Maine

Department of Health and Human Services
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

FY 2024
PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS
Short Title: 2024 PAIMI Progress Report

Funding Opportuntity Announcement (FOA)
No. SM-17-F2

Catalog of Federal Domestic Assistance (CFDA)
No.: 93-138

A. PAIMI Program Information

General Information

1. P &A Identification

Name of state or jurisdiction	Maine
Name of P&A systems	Disability Rights Maine
Unique Entity ID	GJEPWTMKF5A3

2. Main Office

Agency Name of Main Office	Disability Rights Maine
Mailing Address of Main Office	160 Captiol St. Suite #4
City	Augusta
Zip Code	04330
Phone Number of Main Office	2076262774
Toll Free Number	8004521948
Email address	advocate@drme.org
Website address	www.drme.org
TTY phone number	2076262774
County of Main Office	Kennebec

3. Other Offices (if any)

Agency Name of Other Office	
Mailing Address (Each Statellite Office)	
City	
Zip Code	
County of Each Satellite Office (Location)	

4. Executive Director/Chief Executive Officer Contact Information

Name	Kimberly Moody
Mailing Address	Disability Rights Maine, 160 Captiol St. Suite #4
City	Augusta
Zip Code	04330
Phone Number & Extension	2076262774
E-mail Address	kim@drme.org

5. PPR Preparer Contact Information

Name	Mark Joyce
Title	Managing Attorney
Phone Number & Extension	2076262774
Email Address	mjoyce@drme.org

6. Governing Board President/Chair Name

Name	Andrew R. Sarapas, Esq.
Mailing Address	18 Pleasant Street Suite 214
City	Brunswick
Zip Code	04011
County of Residence	ME
Email Address	andy@sarpas.law
Current Term Started	9/30/2023 12:00:00 AM
Current Term Expires	9/30/2026 12:00:00 AM

7. PAIMI Advisory Council President/Chair Name

Name	April Kerr
Mailing Address	P.O. Box 244
City	Farmington
Zip Code	04938
County of Residence	ME
Email Address	aprillkerr2020@gmail.com
Current Term Started	4/15/2022 12:00:00 AM
Current Term Expires	4/15/2026 12:00:00 AM

8. Name Of P&A Chief Financial Officer/Accountant

Name	Shannon Crocker
Title	Chief Financial Officer
Phone Number/Extension	207-626-2774
Email Address	scrocker@drme.org

9. Governor's Liaison

Name	Sarah Squirrell
Official Title	Director Office of Behavioral Health
Mailing Address	State House Station, #11
City	Augusta
Zip Code	04333
County of Residence	Kennebec
Phone Number/Extension	
Email Address	Sarah.Squirrell@maine.gov

10. Commissioner/Director of the State Mental Health Agency

Name	Sarah Squirrell
Mailing Address	SAMHS State House Station #11
City	Augusta
Zip Code	04333
Phone Number/Extension	207-592-6406
Email Address	Sarah.Squirrell@maine.gov

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Footnotes:

A. PAIMI Program Information

Demographic Composition of PAIMI Governing Board, Advisory Council, and Program Staff

		Governing Board	Advisory Council	Program Staff
Ethnicity				
	Hispanic/Latino	0	0	0
	Non-Hispanic/Latino	9	12	9
	Ethnicity Unknown	0	0	0
Race				
	American Indian/Alaska Native	0	1	0
	Asian	0	0	0
	Black/African American	0	0	0
	Native Hawaiian/Pacific Islander	0	0	0
	White	9	12	9
	Two or more races	0	0	0
	Some other race	0	0	0
	Race Unknown	0	0	0
Gender				
	Female	5	10	3
	Male	4	3	6
	Transgender (Trans Woman)	0	0	0
	Transgender (Trans Man)	0	0	0
	Two-Spirit (if Client is AIAN)	0	0	0
	Gender Non-Conforming	0	0	0
	Other (if use a different term)	0	0	0
	Prefer not to say	0	0	0
Sexual Orientation				

	Lesbian or gay	0	0	0
	Straight (not lesbian or gay)	0	0	0
	Bisexual	0	0	0
	Other (if use a different term)	0	0	0
	Prefer not to say	0	0	0

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Footnotes:

A. PAIMI Program Information

Governing Board Information

Governing Board (GB) Type and Number of Members Included in Governing Board Information

Governing Board	Minimum # of Members	Maximum # of Members
Private, non-profit with multi-member	10	15
State-operated with governing board	0	0
State-operated with no governing board	0	0

Governing Board Information

In the following table, please provide the requested information for the GB members

	Number
Total seats available	15
Total members serving as of 9/30/2023	9
Total vacancies on 9/30/2023	6
Term of appointment (number of years)	4
Term maximum	2
Meeting Frequency	5
Number of meetings held this fiscal year (2023)	4
Percentage of members present at meetings during the 2023	91.1 %

Governing Board Composition

The governing board shall be composed of members who broadly represent or are knowledgable about the needs of clients served by the P&A System (count each GB member only once)

	Number
Number of individuals with mental illness who are recipients/former recipients (CR/FR) of mental health services or have been eligible for services.	3
Number of family members of individuals with mental illness who are (CR/FR) of mental health services, guardians, advocates or authorized representatives or other persons who broadly represent or are knowledgeable about the needs of clients served by the P&A system	6
Total	**9**

Footnotes:

A. PAIMI Program Information

Executive Director

Intial Appointment Date	12/10/1996 (mm/dd/yyyy)
Recent performance evaluation completed	07/25/2024 (mm/dd/yyyy)
Date of previous performance evaluation	08/24/2023 (mm/dd/yyyy)

Agency has written policy and procedures to guide the ED's evaluation process? Yes ○ No ◉

Input on ED's performance evaluation obtained from the following (check all that apply)	
All agency employees/staff	Yes ○ No ◉
Senior managers	Yes ○ No ◉
All board directors	Yes ◉ No ○
All PAIMI Advisory Council members	Yes ○ No ◉
Stakeholders	Yes ○ No ◉
Consumers	Yes ○ No ◉
Family members of consumers	Yes ○ No ◉
State mental health providers	Yes ○ No ◉
Private mental health providers	Yes ○ No ◉
Other	Yes ○ No ◉

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Footnotes:

A. PAIMI Program Information

Number of Mental Health Professionals On the Advisory Council

Professional Category	Number On Advisory Council
Social Worker	0
Psychologist	2
Psychiatric Nurse	0
Psychiatrist	0
Psychiatric Nurse Practitioner	0
Peer Support Specialist	1
Other (Identify the Professional in the Footnotes)	0
Total	**3**

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Footnotes:

A. PAIMI Program Information

PAIMI Advisory Council (PAC)/Assigned Staff

PAIMI Advisory Council (PAC)	
Sits on the governing board?*	(●) Yes ( ) No
Appointment Date	01/27/2022
Other PAC member(s) sit on the governing board?	(●) Yes ( ) No
If yes, number serving	1

** If no please explain in Footnotes*

Assigned PAIMI Staff

	Attorneys					Advocates				
	#	Full-time	Part-time	Male	Female	#	Full-time	Part-time	Male	Female
Ethnicity										
Hispanic/Latino (of any race)	0	0	0	0	0	0	0	0	0	0
Non-Hispanic/Latino	6	1	5	4	2	3	0	3	2	1
Race										
American Indian/Alaska Native	0	0	0	0	0	0	0	0	0	0
Asian	0	0	0	0	0	0	0	0	0	0
Black/African American	0	0	0	0	0	0	0	0	0	0
Native Hawaiian/Pacific Islander	0	0	0	0	0	0	0	0	0	0
White	6	1	5	4	2	3	0	3	2	1
Two or more races	0	0	0	0	0	0	0	0	0	0
Some other race	0	0	0	0	0	0	0	0	0	0
Race Unknown	0	0	0	0	0	0	0	0	0	0

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Footnotes:

B. Demographics - Interventions on Behalf of PAIMI Individuals

Population Information

Age of PAIMI-eligible Individuals Served

Age	Number
0-2	0
3-5	1
6-10	17
11-22	52
23-64	196
65+	29
Prefer not to say	0
Total	**295**

Gender and Sexual Orientation of PAIMI-eligible Individuals Served

Gender	Number
Female	139
Male	141
Transgender (Trans Woman)	1
Transgender (Trans Man)	0
Two-Spirit (if Client is AIAN)	0
Gender Non-Conforming	8
Other (if use a different term)	0
Prefer not to say	6
Total	**295**

Sexual Orientation	Number
Lesbian or Gay	5

Straight (not lesbian or gay)	60
Bisexual	5
Other (if use a different term)	0
Prefer not to say	225
Total	**295**

Ethnicity and Race of Individuals Served

Ethnicity	Number	PAIMI %	State %
Hispanic/Latino (of any race)	9	3.00	2.20
Non-Hispanic/Latino	182	61.70	97.80
Ethnicity Unknown	104	35.30	0.00
Total	**295**		

Race	Number	PAIMI %	State %
American Indian/Alaska Native	4	1.40	0.70
Asian	0	0.00	1.40
Black/African American	15	5.00	2.20
Native Hawaiian/Other Pacific Islander	0	0.00	0.00
White	210	71.20	93.60
Two or more races	13	4.40	2.10
Some other race	0	0.00	0.00
Race unknown	53	18.00	0.00
Total	**295**		

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Footnotes:

B. Demographics - Interventions on Behalf of PAIMI Individuals

PAIMI-Eligible Individuals served with PAIMI Program Funds

Count individual once per fiscal year (FY). Multiple counts not permitted for lines 1-2.

		Enter Number
1. Number of PAIMI-eligible individuals continued to be served with PAIMI program funds, including any program income resulting from legal actions supported by PAIMI program funds as of October 1, from the previous FY into the reporting year.		63
2. Number of new PAIMI-eligible individuals served during the reporting year.		232
3. Total number of PAIMI-eligible individuals served during this FY (Add lines 1 and 2).		295
4. Individuals with more than one (1) intervention opened/closed during the reporting year.		39
5. Individuals with a co-occurring mental illness and Intellectual and Developmental Disability (IDD).		11
6. Total number of PAIMI-eligible individuals who requested program related advocacy services during the reporting year, but were not served within 30-days of initial contact due to:		
	a. insufficient PAIMI Program resources.	266
	b. non-priority areas.	126
7. Individuals served as of September 30 and will be carried over to next reporting year (This should equal ≤ item 3 above).		55

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Footnotes:

B. Demographics - Interventions on Behalf of PAIMI Individuals

Living Arrangements of PAIMI-eligible Individuals at Intake

Living Arrangements	Number
Community Residential Home for Children/Youth up to age 18 Yrs.	4
Community Residential Home for Adults	41
Non-Medical Community-Based Residential Facility for Children/Youth	0
Foster Care	2
Nursing homes, including skilled nursing facilities	5
Intermediate care facilities	0
Public and Private general hospitals including Emergency Rooms	14
Public Institutional living arrangement	0
Private Institutional living arrangement	0
Psychiatric Hospitals (Public or Private)	
a. Public/State	102
b. Private	25
Jails	5
State Prison	1
Federal Detention Center	0
Federal Prison	0
Veterans' administration hospital/Clinic	0
Other Federal Facility	0
Homeless	38
Independent (in the community & PAIMI-eligible)	64
Parental or Other Family Home & PAIMI-eligible	55
Unknown	0
Total	356

Footnotes:

C. Complaints/Problems of PAIMI Individuals

Areas of Alleged Abuse

Number of complaints/problems – Make every effort to report within the following categories:

Areas of Alleged Abuse	Outcomes											Number from Closed Cases Only
	A	B	C	D	E	F	G	H	I	J	K	Total
a. Inappropriate or excessive medication	0	0	1	0	0	0	0	0	0	0	0	1
b. Inappropriate or excessive restraint and seclusion	0	1	2	0	0	0	0	0	0	0	0	3
c. Involuntary medication	0	0	3	1	0	0	0	0	0	0	0	4
d. Involuntary Electric Convulsive Therapy (ECT)	0	1	0	0	0	0	0	0	0	0	0	1
e. Involuntary aversive behavioral therapy	0	0	0	0	0	0	0	0	0	0	0	0
f. Involuntary sterilization	0	0	0	0	0	0	0	0	0	0	0	0
g. Physical assault	0	0	0	0	0	0	0	0	0	0	0	0
h. Sexual assault	0	0	0	0	0	0	0	0	0	0	0	0
i. Threats of retaliation or verbal abuse by facility staff	0	0	4	0	0	0	0	0	0	0	0	4
j. Coercion	0	0	2	0	0	0	0	0	0	0	0	2
k. Financial exploitation	0	0	1	0	0	0	0	0	0	0	0	1
l. Suspicious death	0	0	0	0	0	0	0	0	0	0	0	0
m. Other *Specify types of complaints. Please describe below. [This number should be less than 1% of the total number of total complaints.]*	0	0	0	0	0	0	0	0	0	0	0	0

Abuse Complaints Disposition	
For total closed cases listed in Table C.1., provide the number of abuse complaints/problems for each disposition category.	
A. Number of complaints/problems determined after investigation not to have merit	0

B. Number of complaints/problems withdrawn or terminated by client	2
C. Number of complaints/problems resolved in the client's favor	13
D. Number of complaints/problems not resolved in the client's favor	1
E. Other Indicators of success or outcomes that resulted from P&A involvement	0
F. Other Representation found	0
G. Services not needed due to client death or relocation	0
H. P&A withdrew due to conflict of interest or other reasons	0
I. Lost Contact	0
J. Outcome Unknown	0
K. Lack of Resources	0
Total number of Abuse complaints/problem addressed from closed cases	**16**

At least 1 case required.

Case of Alleged Abuse

A 45-year-old deaf woman was placed under an involuntary psychiatric hold in an Emergency Department (ED), where state law required her transfer to a psychiatric hospital when a bed became "available." However, psychiatric hospitals in the state are not legally obligated to accept patients referred by emergency departments or explain their refusals. This discretionary system left the woman stuck in the emergency department for 63 days, even as other patients in similar situations were transferred ahead of her. DRM filed a Writ of Habeas Corpus against the hospital, which had also had its own psychiatric unit that had also been refusing the client. Within two days of DRM's filing of the Writ the client was moved from the ED to that psychiatric unit. While this resolved her immediate situation, the court recognized the broader systemic problem that allows such prolonged confinement without accountability. Although her issue was technically moot, the Court ordered that a full hearing be conducted and issued a decision underscoring that only legislative or executive action could address the root issues in the current system and pointing out that without DRM's intervention, the client could have remained indefinitely in the emergency department.

Case of Alleged Abuse

A 30-year-old man, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, was strip-searched upon admission to a private psychiatric unit as part of a policy to check for pressure injuries like bedsores. DRM engaged with the hospital's risk management department, resulting in a policy change. The hospital agreed to inform psychiatric patients that such searches were voluntary and to ensure that future searches were conducted only for safety reasons. Additionally, alternatives like one-to-one monitoring would be used if a patient refused, preventing the use of force.

Case of Alleged Abuse

A 36-year-old psychiatric hospital patient reported verbal abuse by a staff member. DRM facilitated a meeting with the patient and the supervising nurse, during which the abuse was detailed. The nurse confirmed the incident violated the patient's rights and acted swiftly, removing the staff member from the unit within 15 minutes and prohibiting their return. DRM confirmed the required reports were filed with the State and the hospital. Follow-up verified the staff member's removal, and the client expressed gratitude for the support and safe reporting process.

Case of Alleged Abuse

A 51-year-old, woman, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, was strip-searched upon transfer to the emergency room of a general hospital. DRM reviewed her records and raised concerns with hospital administrators about this practice. As a result, the hospital implemented a new policy: patients deemed "high risk" who do not consent to a strip search will instead be placed on 1:1 observation status, ensuring a more respectful approach to patient safety.

Case of Alleged Abuse

A 52-year-old man involuntarily hospitalized in a psychiatric facility had a medical restriction on daily fluid intake. Staff were instructed to forcibly remove drinks if he exceeded his limit, triggering frustration and leading to physical restraint when he tried to retrieve his drink. DRM highlighted to his treatment team how this plan unnecessarily provoked the client and violated his rights. As a result, the treatment team revised the plan to use less confrontational interventions, reducing the risk of restraint and promoting a more respectful approach to care.

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Footnotes:

C. Complaints/Problems of PAIMI Individuals

Areas of Alleged Neglect

Number of complaints/problems	Outcomes											Number from closed cases only
	A	B	C	D	E	F	G	H	I	J	K	TOTAL
a. Failure to provide necessary or appropriate medical (other than psychiatric) treatment.	0	0	6	0	0	0	0	0	1	0	0	7
b. Failure to provide necessary or appropriate mental health treatment, including access to prescribed medication	0	1	16	0	0	0	0	0	1	0	0	18
c. Failure to provide necessary or appropriate personal care and safety	0	0	5	2	0	0	0	0	0	0	0	7
d. Failure to provide appropriate discharge planning or release from a residential care or treatment facility	1	2	10	0	0	0	0	0	0	0	0	13
e. Mental health diagnostic or other evaluation (does not include treatment)	0	0	0	0	0	0	0	0	0	0	0	0
f. Medical (non-mental health related) diagnostic physical examination	0	0	0	0	0	0	0	0	0	0	0	0
g. Other *[Describe and make every effort to report within the above categories].*	0	0	0	0	0	0	0	0	0	0	0	0
0												

Neglect Complaints Disposition

For total closed cases listed in Table C.3., provide the numbers of neglect complaints or problem areas for each disposition category.	
A. Number of complaints/problems determined after investigation not to have merit	1
B. Number of complaints/problems withdrawn or terminated by client	3
C. Number of complaints/problems resolved in the client's favor	37
D. Number of complaints/problems not resolved in the client's favor	2
E. Other Indicators of success or outcomes that resulted from P&A involvement	0
F. Other Representation found	0
G. Services not needed due to client death or relocation	0
H. P&A withdrew due to conflict of interest or other reasons	0
I. Lost Contact	2
J. Outcome Unknown	0
K. Lack of Resources	0

Total number of Neglect complaints/problem addressed from closed cases	45

Case of Alleged Neglect

A 47-year-old involuntary psychiatric hospital patient on court-ordered psychotropic medications experienced tremors but could not promptly meet with his prescriber. DRM assisted the client in submitting a formal request to meet with the prescriber, which went unanswered. DRM met with the client on the unit and both then went to the nurses' station and explained the urgency. The nurse contacted the prescriber, who arrived within minutes. As a result, the patient met with the prescriber, and his medication regimen was adjusted to address his concerns.

Case of Alleged Neglect

A 65-year-old involuntary psychiatric hospital patient repeatedly requested a COVID-19 booster shot for three months but was ignored, ultimately contracting the virus. DRM intervened, contacting hospital administration, which acknowledged the oversight. The client received the booster after recovery, and the hospital implemented a new policy to ensure timely access to vaccines, preventing similar incidents in the future.

Case of Alleged Neglect

A 15-year-old boy who was a patient in a psychiatric hospital expressed concerns about being excluded from his treatment planning process. Although state law grants individuals aged 14 and older the right to fully participate in their treatment planning, the team had attempted to exclude him due to disagreements over a rewards/levels determination being used on his unit. DRM assisted the client in developing a plan which included communicating directly with his clinical team. Using these skills, the client successfully influenced the team to revise the rewards/levels plan, ensuring his active involvement and reinforcing his rights.

Case of Alleged Neglect

A 41-year-old involuntary psychiatric hospital patient required an urgent follow-up dental appointment for painful gum issues risking permanent tissue damage but was having difficulty in accessing care. DRM assisted the client in completing and submitting an urgent care request form that the hospital required. As a result, a dental appointment was promptly scheduled, and treatment began immediately, alleviating her pain and preventing long-term complications

Case of Alleged Neglect

A 41-year-old man involuntarily hospitalized in a psychiatric facility experienced worsening mental health due to ongoing conflict with another patient on the same unit. Despite clear evidence of the detrimental impact, the hospital denied the man’s reasonable request to move to a different unit, offering ineffective solutions that failed to address the proximity issue. DRM intervened, advocating for the client’s transfer to another unit. Following this advocacy, the hospital agreed to the move, resolving the conflict and improving the client’s mental health.

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Footnotes:

C. Complaints/Problems of PAIMI Individuals

Areas of Alleged Rights Violations

Number of Complaints/Problems	Outcomes											Number from Closed Cases only
	A	B	C	D	E	F	G	H	I	J	K	TOTAL
a. Failure to provide individualized written treatment or service plan	0	2	0	0	0	0	0	0	0	0	0	2
b. Failure to provide written discharge plan including a description of mental health services needed upon discharged from such program or facility	0	0	4	0	0	0	0	0	0	0	0	4
c. Failure to allow ongoing participation, in a manner appropriate to such person's capabilities, in the planning of mental health services to be provided such person (including the right to participate in the development and periodic revision of the plan)	0	1	19	0	0	0	0	0	0	0	0	20
d. The right to refuse treatment	0	0	0	0	0	0	0	0	0	0	0	0
e. The right to refuse to take prescribed medications	0	0	0	0	0	0	0	0	0	0	0	0
f. The denial of financial benefits/entitlements (e.g., SSI, SSDI, Insurance)	0	0	11	0	0	0	0	0	0	0	0	11
g. Guardianship/Conservator problems	1	0	4	0	0	0	0	0	0	0	0	5
h. The denial of rights protection information or legal assistance, including adequate and appropriate representation during commitment hearings	0	0	20	0	0	0	0	0	0	0	0	20
i. The denial of privacy rights (e.g., congregation, telephone calls, receiving mail)	0	1	10	0	0	0	0	0	0	0	0	11
j. The denial of recreational opportunities (e.g., grounds access, television, and smoking)	0	0	3	0	0	0	0	0	0	0	0	3
k. The denial of visitors	0	0	2	0	0	0	0	0	0	0	0	2
l. The denial of access to or correction of records	0	1	4	0	0	0	0	0	0	0	0	5
m. Breach of confidentiality of records (e.g., failure to obtain consent before disclosure)	0	0	0	0	0	0	0	0	0	0	0	0
n. Failure to obtain informed consent	0	0	0	0	0	0	0	0	0	0	0	0
o. Advance directives issues	0	0	6	0	0	0	0	0	0	0	0	6
p. The denial of parental/family rights	0	0	0	0	0	0	0	0	0	0	0	0
q. Housing Discrimination	0	1	23	0	0	0	0	0	1	0	0	25
r. The denial of access to administrative or judicial process	0	0	2	0	0	0	0	0	0	0	0	2
s. Failure to provide educational services in the least restricted environment for PAIMI-eligible individuals	1	8	28	1	0	1	0	0	2	0	0	41
t. The denial of access to community-based rehabilitation services and/or treatment	1	4	46	2	0	0	0	0	1	0	0	54

u. The denial of access to transportation	0	0	2	0	0	0	0	0	0	0	0	2
v. Employment Discrimination	0	4	1	1	0	0	0	0	0	0	0	6
w. The denial of access to personal possessions	0	0	11	0	0	0	0	0	0	0	0	11
x. Failure to comply with commitment regulations	0	0	2	0	0	0	0	0	0	0	0	2
y. Failure to comply with commitment time frames	0	0	0	0	0	0	0	0	0	0	0	0
z. Other *[Please make every effort to report within the above categories].*	0	1	3	0	0	0	0	0	0	0	0	4

Rights Violations Disposition	
For closed cases listed in this Table, provide the number of rights complaints or problem areas for each disposition category.	
A. Number of complaints/problems determined after investigation not to have merit	3
B. Number of complaints/problems withdrawn or terminated by client	23
C. Number of complaints/problems resolved in the client's favor	201
D. Number of complaints/problems not resolved in the client's favor	4
E. Other Indicators of success or outcomes that resulted from P&A involvement	0
F. Other Representation found	1
G. Services not needed due to client death or relocation	0
H. P&A withdrew due to conflict of interest or other reasons	0
I. Lost Contact	4
J. Outcome Unknown	0
K. Lack of Resources	0
Total number of Rights Violation complaints/problems addressed from closed cases	**236**

Cases of Alleged Rights Violations

A 52-year-old involuntary psychiatric hospital patient contacted DRM regarding a phone system issue that labeled all outgoing calls as "scam likely" or "fraudulent." This prevented the patient from effectively reaching family, friends, lawyers, and community resources. Despite prior assurances from the hospital, DRM's testing showed the problem persisted. DRM escalated the issue to the superintendent, ensuring corrective actions were taken. Follow-up testing confirmed the issue was resolved, restoring the patient's ability to communicate

Cases of Alleged Rights Violations

49-year-old woman undergoing a forensic evaluation at a psychiatric hospital was denied all visitation, including with her family, due to a blanket hospital policy prohibiting visits for such patients. DRM investigated and found the policy violated patient rights regulations. Despite DRM informing staff and supervisors of the violation, visitation continued to be denied. DRM

escalated the matter to senior hospital administration, who acknowledged the policy's illegality and withdrew it. As a result, the client's visitation rights were restored, allowing her to reconnect with her family.

Cases of Alleged Rights Violations

A 46-year-old man involuntarily hospitalized at a psychiatric facility was unable to attend his weekly community church services, violating his right to practice his religion. DRM addressed this issue with hospital staff, and the hospital agreed to provide a laptop for the client to attend services virtually each week. This resolution ensured the client's rights to freedom of religion were being met during his hospitalization.

Cases of Alleged Rights Violations

A 14-year-old boy residing in a children's residential facility, where Medicaid rules require that all residents must have a prior diagnosis of a significant mental illness or emotional impairment by a qualified Maine Mental Health professional as a condition of admission, expressed concerns during a DRM monitoring visit about rights violations, including lack of access to private phone calls, exclusion from treatment planning, and inappropriate staff interactions. DRM resolved the client's specific issues, restoring his rights and improving access to phone calls, staff interactions, and treatment planning. Additionally, the case contributed to broader systemic improvements within the facility, benefiting all youth receiving services. The client reported significant improvements in his living conditions and treatment experience.

Cases of Alleged Rights Violations

A 40-year-old involuntary psychiatric hospital patient reported that staff were altering his formal grievances and dictating what he could and could not include, violating his rights under state regulations. DRM connected the client with a Peer Support worker unaffiliated with the hospital to assist with grievances. DRM also met with the Nurse Manager to provide education on the proper grievance process. As a result, the client was able to file grievances in compliance with state regulations without interference

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Footnotes:

C. Complaints/Problems of PAIMI Individuals

Reasons for Closing Individual Advocacy Case Files

	Number
1. Client's objective was partially or fully met.	162
2. Case or investigation lacked merit.	4
3. Case withdrawn or terminated by the client.	28
4. Issue favorably resolved.	88
5. Issue not favorably resolved.	7
6. Other success or outcomes due to P&A involvement (i.e., provided self-advocacy assistance)	0
7. Other representation found.	1
8. Services not needed due to client's death or relocation.	0
9. P&A withdrew due to conflict of interest or other reasons (i.e., client would not cooperate).	0
10. Appeal(s) unsuccessful.	0
11. Other appropriate entity investigating.	0
12. Lost Contact.	6
13. Lack of Resources.	0
Total	**296**

At least 1 case required.

Case of Closing an Individual Advocacy Case File

ISSUE RESOLVED: A 77-year-old woman involuntarily hospitalized at a psychiatric facility faced losing her dog of over eight years, which had been taken by police and brought to a local shelter during the events leading to her commitment. Being involuntarily committed for 30 days, she was unable to address the shelter's warning that state law allowed them to rehome or euthanize the dog within 10 days unless arrangements were made by her to pick up the dog within that time. The woman's bond with her dog was crucial to her mental health, and its loss would likely jeopardize her ability to transition successfully back home, prolonging her hospitalization. DRM intervened, negotiating an extension with the shelter and helping the client secure resources to transport the dog to an external kennel during the time of the client's commitment. This allowed the client to focus on her recovery while hospitalized knowing that she would be able to be reunited with her dog upon discharge which occurred.

Case of Closing an Individual Advocacy Case File

OBJECTIVE MET: A 34-year-old forensic psychiatric hospital patient had no contact with his court-appointed attorney for over two months, despite repeated attempts to reach him. DRM worked with the hospital social worker to initiate a complaint with the state agency overseeing court-appointed attorneys. This led to a meeting between the client, the social worker, and the agency

director to address the issue. As a result, the client's attorney contacted him the following day, restoring access to legal representation.

Case of Closing an Individual Advocacy Case File

ISSUE RESOLVED: A 28-year-old involuntary psychiatric hospital patient was denied access to his SD card containing music, which he relied on as a key component of his mental health support. The SD card was playable only on a non-internet-connected device, but the treatment team incorrectly claimed a court order prohibited him from possessing it. Recognizing the importance of music to the client's well-being, DRM reviewed the court order with the team and clarified that the restriction applied only to internet-connected devices. As a result, the SD card was returned, allowing the client to reconnect with his music and regain this essential source of emotional support.

Case of Closing an Individual Advocacy Case File

OBJECTIVE MET: A 23-year-old involuntary patient at a psychiatric hospital was at risk of not completing her final class for a peer support specialist certificate. DRM coordinated with her educator to determine the requirements for participation and advocated for the hospital to provide necessary resources, including a computer, headset, video link, and private room. With these supports in place, the client successfully completed the program and earned her certificate, paving the way for potential employment in the field.

Case of Closing an Individual Advocacy Case File

ISSUE RESOLVED: A 28-year-old involuntary psychiatric hospital patient raised serious concerns about dangerously hot shower water. Recognizing the urgency of the issue, DRM promptly intervened, contacting the hospital's facilities director. Upon investigation, the director confirmed the problem, and the hospital immediately adjusted the water temperature to a safe level. This swift action not only resolved the immediate danger but ensured a safer environment for all patients.

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Footnotes:

C. Complaints/Problems of PAIMI Individuals

Intervention Strategies

The totals reported for the Abuse, Neglect, and Rights Violations Outcomes in this table **should be** the same as the totals reported in the Areas of Alleged Abuse, Areas of Alleged Neglect, and Areas of Alleged Rights Violations tables.

Outcomes												
Abuse	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**Total**
1. Self Advocacy Assistance	0	2	1	0	0	0	0	0	0	0	0	3
2. Limited Advocacy	0	0	5	1	0	0	0	0	0	0	0	6
3. Administrative Remedies	0	0	0	0	0	0	0	0	0	0	0	0
4. Litigation	0	0	0	0	0	0	0	0	0	0	0	0
5. Abuse/Neglect Investigations	0	0	0	0	0	0	0	0	0	0	0	0
6. Mediation	0	0	0	0	0	0	0	0	0	0	0	0
7. Negotiation	0	0	7	0	0	0	0	0	0	0	0	7
Total	**0**	**2**	**13**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**16**
Neglect	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	
1. Self Advocacy Assistance	0	2	5	0	0	0	0	0	1	0	0	8
2. Limited Advocacy	1	0	13	0	0	0	0	0	1	0	0	15
3. Administrative Remedies	0	0	0	0	0	0	0	0	0	0	0	0
4. Litigation	0	0	1	0	0	0	0	0	0	0	0	1
5. Abuse/Neglect Investigations	0	0	1	0	0	0	0	0	0	0	0	1
6. Mediation	0	0	0	0	0	0	0	0	0	0	0	0
7. Negotiation	0	1	17	2	0	0	0	0	0	0	0	20
Total	**1**	**3**	**37**	**2**	**0**	**0**	**0**	**0**	**2**	**0**	**0**	**45**
Rights Violations	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	
1. Self Advocacy Assistance	2	22	79	2	0	1	0	0	2	0	0	108
2. Limited Advocacy	1	1	51	1	0	0	0	0	2	0	0	56
3. Administrative Remedies	0	0	3	1	0	0	0	0	0	0	0	4

4. Litigation	0	0	2	0	0	0	0	0	0	0	0	2
5. Abuse/Neglect Investigations	0	0	0	0	0	0	0	0	0	0	0	0
6. Mediation	0	0	6	0	0	0	0	0	0	0	0	6
7. Negotiation	0	0	60	0	0	0	0	0	0	0	0	60
Total	**3**	**23**	**201**	**4**	**0**	**1**	**0**	**0**	**4**	**0**	**0**	**236**

At least 1 case required.

Case of Intervention

LIMITED ADVOCACY: A 50-year-old involuntary psychiatric hospital patient reached out to DRM for help in safely viewing the 2024 total solar eclipse, a rare and historic event visible across the U.S. Without access to protective glasses, he and other patients faced missing this extraordinary opportunity. DRM advocated with hospital administration, resulting in the hospital providing free solar eclipse glasses to the client as well as other patients ensuring that they could witness this rare astronomical event.

Case of Intervention

ADMINISTRATIVE REMEDIES: A 50-year-old woman, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, faced the risk of losing her residence at a mental health group home due to a Medicaid coverage denial by the state's Managed Care Organization (MCO). The denial resulted from a broader eligibility review triggered by the group home's request to evaluate her for a supported apartment setting. DRM identified violations of the client's procedural and substantive due process rights and promptly filed an administrative appeal with pre-hearing motions. Before the hearing, the MCO reassessed the case and reversed its decision, approving the client for a supported apartment. This decision allowed her to successfully transition to independent housing, safeguarding her stability and autonomy

Case of Intervention

LITIGATION A 46-year-old PAIMI-eligible woman who was involuntarily hospitalized at a psychiatric facility faced eviction proceedings from her supported apartment, which was specifically designed for individuals with mental health needs. Losing access to this essential housing would likely have resulted in her extended stay at the psychiatric hospital, as no comparable community resources were available to meet her needs. DRM represented the client in court and negotiated a reasonable accommodation agreement before the final hearing. This agreement allowed her to return to her supported apartment with added supports, ensuring access to the critical mental health resources required for her recovery. The eviction action was dismissed, safeguarding her housing stability and enabling her discharge from the hospital.

Case of Intervention

ABUSE/NEGLECT INVESTIGATION A 32-year-old involuntary psychiatric hospital patient alleged physical abuse by male night-shift staff members. DRM promptly responded after a nurse reported the incident and obtained security camera footage from the hospital. However, the footage did not provide a full view of the event, making it impossible to confirm whether the abuse occurred. A physical examination revealed no signs of injury, but DRM ensured the allegations were reported to the hospital and State DHHS as required by protocol. In response, the hospital updated safety measures and assigned an additional staff member to the night shift to improve oversight. DRM's swift action upheld the patient's right to safety, ensured proper reporting, and led to preventive measures being implemented.

Case of Intervention

A 70-year-old man, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, was denied mental health treatment at a general hospital's emergency department and served with a no-trespass order, effectively barring him from receiving care. Under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals are legally required to provide a screening examination to anyone seeking emergency treatment and cannot turn individuals away without assessment. DRM contacted the hospital's attorney to highlight the violation of EMTALA. As a result, the hospital promptly

revoked the no-trespass order, restoring the client's right to access emergency room care as required by federal law.

Footnotes:

C. Complaints/Problems of PAIMI Individuals

Death Investigation Activities

A. The number of deaths reported to the P&A for investigation by the following entities:	
1. State	0
2. The Center for Medicaid & Medicare Services (Regional Offices). If zero means the P&A did not receive any death reports from CMS for investigation, please note this in the Footnotes.	0
3. Other Sources. Briefly list the source for each death reported in this category (e.g., newspaper, concerned citizen, relative, etc.). N/A	0
Total Number of deaths investigated	**0**

If the information requested in this section was not available please explain

B. All death investigations conducted involving PAIMI-eligible individuals related to the following:	
a. Number of deaths investigated involving incidents of seclusion (S).	0
b. Number of deaths investigated involving incidents of abuse (A).	0
c. Number of deaths investigated involving incidents of restraint (R).	0
d. Number of deaths investigated NOT related to incidents of S&R, (e.g., suicides.).	0
e. Death investigations with a finding of determination.	0
f. Provision in policy added or prevented as a result of a death investigation.	0
Total Number of deaths investigated [Sum of 9b 1-6]	**0**

C. Provide a brief summary example of an individual's death, P&A involvement, and outcome.
If you reported deaths in categories B.9.b., please provide the following information on one death from each category, as appropriate:

A brief summary of the circumstances about the death.

A brief description of P&A involvement in the death investigation.

A summary of the outcome(s) resulting from the P&A death investigation.

