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Recommendations for Improving the Involuntary Commitment Process

Report to the Maine Supreme Judicial Court and
the Joint Standing Committee on Judiciary by the
Judicial Branch Mental Health Working Group

December 15, 2014

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EXECUTIVE SUMMARY

Pursuant to Resolve Chapter 106 of the 126th Maine Legislature, the Chief Justice of the Maine Supreme Judicial Court chartered a Mental Health Working Group. A copy of the Legislative Resolve and Charter are available in Appendices A and B. Co-Chaired by the Chief Justice of the Maine Superior Court and the Chief Judge of the Maine District Court, the fourteen-member working group included individuals representing various stakeholders, including community hospitals, medical professionals, psychiatric hospitals, the Department of Health and Human Services, as well as patient and family advocates.

The Working Group met four times. Immediately recognizing that the problems associated with treating acute mental illness in Maine extend far beyond the scope of Working Group's Charter, members offered an array of comprehensive suggestions set forth in Appendix D to this Report. Within the confines of the task established by its Charter, The Working Group divided its conversations into the following two important areas of focus: first, the emergency detention, examination, and treatment of patients experiencing psychiatric crisis who are in community hospitals awaiting an inpatient psychiatric bed or community-based services and second, the recruitment, appointment, and compensation of independent examiners at the judicial stage of the involuntary commitment process.

After great and lively discussion among all parties attending, the Working Group recommends that the Legislature consider amending the statutory involuntary commitment process in Title 34-B of the Maine Revised States in order to:

- authorize hospitals to extend the current 24-hour emergency hold when an appropriate placement and resources for a patient are unavailable:
  - by up to 48 hours when heightened standards are met; and
  - for one additional 48-hour period provided that the heightened standards continue to be met and DHHS agrees to assist the hospital with securing an appropriate placement and resources for the patient.
- authorize hospitals to provide involuntary treatment to patients awaiting appropriate placements in specific, limited circumstances
- permit the use of telemedicine when conducting mental health examinations
- explicitly permit family input in certifying examinations; and
- provide independent examination services through a public entity either located in or modeled upon the state forensic service.

The Working Group appreciated the opportunity to meet and would be happy to provide additional details to the Legislature or to the Supreme Judicial Court regarding these recommendations.

I. INTRODUCTION

By Resolve, the 126th Maine Legislature recognized that there are often inadequate resources available for a hospital to respond to an individual who arrives at the emergency department in need of psychiatric treatment. A copy of Resolves 2013, chapter 106, is attached as Appendix A. Due to the number and utilization of inpatient beds at state psychiatric hospitals, community hospitals face both practical and legal challenges as they hold and attempt to treat patients in psychiatric crisis. Moreover, a statewide shortage of trained health care providers willing and able to serve as independent examiners has added strain to the judicial portion of the involuntary commitment process. The Resolve therefore directed that "the Chief Justice [of the Supreme Judicial Court] or the Chief Justice's designee shall convene a working group to review the current situation for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments and to develop recommendations for addressing immediate and long-term needs of individuals, hospitals, psychiatric hospitals and health care providers."

Accordingly, on August 15, 2014, the Chief Justice of the Maine Supreme Judicial Court established and appointed a Mental Health Working Group "to review the judicial process for involuntary commitment and treatment; examine immediate and long-term needs; and develop short-term and long-term solutions that address both legislative changes needed and resource improvements." The complete charge to the Working Group is included in Appendix B.

Co-Chaired by the Chief Justice of the Maine Superior Court and the Chief Judge of the Maine District Court, the fourteen-member working group was comprised of representatives of Maine entities and groups interested in the detention of individuals for emergency observation, involuntary treatment, and involuntary commitment, including representatives from the Attorney General's office, the Department of Health and Human Services (DHHS), the National Association of Mental Illness (NAMI), the Maine Hospital Association (MHA), the Maine Medical Association (MMA), the Maine Nurse Practitioner's Association (MNPA), the Consumer Council System of Maine (CCSM), and the Disability Rights Center (DRC), as well as a patient attorney, family advocate, mental health institution representative and Treatment Advocacy Center representative. A list of Working Group members is included in Appendix C.

The Working Group met four times from September to November 2014. From the outset, there was complete and full agreement among Working Group members that the long-term solutions for many of the issues complicating the care and treatment of individuals experiencing an acute need for mental health services in Maine include:

- Increasing the attention and resources given to individuals experiencing mental health issues in the State of Maine;
- Evaluating the amount and type of community resources as well as inpatient psychiatric treatment resources available for patients with mental illness in Maine as compared to the community and inpatient resources needed by these patients; and

- Increasing the financial resources available to compensate medical professionals who provide the independent examinations that are crucial to protecting the due process rights of patients during the judicial involuntary commitment process.

