STATE OF MAINE
KENNEBEC, ss.

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

PAUL BATES, et al.,

Plaintiffs

v.

BRENDA HARVEY, 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 1, 2010 to December 1, 2010.

Overview Of The Remaining Financial Resources Needed To Reasonably Satisfy The Requirements Of The Consent Decree.

The Department has yet to complete every goal set forth in the twenty-year old Consent Decree. Progress has been made, however, and the Department's quarterly reports evidence its continuing commitment to work effectively on the Consent Decree components defined in the mental health plan that it prepared in 2006 for Riverview Psychiatric Center and the community mental health service system. The hospital continues to make steady and substantial progress. The provision of community mental health services is compromised first and foremost by the withdrawal of state funding for services for clients ineligible for MaineCare that has occurred most dramatically within the last two years. In my last progress report dated June 25, 2010, I attempted to outline and quantify the remaining mental health needs that the State must address in order to reasonably meet the obligations that it assumed under the Consent Decree. The major requirements may be stated quite simply-- The budget and staffing of Riverview Psychiatric Center should be maintained at current levels, as it has been for the last two years. An additional

$4.6 million is required for community mental health services for those ineligible for MaineCare and $1 million for additional rental assistance for both MaineCare and non-MaineCare clients. The Department has filed budget requests to accomplish these remaining goals and those requests are currently being considered by the outgoing and incoming administrations. The Department's ability to meet the terms of the Consent Decree in the near future depends very much on the outcome of the budget deliberations in the coming legislative session.

Community Mental Health Services.

Many of the changes made necessary by budget reductions enacted in the last legislative session are still under study and without a definitive resolution. The funding reductions have gone into effect but the detailed changes to accommodate the reductions are still under consideration. Thus, work groups continue to address the details of outpatient mental health services, standardizing PNMI rates and creating rate structures for two levels of crisis services. In addition, the Department has a proposal for placing all MaineCare services, including mental health, under a managed care system. Initially, the plans called for the issuance of an RFP within the next few months. It now appears that the schedule may be delayed somewhat. Managed care, properly designed and implemented, could enhance the delivery of services and address long standing concerns relating to continuity of care. The managed care initiative will be followed carefully in the coming months.

In an effort to enhance the recovery orientation of the system, the Office of Adult Mental Health Services has conducted a number of meetings to review the Connecticut Recovery Guidelines. The process will be completed in the near future and is intended to result in the creation of Maine based recovery guidelines for all aspects of the mental health system. In addition the Office is conducting a technology based pilot project for collecting and analyzing

consumer input in real time as community integration services are provided. To this point, two Community Integration workers at three different agencies have participated in the project. Recently the project was expanded to include all of the CI workers at the three agencies. This is a program that has been used successfully in other states to enhance consumer voice and strengthen the use of recovery principles, as well as to inform and improve the delivery of services. The results in Maine should be monitored and carefully evaluated in the coming months.

As suggested above, the primary deficiency in the community mental health system is the unavailability of mental health services for the segment of the population that is not eligible for MaineCare. As detailed in my last progress report, by shifting costs too aggressively to Medicaid the Department has virtually destroyed the safety net of services that was previously available for that portion of the low income population that is ineligible for MaineCare. The Waitlist Reports prepared for the Department for the first quarter of this fiscal year tell the story: On the last day of the 1st quarter, one hundred and eight people ineligible for MaineCare were waiting for the most basic mental health service that the system supplies--Community Integration Services, essentially a caseworker. Some in this group have been waiting for the assignment of a caseworker for as long as 695 days. Under the terms of the Consent Decree the Department promised to make such services available within three working days of application. That is a simple promise that the State has never met. On the last day of the previous quarter, one hundred and six people were waiting. In the intervening three months, only ten people were assigned to service. Similarly, at the end of the first quarter, seven people were waiting for ACT services, the most intensive form of mental health service short of hospitalization. Some in this group have been waiting as long as 324 days. Four people were waiting on the last day of previous quarter

and no one was admitted to service during the intervening three months. (Waitlists exist for MaineCare funded services as well but for the most part clients are eventually admitted to service.)

