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STATE OF MAINE
KENNEBEC, ss.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-89-088

PAUL BATES, et al.,

Plaintiffs

v.

COMMISSIONER,
DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,

Defendants

COURT MASTER'S PROGRESS
REPORT PURSUANT TO
PARAGRAPH 299

The following report covers the period from June 30, 2013 to February 15, 2014.

Riverview Psychiatric Center

On October 25, 2013, this Court reinstated active supervision of Riverview Psychiatric Center (RPC) following the involuntary termination of RPC's provider agreement with the Center for Medicare & Medicaid Services as a result of service deficiencies in one of the forensic units. Although the Department has appealed from the order of termination and is simultaneously pursuing a petition for recertification, no definitive result has yet been achieved and RPC continues to operate without Medicare, Medicaid or Disproportionate Share funding. Under any likely scenario, there will be a need for a substantial increase in state funding to meet expenses during the upcoming fourth quarter of the fiscal year. The supplemental budget process, now underway, is somewhat more obscure than usual because the Executive Department has declined to submit a proposed budget. Thus at this point, the resolution of the fiscal needs of RPC rests in the hands of the Legislature.

The operation of RPC shows encouraging but modest signs of recovery. As this report was being prepared, it was announced that RPC had received continuing accreditation from the Joint Commission on Accreditation of Healthcare Organizations after an unannounced survey conducted in November of 2013. In recent weeks, the ability of the hospital to make greater use of its licensed capacity has improved slightly. Although there is a good deal of variation from day to day, the daily census now approaches eighty rather than remaining in the low seventies as it did in October and November and forensic admissions as a percentage of the whole has dipped from 70% to 63%. With the reduction in numbers, RPC is slowly moving forensic clients from the civil units back to the forensic units. At present, ten forensic clients are housed in the civil units.

Although the hospital has a licensed capacity of ninety two, it has been unable to fully utilize its capacity since at least the spring of 2013 because of staffing shortages and the acuity level of clients within individual sections of the hospital. The recruitment and retention of nurses and psychologists is particularly challenging because of the salary structure for both

classifications. RPC has obtained a modification of the salary scale for nurses. In the meantime, RPC uses contract nurses provided by a staffing agency. An adjustment in the salary scale for psychologists is still under review. In both cases, no adjustment in salary will occur uless funding is included in the supplemental budget for the fourth quarter.

Exacerbating the challenges in managing the forensic population of RPC is the fact that placements for forensic clients who had received court approval to transfer to less restrictive housing alternatives were backed-up and seriously delayed. On December 13, 2013, based on information provided by RPC, I found that there were six forensic clients awaiting placement in a secure group home and four of those clients had been waiting for nearly six months. In addition, there were three or four clients who were likely to receive court permission for placement in the near future. No placement opportunities were available and no plans existed for development within the short term. In December, the forensic population comprised 70% of the hospital's reduced daily census and there was a waitlist of eighteen persons seeking forensic admission. As a result, I issued a recommendation that the Department reactivate within 130 days the two state-owned group homes on Arsenal Street in Augusta that had previously been used to house forensic patients. In my progress report of September 10, 2012, I noted the loss of those units of housing and cautioned that the continued availability of alternative housing was critical if the hospital was to remain current with the demand for forensic services.

In response to my recommendation, the Department presented a series of alternative proposals for meeting the immediate needs of the forensic clients. As of February 11, 2014, the Department had developed ten placement opportunities from existing housing stocks by using a new analytical tool for assessing the readiness of clients in those units to move to a less restrictive placement. Standing alone, this response would not have been sufficient but the Department and the Commissioner's office also authorized the immediate development of additional outpatient forensic capacity at Dorothea Dix Psychiatric hospital together with the development of supported apartments and group homes necessary to meet the projected needs of forensic clients. Although the proposal requires further definition and detail, in my judgment it provides more relief than would be achieved by the implementation of my prior recommendation. Accordingly, I have withdrawn the recommendation and, in return, I have asked the Department to prepare a protocol for periodically projecting the needs of RPC for forensic placements and a planning and implementation process for meeting those needs in a timely manner. Once approved, such a protocol will be an important part of ensuring that the resources of RPC are used effectively and efficiently in the future and that the rights of forensic clients are respected.

Finally, RPC has plans underway to improve its ability to ensure the safety of clients and staff in dealing with behavior problems of the most aggressive forensic clients. Four acuity specialists have been hired, trained and certified as Management of Aggressive Behavior trainers. They have been assigned to the Lower Saco unit, the unit that houses the most acute forensic clients. The correctional officers previously assigned to this unit have been withdrawn and they will be replaced by an officer from the Capitol Police who will be stationed in the RPC lobby. RPC staff members, including those working in Lower Saco, have received additional training in de-escalation techniques. The mental health unit at Maine State prison is undergoing

improvement and development and will in the future allow the diversion of jail transfers and stage evaluations from RPC, thereby relieving some of the demand for forensic admissions.

It is too early to determine whether RPC will succeed in regaining federal certification and be able to utilize its full capacity in compliance with the requirements of the consent decree and all other regulatory controls. Progress is being made but, at this point, careful monitoring and a wait and see attitude seems most appropriate.

Developments in Community Mental Health

In my last progress report I noted that the Office of Substance Abuse and Mental Health Services ("SAMHS") had embarked on a project to improve the timely assignment of caseworkers to provide community integration services, the most basic form of mental health service and the gateway to other services provided in the community. At that time, 543 people with severe and persistent mental illness were on a waitlist for assignment of a caseworker and they were waiting for an average of 58 days, with some waiting for more than 350 days. The Consent Decree and the mental health services plan submitted by the Department requires the assignment of a caseworker within two days of a request if the client is hospitalized and within three days of a request if the client is not hospitalized. Non-class members are to have a caseworker assigned within seven days of a request.

The total number of persons currently awaiting the assignment of a caseworker is 447, and the average number of days waiting has been reduced to 27. Although there are individuals with Mainecare who have been waiting for more than 250 days and persons without Mainecare who have been waiting for more than 300 days, the statistical trend is moving, albeit slowly and incrementally, in the right direction. Whether the Department has the capacity to sustain and strengthen the rate of improvement will be determined in the coming months.

For the last several months, counsel for plaintiffs and the Department have met with me and a team from SAMHS to revisit the performance standards and the reporting requirements of the Consent Decree and the mental health service plan. The goal has been to maintain and improve the quality and availability of data that is useful for measuring the Department's compliance with the Consent Decree while eliminating unnecessary administrative structure and burden. To that end we have separated forty five separate performance standards into five different categories: (1) measures and standards which continue to have clinical or quality management value, (2) measures and standards that have been consistently met, (3) measures and standards with diminished clinical value, (4) standards beyond the control of the Department and (5) administrative procedures proposed for elimination. Although there are a few points of disagreement remaining, I expect that we will complete the task within the next two months. It is proposed that measurement and reports would continue with regard to the first category. Collection of data would continue with respect to the second category and be made available upon request, but routine reporting would not be required. The remaining three categories would be eliminated. Once completed, this project should significantly reduce the administrative burden imposed by the Consent Decree and permit more focused attention on the aspects of the Department's performance that are in the greatest need of improvement.

Dated: February 25, 2014

Daniel E. Wathen, Court Master