Unfortunately, many of the fundamental issues and potential solutions are beyond the scope of the Charter governing this Working Group. The Working Group nevertheless felt strongly that the Legislature should carefully review the list of major issues and potential solutions prepared by several members of the group, which is attached as Appendix D to this report. Critically, although the Working Group believes that adopting the recommendations in this report will likely relieve to some degree the current crisis facing the provision of acute mental health services in Maine, the issues discussed in Appendix D should also be addressed and resolved in order to achieve long-term resolution.

II. AREAS OF FOCUS

The Working Group agreed at the first meeting to divide its work into two main areas of focus, which served as topics of discussion for each of the next two meetings.

The first area of focus involves the emergency detention, observation, and treatment of patients in community hospital emergency rooms prior to location of appropriate community resources or an inpatient psychiatric bed and initiation of the judicial involuntary commitment process. Dr. Steven Diaz, emergency room physician and Chief Medical Officer at Maine General Medical Center in Augusta, graciously presented the Working Group with an overview of the protocols for and challenges of providing emergency room evaluations, treatment and care for patients in psychiatric crisis at the outset of the meeting.

The second area of focus involved independent medical examinations of patients during the judicial involuntary commitment process. This discussion was informed by statistics gathered by the Judicial Branch regarding the current appointment process.

III. EMERGENCY DETENTION, EXAMINATION, AND TREATMENT OF PATIENTS IN COMMUNITY HOSPITALS

A. *Overview*

Individuals experiencing psychiatric symptoms arrive at the emergency departments of community hospitals both voluntarily and involuntarily, oftentimes through the efforts of law enforcement. Upon arrival a "medical practitioner"—defined by statute as a licensed physician, registered physician assistant, certified psychiatric clinical nurse specialist, certified nurse practitioner or licensed clinical psychologist—must perform a certifying evaluation of the patient to determine whether he or she is mentally ill and, because of that mental illness, "poses a likelihood of serious harm." If the medical practitioner concludes that the patient meets these criteria and that

community resources are inadequate to treat the patient, emergency department staff begin seeking an inpatient bed for the patient at a psychiatric hospital. Current law only authorizes emergency department staff to detain patients for "a reasonable period of time, not to exceed 24 hours" while a psychiatric hospital opening is sought.

Unfortunately, due to the unavailability of inpatient psychiatric beds in Maine, community hospitals frequently are presented with the following untenable situation: the 24-hour emergency hold period has elapsed but the medical practitioner cannot ethically discharge the patient because the patient continues to poses a likelihood of serious harm to him/ herself or others. Dr. Diaz of Maine General Medical Center reported that currently his hospital has difficulty locating an inpatient bed within the statutory 24-hour timeframe up to 40% of the time. Moreover, it is not unusual to have as many as 16 patients at a time waiting in hospital emergency rooms for inpatient psychiatric beds in Maine.

As a result of the unavailability of inpatient psychiatric beds, patients in psychiatric crisis remain in community hospital emergency departments for significant periods of time, being treated and cared for by medical personnel who may not be experts in the care of mentally ill patients. The Maine Hospital Association (MHA) proposed measures to address this situation by introducing L.D. 1738 during the Second Regular Session of the 126th Legislature. Had it been enacted, that bill would have made several changes to the involuntary commitment laws, including:

- Authorizing hospitals to detain patients meeting the criteria for emergency psychiatric hospitalization for up to 4 days when supported by daily medical evaluations;
- Authorizing hospitals to detain patients for an additional 3 days after obtaining judicial endorsement of an emergency involuntary commitment application;
- Authorizing health care practitioners to administer involuntary treatment to detained patients if the patient's condition poses a serious, imminent risk to the person's physical or mental health and creating an expedited process for judicial review of these treatment plans;
- Permitting hospitals to conduct involuntary commitment examinations and consultations using telemedicine or similar technologies; and
- Affording hospitals and medical practitioners detaining a patient while awaiting the availability of an inpatient bed both civil immunity and an exemption from the licensing standards applicable to psychiatric hospitals for the detention, care, and treatment of psychiatric patients.

Ultimately, L.D. 1738 was amended to create the Resolve that led to the establishment of this Working Group, whose members have examined and discussed at length the issues surrounding emergency detention, examination, and treatment of patients in psychiatric crisis in detail, reaching consensus on several key recommendations for improving the current statutory framework.

B. *Working Group Recommendations*

After extensive, thoughtful discussion and debate, the Working Group respectfully recommends that the Legislature amend the involuntary commitment statutes in Title 34-B in the following ways:

1. Authorize Hospitals To Extend Emergency Holds When Appropriate Placements and Resources for Patients are Unavailable And Heightened Standards Are Met

A. Allow An Extension of up to 48 Hours, if Necessary, To Provide Hospital Staff Additional Time To Secure an Appropriate Community or Inpatient Placement

The Working Group unanimously recommends that that the initial 24-hour emergency hold time frame for detaining a patient in a community hospital based upon a medical practitioner's initial certifying examination should be retained. Section 3863 of Title 34-B should be amended to permit hospitals to extend the emergency hold for up to 48 additional hours, however, if the patient continues to pose a likelihood of serious harm but an appropriate placement has not yet been secured.

