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Admitted in: ME

August 29, 2018

Michele Lumbert, Clerk
Kennebec County Superior Court
1 Court Street, Suite 101
Augusta, ME 04330

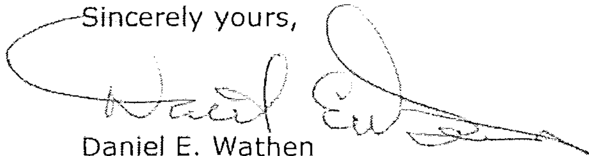
Re: Paul Bates, et al. v. Commissioner, Department of Health and Human Services, et al.
Docket No. CV-89-088

Dear Michele:

Enclosed please find for filing the Court Master's Progress Report Pursuant to Paragraph 299 dated August 28, 2018 in the above-captioned matter. I provided a copy to Justice Horton.

Thank you for your attention to this letter and enclosure.

Sincerely yours,



Daniel E. Wathen

DEW/sln
Enclosure

Cc/w/enc: Phyllis Gardiner, AAG
Mark Joyce, Esq.
Kevin Voyvodich, Esq.
Peter Rice, Esq.

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 August 1, 2017 to July 31, 2018.

Riverview Psychiatric Center

Despite an ever increasing demand for forensic admissions and a mix of patients that present a high level of acuity on all four units, there have been many signs of improvement at the hospital in the last year, particularly in areas of operation that have been chronic trouble spots in the past. Treatment plans are now prepared in a timely manner and are much improved in content. Discharges from the hospital occur in a timely manner despite housing shortages, and institutional reports for forensic patients are prepared and presented to the Court within ten business days of request. Staffing ratios are consistently met and overtime hours and mandated shifts have been reduced significantly. For example, monthly hours of overtime have been reduced from 2900 hours in March of 2014 to 240 hours in March of this year. Monthly mandated shifts have been reduced over the same time span from sixty nine to three. Nursing mandates, that had been as high as fourteen, were reduced to zero in the most recent reported quarter. Mandated shifts for mental health workers occurred only four times in the last quarter, down from an historical high of forty nine. The incidence and duration of confinement events, i.e., the use of seclusion, manual holds or mechanical restraints, compare favorably with national averages. Within the last year, despite an increase in acuity, the incidence of confinement events has been reduced significantly. The monthly average of manual holds in FY17 was thirty and was reduced to twenty in FY18. There has been no use of mechanical restraints in FY18, down from seven in FY17. The use of locked seclusion was reduced from a monthly average of seventeen to eleven. The care and safety provided by the hospital has definitely improved.

The challenge for Riverview in the last year, however, has been to keep pace with the growing demand for admission of persons with a higher level of acuity and behavioral concerns, while at the same time providing safe and appropriate care for all patients. The pace and incidence of hospital discharges is much improved but as this report period closes out, Riverview nevertheless has a record number of patients awaiting admission. On July 31, 2018, after two people were admitted, there were sixteen persons waiting for a forensic admission and thirteen persons waiting for a civil admission. Although the figures fluctuate on a daily basis, the demand for forensic admissions has increased markedly and the trend has been upward for several months. Among the sixteen waiting, eight have been referred for evaluation, two have been found incompetent to stand trial and six are jail transfers. On the same date, on the forensic side of the hospital, Riverview had seven vacant beds on Lower Saco and no vacant beds on Upper Saco. On the civil side, there were eight vacant beds on Lower Kennebec and three vacant beds on Upper Kennebec. The lower units in each case are the intake units and serve clients who have a higher level of acuity and present elevated safety concerns for themselves and others. The upper units have a lower level of acuity and people move into them after they have been stabilized on the lower units. Placing forensic patients on the civil unit is a practice that past history suggests should be resorted to only under very special circumstances.

