Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

February 1, 2022

Senator Ned Claxton, Chair
Representative Michele Meyer, Chair
Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, Maine 04333-0100

Senator Claxton, Representative Meyer, and Honorable Members of the Joint Standing Committee on Health and Human Services,

Please find attached a summary of the work of the stakeholder group established by Resolves 2021, Chapter 60, which was tasked with reviewing the Progressive Treatment Program and processes by which a person may be involuntarily admitted to a psychiatric hospital or receive court-ordered community treatment.

As is noted in the report, the Department has not taken any position on the recommendations made by the stakeholder group. DHHS and the Governor's Administration will review and react to any proposals related to this work through the Committee Process.

Finally, it should be noted that the Legislature did not provide any resources to the Department for the convening of the task force, research, and writing of this report.

Sincerely,

Jeanne M. Lambrew, Ph.D.
Commissioner

LD 869 Stakeholder Group Report

Introduction

Resolves 2021, Ch. 60 (introduced as LD 869) instructed the Department of Health and Human Services (DHHS) to convene a stakeholder group to review the Progressive Treatment Program (PTP) as well as processes by which a person may be involuntarily admitted to a psychiatric hospital or receive court-ordered community treatment. This review was intended to accomplish the following:

1. Examine the PTP, including the feasibility of and barriers to filing applications to the District Court by authorized persons; and
2. Assess consistency and efficiencies of processes by which a person may be involuntarily admitted to a psychiatric hospital or receive court-ordered community treatment and develop recommendations to make the processes more effective and easier to administer in order to reduce the consequences of delayed treatment or lack of treatment.

Additionally, the Legislature's Health and Human Services Committee sent a letter to the Commissioner of Health and Human Services on July 19, 2021, further requesting that this review consider ways to increase the availability of the PTP and any barriers to access. A copy of this letter is included at the end of this report.

The stakeholder meetings included participants sharing a wide range of viewpoints. It is important to understand that the topic of involuntary treatment and hospitalization raises a natural tension between patients' rights and autonomy, and treatment approaches recommended by clinicians, and often supported by families and others in the patients' lives.

Finally, while the Department facilitated this stakeholder group, Maine DHHS does not take a position on the recommendations from this group and will review and react to proposed statutory changes as they are developed. The Department looks forward to working with all stakeholders engaged in improving the lives of individuals with serious and persistent mental illness. We have deep gratitude for the participants who contributed to this conversation.

Participants:

- Facilitator: Dr. Debra Baeder, PhD, ABPP Clinical Director, Office of Behavioral Health
- Jeff Austin, VP of Government Affairs & Communications, Maine Hospital Association
- Bobby-Jo Bechard, Program Manager, LINC Center
- Sarah Calder, Director of Government Affairs, Maine Health
- Dr. John Campbell, MD, Senior Physician Executive, Northern Light Acadia Hospital
- Senator Ned Claxton, MD, Maine State Senate
- Tammy Cooper, Director of Social Services, Dorothea Dix Psychiatric Center (DDPC)
- Dr. Matthew J Davis, MD, DFAPA, Medical Director, Riverview Psychiatric Center and President, Maine Association of Psychiatric Physicians
- Antoinette Gagnon, Director of Quality Assurance and Admissions, Motivational Services Inc.
- Stephanie George-Roy, LCSW, Deputy Supt., Riverview Psychiatric Center (RPC)
- Jeanne Gore, Coordinator, National Shattering Silence Coalition
- Connie Jordan, MSN, ANP, PMHNP, CEO & Clinical Dir., Behavioral Health Resources of ME
- Simonne Maline, Executive Director, Consumer Council System of Maine
- Dr. Robert McCarley, MD, VP Medical Affairs, Spring Harbor Hospital

- Lisa Harvey-McPherson, VP of Government Relations, Northern Light Health
- Marcus Michaud, LSW, Human Services Caseworker, Maine DHHS
- Chief Jared Mills, Augusta Police Department
- Judge Cynthia Montgomery, Maine Judicial Branch
- Hon. John Nutting, Family member and former State Senator
- Representative Anne Perry, FNP, Maine House of Representatives
- Kimberly Richardson, Esq., Assistant Attorney General
- Malory Shaughnessy, Exec. Director, Alliance for Addiction and Mental Health Services
- Ben Strick, LCSW, Senior Director Adult Behavioral Health, Spurwink
- Kevin Voyvodich, Esq., Managing Attorney, Disability Rights Maine
- Jim Bailinson, Esq., MaineHealth Legal Affairs

Additional staff support provided by Hope Glassberg and Molly Bogart with Maine DHHS.