The Working Group discussed at length the appropriate procedural safeguards to be applied when a patient is held in a community hospital's emergency department for more than 24 hours. The Working Group considered requiring judicial endorsement for extending an emergency hold, but concluded that such a process would impose additional unacceptable strain upon the State's limited judicial resources. Instead, because not all emergency department medical personnel have sufficient experience and expertise with mental health issues to coordinate care for patients in psychiatric crisis for extended periods of time, the Working Group agreed that patients should be evaluated by professionals with heightened psychiatric expertise before an emergency hold is extended. The Working Group encourages hospitals that do not have professionals with the required expertise on staff to obtain the necessary evaluations through the use of telemedicine, a practice recommended later in this report.

Accordingly, the Working Group unanimously recommends that hospitals be permitted to extend an initial 24-hour emergency holds for up to an additional 48 hours if and only if the hospital certifies the following in writing:

(a) an additional evaluation performed by an "appropriately designated individual" demonstrates that the person poses a likelihood of serious harm due to mental illness;

(b) despite its best efforts, the hospital has been unable to locate an inpatient psychiatric bed or other appropriate alternatives; and

(c) the Commissioner of DHHS has been notified of the situation.

B. Allow One Additional Extension of up to 48 Hours, if Necessary, and Require DHHS To Assist the Hospital in Securing an Appropriate Community or Inpatient Placement

Unfortunately, while hospitals should be able to secure the necessary community resources or inpatient placements for most patients within the extended timeframe proposed above, circumstances might arise where necessary resources do not become available as quickly as they are needed. The Office of Substance Abuse and Mental Health Services reported, for example, that approximately 3% of patients who were involuntarily committed to a psychiatric hospital between July 2013 and October 2014 had been held in an emergency department for greater than 72 hours before an inpatient placement was secured. Although Working Group members unanimously agreed that in these situations the community hospital should be authorized to extend the patient's emergency detention for a second 48 hours by certifying that the criteria for extended detention continue to be met, they felt it necessary to require that DHHS step in at this point and lend its expertise and assistance to the hospital for the purposes of securing the necessary placement and resources for the patient.

For these reasons, the Working Group unanimously agreed that after the expiration of 72 hours (the initial 24-hour emergency hold period and one 48-hour extended hold), the hospital should be authorized to detain the patient for an additional period of up to 48 hours when the following criteria have been met:

1. The hospital certifies that:

   (a) an additional evaluation performed by an "appropriately designated individual" demonstrates that the person poses a likelihood of serious harm due to mental illness;

   (b) despite its best efforts, the hospital has been unable to locate an inpatient psychiatric bed or other appropriate alternatives; and

   (c) the Commissioner of DHHS has been notified of the situation.

2. The Commissioner of DHHS, or the commissioner's designee, certifies that:

   (a) the commissioner has been notified that the hospital utilized its best efforts to locate an inpatient psychiatric bed or other appropriate alternative and has been unable to do so; and

   (b) DHHS will use its best efforts in the next 48 hours to assist the hospital in locating an inpatient psychiatric bed or other appropriate alternative.

2. Authorize Hospitals To Provide Involuntary Treatment to Patients Awaiting Appropriate Placements In Specific, Limited Circumstances

Unlike situations where an unconscious patient arrives at a hospital emergency room after a motor vehicle accident in need of emergency surgical treatment, current

law does not provide clear standards regarding the involuntary treatment of patients with mental illness who are being held by a hospital on an emergency basis while an appropriate placement is sought. The Working Group spent a lengthy period of time crafting statutory language that will provide guidance for professionals when emergency mental health treatment is necessary as well as procedural protections for patients with mental illnesses. This statutory amendment is designed to authorize and to regulate the provision of involuntary treatment for patients with mental illness only as long as the patient is being held by the community hospital in accordance with the requirements of Title 34-B. The Working Group therefore unanimously recommends that the Legislature enact the following language, perhaps as a new subsection (4) to 34-B M.R.S. § 3861:

> **4. Emergency involuntary treatment.** Nothing in this section precludes a medical practitioner from administering involuntary treatment to a person who is being held or detained by a hospital against the person's will under the provisions of this subchapter if the following conditions are met:
>
> A. As a result of mental illness, the person poses a serious and immediate risk of harm to that person or others;
>
> B. The patient lacks the decisional capacity either to provide informed consent for treatment or to make an informed refusal of treatment;
>
> C. A person legally authorized to provide consent for treatment on behalf of the person is not reasonably available under the circumstances;
>
> D. The treatment being administered is a recognized form of treatment for the person's mental illness and is the least restrictive form of treatment appropriate in the circumstances;
>
> E. For purposes of evaluation for emergency involuntary treatment, the medical practitioner shall consider available history and information from other sources considered reliable by the examiner including, but not limited to, family members;
>
> F. A reasonable person concerned for the welfare of the patient would conclude that the benefits of the treatment outweigh the risks and potential side effects of the treatment and would consent to the treatment under the circumstances.