N/A

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Footnotes:

2. The Center for Medicaid & Medicare Services (Regional Offices). If zero means the P&A did not receive any death reports from CMS for investigation, please note this in the Footnotes.:

DRM did not receive any death reports from CMS for investigation.

C. Complaints/Problems of PAIMI Individuals

Number of Interventions on behalf of Groups of PAIMI Eligible Individuals - Individuals Impacted

Multiple counts not permitted for lines 1 –3 and 6.

What to Count	
1. Group cases/projects still open on October 1, 2022 to 2023. (Carried over from prior FY (s))	21
2. New group cases/projects opened during the year.	96
3. Total group cases/projects worked on during the year (Add lines 1 & 2)	117
4. Total group cases/projects as of September 30, 2023 to 2024. (Carry over to next FY)	21
5. Group cases/projects targeted at serving the following special populations:	
a. Ethnicity	0
b. Racial Minorities	0
c. Homeless	0
d. Veterans	0
e. Urban	0
f. Rural/Frontier	0
g. Older Adults/geriatric	0
6. Total # of individuals potentially impacted by line 3	140,000

Only the number of cases are needed for the last three columns, not the number of individuals

Intervention Types (See the Instructions for Guidance)	Potential # of Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	On-going
Group Advocacy (non-Litigation)	20,000	20	0	0
Abuse and Neglect Investigations (non-death related)	20,000	5	0	0
Facility Monitoring Services	20,000	20	0	20
Community Based Monitoring Services	20,000	35	0	0
Court Ordered Monitoring	0	0	0	0
Systemic Litigation	20,000	0	1	1

Educating Policy Makers	20,000	5	5	0
Other Systemic Advocacy	20,000	5	0	0
Total	**140,000**	**90**	**6**	**21**

Case of Intervention on Behalf of a Group

CLASS ACTION LAWSUIT: DRM continues to serve as Class counsel in the Bates v. Glover case, a significant legal action involving institutional litigation. The case aimed to secure comprehensive relief for approximately 3,500 individuals, both current and former residents of AMHI/Riverview Psychiatric Center, as well as 15,000 other qualified individuals with mental illness. The case reached a settlement in 1990, and one crucial aspect of the agreement is that community members are entitled to receive community services as outlined in the settlement terms. As part of the settlement negotiations, Maine committed to implementing compliance targets in 14 critical service areas. These areas include the duration of stay in state psychiatric hospitals, the obligations of contracted providers to accept clients, and the provision of state-funded housing vouchers for individuals with psychiatric disabilities who are homeless or undergoing discharge from a psychiatric or correctional facility. As part of this agreement, the state contracts with DRM to monitor the implementation of some of these compliance measures Settlement Agreement as well as provide on the ground advocacy. DRM provides quarterly reports on the status of the mental health system and offers recommendations to both the state and the Court Master. The Court Master, a former chief justice of the Maine Supreme Court, is responsible for ensuring the effective execution of the Settlement Agreement. Regular meetings take place between the state, DRM, and the Court Master, occurring at least quarterly. These meetings serve as a platform for discussions on the progress and compliance with the terms of the settlement, fostering ongoing collaboration to uphold the rights and well-being of individuals with severe and persistent mental illness throughout the state.

Case of Intervention on Behalf of a Group

STATE AND PRIVATE PSYCHIATRIC FACILITY MONITORING ADULTS AND CHILDREN: DRM provides contract advocacy services to both of Maine's state psychiatric hospitals. (This is reported in the "Accomplishments" section G of the PPR). There are also 8 more private psychiatric hospitals throughout the state. The total bed count in all of these hospitals is over 500. Four of these private hospitals also have children’s units DRM continues to provide in person regular outreach and monitoring visits to one or more of these psychiatric hospitals each month.

Case of Intervention on Behalf of a Group

YOUTH CORRECTIONAL FACILITY MONITORING: Monitoring Long Creek Youth Development Center: The Long Creek Youth Development Center is Maine’s only juvenile correctional facility in Maine. It is administered by the Maine Department of Corrections. DRM periodically monitors this facility on a including meeting with youth who are detained and bringing concerns to the administration.

Case of Intervention on Behalf of a Group

ADULT COMMUNITY MOINTORING AND OUTREACH: The State of Maine currently contracts with DRM, as the P&A, to provide community outreach and advocacy services for individuals across the state who have been determined to have a significant mental illness or emotional impairment by a qualified Maine mental health professional, and are eligible to be so determined, or whose eligibility for the service they currently receive requires such a previous determination. This program is designed to reach people in the community by going to where they are at. The Adult Community Monitoring and Outreach program in Maine, conducted by DRM, serves individuals with significant mental health conditions by providing community outreach and advocacy services. The program is designed to reach individuals where they are in the community, offering support and addressing rights violations. Key aspects of the program include: 1. Community Outreach Visits: DRM has conducted over 180 separate outreach visits to various locations across the state, reaching more than 1000 people. These locations include mental health crisis units, group homes, homeless shelters, public libraries, peer recovery centers, clubhouses, homeless tent encampments, and mental health agencies. 2. Individual Advocacy: Advocates work to correct rights violations observed during outreach visits. This includes addressing any restrictions on the exercise of basic rights and assisting individuals during treatment team meetings. 3. Assistance with Accessing Services: The program focuses on helping eligible individuals navigate the mental health system, especially when facing difficulties accessing services or being placed

on waitlists. Advocates also offer support to individuals in inpatient psychiatric units who may encounter barriers to discharge due to a lack of community services. 4.Statewide Coverage: The program covers the entire state of Maine, which spans over 33,000 square miles. Advocates work across diverse settings to ensure that individuals with mental health conditions receive the support they need. This comprehensive outreach and advocacy initiative reflects DRM's commitment to addressing the unique needs of individuals with mental health conditions and ensuring their rights are upheld throughout the state

Case of Intervention on Behalf of a Group

Abuse/Neglect Investigation. During a monitoring visit to a youth correctional facility during a hot summer month, our agency identified concerns regarding a teenager housed in the administrative segregation area, which lacked central air conditioning. Upon investigation and a meeting with the youth, it was evident that there was no airflow in the unit. Our agency discovered that the central air system had been nonfunctional for several days, with no apparent urgency to address the issue. We promptly contacted the Superintendent, who took immediate action to rectify the situation and ensured that the problem was resolved.

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Footnotes:

Note to 5C. Most projects were not targeted to specific groups. They are targeted to PAIMI-eligible individuals. Projects will reach many members of the group this PPR reporting requirement lists. Examples of this type of outreach DRM conducts are: :

Outreach and Needs Assessment with Immigrant Communities in Maine
DRM partnered with a New Mainer with a disability from Rwanda who is seeking asylum to conduct outreach and a comprehensive needs assessment within Maine's immigrant communities. This initiative aims to deepen DRM’s understanding of the disability-related needs of immigrant and asylum-seeking individuals by completing a needs assessment and producing a written report with actionable recommendations. Additionally, DRM organized three focus groups to collect firsthand input from individuals with disabilities and their family members within immigrant communities. Two focus groups were held in person, and one was conducted virtually. These sessions were well-attended, and participants shared their experiences, needs, and suggestions.

Focused Outreach to Underserved Communities
This year, DRM prioritized outreach to Maine's Wabanaki communities, LGBTQA communities, and immigrant communities. DRM participated in three tribal community fairs, three pride events, and engaged with immigrant communities through a series of three focus groups. Additionally, DRM expanded efforts to connect with rural areas and older Mainers with disabilities. Moving forward, DRM will continue cross-program collaboration to enhance outreach and support for underserved populations in the next fiscal year.

C. Complaints/Problems of PAIMI Individuals

Performance Measures of P&A Activities

Outcomes	Number from Closed Cases Only
a) PAIMI-eligible individuals who access community-based mental health or health care services that resulted in community integration and independence or are better able to advocate to do so;	57
b) PAIMI-eligible individuals who access benefits or services or are better able to advocate to do so;	26
c) PAIMI-eligible individuals who live in a healthier, safer, improved, or more integrated settings or are better able to advocate to do so;	34
d) PAIMI-eligible individuals are able to stay in their own home or better able to advocate to do so;	8
e) PAIMI-eligible individuals who can secure or maintain employment and/or are not subject to workplace discrimination or are better able to advocate for to do so;	0
f) PAIMI-eligible individuals who receive appropriate educational services and supports and/or are not subject to discrimination in educational settings or are better able to advocate for those outcomes;	27
g) PAIMI-eligible individuals who go to school in safe and more humane conditions;	4
h) PAIMI-eligible children (individuals) who receive appropriate services in the most integrated settings;	6
i) PAIMI-eligible individuals who were not subject to discrimination in government benefits/services, housing, public accommodations, etc. or are better able to advocate for such outcomes;	6
j) PAIMI-eligible individuals who were not subject to abuse, neglect, or rights violations or are better able to advocate for to do so;	4,052
k) PAIMI-eligible individuals who can make their own decisions to the maximum extent feasible or are better able to advocate to do so;	56
l) PAIMI-eligible individuals who had their rights enforced, retained, restored and/or expanded or are better able to advocate for to do so; and	102
m) PAIMI-eligible individuals who were more able to participate in the voting process or are better able to advocate for to do so.	0

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Footnotes:

D. Non-Client Directed Advocacy Activities

Non-client Directed Advocacy Activities

1. Individual Information and Referral (I&R).	Total
Provide the number of PAIMI Program I&R services.	764

2. State Mental Health planning activities
1. Collaboration with OCFS: DRM regularly meets with the Director of the Maine State Office of Child and Family Services (OCFS) and other staff to discuss concerns and seek updates on OCFS projects. These discussions focus on ensuring children with disabilities served by OCFS receive appropriate services in the most integrated settings. 2. Participation in JJAG: DRM is an active member of the Maine Juvenile Justice Advisory Group (JJAG), which advises state policymakers and promotes effective system-level responses aligned with the goals of the Juvenile Justice and Delinquency Prevention Act. 3. Engagement with MaineCare Advisory Committee: DRM serves on the MaineCare Advisory Committee, a stakeholder group advising Maine's Medicaid agency on all aspects of the state's Medicaid program. 4. Oversight of Consent Decree Compliance: As class counsel, DRM participates in monthly meetings with the Court Master, state mental health officials, and the Director of Maine's Substance Abuse and Mental Health agency to monitor compliance with the consent decree and address mental health system issues. 5. Transportation Advisory Committee Membership: DRM contributes as a member of the MaineCare Transportation Advisory Committee, advising on the Medicaid agency's Non-Emergency Transportation Service for MaineCare members. 6. Collaboration with the Department of Education: DRM and the Maine Department of Education meet to share updates and address concerns affecting students with disabilities. Topics include abbreviated school days, lack of positive behavior supports, discriminatory practices in private-public schools, overuse of restraint and seclusion, and compensatory education for pandemic-related impacts. 7. Engagement with Department of Corrections: DRM participates in quarterly meetings with the Maine Department of Corrections to address ADA compliance and ensure appropriate responses to reasonable accommodation requests for prisoners with disabilities. 8. Commission for Disability Employment: DRM continues its role on the Commission for Disability Employment, a statutory committee of the State Workforce Board, focusing on systemic solutions to improve employment outcomes for people with disabilities. 9. Collaboration with Bureau of Rehabilitation Services: DRM holds quarterly meetings with the Maine Bureau of Rehabilitation Services to discuss joint initiatives such as Employment First and contract compliance monitoring for service providers. 10. Advisory Committee on Probate Procedure: DRM serves on the Advisory Committee for Maine Rules of Probate Procedure, contributing to the review and improvement of probate rules and forms. 11. Monitoring IDEA Part B Advisory Panel: DRM monitors bi-monthly IDEA Part B State Advisory Panel meetings, where the Maine Department of Education and stakeholders discuss updates and concerns related to IDEA Part B implementation in Maine. 12. Meetings with Children's Residential Licensing: DRM meets with Children's Residential Licensing and OCFS to discuss monitoring updates, out-of-state placements, and other concerns regarding children's residential programs. 13. Participation in the State Health Improvement Plan Advisory Committee: DRM's Health Equity Project Coordinator collaborates with the Maine Center for Disease Control and Prevention (Maine CDC) as a member of the State Health Improvement Plan (SHIP) Advisory Committee. This strategic initiative guides health departments, community partners, and organizational stakeholders in improving population health through targeted planning and coordinated efforts. 14. Partnership with Office of Behavioral Health: DRM meets with the Maine Office of Behavioral Health (OBH) to address systemic issues and collaborate on solutions. A recent result of this partnership included a joint training for mental health case management providers on a new process for accepting self-referrals. Excerpts of this training are attached.

3. Education, Public Awareness Activities, and Events	
1. Number of public awareness activities or events.	349
2. Number of education/training activities undertaken.	135
3. Number (approximate) of persons trained in 2.	2,580

4. Technical Assistance	
Provide the number of PAIMI Program TA services.	121

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Footnotes:

E. Grievance Procedures

Grievance Procedures

1. Do you have a systemic/program assurance grievance policy as mandated 42 CFR 51.25 (a)(2)?	(●) Yes ( ) No
If Yes please upload your organizations Grievance Policy using the attachment tab	
2. The number of grievances filed by PAIMI-eligible clients, including representatives or family member of such individuals receiving services during this fiscal year. Total	0
3. The number of grievances filed by prospective PAIMI-eligible clients (those who were not served due to limited PAIMI Program resources or because of non-priority issues). 42 CFR § 51.25 (a)(1)(2)	0
4. The number of grievances appealed to : a. The Governing Authority/Board b. The Executive Director	 0 0
Total 4.a & 4.b	0
5. The number of reports sent to the Governing Board and the Advisory Board. Total	1
6. Please IDENTIFY ALL INDIVIDUALS, by name & title, responsible for grievance reviews (maximum 5): Name:Kimberly Moody Title:Executive Director Name:Mark Joyce Title:PAIMI Director Name:Lauren Wille Title:Litigation Director	
7. What is the timetable (in days) used to ensure prompt notification of the grievance procedure process to clients, prospective clients or persons derided representation, and ensure prompt resolution? Total # of days	42
8. Were written responses sent to each grievant? *If no, explain below*	( ) Yes (●) No
Not Applicable. No Grievances filed.	
9. Was client confidentiality protected? *If no, explain below*	( ) Yes (●) No
Not Applicable. No Grievances filed.	

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Footnotes:

Be sure to read the DRM Grievance Procedure before you fill out the form. You can also send your grievance by mail or fax.

Download the DRM Grievance Procedure (PDF)

Augusta, ME 04330
800.452.1948 (V/TTY)
207.626.2774 (V/TTY)
207.766.7111 (VP)
207.621.1419 (FAX)
advocate@drme.org
deafservices@drme.org

Grievance Form

Items with an asterisk (*) are required.

If you are seeking the assistance of an advocate or attorney regarding a rights violation or discrimination based on your disability, please complete our Online Intake Form.

First Name *

Last Name *

Phone

Email *

Address

City

State

Zip/Postal

I am a: *

Client or Prospective Client

Client or Prospective Client
Parent of a Minor Child Client or Prospective Client
Guardian of a Client or Prospective Client

were involved, and with what, specifically, you are dissatisfied.

Captcha

Grievance Message: *

Please explain why you are filing a grievance, including what happened, which agency staff were involved, and with what, specifically, you are dissatisfied.

Captcha

Submit

DISABILITY RIGHTS MAINE

GRIEVANCE PROCEDURE

WHO MAY FILE:

1. Clients of Disability Rights Maine (DRM).
   - Parents of a minor child may file on behalf of their child.
   - Guardians may file on behalf of their wards.
2. Applicants who believe they are eligible for DRM's services.

BASIS FOR GRIEVANCE:

Clients or applicants may submit a grievance:
1. if they have been refused representation by DRM;
2. if DRM has terminated representation; or
3. if they believe they are not being appropriately represented.

SUBMITTED IN WRITING OR IF UNABLE TO WRITE:

1. Clients and applicants should submit the grievance in writing.
2. If the client or applicant is unable to submit the grievance in writing, they may call DRM and the Executive Director will designate a staff person to assist the client or applicant by collecting the information as outlined in the next section.

CONTENTS OF GRIEVANCE:

The grievance should include
1. a statement of what happened,
2. which agency staff were involved, and
3. as specifically as possible, what the client or applicant was dissatisfied with.

CONFIDENTIALITY:

DRM will keep all information about you confidential and will not release any information without your written permission.

EXECUTIVE DIRECTOR'S DECISION:

Within fourteen (14) days of receiving the grievance, the Executive Director or designee, will investigate and reply to the client in writing. The written reply must include:
1. the agency's findings, and

2. if the grievance is substantiated, what the Executive Director will do to correct the problem.

APPEAL OF EXECUTIVE DIRECTOR'S DECISION TO BOARD; APPOINTMENT OF BOARD PANEL:

The client or applicant can appeal the Executive Director's decision to the Board of Directors. If the client or applicant chooses to appeal, the Executive Director will immediately forward the appeal to the President of the Board. Within seven (7) days, the President will appoint a panel of three Board members to review the appeal, and will appoint one of the panel members as Chairperson.

REVIEW BY BOARD PANEL/HEARING (OPTIONAL):

The panel may review the appeal based on the written documents generated during the grievance, or, at its discretion, may hold a hearing to review the appeal. In either event, the Board members must issue a decision in writing within twenty-one (21) days of their appointment to the panel.

IF HEARING IS HELD:

If the panel chooses to hold a hearing, the Chairperson must immediately notify the client or applicant in writing. The notification must include the date, time, and location of the hearing, and what staff and Board members will be present. Hearings are informal, and the rules of evidence do not apply. The client or applicant has the right to representation by a person of his or her choosing, and the right to give testimony.

PANEL DECISION FINAL:

The decision of the panel is final.

Grievance Procedure

File a Grievance

You can file a written grievance (complaint) with Disability Rights Maine if you believe DRM has not treated you fairly or respectfully. You can send your grievance by:

1. Email
2. Mail
3. Fax

DRM will keep all information about you confidential and will not release any information without your written permission.

If you are unable to submit your grievance in writing, please call DRM and the Executive Director will designate a staff person to assist with gathering the information.

Grievance Procedure

Who May File:

1. Clients of Disability Rights Maine (DRM).
    - Parents of a minor child may file on behalf of their
    - Guardians may file on behalf of their
2. Applicants who believe they are eligible for DRM's services.

Basis for Grievance:

Clients or applicants may submit a grievance:

1. If they have been refused representation by DRM;
2. If DRM has terminated representation; or
3. If they believe they are not being appropriately represented.

Submitted in Writing or if Unable to Write:

1. Clients and applicants should submit the grievance in
2. If the client or applicant is unable to submit the grievance in writing, they may call DRM and the Executive Director will designate a staff person to assist the client or applicant by collecting the information as outlined in the next section.

Contents of Grievance:

The grievance should include:

1. A statement of what happened;
2. Which agency staff were involved; and
3. As specifically as possible, what the client or applicant was dissatisfied with.

Confidentiality:

DRM will keep all information about you confidential and will not release any information without your written permission.

Executive Director's Decision:

Within fourteen (14) days of receiving the grievance, the Executive Director or designee, will investigate and reply to the client in writing. The written reply must include:

1. The agency's findings; and
2. If the grievance is substantiated, what the Executive Director will do to correct the problem.

Appeal of Executive Director's Decision to Board; Appointment of Board Panel:

The client or applicant can appeal the Executive Director's decision to the Board of Directors. If the client or applicant chooses to appeal, the Executive Director will immediately forward the appeal to the President of the Board. Within seven (7) days, the President will appoint a panel of three Board members to review the appeal, and will appoint one of the panel members as Chairperson.

Review by Board Panel/Hearing (Optional):

The panel may review the appeal based on the written documents generated during the grievance, or, at its discretion, may hold a hearing to review the appeal. In either event, the Board members must issue a decision in writing within twenty-one (21) days of their appointment to the panel.

If Hearing is Held:

If the panel chooses to hold a hearing, the Chairperson must immediately notify the client or applicant in writing. The notification must include the date, time, and location of the hearing, and what staff and Board members will be present. Hearings are informal, and the rules of evidence do not apply. The client or applicant has the right to representation by a person of his or her choosing, and the right to give testimony.

Panel Decision Final:

The decision of the panel is final.

Download DRM's Grievance Procedure (PDF)

Request Help

Grievance Procedure

Contact Us

160 Capitol Street, Suite 4
Augusta, ME 04330
800.452.1948 (V/TTY)
207.626.2774 (V/TTY)
207.766.7111 (VP)
207.621.1419 (FAX)
advocate@drme.org
deafservices@drme.org

How Can We Help?

Contact us anytime. DRM wants to hear from you. Whether you're looking for advocacy, have a question, or just want to connect, please reach out.

By Phone

800.452.1948 (V/TTY)

Online

Request Help

Contact Us

160 Capitol Street, Suite 4
Augusta, ME 04330
800.452.1948 (V/TTY)
207.626.2774 (V/TTY)
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Connect with Us

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Client Satisfaction Survey
Support Our Work
Frequently Asked Questions
Grievance Procedure
Accessibility Statement

DISABILITY RIGHTS MAINE

Member of the National Disability Rights Network

Maineshare PARTNER ORGANIZATION

Disability Rights Maine (DRM) is the federally mandated protection and advocacy system for Maine, which receives part of its funding from the HHS-Administration for Community Living, DOE-Rehabilitation Services Administration, HHS-Substance Abuse & Mental Health Services Administration – Center for MH services, Social Security Administration, and the State of Maine.

Information contained on the DRM website is for informational purposes only and does not constitute legal advice and does not create a contract or an attorney-client relationship. DRM makes no legal promise or warranty as to the accuracy, completeness, adequacy, timeliness, or relevance of the information contained on the website. DRM is not responsible for the content of comments posted to its website or any site accessible through a hyperlink. We developed this website at U.S. taxpayer expense.

F. Other Services & Activities

Public Comment

1. Does the P&A have procedures established for public comment?

a. (●) Yes, briefly describe how the notice is used to reach persons with mental health illness and their families.
nmlkjiYes, briefly describe how the notice is used to reach persons with mental health illness and their families. All clients are sent satisfaction surveys upon the closure of their cases. The survey includes a general question soliciting suggestions for change. All callers are sent copies of our priorities. At all public presentations, training and monitoring visits to psychiatric hospitals and residential facilities we hand out copies of our brochures and solicit input and comment. We also have state funded advocates at the two state freestanding hospitals and one private free standing hospital. These advocates also distribute DRM materials residential facilities we hand out copies of our brochures and solicit input and comment. We also have state funded advocates at the two state freestanding hospitals and one private free standing hospital. These advocates also distribute DRM materials

b. ( ) No, (if no, briefly explain, limit 500 characters).

2. Were the notices provided to the following persons:

a. Individuals with mental illness in residential facilities? (●) Yes ( ) No

b. Family members and representatives of such individuals? (●) Yes ( ) No

c. Other individuals with disabilities? (●) Yes ( ) No

d. Brief explanation is required for each no answer in 2.a., b., or c.

3. Do the procedures provide for receipt of the comments in writing or in person?

3a. (●) Yes, attach a copy of the agency's Policies & Procedures pertaining to public comment.

3b. ( ) If no to 2 a, b, c., explain why the agency does not have such procedures in place

4. Was the public provided an opportunity for public comment. (●) Yes ( ) No

5. If you answered Yes to 4 briefly describe the activities used to obtain public comment.
DRM provides ongoing outreach to provide information to service providers and individuals throughout the state both in person and virtually. For example in person outreach has been conducted that spans a distance of over 300 miles reaching hundreds of people, with in webcasts and zoom training reaching hundreds more.

6. What formats and languages (as applicable) were used in materials to solicit public comment?
DRM provides ongoing outreach to provide information to service providers and individuals throughout the state both in person and virtually. For example in person outreach has been conducted that spans a distance of over 300 miles reaching hundreds of people, with in webcasts and zoom training reaching hundreds more.

7. If you answered No to 4, briefly explain why the public was not provided an opportunity to comment.

8. List groups (e.g., states, consumer advocacy, service providers, professional organizations and others, including groups of current and former mental health consumers or family members of such individuals) with whom the PAIMI Program coordinated systems, activities and mechanisms. [42 CFR 51.21 (a) (D)]
AARP Acadia Hospital ACLU of Maine Alpha One Alzheimer's Association American Association of People with Disabilities (AAPD) American Council for the Blind of Maine Area Agencies on Aging Ascentria Care Alliance Autism Society of Maine (ASM) Brain Injury Association of America - Maine Chapter Capitol Clubhouse CARES, Inc. Catholic Charities Center for Community Inclusion & Disability Studies (CCIDS) Center for Public Representation Citizens of Maine City of Portland City of Westbrook Community Living Association (CLA) Consumer Council System of Maine Consumers for Affordable Health Care (CAHC) Cumberland Legal Aid Clinic Dorothea Dix Psychiatric Center (DDPC) EqualityMaine G.E.A.R. Parent Network GLAD Legal Advocates and Defenders GLEAM Goodwill NNE Group Main Stream (GMS) Hands & Voices Maine Health Affiliates of Maine Home Care Alliance of Maine Home Care for Maine Immigrant Legal Advocacy Project (ILAP) Independence Association Kennebec Behavioral Health (KBH) KIDS Legal Legal Service Providers Legal Services for the Elderly (LSE) Long-Term Care Ombudsman Program Looking Ahead Clubhouse Maine Adaptive Sports & Recreation Maine Alliance for Addiction Recovery Maine Association for Community Service Providers (MACSP) Maine Association of Mental Health Services Maine Association of Peer Support & Recovery Centers (MPSRC) Maine Association of the Deaf (MeAD) Maine Behavioral Health Maine CareerCenters Maine Children's Alliance Maine CITE Maine Coalition Against Sexual Assault (MECASA) Maine Coalition for Housing & Quality Services Maine Council of Senior Citizens-ARA Maine Developmental Disabilities Council (MDDC) Maine Developmental Services Oversight & Advisory Board (MDSOAB) Maine Disability Employment Initiative (DEI) Maine Educational Center for the Deaf & Hard of Hearing (MECDHH) Maine Equal Justice (MEJ) Maine Family Planning Maine Health Access Foundation (MeHAF) Maine Health Care Association Maine Human Rights

Commission (MHRC) Maine Medical Association Maine Medical Center Vocational Services / WIPA Program Maine Parent Federation (MPF) Maine Registry of Interpreters for the Deaf (MeRID) MaineHousing Authority ME Attorney General's Office ME Department of Corrections (DOC) ME Department of Education (DOE) ME DHHS - Office of Aging & Disability Services (OADS) ME DHHS - Office of Behavioral Health (OBH) ME DHHS - Office of Child & Family Services (OCFS) ME DHHS - Office of MaineCare Services (OMS) ME DOL - Commission for the Deaf, Hard of Hearing & Late Deafened ME DOL - Division for the Blind ME DOL - Division for the Deaf, Hard of Hearing & Late Deafened ME DOL - Division of Vocational Rehabilitation (VR) ME Secretary of State's Office Mobius, Inc. Motivational Services (MoCo) Moving Maine Transportation Network NAMI Maine National Disability Rights Network (NDRN) New Ventures Maine Pine Tree Legal Assistance (PTLA) Pine Tree Society Portland Disability Advisory Committee Private Bar Riverview Psychiatric Center (RPC) Southern Maine Workers' Center Speaking Up for Us (SUFU) Spring Harbor Hospital Spurwink State of Maine Judicial Branch State of Maine Legislative Branch State of Maine Treasurer's Office Statewide Independent Living Council (SILC) The Iris Network The League of Women Voters (LWV) The Maine Hospital Association The Progress Center UCP of Maine United Way University of Maine (UMO) University of Maine at Augusta (UMA) University of Maine at Farmington (UMF) University of Maine School of Law University of New England (UNE) University of Southern Maine (USM) USM Interpreter Training Program Volunteer Lawyers Project Western Maine Community Action, Inc. Woodfords Family Services

9. Briefly describe the outreach efforts/activities used to increase the number of ethnic and racial minority clients served or educated about the PAIMI program [this information will be evaluated by using the demographic/state profile information contained in the PAIMI application for the same FY]

DRM provides ongoing outreach to provide information to service providers and individuals throughout the state. Including outreach to ethnic and racial minority populations. Examples of outreach include: Outreach and Needs Assessment with Immigrant Communities in Maine DRM partnered with a New Mainer with a disability from Rwanda who is seeking asylum to conduct outreach and a comprehensive needs assessment within Maine's immigrant communities. This initiative aims to deepen DRM’s understanding of the disability-related needs of immigrant and asylum-seeking individuals by completing a needs assessment and producing a written report with actionable recommendations. Additionally, DRM organized three focus groups to collect firsthand input from individuals with disabilities and their family members within immigrant communities. Two focus groups were held in person, and one was conducted virtually. These sessions were well-attended, and participants shared their experiences, needs, and suggestions. Focused Outreach to Underserved Communities This year, DRM prioritized outreach to Maine's Wabanaki communities, LGBTQA communities, and immigrant communities. DRM participated in three tribal community fairs, three pride events, and engaged with immigrant communities through a series of three focus groups. Additionally, DRM expanded efforts to connect with rural areas and older Mainers with disabilities. Moving forward, DRM will continue cross-program collaboration to enhance outreach and support for underserved populations in the next fiscal year.

10. Did the activities described in question 9 result in an increase of ethnic and/or minorities in the following categories?

a. Staff ○ Yes ◉ No

b. Advisory Council ○ Yes ◉ No

c. Governing Board ○ Yes ◉ No

d. Clients ○ Yes ◉ No

If you answer no to any item (10.a-d), please provide a brief explanation, such as 10.a, b., or c. – no vacancies.

There was no increase due to the activities listed in 10. Maine has a very small minority population

0930-0169 Approved: 07/27/2023 Expires: 07/31/2026

Footnotes:

DISABILITY RIGHTS MAINE

CLIENT RIGHTS STATEMENT

You have the right to be treated with courtesy and respect by Disability Rights Maine staff.

Rights of Callers We Do Not Represent

If we are unable to provide you direct advocacy services, you have the right to receive:

- information and referrals, and
- a letter explaining our decision.

Rights of Clients We Represent

Clients of Disability Rights Maine (DRM) have the right to:

- prompt and ethical representation;
- be involved in the decision about how DRM can best represent you;
- be informed of all activity in your case;
- approve any action before it is taken; and
- a written explanation if DRM decides it can no longer represent you.

Confidentiality

- We keep all information about you confidential
- It will not be released without your written permission

There is one exception to this rule. Agencies that fund us have the right to review client files in order to make sure that DRM is meeting the requirements of its contract or grant. More than one agency funds DRM. Only the agency that funds our activity on your behalf would be able to look at your file and we will remove your name from your file.

Complaints

If you are not happy with how DRM has handled your call or your case:

- you should discuss this with the individual staff person involved;
- you may contact the staff person's supervisor;
- you may file a formal grievance with the Executive Director if the problem is not resolved.

Please ask for a copy of the Client Grievance Procedure for information on how to file a formal grievance.

Public Comment

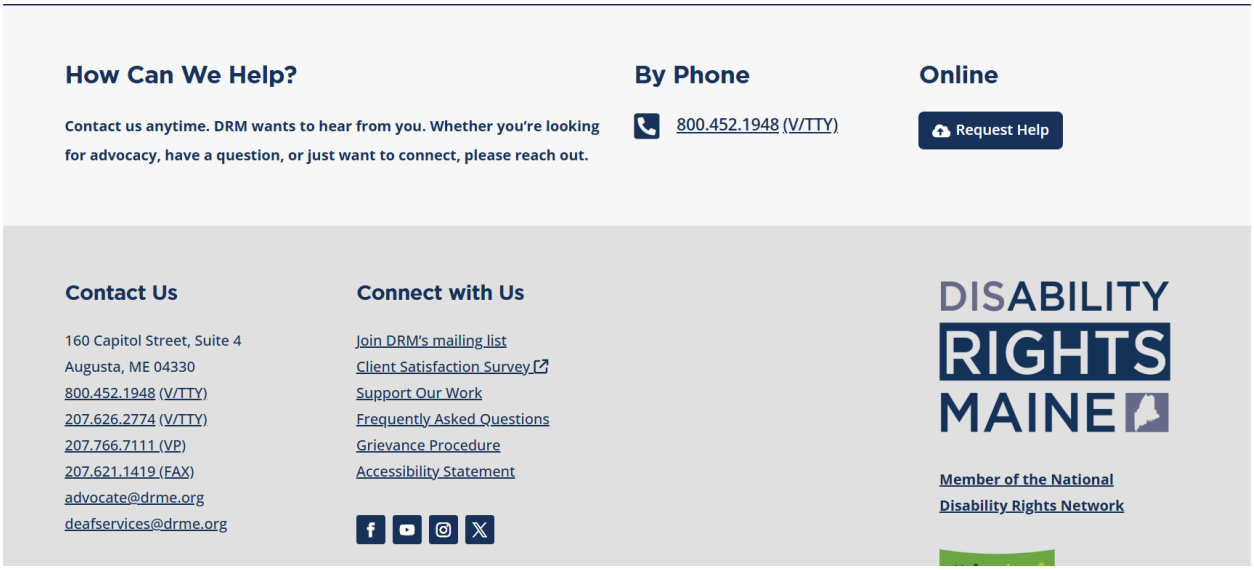
DRM is always seeking public input on the priorities of our legal and advocacy work. You can view our priorities on our website, www.drme.org, and provide us your input:

- by sending us a message on Facebook at Disability Rights Maine;
- by emailing us advocate@drme.org;
- by attending a public forum or focus group that is advertised on our website, on Facebook and sent out via Constant Contact;
- by locating the email address of any staff person on our website and sharing your thoughts via email.

PUBLIC COMMENT:

DRM WEBSITE

WITH LINKS TO FACEBOOK, YOUTUBE, INSTGRAM AND X



DRM CLIENT RIGHTS STATEMENT

DRM client rights statement includes the following for Public Comment

Public Comment

DRM is always seeking public input on the priorities of our legal and advocacy work. You can view our priorities on our website, www.drme.org, and provide us your input:

- by sending us a message on Facebook at Disability Rights Maine;
- by emailing us advocate@drme.org;
- by attending a public forum or focus group that is advertised on our website, on Facebook and sent out via Constant Contact;
- by locating the email address of any staff person on our website and sharing your thoughts via email.

Disability Rights Maine
Client Satisfaction Survey

1. Which staff person(s) at Disability Rights Maine assisted you?

2. Please rate the help you received from DRM:
___Very Good ___Good ___Not Good

3. Did DRM keep you informed and up-to-date on your case?
___Yes ___No

4. Did you receive prompt responses from DRM staff?
___Yes ___No

5. Was DRM staff respectful of you?
___Yes ___No

6. Would you use DRM services again?
___Yes ___No

7. If you could improve anything about DRM's services, what would it be?

8. Is there anything else you would like to share about your experience with DRM that you think others might want to know?

9. What do you think is the most important issue Disability Rights Maine should work on over the next few years?

10. Would you like to receive email updates from DRM?

___Yes ___No

Email Address:

Service request number_____

DRM GENERAL AGENCY BROCHURE WITH "CONTACT DRM" INFORMATION

TYPES OF ASSISTANCE

- Information and Referral
- Individual Advocacy
- Legal Representation
- Education and Training
- Assistance with Self-Advocacy

SYSTEMIC ADVOCACY

DRM also engages in extensive systemic advocacy efforts, including:

- Participation in stakeholder groups;
- Community outreach;
- Investigation and monitoring of facilities and programs; and
- Public policy reform.

Upon request, this brochure is available in alternative formats.

Cover art designed by Amy Fecteau.

CONTACT DRM

160 Capitol Street, Suite 4
Augusta, ME 04330
800.452.1948 (V/TTY)
207.626.2774 (V/TTY)
207.766.7111 (VP)
207.621.1419 (FAX)
advocate@drme.org
deafservices@drme.org

Disability Rights Maine is supported by grants from the Administration on Disabilities, the Center for Mental Health Services, the Rehabilitation Services Administration, the Social Security Administration, the U.S. Department of Justice Office on Violence Against Women, the State of Maine, the MCLSFC, the Maine Health Access Foundation, and private donations.

Disability Rights Maine is a 501(c)(3) corporation.

Donations are tax deductible and gratefully accepted.

DISABILITY RIGHTS MAINE

ACCESS.

EQUALITY.

INDEPENDENCE.