Thus, despite the theoretical availability of beds noted above, the hospital is unable to fully utilize its capacity safely. It is not uncommon for the hospital to have at least one patient on each unit requiring one to one observation. On the forensic side, the upper unit is full even if there was someone stable enough to move from the lower unit. Although there are three vacant beds on the lower unit, admissions are made sparingly after careful evaluation of acuity and safety in the milieu. On the civil side, despite the availability of beds on the lower unit, acuity dictates paced admissions and movement to the upper unit. It is not advisable to admit patients directly to the upper unit or to move clients to the upper unit solely to make space on the lower unit. Therefore, as a result of increased acuity, i.e., patients who are more seriously ill and more difficult to control, the hospital has operated in recent months with about 80 to 85% of its ninety two beds filled. Clearly increased capacity is called for, particularly on the forensic side.

In my report one year ago, I noted that forensic capacity was a problem but that the forensic waitlist was kept within manageable levels of two or three delayed admissions by placing twenty to thirty forensic patients at Dorothea Dix Psychiatric Center. Such patients continue to be diverted to Dorothea Dix whenever possible; at present twenty two forensic patients are housed there, but now, one year later, Riverview has a forensic waitlist of sixteen and a total waitlist of twenty nine.[1]

The plans for the construction of a twenty one bed secure forensic rehabilitation facility at Bangor, proposed to commence April 2018, are behind schedule, but building plans were approved by the Bangor Planning Board on June 27, 2018 and the project is under construction. A potential operator has been identified by the Department and I have been assured that I will have an opportunity to review and comment on the operator's contract well before it is finalized. The

[1] As an aside, it should be noted that increased forensic demand affects the capacity of the civil side of the hospital as well. Patients having been found incompetent to stand trial, who are then found non-restorable, or patients who have their criminal charges dismissed, are sometimes immediately committed involuntarily as civil patients. At present, eight of the thirty nine civil patients at Riverview were admitted directly from the forensic side of the hospital.

construction of this unit could ease some of the pressure for forensic admissions by moving patients, with court approval, from the upper forensic unit at Riverview. It will be important, however, to detail specifically in the operator's contract, the clientele that this project will serve. Riverview has a need for housing forensic patients who cannot be handled safely in a hospital setting, a need for housing forensic patients who no longer meet the criteria for inpatient hospitalization, and a need for housing forensic patients who have progressed in their recovery to the point that they are ready to step down from inpatient hospitalization to a secure community placement. It seems unlikely that the new unit can satisfy all of these needs.

There are two developments outside of the mental health system that are contributing to the increased pressure for both civil and forensic admissions to Riverview and Dorothea Dix. First, due to changes in the resources available in the Office of Aging and Disability Services (OADS), persons with intellectual and developmental disabilities and possibly a secondary diagnosis of mental illness are being referred to both State Hospitals. It is reported that in the last year the crisis beds available to OADS for persons presenting behavioral issues have been reduced from twenty four to eight as a result of a lapsed contract and the situation has not been remedied. When these persons find their way into emergency rooms, hospitals or jails, they are often referred to Riverview or Dorothea Dix because there is no other place to house them. A similar situation exists with regard to veterans. It is reported that the Veterans Administration at Togus has at least temporarily reduced its sixteen bed mental health unit to eight because of staffing shortages, This has resulted in increased referrals for admission to Riverview or Dorothea Dix for persons who are entitled to full veteran's benefits. Often, such persons are taken to an emergency department and are arrested after a blue paper request is denied. Given the shortage of hospital beds, it is understandable, although not appropriate, that blue paper commitment is used sparingly.

In my last Progress report in August of 2017, I noted that the Department had reorganized forensic services at both hospitals and had appointed the clinical director of Dorothea Dix as Chief of Forensic Services/Clinical Director. In response to LD 966 which was then pending in the Legislature a group was formed to work on jail diversion as outlined in the attached memorandum (Exhibit A) presented to the Joint Committee on Health and Human Services. Although the group was active for some time, it has fallen by the wayside. Given the continued increase in forensic referrals to Riverview and the extended periods of time that person with mental illness are currently spending in emergency departments or jails before entering the forensic system, I suggest that the Department reinvigorate its effort to address jail diversion. Often a person with serious mental illness may spend long periods of time in jail and/or in inpatient hospitalization for evaluation of criminal competence and responsibility, when all that may be required is a prompt and appropriate community placement with services. Such an effort should include representatives from the courts, pretrial services, probation officers and community providers.