3. Permit the Use of Telemedicine When Conducting Mental Health Examinations

All members of the Working Group agreed that the current dearth of medical practitioners both qualified to perform and comfortable performing critical psychiatric examinations could best be addressed by permitting emergency room practitioners to consult with qualified professionals at remote locations or by having those remotely-located professionals perform the examinations through the use of available video technology.

To this end, the Working Group unanimously recommends that the Legislature add a new section to Title 34-B, which provides:

> **Medical examinations and consultations conducted via telemedicine or similar technologies**. Notwithstanding any other provision of this subchapter, a medical examination or consultation required or permitted to be conducted under this subchapter may be conducted using telemedicine as defined in Title 24-A, section 4316, subsection 1 or similar technologies that enable the medical examination or consultation to be conducted in accordance with applicable standards of care.

4. Explicitly Permit Family Input in Certifying Examinations

Family members sometimes have important, relevant information upon which a medical practitioner may wish to rely in performing an examination in the emergency room at the initial stage of the involuntary commitment process; yet, current law does not clearly permit such consultation and reliance. The current language in Section 3863(2) of Title 34-B does not provide medical practitioners with explicit authorization permitting consultation with family members, where appropriate, as part of the examination process. The Working Group realizes that it may not be appropriate for medical practitioners to consult with family members in some situations, for example, if the family member is suspected of having subjected the patient to sexual abuse or other forms of domestic violence.

Accordingly, the Working Group unanimously recommends that the following sentence be added at the end of § 3863(2)(B): "The opinion may be based on personal observation or on history and information from other sources considered reliable by the examiner including, but not limited to, family members." In addition, § 3863(2)(D), which contains repetitive language, should be deleted.

5. Miscellaneous Helpful Amendments to Title 34-B

In addition, the Working Group unanimously recommends the following minor amendments that will serve to clarify and to enhance the statutory involuntary commitment process:

- Amend 34-B M.R.S. § 3863(4)(B) to clarify that, when a judicial officer has endorsed an emergency involuntary commitment application ("blue paper"), DHHS is only responsible for the patient's "reasonable" transportation expenses;
- Amend 34-B M.R.S. § 3864(2) to clarify that a hospital may discontinue the judicial involuntary commitment process if the patient voluntarily submits to psychiatric care; and
- Amend 34-B M.R.S. § 3868 to clarify that when the Commissioner of DHHS transfers a patient to a different psychiatric hospital in Maine, both the order of

involuntary commitment <u>and</u> the order of involuntary treatment (if any) are automatically transferred to the receiving psychiatric hospital.

C. Issues Requiring Further Legislative Examination

The Working Group's unanimous agreement to the recommendations outlined above is premised on an assumption that all of the existing standards of care for hospital patients apply to patients who are held on an emergency basis while awaiting inpatient psychiatric placements. Moreover, because the recommendations outlined above include built-in mechanisms for protecting patient rights, the Working Group does not believe that the Legislature should promulgate additional judicial processes for challenging the detention and treatment of patients in community hospitals. Should a patient believe his or her statutory or constitutional rights have been violated, he or she can file a habeas corpus action pursuant to existing Section 3804 of Title 34-B.

The Working Group was unable to reach agreement on several important issues, however, and respectfully suggests that the Legislature explore the following:

- What qualifications must an "appropriately designated individual" possess in order to perform examinations authorizing a community hospital to hold a patient beyond 24 hours?
- Should a community hospital holding a patient for more than 24 hours be required to provide the patient with social work services (*e.g.,* to assist the patient with notifying landlords or employers or in taking care of pets)?
- Under what circumstances should family members be notified of the patient's situation during an extended emergency hold (*e.g.,* how can the law ensure that domestic violence perpetrators are not notified of a victim's location)?

IV. RECRUITMENT, APPOINTMENT, AND PAYMENT OF INDEPENDENT EXAMINERS

A. *Overview*

In fiscal year 2013, a total of 921 involuntary commitment cases were filed in the Maine District Court. In a significant number of these cases the psychiatric hospital also requested judicial authorization to provide involuntary medical treatment to the patient. An independent medical examiner must be appointed immediately in each case. Currently, Title 34-B requires the District Court to appoint the independent examiner, who will examine the patient, submit a report to the court, and provide testimony at the involuntary commitment hearing. Questions have been raised regarding the propriety of having the court—the neutral arbiter of fact—appoint the expert witness upon whose testimony the outcome of the case likely will hinge.

Despite its best efforts, the court system has encountered significant difficulty locating qualified experts willing to serve this crucial role. Due to fiscal constraints, the

Judicial Branch pays examiners $100 per hour, with a 2.5-hour cap imposed for each examination. The courts have generally been forced to exceed these limits in order to find willing examiners, however. Currently examination costs average approximately $500 to $600. Even if the court could find more professionals willing to perform examinations at this level of compensation, the evaluations are extremely disruptive to the professional's schedule. Independent examiners must on quite short notice visit the patient at the psychiatric hospital, review the patient's records, draft a written report addressing statutory criteria for commitment and/or treatment, appear in court on the date of the hearing, and sometimes wait several hours before being called to testify. During this time the professional is called away from his or her patients, who also need medical attention and care.