WWW.DRME.ORG

Our Mission

Disability Rights Maine (DRM) is Maine's designated Protection and Advocacy agency whose mission is to advance justice and equality by enforcing rights and expanding opportunities for people with disabilities in Maine.

Our Values

DRM believes the disability rights movement is inseparable from the human rights movements for racial, economic and gender equity. We renew our commitment to eradicate ableism, racism, sexism and bigotry, and to dismantle institutional and structural disadvantage.

Our Vision

People with disabilities must not be stigmatized, undervalued, institutionalized or excluded. Disability Rights Maine envisions a just world, without barriers, where all disabled people have power and autonomy. In this world, disabled people have full and equitable access to education, jobs, resources and community.

DRM does not discriminate on the basis of sex, race, color, national origin, religion, disability, age, or sexual orientation in its programs or activities.

Who Does DRM Advocate For?

DRM represents individuals who:

- Meet the eligibility criteria for one of our programs;
- Have an issue that falls within our program priorities;
- Are seeking assistance with a problem that relates to their disability; and
- Have an issue that has merit and that can be addressed through legal advocacy.

DRM also makes case decisions based on the availability of agency resources.

For more information about eligibility criteria and individual program priorities, please visit our website or call our office.

What Can DRM Help Me With?

The types of issues DRM assists with include:

- Allegations of abuse, neglect and violations of basic rights;
- Accessing medical and mental health services in the community;
- Advocating for individuals to live independently, in the communities of their choosing;
- Discrimination in housing, public accommodations and governmental services;
- Denial of an inclusive education or transition services;
- Guardianship & supported decision-making;
- Employment & return-to-work issues;
- Access to assistive technology (AT);
- Deaf advocacy & communication access;
- Access to voting; and
- Access to Vocational Rehabilitation & Independent Living Services programs.

F. Other Services & Activities

Impediments

External Impediments
Describe any problems with implementation of mandated PAIMI activities, including those activities required by Parts H and I of the Children's Heath Act of 2000 that pertain to requirements related to incidents involving seclusion and restraint and related deaths and serious injuries (e.g., access issues, delays in receiving records and documents, etc.).
As we have stated in years past, we simply do not have sufficient resources to adequately conduct all of the activities that we know are needed to protect individuals with mental illness and promote their rights. The lack of resources is related to funding. DRM is a minimum allotment state. In 2004 our PAIMI grant was $410,000. According to a U.S. inflation calculator for this grant to just keep up with inflation the grant would need to be increased by almost 60% to $684,700.
Internal Impediments
Describe any problems with implementation of mandated PAIMI activities, including any identified annual priorities and objectives (e.g., lack of sufficient resources, necessary expertise, etc.).
See above

0930-0169 Approved: 07/27/2023 Expires: 07/31/2026

Footnotes:

F. Other Services & Activities

Accomplishments/Recommendations/Training Needs

Accomplishments

For this fiscal year, briefly describe the most important accomplishment(s) that resulted from PAIMI Program activities. Provide copies of supporting documents, e.g., case law, news, articles, legislation, etc.

1. Advocacy and Support Following a Tragic Mass Shooting

In the wake of the largest mass shooting in our state's history, which claimed the lives of 18 individuals, our agency played a pivotal role in addressing widespread misinformation and providing critical support to affected communities. Following the tragedy, public discourse quickly turned to unfounded assumptions that mental illness was a driving factor behind the violence, perpetuating harmful stereotypes about individuals with mental health conditions.
Recognizing the urgency of the situation, our agency acted swiftly to counteract this narrative. We issued a press release and appeared on multiple

Recommendations

Please provide recommendations for activities and services to improve the PAIMI Program. Include a brief description of why such activities and services are needed. [42 U.S.C. 10824(a)(4)].

Please see impediments response.

Training Needs

Please identify any training and technical assistance requests. [42 U.S.C. 10825]

Upload supporting documents for Accomplishments here

PRESS RELEASE: Disability Rights Maine Statement on Lewiston Shooting

Oct 26, 2023 | Press Releases

CONTACT: Julia Endicott
207-626-2774
jendicott@drme.org

FOR IMMEDIATE RELEASE

October 26, 2023

Augusta – Disability Rights Maine is horrified and deeply saddened by the shootings in Lewiston yesterday evening. Our hearts are with the Lewiston/Auburn community, the Maine Deaf Community and all impacted by the unfathomable acts of violence that took place at Just In Time Recreation Center and Schemengees Bar and Grille.

Much information remains unknown at this time and we anticipate more answers to yesterday's events in the coming days. As this develops, we are concerned about any narrative that focuses on mental illness as the cause of such violence. Across the world, more than 790 million people live with a diagnosed mental health disorder. Yet, we only see this level of pervasive violence occur in the United States, where the number of guns owned by civilians outnumbers our total population.[1] This is a societal problem where hate is allowed to flourish and inaction is far too often the response.

In 2020, DRM signed onto a joint statement from the Coalition for Smart Safety. As this statement recognizes, more often, people with psychiatric labels are victims, rather than perpetrators of violence. Simply put, placing blame on people with mental illness will not solve our country's gun violence problem. Rather, it makes people with mental health disabilities the scapegoat while failing to implement effective policy changes.

Mass violence is a public health crisis.

To dispel myths about mental illness and gun violence, we encourage you to access the following resources:

- NAMI CA – The Truth About Mental Health and Gun Violence
- NARPA – Prior Statements on Mass Shootings in Buffalo and Uvalde
- Disability Rights Washington – People with Mental Health Disabilities Shut Down Dangerous Ideas About Gun Violence

DRM also wants to share additional resources for those who may wish to seek support in navigating the trauma and grief of mass violence:

- Maine Crisis Line: 1-888-568-1112 (Voice) or 711 (Maine Relay)
- National Crisis Line: call or text 988
- NAMI Maine Helpline: 1-800-464-5767 (Press 1)

Disability Rights Maine is Maine's Protection & Advocacy organization. Our mission is to advance justice and equality by enforcing rights and expanding opportunities for people with disabilities in Maine.

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[1] https://www.bloomberg.com/news/articles/2022-05-25/how-many-guns-in-the-us-buying-spree-bolsters-lead-as-most-armed-country?leadSource=uverify%20wall

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Press Release: Disability Rights Maine Maintains Opposition to Psychiatric Residential Treatment Facilities in Maine

Dec 4, 2024

read more

Press Release: Advocates Respond to Settlement Agreement Requiring Maine to Bring its Behavioral Health System for Children into

Compliance with the Americans with Disabilities Act

Nov 26, 2024

read more

Press Release: Disability Rights Maine Releases Report on the State of Guardianship in Maine

Oct 16, 2024

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How Can We Help?

Contact Us Anytime. We want to hear from you! Whether you're looking for advocacy, have a question, or just want to connect, please reach out.

By Phone

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Online

Request Help

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207.626.2774 (V/TTY)
207.766.7111 (VP)
207.621.1419 (FAX)
advocate@drme.org
deafservices@drme.org

Connect with Us

Join DRM's mailing list
Client Satisfaction Survey
Support Our Work
Frequently Asked Questions
Grievance Procedure
Accessibility Statement

DISABILITY RIGHTS MAINE

Member of the National Disability Rights Network

mainesharе PARTNER ORGANIZATION

Disability Rights Maine (DRM) is the federally mandated protection and advocacy system for Maine, which receives part of its funding from the HHS-Administration for Community Living, DOE-Rehabilitation Services Administration, HHS-Substance Abuse & Mental Health Services Administration – Center for MH services, Social Security Administration, and the State of Maine.

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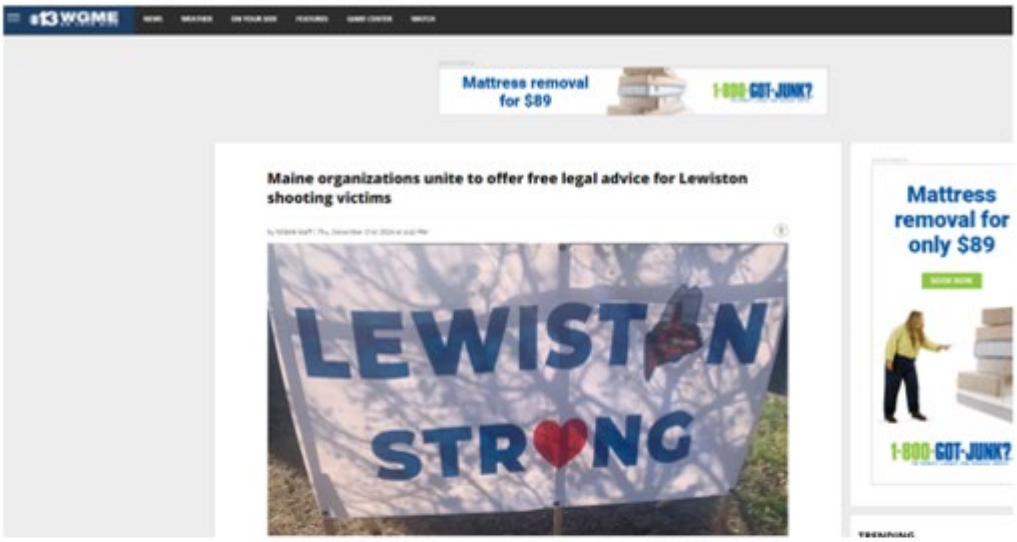
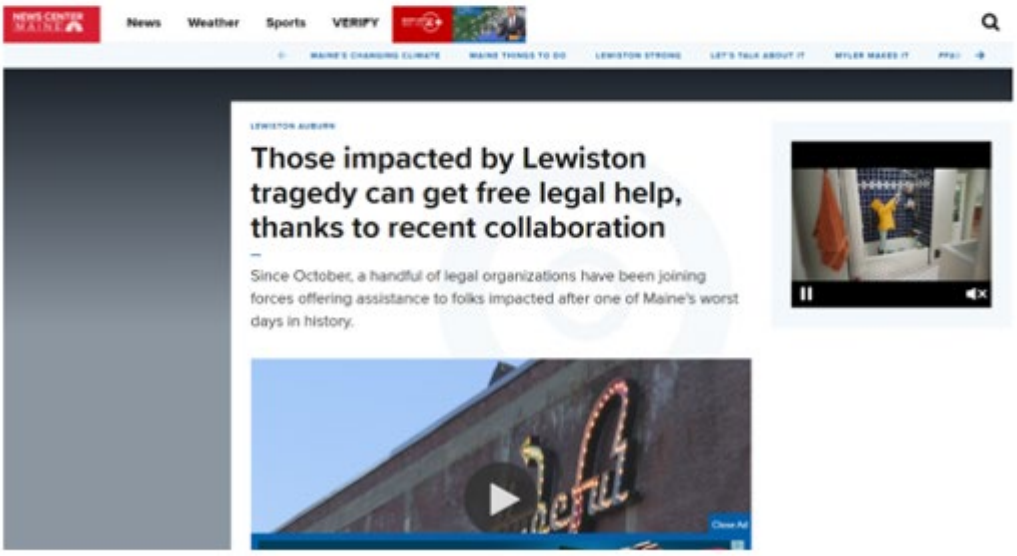
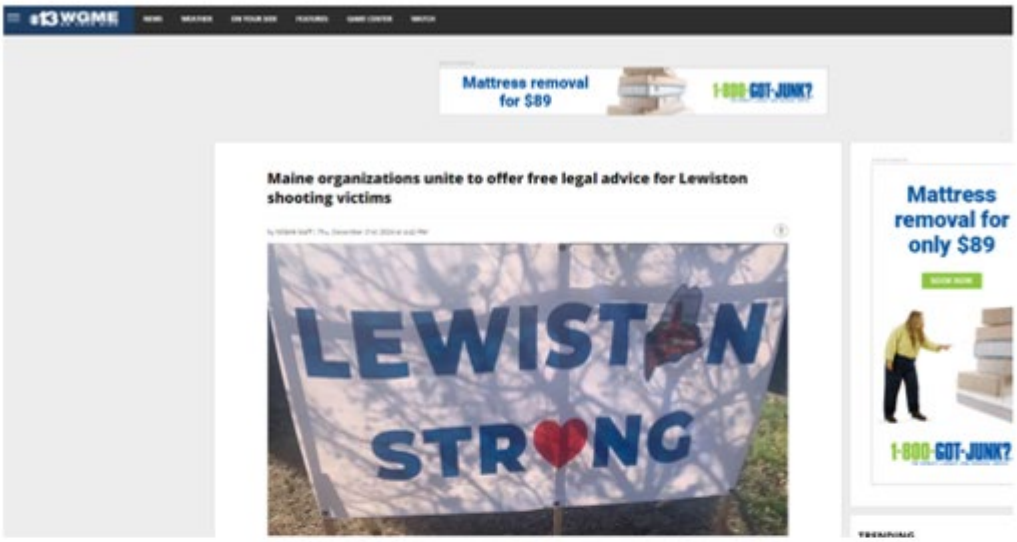


https://wgme.com/news/local/maine-organizations-unite-to-offer-free-legal-advice-for-lewiston-shooting-victims





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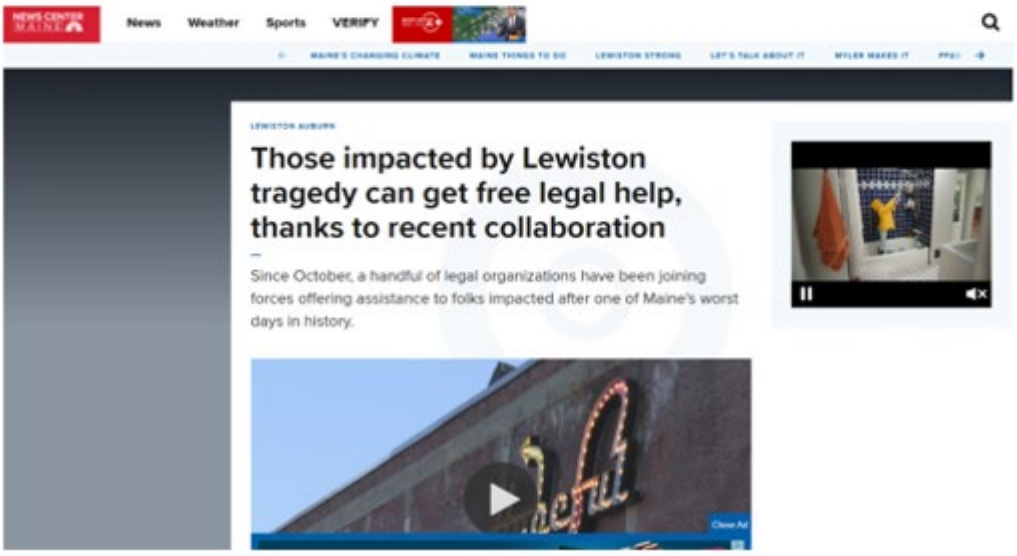

Since October, a handful of legal organizations have been joining forces offering assistance to folks impacted after one of Maine's worst days in history.

https://www.newscentermaine.com/article/news/local/lewiston-auburn/lewiston-families-can-receive-free-legal-assistance/97-ef5d625c-4e84-4604-be71-20ae437c157e

DISABILITY RIGHTS MAINE

PRESS RELEASE: Advocates Respond to U.S. Department of Justice Lawsuit Against State of Maine for Failures in Maine's Children's Behavioral Health System

Sep 9, 2024 | Children's & Education Rights, Children's Advocacy, News, Press Releases

CONTACT:
Julia Endicott
978-877-3871
jendicott@drme.org

FOR IMMEDIATE RELEASE
September 9, 2024

Advocates Respond to U.S. Department of Justice Lawsuit Against State of Maine for Failures in Maine's Children's Behavioral Health System

The suit comes after more than two years of negotiations between the parties

Augusta – Today, the U.S. Department of Justice (DOJ) filed suit against the State of Maine based on its June 2022 findings that Maine discriminated against youth with disabilities by failing to maintain an adequate system of behavioral health services that prevent institutionalization. The lawsuit comes after settlement negotiations broke down.

"Twenty-five years after the landmark Supreme Court decision *Olmstead v. L.C.*, which found that unnecessarily segregating people with disabilities into institutional settings violates the Americans with Disabilities Act, Maine children and their families are still waiting for a legally compliant behavioral health system. And despite calls for more than a decade to ensure the availability of those services, Maine has failed to do so. Unfortunately, this lawsuit was the necessary result of that continued failure," said Atlee Reilly, Managing Attorney, Disability Rights Maine.

After initially receiving a complaint filed by Disability Rights Maine, the U.S. DOJ conducted a lengthy investigation and found:

- "Maine's community-based behavioral health system fails to provide sufficient services. As a result, hundreds of children are unnecessarily segregated in institutions each year, while other children are at serious risk of entering institutions."
- "Children are unable to access behavioral health services in their homes and communities—services that are part of an existing array of programs that the State advertises to families through its Medicaid program (MaineCare), but does not make available in a meaningful or timely manner."

- "Maine children with behavioral health needs are eligible and appropriate for the range of community-based services the State offers, but either remain in segregated settings or are at serious risk of institutionalization."
- "Families and children in Maine are overwhelmingly open to receiving services in integrated settings. In fact, parents indicated a strong preference that their children receive services at home due to trauma, neglect, and abuse that their children reportedly endured in residential facilities within and outside of Maine."

Those findings should not have been a surprise to the State of Maine, which had been on clear notice of the widespread inadequacy of its community-based behavioral health system for children when a comprehensive assessment concluded, in 2018, that children's behavioral health services were not available when needed, or not available at all. Two years later, a separate independent assessment of the juvenile justice system found that many youth are detained and incarcerated at Long Creek because they could not access appropriate community-based services for their behavioral and mental health needs.

What was true in 2018 remains true today- Maine continues to fail to ensure that children with disabilities have access to the community-based behavioral health services they need in their homes and communities. As a result, children with disabilities in Maine are unnecessarily institutionalized in residential facilities, including at Long Creek and in other residential facilities both inside and outside the state, severing their ties to family and community. This violates their right, under the Americans with Disabilities Act, to receive services in the most integrated settings appropriate to their needs.

"When kids can access treatment and support close to home, they can stay connected with their families and communities," said ACLU of Maine Legal Director Carol Garvan. "Unfortunately, for far too long, Maine has not ensured these services. Since 2016, we have been working to address human rights violations at Long Creek, but not enough has been done. Maine must provide its kids the services they need to live healthy and safe lives."

"Maine children with disabilities and their families deserve what the law requires, which is community-based behavioral health services. The failure to provide those services harms children, strains and fragments families, and ripples across communities. Maine can and must step up to meet its obligations with the services the law requires," said Mary Bonauto, Senior Director at GLBTQ Legal Advocates & Defenders.

As the U.S. DOJ indicated in its complaint,

- "Maine can implement reasonable modifications so that children with behavioral health disabilities can live and thrive in integrated settings instead of entering institutions to access care."
- "But instead of modifying its service system to prevent and resolve unnecessary segregation, Maine has prioritized expanding its institutional services."

Read the DOJ press release.

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Disability Rights Maine is Maine's Protection & Advocacy organization. Our mission is to advance justice and equality by enforcing rights and expanding opportunities for people with disabilities in Maine.

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Dec 4, 2024

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Nov 26, 2024

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Disability Rights Maine (DRM) is the federally mandated protection and advocacy system for Maine, which receives part of its funding from the HHS-Administration for Community Living, DOE-Rehabilitation Services Administration, HHS-Substance Abuse & Mental Health Services Administration – Center for MH services, Social Security Administration, and the State of Maine.

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PRESS RELEASE

Justice Department Sues Maine for Violating the Americans with Disabilities Act

Monday, September 9, 2024

For Immediate Release

Office of Public Affairs

The Justice Department sued the State of Maine today for unnecessarily segregating children with behavioral health disabilities in hospitals, residential facilities and a state-operated juvenile detention facility in violation of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.* The department previously notified Maine of its findings of civil rights violations in a June 2022 letter to Maine. The letter identified steps that Maine should take to remedy the violations.

"The State of Maine has an obligation to protect its residents, including children with behavioral health disabilities, and such children should not be confined to facilities away from their families and community resources," said Assistant Attorney General Kristen Clarke of the Justice Department's Civil Rights Division. "The Civil Rights Division is committed to ensuring that people with disabilities can get the services they need to remain at home with their families and loved ones, in their communities."

"Families across Maine must be able to access to local community-based services for their children with behavioral health disabilities," said U.S. Attorney Darcie N. McElwee for the District of Maine. "The alleged violations identified by the Justice Department must be remedied so that these children and their families can obtain services in their own communities, as required by the Americans with Disabilities Act."

The ADA and the *Olmstead* decision require state and local governments to ensure the services they provide for children with disabilities are available in the most integrated setting appropriate to each child's needs. These services can include assistance with daily activities, behavior management and individual or family counseling. Community-based behavioral health services also include crisis services that can help prevent a child from being institutionalized during a mental health crisis. Absent these services, Maine children with disabilities enter emergency rooms, come into contact with law enforcement and remain in institutions when they could remain with their families if Maine provided them sufficient community-based services.

The lawsuit alleges that Maine administers its system in a way that limits behavioral health services in the community. As a result, Maine children must enter in- and out-of-state facilities, or even the state-operated juvenile detention facility, Long Creek Youth Development Center, to receive behavioral health services. Others are at serious risk of entering these facilities, as their families struggle to keep them home despite the lack of necessary services.

The Civil Rights Division's Disability Rights Section investigated this case with assistance from the U.S. Attorney's Office for the District of Maine.

For more information on the ADA, please call the department's toll-free ADA Information Line at 1-800-514-0301 (TDD 800-514-0383) or visit www.ada.gov/topics/community-integration/.

For more information on the Civil Rights Division, please visit www.justice.gov/crt.

The letter of findings can be viewed here.

Updated September 9, 2024

Topics

CIVIL RIGHTS | DISABILITY RIGHTS

Components

Civil Rights Division | Civil Rights - Disability Rights Section | USAO - Maine

Press Release Number: 24-1114

DOJ sues Maine over ADA violations involving kids with behavioral health disabilities

PORTLAND, Maine — The U.S. Department of Justice announced Monday that it has sued the state of Maine for unnecessarily segregating children with behavioral health disabilities in hospitals, residential facilities and a state-operated juvenile detention facility.

https://www.youtube.com/watch?v=5r70pQ7f60c

BDN BANGOR DAILY NEWS

Feds sue Maine for allegedly segregating children with disabilities

by **Callie Ferguson** and **Christopher Burns**
September 9, 2024 Updated September 11, 2024

The U.S. government sued Maine on Monday for allegedly unnecessarily institutionalizing children with behavioral health disabilities, separating them from their families and segregating them from their communities.

The lawsuit comes more than two years after the U.S. Department of Justice noti
that its failure to provide timely and appropriate behavioral health services for ch
systematic discrimination. The escalation indicates that federal authorities and sta
come up with a plan to resolve the problems without going to court.

In **its 24-page complaint**, filed Monday in U.S. District Court, the Justice Department accused Maine of violating the **Americans with Disabilities Act** and **a 1999 U.S. Supreme Court decision**, which require state and local governments to provide services to children with disabilities in the least restrictive setting appropriate to their needs. The Justice Department said Monday that community-based services, such as programs where behavioral health clinicians work with children in their homes, can prevent them from ending up in institutions like emergency rooms, psychiatric hospitals, residential facilities in and out of state, or the state's youth prison.

In the complaint, the Justice Department said that Maine "in theory" uses Medicaid and other public funds to support such services, but in reality, the state administers them in a way that offers parents and guardians "no meaningful choice" other than institutions, separating those children from their families and segregating them from their communities.

"When Maine children are placed in institutions, such as psychiatric hospitals, juvenile detention, and other residential facilities, they miss the chance to wake up in their own beds, to develop bonds with family and friends, and to go to school with their siblings and peers," the Justice Department wrote.

The allegations echoed the findings of previous reports, including **a critical review** of Maine's behavioral health system for children in 2018 which identified long waiting lists for community-based services, increasing the likelihood of a behavioral health crisis that prompted families to call police or seek the hospital.

In 2020, a **comprehensive assessment** of the state's juvenile justice system found that far fewer adolescents would end up in Long Creek Youth Development Center in South Portland, the state's only juvenile detention center, if the state had a more robust behavioral health system.

"Maine children and their families are still waiting for a legally compliant behavioral health system," Atlee Reilly, a lawyer with Disability Rights Maine, the organization that drew the Justice Department's attention to Maine in a 2019 complaint, said in a statement on Monday. "And despite calls for more than a decade to ensure the availability of those services, Maine has failed to do so. Unfortunately, this lawsuit was the necessary result of that continued failure."

Lindsay Hammes, a spokeswoman for the Maine Department of Health and Human Services, which oversees the children's behavioral health system, said in a statement that the department was "deeply disappointed that the U.S. DOJ has decided to sue the State rather than continue our collaborative, good-faith effort to strengthen the delivery of children's behavioral health services."

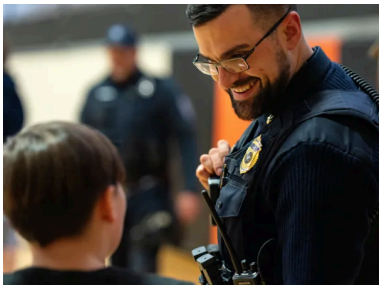
The department had been "working closely with the Department of Justice to address its initial allegations from March 2022," she said. Now, "The State of Maine will vigorously defend itself and, throughout the litigation, will continue to work hard to strengthen the delivery of what we all agree are vital services."

Hammes said the Gov. Janet Mills' administration and the Maine Legislature has worked to strengthen community-based services for children in recent years investing more money into behavioral health programs. In 2022, a spokesperson **told the Bangor Daily News** the problems Maine faces in providing care for children go back decades, and the COVID-19 pandemic set back the state as it made it difficult for providers to hire and maintain staff.

But the Justice Department argued in its complaint Monday that the state's invest
backing up complaints from families and advocacy groups that inadequate access

not worsened, in recent years.

GO DEEPER



They came together to help at-risk kids in the midcoast. Will it be enough?

by **Callie Ferguson**

Carrie Woodcock, executive director for the Maine Parent Federation, which helps families navigate services for their children with behavioral health disabilities, had hoped the Justice Department's letter to the state in June 2022 might be a turning point, but it wasn't, she said.

"When that letter first came out, the families in our organization thought, "OK, they are being duly noted, we are going to see some progress. And we've seen nothing," Woodcock said.

When families have called over the past year, "all I could say to them was, 'Here is the number for our contact at [the Department of Justice] leading the investigation into the state. We recommend you call and talk to them,'" she said.

The Justice Department's complaint goes into extensive detail about the challenges that parents and guardians face when attempting to access community-based services that their children are eligible for under MaineCare, including lengthy waitlists, insufficient provider networks, inadequate crisis services and a lack of support for foster parents.

For example, one program called Children's Home and Community Based Treatment, which provides individual and family counseling for children with emotional disturbances in their home, had an average waitlist of 172 days between March and June 2024, the complaint states.

READ ABOUT THE CRISIS

Maine's juvenile justice crisis

Efforts to address chronic problems in Maine's juvenile justice system have all but stalled.

When children go into crisis, the state operates a 24/7 hotline for parents to call –
are frequently unavailable, or no one answers the phone, lawyers for the Justice D

For children in state custody, the state has failed to recruit and support enough therapeutic foster homes, a program where foster families are trained and provided the resources to house kids with behavioral health disabilities. As a result, some foster children "have been dropped off at homeless shelters because Maine did not secure community-based services for their care, including Therapeutic Foster Care."

When children don't get the interventions they need at home, they are at greater risk of hospitalization, incarceration or lengthy stays in residential treatment facilities, both in **and out of state**. Those options are often more traumatizing and expensive than serving youth in their homes and communities, the complaint states. It accused the state of using Long Creek in South Portland as a "de facto psychiatric hospital" for adolescents with behavioral health disorders who can't find help anywhere but inside the state's youth detention center.

The Justice Department suggested that Maine has missed opportunities to fill gaps in its community-based system that would prevent unnecessarily institutionalization, the complaint states. Instead, the state "has prioritized expanding its institutional services" by committing to establishing the state's first secure residential program.

"The State of Maine has an obligation to protect its residents, including children with behavioral health disabilities, and such children should not be confined to facilities away from their families and community resources," Assistant Attorney General Kristen Clarke, who serves in the Justice Department's civil rights division, said Monday.

"The Civil Rights Division is committed to ensuring that people with disabilities can get the services they need to remain at home with their families and loved ones, in their communities."

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

UNITED STATES OF AMERICA, ***Plaintiff*,** **v.** **STATE OF MAINE,** ***Defendant*.**	**CIVIL ACTION NO.**

COMPLAINT

1. Each year, the State of Maine ("Maine" or "State") segregates hundreds of children with mental health and/or developmental disabilities, referred to throughout as behavioral health disabilities, away from their families and communities in institutions in- and out-of-state. These children do not need to be segregated. The families of many of these children want them home. Other families would choose to have their children live at home or in another family home if provided a meaningful opportunity to do so. Maine administers its behavioral health service system for children in a manner that gives the families and guardians of these children no meaningful choice other than institutions. This leaves hundreds of children separated from their families and segregated from their communities.

2. The United States of America ("United States") brings this action to enforce the rights of Maine children with behavioral health disabilities who are unnecessarily segregated—or at serious risk of segregation—in institutions because Maine has failed to provide them access to the behavioral health services they need in the community. These children (*i.e.*, individuals under the age of 21) make up the population at issue here, referred to throughout as children with behavioral health disabilities or simply children.

3. When Maine children are placed in institutions, such as psychiatric hospitals, juvenile detention, and other residential facilities, they miss the chance to wake up in their own beds, to develop bonds with family and friends, and to go to school with their siblings and peers.

4. In theory, Maine funds and administers an array of behavioral health services, which it uses Medicaid and other publicly funded programs to fund, that help children with disabilities avoid or recover from mental health crises and manage their behavioral health disabilities so that they can stay in their homes and communities.

5. But, in reality, Maine fails to provide children access to community-based behavioral health services. As a result, hundreds of children are segregated in institutions because they cannot access the community-based services they are entitled to receive. Many more children are at serious risk of segregation because they cannot access Maine's community-based services in a meaningful or timely manner. Maine's mental health crisis services for children are often unavailable. When a child is in crisis, families are often directed to call the police or take the child to the emergency room. This puts the child at risk of institutionalization. Similarly, because the behavioral health services children need to return home are often unavailable, children who are taken to the emergency room often get stuck there. They are then sent to institutions.

6. Most Maine children who have had to enter institutions could live at home with a family if they could access the services they need there.

7. Children and their families would prefer for the children to live at home with services.

8. Maine could prevent discrimination against children with behavioral health disabilities by making reasonable modifications to its service system. With changes to Maine's

system to make community-based behavioral health services available to avoid the unnecessary segregation of children with behavioral health disabilities who need them, these children could live and thrive in their communities. Maine could thereby enable children with behavioral health disabilities to avoid unnecessary segregation.

9. Representatives of children across Maine have filed complaints with the United States describing how children want to live at home and how their families want them at home but that the children are stuck in institutions or face imminent institutionalization because Maine policies and practices make it hard for them to get services at home.

10. The United States of America brings this lawsuit, seeking a judicial order compelling Maine to provide behavioral health services to children with disabilities in their homes and communities when they can be served there, rather than unnecessarily segregating them or placing them at serious risk of unnecessary segregation in institutions. 42 U.S.C. §§ 12131–34; 28 C.F.R. pt. 35.

JURISDICTION AND VENUE

11. This Court has jurisdiction over this action under 28 U.S.C. §§ 1331, 1345, because it involves claims arising under federal law. *See* 42 U.S.C. § 12133. The Court may grant the relief sought in this action pursuant to 28 U.S.C. §§ 2201–02.

12. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the acts and omissions giving rise to this action occurred in the District of Maine.

PARTIES

13. Plaintiff is the United States of America.

14. Defendant, the State of Maine, is a public entity within the meaning of the

Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12131(1), and is therefore subject to Title II of the ADA, 42 U.S.C. §§ 12131–34, and its implementing regulation, 28 C.F.R. pt. 35.

LEGAL BACKGROUND

15. Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1).

16. In enacting the ADA, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities," and that "such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." *Id.* § 12101(a)(2).

17. Title II of the ADA prohibits public entities from discriminating against people on the basis of disability. *Id.* § 12132. A "public entity" includes any state or local government, as well as any department, agency, or other instrumentality of a state or local government, and it applies to all services, programs, and activities provided or made available by public entities, such as through contractual, licensing, or other arrangements. *Id*. § 12131(1); 28 C.F.R. § 35.130(b)(3)(i).

18. Congress directed the Attorney General to issue a regulation implementing Title II of the ADA. 42 U.S.C. § 12134. The Title II regulation includes an "integration mandate," which requires public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The most integrated setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." *Id.* pt. 35, app. B.

19. In *Olmstead v. L.C.*, the Supreme Court held that Title II prohibits the unjustified

segregation of individuals with disabilities. 527 U.S. 581, 597 (1999). The Supreme Court explained that its holding "reflects two evident judgments." *Id.* at 600. First, the Supreme Court explained that unnecessary institutionalization of people with disabilities "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id*. "Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 601.

20. Under Title II, as interpreted by the Supreme Court in the *Olmstead* decision, public entities are required to provide community-based services when (a) such services are appropriate, (b) the affected individuals do not oppose community-based treatment, and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other people with disabilities. *Id.* at 607.

MAINE'S BEHAVIORAL HEALTH SERVICE SYSTEM FOR CHILDREN

21. Maine administers and funds services for children with behavioral health disabilities through various agencies, departments, and programs.

22. Behavioral health services help children with disabilities manage their behavioral health needs and learn the skills they need to be independent and engage with the community.

23. For example, a child with a mental health diagnosis and autism may need several different behavioral health services, including help with personal care, supervision, redirection to prevent the child from wandering off, and one-on-one therapy.

24. Maine offers behavioral health services in both community-based settings (such as family homes) and in segregated settings.

25. But children with behavioral health disabilities struggle to remain at home or

return home from institutions due to barriers to accessing Maine's behavioral health services at home.

26. Maine provides healthcare coverage to eligible children through its state and federally funded Medicaid program, known as MaineCare. Maine also funds behavioral health services through other state and federal funding sources.

27. Medicaid is a health care system created by federal law but administered by states that are subject to certain federal statutory requirements. In broad terms, Medicaid's purpose is to provide government-funded health coverage and related services for low-income individuals and individuals with disabilities. When these individuals receive authorized services from providers that are enrolled with Medicaid, the providers' costs are reimbursed with Medicaid funds.

28. Federal law requires every state that participates in Medicaid to designate a state agency to administer its Medicaid services. That agency must create a "Medicaid State Plan," which describes and defines the services that it will cover through Medicaid.

29. Maine's Department of Health and Human Services ("DHHS") is responsible for administering MaineCare under Title XIX of the Social Security Act (the "Medicaid Act"). *See* Me. Rev. Stat. Ann. tit. 22, § 3173; 10-144-101 Me. Code R. § 1.02-1.

30. Under the Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") requirements of the Medicaid Act, DHHS must provide all medically necessary services to Medicaid-eligible children up to 21 years of age. *See* 42 U.S.C. §§ 1396a(a)(43), 1396d(a), 1396d(r).

31. DHHS administers behavioral health services for children up to their 21st birthday.

32. Behavioral health services for children are primarily funded by MaineCare.

Segregated Settings for Children with Behavioral Health Disabilities

33. Maine reimburses private institutional providers, such as hospitals and residential facilities, under MaineCare and other state and federal funding sources.

34. Maine sets reimbursement payment rates for institutional providers.

35. Maine has multiple psychiatric hospitals that serve children with behavioral health disabilities.

36. Maine has general hospitals that have psychiatric units for children.

37. Maine has general hospitals with emergency rooms, where children experiencing mental health crises may be taken.

38. In addition to other institutions for children, Maine also has at least a dozen Children's Residential Care Facilities ("CRCFs"), which provide residential treatment services to children as young as five years old with behavioral health disabilities.

39. CRCFs are inpatient care settings that serve only children with disabilities.

40. During each month between January 2018 and June 2024, between 133 and 353 Maine children per month lived in Maine CRCFs to receive residential treatment services.

41. During each month between January 2018 and June 2024, between 41 and 85 Maine children per month lived in out-of-state residential facilities to receive residential treatment services.