Meeting Times and Dates:

1. October 1, 2021 - 2:00-3:30 PM
2. November 5, 2021 - 10:00-11:30 AM
3. December 3, 2021 - 10:00-11:30 AM
4. January 14, 2022 - 10:00-11:30 AM

Background and Context

Maine's Progressive Treatment Program (PTP)

Maine's PTP is established in Title 34-B MRSA, §3873-A. For a summary of the LegislativeHistory of this statute, please see Appendix A.

The current PTP statute largely resembles the same laws that have been in place for nearly a decade. The statute allows designated parties to make an application and then petition the District Court to order the admission of a patient to the PTP. These designated parties specifically include: the superintendent or chief administrative officer of a psychiatric hospital (both state and nonstate), the DHHS Commissioner, the Director of an ACT Team, a medical practitioner, a law enforcement officer, or the legal guardian of the patient. The application must be accompanied by a certificate of a medical practitioner providing the facts and opinions necessary to support the application. The application must also include a proposed individualizedtreatment plan and identify one or more licensed and qualified community providers willing to support the plan. The applicant must also provide a written statement certifying that a copy of the application and the accompanying documents were given personally to the patient and that the patient and the patient's guardian or next of kin, if any, have been notified of the patient's rightsregarding appointment of counsel and selection of an independent examiner.

Upon filing of the application, the District Court issues a notice of hearing to be held within14days of when the application is filed, unless good cause is shown to continue the hearing for upto 21 additional days. Barring certain exceptions, the hearing is confidential, and a report of theproceedings may not be released to the public or press.

Filing of the application also triggers the District Court to cause the patient to be examined by a medical practitioner. The independent examiner must report to the court on whether the patient isa mentally ill person, is suffering from a severe and persistent mental illness, and is posing a likelihood of serious

harm, all terms defined elsewhere in Title 34-B.[1]

Patients who are subject to a PTP application must be afforded an opportunity to be represented by counsel. The District Court is required to appoint counsel if none is provided by the patient orothers. Although the statute does not specify when the court must make such appointment, the court's practice is to appoint counsel when issuing the notice of hearing.

Admission to the PTP is contingent upon the following conditions: the patient suffers from a severe and persistent mental illness; the patient poses a likelihood of serious harm; the patient has the benefit of a suitable individualized treatment plan; licensed and qualified providers are available to support the plan; the patient is unlikely to follow the plan voluntarily; court-orderedcompliance will help protect the patient from interruptions in treatment, relapses or deteriorationof mental health; and compliance will enable the patient to survive more safely in a community setting without posing a likelihood of serious harm. In terms of evidence presented at hearing, the patient, the applicant, and noticed parties are afforded the opportunity to appear, to testify, and to present and cross-examine witnesses. Additionally, the applicant is required to submit to the court expert testimony to support the application and to describe the proposed individualtreatment plan.

After notice, examination, and hearing, the court may issue an order effective for a period of up to 12 months directing the patient to follow an individualized treatment plan and identifying incentives for compliance and potential consequences for noncompliance. Compliance measurescan include endorsement of an application for the patient's admission to a psychiatric hospital under the emergency involuntary hospitalization procedures set forth in 34-B M.R.S. § 3863 conditioned upon a certificate from a medical practitioner that the patient has failed to comply with an essential element of the treatment plan. This certificate and endorsement are colloquiallyreferred to as the "green paper." Other consequences include the ability of the applicant to file a motion for enforcement with the court supported by a certificate of a medical practitioner identifying the patient's noncompliance with the plan. Additionally, if the court directs a patient to follow an individualized treatment plan, the court may prohibit the patient from possessing a dangerous weapon for the duration of the treatment plan. Finally, for good cause shown, any party to the application may move to dissolve or modify an order or to extend the term of the treatment plan for an additional term of up to one year.