Finally, Riverview anticipates a survey by Centers for Medicare & Medicaid Services in the near future. The hospital is reasonably well prepared for such a survey and it would be an important milestone to regain federal certification.

Developments in Community Mental Health

Nearly two years ago, the Department and I, together with counsel for all parties, reviewed the performance reports of the Department and the provisions of the Consent Decree to determine the remaining trouble spots that stand in the way of the Department achieving a reasonable degree of compliance with regard to services provided in the community. The broad categories identified were (1) housing (2) timely access to services (3) improving client employment readiness and opportunities, and (4) improved management of contracted mental health services. A degree of progress has been made on each of these fronts during the last year.

First, with regard to housing: The Office of Substance Abuse and Mental Health Services (SAMHS) has historically been challenged to provide community housing and mental health services to persons awaiting discharge from psychiatric hospitals and for persons with mental health needs in the community. Such persons are often referred to Private Non-Medical Institutions (PNMIs) that are under contract to the Department. SAMHS serves as gatekeeper to these facilities. At present, there are 137 outstanding referrals and only twenty two vacancies in the PNMI mental health portfolio which has a total capacity of 671. SAMHS projects opening a total of forty five beds in five different facilities in the coming months and has two other potential projects that could add an additional fourteen beds. Importantly, the projected openings are designed to serve populations for which services are often in short supply, i.e., individuals with underlying medical conditions, younger adult clients and those with co-occurring substance abuse disorders.

SAMHS staff does a commendable job in prioritizing the few available placements for persons awaiting discharge from psychiatric hospitals but the lack of facilities does impact the movement of clients from Riverview into the community. At the present time, eleven of the outstanding housing referrals relate to clients awaiting discharge from Riverview and nine awaiting discharge from Dorothea Dix, the two State Hospitals. Discharge planning at the hospitals often reflects an awareness of the likelihood of delay and referrals are sometimes made in anticipation of a projected discharge date in the future. Although Riverview discharges most patients within the targeted cumulative timeframes; 70%> within seven days of clinical readiness, 80%> within thirty days, and 90%> within forty five days, the most common cause for those who are kept beyond forty five days is the absence of an available community placement that offers the required services. As a tertiary facility, Riverview is under continuous pressure to serve those who require inpatient hospitalization. In order to maximize the effective use of the hospital, it is imperative that discharges are not impeded by the lack of facilities for community placement.

The Bridging Rental Assistance Program (BRAP) is funded at $6,606,360 just as it was in the past fiscal year. Although this housing assistance program has been underutilized at times in the past, BRAP now has a waitlist. Thus far, through attrition, sufficient grants have been available to provide housing assistance for persons awaiting discharge from psychiatric hospitals and those ready to move from PNMIs into more independent settings in the community. Those with less priority, however, i.e., those who are homeless, those living in sub-standard housing and those discharged from jail or prison, are experiencing delay. In the coming year, if the trend continues, the Department will find it necessary to seek supplemental funding to meet the demand.

Access to services and improving employment readiness: In the past, it has been difficult for those who are either temporarily or permanently ineligible for MaineCare to access needed mental health services because of a lack of State funding. Waitlists for community integration, the most basic service for those who have severe and persistent mental illness, have been the result. In recent years, grant funding, usually referred to as consent decree funding, has been included in the base budget of the Department. The current fiscal year, which has just commenced, includes an appropriation of $5,708,780 and SAMHS is moving toward a payment system that will be totally based on fee for service rather than a cost settled basis. Utilizing monthly rather than annual allocations to providers for the most common types of mental health services, SAMHS hopes to achieve a degree of flexibility in providing services to clients placed on a waitlist and avoid the delay that has been involved in the past in amending service provider contracts in order to distribute grant funding to those providers who are experiencing a waitlist.

Beyond funding, in the past year SAMHS has devoted considerable effort to the management of waitlists for community integration and the results have been positive. As of June 1, thirteen people were waiting longer than thirty days for grant-funded or MaineCare-funded community integration services. An additional forty three people were waiting for more than thirty days for services at a Behavioral Health Home, an alternate means of obtaining community integration services for those with MaineCare coverage. Although there has been a bit of slippage in the past year, it represents a significant improvement over recent years, when the number waiting more than thirty days has ranged as high as 325+.