42. According to data provided by the State, children sent to in-state CRCFs stayed there for an average of 246 days in fiscal year 2020.

43. In hospitals, residential facilities, and other institutions, children with behavioral health disabilities are separated from their families and communities in congregate settings to receive services.

44. In these settings, children with behavioral health disabilities have little to no interaction with people without disabilities other than the staff who serve them.

45. Maine also sends children to its secure juvenile detention facility, Long Creek Youth Development Center ("Long Creek"), to receive behavioral health services.

46. Maine owns and operates Long Creek.

47. As explained further below, Maine uses Long Creek as a *de facto* psychiatric hospital.

48. Contrary to state law requirements that children in the juvenile justice system be rehabilitated at home wherever possible, children with behavioral health disabilities are instead sent to or remain in Long Creek because it is the only setting where they can access behavioral health services.

49. As a result, most children at Long Creek have behavioral health disabilities.

50. Children who are held at Long Creek have few, if any, opportunities to see their families and friends or engage with their communities.

51. These hospitals, residential facilities, and Long Creek are segregated settings.

Community-Based Behavioral Health Services

52. Maine licenses, certifies, or otherwise regulates private community-based behavioral health service providers.

53. Maine pays private community-based behavioral health service providers with MaineCare and other state and federal funding.

54. Maine sets reimbursement payment rates for community-based behavioral health service providers.

55. Maine's community-based behavioral health services include crisis services for children experiencing behavioral health emergencies and longer-term behavioral health services for children living at home.

Crisis Services

56. DHHS operates a crisis hotline that dispatches mobile crisis teams who provide in-home assistance to children experiencing mental health crises.

57. Maine claims that its crisis hotline is available 24 hours per day, 7 days per week.

58. But parents and advocates report that the crisis hotline and mobile crisis teams are frequently unavailable—either because no one answers the phone, or because no teams are available to come to the child's home to help.

59. Maine also has Crisis Stabilization Units ("CSUs") where children can receive short-term, inpatient care during a mental health crisis.

60. Parents and providers report that CSU beds are frequently unavailable.

61. Although children enrolled in MaineCare are eligible for various crisis services in the community, *see, e.g.*, 10-144-101 Me. Code R. § 65.05-1, many must enter emergency departments to get crisis services that Maine ostensibly offers in the community.

Longer-Term Behavioral Health Services

62. In addition to crisis services, Maine also offers longer-term behavioral health services through MaineCare.

63. For instance, Maine claims to offer Assertive Community Treatment ("ACT"), an intensive, team-based service that includes crisis response, to children who are eligible for MaineCare.

64. Although ACT is ostensibly an available service, Maine currently has only one ACT MaineCare provider, and very few children in Maine can find a provider and access the service.

65. Maine also offers Rehabilitative and Community Support Services as well as Specialized Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations, which provide children with developmental disabilities—who may also have mental health disabilities—with assistance with activities of daily living and behavior management.

66. There are lengthy waitlists for these services. In recent publicly available data, Maine reported that, from March 2024 to June 2024, the average time that a child was on a waitlist for Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations was 167 days, while the average time that a child was on a waitlist for Specialized Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations was 357 days.

67. Another service, called Children's Home and Community Based Treatment ("HCT"), is designed for children who are diagnosed with serious emotional disturbance, as defined in the MaineCare rules.

68. HCT includes individual counseling, family counseling, and in-home services provided by trained staff.

69. Children also face a long waitlist for HCT. Maine has reported that, from March 2024 to June 2024, the average time a child was on a waitlist for HCT was 172 days.

70. MaineCare also offers a service called Targeted Case Management that coordinates care for children with disabilities.

71. In State Fiscal Year 2020, children with behavioral health disabilities waited an average of 328 days to receive Targeted Case Management. Some of these children waited more than 650 days to receive Targeted Case Management.

72. Maine previously offered more intensive care coordination statewide to MaineCare eligible children with behavioral health disabilities through a high-fidelity wraparound program called Maine Wraparound.

73. High-fidelity wraparound is a comprehensive service delivery strategy that coordinates a wide net of resources for children with behavioral health disabilities, including family and community resources, to support these children in the community.

74. While it was offered, Maine Wraparound was critical in preventing significant numbers of Maine children with behavioral health disabilities from being placed in institutions.

75. Maine's statewide wraparound program also resulted in significant cost savings to the State, because Maine Wraparound successfully diverted children from expensive institutionalization.

76. Although Maine discontinued its Maine Wraparound program, Maine has stated that it intends to reintroduce high-fidelity wraparound services for MaineCare eligible children. Despite setting aside funds for these wraparound services, Maine has spent little of the funds it estimated it would need to re-establish high-fidelity wraparound. Maine therefore is not on track

to make high fidelity wraparound available to the many children with behavioral health disabilities who qualify.

77. Currently, Maine offers high-fidelity wraparound to only a limited number of youth who are involved in the juvenile justice system.

Therapeutic Foster Care

78. DHHS also administers Maine's child welfare system.

79. Children are removed from their homes and enter the child welfare system following claims that they were neglected or abused by their parents, legal guardian, or custodian.

80. Maine's child welfare system offers a specialized form of foster care, known as Therapeutic Foster Care, for children with behavioral health needs in the child welfare system.

81. Therapeutic Foster Care parents are trained, supervised, and supported by qualified staff to care for foster children with behavioral health disabilities.

82. Therapeutic Foster Care parents are contracted by private placement agencies that are licensed through the Office of Child and Family Services, which is housed within DHHS.

83. Maine does not offer sufficient incentives to encourage the needed number of Maine adults to become licensed Therapeutic Foster Care parents.

84. Maine does not recruit enough Therapeutic Foster Care parents to serve eligible children with behavioral health disabilities.

85. Maine does not provide Therapeutic Foster Care parents with the training or services they need to support foster children with behavioral health disabilities.

86. As a result, there are too few Therapeutic Foster Care parents in Maine to serve eligible foster children with behavioral health disabilities.

87. Foster children with behavioral health disabilities therefore enter and remain in segregated settings unnecessarily while they await Therapeutic Foster Care placements.

88. Other children with behavioral health disabilities are at risk of entering segregated settings if they enter the foster system.

89. Maine previously offered an additional option, called Multidimensional Therapeutic Foster Care, for children other than those in the child welfare system.

90. When it existed, Multidimensional Therapeutic Foster Care placed children with behavioral health disabilities with specially trained foster parents so that these children could receive services in a home-based setting and maintain legal and social ties to their families.

91. Multidimensional Therapeutic Foster Care helped avoid institutionalization of children who were not in the child welfare system but whose families could not care for them at home, for example due to a parent's illness or the needs of other children in the home.

92. Maine plans to re-establish this program but does not currently make it available to those who qualify.

Maine's Community-Based Services Are Not Available when Children with Behavioral Health Disabilities Need Them, Resulting in Unnecessary Segregation or Serious Risk of Such Segregation

93. Maine's behavioral health system makes it difficult for children with behavioral health disabilities to access community-based services to prevent segregation and serious risk of segregation.

Maine Has Long Waitlists for Community-Based Services

94. Maine maintains separate waitlists for each community-based behavioral health service that it offers to children with behavioral health disabilities.

95. But children with behavioral health disabilities who would be ready to return to

the community with appropriate services remain in segregated settings due to Maine's waitlists for community-based behavioral health services.

96. For each month between January 2023 to June 2024, at least 400 children waited to receive at least one community-based service.

97. When faced with months of waiting for community-based services, children with behavioral health disabilities are at serious risk of entering institutions to receive care.

98. These children may enter institutions directly, or through hospital emergency rooms or law enforcement involvement, when they experience behavioral health crises because they cannot access the services they need in the community.

Maine Does Not Invest in Community-Based Providers

99. Community-based providers are service providers that provide community-based behavioral health services.

100. Maine reimburses community-based providers through MaineCare and other state and federal funding sources.

101. Maine sets reimbursement payment rates for community-based providers.

102. Maine's own recent report reiterated that "[s]ervice availability and accessibility is undoubtedly one of the most significant factors impacting" children's behavioral health services.

103. This lack of service availability and accessibility in the community places children currently living at home with their families at serious risk of entering institutions.

104. Under the Medicaid Act's EPSDT provision, states must provide access to providers so that children can get required services.

105. Providers need support, guidance, and technical assistance from the State to

provide community-based services to avoid the needless segregation of children with behavioral health disabilities.

106. Maine does not offer incentives or support to ensure that the State's network of providers can serve children with behavioral health disabilities in the community.

107. Maine also has complicated application and approval processes for certain community-based services like respite care,[1] which discourage potential providers from signing up to provide those services.

108. For certain services in some areas of the State, there are no community-based providers at all.

109. Even where providers are available, the demand for community-based services far outpaces providers' ability to provide those services.

110. And Maine does not ensure that providers serve eligible children with behavioral health disabilities.

111. Due to Maine's failure to address its gap in community-based services, children with behavioral health disabilities are forced to enter or remain in institutions to get services.

112. Due to Maine's failure to address its gap in community-based services, children with behavioral health disabilities are at serious risk of entering institutions to get services.

113. Long Creek, Maine's juvenile detention facility, both provides behavioral health services and cannot refuse to serve any children.

[1] Respite care provides trained temporary alternate caregivers so that parents and guardians can take care of other needs or travel, much the same way a neighbor or babysitter provides temporary care to a child without a disability.

Maine's Crisis Services Are Often Unavailable

114. Since Maine's crisis services are often unavailable, children with behavioral health disabilities may enter hospital emergency rooms during behavioral health crises.

115. Children with behavioral health disabilities have stayed in hospital emergency rooms for weeks or months because there are no community-based services available.

116. Families are forced to choose between bringing their children with behavioral health disabilities home from the hospital with no services in place or sending their children to residential facilities. The lack of available community-based services causes many children with behavioral health disabilities to enter residential facilities and places others at serious risk of entering those facilities.

117. When crisis services are unavailable, crisis staff have told families to call the police.

118. Hospitals and residential facilities have also called the police while children are experiencing behavioral health crises.

119. Law enforcement officers are not mental health professionals and so, in general, they cannot effectively provide behavioral health services.

120. And when law enforcement officers respond to a child's mental or behavioral health crisis, they may interpret the child's disability-related behaviors, such as not responding to police commands, as criminal activity.

121. Law enforcement contact places children in behavioral health crisis at serious risk of entering institutions such as Long Creek.

Maine Uses Its Juvenile Detention Facility as a De Facto Psychiatric Facility

122. Once law enforcement is involved, juvenile justice officers may charge the child with a crime based on their disability-related behaviors and recommend that the child be placed at Long Creek.

123. Maine's juvenile justice law requires the State to provide juvenile justice rehabilitative services in the least restrictive setting—typically a family home—with few exceptions.

124. But children with behavioral health disabilities are sent to or remain in Long Creek because of the insufficient behavioral health services available to them in the community.

125. As a result, children with behavioral health disabilities whose needs could be met with community-based services become institutionalized at Long Creek, or are at serious risk of entering Long Creek, to receive behavioral health services.

126. Long Creek is not an appropriate therapeutic setting for children who are having behavioral health crises.

127. For instance, according to recent reports, children may be locked in their cells for up to 23-hours per day. Children may also be subjected to use of force, which results in trauma. These practices have only increased instances of mental health crises and suicide watches at Long Creek.

128. In 2016, Maine's Department of Corrections reported that 84.6% of youth arrive at Long Creek with three or more mental health diagnoses.

129. In 2020, a State-commissioned assessment of Maine's juvenile justice system found that approximately 70% of a sample of children committed to Long Creek had received behavioral health services through MaineCare within the year prior to their incarceration.

130. In testimony before the State Legislature, Maine's Department of Corrections Commissioner stated that despite efforts to reduce detention solely to provide care to children, "some of our youth are at Long Creek because there are no other options."

131. Maine thereby uses Long Creek as a *de facto* psychiatric hospital.

Maine Does Not Invest in Therapeutic Foster Care

132. Maine is responsible for administering training, supports, and services to Therapeutic Foster Care parents so that these parents can meet their foster children's behavioral health disabilities at home.

133. Maine fails to recruit, train, and support Therapeutic Foster Care parents to serve eligible children with behavioral health disabilities who are in the child welfare system.

134. Because of Maine's lack of support, few Therapeutic Foster Care placements are available.

135. Foster children with behavioral health disabilities therefore frequently remain institutionalized in psychiatric hospitals or other segregated settings long after they are ready for discharge.

136. Some foster children with behavioral health disabilities have been dropped off at homeless shelters because Maine did not secure community-based services for their care, including Therapeutic Foster Care.

137. Children in Maine's child welfare system are overrepresented in institutions.

138. Since Maine discontinued the Multidimensional Therapeutic Foster Care option, there is a lack of home-based options for children who are not in the child welfare system but who cannot live with their family of origin for various reasons.

Maine Children with Behavioral Health Disabilities Are Qualified to Receive Services in the Community and Could Be Served with Appropriate Community-Based Services and Supports

139. Children with behavioral health disabilities segregated in hospitals, residential facilities, and Long Creek are eligible for MaineCare and other state and federally funded behavioral health services that Maine administers. Behavioral health disabilities are mental or physical impairments that substantially limit one or more major life activities, as defined in 28 C.F.R. § 35.108.

140. Children with these disabilities living in the community, but who are at serious risk of entering institutions, are eligible for MaineCare and other state and federally funded behavioral health services that Maine administers.

141. With appropriate services, children with behavioral health disabilities can live at home with their families and be fully integrated into their communities.

142. Children with behavioral health disabilities in hospitals, residential facilities, and Long Creek, and those living in the community but at risk of entering these settings, are qualified to receive community-based behavioral health services.

143. Children with behavioral health disabilities who live in the community but are at serious risk have lived at home with their disabilities and can continue living at home if they receive the behavioral health services they need. Community-based behavioral health services are appropriate for these children.

144. Many children who are currently living in institutions have similar diagnoses and behavioral health disabilities as other children who are already living and receiving services in the community. With appropriate community-based services, these children could also live at home.

145. Many children with behavioral health disabilities who are currently living in institutions have previously lived and received behavioral health services at home, and the vast majority could return home with community-based services. Community-based behavioral health services are appropriate for these children.

146. Institutional providers in Maine consistently report that there are children in their facilities who would be ready to return home if community-based services were available. Community-based behavioral health services are appropriate for these children.

147. Staff and administrators at Long Creek have repeatedly estimated that many of the children who are currently held at Long Creek could be released to the community if appropriate mental health programs and services were available.

148. Although children with behavioral health disabilities are qualified for community-based services and such services are appropriate for them, these children remain in segregated settings or are at serious risk of segregation.

Children with Behavioral Health Disabilities and Their Families Would Not Oppose Community Living

149. Children with behavioral health disabilities and their families overwhelmingly do not oppose the children being served in the community with appropriate services and supports.

150. Children with behavioral health disabilities want to live at home, go to school, and engage with their family, friends, and communities.

151. Parents of these children also want their children to live at home.

152. These children and their parents would choose to receive services in their homes and communities instead of in segregated settings if they could access appropriate services and supports at home.

153. Many children with behavioral health disabilities who are at serious risk of

entering institutions, who already live in the community, and their families would choose to continue receiving services in the community if Maine improves access to those services.

Maine Could Serve Children with Behavioral Health Disabilities at Home Through Reasonable Modifications

154. Maine can implement reasonable modifications so that children with behavioral health disabilities can live and thrive in integrated settings instead of entering institutions to access care.

155. With reasonable modifications, children with behavioral health disabilities currently in institutions could transition to, and live successfully in, family and foster homes in the community. Maine could make reasonable modifications to prevent the serious risk of segregation for numerous other Maine children with behavioral health disabilities.

156. To start, Maine could ensure that children actually receive the community-based behavioral health services that the State offers in theory.

157. Maine could also implement a process to determine each child's behavioral health service needs and ensure that families are informed of, and considered for, the MaineCare behavioral health services the child needs to avoid segregation or serious risk of segregation.

158. Maine could address its long waitlists and ensure timely access to community-based services by expanding its capacity of community-based services, for example by providing additional support to community-based providers and expanding the direct care work force, including in rural and frontier areas.

159. Maine could implement measures that would ensure that community-based behavioral health care providers are available to all eligible children at serious risk of unnecessary segregation.

160. For example, Maine could implement a policy that would ensure that community-

based behavioral health care providers serve eligible children who are assigned to their caseload.

161. Serving children with behavioral health disabilities in the community is a cost-effective alternative to segregation.

162. The average cost per child of community-based services is equal to or less than the average cost per child of institutional services.

163. When comparing average costs per child of Maine's behavioral health services, community-based services are among the least expensive services, while residential facilities are more expensive, and hospitals, emergency departments, and Long Creek are the most expensive.

164. But instead of modifying its service system to prevent and resolve unnecessary segregation, Maine has prioritized expanding its institutional services.

165. For example, Maine has committed to establishing one or more psychiatric residential treatment facilities for children—the first of their kind in Maine.

166. But Maine has not committed to providing community-based services to the many children with behavioral health disabilities who are unnecessarily segregated or at serious risk of segregation.

VIOLATION OF TITLE II OF THE ADA, 42 U.S.C. §§ 12131–34

167. The United States repeats and incorporates by reference all the allegations set forth above.

168. Defendant, the State of Maine, is a public entity that must comply with Title II of the ADA. 42 U.S.C. § 12131(1).

169. Maine children with behavioral health disabilities who are segregated or at serious risk of segregation are persons with disabilities protected by Title II of the ADA, and they are qualified to participate in Maine's services, programs, and activities, including community-based

services. *Id.* §§ 12102, 12131(2).

170. Community-based services are appropriate for these children, many of whom, along with their parents or guardians, do not oppose community integration.

171. Maine violates Title II of the ADA by administering its service system for children with behavioral health disabilities in a manner that fails to ensure that such children receive services in the most integrated setting appropriate to their needs. *Id.* § 12132.

172. Maine's actions constitute discrimination in violation of Title II of the ADA, *id.*, and its implementing regulation at 28 C.F.R. pt. 35.

173. Maine could reasonably modify its programs and services to serve children in integrated settings.

174. All conditions precedent to the filing of this Complaint have been satisfied. Fed. R. Civ. P. 9(c); 28 C.F.R. pt. 35, subpt. F.

REQUEST FOR RELIEF

The United States respectfully requests that the Court:

175. Grant judgment in favor of the United States on its Complaint and declare that the State of Maine has violated Title II of the ADA, 42 U.S.C. §§ 12131–34, by failing to administer its services, programs, and activities for children with behavioral health disabilities in the most integrated setting appropriate to their needs.

176. Enjoin the State of Maine to:

a. Cease discriminating against children with behavioral health disabilities, and instead provide them appropriate, integrated community-based services consistent with their individual needs, so that currently segregated children can transition to living at home, and to prevent children at serious

risk of unnecessary segregation from entering institutions; and

b. Take steps as may be necessary to prevent the recurrence of any discriminatory conduct in the future and to eliminate the effects of Maine's unlawful conduct.

177. Order other appropriate relief as the interests of justice may require.

Dated: September 9, 2024

Respectfully submitted,

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2024 WL 3568707 (Me.Super.) (Trial Order)
Superior Court of Maine.
Kennebec County

A.F., Petitioner,

v.

MAINEGENERAL MEDICAL CENTER, Respondent.

No. AUGSC-CV-22-189.
February 13, 2024.

Order on Petition for Writ of Habeas Corpus

Michaela Murphy, Justice.

BACKGROUND

***1** Before the Court is a Petition for a Writ of Habeas Corpus brought by A.F., a 45-year-old deaf woman who suffers from mental illness. She was detained at MaineGeneral Medical Center's ("MGMC") Emergency Department ("ED") for 65 days from October 12, 2022 until December 14, 2022, when MGMC finally admitted her to their A-3 in-patient psychiatric unit.

The Court has considered the evidence at hearing on October 19, 2023, and has considered the written post-hearing arguments of the parties, the last of which was received on December 20, 2023, and has concluded that Petitioner A.F. is entitled to some form of relief, but the Court will be ordering further proceedings to hear arguments as to what form the relief should take.

Petitioner has asked the Court to grant her Petition based upon a finding that hospitals such as MGMC do not enjoy "plenary, unreviewable discretion" to decide which patients they admit from a "waiting list" of patients like A.F. who wait—sometimes for months—to be admitted to a psychiatric hospital after being "blue papered" under Maine law. Petitioner claims she was entitled to appointment of counsel, along with other due process protections, while waiting for placement. She claims hospitals such as MGMC who contract with the Maine Department of Health and Human Services ("DHHS") to admit and treat "blue papered" individuals cannot simply reject a patient such as A.F. by asserting the person does not meet their standards for "acuity" and/or are not a good fit for their "milieu." MGMC asserts that it adhered to and went above and beyond the requirements under Maine law and pursuant to its contract with DHHS.

The parties do agree that under Maine's current system, psychiatric patients such as A.F. are living in emergency rooms across Maine for up to months at a time while they are waiting for admission to psychiatric facilities, including Maine's two State psychiatric hospitals, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, along with the 8 private hospitals that have contracted with the State to accept such patients in their psychiatric units. The parties agree that A.F. was detained at the MGMC ED while awaiting the so-called "white paper process" to unfold. That process carries with it elevated due process protections, including appointment of counsel and which may culminate in a full, confidential hearing before a District Court Judge.

The parties essentially agree as to what happened over the course of those 65 days. A.F. was held against her will at the MGMC ED while the process played out. MGMC provided her basic needs including interpreter services and medication, but she did not receive the same level of psychiatric treatment she would have received had she been admitted to either a State or private psychiatric hospital while being further assessed for court proceedings, nor was she afforded legal representation. The parties

further seem to agree that MGMC followed the "blue paper" process established by the Maine Legislature twelve separate times by completing three statutorily mandated steps: (1) application; (2) certifying examination; and (3) judicial review and endorsement. 34-B M.R.S. §§ 3863(1)-(3). Each time after these steps were completed, a District Court Judge who reviewed and endorsed the application stated, as printed on the form:

> ***2** I find this application and certificate to be regular and in accordance with the law. No psychiatric hospital has been located as of the date of the certifying examination. [A.F.] may remain at [MGMC ED] pending the location of an inpatient bed at a psychiatric hospital or other appropriate alternative subject to the requirements of 34-B M.R.S. § 3863(3). If an available inpatient bed at a psychiatric hospital is located, and the emergency admission of [A.F.] is still sought, the applicant shall immediately notify a judicial officer for final review and endorsement under Section 3.B.2 below.

Ex. 9.

Over the course of the 65 days, A.F. was rejected by the following hospitals: Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, Spring Harbor Hospital, Northern Light Acadia Hospital, Southern Maine Medical Center, St. Mary's Regional Medical Center, Mid Coast Hospital, Penobscot Bay Hospital, Maine Medical Center, and MGMC. They all claimed that she was not a good fit for their hospital as her acuity level was too high, or otherwise did not fit their milieu. And these rejections repeatedly occurred while other patients, who were also awaiting admission from MGMC's ED, were admitted to psychiatric hospitals. Janelynn Duprey, Nursing Director for the ED at MGMC, testified that there is essentially no "waiting list" for these patients as that term is conventionally understood. Instead, prospective hospitals are permitted to decide whether a patient is a good fit for their facility. If not, the patient and the ED where the patient is being detained, have no option but to accept that decision, and to wait. And wait they did.

In A.F.'s case, her waiting finally ended when Nursing Director Duprey, clearly frustrated but undeterred, advised A.F. to contact Disability Rights Maine to take her case. This Petition was soon filed with their assistance. Two days later, MGMC moved A.F. from their ED upstairs to their psychiatric unit.[1]

STANDARD OF REVIEW

Approximately three years ago, the Law Court stated in .4.5. *v. LincolnHealth* that Section 3863 of Title 34-B was "an imprecise 'fit' for what is actually happening in Maine's emergency departments as they struggle to deal with patients who need psychiatric beds at a time when the State has failed to create or fund enough of those beds." 2021 ME 6, ¶ 16, 246 A.3d 157. The Law Court further noted that this statute is one of a very few "that provides the civil authority for a person or entity to hold another person against his wishes." *Id.* In addition, the Law Court recognized the guiding principle from the United States Supreme Court that "'civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.'" *Id.* (quoting *Addington v. Texas,* 441 U.S. 418, 425 (1979)).

Eight years before its decision in *LincolnHealth,* the Law Court held in *In re Marcia E.,* that "[u]nder no circumstances may a hospital hold a person against his or her will for longer than twenty-four hours unless the hospital has obtained a judge's endorsement." 2012 ME 139, ¶ 6, 58 A.3d 1115. Three years later, the Maine Legislature amended Section 3863. *LincolnHealth,* 2021 ME 6, ¶ 20, 246 A.3d 157 (citing P.L. 2015, ch. 309, § 3 (effective July 2, 2015)). The Law Court noted that the amendments did not change the language requiring judicial endorsement within the first twenty-four hours after a person is detained. *Id.* ¶¶ 20-21. It continued:

> ***3** What was changed by the 2015 amendments, however, is the *duration* of the detention that such a judicial endorsement allows. The unambiguous language of the 2015 amendments permits a hospital that obtained judicial endorsement for a patient's detention during the "original" twenty-four-hour period of detention to continue to hold that individual for two additional forty-eight-hour periods if the hospital complies with certain requirements.

Id. ¶ 21 (emphasis in original).

The Law Court rejected LincolnHealth's central premise—that "there is simply no due process for those held by but not admitted to hospitals," as that position was "not supported by the language of the statute or by [Maine] case law." *Id.* ¶ 24. And the Court stated that it "could not endorse an interpretation of the statute that provides no legal protections for patients before an actual placement in a psychiatric hospital occurs." *Id.* It clarified, however, that LincolnHealth was not required to either discharge the Plaintiff in that case or transfer him to a psychiatric hospital at the end of the 120-hour authorized hold period. *Id.* ¶ 25. Instead, the Law Court held that the hospital could "restart" the process so long as certain requirements were met: a new application along with certifying information had to be supplied, "including adequate and updated information relevant to the individual at that moment in time," and it had to be submitted for judicial endorsement within twenty-four hours after the 120-hour period ends. *Id.* "With a new judicial endorsement in hand, the hospital may then continue its efforts to find an appropriate placement for the patient and will not be required to discharge him." *Id.*

The Law Court in *LincolnHealth* did not, however, have before it the exact issues presented here, and it did not address how many "restarts" are permissible before a patient's due process rights are violated. It seemed satisfied, however, that restarting the process after the 120-hour period, with a new application containing certifying information and updated clinical information on the individual—so long as judicially endorsed—would comport with due process requirements. That process was actually followed here. Importantly, however, the blue paper process was repeated 11 times after the first application was judicially endorsed on October 14, 2022. There is no indication in *LincolnHealth* that the Law Court ever expected that the "restart process" could go on indefinitely, and it stated plainly that patients in A.F.'s circumstances continue to be protected by due process while waiting. *Id.* ¶¶ 24-25. A fair reading of the case would be that the Law Court went as far as it deemed appropriate with the record before it, but that it expected and hoped—along with the hospitals and Maine citizens who reside for extended periods in EDs—that the Executive and Legislative branches of Maine government would remedy what has now become a chronic problem.

The issue here as framed by the Petitioner is that detentions have indeed become indefinite in length for many vulnerable psychiatric patients. MGMC agreed this was the case, and candidly acknowledged that hospitals in Maine are indeed "warehousing" these patients. The parties also agree that the length of time an individual is now detained in Maine's EDs is affected by *how* they are chosen for admission by receiving hospitals, or not, from off the "waiting list." Clearly, the fundamental problem has not been addressed—not enough beds are available—but it is also the case that not everyone on the "waiting list" is treated the same. MGMC claims that this is by necessity and is legal based upon the contract they signed with DHHS. Petitioner claims that her due process rights were violated because there were in fact other "available beds" for A.F. during her long wait. But as her attorney essentially puts it, the beds were just not available *to her.* Pet'r's Br. 11-12. Petitioner therefore asks the Court to interpret the statutes and the contracts between the hospitals and DHHS and find that hospitals do not enjoy unreviewable discretion to reject patients such as A.F. based upon concerns of "acuity" and "milieu."

***4** In any event, the parties seem to recognize that the only reason A.F. was finally placed in a psychiatric unit after 65 days of detention was that she was fortunate to have a medical professional at MGMC who advocated for her and arranged for her to call Disability Rights of Maine to get legal advice. That led to representation, and the filing of this Petition for Writ of Habeas Corpus. Nursing Director Duprey testified, without contradiction, that at MGMC, "We have had people in our emergency department for up to six months." Tr. at 44-45. She emphasized that while their ED did their best to work with patients like A.F., what they are actually able to do is "provide safety with absolutely no treatment." *Id.* at 37. She stated that conditions can be "worse than jail in most situations. We have no outside time, we've got no windows.... [W]e're in four white walls here. So please consider that this place is like jail." *Id.* at 48-49.

The Court will address these issues separately.

FINDINGS AND CONCLUSIONS

DHHS currently contracts with eight private hospitals that contain psychiatric units and requires them to admit and involuntarily hold psychiatric patients, such as A.F., from EDs across the State. In addition, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center can also receive such "blue papered" patients who are waiting for the process of civil commitment—

sometimes referred to as the "white paper" process—to unfold. Section 3863(3)(D)-(E) of Title 34-B sets forth the requirements established by the Legislature in the 2015 amendments, which amendments extended the authority of these hospitals to hold patients up to 120 hours before the hospitals are permitted to "restart" the process pursuant to the Law Court's *LincolnHealth* decision.

A.F. points to two terms in the statute— "available inpatient bed" and "inpatient bed" — which she says are ambiguous, meaning that the terms are "reasonably susceptible to different interpretations." *Estate of Joyce v. Commercial Welding Co.,* 2012 ME 62, ¶ 12, 55 A.3d 411. And because the terms are ambiguous, she claims that they must be construed in this case so as to avoid the unconstitutional result of indefinite detention without due process. The Court disagrees with this analysis, as it has concluded that MGMC followed the requisite statutes as elucidated by the Law Court in *LincolnHealth.* Assuming, without deciding, that these undefined terms are ambiguous, the cases relied upon for this general proposition are cases where an agency has been told it cannot interpret ambiguous terms in a statute or regulation in such a way that it leads to an absurd, or as posited here, an unconstitutional result. It is important to note that the agency in question, DHHS, is not a party to this case. In addition, MGMC entered into a contract that specifically gave it the authority to decline admission to a patient who it deemed to not be "appropriate" for its facility. *See* Ex. 3, ¶¶ 1(b), 2(a)(i).

The reality is that MGMC, like all the other hospitals, are "stuck" with the determinations about "acuity" and "milieu" made by other hospitals, and the other hospitals are "stuck" with determinations made by MGMC. The Court agrees with MGMC that the Court cannot and should not involve itself in making such clinical judgments, particularly when DHHS has apparently bargained away its own right to object to these clinical decisions, presumably to find private hospitals such as MGMC willing to accept patients like A.F.

The Court is also concerned that if it held A.F. should have been admitted by one of the hospitals that declined to accept her, the Court would be blindly consigning another patient to a lower rung on the waiting list, creating an unfavorable or even "unconstitutional" result for the other patient. The Court is not willing to create such unintended and problematic consequences for other patients by ordering that sort of relief here.

***5** Which is not to say that A.F.'s prolonged, indefinite confinement in the ED at MGMC comports with due process. As A.F.'s attorney points out, these multiple Applications, along with the "restart" of the process authorized by the Law Court in *LincolnHealth,* resulted in A.F.'s detention in an ED for 65 days. The Court concludes that given the length and circumstances of her detention, more due process protections for A.F. were required. But for Nurse Duprey's intervention and Disability Rights Maine's willingness to file this case, A.F. could have easily become another patient who lived at MGMC's ED for six months.

The Court therefore concludes that A.F. was entitled to more due process than completion of multiple "blue papers" by District Court Judges at the Capital Judicial Center. The Court finds that due process requires that she was entitled to appointment of counsel once the "restart" of the process failed to result in her admission to a private or State hospital where she could have been further evaluated and treated.

The Court is aware that another Superior Court Justice recently ordered in a very similar Habeas Corpus case, implementation of a process, coordinated with the District Court, to establish a hearing process for a patient who was detained at Northern Light Eastern Maine Medical Center. *See* attached Amended Order, *In re: Singer,* PENSC-MTH-2023-00275 (Nov. 22, 2023). The Superior Court ordered appointment of an examiner, with the consent of Northern Light and her attorney, and further ordered that a hearing would be conducted as part of the Habeas proceeding to determine if the patient met the criteria for involuntary hospitalization. This proceeding was also similar to the hearing conducted by the Lincoln County Superior Court in the *LincolnHealth* case that resulted in the Law Court decision providing for the "restart" process that is one of the issues in this case.

The Court has concluded in this matter that A.F.'s due process rights were violated by the length of her detention at MGMC. She was entitled to appointment of counsel and a hearing before a Maine Court once it became apparent that the "restart" process

would fail to result in admission to a psychiatric hospital where she could be held while the "white paper" process, with its elevated due process protections, would unfold. So while the Court concludes that MGMC did not violate her due process rights by engaging in the current process by which beds are found for patients awaiting admission, A.F.'s due process rights were nevertheless violated while she was in MGMC's custody due to the length and circumstances of her detention.

The Court recognizes that fashioning a remedy in this case presents legal and practical challenges. The Court will therefore order further proceedings to hear from the parties as to what might be constructively done to create a process between MGMC and the District Court at the Capital Judicial Center to provide due process for A.F. and others like her, should these patients find themselves detained at MGMC for similar lengths of time due to the chronic shortage of psychiatric beds. It may be that the parties and the Court will be able to agree upon a process to protect A.F. and others from further violations of due process.

The Clerk is therefore directed to schedule a conference with counsel for the parties to discuss the course of future proceedings. The conference can either occur in person or by Zoom. Notice shall be sent to the parties, as well as to DHHS, which may or may not want to appear and be heard.

CONCLUSION

The entry will be: The Petition for Writ of Habeas Corpus is granted in part based upon the Court's finding that A.F.'s rights to due process were violated by the length of her detention at the MGMC Emergency Department for 65 days without representation or hearing. The Court will conduct further proceedings to determine what remedy, if any, it can legally provide under these circumstances. Notice to follow.

***6** This Order shall be noted on the docket by reference pursuant to Rule 79(a) of the Maine Rules of Civil Procedure.

DATED: 2/13/24

<<signature>>

Michaela Murphy

Justice, Superior Court

Footnotes

1 MGMC does not argue in the post-hearing briefing that this case is moot. And even if it did, the Court concludes that the exceptions to the mootness doctrine applied by the Law Court in *A.S. v. LincolnHealth*—the public interest exception and the repeat presentation exception— apply with equal force here. 2021 ME 6, ¶¶ 8-10, 246 A.3d 157.

2024 WL 3568708 (Me.Super.) (Trial Order)
Superior Court of Maine.
Kennebec County

A.F., Petitioner,

v.

MAINEGENERAL MEDICAL CENTER, Respondent.

No. AUGSC-CV-22-189.
April 5, 2024.

Order for Remedy

Michaela Murphy, Justice.

RELIEF

***1** After conference with counsel, the parties have agreed in part with the remedy the Court should provide A.F. in light of the findings and conclusions set out in the Court's previous Order. Their disagreement was limited to the length of time the agreed-upon Remedy should remain available for A.F.

After consideration of their positions, the entry will be:

A.F. shall provide to Respondent, MaineGeneral Medical Center ("MGMC"), an authorization to disclose Petitioner's confidential patient information ("ROI") in which Petitioner directs MGMC to notify Disability Rights Maine if and when Petitioner is being detained in MGMC's Emergency Department pursuant to 34-B M.R.S.A. § 3863, provided that MGMC may not act on any such ROI that is more than one year old. Petitioner shall be responsible for providing a new ROI following the expiration of any prior ROI.

The remedy for A.F. provided herein shall be effective immediately, and will be enforceable for a period of five years.

This Order shall be noted on the docket by reference pursuant to Rule 79(a) of the Maine Rules of Civil Procedure.

