
- Substance use disorders were significantly correlated to homelessness.
- Race and gender were indirectly correlated to number of bookings and a history of violent offense.
- Depressive disorders, PTSD, bipolar disorders, and anxiety disorders were the most prevalent mental illnesses after substance use disorders.
- Some pattern exists in prevalence changes over time. A number of variables, including total prevalence substance use disorders and certain mental illnesses reached peak prevalence in the second half of 2014. Prevalence rates for even more variables dropped at the beginning half of 2016, and began to rise during the second half of the year.
- Substance use disorders were independently correlated with all of the variables that reached their peak prevalence in the second half of 2014. Substance use disorder rates also peaked during these years.