As of April 1, the Crisis system, which includes crisis stabilization units and crisis workers in the community to serve persons requiring mental health services, has been placed on a fee for service basis. This service has been underutilized in the past, particularly in the use of crisis units, and its lack of success in diverting persons in crisis from the emergency rooms of community hospitals. SAMHS's rationale for the change was to increase utilization. It is too early at this stage to determine the overall impact of this change.

At the end of 2017, SAMHS issued an RFP and implemented a new model for peer run centers, now known as the Consumer Operated Service Program. Eight providers now operate centers at twelve different locations. The goals of the change are to offer a service that is more structured than it has been in the past, with emphasis on structured groups, empowering activities, and other activities related to employment and employment readiness. SAMHS plans to contract with the Consumer Council System of Maine to perform an evaluation of each center, assisted by a nationally known consultant. The first evaluation will serve as a baseline and will be repeated on an annual basis thereafter, with recommendations for improvement. The emphasis on employment is consistent with the Consent Decree and should supplement the support that SAMHS provides through statewide support employment specialists and long term supported employment. Peer services and centers in particular are a valuable and important component of a functional mental health system. In addition, the involvement of informed peers in the annual evaluation process is a positive development. More effort will be required in the area of employment opportunities but the steps taken thus far are positive.

Medication management is a service that has been in short supply and in my judgment that is a reflection of the reimbursement rates. In the last legislative session, LD 1737 proposed a 25% rate increase. After being amended to 15%, it was enacted as emergency legislation as part of LD 925 and took effect on July 9, 2018 when the Governor's veto was overridden. This rate increase should improve the availability of this critical service.

Finally, a useful community service that is becoming available less frequently is the Progressive Treatment Plan (PTP). Stated simply this is a form of outpatient commitment. The civil client is discharged from Riverview and placed in the community on the condition that the treatment and medication plan is followed. In the event of failure the client can be returned to a hospital. This is a particularly useful tool when dealing with someone who has a long history of quitting their medication and decompensating once they are placed in the community. In order to be meaningful, however, hospital admission must be available whenever there is a failure. As noted above, the availability of hospital admission cannot keep up with demand and that is true for hospitals other than those operated by the State. The situation has been aggravated by providers in the community insisting on PTP before they will accept a placement. Providers have no legal right to impose that condition under the terms of their contract but such discussions unnecessarily prolong inpatient hospitalization and requires stronger enforcement efforts by the Department. The PTP service seems likely to become available less often or at least to lose its efficacy.

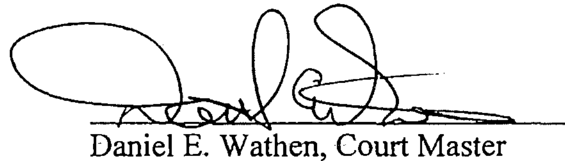
Contract management: It is important to realize that with the exception of the two psychiatric hospitals, the State provides very few mental health services directly. Most mental health services, whether funded by MaineCare or state funds, are delivered by private providers under contract with the Department. Thus the Department determines the quality of those services by the terms of the contracts and the management and enforcement of the contracts. SAMHS has devoted considerable effort in the past year to incorporate performance goals into the contracts and to improve the quality of their management information system and their methods for managing and enforcing the contracts.

Stronger contract provisions have been put into effect but improved management information has been slow in coming. Improvements were to come primarily from two sources; reports provided by KEPRO, the administrative service organization hired by the State, and a computerized Tableau program that is being developed within SAMHS office. The reporting procedure with KEPRO was changed more than a year ago and that has led to problems that have slowed down the production of the routine quarterly reports required under the Consent Decree. The problems are still not resolved and reports are not current. Those that have been provided are lacking basic information that has been tracked for years. In addition, the Tableau system being developed within SAMHS has been delayed considerably and it seems to have resulted from a reduction in staffing. In any event, at this point there is little to report in terms of concrete achievement although I anticipate further progress will be made, but slowly.