In terms of costs, the PTP statute provides that the applicant bears the expense of providing witnesses to testify in support of the application and to describe the proposed individual treatment plan. All other expenses are the responsibility of the District Court, including fees of appointed counsel for the patient, witness, and notice fees, and expenses of transportation for thepatient.

---

[1] *See* 34-B M.R.S. § 3801(5) (defining "mentally ill person"); § 3801(8-A) (defining "severe and persistent mental illness"); *and* § 3801(4-A) (defining "likelihood of serious harm"). Of note, the statutory definition of "likelihood of serious harm" includes four paragraphs:

> A. A substantial risk of physical harm to other persons as manifested by recent threats of, or attempts at, suicide or serious self-inflicted harm;
>
> B. A substantial risk of physical harm to other persons as manifested by recent homicidal or violent behavior or by recent conduct placing others in reasonable fear of serious physical harm;
>
> C. A reasonable certainty that the person will suffer severe physical or mental harm as manifested by recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury; or
>
> D. For purposes of section 3873-A, in view of the person's treatment history, current behavior and inability to make an informed decision, a reasonable likelihood that the person's mental health will deteriorate and that the person will in the foreseeable future pose a likelihood of serious harm as defined in paragraphs A, B or C.

The definition in paragraph (D) applies strictly to the PTP. The independent examiner is tasked with assessing whether the individual is meeting this "reasonable likelihood" and "foreseeable future" standard.

Current PTP Participation

As of January 28, 2022, there are approximately 78 individuals in Maine who are currently admitted to the PTP and subject to a District Court order. This includes 36 individuals for whomthe superintendent of RPC initially petitioned the court for admission to the program and 22 individuals for whom the superintendent of DDPC initially petitioned the court for admission tothe program. Eighteen individuals participate in the PTP pursuant to applications brought by Northern Light Acadia Hospital. Two individuals participate in the PTP pursuant to applications brought by Spring Harbor Hospital.

Stakeholder Meetings

Over the course of 4 meetings, the PTP Stakeholder group addressed in detail the required topicsin the Legislative Resolve. Apparent in those discussions were areas of consensus as well as areas where there was a diversity of opinion. Divergence primarily was philosophical and reflected the tension between maintaining patient's rights and autonomy within the context of thecurrent PTP statute and providing more assertive interventions via proposed changes to the current PTP statute.

One area of consensus among the group involved the need to establish some level of oversight by DHHS of the PTP program. That oversight was conceptualized as including a PTP Monitor within DHHS to manage expanded clarification of and training about the PTP includingenforcement mechanisms, data collection about outcomes related to the PTP, and support/consultation for non-state entities wishing to initiate a PTP plan. It was noted that, currently, the overwhelming majority of the PTP plans were initiated by representatives of the state psychiatric facilities. It was also observed that representatives of private entities have beenreluctant or unable to initiate PTP plans. According to providers, this is related to confusion about the process, workforce limitations, and the legal expenses involved in initiating PTPs.

There was considerable support among providers for the state to establish a way to fund the legal expenses of private entities initiating a PTP to remove that barrier. Alternatively, a suggestion was made to have the DHHS Commissioner be the moving party in all PTP plans going forward before the District Courts. It was observed by proponents of either a fund or of the DHHS Commissioner being the moving party in these cases that most other states with provisions similar to the PTP statute in Maine do not require private entities to fund the legal costs in the initiation and/or maintenance of a PTP. However, the representative from the Attorney General's (AG) Office and others expressed legal concerns about the latter suggestion, primarilyciting the inability of the AG's Office to represent or provide legal advice to a non-state entity.

Secondarily, the representative from the AG's Office expressed concerns about the additionalworkload challenges that suggestion would entail. Specifically, the representative and others offered observations about the work and coordination that is involved on the part of multiple parties in drafting and development of the individualized plan.

Another clear area of consensus involved the need to better clarify in policy and practice who arethe appropriate candidates for the PTP program, as well as clarify achievable goals in PTP plans.It was observed that appropriate candidates should be individuals who are at risk of posing serious harm in the foreseeable future, with major mental illnesses amendable to psychotropic medications, who would benefit from the structure and support a PTP plan offers, for whom re- hospitalization is a disincentive,

and who understand that they are subject to a PTP plan.