By statute, a licensed physician, registered physician assistant, certified psychiatric clinical nurse specialist, certified nurse practitioner or licensed clinical psychologist may serve as an independent examiner for involuntary commitment cases. Yet, if the psychiatric hospital seeks an order of involuntary treatment, an independent examination must be performed by a professional "qualified to prescribe medication relevant to the patient's care." The courts have been unable to find experts with the necessary prescribing authority who are also able to complete necessary evaluations within the mandatory fourteen-day statutory time frame for holding involuntary commitment hearings. Thus, the courts have had to bifurcate the proceedings and appoint two independent examiners in cases where both involuntary commitment and involuntary treatment orders are requested, further driving up costs.

B. *Working Group Recommendation*

The Working Group unanimously agreed that the current statutory model of having the Judicial Branch hire private evaluators to perform independent mental health examinations is both inadequate and possibly inappropriate. It therefore recommends that the Legislature take the following steps to resolve these issues.

1. Provide Independent Examination Services Through A Public Entity Either Located In or Modeled Upon the State Forensic Service

The Working Group believes that having a State agency hire qualified staff to perform independent medical examinations in involuntary commitment and involuntary treatment proceedings represents the most cost-efficient method for providing these services. The State currently pays professionals to conduct these examinations through the Judicial Branch, but in a fractured, inefficient way. These funds should be reallocated from the Judicial Branch to a separate State agency, which will hire professionals specifically dedicated to this task. The members of the Working Group agreed that the current model under which the Judicial Branch hires professionals on a case-by-case basis on short notice, interrupting their private practices, is untenable. The current model's failings will be eliminated by hiring professionals who can dedicate their time to these critically important evaluations.

Moreover, as state employees the professionals will be freed to provide their services across a wide geographic area, reaching traditionally underserved locations in the State.

The public agency responsible for hiring and supervising independent examiners should not be located either within the Judicial Branch or the psychiatric hospitals. The Working Group agreed that it might be appropriate to locate these professionals within the State Forensic Service, which currently provides mental health competency and capacity examinations in criminal and juvenile court proceedings. Alternatively, the Legislature could establish a separate agency to provide these examinations, using the State Forensic Service as a model of how government employees can provide truly independent professional evaluation services to assist the court system. The Judicial Branch is willing to transfer the funds currently budgeted for independent involuntary commitment evaluations to whichever agency is tasked with assuming this responsibility.

Most members of the Working Group believed that it might be possible for two full-time professionals to serve the independent examiner role required by the involuntary commitment and involuntary treatment processes. The Legislature may wish to explore whether it would be best for the state agency recruiting independent examiners to contract with several medical professionals across the State, hire a number of part-time independent medical professionals, or hire full-time staff who could, during time periods where fewer involuntary commitment applications are filed, work on other projects for the State agency.

V. CONCLUSION

Working Group members appreciated the opportunity to meet and to develop recommendations that, if adopted, will provide a necessary first step toward alleviating the difficulties currently experienced by patients in need of acute mental health care in Maine.

The Working Group suggests that Title 34-B be amended to create clear statutory authority for the care and treatment of patients detained in emergency departments while appropriate community-based or inpatient resources are being secured, as well as guidelines ensuring that patients are not detained unnecessarily. In addition, the proposed legislative amendments will ensure that medical practitioners performing involuntary commitment evaluations have both the necessary expertise and relevant information necessary to accurately assess the patient's mental health needs. Moreover, community hospitals will be provided the additional time and assistance they need in circumstances where it is especially difficult to secure appropriate community or inpatient resources for patients.

Finally, the delays and expense the State incurs in a process that requires the Judicial Branch, often without success, to timely locate and pay for independent medical evaluations for patients during the judicial portion of the involuntary commitment process will be greatly reduced by reallocating the current funds spent on these evaluations from the current, fractured system to a more streamlined system housed outside of the Judicial Branch.

While the Working Group feels confident that the proposals offered in this report will assist in the short run with the acute problems examined, the group also felt strongly that more permanent resolution could be achieved by implement of the suggestions made in Appendix D.