Beyond improvements in SAMHS contract management and enforcement capabilities, Counsel and I, together with representative of the Department, extensively discussed supplementing the Department's contract enforcement capabilities by adding a procedure for departmental review and a private right of action in cases of contested refusal or termination of services. Jointly we proposed LD 1911 (attached as Exhibit B) which was submitted by the

Governor late in the session. It did not receive legislative consideration but will be presented in the next regular session. In my judgment this measure, which has been used in connection with similar state services, could be a significant tool to assist the Department in managing and enforcing the contracts that it holds for the provision of mental health services. Many of the service delivery issues identified in this report would be easily resolved with prompt departmental review and the availability of a private right of action by the person in need of the services. Such a provision, once enacted, would move the State measurably closer to complying with the terms of the twenty eight-year old consent decree.

Dated: August 29, 2018



Daniel E. Wathen, Court Master

EXHIBIT A

LD 966

Work Session / April 12, 2017

Leadership is committed to reducing the number of people with mental illnesses in their jails:

- The Commissioner, Deputy Commissioner of Programs, Director of SAMHS, Chief of Forensics and the two Superintendents have developed a forensic services infrastructure to include work with ICMs, oversight of admissions form jails and outpatient services, connections to the SFS and future contract administration for the 21 bed Secure Forensic Rehabilitation Facility and the proposed mental health jail pod.

- The Commissioner charged the forensic leadership team to develop an initiative/pilot to reduce the number of county jail inmates with mental health issues from entering Title 15. This pilot is currently developing a triage system regarding inmates with mental health issues to be referred to an appropriate level of treatment. (Hospital, Jail, Mental; Health Jail Pod).

- Forensic Leadership Team: Commissioner, Deputy Commissioner, Superintendents at RPC & DDPC, Director of SAMHS, Chief of Forensic Program/Clinical Director, Director of Forensic and Outpatient Services, Director of Social Work and the Chief Forensic Liaison. With no additional funding required this team which is richly represented with clinical depth, ensures that the services and systems are for the forensic population is evidence-based and appropriate for individuals' level of care needs.

- Dr. Gardner is currently the Chief of Forensic Services for the State of Maine providing oversight to all inpatient, outpatient and contracted forensic services. Her administrative and psychiatric expertise is creating consistency. The forensic team has a strong relationship with State Forensic Services to balance treatment needs and the safety of patients and the public.

Screening and Assessment

- The forensic team is currently developing:
    - More timely screening and assessment at the county jails.
    - A process for inmates to be screened at admission creating a greater consistency in the assessment process.
    - Validated assessment for pretrial risk and exploring current pretrial services.
    - Incorporating individual and aggregate data from MaineCare's Continuing Care Unit, the electronic health record system for the ICMs and available jail databases.

Baseline data for people with mental illnesses who are incarcerated:

- DHHS is developing data processes to assist triage, admission and discharge processes.
- DHHS is in the unique position to create an integrated system within the jails across the State of Maine that collects screening and assessment data.
- The current pilot program will better inform our restructure for jails across the State of Maine.

Comprehensive process analysis and inventory of services:

- Currently developing a complete inventory of services in the jails.
- Currently analyzing processes for screening and assessment at the point of people entering the jail. Prior to this, questions have not been asked at pre-admission decision points.
- Access to treatment options are facilitated by the integrated nature of the Department and hospitals.

Prioritizing policy, practice and funding:

- Primary goals for the forensic leadership team are to reduce the length of stay for people with mental illness in jails, reduce Title 15 referrals and increase the number of people receiving appropriate and adequate mental health treatment.
- Currently have a good description of needs based on existing analysis and continue to further analyze this area.
- The pilot will begin with Kennebec and Penobscot Counties. Additional outcomes to be further developed as the forensic leadership team, Sheriffs and ICM team develop the pilots.
- DHHS staff and resources have been reallocated to support these efforts.
- ICM's will be instrumental in facilitating inmates to appropriate levels of care such as inpatient, contracted services, outpatient providers, the forensic mobile team and additional assessments.
- State hospital staff currently collaborates with the SFS, jails, courts and attorneys to support people through the court system and assessment and treatment processes. This will be enhanced with the integrated forensic infrastructure.