Correspondingly, PTP plan goals including medication compliance and regular contact with treatment providers on the designated ACT team are examples of directly achievable goals applicable to sustained mental health and recovery. It was observed that PTP plans often fail when too many goals are tethered to the PTP plan that, while aspirational, are either not directlytied to risk for decompensation or are not enforceable, including strict prohibitions on substancemisuse, particularly legal substance misuse. There was a view that if there was more clarity about appropriate candidates and goals at the front end of the process, the PTP plans would be easier to enforce on the back end.

There was considerable discussion of the process of enforcing a PTP plan and that discussion represented the area of greatest divergence of opinions. As noted, the statute includes different enforcement mechanisms. The stakeholder meeting discussions focused on the "green paper," *i.e.*, the enforcement mechanism that involves the certification by a medical practitioner that thepatient has failed to comply with an "essential requirement" of the treatment plan followed by judicial endorsement authorizing admission to a psychiatric hospital. An initial barrier involvedin this process identified by some stakeholders is that, in many instances, an admitting psychiatric hospital will not admit the patient under a PTP order directly from the community absent medical clearance at an emergency department. The "green paper" mechanism onlyauthorizes admission to a psychiatric hospital.

Another initial obstacle in this enforcement process cited by stakeholders involves securing transportation for the patient's admission to the psychiatric hospital, particularly if law enforcement is required for such a transport. Some law enforcement officers are reluctant to transport an individual when a judicial officer has authorized transport on the "green paper" itself, which in part, may be due to lack of knowledge about the PTP or the legality of the transport. The PTP statute authorizes the court to endorse the "green paper" application for admission to the psychiatric hospital "under section 3863," *i.e.*, the section governing emergencyhospitalization colloquially known as the "blue paper" process. This emergency hospitalization section of the statute contains clear provisions on custody and transportation. However, the PTP statute itself does not include such provisions.

Additionally, depending on the circumstances, the protective custody statute may not permit law enforcement to involuntarily transport a patient on the PTP in the community to either a psychiatric hospital or emergency department. To take an individual into protective custody, the law enforcement officer must have probable cause to believe that the person may be mentally ill and due to that condition is posing a likelihood of serious harm as defined in paragraphs A, B, and C of section 3801(4-A). This definition of likelihood of serious harm is the same standard applied when a medical practitioner evaluates the need for an emergency "blue paper" hospitalization. These are stricter criteria than the "green paper" certification of failure to complywith an essential requirement of the PTP treatment plan.

Another major obstacle identified is that if the individual is transferred to a psychiatric hospitalpursuant to an endorsed "green paper," the hospital may not be able to hold the individual involuntarily beyond 24 hours. Because the PTP statute authorizes the court to endorse the "green paper" application for admission to the psychiatric hospital "under section 3863," the provisions set forth in the emergency "blue paper" hospitalization statute are triggered upon thepatient's admission. This includes the post-admission examination certifying that the person is presently mentally ill and meeting the likelihood of serious harm standard for hospitalization. That limitation often results in a rapid return to the care of community providers.

Even when an individual meets the criteria for an emergency "blue paper" hospitalization and a psychiatric hospital bed is located, an additional obstacle was identified. The PTP statute does not clearly articulate what effect an involuntary admission has on the existing District Court PTPorder, leaving the statute open to interpretation on whether the PTP order is nullified. The Officeof the Attorney General has taken the position that the PTP order remains intact upon admission to the psychiatric hospital, however a subsequent District Court involuntary commitment order pursuant to 34-B M.R.S. § 3864 (colloquially known as the "white paper" process) would supersede the PTP order. The Office of the Attorney General reports that this interpretation has also been adopted by some counsel who practice in this area of the law and by some District Court judges who frequently preside over these types of cases. For some stakeholders, the notionthat a District Court PTP order is superseded by a District Court involuntary commitment order is an obstacle necessitating the need to reapply for the patient's admission to the PTP at the end of the commitment if deemed appropriate— a task that is involved and time-consuming. Onesuggestion was discussed to address that concern and involved developing a mechanism to maintain a PTP plan, subject to re-evaluation, after an involuntary hospitalization and District Court commitment order.