DATED: 4/5/24

<<signature>>

Michaela Murphy

Justice, Maine Superior Court

DISABILITY RIGHTS MAINE

"The Beds Were Just Not Available to Her." When Psychiatric Hospitals Refuse to Admit Patients from Emergency Departments

by Mark Joyce | May 24, 2024 | Community Mental Health, Inpatient Psychiatric Settings & Group Homes

In the fall of 2022, Disability Rights Maine (DRM) represented a woman who had been "blue papered"[1] in an emergency department (ED) and was awaiting transfer to a psychiatric bed. She remained in the ED for 65 days until eventually being transferred to a psychiatric unit, two days after DRM filed a Petition for a Writ of Habeas Corpus in the Superior Court against the ED. After receiving treatment, she was discharged back to her apartment.

Her petition acknowledged meeting the standard for emergency involuntary psychiatric hospitalization but argued her due process rights were violated due to the prolonged wait for transfer from the ED to a psychiatric facility.

Some would argue that this case highlights the need for more psychiatric beds in Maine to prevent such lengthy stays in EDs due to long waitlists at psychiatric hospitals. However, a closer examination reveals a different reality.

Although technically moot, the Superior Court held a hearing on her petition even after her discharge. The court, in its opinion, found that her due process rights were indeed violated and she had the right to court appointed legal representation. This opinion is attached as A.F. v. MaineGeneral Medical Center.

The court noted that one reason for her extended stay in the ED was the repeated rejection by numerous psychiatric hospitals, citing reasons such as her acuity level being too high or not fitting their "milieu". This selection process led to her being "stuck" in the ED, as these hospitals could refuse admission without any waitlist.

In its decision the Superior Court observed:

> **Over the course of the 65 days, A.F. was rejected by the following hospitals: Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, Spring Harbor Hospital, Northern Light Acadia Hospital, Southern Maine Medical Center, St. Mary's Regional Medical Center, Mid Coast Hospital, Penobscot Bay Hospital, Maine Medical Center, and MGMC. They all claimed that she was not a good fit for their hospital as her acuity level was too high, or otherwise did not fit their milieu. And these rejections repeatedly occurred while other patients, who were also awaiting admission from MGMC's ED, were admitted to psychiatric hospitals.**

> **The nursing director for the ED at MGMC, testified that there is essentially no "waiting list" for these patients as that term is conventionally understood. Instead, prospective hospitals are permitted to decide whether a patient is a good fit for their facility. If not, the patient and the ED where the patient is being detained, have no option but to accept that decision, and to wait. And wait they did.**

Consequently, A.F. found herself confined to the emergency department until one of these hospitals had a change of heart. However, despite more than two months passing, this change didn't materialize until after she filed her petition in the Superior Court.

Hence, increasing the number of beds would not have eased AF's situation in the ED; it would have merely increased the count of beds inaccessible to her.

The court noted:

> **As her attorney essentially puts it, the beds were just not available *to her*" (emphasis in original).**

How frequently does this scenario unfold, where individuals languish in the ED not due to bed availability but for reasons that could persist indefinitely due to these psychiatric hospitals refusing to admit?

Answering these questions is challenging. The Maine Department of Health and Human Services (DHHS) lacks centralized data on when psychiatric hospitals decline to admit "blue papered" patients from EDs based on reasons such as acuity level or not a good fit for milieu. Consequently, it's difficult to ascertain whether, at a statewide level, individuals remain stuck in the ED primarily due to bed shortages or other reasons.

Furthermore, there's no oversight to evaluate the acceptability of these hospitals' determinations to refuse such patients.

For instance, many hospitals cited the concept of not being a good fit for the "milieu" as a justification for refusing A.F. The court, citing to the testimony of

the ED nursing director, described the conditions in which A.F. was detained in the ED for over two months as follows:

> **The nursing director described the conditions as potentially worse than jail in most cases. There was no outdoor time, no windows, just four white walls. She urged consideration that the environment was akin to being in jail.**

There appears to be insufficient oversight regarding whether psychiatric hospitals' refusal to admit a "blue papered patient" due to their milieu or acuity is justified, particularly when the patient is subjected to conditions akin to jail with minimal treatment while waiting in the ED.

Moreover, it's reasonable to speculate that an individual's acuity level could intensify the longer they are exposed to such an environment, potentially reducing their appeal to psychiatric hospitals that reject admission based on escalating acuity levels.

Despite the DHHS contracting with these hospitals to accept "blue papered" patients, the court found that DHHS had essentially forfeited its right to object to these hospitals' refusal to admit patients like A.F. The court stated:

> **The reality is that MGMC, like all the other hospitals, are "stuck" with the determinations about "acuity" and "milieu" made by other hospitals, and the other hospitals are "stuck" with determinations made by MGMC. The Court agrees with MGMC that the Court cannot and should not involve itself in making such clinical judgments, *particularly when DHHS has apparently bargained away its own right to object to these clinical decisions*, presumably to find private hospitals such as MGMC willing to accept patients like A.F. (emphasis added).**

The court clearly recognized that the system's flaw could have resulted in A.F. being detained indefinitely in the ED as psychiatric hospitals opted for other patients. The court emphasized:

> **But for Nurse Duprey's intervention and Disability Rights Maine's willingness to file this case, A.F. could have easily become another patient who lived at MGMC's ED for six months.**

The court, citing to a recent Maine Supreme Judicial Court decision, further noted that the problem with the system is not something that can be fixed judicially but should be addressed by the Executive and Legislative branches, stating:

> **There is no indication in *LincolnHealth* that the Law Court ever expected that the "restart process" could go on indefinitely, and it stated plainly that patients in AF's circumstances continue to be protected by due process while waiting. A fair reading of the case would be that the Law Court went as far as it deemed appropriate with the record before it, but that it expected and hoped, along with the hospitals and Maine citizens who reside for extended periods in EDs, that the Executive and Legislative branches of Maine government would remedy what has now become a chronic problem.**

The case of A.F. exemplifies the challenges faced by individuals awaiting transfer from emergency departments to psychiatric beds. The Superior Court's observation of her extended emergency department stay, marked by repeated rejections from psychiatric hospitals, underscores systemic issues. The lack of oversight exacerbates the situation, with no centralized data to assess the frequency of such refusals or the appropriateness of hospital decisions. The Superior Court's acknowledgment of the systemic flaw underscores the need for executive and legislative action to address the chronic problem of this type of selection process, as judicial intervention alone cannot rectify the issue. This was underscored by the court's authority being restricted to ordering MaineGeneral to notify DRM if A.F. found herself in the same situation in the emergency department within the next five years.

[1] "Blue papered" is often used to describe Maine's emergency involuntary psychiatric hospitalization process.

2024 WL 3568707 (Me.Super.) (Trial Order)
Superior Court of Maine.
Kennebec County

A.F., Petitioner,

v.

MAINEGENERAL MEDICAL CENTER, Respondent.

No. AUGSC-CV-22-189.
February 13, 2024.

Order on Petition for Writ of Habeas Corpus

Michaela Murphy, Justice.

BACKGROUND

***1** Before the Court is a Petition for a Writ of Habeas Corpus brought by A.F., a 45-year-old deaf woman who suffers from mental illness. She was detained at MaineGeneral Medical Center's ("MGMC") Emergency Department ("ED") for 65 days from October 12, 2022 until December 14, 2022, when MGMC finally admitted her to their A-3 in-patient psychiatric unit.

The Court has considered the evidence at hearing on October 19, 2023, and has considered the written post-hearing arguments of the parties, the last of which was received on December 20, 2023, and has concluded that Petitioner A.F. is entitled to some form of relief, but the Court will be ordering further proceedings to hear arguments as to what form the relief should take.

Petitioner has asked the Court to grant her Petition based upon a finding that hospitals such as MGMC do not enjoy "plenary, unreviewable discretion" to decide which patients they admit from a "waiting list" of patients like A.F. who wait—sometimes for months—to be admitted to a psychiatric hospital after being "blue papered" under Maine law. Petitioner claims she was entitled to appointment of counsel, along with other due process protections, while waiting for placement. She claims hospitals such as MGMC who contract with the Maine Department of Health and Human Services ("DHHS") to admit and treat "blue papered" individuals cannot simply reject a patient such as A.F. by asserting the person does not meet their standards for "acuity" and/or are not a good fit for their "milieu." MGMC asserts that it adhered to and went above and beyond the requirements under Maine law and pursuant to its contract with DHHS.

The parties do agree that under Maine's current system, psychiatric patients such as A.F. are living in emergency rooms across Maine for up to months at a time while they are waiting for admission to psychiatric facilities, including Maine's two State psychiatric hospitals, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, along with the 8 private hospitals that have contracted with the State to accept such patients in their psychiatric units. The parties agree that A.F. was detained at the MGMC ED while awaiting the so-called "white paper process" to unfold. That process carries with it elevated due process protections, including appointment of counsel and which may culminate in a full, confidential hearing before a District Court Judge.

The parties essentially agree as to what happened over the course of those 65 days. A.F. was held against her will at the MGMC ED while the process played out. MGMC provided her basic needs including interpreter services and medication, but she did not receive the same level of psychiatric treatment she would have received had she been admitted to either a State or private psychiatric hospital while being further assessed for court proceedings, nor was she afforded legal representation. The parties

further seem to agree that MGMC followed the "blue paper" process established by the Maine Legislature twelve separate times by completing three statutorily mandated steps: (1) application; (2) certifying examination; and (3) judicial review and endorsement. 34-B M.R.S. §§ 3863(1)-(3). Each time after these steps were completed, a District Court Judge who reviewed and endorsed the application stated, as printed on the form:

> ***2** I find this application and certificate to be regular and in accordance with the law. No psychiatric hospital has been located as of the date of the certifying examination. [A.F.] may remain at [MGMC ED] pending the location of an inpatient bed at a psychiatric hospital or other appropriate alternative subject to the requirements of 34-B M.R.S. § 3863(3). If an available inpatient bed at a psychiatric hospital is located, and the emergency admission of [A.F.] is still sought, the applicant shall immediately notify a judicial officer for final review and endorsement under Section 3.B.2 below.

Ex. 9.

Over the course of the 65 days, A.F. was rejected by the following hospitals: Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, Spring Harbor Hospital, Northern Light Acadia Hospital, Southern Maine Medical Center, St. Mary's Regional Medical Center, Mid Coast Hospital, Penobscot Bay Hospital, Maine Medical Center, and MGMC. They all claimed that she was not a good fit for their hospital as her acuity level was too high, or otherwise did not fit their milieu. And these rejections repeatedly occurred while other patients, who were also awaiting admission from MGMC's ED, were admitted to psychiatric hospitals. Janelynn Duprey, Nursing Director for the ED at MGMC, testified that there is essentially no "waiting list" for these patients as that term is conventionally understood. Instead, prospective hospitals are permitted to decide whether a patient is a good fit for their facility. If not, the patient and the ED where the patient is being detained, have no option but to accept that decision, and to wait. And wait they did.

In A.F.'s case, her waiting finally ended when Nursing Director Duprey, clearly frustrated but undeterred, advised A.F. to contact Disability Rights Maine to take her case. This Petition was soon filed with their assistance. Two days later, MGMC moved A.F. from their ED upstairs to their psychiatric unit.[1]

STANDARD OF REVIEW

Approximately three years ago, the Law Court stated in .4.5. *v. LincolnHealth* that Section 3863 of Title 34-B was "an imprecise 'fit' for what is actually happening in Maine's emergency departments as they struggle to deal with patients who need psychiatric beds at a time when the State has failed to create or fund enough of those beds." 2021 ME 6, ¶ 16, 246 A.3d 157. The Law Court further noted that this statute is one of a very few "that provides the civil authority for a person or entity to hold another person against his wishes." *Id.* In addition, the Law Court recognized the guiding principle from the United States Supreme Court that "'civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.'" *Id.* (quoting *Addington v. Texas,* 441 U.S. 418, 425 (1979)).

Eight years before its decision in *LincolnHealth,* the Law Court held in *In re Marcia E.,* that "[u]nder no circumstances may a hospital hold a person against his or her will for longer than twenty-four hours unless the hospital has obtained a judge's endorsement." 2012 ME 139, ¶ 6, 58 A.3d 1115. Three years later, the Maine Legislature amended Section 3863. *LincolnHealth,* 2021 ME 6, ¶ 20, 246 A.3d 157 (citing P.L. 2015, ch. 309, § 3 (effective July 2, 2015)). The Law Court noted that the amendments did not change the language requiring judicial endorsement within the first twenty-four hours after a person is detained. *Id.* ¶¶ 20-21. It continued:

> ***3** What was changed by the 2015 amendments, however, is the *duration* of the detention that such a judicial endorsement allows. The unambiguous language of the 2015 amendments permits a hospital that obtained judicial endorsement for a patient's detention during the "original" twenty-four-hour period of detention to continue to hold that individual for two additional forty-eight-hour periods if the hospital complies with certain requirements.

Id. ¶ 21 (emphasis in original).

The Law Court rejected LincolnHealth's central premise—that "there is simply no due process for those held by but not admitted to hospitals," as that position was "not supported by the language of the statute or by [Maine] case law." *Id.* ¶ 24. And the Court stated that it "could not endorse an interpretation of the statute that provides no legal protections for patients before an actual placement in a psychiatric hospital occurs." *Id.* It clarified, however, that LincolnHealth was not required to either discharge the Plaintiff in that case or transfer him to a psychiatric hospital at the end of the 120-hour authorized hold period. *Id.* ¶ 25. Instead, the Law Court held that the hospital could "restart" the process so long as certain requirements were met: a new application along with certifying information had to be supplied, "including adequate and updated information relevant to the individual at that moment in time," and it had to be submitted for judicial endorsement within twenty-four hours after the 120-hour period ends. *Id.* "With a new judicial endorsement in hand, the hospital may then continue its efforts to find an appropriate placement for the patient and will not be required to discharge him." *Id.*

The Law Court in *LincolnHealth* did not, however, have before it the exact issues presented here, and it did not address how many "restarts" are permissible before a patient's due process rights are violated. It seemed satisfied, however, that restarting the process after the 120-hour period, with a new application containing certifying information and updated clinical information on the individual—so long as judicially endorsed—would comport with due process requirements. That process was actually followed here. Importantly, however, the blue paper process was repeated 11 times after the first application was judicially endorsed on October 14, 2022. There is no indication in *LincolnHealth* that the Law Court ever expected that the "restart process" could go on indefinitely, and it stated plainly that patients in A.F.'s circumstances continue to be protected by due process while waiting. *Id.* ¶¶ 24-25. A fair reading of the case would be that the Law Court went as far as it deemed appropriate with the record before it, but that it expected and hoped—along with the hospitals and Maine citizens who reside for extended periods in EDs—that the Executive and Legislative branches of Maine government would remedy what has now become a chronic problem.

The issue here as framed by the Petitioner is that detentions have indeed become indefinite in length for many vulnerable psychiatric patients. MGMC agreed this was the case, and candidly acknowledged that hospitals in Maine are indeed "warehousing" these patients. The parties also agree that the length of time an individual is now detained in Maine's EDs is affected by *how* they are chosen for admission by receiving hospitals, or not, from off the "waiting list." Clearly, the fundamental problem has not been addressed—not enough beds are available—but it is also the case that not everyone on the "waiting list" is treated the same. MGMC claims that this is by necessity and is legal based upon the contract they signed with DHHS. Petitioner claims that her due process rights were violated because there were in fact other "available beds" for A.F. during her long wait. But as her attorney essentially puts it, the beds were just not available *to her.* Pet'r's Br. 11-12. Petitioner therefore asks the Court to interpret the statutes and the contracts between the hospitals and DHHS and find that hospitals do not enjoy unreviewable discretion to reject patients such as A.F. based upon concerns of "acuity" and "milieu."

***4** In any event, the parties seem to recognize that the only reason A.F. was finally placed in a psychiatric unit after 65 days of detention was that she was fortunate to have a medical professional at MGMC who advocated for her and arranged for her to call Disability Rights of Maine to get legal advice. That led to representation, and the filing of this Petition for Writ of Habeas Corpus. Nursing Director Duprey testified, without contradiction, that at MGMC, "We have had people in our emergency department for up to six months." Tr. at 44-45. She emphasized that while their ED did their best to work with patients like A.F., what they are actually able to do is "provide safety with absolutely no treatment." *Id.* at 37. She stated that conditions can be "worse than jail in most situations. We have no outside time, we've got no windows.... [W]e're in four white walls here. So please consider that this place is like jail." *Id.* at 48-49.

The Court will address these issues separately.

FINDINGS AND CONCLUSIONS

DHHS currently contracts with eight private hospitals that contain psychiatric units and requires them to admit and involuntarily hold psychiatric patients, such as A.F., from EDs across the State. In addition, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center can also receive such "blue papered" patients who are waiting for the process of civil commitment—

sometimes referred to as the "white paper" process—to unfold. Section 3863(3)(D)-(E) of Title 34-B sets forth the requirements established by the Legislature in the 2015 amendments, which amendments extended the authority of these hospitals to hold patients up to 120 hours before the hospitals are permitted to "restart" the process pursuant to the Law Court's *LincolnHealth* decision.

A.F. points to two terms in the statute— "available inpatient bed" and "inpatient bed" — which she says are ambiguous, meaning that the terms are "reasonably susceptible to different interpretations." *Estate of Joyce v. Commercial Welding Co.,* 2012 ME 62, ¶ 12, 55 A.3d 411. And because the terms are ambiguous, she claims that they must be construed in this case so as to avoid the unconstitutional result of indefinite detention without due process. The Court disagrees with this analysis, as it has concluded that MGMC followed the requisite statutes as elucidated by the Law Court in *LincolnHealth.* Assuming, without deciding, that these undefined terms are ambiguous, the cases relied upon for this general proposition are cases where an agency has been told it cannot interpret ambiguous terms in a statute or regulation in such a way that it leads to an absurd, or as posited here, an unconstitutional result. It is important to note that the agency in question, DHHS, is not a party to this case. In addition, MGMC entered into a contract that specifically gave it the authority to decline admission to a patient who it deemed to not be "appropriate" for its facility. *See* Ex. 3, ¶¶ 1(b), 2(a)(i).

The reality is that MGMC, like all the other hospitals, are "stuck" with the determinations about "acuity" and "milieu" made by other hospitals, and the other hospitals are "stuck" with determinations made by MGMC. The Court agrees with MGMC that the Court cannot and should not involve itself in making such clinical judgments, particularly when DHHS has apparently bargained away its own right to object to these clinical decisions, presumably to find private hospitals such as MGMC willing to accept patients like A.F.

The Court is also concerned that if it held A.F. should have been admitted by one of the hospitals that declined to accept her, the Court would be blindly consigning another patient to a lower rung on the waiting list, creating an unfavorable or even "unconstitutional" result for the other patient. The Court is not willing to create such unintended and problematic consequences for other patients by ordering that sort of relief here.

***5** Which is not to say that A.F.'s prolonged, indefinite confinement in the ED at MGMC comports with due process. As A.F.'s attorney points out, these multiple Applications, along with the "restart" of the process authorized by the Law Court in *LincolnHealth,* resulted in A.F.'s detention in an ED for 65 days. The Court concludes that given the length and circumstances of her detention, more due process protections for A.F. were required. But for Nurse Duprey's intervention and Disability Rights Maine's willingness to file this case, A.F. could have easily become another patient who lived at MGMC's ED for six months.

The Court therefore concludes that A.F. was entitled to more due process than completion of multiple "blue papers" by District Court Judges at the Capital Judicial Center. The Court finds that due process requires that she was entitled to appointment of counsel once the "restart" of the process failed to result in her admission to a private or State hospital where she could have been further evaluated and treated.

The Court is aware that another Superior Court Justice recently ordered in a very similar Habeas Corpus case, implementation of a process, coordinated with the District Court, to establish a hearing process for a patient who was detained at Northern Light Eastern Maine Medical Center. *See* attached Amended Order, *In re: Singer,* PENSC-MTH-2023-00275 (Nov. 22, 2023). The Superior Court ordered appointment of an examiner, with the consent of Northern Light and her attorney, and further ordered that a hearing would be conducted as part of the Habeas proceeding to determine if the patient met the criteria for involuntary hospitalization. This proceeding was also similar to the hearing conducted by the Lincoln County Superior Court in the *LincolnHealth* case that resulted in the Law Court decision providing for the "restart" process that is one of the issues in this case.

The Court has concluded in this matter that A.F.'s due process rights were violated by the length of her detention at MGMC. She was entitled to appointment of counsel and a hearing before a Maine Court once it became apparent that the "restart" process

would fail to result in admission to a psychiatric hospital where she could be held while the "white paper" process, with its elevated due process protections, would unfold. So while the Court concludes that MGMC did not violate her due process rights by engaging in the current process by which beds are found for patients awaiting admission, A.F.'s due process rights were nevertheless violated while she was in MGMC's custody due to the length and circumstances of her detention.

The Court recognizes that fashioning a remedy in this case presents legal and practical challenges. The Court will therefore order further proceedings to hear from the parties as to what might be constructively done to create a process between MGMC and the District Court at the Capital Judicial Center to provide due process for A.F. and others like her, should these patients find themselves detained at MGMC for similar lengths of time due to the chronic shortage of psychiatric beds. It may be that the parties and the Court will be able to agree upon a process to protect A.F. and others from further violations of due process.

The Clerk is therefore directed to schedule a conference with counsel for the parties to discuss the course of future proceedings. The conference can either occur in person or by Zoom. Notice shall be sent to the parties, as well as to DHHS, which may or may not want to appear and be heard.

CONCLUSION

The entry will be: The Petition for Writ of Habeas Corpus is granted in part based upon the Court's finding that A.F.'s rights to due process were violated by the length of her detention at the MGMC Emergency Department for 65 days without representation or hearing. The Court will conduct further proceedings to determine what remedy, if any, it can legally provide under these circumstances. Notice to follow.

***6** This Order shall be noted on the docket by reference pursuant to Rule 79(a) of the Maine Rules of Civil Procedure.

DATED: 2/13/24

<<signature>>

Michaela Murphy

Justice, Superior Court

Footnotes

1 MGMC does not argue in the post-hearing briefing that this case is moot. And even if it did, the Court concludes that the exceptions to the mootness doctrine applied by the Law Court in *A.S. v. LincolnHealth*—the public interest exception and the repeat presentation exception— apply with equal force here. 2021 ME 6, ¶¶ 8-10, 246 A.3d 157.

End of Document

2024 WL 3568708 (Me.Super.) (Trial Order)
Superior Court of Maine.
Kennebec County

A.F., Petitioner,

v.

MAINEGENERAL MEDICAL CENTER, Respondent.

No. AUGSC-CV-22-189.
April 5, 2024.

Order for Remedy

Michaela Murphy, Justice.

RELIEF

***1** After conference with counsel, the parties have agreed in part with the remedy the Court should provide A.F. in light of the findings and conclusions set out in the Court's previous Order. Their disagreement was limited to the length of time the agreed-upon Remedy should remain available for A.F.

After consideration of their positions, the entry will be:

A.F. shall provide to Respondent, MaineGeneral Medical Center ("MGMC"), an authorization to disclose Petitioner's confidential patient information ("ROI") in which Petitioner directs MGMC to notify Disability Rights Maine if and when Petitioner is being detained in MGMC's Emergency Department pursuant to 34-B M.R.S.A. § 3863, provided that MGMC may not act on any such ROI that is more than one year old. Petitioner shall be responsible for providing a new ROI following the expiration of any prior ROI.

The remedy for A.F. provided herein shall be effective immediately, and will be enforceable for a period of five years.

This Order shall be noted on the docket by reference pursuant to Rule 79(a) of the Maine Rules of Civil Procedure.

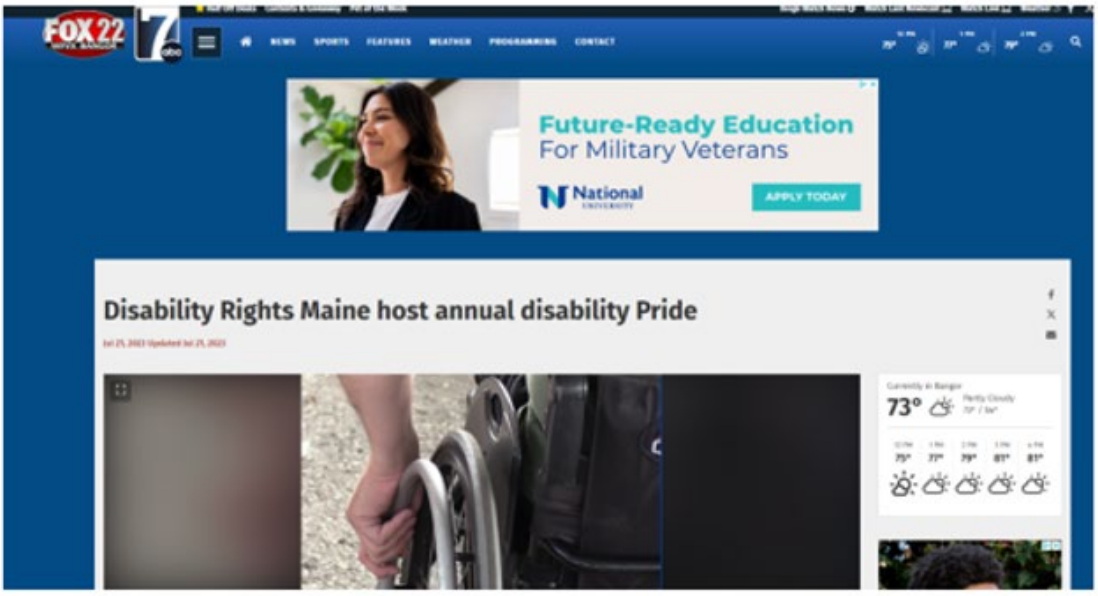
DATED: 4/5/24

<<signature>>

Michaela Murphy

Justice, Maine Superior Court

https://www.wabi.tv/2024/07/19/6th-annual-disability-pride-day/



https://www.foxbangor.com/news/local/disability-rights-maine-host-annual-disability-pride/article_7ae3918c-2811-11ee-8dfd-6b608083ac3c.html

Footnotes:

PRESS RELEASE: Disability Rights Maine Statement on Lewiston Shooting

Oct 26, 2023 | Press Releases

CONTACT: Julia Endicott
207-626-2774
jendicott@drme.org

FOR IMMEDIATE RELEASE

October 26, 2023

Augusta – Disability Rights Maine is horrified and deeply saddened by the shootings in Lewiston yesterday evening. Our hearts are with the Lewiston/Auburn community, the Maine Deaf Community and all impacted by the unfathomable acts of violence that took place at Just In Time Recreation Center and Schemengees Bar and Grille.

Much information remains unknown at this time and we anticipate more answers to yesterday's events in the coming days. As this develops, we are concerned about any narrative that focuses on mental illness as the cause of such violence. Across the world, more than 790 million people live with a diagnosed mental health disorder. Yet, we only see this level of pervasive violence occur in the United States, where the number of guns owned by civilians outnumbers our total population.[1] This is a societal problem where hate is allowed to flourish and inaction is far too often the response.

In 2020, DRM signed onto a joint statement from the Coalition for Smart Safety. As this statement recognizes, more often, people with psychiatric labels are victims, rather than perpetrators of violence. Simply put, placing blame on people with mental illness will not solve our country's gun violence problem. Rather, it makes people with mental health disabilities the scapegoat while failing to implement effective policy changes.

Mass violence is a public health crisis.

To dispel myths about mental illness and gun violence, we encourage you to access the following resources:

- NAMI CA – The Truth About Mental Health and Gun Violence
- NARPA – Prior Statements on Mass Shootings in Buffalo and Uvalde
- Disability Rights Washington – People with Mental Health Disabilities Shut Down Dangerous Ideas About Gun Violence

DRM also wants to share additional resources for those who may wish to seek support in navigating the trauma and grief of mass violence:

- Maine Crisis Line: 1-888-568-1112 (Voice) or 711 (Maine Relay)
- National Crisis Line: call or text 988
- NAMI Maine Helpline: 1-800-464-5767 (Press 1)

Disability Rights Maine is Maine's Protection & Advocacy organization. Our mission is to advance justice and equality by enforcing rights and expanding opportunities for people with disabilities in Maine.

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Disability Rights Maine is Maine's Protection & Advocacy organization. Our mission is to advance justice and equality by enforcing rights and expanding opportunities for people with disabilities in Maine.

[1] https://www.bloomberg.com/news/articles/2022-05-25/how-many-guns-in-the-us-buying-spree-bolsters-lead-as-most-armed-country?leadSource=uverify%20wall

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Disability Rights Maine (DRM) is the federally mandated protection and advocacy system for Maine, which receives part of its funding from the HHS-Administration for Community Living, DOE-Rehabilitation Services Administration, HHS-Substance Abuse & Mental Health Services Administration – Center for MH services, Social Security Administration, and the State of Maine.

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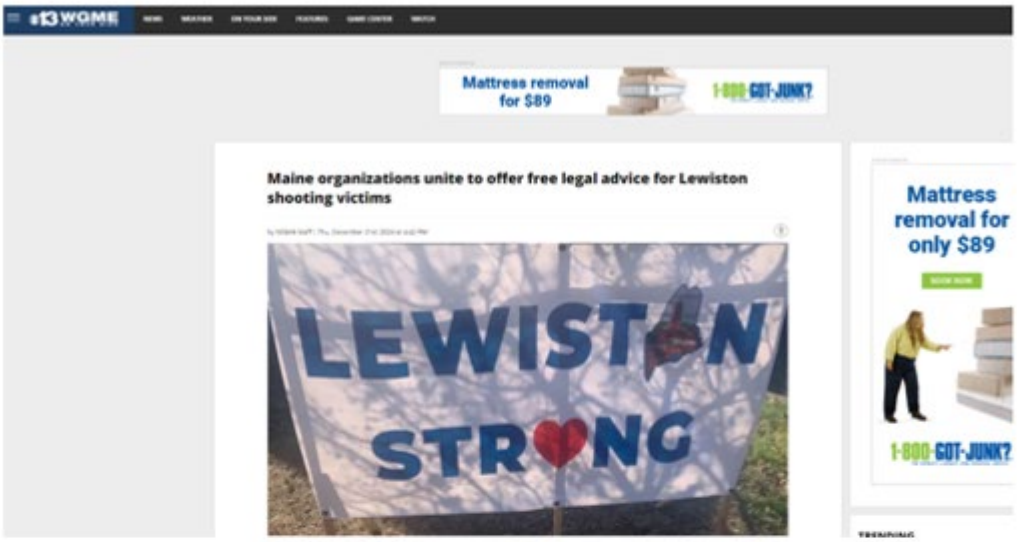
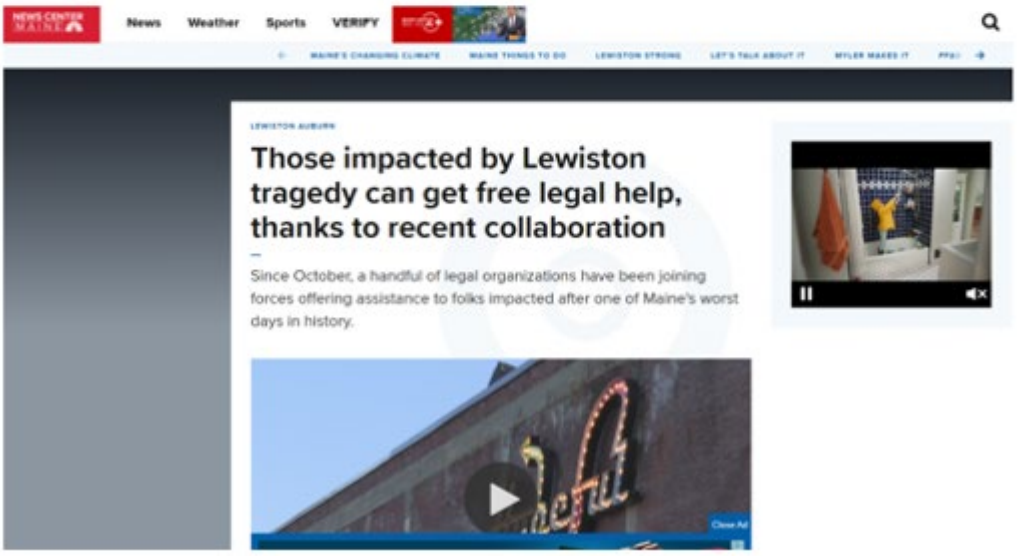
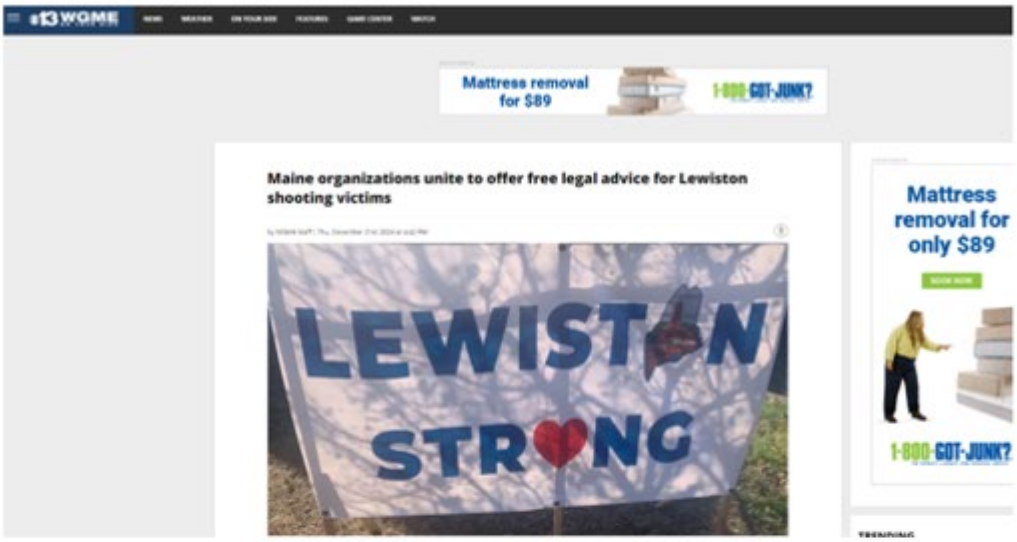
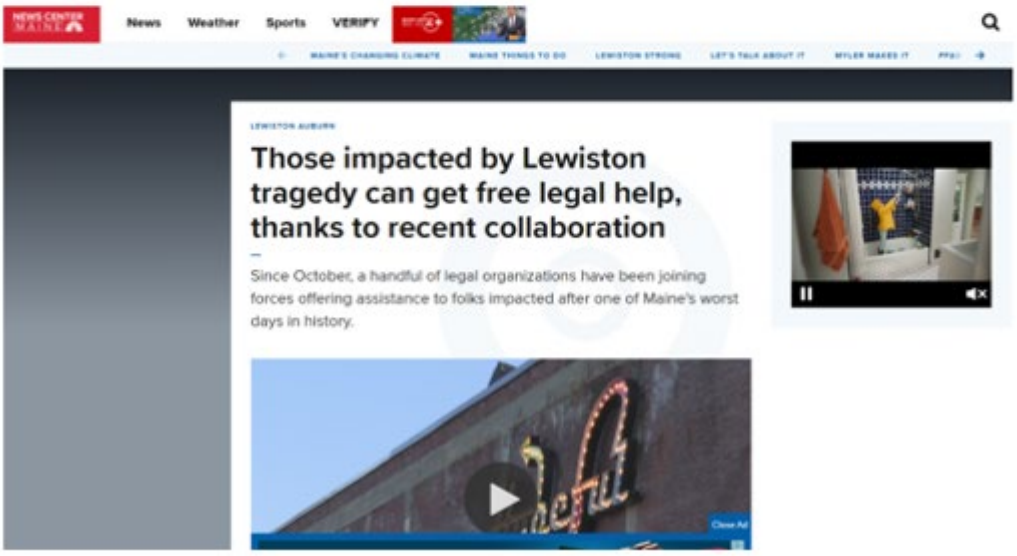


https://wgme.com/news/local/maine-organizations-unite-to-offer-free-legal-advice-for-lewiston-shooting-victims





https://wgme.com/news/local/maine-organizations-unite-to-offer-free-legal-advice-for-lewiston-shooting-victims



Since October, a handful of legal organizations have been joining forces offering assistance to folks impacted after one of Maine's worst days in history.

https://www.newscentermaine.com/article/news/local/lewiston-auburn/lewiston-families-can-receive-free-legal-assistance/97-ef5d625c-4e84-4604-be71-20ae437c157e

DISABILITY RIGHTS MAINE

PRESS RELEASE: Advocates Respond to U.S. Department of Justice Lawsuit Against State of Maine for Failures in Maine's Children's Behavioral Health System

Sep 9, 2024 | Children's & Education Rights, Children's Advocacy, News, Press Releases

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FOR IMMEDIATE RELEASE
September 9, 2024

Advocates Respond to U.S. Department of Justice Lawsuit Against State of Maine for Failures in Maine's Children's Behavioral Health System

The suit comes after more than two years of negotiations between the parties

Augusta – Today, the U.S. Department of Justice (DOJ) filed suit against the State of Maine based on its June 2022 findings that Maine discriminated against youth with disabilities by failing to maintain an adequate system of behavioral health services that prevent institutionalization. The lawsuit comes after settlement negotiations broke down.