When you consider that many people may choose not to seek services that are non-existent, the impact on the safety net resulting from the withdrawal of funding for persons ineligible for MaineCare can be appreciated. Clearly the State of Maine is neglecting the needs of some of our most vulnerable citizens. Those who are deprived of needed services often reappear in the criminal justice system, jails, homeless settings and hospitals, both state and private. It is critically important that we restore the funding and repair the safety net by funding the Department's budget requests.

Riverview Psychiatric Center.

Riverview, Maine's only tertiary mental health facility for both civil and forensic clients continues to show improvement. At present, the census at the hospital is below capacity and there is no waiting list for admission on either the civil or forensic side. Many performance indicators continue to reflect favorably on the operation of the hospital. Elopement, medication error rate and readmissions within 30 days continue to remain below the national mean. The hospital acknowledges concerns "regarding the acuity of clients and the perception of an increase in the number of events that result in client and staff injuries as well as an increase in the number of seclusion and restraint events." The Superintendent is cognizant of the need to monitor the use of restraint, including manual holds, and the quarterly report reflects initiatives that are underway to identify trends, common elements and timeframes, leading to the use of physical restraint with certain individual clients. The results should be the subject of discussion and analysis in the next Performance Improvement Report. I have also had recent conversations with

the Superintendent regarding an improved monitoring system for the use of prn medications when used coercively for behavior control.

There has been a marked improvement in recent months in the completion of employee performance evaluation reports, AIMS testing for adverse reactions to psychotropic medications and the timely filing of institutional reports for forensic clients.. Despite the shortage of mental health services in the community, particularly for those without MaineCare, the discharge process for civil clients is timely and effective. At present, only one civil client remains in the hospital for an appreciable period of time after achieving clinical readiness. As recently as 2005-2006, my progress reports recited the fact that as many as twenty out of a total of forty eight civil clients were "stuck" in the hospital awaiting community placement. The discharge process is managed by a very capable staff. Although their work has been aided a bit by a recent and temporary decline in the number of clients seeking admission, the improvements noted are a tribute to their diligence and perseverance over several years. In the past there has been much controversy over the size and capacity of the hospital. An effective discharge process is an important factor in utilizing the available capacity of the hospital to the maximum extent possible.

The discharge process on the forensic side of the hospital also shows some improvement, but in this arena the same capable staff confronts special challenges resulting from the State's heavy reliance on MaineCare funding for community services and the withdrawal of support for state-funded services. Persons charged with a crime but found not criminally responsible by reason of insanity are subject to discharge from the hospital only by order of the court. Although clinical improvement is an important element of the forensic discharge process, courts often take a conservative and incremental approach in releasing persons who have previously engaged in

behavior that is dangerous to society. For those who present the greatest risk, courts appropriately often approve release into the community only on condition that they reside in a group home or supported apartment with staff in attendance and, in addition, that they receive the intensive supervision and services of an ACT team. Such a resolution presents at least two challenges in terms the availability of community resources. First, group homes and supported apartments are in short supply in the catchment area served by the Forensic ACT team-- a twenty five mile radius around Augusta. Second, even those forensic clients who have MaineCare often fail to qualify for the services provided by a group home or supported apartment because they fail to meet the criteria for medical necessity. In short, from a strict medical point of view, they do not require the services ordered by the court and thus there is no MaineCare funding. The net result is that the client continues to occupy the scarce and expensive resources of the hospital long after the court has concluded that a less expensive placement in the community is safe and therapeutically appropriate. Once again this points up the critical need to restore funding for mental health services for the members of the low income population who are ineligible for MaineCare. The Department's budget requests for state-funded mental health services represent an important step in the effort to achieve compliance.

Conclusion.

We are at a critical stage of the Department's effort to meet the obligations of the Consent Decree. As I stated in my last progress report in June, the resolution of this long-standing challenge is well within the grasp and means of our State. In the coming months, I look forward to having the opportunity to discuss with the incoming administration and legislature the repair and restoration of the mental health safety net that is required for Maine's vulnerable citizens.

Dated: December 16, 2010

Daniel E. Wathen Court Master