Other suggestions were discussed to remedy identified obstacles, none of which were supported by consensus. One suggestion included allowing an involuntary admission to a psychiatric hospital for a specified number of days (*e.g.*, 7 days or longer) based solely on the "green paper"criteria of the patient's non-compliance with an essential requirement of the individualized PTP treatment plan. Another suggestion involved enforcing medication compliance even over objection, when necessary and when other means of persuasion have been exhausted, (particularly for individuals prescribed a long-acting injectable medication) during the 24-hour period following the PTP patient's admission to a psychiatric hospital on a "green paper" and prior to the required post-admission certification for continued hospitalization as a means of a quick return to the community with medication.

By way of example, medical practitioners distinguished between the efficacy of enforced medication compliance over objection for patients prescribed long-acting injectables versus patients prescribed oral medications, assuming other means of persuasion have been exhausted. Stakeholders supporting expanded use of the PTP cited the benefits of compelled compliance, ifnecessary, for a limited period to forestall further dangerous mental health decompensation. Other stakeholders cited objections to any loosening of criteria for involuntary hospitalization ormedication over objection as significant infringements on patients' rights.

Strategies Considered for Improving PTP

While the Department facilitated these stakeholder meetings and individuals within the Department participated in the discussion, Maine DHHS does not take a position on these strategies and will review and react to proposed statutory changes as they are developed. The stakeholders reviewed several strategies and weighed in on each. Please see Appendix B for a breakdown on the relative support or lack thereof for each of these recommendations as well as the positions of the individual stakeholders who responded to a survey poll.

1. Establish a PTP Monitor under the auspices of DHHS. That monitor would be responsible for:
    a. Providing standardized training to PTP stakeholders including but not limited to hospitals, ACT Teams, and Law Enforcement. Training will focus on understanding

the PTP statute, consulting with private hospitals in the initiation of PTPs, identifying appropriate PTP candidates, establishing enforceable PTP plan goals tied to known risks for psychiatric decompensation, and clarifying that PTP enforcement is focused on previously established, judicially endorsed goals.

   b. Ensuring that patients' rights are maintained, that the PTP plan is based on good risk assessment, and that treatment is appropriate and coordinated.
   c. Collecting data on PTP outcomes statewide.
   d. Recommending to the Legislature changes to the existing PTP statute as necessary.

2. Establish a new fund, administered by DHHS, to reimburse the legal costs of private entities for PTP initiation and maintenance.
3. Establish a new mechanism within the PTP statute to maintain an existing PTP during an involuntary hospitalization based on a District Court Commitment, and/or establish a mechanism to make it easier to renew or amend a PTP after such a commitment, if deemed clinically appropriate, necessary to maintain safety, and in accordance with patients' rights.
4. Establish within the PTP statute an enhanced timeframe under which a person subject to a PTP could be involuntarily hospitalized in any psychiatric hospital under the green paper criteria, after endorsement by any District Court Judge, presuming they continued to meet those criteria during that timeframe. This would require a change to statutes involving emergency procedures involuntary hospitalization.
5. Reconcile involuntary transport to hospitals via Law Enforcement by using the green paper criteria versus the current protective custody criteria. This would require an additional change to the protective custody statute.
6. Establish within the PTP statute that the DHHS Commissioner is the moving party in all PTP applications to the District Court. This would require the Attorney General's Office to represent the DHHS Commissioner in every PTP application to the District Court from both public and private entities and, as a consequence, create legal concerns regarding representation and provision of legal advice to non-state entities and expand the work of the AG's Office.
7. Allow for medication over objection if a green paper is executed and if medication compliance is listed on the judicially endorsed PTP plan. Currently there is a District Court process for medication over objection that requires, among other provisions, statutory notice that does not currently comport with the filing of a green paper.
8. Allow for expedited treatment over objection Court filings; for example, require the Courts to hold a hearing within 48 hours of such an application with a provision that failure to hold a hearing would allow the petitioner to proceed with administration of medications previously administered during the PTP over objection without court order. This would require changes to statutes pertaining to medications over objection.
9. Clarify that PTP plans can be renewed where appropriate on an annual basis or clarify that if a PTP needs to be extended beyond an initial year and a 1 year extension, the applicant should initiate a new PTP plan rather than seek to extend the prior plan.