Appendix A
Resolves 2013, ch. 106

Resolve, Concerning Maine's Involuntary Treatment and Involuntary Commitment Processes

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, resources to respond to an individual who presents an emergency psychiatric situation at a hospital are currently inadequate; and

Whereas, hospitals currently face both practical and legal challenges in responding to individuals who arrive in emergency departments in need of psychiatric treatment when insufficient psychiatric beds are available; and

Whereas, the Legislature recognizes the necessity for remedies while protecting the rights of individuals and attempting to address their medical and psychiatric needs; and

Whereas, the best solution involves the participation of all those interested in the judicial process concerning detention for emergency responses, involuntary treatment and involuntary commitment; and

Whereas, the Chief Justice of the Supreme Judicial Court has offered to convene a working group to examine the immediate and long-term needs and develop short-term and long-term solutions to improve the judicial involuntary commitment and treatment process; and

Whereas, it is imperative that this resolve take effect immediately so that the working group can complete its work in time for the committee of jurisdiction to submit legislation to the First Regular Session of the 127th Legislature; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1 Working group convened. Resolved: That, in accordance with the offer extended by the Chief Justice of the Supreme Judicial Court in her letter to the Joint Standing Committee on Judiciary dated March 3, 2014, the Chief Justice or the Chief Justice's designee shall convene a working group to review the current situation for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments and to develop recommendations for addressing immediate and long-term needs of individuals, hospitals, psychiatric hospitals and health care providers. Specifically, the working group shall address the following issues:

1. The timing and length of preliminary and follow-up holding and commitment periods and requirements for involuntary treatment during such periods;

2. Process improvements for holding and commitment period determinations;

3. The current lack of health care providers available to address compliance with due process requirements and any procedural changes recommended by the working group; and

4. Any additional recommendations for improvement in the judicial commitment and involuntary treatment process; and be it further

Sec. 2 Participants. Resolved: That the Chief Justice of the Supreme Judicial Court or the Chief Justice's designee may invite the participation of the following in the working group convened under section 1:

1. A representative of an organization representing hospitals with emergency departments and hospitals with psychiatric units;

2. A representative of the Department of Health and Human Services;

3. Attorneys who represent patients in the judicial commitment process;

4. Disability rights advocates;

5. Medical and mental health professionals;

6. Mental health advocates;

7. Family advocates;

8. The Attorney General; and

9. Other interested parties; and be it further

Sec. 3 Report. Resolved: That the working group convened under section 1 shall submit a report of its findings and recommendations, including any legislative recommendations, by December 15, 2014 to the joint standing committee of the Legislature having jurisdiction over judiciary matters. The joint standing committee of the Legislature having jurisdiction over judiciary matters may report out legislation to the First Regular Session of the 127th Legislature to implement matters relating to the report.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B
JUDICIAL BRANCH
MENTAL HEALTH WORKING GROUP

Type:	**Short-Term Working Group**
Established:	**August 15, 2014**
Chair:	**Chief Justice Thomas E. Humphrey and Chief Judge Charles LaVerdiere**
Report Date:	**December 15, 2014**
Reports to:	**Supreme Judicial Court and the Joint Standing Committee on Judiciary**
Completion Date:	**June 30, 2015**

I. Purpose:

At the request of the 126th Maine Legislature, the Chief Justice calls together this stakeholder Working Group to review the judicial process for involuntary commitment and treatment; examine immediate and long-term needs; and develop short-term and long-term solutions that address both legislative changes needed and resource improvements.

II. Authority:

Authorized by Resolves 2013, ch. 106, § 1, which provides that "the Chief Justice or the Chief Justice's designee shall convene a working group to review the current situation for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments and to develop recommendations for addressing immediate and long-term needs of individuals, hospitals, psychiatric hospitals and health care providers."

III. Issues to be Considered:

A. Hospitals—Liability and Resources

A complete review of the judicial process for proposed involuntary commitment and treatment will be undertaken to determine whether improvements and clarification in the procedures and communication of those procedures can be identified, with the goal of providing appropriate due process, greater clarity for treatment providers, and improved public safety.

B. Judicial Branch—Independent Examiners—Due Process

An update on professional resources for evaluations, preliminary examinations, and full mental health exams will be undertaken. There is a growing lack of independent examiners available to timely evaluate individuals for court

hearings related to involuntary commitments and/or medications; as a result, either the involuntary medication request is unable to be heard, or there are inordinate delays in scheduling such hearings

C. Other—Independent Examiners—Responsibility and Resources

Independent examiners perform services and appear as witnesses for parties in court cases and hearings related to involuntary commitments and/or medications. As a result of historic budgeting processes, the payment of those individuals is channeled through the Judicial Branch, which has no expertise in setting appropriate professional rates, in seeking third-party contributions, or in seeking Medicaid reimbursement. Consideration must be given to reallocating responsibility for engaging and maintaining a sufficient roster of independent examiners for court proceedings. In addition, increases in costs must be addressed in order to assure prompt assignment of cases and timely resolution.

IV. Tasks of Working Group:

(1) Review the current process for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments;

(2) Develop recommendations for addressing immediate and long-term process improvement for individuals, hospitals, psychiatric hospitals, and healthcare providers regarding involuntary commitments and involuntary medication; and

(3) Address the following:

(a) Timing and length of preliminary and follow-up holding and commitment periods and requirements for involuntary treatment during such periods;

(b) Process improvements for holding and commitment period determinations;

(c) Current lack of healthcare providers available to address (i) compliance with due process requirements, and (ii) any procedural changes recommended by the Working Group;

(d) Establish responsibilities for (i) engaging and maintaining a

sufficient roster of independent examiners to timely perform services and appear as witnesses for parties in court cases and hearings related to involuntary commitments and/or medications, and (ii) paying all costs and fees associated with their services, including court appearances; and

(e) Any other recommendations for improvement in the judicial process for involuntary commitment and treatment.