Tracking Progress:

- DHHS data experts are currently working with the leadership team to assess data needs, capabilities and privacy concerns.
- DHHS and jails will develop a process to track inmates with mental illness, charges and length of stay, treatment provided and recidivism.
- A transparent approach with outcomes, monitoring and compliance will be implemented.

EXHIBIT B

128th MAINE LEGISLATURE

SECOND REGULAR SESSION-2018

Legislative Document	**No. 1911**
H.P. 1350	House of Representatives, April 18, 2018

An Act To Improve Access to Services for Adults with Serious and Persistent Mental Illness

Reference to the Committee on Health and Human Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Representative MALABY of Hancock. (GOVERNOR'S BILL)

Printed on recycled paper

1 **Be it enacted by the People of the State of Maine as follows:**

2 **Sec. 1. 34-B MRSA §3613** is enacted to read:

3 §3613. Access to services

4 **1. Department review.** An adult with serious and persistent mental illness, as
5 defined in rules adopted by the department pursuant to this section, who is receiving or is
6 eligible to receive mental health services from a provider operating an agency, facility or
7 program under contract with the department may seek department review of the
8 provider's actions in the following circumstances:

9 A. When the provider refuses to accept a referral to provide a mental health service
10 for which the adult is clinically eligible that is included in rules of the department
11 governing the MaineCare program or otherwise required to be provided under the
12 terms of the provider's contract with the department and that the adult's treatment or
13 discharge planning team has determined is necessary in order for that adult to
14 transition from a hospital into the community, unless accepting the referral would
15 cause the provider to exceed preestablished staff-client ratios required by law, rule or
16 contract or unless the service is a residential service and the provider has no
17 vacancies;

18 B. When the provider refuses to accept a referral to provide community integration
19 services or assertive community treatment as defined in section 3801, subsection 11
20 to an adult with serious and persistent mental illness who is clinically eligible for the
21 services, unless accepting the referral would cause the provider to exceed
22 preestablished staff-client ratios required by law, rule or contract; or

23 C. When the provider terminates or suspends a mental health service included in
24 rules of the department governing the MaineCare program or otherwise required to be
25 provided under the terms of the provider's contract with the department in violation of
26 the terms of that contract.

27 **2. Private right of action.** An adult with serious and persistent mental illness who
28 is aggrieved by the action of a provider as described in subsection 1 and whose access to
29 services has not been resolved following department review may bring a private civil
30 action in District Court to restrain or enjoin a provider by restraining order or injunction,
31 temporarily or permanently, or enforce by restraining order or injunction, temporarily or
32 permanently, the terms of the provider's contract with the department.

33 A. An individual bringing an action under this subsection is not required to allege or
34 prove that the refusal, termination or suspension of services would cause irreparable
35 injury or harm to that individual.

36 B. An individual bringing an action under this subsection is not required to post a
37 bond.

38 C. The remedies available in an action under this subsection include both mandatory
39 and prohibitory injunctive relief.

1 D. An individual who obtains injunctive relief in an action under this subsection may
2 recover reasonable attorney's fees and costs, not to exceed $1,000, from the provider
3 against whom judgment was entered.

4 E. An individual who brings an action under this subsection is not liable to the
5 provider for damages resulting from bringing or pursuing the action unless the action
6 was brought in bad faith or without a reasonable belief that the provider was not
7 acting in compliance with its obligations under its contract with the department.

8 **3. Rulemaking.** The department shall adopt rules, which are routine technical rules
9 pursuant to Title 5, chapter 375, subchapter 2-A, governing the process for department
10 review described in this section. The rules must include a definition of "adult with
11 serious and persistent mental illness."

12 **SUMMARY**

13 This bill establishes the right of an adult with serious and persistent mental illness
14 who is denied access to services by a provider contrary to the terms of the provider's
15 contract with the Department of Health and Human Services to seek department review
16 of that action. If department review does not resolve the matter, the consumer may bring
17 a private right of action in District Court for injunctive relief.