Appendix A: PTP Legislative History

Summary of Legislative History

The program was initially established during the 122nd Legislature pursuant to P.L. 2005, Ch. 519, pt. BBBB (effective July 1, 2006). In addition to clinical requirements, the original PTP criteria included: that the application to District Court for a person's admission to the PTP be made by the superintendent of a state mental health institute; that an assertive community treatment (ACT) team be available to provide treatment and care for the person; that the person be 21 years of age or older and under an involuntary commitment to the state mental health institute at the time of the filing of the PTP application; and that, absent certain exceptions, the duration of the PTP program would be for 6 months. *Id.* § BBBB-14. The original legislation had a repeal date of July 1, 2010, set forth provisions for the implementation of the PTP, and allocated funding associated with this implementation including funding to establish ACT services. *Id.* §§ BBBB-14 through BBBB-19.

By January 2010, the PTP was fully operational. *See* Report to the Joint Standing Committee on Health and Human Services on the Progressive Treatment Program (Jan. 2010). There had been some legislative changes to the PTP statute during the 124th Legislature, including reducing the age of eligibility to 18 years of age and extending the permitted duration of participation in the PTP to 12 months. *See* P.L. 2009, Ch. 321 (effective September 12, 2009); *see also* P.L. 2009, Ch. 276 (effective September 12, 2009). Over a three-year period of program operation, Riverview Psychiatric Center had 19 admissions (involving 15 individuals) to the PTP with ACT services in the community provided by an RPC ACT Team. *See* January 2010 Report. Over the course of two years and five months of program operation, Dorothea Dix Psychiatric Center had 17 admissions (involving 16 individuals) to the PTP with ACT services in the community provided by Community Health and Counseling Services in Bangor. *Id.*

With the impending repeal of the initial PTP legislation, the 124th Legislature determined to extend the PTP and make further amendments to the law with the passage of P.L. 2009, Ch. 651 (effective April 14, 2010). Among other amendments, the new law expanded who could initiate and apply for a person's admission to the PTP to include the commissioner, the chief administrative officer of a nonstate mental health institution, and the director of an ACT team. *Id.* § 29. Applications were no longer contingent upon the person being under an involuntary commitment order, nor was it required that the person partake in ACT services. *Id.* §§ 7, 29.

Other amendments included extending the possible duration of admission to the PTP. *Id.* § 29. Sections addressing treatment plan compliance and consequences for noncompliance were also added. *Id.* Following these changes in 2010, efforts were made to educate and provide guidance to stakeholders so that nonstate psychiatric hospitals and community ACT teams could petition the court for an individual's admission to the PTP. *See* Report to the Joint Standing Committee on Health and Human Services on the Progressive Treatment Program (Jan. 2012). Nonetheless, as of January 2012, aside from the two state psychiatric hospitals and the two existing ACT teams affiliated with the initial PTP legislation, there had been no other psychiatric hospitals or ACT

teams that had petitioned the court for an individual's admission to the PTP. *Id.* After five years of program operation, RPC reported 21 total admissions (involving 15 individuals). DDPC reported 45 admissions (involving 42 individuals) over four-and-a-half years of program operation.
Effective August 30, 2012, additional amendments to the PTP laws were passed during the 125th Legislature. This included further expanding who could apply for an individual's admission to the PTP

to include a medical practitioner, a law enforcement officer, or the legal guardian of the patient subject to the PTP application. P.L. 2011, Ch. 492, § 1. The application now required a proposed individualized treatment plan. *Id.* PTP compliance language was also revised. P.L.2011, Ch. 541, § 3.