V. Membership:

The Working Group shall be comprised of various stakeholders in the judicial process for involuntary commitment and treatment.

Its members shall include representatives of persons and entities interested in the judicial process concerning the detention of individuals for emergency responses, involuntary treatment, and involuntary commitment in connection with the medical and psychiatric needs of such individuals.

A. Members of Stakeholders Group:
   - Trial Court Chiefs
   - Attorney General's Representative
   - DHHS Representative
   - NAMI Representative
   - Patient Attorneys Representative
   - Maine Hospital Association Representative
   - Maine Medical Association
   - Maine Nurse Practitioner's Association Representative
   - Mental Health Institution Representative
   - Consumer Council System Of Maine (CCSM) Representative
   - Disability Rights Center Representative
   - Family Advocate Representative
   - Treatment Advocacy Center Representative

B. Subgroups of the Stakeholders Group:
   - (i) Due Process Subgroup
   - (ii) Providers & Costs Subgroup

VI. Statutes That Implicate Mental Health Issues In Court Proceedings:

1. Involuntary Medication – 34-A M.R.S. § 3049
2. Hospitalization for Mental Illness – 34-A M.R.S. § 3069
3. Transfer of Inmates for Mental Health Services – 34-A M.R.S. § 3069-A
4. Placement of Defendants for Observation – 34-A M.R.S. § 3069-B
5. Reception of Involuntary Patients – 34-B M.R.S. § 3861
6. Notification of Hospitalization – 34-B M.R.S. § 3861-A
7. Involuntary Medication – 34-A M.R.S. § 3049
8. Protective Custody – 34-B M.R.S. § 3862
9. Emergency Procedure – 34-B M.R.S. § 3863
10. Judicial Procedure and Commitment – 34-B M.R.S. § 3864

VII. Meetings:

The Workgroup shall meet as often as necessary to complete its responsibilities.

VIII. Reporting:

The Workgroup shall report to the Maine Supreme Judicial Court and the Joint Standing Committee on Judiciary on or before December 15, 2014.

IX. Duration:

Unless the Chief Justice extends the charter, the Workgroup will cease to exist on June 30, 2015.

Dated: December 15, 2014

Approved by:

/s/
Chief Justice Leigh I. Saufley
Maine Supreme Judicial Court

APPENDIX C
JUDICIAL BRANCH
MENTAL HEALTH WORKING GROUP

Membership Roster

Trial Court Chiefs
Chief Justice Thomas E. Humphrey
Chief Justice Charles LaVerdiere

Attorney General's Representative
Katherine Greason, Esq.

DHHS Representative
Jasmil Patillo

Maine Hospital Association Representative
Jeffrey Austin

Maine Medical Association
Gordon Smith, Esq.

Maine Nurse Practitioner's Association Representative
Constance Jordan, ANP, PMHNP

NAMI Representative
Jenna Mehnert

Mental Health Institution Representative
Dr. Michelle Gardner

Patient Attorneys Representative
William Lee, Esq.

Consumer Council System Of Maine (CCSM) Representative
Charlie Ames

Disability Rights Center Representative
Helen Bailey

Family Advocate Representative
Jeanie Coltart

Treatment Before Tragedy
Joe Bruce

APPENDIX D
JUDICIAL BRANCH
MENTAL HEALTH WORKING GROUP

Long-Term Issues for Individuals Experiencing Mental Illness in Maine

While the changes proposed in this report are important, they will not solve all the underlying problems associated with providing the necessary support to individuals experiencing an acute need for mental health services. It is very important to the members of the Working Group that the Legislature understand that more work needs to be done to help individuals with mental illness. Following is a list of issues that different members identified as factors to the underlying problem.

- **Lack of inpatient psychiatric beds**.

Several Working Group members voiced concern that a lack of inpatient psychiatric beds contributes to the problem of extended stays in emergency departments. The Working Group was unable to obtain comprehensive information on the length of time that individuals are spending in emergency departments. The statistics DHHS and MHA were able to compile did not include data from all community hospitals. Nor did we obtain information systematically collected on the specific needs of individuals awaiting admission to psychiatric hospitals. One emergency department physician who provided information to the task force stated that the patients who have extended stays are primarily elders, juveniles, and individuals displaying violent behaviors. Other members stated that individuals with dual diagnoses of intellectual disabilities and mental illness also experience extended stays. As all psychiatric hospitals may not be appropriate for all patients, it may be that there is a need for increased numbers of specialized psychiatric beds. The Legislature may wish to ask DHHS or another entity to collect data detailing the exact number of individuals who experience extended stays in all emergency departments during a set time period, the duration of those stays, and the type of any specialized psychiatric needs with which those individuals present. This information would better inform the Legislature and DHHS as to the number and type of inpatient psychiatric beds needed.