"Twenty-five years after the landmark Supreme Court decision *Olmstead v. L.C.*, which found that unnecessarily segregating people with disabilities into institutional settings violates the Americans with Disabilities Act, Maine children and their families are still waiting for a legally compliant behavioral health system. And despite calls for more than a decade to ensure the availability of those services, Maine has failed to do so. Unfortunately, this lawsuit was the necessary result of that continued failure," said Atlee Reilly, Managing Attorney, Disability Rights Maine.

After initially receiving a complaint filed by Disability Rights Maine, the U.S. DOJ conducted a lengthy investigation and found:

- "Maine's community-based behavioral health system fails to provide sufficient services. As a result, hundreds of children are unnecessarily segregated in institutions each year, while other children are at serious risk of entering institutions."
- "Children are unable to access behavioral health services in their homes and communities—services that are part of an existing array of programs that the State advertises to families through its Medicaid program (MaineCare), but does not make available in a meaningful or timely manner."

- "Maine children with behavioral health needs are eligible and appropriate for the range of community-based services the State offers, but either remain in segregated settings or are at serious risk of institutionalization."
- "Families and children in Maine are overwhelmingly open to receiving services in integrated settings. In fact, parents indicated a strong preference that their children receive services at home due to trauma, neglect, and abuse that their children reportedly endured in residential facilities within and outside of Maine."

Those findings should not have been a surprise to the State of Maine, which had been on clear notice of the widespread inadequacy of its community-based behavioral health system for children when a comprehensive assessment concluded, in 2018, that children's behavioral health services were not available when needed, or not available at all. Two years later, a separate independent assessment of the juvenile justice system found that many youth are detained and incarcerated at Long Creek because they could not access appropriate community-based services for their behavioral and mental health needs.

What was true in 2018 remains true today- Maine continues to fail to ensure that children with disabilities have access to the community-based behavioral health services they need in their homes and communities. As a result, children with disabilities in Maine are unnecessarily institutionalized in residential facilities, including at Long Creek and in other residential facilities both inside and outside the state, severing their ties to family and community. This violates their right, under the Americans with Disabilities Act, to receive services in the most integrated settings appropriate to their needs.

"When kids can access treatment and support close to home, they can stay connected with their families and communities," said ACLU of Maine Legal Director Carol Garvan. "Unfortunately, for far too long, Maine has not ensured these services. Since 2016, we have been working to address human rights violations at Long Creek, but not enough has been done. Maine must provide its kids the services they need to live healthy and safe lives."

"Maine children with disabilities and their families deserve what the law requires, which is community-based behavioral health services. The failure to provide those services harms children, strains and fragments families, and ripples across communities. Maine can and must step up to meet its obligations with the services the law requires," said Mary Bonauto, Senior Director at GLBTQ Legal Advocates & Defenders.

As the U.S. DOJ indicated in its complaint,

- "Maine can implement reasonable modifications so that children with behavioral health disabilities can live and thrive in integrated settings instead of entering institutions to access care."
- "But instead of modifying its service system to prevent and resolve unnecessary segregation, Maine has prioritized expanding its institutional services."

Read the DOJ press release.

###

Disability Rights Maine is Maine's Protection & Advocacy organization. Our mission is to advance justice and equality by enforcing rights and expanding opportunities for people with disabilities in Maine.

View More About:

Press Release: Disability Rights Maine Maintains Opposition to Psychiatric Residential Treatment Facilities in Maine

Dec 4, 2024

read more

Press Release: Advocates Respond to Settlement Agreement Requiring Maine to Bring its Behavioral Health System for Children into Compliance with the Americans with Disabilities Act

Nov 26, 2024

read more

Disability Rights Maine (DRM) is the federally mandated protection and advocacy system for Maine, which receives part of its funding from the HHS-Administration for Community Living, DOE-Rehabilitation Services Administration, HHS-Substance Abuse & Mental Health Services Administration – Center for MH services, Social Security Administration, and the State of Maine.

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PRESS RELEASE

Justice Department Sues Maine for Violating the Americans with Disabilities Act

Monday, September 9, 2024

For Immediate Release

Office of Public Affairs

The Justice Department sued the State of Maine today for unnecessarily segregating children with behavioral health disabilities in hospitals, residential facilities and a state-operated juvenile detention facility in violation of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in *Olmstead v. L.C.* The department previously notified Maine of its findings of civil rights violations in a June 2022 letter to Maine. The letter identified steps that Maine should take to remedy the violations.

"The State of Maine has an obligation to protect its residents, including children with behavioral health disabilities, and such children should not be confined to facilities away from their families and community resources," said Assistant Attorney General Kristen Clarke of the Justice Department's Civil Rights Division. "The Civil Rights Division is committed to ensuring that people with disabilities can get the services they need to remain at home with their families and loved ones, in their communities."

"Families across Maine must be able to access to local community-based services for their children with behavioral health disabilities," said U.S. Attorney Darcie N. McElwee for the District of Maine. "The alleged violations identified by the Justice Department must be remedied so that these children and their families can obtain services in their own communities, as required by the Americans with Disabilities Act."

The ADA and the *Olmstead* decision require state and local governments to ensure the services they provide for children with disabilities are available in the most integrated setting appropriate to each child's needs. These services can include assistance with daily activities, behavior management and individual or family counseling. Community-based behavioral health services also include crisis services that can help prevent a child from being institutionalized during a mental health crisis. Absent these services, Maine children with disabilities enter emergency rooms, come into contact with law enforcement and remain in institutions when they could remain with their families if Maine provided them sufficient community-based services.

The lawsuit alleges that Maine administers its system in a way that limits behavioral health services in the community. As a result, Maine children must enter in- and out-of-state facilities, or even the state-operated juvenile detention facility, Long Creek Youth Development Center, to receive behavioral health services. Others are at serious risk of entering these facilities, as their families struggle to keep them home despite the lack of necessary services.

The Civil Rights Division's Disability Rights Section investigated this case with assistance from the U.S. Attorney's Office for the District of Maine.

For more information on the ADA, please call the department's toll-free ADA Information Line at 1-800-514-0301 (TDD 800-514-0383) or visit www.ada.gov/topics/community-integration/.

For more information on the Civil Rights Division, please visit www.justice.gov/crt.

The letter of findings can be viewed here.

Updated September 9, 2024

Topics

CIVIL RIGHTS | DISABILITY RIGHTS

Components

Civil Rights Division | Civil Rights - Disability Rights Section | USAO - Maine

Press Release Number: 24-1114

DOJ sues Maine over ADA violations involving kids with behavioral health disabilities

PORTLAND, Maine — The U.S. Department of Justice announced Monday that it has sued the state of Maine for unnecessarily segregating children with behavioral health disabilities in hospitals, residential facilities and a state-operated juvenile detention facility.

https://www.youtube.com/watch?v=5r70pQ7f60c

BDN BANGOR DAILY NEWS

Feds sue Maine for allegedly segregating children with disabilities

by **Callie Ferguson** and **Christopher Burns**
September 9, 2024 Updated September 11, 2024

The U.S. government sued Maine on Monday for allegedly unnecessarily institutionalizing children with behavioral health disabilities, separating them from their families and segregating them from their communities.

The lawsuit comes more than two years after the U.S. Department of Justice noti
that its failure to provide timely and appropriate behavioral health services for ch
systematic discrimination. The escalation indicates that federal authorities and sta
come up with a plan to resolve the problems without going to court.

In **its 24-page complaint**, filed Monday in U.S. District Court, the Justice Department accused Maine of violating the **Americans with Disabilities Act** and **a 1999 U.S. Supreme Court decision**, which require state and local governments to provide services to children with disabilities in the least restrictive setting appropriate to their needs. The Justice Department said Monday that community-based services, such as programs where behavioral health clinicians work with children in their homes, can prevent them from ending up in institutions like emergency rooms, psychiatric hospitals, residential facilities in and out of state, or the state's youth prison.

In the complaint, the Justice Department said that Maine "in theory" uses Medicaid and other public funds to support such services, but in reality, the state administers them in a way that offers parents and guardians "no meaningful choice" other than institutions, separating those children from their families and segregating them from their communities.

"When Maine children are placed in institutions, such as psychiatric hospitals, juvenile detention, and other residential facilities, they miss the chance to wake up in their own beds, to develop bonds with family and friends, and to go to school with their siblings and peers," the Justice Department wrote.

The allegations echoed the findings of previous reports, including **a critical review** of Maine's behavioral health system for children in 2018 which identified long waiting lists for community-based services, increasing the likelihood of a behavioral health crisis that prompted families to call police or seek the hospital.

In 2020, a **comprehensive assessment** of the state's juvenile justice system found that far fewer adolescents would end up in Long Creek Youth Development Center in South Portland, the state's only juvenile detention center, if the state had a more robust behavioral health system.

"Maine children and their families are still waiting for a legally compliant behavioral health system," Atlee Reilly, a lawyer with Disability Rights Maine, the organization that drew the Justice Department's attention to Maine in a 2019 complaint, said in a statement on Monday. "And despite calls for more than a decade to ensure the availability of those services, Maine has failed to do so. Unfortunately, this lawsuit was the necessary result of that continued failure."

Lindsay Hammes, a spokeswoman for the Maine Department of Health and Human Services, which oversees the children's behavioral health system, said in a statement that the department was "deeply disappointed that the U.S. DOJ has decided to sue the State rather than continue our collaborative, good-faith effort to strengthen the delivery of children's behavioral health services."

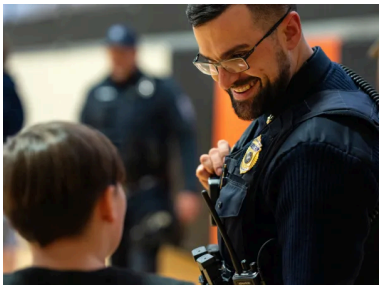
The department had been "working closely with the Department of Justice to address its initial allegations from March 2022," she said. Now, "The State of Maine will vigorously defend itself and, throughout the litigation, will continue to work hard to strengthen the delivery of what we all agree are vital services."

Hammes said the Gov. Janet Mills' administration and the Maine Legislature has worked to strengthen community-based services for children in recent years investing more money into behavioral health programs. In 2022, a spokesperson **told the Bangor Daily News** the problems Maine faces in providing care for children go back decades, and the COVID-19 pandemic set back the state as it made it difficult for providers to hire and maintain staff.

But the Justice Department argued in its complaint Monday that the state's invest
backing up complaints from families and advocacy groups that inadequate access

not worsened, in recent years.

GO DEEPER



They came together to help at-risk kids in the midcoast. Will it be enough?

by **Callie Ferguson**

Carrie Woodcock, executive director for the Maine Parent Federation, which helps families navigate services for their children with behavioral health disabilities, had hoped the Justice Department's letter to the state in June 2022 might be a turning point, but it wasn't, she said.

"When that letter first came out, the families in our organization thought, "OK, they are being duly noted, we are going to see some progress. And we've seen nothing," Woodcock said.

When families have called over the past year, "all I could say to them was, 'Here is the number for our contact at [the Department of Justice] leading the investigation into the state. We recommend you call and talk to them,'" she said.

The Justice Department's complaint goes into extensive detail about the challenges that parents and guardians face when attempting to access community-based services that their children are eligible for under MaineCare, including lengthy waitlists, insufficient provider networks, inadequate crisis services and a lack of support for foster parents.

For example, one program called Children's Home and Community Based Treatment, which provides individual and family counseling for children with emotional disturbances in their home, had an average waitlist of 172 days between March and June 2024, the complaint states.

READ ABOUT THE CRISIS

Maine's juvenile justice crisis

Efforts to address chronic problems in Maine's juvenile justice system have all but stalled.

When children go into crisis, the state operates a 24/7 hotline for parents to call –
are frequently unavailable, or no one answers the phone, lawyers for the Justice D

For children in state custody, the state has failed to recruit and support enough therapeutic foster homes, a program where foster families are trained and provided the resources to house kids with behavioral health disabilities. As a result, some foster children "have been dropped off at homeless shelters because Maine did not secure community-based services for their care, including Therapeutic Foster Care."

When children don't get the interventions they need at home, they are at greater risk of hospitalization, incarceration or lengthy stays in residential treatment facilities, both in **and out of state**. Those options are often more traumatizing and expensive than serving youth in their homes and communities, the complaint states. It accused the state of using Long Creek in South Portland as a "de facto psychiatric hospital" for adolescents with behavioral health disorders who can't find help anywhere but inside the state's youth detention center.

The Justice Department suggested that Maine has missed opportunities to fill gaps in its community-based system that would prevent unnecessarily institutionalization, the complaint states. Instead, the state "has prioritized expanding its institutional services" by committing to establishing the state's first secure residential program.

"The State of Maine has an obligation to protect its residents, including children with behavioral health disabilities, and such children should not be confined to facilities away from their families and community resources," Assistant Attorney General Kristen Clarke, who serves in the Justice Department's civil rights division, said Monday.

"The Civil Rights Division is committed to ensuring that people with disabilities can get the services they need to remain at home with their families and loved ones, in their communities."

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

UNITED STATES OF AMERICA, ***Plaintiff*,** **v.** **STATE OF MAINE,** ***Defendant*.**	**CIVIL ACTION NO.**

COMPLAINT

1. Each year, the State of Maine ("Maine" or "State") segregates hundreds of children with mental health and/or developmental disabilities, referred to throughout as behavioral health disabilities, away from their families and communities in institutions in- and out-of-state. These children do not need to be segregated. The families of many of these children want them home. Other families would choose to have their children live at home or in another family home if provided a meaningful opportunity to do so. Maine administers its behavioral health service system for children in a manner that gives the families and guardians of these children no meaningful choice other than institutions. This leaves hundreds of children separated from their families and segregated from their communities.

2. The United States of America ("United States") brings this action to enforce the rights of Maine children with behavioral health disabilities who are unnecessarily segregated—or at serious risk of segregation—in institutions because Maine has failed to provide them access to the behavioral health services they need in the community. These children (*i.e.*, individuals under the age of 21) make up the population at issue here, referred to throughout as children with behavioral health disabilities or simply children.

3. When Maine children are placed in institutions, such as psychiatric hospitals, juvenile detention, and other residential facilities, they miss the chance to wake up in their own beds, to develop bonds with family and friends, and to go to school with their siblings and peers.

4. In theory, Maine funds and administers an array of behavioral health services, which it uses Medicaid and other publicly funded programs to fund, that help children with disabilities avoid or recover from mental health crises and manage their behavioral health disabilities so that they can stay in their homes and communities.

5. But, in reality, Maine fails to provide children access to community-based behavioral health services. As a result, hundreds of children are segregated in institutions because they cannot access the community-based services they are entitled to receive. Many more children are at serious risk of segregation because they cannot access Maine's community-based services in a meaningful or timely manner. Maine's mental health crisis services for children are often unavailable. When a child is in crisis, families are often directed to call the police or take the child to the emergency room. This puts the child at risk of institutionalization. Similarly, because the behavioral health services children need to return home are often unavailable, children who are taken to the emergency room often get stuck there. They are then sent to institutions.

6. Most Maine children who have had to enter institutions could live at home with a family if they could access the services they need there.

7. Children and their families would prefer for the children to live at home with services.

8. Maine could prevent discrimination against children with behavioral health disabilities by making reasonable modifications to its service system. With changes to Maine's

system to make community-based behavioral health services available to avoid the unnecessary segregation of children with behavioral health disabilities who need them, these children could live and thrive in their communities. Maine could thereby enable children with behavioral health disabilities to avoid unnecessary segregation.

9. Representatives of children across Maine have filed complaints with the United States describing how children want to live at home and how their families want them at home but that the children are stuck in institutions or face imminent institutionalization because Maine policies and practices make it hard for them to get services at home.

10. The United States of America brings this lawsuit, seeking a judicial order compelling Maine to provide behavioral health services to children with disabilities in their homes and communities when they can be served there, rather than unnecessarily segregating them or placing them at serious risk of unnecessary segregation in institutions. 42 U.S.C. §§ 12131–34; 28 C.F.R. pt. 35.

JURISDICTION AND VENUE

11. This Court has jurisdiction over this action under 28 U.S.C. §§ 1331, 1345, because it involves claims arising under federal law. *See* 42 U.S.C. § 12133. The Court may grant the relief sought in this action pursuant to 28 U.S.C. §§ 2201–02.

12. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the acts and omissions giving rise to this action occurred in the District of Maine.

PARTIES

13. Plaintiff is the United States of America.

14. Defendant, the State of Maine, is a public entity within the meaning of the

Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12131(1), and is therefore subject to Title II of the ADA, 42 U.S.C. §§ 12131–34, and its implementing regulation, 28 C.F.R. pt. 35.

LEGAL BACKGROUND

15. Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1).

16. In enacting the ADA, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities," and that "such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." *Id.* § 12101(a)(2).

17. Title II of the ADA prohibits public entities from discriminating against people on the basis of disability. *Id.* § 12132. A "public entity" includes any state or local government, as well as any department, agency, or other instrumentality of a state or local government, and it applies to all services, programs, and activities provided or made available by public entities, such as through contractual, licensing, or other arrangements. *Id*. § 12131(1); 28 C.F.R. § 35.130(b)(3)(i).

18. Congress directed the Attorney General to issue a regulation implementing Title II of the ADA. 42 U.S.C. § 12134. The Title II regulation includes an "integration mandate," which requires public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The most integrated setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." *Id.* pt. 35, app. B.

19. In *Olmstead v. L.C.*, the Supreme Court held that Title II prohibits the unjustified

segregation of individuals with disabilities. 527 U.S. 581, 597 (1999). The Supreme Court explained that its holding "reflects two evident judgments." *Id.* at 600. First, the Supreme Court explained that unnecessary institutionalization of people with disabilities "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id*. "Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 601.

20. Under Title II, as interpreted by the Supreme Court in the *Olmstead* decision, public entities are required to provide community-based services when (a) such services are appropriate, (b) the affected individuals do not oppose community-based treatment, and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other people with disabilities. *Id.* at 607.

MAINE'S BEHAVIORAL HEALTH SERVICE SYSTEM FOR CHILDREN

21. Maine administers and funds services for children with behavioral health disabilities through various agencies, departments, and programs.

22. Behavioral health services help children with disabilities manage their behavioral health needs and learn the skills they need to be independent and engage with the community.

23. For example, a child with a mental health diagnosis and autism may need several different behavioral health services, including help with personal care, supervision, redirection to prevent the child from wandering off, and one-on-one therapy.

24. Maine offers behavioral health services in both community-based settings (such as family homes) and in segregated settings.

25. But children with behavioral health disabilities struggle to remain at home or

return home from institutions due to barriers to accessing Maine's behavioral health services at home.

26. Maine provides healthcare coverage to eligible children through its state and federally funded Medicaid program, known as MaineCare. Maine also funds behavioral health services through other state and federal funding sources.

27. Medicaid is a health care system created by federal law but administered by states that are subject to certain federal statutory requirements. In broad terms, Medicaid's purpose is to provide government-funded health coverage and related services for low-income individuals and individuals with disabilities. When these individuals receive authorized services from providers that are enrolled with Medicaid, the providers' costs are reimbursed with Medicaid funds.

28. Federal law requires every state that participates in Medicaid to designate a state agency to administer its Medicaid services. That agency must create a "Medicaid State Plan," which describes and defines the services that it will cover through Medicaid.

29. Maine's Department of Health and Human Services ("DHHS") is responsible for administering MaineCare under Title XIX of the Social Security Act (the "Medicaid Act"). *See* Me. Rev. Stat. Ann. tit. 22, § 3173; 10-144-101 Me. Code R. § 1.02-1.

30. Under the Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") requirements of the Medicaid Act, DHHS must provide all medically necessary services to Medicaid-eligible children up to 21 years of age. *See* 42 U.S.C. §§ 1396a(a)(43), 1396d(a), 1396d(r).

31. DHHS administers behavioral health services for children up to their 21st birthday.

32. Behavioral health services for children are primarily funded by MaineCare.

Segregated Settings for Children with Behavioral Health Disabilities

33. Maine reimburses private institutional providers, such as hospitals and residential facilities, under MaineCare and other state and federal funding sources.

34. Maine sets reimbursement payment rates for institutional providers.

35. Maine has multiple psychiatric hospitals that serve children with behavioral health disabilities.

36. Maine has general hospitals that have psychiatric units for children.

37. Maine has general hospitals with emergency rooms, where children experiencing mental health crises may be taken.

38. In addition to other institutions for children, Maine also has at least a dozen Children's Residential Care Facilities ("CRCFs"), which provide residential treatment services to children as young as five years old with behavioral health disabilities.

39. CRCFs are inpatient care settings that serve only children with disabilities.

40. During each month between January 2018 and June 2024, between 133 and 353 Maine children per month lived in Maine CRCFs to receive residential treatment services.

41. During each month between January 2018 and June 2024, between 41 and 85 Maine children per month lived in out-of-state residential facilities to receive residential treatment services.

42. According to data provided by the State, children sent to in-state CRCFs stayed there for an average of 246 days in fiscal year 2020.

43. In hospitals, residential facilities, and other institutions, children with behavioral health disabilities are separated from their families and communities in congregate settings to receive services.

44. In these settings, children with behavioral health disabilities have little to no interaction with people without disabilities other than the staff who serve them.

45. Maine also sends children to its secure juvenile detention facility, Long Creek Youth Development Center ("Long Creek"), to receive behavioral health services.

46. Maine owns and operates Long Creek.

47. As explained further below, Maine uses Long Creek as a *de facto* psychiatric hospital.

48. Contrary to state law requirements that children in the juvenile justice system be rehabilitated at home wherever possible, children with behavioral health disabilities are instead sent to or remain in Long Creek because it is the only setting where they can access behavioral health services.

49. As a result, most children at Long Creek have behavioral health disabilities.

50. Children who are held at Long Creek have few, if any, opportunities to see their families and friends or engage with their communities.

51. These hospitals, residential facilities, and Long Creek are segregated settings.

Community-Based Behavioral Health Services

52. Maine licenses, certifies, or otherwise regulates private community-based behavioral health service providers.

53. Maine pays private community-based behavioral health service providers with MaineCare and other state and federal funding.

54. Maine sets reimbursement payment rates for community-based behavioral health service providers.

55. Maine's community-based behavioral health services include crisis services for children experiencing behavioral health emergencies and longer-term behavioral health services for children living at home.

Crisis Services

56. DHHS operates a crisis hotline that dispatches mobile crisis teams who provide in-home assistance to children experiencing mental health crises.

57. Maine claims that its crisis hotline is available 24 hours per day, 7 days per week.

58. But parents and advocates report that the crisis hotline and mobile crisis teams are frequently unavailable—either because no one answers the phone, or because no teams are available to come to the child's home to help.

59. Maine also has Crisis Stabilization Units ("CSUs") where children can receive short-term, inpatient care during a mental health crisis.

60. Parents and providers report that CSU beds are frequently unavailable.

61. Although children enrolled in MaineCare are eligible for various crisis services in the community, *see, e.g.*, 10-144-101 Me. Code R. § 65.05-1, many must enter emergency departments to get crisis services that Maine ostensibly offers in the community.

Longer-Term Behavioral Health Services

62. In addition to crisis services, Maine also offers longer-term behavioral health services through MaineCare.

63. For instance, Maine claims to offer Assertive Community Treatment ("ACT"), an intensive, team-based service that includes crisis response, to children who are eligible for MaineCare.

64. Although ACT is ostensibly an available service, Maine currently has only one ACT MaineCare provider, and very few children in Maine can find a provider and access the service.

65. Maine also offers Rehabilitative and Community Support Services as well as Specialized Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations, which provide children with developmental disabilities—who may also have mental health disabilities—with assistance with activities of daily living and behavior management.

66. There are lengthy waitlists for these services. In recent publicly available data, Maine reported that, from March 2024 to June 2024, the average time that a child was on a waitlist for Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations was 167 days, while the average time that a child was on a waitlist for Specialized Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations was 357 days.

67. Another service, called Children's Home and Community Based Treatment ("HCT"), is designed for children who are diagnosed with serious emotional disturbance, as defined in the MaineCare rules.

68. HCT includes individual counseling, family counseling, and in-home services provided by trained staff.

69. Children also face a long waitlist for HCT. Maine has reported that, from March 2024 to June 2024, the average time a child was on a waitlist for HCT was 172 days.

70. MaineCare also offers a service called Targeted Case Management that coordinates care for children with disabilities.

71. In State Fiscal Year 2020, children with behavioral health disabilities waited an average of 328 days to receive Targeted Case Management. Some of these children waited more than 650 days to receive Targeted Case Management.

72. Maine previously offered more intensive care coordination statewide to MaineCare eligible children with behavioral health disabilities through a high-fidelity wraparound program called Maine Wraparound.

73. High-fidelity wraparound is a comprehensive service delivery strategy that coordinates a wide net of resources for children with behavioral health disabilities, including family and community resources, to support these children in the community.

74. While it was offered, Maine Wraparound was critical in preventing significant numbers of Maine children with behavioral health disabilities from being placed in institutions.

75. Maine's statewide wraparound program also resulted in significant cost savings to the State, because Maine Wraparound successfully diverted children from expensive institutionalization.

76. Although Maine discontinued its Maine Wraparound program, Maine has stated that it intends to reintroduce high-fidelity wraparound services for MaineCare eligible children. Despite setting aside funds for these wraparound services, Maine has spent little of the funds it estimated it would need to re-establish high-fidelity wraparound. Maine therefore is not on track

to make high fidelity wraparound available to the many children with behavioral health disabilities who qualify.

77. Currently, Maine offers high-fidelity wraparound to only a limited number of youth who are involved in the juvenile justice system.

Therapeutic Foster Care

78. DHHS also administers Maine's child welfare system.

79. Children are removed from their homes and enter the child welfare system following claims that they were neglected or abused by their parents, legal guardian, or custodian.

80. Maine's child welfare system offers a specialized form of foster care, known as Therapeutic Foster Care, for children with behavioral health needs in the child welfare system.

81. Therapeutic Foster Care parents are trained, supervised, and supported by qualified staff to care for foster children with behavioral health disabilities.

82. Therapeutic Foster Care parents are contracted by private placement agencies that are licensed through the Office of Child and Family Services, which is housed within DHHS.

83. Maine does not offer sufficient incentives to encourage the needed number of Maine adults to become licensed Therapeutic Foster Care parents.

84. Maine does not recruit enough Therapeutic Foster Care parents to serve eligible children with behavioral health disabilities.

85. Maine does not provide Therapeutic Foster Care parents with the training or services they need to support foster children with behavioral health disabilities.

86. As a result, there are too few Therapeutic Foster Care parents in Maine to serve eligible foster children with behavioral health disabilities.

87. Foster children with behavioral health disabilities therefore enter and remain in segregated settings unnecessarily while they await Therapeutic Foster Care placements.

88. Other children with behavioral health disabilities are at risk of entering segregated settings if they enter the foster system.

89. Maine previously offered an additional option, called Multidimensional Therapeutic Foster Care, for children other than those in the child welfare system.

90. When it existed, Multidimensional Therapeutic Foster Care placed children with behavioral health disabilities with specially trained foster parents so that these children could receive services in a home-based setting and maintain legal and social ties to their families.

91. Multidimensional Therapeutic Foster Care helped avoid institutionalization of children who were not in the child welfare system but whose families could not care for them at home, for example due to a parent's illness or the needs of other children in the home.

92. Maine plans to re-establish this program but does not currently make it available to those who qualify.

Maine's Community-Based Services Are Not Available when Children with Behavioral Health Disabilities Need Them, Resulting in Unnecessary Segregation or Serious Risk of Such Segregation

93. Maine's behavioral health system makes it difficult for children with behavioral health disabilities to access community-based services to prevent segregation and serious risk of segregation.

Maine Has Long Waitlists for Community-Based Services

94. Maine maintains separate waitlists for each community-based behavioral health service that it offers to children with behavioral health disabilities.

95. But children with behavioral health disabilities who would be ready to return to

the community with appropriate services remain in segregated settings due to Maine's waitlists for community-based behavioral health services.

96. For each month between January 2023 to June 2024, at least 400 children waited to receive at least one community-based service.

97. When faced with months of waiting for community-based services, children with behavioral health disabilities are at serious risk of entering institutions to receive care.

98. These children may enter institutions directly, or through hospital emergency rooms or law enforcement involvement, when they experience behavioral health crises because they cannot access the services they need in the community.

Maine Does Not Invest in Community-Based Providers

99. Community-based providers are service providers that provide community-based behavioral health services.

100. Maine reimburses community-based providers through MaineCare and other state and federal funding sources.

101. Maine sets reimbursement payment rates for community-based providers.

102. Maine's own recent report reiterated that "[s]ervice availability and accessibility is undoubtedly one of the most significant factors impacting" children's behavioral health services.

103. This lack of service availability and accessibility in the community places children currently living at home with their families at serious risk of entering institutions.

104. Under the Medicaid Act's EPSDT provision, states must provide access to providers so that children can get required services.

105. Providers need support, guidance, and technical assistance from the State to

provide community-based services to avoid the needless segregation of children with behavioral health disabilities.

106. Maine does not offer incentives or support to ensure that the State's network of providers can serve children with behavioral health disabilities in the community.

107. Maine also has complicated application and approval processes for certain community-based services like respite care,[1] which discourage potential providers from signing up to provide those services.

108. For certain services in some areas of the State, there are no community-based providers at all.

109. Even where providers are available, the demand for community-based services far outpaces providers' ability to provide those services.

110. And Maine does not ensure that providers serve eligible children with behavioral health disabilities.

111. Due to Maine's failure to address its gap in community-based services, children with behavioral health disabilities are forced to enter or remain in institutions to get services.

112. Due to Maine's failure to address its gap in community-based services, children with behavioral health disabilities are at serious risk of entering institutions to get services.

113. Long Creek, Maine's juvenile detention facility, both provides behavioral health services and cannot refuse to serve any children.

[1] Respite care provides trained temporary alternate caregivers so that parents and guardians can take care of other needs or travel, much the same way a neighbor or babysitter provides temporary care to a child without a disability.

Maine's Crisis Services Are Often Unavailable

114. Since Maine's crisis services are often unavailable, children with behavioral health disabilities may enter hospital emergency rooms during behavioral health crises.

115. Children with behavioral health disabilities have stayed in hospital emergency rooms for weeks or months because there are no community-based services available.

116. Families are forced to choose between bringing their children with behavioral health disabilities home from the hospital with no services in place or sending their children to residential facilities. The lack of available community-based services causes many children with behavioral health disabilities to enter residential facilities and places others at serious risk of entering those facilities.

117. When crisis services are unavailable, crisis staff have told families to call the police.

118. Hospitals and residential facilities have also called the police while children are experiencing behavioral health crises.

119. Law enforcement officers are not mental health professionals and so, in general, they cannot effectively provide behavioral health services.

120. And when law enforcement officers respond to a child's mental or behavioral health crisis, they may interpret the child's disability-related behaviors, such as not responding to police commands, as criminal activity.

121. Law enforcement contact places children in behavioral health crisis at serious risk of entering institutions such as Long Creek.

Maine Uses Its Juvenile Detention Facility as a De Facto Psychiatric Facility

122. Once law enforcement is involved, juvenile justice officers may charge the child with a crime based on their disability-related behaviors and recommend that the child be placed at Long Creek.

123. Maine's juvenile justice law requires the State to provide juvenile justice rehabilitative services in the least restrictive setting—typically a family home—with few exceptions.

124. But children with behavioral health disabilities are sent to or remain in Long Creek because of the insufficient behavioral health services available to them in the community.

125. As a result, children with behavioral health disabilities whose needs could be met with community-based services become institutionalized at Long Creek, or are at serious risk of entering Long Creek, to receive behavioral health services.

126. Long Creek is not an appropriate therapeutic setting for children who are having behavioral health crises.

127. For instance, according to recent reports, children may be locked in their cells for up to 23-hours per day. Children may also be subjected to use of force, which results in trauma. These practices have only increased instances of mental health crises and suicide watches at Long Creek.

128. In 2016, Maine's Department of Corrections reported that 84.6% of youth arrive at Long Creek with three or more mental health diagnoses.

129. In 2020, a State-commissioned assessment of Maine's juvenile justice system found that approximately 70% of a sample of children committed to Long Creek had received behavioral health services through MaineCare within the year prior to their incarceration.

130. In testimony before the State Legislature, Maine's Department of Corrections Commissioner stated that despite efforts to reduce detention solely to provide care to children, "some of our youth are at Long Creek because there are no other options."

131. Maine thereby uses Long Creek as a *de facto* psychiatric hospital.

Maine Does Not Invest in Therapeutic Foster Care

132. Maine is responsible for administering training, supports, and services to Therapeutic Foster Care parents so that these parents can meet their foster children's behavioral health disabilities at home.

133. Maine fails to recruit, train, and support Therapeutic Foster Care parents to serve eligible children with behavioral health disabilities who are in the child welfare system.

134. Because of Maine's lack of support, few Therapeutic Foster Care placements are available.

135. Foster children with behavioral health disabilities therefore frequently remain institutionalized in psychiatric hospitals or other segregated settings long after they are ready for discharge.

136. Some foster children with behavioral health disabilities have been dropped off at homeless shelters because Maine did not secure community-based services for their care, including Therapeutic Foster Care.

137. Children in Maine's child welfare system are overrepresented in institutions.

138. Since Maine discontinued the Multidimensional Therapeutic Foster Care option, there is a lack of home-based options for children who are not in the child welfare system but who cannot live with their family of origin for various reasons.

Maine Children with Behavioral Health Disabilities Are Qualified to Receive Services in the Community and Could Be Served with Appropriate Community-Based Services and Supports

139. Children with behavioral health disabilities segregated in hospitals, residential facilities, and Long Creek are eligible for MaineCare and other state and federally funded behavioral health services that Maine administers. Behavioral health disabilities are mental or physical impairments that substantially limit one or more major life activities, as defined in 28 C.F.R. § 35.108.

140. Children with these disabilities living in the community, but who are at serious risk of entering institutions, are eligible for MaineCare and other state and federally funded behavioral health services that Maine administers.

141. With appropriate services, children with behavioral health disabilities can live at home with their families and be fully integrated into their communities.

142. Children with behavioral health disabilities in hospitals, residential facilities, and Long Creek, and those living in the community but at risk of entering these settings, are qualified to receive community-based behavioral health services.

143. Children with behavioral health disabilities who live in the community but are at serious risk have lived at home with their disabilities and can continue living at home if they receive the behavioral health services they need. Community-based behavioral health services are appropriate for these children.

144. Many children who are currently living in institutions have similar diagnoses and behavioral health disabilities as other children who are already living and receiving services in the community. With appropriate community-based services, these children could also live at home.

145. Many children with behavioral health disabilities who are currently living in institutions have previously lived and received behavioral health services at home, and the vast majority could return home with community-based services. Community-based behavioral health services are appropriate for these children.

146. Institutional providers in Maine consistently report that there are children in their facilities who would be ready to return home if community-based services were available. Community-based behavioral health services are appropriate for these children.

147. Staff and administrators at Long Creek have repeatedly estimated that many of the children who are currently held at Long Creek could be released to the community if appropriate mental health programs and services were available.

148. Although children with behavioral health disabilities are qualified for community-based services and such services are appropriate for them, these children remain in segregated settings or are at serious risk of segregation.