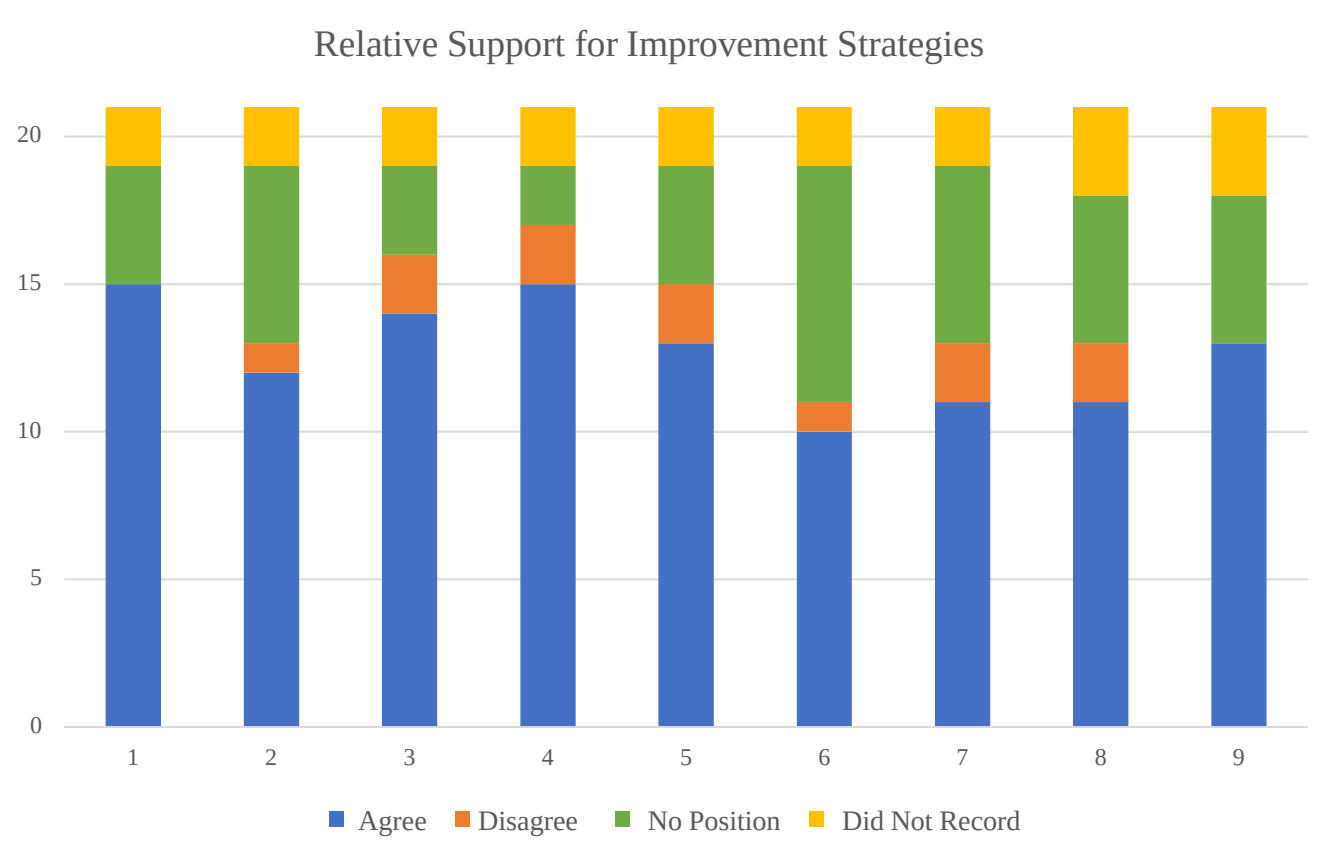
Most recently, in the context of protective custody and protection from substantial threats laws, the 129th Legislature incorporated new language into the PTP laws that authorized the District Court to enter an order that could prohibit a person admitted to the PTP from possessing a dangerous weapon. P.L. 2019, Ch. 411, pt. B (effective September 19, 2019).

Several other bills related to the PTP have been considered, but not passed, in recent years. *See, e.g.*, LD 232 (129th Legis. 2019) *and* LD 1090 (130th Legis. 2021).

Appendix B: Strategies Poll Results

Improvement Strategies (additional detail offered in body of report):

1. Establish a PTP Monitor under the auspices of DHHS
2. Establish a new fund, administered by DHHS, to reimburse the legal costs of private entities for PTP initiation and maintenance
3. Establish a new mechanism within the PTP statute to maintain an existing PTP during an involuntary hospitalization
4. Establish a timeframe under which PTP participants could be involuntarily hospitalized under green paper criteria
5. Reconcile involuntary transport to hospitals by Law Enforcement by using green paper criteria rather than protective custody criteria
6. Make DHHS Commissioner the moving party in all PTP applications, requiring AAG representation
7. Allow for medication over objection if under green paper and medication compliance is listed on PTP
8. Allow for expedited treatment over objection Court filings
9. Clarify that PTP plans can be renewed on an annual basis when appropriate