- **Clearinghouse of available inpatient psychiatric beds and community services**

There was a sense among Working Group members that the current "census" process used to identify available inpatient psychiatric beds is helpful, but could be greatly enhanced. An electronic database, updated in real time, identifying the number of inpatient beds available and types of patients accepted (dual diagnoses, geriatric, juvenile, etc.) could greatly assist community hospital providers, crisis workers, and DHHS staff in locating appropriate facilities for patients in a timely fashion. Moreover, the database should include similar information regarding the availability of community resources for patients with mental illness. This latter functionality may help reduce patient stays in hospital emergency departments by alleviating the over-identification of patients for inpatient services (discussed below).

- **Over identification of need for beds by hospitals/providers**.

There was some suggestion that given the pressures experienced by emergency departments and the inconsistent availability of psychiatric expertise in emergency departments, involuntary hospitalization may be recommended unnecessarily in some instances. If psychiatric expertise were consistently available in all emergency departments, through telemedicine, for example, more proper utilization of existing inpatient psychiatric hospital beds might be enhanced.

- **Rapid Response**

In the past, DHHS has taken part in a "Rapid Response" protocol when a patient has spent eight or more hours in a community hospital emergency department awaiting an inpatient psychiatric bed. In 2011, DHHS ceased its participation in these teams, indicating that it found the process to be of limited utility and that it was shifting its focus toward the use of regional crisis systems. Several Working Group members expressed a belief that the Rapid Response teams provided needed assistance and request that DHHS review whether or not it should reinstate this program.

- **Failure by hospitals/providers to assist patients who seek voluntary treatment**.

There was the sense among several Working Group members that there is inconsistency in how individuals who present to emergency departments are assessed or referred for *voluntary* treatment. Individuals may present repeatedly at emergency departments over the course of several days, yet they do not meet admission standards. When the individuals' conditions finally deteriorate, they might then be admitted to the psychiatric hospital because they are more acutely ill. Working Group members believe resources should be made available to all emergency departments to help link patients to needed community-based services and resources when they first arrive at community hospital emergency departments.

- **Limited availability of existing community resources (peer support, ACT teams etc.)**

Working Group members reported that peer support services and ACT teams can be effective in assisting individuals with mental illness to live successfully in the community and avoid hospitalization. These services, however, are not sufficiently available across Maine.

- **Unavailability of other community resources.**

Working Group members also noted that other mental health services are insufficiently available in Maine and that individuals are waitlisted for basic services such as community integration and medication management services.

Lack of available resources not only leads to increased numbers of patients in need of inpatient treatment but also results in individuals remaining in a psychiatric

hospital beyond the time when they could be safely discharged. Those inpatient psychiatric hospital beds are then unavailable to others in need of acute psychiatric hospital services, thus compounding the problem of extended patient stays in emergency departments.

- **Ineffectiveness of other community resources.**

Working Group members noted that several providers of needed services do not offer those services after 5:00 p.m. or on weekends, which unfortunately are oftentimes the periods of greatest need. Many community providers direct individuals who do not need medical care or inpatient hospitalization to hospital emergency departments rather than fully exploring the needs of the person. In addition, several community providers are inconsistent in their approach to persons experiencing mental illness to the degree that different employees of the same community provider disagree about whether hospitalization is needed.

- **Inappropriate refusals by community residential housing providers to permit patients to return home**

Working Group members noted that the extended stays in emergency departments can arise when hospitals are unable to discharge emergency department patients to their residential settings even though the individuals are medically and psychiatrically cleared to return. Other individuals who have been in a psychiatric hospital are unable to return to their residential settings even though they are ready for discharge. If community residential providers refuse to meet their obligation to provide housing to individuals with mental illness, psychiatric hospitals are unable to meet their obligation to provide inpatient services to the individuals truly in need of those services. The legislature may want to explore implementing processes for accelerated licensing or other administrative review of the processes whereby the residential facilities decline to allow the individual to return home.

- **Delays in processing involuntary commitment applications**

Currently, once a patient who is in need of inpatient hospitalization has been transferred from a community hospital to a psychiatric hospital the formal, judicial involuntary commitment process is initiated. Maine's statutes give the courts 14 days to conduct the involuntary commitment hearing. During that 14-day period, a court-appointed medical practitioner (psychiatrist, psychologist etc.) must conduct an independent evaluation of the patient and submit a written report. The hearing is then held to review the evaluation.

It is very difficult for the judicial system to meet this current timeframe due to the lack of available medical professionals to conduct the hearings. Nevertheless, the patient is in limbo for up to two weeks and is being held in an inpatient bed without an approved treatment plan. Accordingly, optimal treatment is delayed. The longer the treatment is delayed, the longer recovery is delayed. The longer recovery is delayed, the longer the inpatient bed is occupied. One way to make beds more available is to

implement strategies to accomplish a quicker turn-around time for patients who need treatment.

Any truly successful long-term solution will only be achieved if the issues identified above are addressed.