Children with Behavioral Health Disabilities and Their Families Would Not Oppose Community Living

149. Children with behavioral health disabilities and their families overwhelmingly do not oppose the children being served in the community with appropriate services and supports.

150. Children with behavioral health disabilities want to live at home, go to school, and engage with their family, friends, and communities.

151. Parents of these children also want their children to live at home.

152. These children and their parents would choose to receive services in their homes and communities instead of in segregated settings if they could access appropriate services and supports at home.

153. Many children with behavioral health disabilities who are at serious risk of

entering institutions, who already live in the community, and their families would choose to continue receiving services in the community if Maine improves access to those services.

Maine Could Serve Children with Behavioral Health Disabilities at Home Through Reasonable Modifications

154. Maine can implement reasonable modifications so that children with behavioral health disabilities can live and thrive in integrated settings instead of entering institutions to access care.

155. With reasonable modifications, children with behavioral health disabilities currently in institutions could transition to, and live successfully in, family and foster homes in the community. Maine could make reasonable modifications to prevent the serious risk of segregation for numerous other Maine children with behavioral health disabilities.

156. To start, Maine could ensure that children actually receive the community-based behavioral health services that the State offers in theory.

157. Maine could also implement a process to determine each child's behavioral health service needs and ensure that families are informed of, and considered for, the MaineCare behavioral health services the child needs to avoid segregation or serious risk of segregation.

158. Maine could address its long waitlists and ensure timely access to community-based services by expanding its capacity of community-based services, for example by providing additional support to community-based providers and expanding the direct care work force, including in rural and frontier areas.

159. Maine could implement measures that would ensure that community-based behavioral health care providers are available to all eligible children at serious risk of unnecessary segregation.

160. For example, Maine could implement a policy that would ensure that community-

based behavioral health care providers serve eligible children who are assigned to their caseload.

161. Serving children with behavioral health disabilities in the community is a cost-effective alternative to segregation.

162. The average cost per child of community-based services is equal to or less than the average cost per child of institutional services.

163. When comparing average costs per child of Maine's behavioral health services, community-based services are among the least expensive services, while residential facilities are more expensive, and hospitals, emergency departments, and Long Creek are the most expensive.

164. But instead of modifying its service system to prevent and resolve unnecessary segregation, Maine has prioritized expanding its institutional services.

165. For example, Maine has committed to establishing one or more psychiatric residential treatment facilities for children—the first of their kind in Maine.

166. But Maine has not committed to providing community-based services to the many children with behavioral health disabilities who are unnecessarily segregated or at serious risk of segregation.

VIOLATION OF TITLE II OF THE ADA, 42 U.S.C. §§ 12131–34

167. The United States repeats and incorporates by reference all the allegations set forth above.

168. Defendant, the State of Maine, is a public entity that must comply with Title II of the ADA. 42 U.S.C. § 12131(1).

169. Maine children with behavioral health disabilities who are segregated or at serious risk of segregation are persons with disabilities protected by Title II of the ADA, and they are qualified to participate in Maine's services, programs, and activities, including community-based

services. *Id.* §§ 12102, 12131(2).

170. Community-based services are appropriate for these children, many of whom, along with their parents or guardians, do not oppose community integration.

171. Maine violates Title II of the ADA by administering its service system for children with behavioral health disabilities in a manner that fails to ensure that such children receive services in the most integrated setting appropriate to their needs. *Id.* § 12132.

172. Maine's actions constitute discrimination in violation of Title II of the ADA, *id.*, and its implementing regulation at 28 C.F.R. pt. 35.

173. Maine could reasonably modify its programs and services to serve children in integrated settings.

174. All conditions precedent to the filing of this Complaint have been satisfied. Fed. R. Civ. P. 9(c); 28 C.F.R. pt. 35, subpt. F.

REQUEST FOR RELIEF

The United States respectfully requests that the Court:

175. Grant judgment in favor of the United States on its Complaint and declare that the State of Maine has violated Title II of the ADA, 42 U.S.C. §§ 12131–34, by failing to administer its services, programs, and activities for children with behavioral health disabilities in the most integrated setting appropriate to their needs.

176. Enjoin the State of Maine to:

a. Cease discriminating against children with behavioral health disabilities, and instead provide them appropriate, integrated community-based services consistent with their individual needs, so that currently segregated children can transition to living at home, and to prevent children at serious

risk of unnecessary segregation from entering institutions; and

b. Take steps as may be necessary to prevent the recurrence of any discriminatory conduct in the future and to eliminate the effects of Maine's unlawful conduct.

177. Order other appropriate relief as the interests of justice may require.

Dated: September 9, 2024

Respectfully submitted,

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2024 WL 3568707 (Me.Super.) (Trial Order)
Superior Court of Maine.
Kennebec County

A.F., Petitioner,

v.

MAINEGENERAL MEDICAL CENTER, Respondent.

No. AUGSC-CV-22-189.
February 13, 2024.

Order on Petition for Writ of Habeas Corpus

Michaela Murphy, Justice.

BACKGROUND

***1** Before the Court is a Petition for a Writ of Habeas Corpus brought by A.F., a 45-year-old deaf woman who suffers from mental illness. She was detained at MaineGeneral Medical Center's ("MGMC") Emergency Department ("ED") for 65 days from October 12, 2022 until December 14, 2022, when MGMC finally admitted her to their A-3 in-patient psychiatric unit.

The Court has considered the evidence at hearing on October 19, 2023, and has considered the written post-hearing arguments of the parties, the last of which was received on December 20, 2023, and has concluded that Petitioner A.F. is entitled to some form of relief, but the Court will be ordering further proceedings to hear arguments as to what form the relief should take.

Petitioner has asked the Court to grant her Petition based upon a finding that hospitals such as MGMC do not enjoy "plenary, unreviewable discretion" to decide which patients they admit from a "waiting list" of patients like A.F. who wait—sometimes for months—to be admitted to a psychiatric hospital after being "blue papered" under Maine law. Petitioner claims she was entitled to appointment of counsel, along with other due process protections, while waiting for placement. She claims hospitals such as MGMC who contract with the Maine Department of Health and Human Services ("DHHS") to admit and treat "blue papered" individuals cannot simply reject a patient such as A.F. by asserting the person does not meet their standards for "acuity" and/or are not a good fit for their "milieu." MGMC asserts that it adhered to and went above and beyond the requirements under Maine law and pursuant to its contract with DHHS.

The parties do agree that under Maine's current system, psychiatric patients such as A.F. are living in emergency rooms across Maine for up to months at a time while they are waiting for admission to psychiatric facilities, including Maine's two State psychiatric hospitals, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, along with the 8 private hospitals that have contracted with the State to accept such patients in their psychiatric units. The parties agree that A.F. was detained at the MGMC ED while awaiting the so-called "white paper process" to unfold. That process carries with it elevated due process protections, including appointment of counsel and which may culminate in a full, confidential hearing before a District Court Judge.

The parties essentially agree as to what happened over the course of those 65 days. A.F. was held against her will at the MGMC ED while the process played out. MGMC provided her basic needs including interpreter services and medication, but she did not receive the same level of psychiatric treatment she would have received had she been admitted to either a State or private psychiatric hospital while being further assessed for court proceedings, nor was she afforded legal representation. The parties

further seem to agree that MGMC followed the "blue paper" process established by the Maine Legislature twelve separate times by completing three statutorily mandated steps: (1) application; (2) certifying examination; and (3) judicial review and endorsement. 34-B M.R.S. §§ 3863(1)-(3). Each time after these steps were completed, a District Court Judge who reviewed and endorsed the application stated, as printed on the form:

> ***2** I find this application and certificate to be regular and in accordance with the law. No psychiatric hospital has been located as of the date of the certifying examination. [A.F.] may remain at [MGMC ED] pending the location of an inpatient bed at a psychiatric hospital or other appropriate alternative subject to the requirements of 34-B M.R.S. § 3863(3). If an available inpatient bed at a psychiatric hospital is located, and the emergency admission of [A.F.] is still sought, the applicant shall immediately notify a judicial officer for final review and endorsement under Section 3.B.2 below.

Ex. 9.

Over the course of the 65 days, A.F. was rejected by the following hospitals: Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, Spring Harbor Hospital, Northern Light Acadia Hospital, Southern Maine Medical Center, St. Mary's Regional Medical Center, Mid Coast Hospital, Penobscot Bay Hospital, Maine Medical Center, and MGMC. They all claimed that she was not a good fit for their hospital as her acuity level was too high, or otherwise did not fit their milieu. And these rejections repeatedly occurred while other patients, who were also awaiting admission from MGMC's ED, were admitted to psychiatric hospitals. Janelynn Duprey, Nursing Director for the ED at MGMC, testified that there is essentially no "waiting list" for these patients as that term is conventionally understood. Instead, prospective hospitals are permitted to decide whether a patient is a good fit for their facility. If not, the patient and the ED where the patient is being detained, have no option but to accept that decision, and to wait. And wait they did.

In A.F.'s case, her waiting finally ended when Nursing Director Duprey, clearly frustrated but undeterred, advised A.F. to contact Disability Rights Maine to take her case. This Petition was soon filed with their assistance. Two days later, MGMC moved A.F. from their ED upstairs to their psychiatric unit.[1]

STANDARD OF REVIEW

Approximately three years ago, the Law Court stated in .4.5. *v. LincolnHealth* that Section 3863 of Title 34-B was "an imprecise 'fit' for what is actually happening in Maine's emergency departments as they struggle to deal with patients who need psychiatric beds at a time when the State has failed to create or fund enough of those beds." 2021 ME 6, ¶ 16, 246 A.3d 157. The Law Court further noted that this statute is one of a very few "that provides the civil authority for a person or entity to hold another person against his wishes." *Id.* In addition, the Law Court recognized the guiding principle from the United States Supreme Court that "'civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.'" *Id.* (quoting *Addington v. Texas,* 441 U.S. 418, 425 (1979)).

Eight years before its decision in *LincolnHealth,* the Law Court held in *In re Marcia E.,* that "[u]nder no circumstances may a hospital hold a person against his or her will for longer than twenty-four hours unless the hospital has obtained a judge's endorsement." 2012 ME 139, ¶ 6, 58 A.3d 1115. Three years later, the Maine Legislature amended Section 3863. *LincolnHealth,* 2021 ME 6, ¶ 20, 246 A.3d 157 (citing P.L. 2015, ch. 309, § 3 (effective July 2, 2015)). The Law Court noted that the amendments did not change the language requiring judicial endorsement within the first twenty-four hours after a person is detained. *Id.* ¶¶ 20-21. It continued:

> ***3** What was changed by the 2015 amendments, however, is the *duration* of the detention that such a judicial endorsement allows. The unambiguous language of the 2015 amendments permits a hospital that obtained judicial endorsement for a patient's detention during the "original" twenty-four-hour period of detention to continue to hold that individual for two additional forty-eight-hour periods if the hospital complies with certain requirements.

Id. ¶ 21 (emphasis in original).

The Law Court rejected LincolnHealth's central premise—that "there is simply no due process for those held by but not admitted to hospitals," as that position was "not supported by the language of the statute or by [Maine] case law." *Id.* ¶ 24. And the Court stated that it "could not endorse an interpretation of the statute that provides no legal protections for patients before an actual placement in a psychiatric hospital occurs." *Id.* It clarified, however, that LincolnHealth was not required to either discharge the Plaintiff in that case or transfer him to a psychiatric hospital at the end of the 120-hour authorized hold period. *Id.* ¶ 25. Instead, the Law Court held that the hospital could "restart" the process so long as certain requirements were met: a new application along with certifying information had to be supplied, "including adequate and updated information relevant to the individual at that moment in time," and it had to be submitted for judicial endorsement within twenty-four hours after the 120-hour period ends. *Id.* "With a new judicial endorsement in hand, the hospital may then continue its efforts to find an appropriate placement for the patient and will not be required to discharge him." *Id.*

The Law Court in *LincolnHealth* did not, however, have before it the exact issues presented here, and it did not address how many "restarts" are permissible before a patient's due process rights are violated. It seemed satisfied, however, that restarting the process after the 120-hour period, with a new application containing certifying information and updated clinical information on the individual—so long as judicially endorsed—would comport with due process requirements. That process was actually followed here. Importantly, however, the blue paper process was repeated 11 times after the first application was judicially endorsed on October 14, 2022. There is no indication in *LincolnHealth* that the Law Court ever expected that the "restart process" could go on indefinitely, and it stated plainly that patients in A.F.'s circumstances continue to be protected by due process while waiting. *Id.* ¶¶ 24-25. A fair reading of the case would be that the Law Court went as far as it deemed appropriate with the record before it, but that it expected and hoped—along with the hospitals and Maine citizens who reside for extended periods in EDs—that the Executive and Legislative branches of Maine government would remedy what has now become a chronic problem.

The issue here as framed by the Petitioner is that detentions have indeed become indefinite in length for many vulnerable psychiatric patients. MGMC agreed this was the case, and candidly acknowledged that hospitals in Maine are indeed "warehousing" these patients. The parties also agree that the length of time an individual is now detained in Maine's EDs is affected by *how* they are chosen for admission by receiving hospitals, or not, from off the "waiting list." Clearly, the fundamental problem has not been addressed—not enough beds are available—but it is also the case that not everyone on the "waiting list" is treated the same. MGMC claims that this is by necessity and is legal based upon the contract they signed with DHHS. Petitioner claims that her due process rights were violated because there were in fact other "available beds" for A.F. during her long wait. But as her attorney essentially puts it, the beds were just not available *to her.* Pet'r's Br. 11-12. Petitioner therefore asks the Court to interpret the statutes and the contracts between the hospitals and DHHS and find that hospitals do not enjoy unreviewable discretion to reject patients such as A.F. based upon concerns of "acuity" and "milieu."

***4** In any event, the parties seem to recognize that the only reason A.F. was finally placed in a psychiatric unit after 65 days of detention was that she was fortunate to have a medical professional at MGMC who advocated for her and arranged for her to call Disability Rights of Maine to get legal advice. That led to representation, and the filing of this Petition for Writ of Habeas Corpus. Nursing Director Duprey testified, without contradiction, that at MGMC, "We have had people in our emergency department for up to six months." Tr. at 44-45. She emphasized that while their ED did their best to work with patients like A.F., what they are actually able to do is "provide safety with absolutely no treatment." *Id.* at 37. She stated that conditions can be "worse than jail in most situations. We have no outside time, we've got no windows.... [W]e're in four white walls here. So please consider that this place is like jail." *Id.* at 48-49.

The Court will address these issues separately.

FINDINGS AND CONCLUSIONS

DHHS currently contracts with eight private hospitals that contain psychiatric units and requires them to admit and involuntarily hold psychiatric patients, such as A.F., from EDs across the State. In addition, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center can also receive such "blue papered" patients who are waiting for the process of civil commitment—

sometimes referred to as the "white paper" process—to unfold. Section 3863(3)(D)-(E) of Title 34-B sets forth the requirements established by the Legislature in the 2015 amendments, which amendments extended the authority of these hospitals to hold patients up to 120 hours before the hospitals are permitted to "restart" the process pursuant to the Law Court's *LincolnHealth* decision.

A.F. points to two terms in the statute— "available inpatient bed" and "inpatient bed" — which she says are ambiguous, meaning that the terms are "reasonably susceptible to different interpretations." *Estate of Joyce v. Commercial Welding Co.,* 2012 ME 62, ¶ 12, 55 A.3d 411. And because the terms are ambiguous, she claims that they must be construed in this case so as to avoid the unconstitutional result of indefinite detention without due process. The Court disagrees with this analysis, as it has concluded that MGMC followed the requisite statutes as elucidated by the Law Court in *LincolnHealth.* Assuming, without deciding, that these undefined terms are ambiguous, the cases relied upon for this general proposition are cases where an agency has been told it cannot interpret ambiguous terms in a statute or regulation in such a way that it leads to an absurd, or as posited here, an unconstitutional result. It is important to note that the agency in question, DHHS, is not a party to this case. In addition, MGMC entered into a contract that specifically gave it the authority to decline admission to a patient who it deemed to not be "appropriate" for its facility. *See* Ex. 3, ¶¶ 1(b), 2(a)(i).

The reality is that MGMC, like all the other hospitals, are "stuck" with the determinations about "acuity" and "milieu" made by other hospitals, and the other hospitals are "stuck" with determinations made by MGMC. The Court agrees with MGMC that the Court cannot and should not involve itself in making such clinical judgments, particularly when DHHS has apparently bargained away its own right to object to these clinical decisions, presumably to find private hospitals such as MGMC willing to accept patients like A.F.

The Court is also concerned that if it held A.F. should have been admitted by one of the hospitals that declined to accept her, the Court would be blindly consigning another patient to a lower rung on the waiting list, creating an unfavorable or even "unconstitutional" result for the other patient. The Court is not willing to create such unintended and problematic consequences for other patients by ordering that sort of relief here.

***5** Which is not to say that A.F.'s prolonged, indefinite confinement in the ED at MGMC comports with due process. As A.F.'s attorney points out, these multiple Applications, along with the "restart" of the process authorized by the Law Court in *LincolnHealth,* resulted in A.F.'s detention in an ED for 65 days. The Court concludes that given the length and circumstances of her detention, more due process protections for A.F. were required. But for Nurse Duprey's intervention and Disability Rights Maine's willingness to file this case, A.F. could have easily become another patient who lived at MGMC's ED for six months.

The Court therefore concludes that A.F. was entitled to more due process than completion of multiple "blue papers" by District Court Judges at the Capital Judicial Center. The Court finds that due process requires that she was entitled to appointment of counsel once the "restart" of the process failed to result in her admission to a private or State hospital where she could have been further evaluated and treated.

The Court is aware that another Superior Court Justice recently ordered in a very similar Habeas Corpus case, implementation of a process, coordinated with the District Court, to establish a hearing process for a patient who was detained at Northern Light Eastern Maine Medical Center. *See* attached Amended Order, *In re: Singer,* PENSC-MTH-2023-00275 (Nov. 22, 2023). The Superior Court ordered appointment of an examiner, with the consent of Northern Light and her attorney, and further ordered that a hearing would be conducted as part of the Habeas proceeding to determine if the patient met the criteria for involuntary hospitalization. This proceeding was also similar to the hearing conducted by the Lincoln County Superior Court in the *LincolnHealth* case that resulted in the Law Court decision providing for the "restart" process that is one of the issues in this case.

The Court has concluded in this matter that A.F.'s due process rights were violated by the length of her detention at MGMC. She was entitled to appointment of counsel and a hearing before a Maine Court once it became apparent that the "restart" process

would fail to result in admission to a psychiatric hospital where she could be held while the "white paper" process, with its elevated due process protections, would unfold. So while the Court concludes that MGMC did not violate her due process rights by engaging in the current process by which beds are found for patients awaiting admission, A.F.'s due process rights were nevertheless violated while she was in MGMC's custody due to the length and circumstances of her detention.

The Court recognizes that fashioning a remedy in this case presents legal and practical challenges. The Court will therefore order further proceedings to hear from the parties as to what might be constructively done to create a process between MGMC and the District Court at the Capital Judicial Center to provide due process for A.F. and others like her, should these patients find themselves detained at MGMC for similar lengths of time due to the chronic shortage of psychiatric beds. It may be that the parties and the Court will be able to agree upon a process to protect A.F. and others from further violations of due process.

The Clerk is therefore directed to schedule a conference with counsel for the parties to discuss the course of future proceedings. The conference can either occur in person or by Zoom. Notice shall be sent to the parties, as well as to DHHS, which may or may not want to appear and be heard.

CONCLUSION

The entry will be: The Petition for Writ of Habeas Corpus is granted in part based upon the Court's finding that A.F.'s rights to due process were violated by the length of her detention at the MGMC Emergency Department for 65 days without representation or hearing. The Court will conduct further proceedings to determine what remedy, if any, it can legally provide under these circumstances. Notice to follow.

***6** This Order shall be noted on the docket by reference pursuant to Rule 79(a) of the Maine Rules of Civil Procedure.

DATED: 2/13/24

<<signature>>

Michaela Murphy

Justice, Superior Court

Footnotes

1 MGMC does not argue in the post-hearing briefing that this case is moot. And even if it did, the Court concludes that the exceptions to the mootness doctrine applied by the Law Court in *A.S. v. LincolnHealth*—the public interest exception and the repeat presentation exception— apply with equal force here. 2021 ME 6, ¶¶ 8-10, 246 A.3d 157.

End of Document

2024 WL 3568708 (Me.Super.) (Trial Order)
Superior Court of Maine.
Kennebec County

A.F., Petitioner,

v.

MAINEGENERAL MEDICAL CENTER, Respondent.

No. AUGSC-CV-22-189.
April 5, 2024.

Order for Remedy

Michaela Murphy, Justice.

RELIEF

***1** After conference with counsel, the parties have agreed in part with the remedy the Court should provide A.F. in light of the findings and conclusions set out in the Court's previous Order. Their disagreement was limited to the length of time the agreed-upon Remedy should remain available for A.F.

After consideration of their positions, the entry will be:

A.F. shall provide to Respondent, MaineGeneral Medical Center ("MGMC"), an authorization to disclose Petitioner's confidential patient information ("ROI") in which Petitioner directs MGMC to notify Disability Rights Maine if and when Petitioner is being detained in MGMC's Emergency Department pursuant to 34-B M.R.S.A. § 3863, provided that MGMC may not act on any such ROI that is more than one year old. Petitioner shall be responsible for providing a new ROI following the expiration of any prior ROI.

The remedy for A.F. provided herein shall be effective immediately, and will be enforceable for a period of five years.

This Order shall be noted on the docket by reference pursuant to Rule 79(a) of the Maine Rules of Civil Procedure.

DATED: 4/5/24

<<signature>>

Michaela Murphy

Justice, Maine Superior Court

DISABILITY RIGHTS MAINE

"The Beds Were Just Not Available to Her." When Psychiatric Hospitals Refuse to Admit Patients from Emergency Departments

by Mark Joyce | May 24, 2024 | Community Mental Health, Inpatient Psychiatric Settings & Group Homes

In the fall of 2022, Disability Rights Maine (DRM) represented a woman who had been "blue papered"[1] in an emergency department (ED) and was awaiting transfer to a psychiatric bed. She remained in the ED for 65 days until eventually being transferred to a psychiatric unit, two days after DRM filed a Petition for a Writ of Habeas Corpus in the Superior Court against the ED. After receiving treatment, she was discharged back to her apartment.

Her petition acknowledged meeting the standard for emergency involuntary psychiatric hospitalization but argued her due process rights were violated due to the prolonged wait for transfer from the ED to a psychiatric facility.

Some would argue that this case highlights the need for more psychiatric beds in Maine to prevent such lengthy stays in EDs due to long waitlists at psychiatric hospitals. However, a closer examination reveals a different reality.

Although technically moot, the Superior Court held a hearing on her petition even after her discharge. The court, in its opinion, found that her due process rights were indeed violated and she had the right to court appointed legal representation. This opinion is attached as A.F. v. MaineGeneral Medical Center.

The court noted that one reason for her extended stay in the ED was the repeated rejection by numerous psychiatric hospitals, citing reasons such as her acuity level being too high or not fitting their "milieu". This selection process led to her being "stuck" in the ED, as these hospitals could refuse admission without any waitlist.

In its decision the Superior Court observed:

> **Over the course of the 65 days, A.F. was rejected by the following hospitals: Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, Spring Harbor Hospital, Northern Light Acadia Hospital, Southern Maine Medical Center, St. Mary's Regional Medical Center, Mid Coast Hospital, Penobscot Bay Hospital, Maine Medical Center, and MGMC. They all claimed that she was not a good fit for their hospital as her acuity level was too high, or otherwise did not fit their milieu. And these rejections repeatedly occurred while other patients, who were also awaiting admission from MGMC's ED, were admitted to psychiatric hospitals.**

> **The nursing director for the ED at MGMC, testified that there is essentially no "waiting list" for these patients as that term is conventionally understood. Instead, prospective hospitals are permitted to decide whether a patient is a good fit for their facility. If not, the patient and the ED where the patient is being detained, have no option but to accept that decision, and to wait. And wait they did.**

Consequently, A.F. found herself confined to the emergency department until one of these hospitals had a change of heart. However, despite more than two months passing, this change didn't materialize until after she filed her petition in the Superior Court.

Hence, increasing the number of beds would not have eased AF's situation in the ED; it would have merely increased the count of beds inaccessible to her.

The court noted:

> **As her attorney essentially puts it, the beds were just not available *to her*" (emphasis in original).**

How frequently does this scenario unfold, where individuals languish in the ED not due to bed availability but for reasons that could persist indefinitely due to these psychiatric hospitals refusing to admit?

Answering these questions is challenging. The Maine Department of Health and Human Services (DHHS) lacks centralized data on when psychiatric hospitals decline to admit "blue papered" patients from EDs based on reasons such as acuity level or not a good fit for milieu. Consequently, it's difficult to ascertain whether, at a statewide level, individuals remain stuck in the ED primarily due to bed shortages or other reasons.

Furthermore, there's no oversight to evaluate the acceptability of these hospitals' determinations to refuse such patients.

For instance, many hospitals cited the concept of not being a good fit for the "milieu" as a justification for refusing A.F. The court, citing to the testimony of

the ED nursing director, described the conditions in which A.F. was detained in the ED for over two months as follows:

> **The nursing director described the conditions as potentially worse than jail in most cases. There was no outdoor time, no windows, just four white walls. She urged consideration that the environment was akin to being in jail.**

There appears to be insufficient oversight regarding whether psychiatric hospitals' refusal to admit a "blue papered patient" due to their milieu or acuity is justified, particularly when the patient is subjected to conditions akin to jail with minimal treatment while waiting in the ED.

Moreover, it's reasonable to speculate that an individual's acuity level could intensify the longer they are exposed to such an environment, potentially reducing their appeal to psychiatric hospitals that reject admission based on escalating acuity levels.

Despite the DHHS contracting with these hospitals to accept "blue papered" patients, the court found that DHHS had essentially forfeited its right to object to these hospitals' refusal to admit patients like A.F. The court stated:

> **The reality is that MGMC, like all the other hospitals, are "stuck" with the determinations about "acuity" and "milieu" made by other hospitals, and the other hospitals are "stuck" with determinations made by MGMC. The Court agrees with MGMC that the Court cannot and should not involve itself in making such clinical judgments, *particularly when DHHS has apparently bargained away its own right to object to these clinical decisions*, presumably to find private hospitals such as MGMC willing to accept patients like A.F. (emphasis added).**

The court clearly recognized that the system's flaw could have resulted in A.F. being detained indefinitely in the ED as psychiatric hospitals opted for other patients. The court emphasized:

> **But for Nurse Duprey's intervention and Disability Rights Maine's willingness to file this case, A.F. could have easily become another patient who lived at MGMC's ED for six months.**

The court, citing to a recent Maine Supreme Judicial Court decision, further noted that the problem with the system is not something that can be fixed judicially but should be addressed by the Executive and Legislative branches, stating:

> **There is no indication in *LincolnHealth* that the Law Court ever expected that the "restart process" could go on indefinitely, and it stated plainly that patients in AF's circumstances continue to be protected by due process while waiting. A fair reading of the case would be that the Law Court went as far as it deemed appropriate with the record before it, but that it expected and hoped, along with the hospitals and Maine citizens who reside for extended periods in EDs, that the Executive and Legislative branches of Maine government would remedy what has now become a chronic problem.**

The case of A.F. exemplifies the challenges faced by individuals awaiting transfer from emergency departments to psychiatric beds. The Superior Court's observation of her extended emergency department stay, marked by repeated rejections from psychiatric hospitals, underscores systemic issues. The lack of oversight exacerbates the situation, with no centralized data to assess the frequency of such refusals or the appropriateness of hospital decisions. The Superior Court's acknowledgment of the systemic flaw underscores the need for executive and legislative action to address the chronic problem of this type of selection process, as judicial intervention alone cannot rectify the issue. This was underscored by the court's authority being restricted to ordering MaineGeneral to notify DRM if A.F. found herself in the same situation in the emergency department within the next five years.

[1] "Blue papered" is often used to describe Maine's emergency involuntary psychiatric hospitalization process.

2024 WL 3568707 (Me.Super.) (Trial Order)
Superior Court of Maine.
Kennebec County

A.F., Petitioner,

v.

MAINEGENERAL MEDICAL CENTER, Respondent.

No. AUGSC-CV-22-189.
February 13, 2024.

Order on Petition for Writ of Habeas Corpus

Michaela Murphy, Justice.

BACKGROUND

***1** Before the Court is a Petition for a Writ of Habeas Corpus brought by A.F., a 45-year-old deaf woman who suffers from mental illness. She was detained at MaineGeneral Medical Center's ("MGMC") Emergency Department ("ED") for 65 days from October 12, 2022 until December 14, 2022, when MGMC finally admitted her to their A-3 in-patient psychiatric unit.

The Court has considered the evidence at hearing on October 19, 2023, and has considered the written post-hearing arguments of the parties, the last of which was received on December 20, 2023, and has concluded that Petitioner A.F. is entitled to some form of relief, but the Court will be ordering further proceedings to hear arguments as to what form the relief should take.

Petitioner has asked the Court to grant her Petition based upon a finding that hospitals such as MGMC do not enjoy "plenary, unreviewable discretion" to decide which patients they admit from a "waiting list" of patients like A.F. who wait—sometimes for months—to be admitted to a psychiatric hospital after being "blue papered" under Maine law. Petitioner claims she was entitled to appointment of counsel, along with other due process protections, while waiting for placement. She claims hospitals such as MGMC who contract with the Maine Department of Health and Human Services ("DHHS") to admit and treat "blue papered" individuals cannot simply reject a patient such as A.F. by asserting the person does not meet their standards for "acuity" and/or are not a good fit for their "milieu." MGMC asserts that it adhered to and went above and beyond the requirements under Maine law and pursuant to its contract with DHHS.

The parties do agree that under Maine's current system, psychiatric patients such as A.F. are living in emergency rooms across Maine for up to months at a time while they are waiting for admission to psychiatric facilities, including Maine's two State psychiatric hospitals, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, along with the 8 private hospitals that have contracted with the State to accept such patients in their psychiatric units. The parties agree that A.F. was detained at the MGMC ED while awaiting the so-called "white paper process" to unfold. That process carries with it elevated due process protections, including appointment of counsel and which may culminate in a full, confidential hearing before a District Court Judge.

The parties essentially agree as to what happened over the course of those 65 days. A.F. was held against her will at the MGMC ED while the process played out. MGMC provided her basic needs including interpreter services and medication, but she did not receive the same level of psychiatric treatment she would have received had she been admitted to either a State or private psychiatric hospital while being further assessed for court proceedings, nor was she afforded legal representation. The parties

further seem to agree that MGMC followed the "blue paper" process established by the Maine Legislature twelve separate times by completing three statutorily mandated steps: (1) application; (2) certifying examination; and (3) judicial review and endorsement. 34-B M.R.S. §§ 3863(1)-(3). Each time after these steps were completed, a District Court Judge who reviewed and endorsed the application stated, as printed on the form:

> ***2** I find this application and certificate to be regular and in accordance with the law. No psychiatric hospital has been located as of the date of the certifying examination. [A.F.] may remain at [MGMC ED] pending the location of an inpatient bed at a psychiatric hospital or other appropriate alternative subject to the requirements of 34-B M.R.S. § 3863(3). If an available inpatient bed at a psychiatric hospital is located, and the emergency admission of [A.F.] is still sought, the applicant shall immediately notify a judicial officer for final review and endorsement under Section 3.B.2 below.

Ex. 9.

Over the course of the 65 days, A.F. was rejected by the following hospitals: Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, Spring Harbor Hospital, Northern Light Acadia Hospital, Southern Maine Medical Center, St. Mary's Regional Medical Center, Mid Coast Hospital, Penobscot Bay Hospital, Maine Medical Center, and MGMC. They all claimed that she was not a good fit for their hospital as her acuity level was too high, or otherwise did not fit their milieu. And these rejections repeatedly occurred while other patients, who were also awaiting admission from MGMC's ED, were admitted to psychiatric hospitals. Janelynn Duprey, Nursing Director for the ED at MGMC, testified that there is essentially no "waiting list" for these patients as that term is conventionally understood. Instead, prospective hospitals are permitted to decide whether a patient is a good fit for their facility. If not, the patient and the ED where the patient is being detained, have no option but to accept that decision, and to wait. And wait they did.

In A.F.'s case, her waiting finally ended when Nursing Director Duprey, clearly frustrated but undeterred, advised A.F. to contact Disability Rights Maine to take her case. This Petition was soon filed with their assistance. Two days later, MGMC moved A.F. from their ED upstairs to their psychiatric unit.[1]

STANDARD OF REVIEW

Approximately three years ago, the Law Court stated in .4.5. *v. LincolnHealth* that Section 3863 of Title 34-B was "an imprecise 'fit' for what is actually happening in Maine's emergency departments as they struggle to deal with patients who need psychiatric beds at a time when the State has failed to create or fund enough of those beds." 2021 ME 6, ¶ 16, 246 A.3d 157. The Law Court further noted that this statute is one of a very few "that provides the civil authority for a person or entity to hold another person against his wishes." *Id.* In addition, the Law Court recognized the guiding principle from the United States Supreme Court that "'civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.'" *Id.* (quoting *Addington v. Texas,* 441 U.S. 418, 425 (1979)).

Eight years before its decision in *LincolnHealth,* the Law Court held in *In re Marcia E.,* that "[u]nder no circumstances may a hospital hold a person against his or her will for longer than twenty-four hours unless the hospital has obtained a judge's endorsement." 2012 ME 139, ¶ 6, 58 A.3d 1115. Three years later, the Maine Legislature amended Section 3863. *LincolnHealth,* 2021 ME 6, ¶ 20, 246 A.3d 157 (citing P.L. 2015, ch. 309, § 3 (effective July 2, 2015)). The Law Court noted that the amendments did not change the language requiring judicial endorsement within the first twenty-four hours after a person is detained. *Id.* ¶¶ 20-21. It continued:

> ***3** What was changed by the 2015 amendments, however, is the *duration* of the detention that such a judicial endorsement allows. The unambiguous language of the 2015 amendments permits a hospital that obtained judicial endorsement for a patient's detention during the "original" twenty-four-hour period of detention to continue to hold that individual for two additional forty-eight-hour periods if the hospital complies with certain requirements.

Id. ¶ 21 (emphasis in original).

The Law Court rejected LincolnHealth's central premise—that "there is simply no due process for those held by but not admitted to hospitals," as that position was "not supported by the language of the statute or by [Maine] case law." *Id.* ¶ 24. And the Court stated that it "could not endorse an interpretation of the statute that provides no legal protections for patients before an actual placement in a psychiatric hospital occurs." *Id.* It clarified, however, that LincolnHealth was not required to either discharge the Plaintiff in that case or transfer him to a psychiatric hospital at the end of the 120-hour authorized hold period. *Id.* ¶ 25. Instead, the Law Court held that the hospital could "restart" the process so long as certain requirements were met: a new application along with certifying information had to be supplied, "including adequate and updated information relevant to the individual at that moment in time," and it had to be submitted for judicial endorsement within twenty-four hours after the 120-hour period ends. *Id.* "With a new judicial endorsement in hand, the hospital may then continue its efforts to find an appropriate placement for the patient and will not be required to discharge him." *Id.*

The Law Court in *LincolnHealth* did not, however, have before it the exact issues presented here, and it did not address how many "restarts" are permissible before a patient's due process rights are violated. It seemed satisfied, however, that restarting the process after the 120-hour period, with a new application containing certifying information and updated clinical information on the individual—so long as judicially endorsed—would comport with due process requirements. That process was actually followed here. Importantly, however, the blue paper process was repeated 11 times after the first application was judicially endorsed on October 14, 2022. There is no indication in *LincolnHealth* that the Law Court ever expected that the "restart process" could go on indefinitely, and it stated plainly that patients in A.F.'s circumstances continue to be protected by due process while waiting. *Id.* ¶¶ 24-25. A fair reading of the case would be that the Law Court went as far as it deemed appropriate with the record before it, but that it expected and hoped—along with the hospitals and Maine citizens who reside for extended periods in EDs—that the Executive and Legislative branches of Maine government would remedy what has now become a chronic problem.