Individual Positions on Strategies

A = Agree, D = Disagree, NP = No position, DR = Did not record

Representation	1	2	3	4	5	6	7	8	9
AAG Kimberly Richardson Office of the Attorney General	NP	NP	NP	NP	NP	NP	NP	NP	NP
Stephanie George-Roy Riverview Psychiatric Center	A	NP	A	A	A	NP	NP	DR	DR
Tammy Cooper Dorothea Dix Psychiatric Center	NP	NP	A	A	A	NP	A	A	NP
Dr. John Campbell Northern Light Acadia Hospital	A	A	A	A	A	A	A	A	A
Dr. Rob McCarley Spring Harbor Hospital	A	A	A	A	A	A	A	A	A
Jeff Austin Maine Hospital Association	DR	DR	DR	DR	DR	DR	DR	DR	DR
Kevin Voyvodich Disability Rights Maine	A	NP	D	D	D	NP	D	D	NP
Simonne Maline Consumer Council System of Maine	A	D	D	D	D	D	D	NP	NP
Bobby-Jo Bechard LINC Center/Impacted Perspective	DR	DR	DR	DR	DR	DR	DR	DR	DR
Jeanne Gore National Shattering Silence Coalition	A	A	A	A	A	A	A	A	A
John Nutting Family Member	NP	A	A	A	A	A	A	NP	A
Marcus Michaud Legal Guardian of a Patient	A	NP	A	A	A	NP	NP	A	A
Malory Shaughnessy Alliance for Addiction & MH Services	A	A	A	A	NP	A	A	A	A
Ben Strick Representing an ACT Team	A	A	A	A	A	A	NP	D	A
Antionette Gagnon Representing a PNMI	A	A	A	A	A	A	A	A	A
Dr. Matt Davis Maine Assoc. Psychiatric Physicians	A	A	A	A	A	A	A	A	A
Connie Jordan Psychiatric Nurse Practitioner	A	A	A	A	A	A	A	NP	A
Chief Jared Mills Augusta Police Department	A	A	NP	A	A	NP	NP	A	A
Judge Cynthia Montgomery Maine Judicial Branch	NP	NP	NP	NP	NP	NP	NP	NP	NP
Rep. Anne Perry, FNP State Representative	A	A	A	A	NP	A	A	A	A
Sen. Ned Claxton, MD State Senator	A	A	A	A	A	NP	A	A	A

STATE OF MAINE
ONE HUNDRED AND THIRTIETH LEGISLATURE
COMMITTEE ON HEALTH AND HUMAN SERVICES

July 19, 2021

Commissioner Jeanne M. Lambrew
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Lambrew,

The Health and Human Services Committee recently considered two bills relating to Progressive Treatment Programs: LD 1090, Resolve, To Equitably Fund Legal Fees for Progressive Treatment Programs, and LD 869, Resolve, Directing the Department of Health and Human Services To Review the Progressive Treatment Program and Processes by Which a Person May Be Involuntarily Admitted to a Psychiatric Hospital or Receive Court-ordered Community Treatment. LD 869 was finally passed as Resolves 2021, ch. 60 on June 15, 2021.

Although the Committee voted "ought not to pass" on LD 1090, we wanted to emphasize the importance of finding a way to increase the availability of the progressive treatment program. LD 1090 would have funded court and legal fees incurred by persons authorized to petition for a progressive treatment program. The committee heard from members of the public that fees, legal representation, availability to patients in State hospitals versus nonstate mental health hospitals and other factors relating to filing these petitions delays the ability of individuals with mental illnesses to obtain access to mental health services and increases the time individuals spend in more restrictive settings. We request that the stakeholder group you convene pursuant to Resolves 2021, ch. 60 considers the barriers to accessing the progressive treatment program as part of its work. We also request that you share this letter with the stakeholder group. Thank you for your attention to this important topic.

Sincerely,

Sen. Ned Claxton
Senate Chair

Rep. Michele Meyer
House Chair

cc: Health and Human Services Committee members
Molly Bogart, Government Relations Director, Department of Health and Human Services