The issue here as framed by the Petitioner is that detentions have indeed become indefinite in length for many vulnerable psychiatric patients. MGMC agreed this was the case, and candidly acknowledged that hospitals in Maine are indeed "warehousing" these patients. The parties also agree that the length of time an individual is now detained in Maine's EDs is affected by *how* they are chosen for admission by receiving hospitals, or not, from off the "waiting list." Clearly, the fundamental problem has not been addressed—not enough beds are available—but it is also the case that not everyone on the "waiting list" is treated the same. MGMC claims that this is by necessity and is legal based upon the contract they signed with DHHS. Petitioner claims that her due process rights were violated because there were in fact other "available beds" for A.F. during her long wait. But as her attorney essentially puts it, the beds were just not available *to her.* Pet'r's Br. 11-12. Petitioner therefore asks the Court to interpret the statutes and the contracts between the hospitals and DHHS and find that hospitals do not enjoy unreviewable discretion to reject patients such as A.F. based upon concerns of "acuity" and "milieu."

***4** In any event, the parties seem to recognize that the only reason A.F. was finally placed in a psychiatric unit after 65 days of detention was that she was fortunate to have a medical professional at MGMC who advocated for her and arranged for her to call Disability Rights of Maine to get legal advice. That led to representation, and the filing of this Petition for Writ of Habeas Corpus. Nursing Director Duprey testified, without contradiction, that at MGMC, "We have had people in our emergency department for up to six months." Tr. at 44-45. She emphasized that while their ED did their best to work with patients like A.F., what they are actually able to do is "provide safety with absolutely no treatment." *Id.* at 37. She stated that conditions can be "worse than jail in most situations. We have no outside time, we've got no windows.... [W]e're in four white walls here. So please consider that this place is like jail." *Id.* at 48-49.

The Court will address these issues separately.

FINDINGS AND CONCLUSIONS

DHHS currently contracts with eight private hospitals that contain psychiatric units and requires them to admit and involuntarily hold psychiatric patients, such as A.F., from EDs across the State. In addition, Riverview Psychiatric Center and Dorothea Dix Psychiatric Center can also receive such "blue papered" patients who are waiting for the process of civil commitment—

sometimes referred to as the "white paper" process—to unfold. Section 3863(3)(D)-(E) of Title 34-B sets forth the requirements established by the Legislature in the 2015 amendments, which amendments extended the authority of these hospitals to hold patients up to 120 hours before the hospitals are permitted to "restart" the process pursuant to the Law Court's *LincolnHealth* decision.

A.F. points to two terms in the statute— "available inpatient bed" and "inpatient bed" — which she says are ambiguous, meaning that the terms are "reasonably susceptible to different interpretations." *Estate of Joyce v. Commercial Welding Co.,* 2012 ME 62, ¶ 12, 55 A.3d 411. And because the terms are ambiguous, she claims that they must be construed in this case so as to avoid the unconstitutional result of indefinite detention without due process. The Court disagrees with this analysis, as it has concluded that MGMC followed the requisite statutes as elucidated by the Law Court in *LincolnHealth.* Assuming, without deciding, that these undefined terms are ambiguous, the cases relied upon for this general proposition are cases where an agency has been told it cannot interpret ambiguous terms in a statute or regulation in such a way that it leads to an absurd, or as posited here, an unconstitutional result. It is important to note that the agency in question, DHHS, is not a party to this case. In addition, MGMC entered into a contract that specifically gave it the authority to decline admission to a patient who it deemed to not be "appropriate" for its facility. *See* Ex. 3, ¶¶ 1(b), 2(a)(i).

The reality is that MGMC, like all the other hospitals, are "stuck" with the determinations about "acuity" and "milieu" made by other hospitals, and the other hospitals are "stuck" with determinations made by MGMC. The Court agrees with MGMC that the Court cannot and should not involve itself in making such clinical judgments, particularly when DHHS has apparently bargained away its own right to object to these clinical decisions, presumably to find private hospitals such as MGMC willing to accept patients like A.F.

The Court is also concerned that if it held A.F. should have been admitted by one of the hospitals that declined to accept her, the Court would be blindly consigning another patient to a lower rung on the waiting list, creating an unfavorable or even "unconstitutional" result for the other patient. The Court is not willing to create such unintended and problematic consequences for other patients by ordering that sort of relief here.

***5** Which is not to say that A.F.'s prolonged, indefinite confinement in the ED at MGMC comports with due process. As A.F.'s attorney points out, these multiple Applications, along with the "restart" of the process authorized by the Law Court in *LincolnHealth,* resulted in A.F.'s detention in an ED for 65 days. The Court concludes that given the length and circumstances of her detention, more due process protections for A.F. were required. But for Nurse Duprey's intervention and Disability Rights Maine's willingness to file this case, A.F. could have easily become another patient who lived at MGMC's ED for six months.

The Court therefore concludes that A.F. was entitled to more due process than completion of multiple "blue papers" by District Court Judges at the Capital Judicial Center. The Court finds that due process requires that she was entitled to appointment of counsel once the "restart" of the process failed to result in her admission to a private or State hospital where she could have been further evaluated and treated.

The Court is aware that another Superior Court Justice recently ordered in a very similar Habeas Corpus case, implementation of a process, coordinated with the District Court, to establish a hearing process for a patient who was detained at Northern Light Eastern Maine Medical Center. *See* attached Amended Order, *In re: Singer,* PENSC-MTH-2023-00275 (Nov. 22, 2023). The Superior Court ordered appointment of an examiner, with the consent of Northern Light and her attorney, and further ordered that a hearing would be conducted as part of the Habeas proceeding to determine if the patient met the criteria for involuntary hospitalization. This proceeding was also similar to the hearing conducted by the Lincoln County Superior Court in the *LincolnHealth* case that resulted in the Law Court decision providing for the "restart" process that is one of the issues in this case.

The Court has concluded in this matter that A.F.'s due process rights were violated by the length of her detention at MGMC. She was entitled to appointment of counsel and a hearing before a Maine Court once it became apparent that the "restart" process

would fail to result in admission to a psychiatric hospital where she could be held while the "white paper" process, with its elevated due process protections, would unfold. So while the Court concludes that MGMC did not violate her due process rights by engaging in the current process by which beds are found for patients awaiting admission, A.F.'s due process rights were nevertheless violated while she was in MGMC's custody due to the length and circumstances of her detention.

The Court recognizes that fashioning a remedy in this case presents legal and practical challenges. The Court will therefore order further proceedings to hear from the parties as to what might be constructively done to create a process between MGMC and the District Court at the Capital Judicial Center to provide due process for A.F. and others like her, should these patients find themselves detained at MGMC for similar lengths of time due to the chronic shortage of psychiatric beds. It may be that the parties and the Court will be able to agree upon a process to protect A.F. and others from further violations of due process.

The Clerk is therefore directed to schedule a conference with counsel for the parties to discuss the course of future proceedings. The conference can either occur in person or by Zoom. Notice shall be sent to the parties, as well as to DHHS, which may or may not want to appear and be heard.

CONCLUSION

The entry will be: The Petition for Writ of Habeas Corpus is granted in part based upon the Court's finding that A.F.'s rights to due process were violated by the length of her detention at the MGMC Emergency Department for 65 days without representation or hearing. The Court will conduct further proceedings to determine what remedy, if any, it can legally provide under these circumstances. Notice to follow.

***6** This Order shall be noted on the docket by reference pursuant to Rule 79(a) of the Maine Rules of Civil Procedure.

DATED: 2/13/24

<<signature>>

Michaela Murphy

Justice, Superior Court

Footnotes

1 MGMC does not argue in the post-hearing briefing that this case is moot. And even if it did, the Court concludes that the exceptions to the mootness doctrine applied by the Law Court in *A.S. v. LincolnHealth*—the public interest exception and the repeat presentation exception— apply with equal force here. 2021 ME 6, ¶¶ 8-10, 246 A.3d 157.

2024 WL 3568708 (Me.Super.) (Trial Order)
Superior Court of Maine.
Kennebec County

A.F., Petitioner,

v.

MAINEGENERAL MEDICAL CENTER, Respondent.

No. AUGSC-CV-22-189.
April 5, 2024.

Order for Remedy

Michaela Murphy, Justice.

RELIEF

***1** After conference with counsel, the parties have agreed in part with the remedy the Court should provide A.F. in light of the findings and conclusions set out in the Court's previous Order. Their disagreement was limited to the length of time the agreed-upon Remedy should remain available for A.F.

After consideration of their positions, the entry will be:

A.F. shall provide to Respondent, MaineGeneral Medical Center ("MGMC"), an authorization to disclose Petitioner's confidential patient information ("ROI") in which Petitioner directs MGMC to notify Disability Rights Maine if and when Petitioner is being detained in MGMC's Emergency Department pursuant to 34-B M.R.S.A. § 3863, provided that MGMC may not act on any such ROI that is more than one year old. Petitioner shall be responsible for providing a new ROI following the expiration of any prior ROI.

The remedy for A.F. provided herein shall be effective immediately, and will be enforceable for a period of five years.

This Order shall be noted on the docket by reference pursuant to Rule 79(a) of the Maine Rules of Civil Procedure.

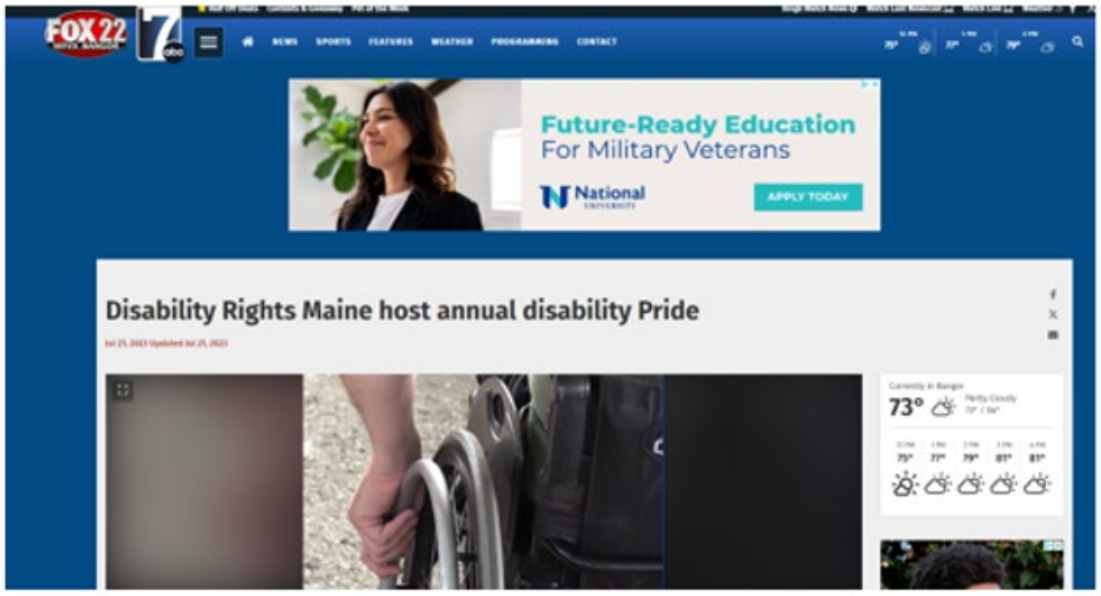
DATED: 4/5/24

<<signature>>

Michaela Murphy

Justice, Maine Superior Court

https://www.wabi.tv/2024/07/19/6th-annual-disability-pride-day/



https://www.foxbangor.com/news/local/disability-rights-maine-host-annual-disability-pride/article_7ae3918c-2811-11ee-8dfd-6b608083ac3c.html

G. PAIMI Budget - Actual

PAIMI Budget

Planning Period From **10/1/2023** to **9/30/2024**

In this section, provide actual expenditures for the FY. Refer to the PAIMI Application [Appendix C] submitted to SAMHSA/CMHS for the same FY. For additional information regarding this Section, please review the PPR Instructions.

PAIMI BUDGET-ACTUAL

*** Indicates a required field**

I. Personnel/Name/Title (Active for PAIMI Supervisor only)

In the section below for each funded staff position provide the name, title, annual salary, level of effort - full time equivalent charged to the PAIMI grant, and the costs billed to the PAIMI grant for each position. Please only include the current FFY's budget figures and use the footnotes to describe methodology and any additional funding carried over from previous years.

Personnel/Name/Title *	Annual Salary * "A"	Total PAIMI Share * "B"	Percent/Level of Effort to PAIMI "B" / "A" = "C"	Comments
Executive Director	$ 165,000.00	$ 17,575.00	10.7 %	Kim Moody
Intake Specialist	$ 67,392.00	$ 4,555.00	6.8 %	Sara Squires
Intake Specialist	$ 62,291.00	$ 6,648.00	10.7 %	Fern Nadeau
Advocate/Case Manager	$ 30,000.00	$ 6,145.00	20.5 %	Cathy Bustin - Term: 02/11/24
Attorney	$ 76,000.00	$ 31,643.00	41.6 %	Kevin Voyvodich
Attorney	$ 96,720.00	$ 7,831.00	8.1 %	Peter Rice - Managing Attorney
Attorney	$ 89,856.00	$ 3,268.00	3.6 %	Atlee Reilly
Senior Staff Attorney	$ 27,496.00	$ 3,027.00	11.0 %	Sheila Hansen
Senior Staff Attorney	$ 97,600.00	$ 63,453.00	65.0 %	Mark Joyce
Attorney	$ 71,580.00	$ 268.00	0.4 %	Clayton Adams Term: 03/20/24
Other (List title in the Comments box)	$ 48,000.00	$ 91.00	0.2 %	Suzzanne Doiron - Admin Coordinator Term: 10/06/23
Director of Finance	$ 96,500.00	$ 10,385.00	10.8 %	Shannon Crocker
Administration	$ 28,641.00	$ 3,200.00	11.2 %	Susan Schroeder
Administration	$ 60,795.00	$ 5,437.00	8.9 %	Tammy Cunningham
Administration	$ 50,809.00	$ 4,836.00	9.5 %	Linda Leighton
Other (List title in the Comments box)	$ 78,408.00	$ 8,366.00	10.7 %	Katrina Ringrose - Deputy Director
Other (List title in the Comments box)	$ 53,500.00	$ 307.00	0.6 %	Harper Chance - Operations Director DOH 05/20/24
Administration	$ 24,960.00	$ 1,600.00	6.4 %	Susan Adams, Admin Asst. DOH 02/12/24
Administration	$ 27,496.00	$ 810.00	2.9 %	Jeanne Curtin DOH Term: 01/16/24
Administration	$ 64,800.00	$ 4,187.00	6.5 %	Julia Endicott - Communications Director
Attorney	$ 64,800.00	$ 33,791.00	52.1 %	Emily Mott - DOH 09-20-23
Attorney	$ 63,000.00	$ 3,407.00	5.4 %	Christina Reese - DOH 03/05/24
Advocate/Case Manager	$ 39,639.00	$ 219.00	0.6 %	Casey Escobar DOH 05/14/19
Advocate/Case Manager	$ 53,816.00	$ 884.00	1.6 %	Mary Green DOH 09/08/20
Advocate/Case Manager	$ 50,467.00	$ 1,904.00	3.8 %	Carlene Mahaffey DOH 07/06/21
Advocate/Case Manager	$ 16,462.00	$ 1,393.00	8.5 %	Jane Moore DOH 06/26/17
Attorney	$ 78,100.00	$ 283.00	0.4 %	Matthew Main - Term 02/24/24
	$ 1,684,128.00	$ 225,513.00		

II. Fringe Benefits

Please only include the current FFY's budget figures and document all other figures in the footnote. Please also describe methodology in the footnotes.

Fringe Breakdown *	Annual Salary * "A"	Total PAIMI Share * "B"	Percent/Level of Effort to PAIMI "B" / "A" = "C"	Comments
Other (Describe the line item in the Comments box)	$ 26,567.00	$ 1,834.00	6.9 %	Cash Benefit in lieu of Health Insurance
FICA/Medicare	$ 210,145.00	$ 18,860.00	9.0 %	FICA
Other (Describe the line item in the Comments box)	$ 310,313.00	$ 24,662.00	7.9 %	Healthcare
Dental Insurance	$ 22,856.00	$ 1,718.00	7.5 %	Dental Insurance
State Unemployment Insurance	$ 10,595.00	$ 949.00	9.0 %	Unemployment Insurance
Other (Describe the line item in the Comments box)	$ 1,646.00	$ 135.00	8.2 %	Life Insurance

Workers Compensation	$ 6,087.00	$ 427.00	7.0 %	Workers Compensation
Employer Match-Retirement	$ 105,466.00	$ 11,124.00	10.5 %	Retirement - Employer Match
Long Term Disability Insurance	$ 11,066.00	$ 916.00	8.3 %	Long Term Disability Insurance
	$ 704,741.00	$ 60,625.00		

III. Travel Expenses

Please only include the current FFY's budget figures and document all other figures (carryover) in the footnote. Using the comment field or footnote, provide the purpose of travel number of staff, PAIMI Advisory Council or board members traveling for each event, and per diem: describe the number of nights and purpose. There is a 10% limit on training, technical assistance and travel expenses [42 CFR 51.6 (3) (e)].

Travel Expenses *	Actual Cost * "A"	Total PAIMI Share * "B"	Percent/Level of Effort to PAIMI "B" / "A" = "C"	Comments
Lodging for Meetings	$ 17,631.30	$ 2,179.00	12.4 %	NARPA and other overnights as necessary
Mileage	$ 84,148.00	$ 5,375.00	6.4 %	10065 Miles for 12 staff Rate of $0.585 per mile Distance travelled can range up to 600 miles round trip
	$ 101,779.30	$ 7,554.00		

IV. Equipment

Include communications and rental equipment directly related to PAIMI project activities. Please only include the current FFY's budget figures and use the footnote to describe any additional funding carried over from previous years.**

Equipment *	Actual Cost * "A"	Total PAIMI Share * "B"	Percent/Level of Effort to PAIMI "B" / "A" = "C"	Comments
Other (Describe the line item in the Comments box)	$ 71,922.00	$ 6,654.00	9.3 %	Repair & Maintenance
Equipment Rental	$ 21,440.00	$ 2,232.00	10.4 %	Copier and postage machine through Pitney Bowes
	$ 93,362.00	$ 8,886.00		

** Per 45 CFR Part 75: Equipment means tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level established by the non-Federal entity for financial statement purposes, or $5,000. See also Capital assets, Computing devices, General purpose equipment, Information technology systems, Special purpose equipment, and Supplies.

V. Supplies

Please list the supplies (both the category of items and the value) expended through using PAIMI funds. Use the comments field to describe the supplies.

Supplies *	Actual Cost * "A"	Total PAIMI Share * "B"	Percent/Level of Effort to PAIMI "B" / "A" = "C"	Comments
Maintenance/Supplies	$ 71,854.00	$ 4,694.00	6.5 %	Supplies
Other (Describe the line item in the Comments box)	$ 8,341.00	$ 465.00	5.6 %	Printing
Network/Computer	$ 18,968.00	$ 1,792.00	9.4 %	Telephone
Internet Services	$ 5,763.00	$ 544.00	9.4 %	Internet/Email
Postage	$ 7,183.00	$ 675.00	9.4 %	Postage
Other (Describe the line item in the Comments box)	$ 4,002.00	$ 215.00	5.4 %	Library Fees
	$ 116,111.00	$ 8,385.00		

VI. Contractual/Consultant Costs

In the section below provide budget expenditure information for each contractual arrangement for PAIMI program services. Any sub-contract that exceeds $25,000 must be pre-approved by SAMHSA Grants Management Officer. Only include the current FFY's budget figures and use the footnote to describe any additional funding carried over from previous years.

Position or Entity*	Service Provided*	Actual Cost* "A"	Total PAIMI Share* "B"	Percent to PAIMI "B" / "A" = "C"	Comments
Subcontractors		$ 229,124.00	$ 10,657.00	4.7 %	Five subcontractors, two of which are being paid more than $25k but are not being paid out of PAIMI
Misc		$ 17,089.00	$ 0.00	0.0 %	Miscellaneous
Interpreters		$ 50,357.00	$ 1,518.00	3.0 %	Interpreters
Casual Labor		$ 3,788.00	$ 346.00	9.1 %	Casual Labor - Temporary or temp-to-hire employees through a temp agency as needed
		$ 300,358.00	$ 12,521.00		

VII. Technical Assistance/Training Costs

In the section below provide technical assistance and training costs for staff, governing board and advisory council members. Explain the training costs in the comment field (i.e. number of meetings, number of participants, explanation of staff travel cost). Only include the current FFY's budget figures; document all other figures in the footnotes. There is a 10% limit on training, technical assistance and travel expenses [42 CFR 51.6 (3) (e)].

Technical Assistance/Training Costs *	Actual Cost * "A"	Total PAIMI Share * "B"	Percent/Level of Effort to PAIMI "B" / "A" = "C"	Comments
(explain costs in the comment field i.e number of meetings and number of participants)				

Other (Describe the line item in the Comments box)	$ 58,106.00	$ 2,575.00	4.4 %	Staff Trainings
Advisory Council meetings	$ 4,011.00	$ 3,088.00	77.0 %	Advisory Council Expenses. Including meetings, travel, trainings, etc as needed.
Other (Describe the line item in the Comments box)	$ 25,622.00	$ 2,360.00	9.2 %	Audit
Governing Board meetings	$ 1,597.00	$ 49.00	3.1 %	Board Expenses
	$ 89,336.00	$ 8,072.00		

VIII. Other Expenses

Please include any other expenses that used Federal PAIMI funds but do not fit into the prior categories. "Litigation" is an example. Please be as specific as possible the nature of other indicated expenses.

Other Expenses *	Actual Cost * "A"	Total PAIMI Share * "B"	Percent/Level of Effort to PAIMI "B" / "A" = "C"	Comments
Rent ? Office Space: (1) Location ? identify full address	$ 146,612.00	$ 14,467.00	9.9 %	Occupancy 160 Capitol St., Suite 4 Augusta, ME 04330 1 Mackworth Island, Bldg. C Falmouth, ME 04105
Other (Describe the line item in the Comments box)	$ 12,011.00	$ 1,093.00	9.1 %	Janitorial
Other (Describe the line item in the Comments box)	$ 12,798.00	$ 1,198.00	9.4 %	Utlities
Other (Describe the line item in the Comments box)	$ 7,179.00	$ 644.00	9.0 %	Litigation/Client Expense
Other (Describe the line item in the Comments box)	$ 100,490.00	$ 804.00	0.8 %	Payroll Services
Dues and Memberships	$ 70,887.00	$ 6,940.00	9.8 %	Dues and Memberships, DAD, PANDA, Westlaw, etc
Insurance	$ 23,539.00	$ 1,885.00	8.0 %	Insurance - business
Other (Describe the line item in the Comments box)	$ 4,823.00	$ 1,269.00	26.3 %	Legal Expenses
Other (Describe the line item in the Comments box)	$ 41,240.00	$ 1,710.00	4.1 %	Agency Development
Other (Describe the line item in the Comments box)	$ 12,479.00	$ 1,028.00	8.2 %	Admin Fees
Other (Describe the line item in the Comments box)	$ 19,331.00	$ 994.00	5.1 %	Annual Meeting
Other (Describe the line item in the Comments box)	$ 2,464.00	$ 154.00	6.3 %	Recruitment
	$ 453,853.00	$ 32,186.00		

IX. Indirect Costs

Attach a copy of the approved rate agreement. Federally approved IDC rate.

No Data Available

X. Carryover of PAIMI Funds Only

Carryover for FY 2023	$ 113,099.00

Please upload your budget plan for 2023 carryover funds

	Total Actual Cost	Total PAIMI Share
Total PAIMI Costs	$ 3,543,668.30	$ 363,742.00

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Footnotes:

FY24 Carryover: $109,958

		FY2023 Carryover		
		113,099		
1	Personnel			
	Executive Director	5,249	14%	Kim
	Intake Specialist	1,361	9%	Sara
	Intake Specialist	1,986	14%	Fern
	Advocate	1,835	27%	Catherine
	Attorney	9,452	54%	Kevin
	Attorney	2,339	11%	Peter
	Attorney	976	5%	Atlee
	Administration	904	14%	Sheila
	Attorney	23,403	89%	Mark
	Attorney	80	0%	Clayton
	Administration	27	0%	Suzzanne
	CFO	3,102	14%	Shannon
	Administration	956	15%	Susan S.
	Administration	1,624	12%	Tammy
	Administration	1,445	12%	Linda
	Deputy Director	2,499	14%	Katrina
	Operations Director	92	1%	Harper
	Administration	478	8%	Susan A.
	Administration	242	4%	Jeanne
	Communications Director	1,251	8%	Julia
	Attorney	10,093	68%	Emily
	Attorney	1,018	7%	Christina
	Advocate	65	1%	Casey
	Advocate	264	2%	Mary
	Advocate	569	5%	Carlene
	Advocate	416	12%	Jane
	Attorney	85	0%	Matthew
		71,810		
2	Fringe		%	
	Other	548	10%	Cash Benefit
	FICA	5,633	16%	FICA
	Other	7,366	15%	Health
	Dental	513	11%	Dental
	SUI	283	13%	SUTA
	Other	40	10%	Life Ins
	Workers Comp	128	12%	Workers Comp
	Retirement	3,323	27%	Retirement
	LTD	274	15%	LTD
		18,109		
3	Travel		%	
	Lodging	651	100%	NARPA
	Mileage	1,606	100%	

		2,257		
4	Equipment			
	Other R&M	1,987	100%	R&M
	Equipment Rental	667	100%	
		2,654		
5	Supplies			
	Supplies	1,402	100%	
	Other	139	100%	Printing
	Network Computer	535	100%	5535 Telephone
	Internet	163	100%	
	Postage	201	100%	
	Other	64	100%	Libraries
		2,504		
6	Contractual			
	Subcontractors	3,183	100%	
	Interpreters	453	100%	
	Casual Labor	103	100%	
		3,740		
7	Technical Assistance			
	Other	769	100%	Staff Trainings
	Advisory Council meetings	923	100%	
	Other	705	100%	Audit
	Governing Board meetings	14	100%	
		2,411		
8	Other Expenses			
	Rent	4,321	100%	Occupancy
	Other Expenses	326	100%	Janitorial
	Other Expenses	358	100%	Utilities
	Other Expenses	193	100%	Litigation
	Other Expenses	240	100%	Payroll Services
	Dues	2,073	100%	Dues & Membership
	Insurance	563	100%	Insurance
	Other Expenses	379	100%	Legal Expenses
	Other Expenses	511	100%	Agency Development
	Other Expenses	307	100%	Admin Fees
	Other Expenses	297	100%	Annual Meeting
	Other Expenses	46	100%	Recruitment
		9,614		
		113,099.00		

G. PAIMI Budget - Actual

PAIMI Expenditures and Revenues

PAIMI Expenditures	
1. Does your P&A have an approved Federal indirect cost rate? If yes, what is the approved rate?	○ Yes ◉ No 0.05% %
2. Total indirect costs	$0
3. Total of all PAIMI program costs listed in **I - VIII** in the Budget	$363,742
Total	**$363,742**

Income sources and other resources (PAIMI program only)	
1. PAIMI program carryover of grant funds identified by FY.	
2. Program income (PAIMI only)	$0
3. State	$0
4. Other funding sources [identify each source]	
Total of all PAIMI Program resources.	**$0**

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Footnotes:

H. Statement of Priorities & Objectives

PAIMI Program Statement of Priorities and Objectives - Report

The PAIMI Program Statement of Priorities and Objectives (SPOs) **must be specific** to individuals with significant mental illness (adults) and/or significant emotional impairment (children/youth), as determined by a mental health professional qualified under the laws and regulations of the state in accordance with 42 U.S.C.A. § 10802(4) (A). The SPOs in the PPR **must match** the same format and order approved in the FY 2024 PAIMI Application.

Priority/Goal Description: PRIORITY 1 – Abuse, Neglect and Rights Violations: PAIMI-eligible individuals will be safe from abuse and neglect, and will be guaranteed personal rights.

Objective: OBJECTIVE 1.1 DRM will assist PAIMI-eligible individuals who are being abused or neglected or whose rights are being violated. This will be limited to PAIMI-eligible individuals living in facilities who are being physically, sexually, seriously verbally abused or financially exploited; • PAIMI-eligible individuals living in the community who are being physically or sexually abused by individuals who have an affirmative duty to protect, treat, care for, educate or provide services; • PAIMI-eligible individuals living in facilities or in the community who are being neglected through the deprivation of essential goods and services by individuals who have an affirmative duty to protect, treat, care for, educate or provide services individuals who are denied due process of law when restricted in the exercise of basic rights; and, • PAIMI-eligible individuals whose rights with respect to governmental benefits or services or to critical services are violated. Critical services include health services; legal services; education; transportation; telecommunications; and other services without which the client would be at risk of injury or at risk of entering a restrictive facility.

Strategies Used: Collaboration,Systemic Litigation,Rights-Based Individual Advocacy Services,Educating Policy Makers,Investigations of Abuse and Neglect,Other Systemic Advocacy,Monitoring,Training/Outreach

Target Measures

Target Population:	Target Population: PAIMI-eligible individuals who are subject to abuse, neglect or financial exploitation and who are living in facilities; PAIMI-eligible individuals living in the community, who are subject to abuse or neglect by a person with an affirmative duty; PAIMI-eligible individuals who are denied due process of law when restricted in the exercise of basic rights; PAIMI-eligible individuals who are wrongfully denied governmental or critical services.
Expected Target:	40
Expected Outcome:	40
Actual Outcome:	116
Achieved: (●) **Not Achieved:** ( )	

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

During a monitoring visit to a juvenile detention facility DRM met a 13-year-old boy, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, who expressed concerns about access to mental health services, including individual counseling. DRM advocated on the client's behalf including collaborating with his guardian and defense attorney to prepare for his successful transition back into the community. Following his release, the client now receives home and community-based treatment services, case management, and educational support through his IEP, setting him on a path toward stability and success.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 37-year-old man won his court commitment hearing conducted via video link but was refused immediate release by the psychiatric hospital, which cited paperwork delays and attempted to return him to a locked unit. The client contacted DRM, objecting to the violation of the court's order. DRM intervened, engaging with hospital staff and emphasizing their lack of legal authority to detain the patient further. As a result, the hospital complied, and the client was allowed to leave immediately, securing his freedom as ordered by the court.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 52-year-old man under involuntary psychiatric hospitalization was initially denied the right to attend a clinical review hearing regarding psychotropic medication, contrary to state law requiring his participation and ability to cross-examine witnesses. The hospital cited safety concerns as justification. DRM filed an objection, highlighting due process violations. Acknowledging the validity of DRM's concerns, the

hospital reversed its decision, allowing the patient to attend and cross-examine witnesses, ensuring the hearing adhered to legal requirements and safeguarded the patient's rights.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 24-year-old man, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, who uses a wheelchair was receiving treatment at a Crisis Stabilization Unit (CSU) where staff refused to allow his Personal Care Attendant (PCA) to assist with essential activities they were unable to provide. This refusal left the client struggling to meet basic needs and jeopardized his overall care. Recognizing the urgency of the situation, DRM intervened, speaking directly with the CSU manager to advocate for the client's rights. Following DRM's involvement, the CSU agreed to allow the PCA to provide necessary support. This resolution not only ensured the client received adequate care during treatment.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 52-year-old woman, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, was a patient on a hospital medical unit and was denied access to a telephone due to her mental health diagnosis, preventing her from attending a scheduled phone appointment with her attorney. DRM was contacted by her case manager and responded immediately. After speaking with the client and hospital staff, DRM ensured a phone was placed in her room and assisted her in making the call. This intervention upheld the client's right to equal treatment and access to legal representation.

Objective: OBJECTIVE 1.2 DRM, in coordination with the PAC and other organizations, will conduct projects that promote the protection of PAIMI-eligible individuals from abuse, neglect and rights violations.

Strategies Used: Collaboration,Educating Policy Makers,Other Systemic Advocacy,Monitoring,Training/Outreach

Target Measures

Target Population:	Target Population: PAIMI-eligible individuals who are subject to abuse, neglect, exploitation, or restriction of their rights. Target: DRM will conduct at least 5 projects.
Expected Target:	5
Expected Outcome:	5
Actual Outcome:	26
Achieved: (●) **Not Achieved:** ( )	

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

Law enforcement officers frequently interact with individuals experiencing mental health crises, balancing public safety with the responsibility to ensure these individuals are directed toward appropriate community treatment options rather than unnecessary incarceration. Specialized police liaisons often play a critical role in this process, including taking individuals into protective custody and transporting them to emergency departments for mental health assessments.
Recognizing the importance of equipping these officers with the knowledge and tools to navigate these situations effectively, DRM conducted a training for police liaison officers. The training focused on the legal framework surrounding patient rights in the community and highlighted the resources available to individuals in crisis. By enhancing the understanding of these officers, DRM supported their efforts to connect individuals with mental health treatment options and reduce reliance on the criminal justice system for managing mental health crises.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

Social workers and clinicians in inpatient psychiatric hospitals often encounter challenges when addressing complex cases involving patients with court-ordered guardians or situations where guardianship is considered the only solution to ensure treatment. However, guardianship can be overly restrictive, stripping individuals of autonomy and potentially creating adversarial dynamics that hinder engagement with treatment and community reintegration.
To address these concerns, DRM provided a training for psychiatric hospital staff on the legal framework of guardianship, its associated challenges, and the importance of exploring less restrictive alternatives, such as supported decision-making. The training emphasized how these alternatives can empower individuals to maintain autonomy while addressing clinical and safety concerns. By equipping staff with this knowledge, DRM supported efforts to prioritize patient-centered approaches that foster independence and community engagement without unnecessarily resorting to guardianship.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

The psychiatric ward of a general hospital hosts an annual Behavioral Health Skills Fair, requiring all employees to participate. This event, held in a large conference room, features booths from various organizations, including community mental health providers, law enforcement, first responders, and advocacy groups. Employees visit each booth to learn about available services, resources, and collaborations, ensuring comprehensive exposure to the support systems integral to behavioral health care.
DRM staffed a booth at the event, providing employees with information on patient rights, community resources, and the services DRM offers. By engaging directly with hospital staff, DRM emphasized its role as an advocacy organization and equipped participants with the knowledge to support individuals with mental health needs effectively. This outreach effort reinforced the importance of integrating rights-based approaches into behavioral health care.

Priority/Goal Description: PRIORITY 2 – Community Inclusion: PAIMI-eligible individuals will live in the communities of their choice and be fully included in all aspects of community life as they may choose

Objective: OBJECTIVE 2.1 Obtain increased community inclusion for PAIMI-eligible individuals who are living in or at risk of entering facilities and who are being denied opportunity to live in the community of their choice or who are being denied opportunity to participate in community life.

Strategies Used: Collaboration,Rights-Based Individual Advocacy Services,Educating Policy Makers,Investigations of Abuse and Neglect,Other Systemic Advocacy,Monitoring,Training/Outreach

Target Measures

Target Population: PAIMI-eligible individuals living in or at risk of entering restrictive facilities who wish to live in more inclusive environments. PAIMI-eligible individuals whose supports, treatment or treatment plans impede participation in community life.

Expected Target: 10

Expected Outcome: 10

Actual Outcome: 54

Achieved: (●) **Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

During an outreach visit to a Crisis Stabilization Unit (CSU), DRM met a 62-year-old woman who wanted her Assertive Community Treatment (ACT) case manager to assist with her housing needs while she was at the CSU. Medicaid rules require that ACT client have a diagnosis of a significant mental illness or emotional impairment by a qualified Maine Mental Health professional as a condition of admission to the service. The ACT case manager denied the request, citing concerns about potential Medicaid "double billing." DRM contacted the state agency overseeing CSU contracts to clarify ACT team responsibilities. Following this intervention, the ACT team agreed to work with the client, providing the support she needed to stay in the community.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

During a monitoring visit, DRM met a 53-year-old veteran who was a patient at a psychiatric hospital who expressed concerns about inadequate discharge planning. The client identified two key issues: reactivating his Social Security benefits, which had been stopped when he moved to Maine, and exploring eligibility for veterans' mental health case management services. DRM engaged with the hospital's patient rights coordinator, ensuring action was taken to resolve the Social Security income issue. Additionally, DRM connected the hospital with a veterans' mental health case management provider to explore services for which the client might qualify, improving his transition and access to resources in the community.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

During outreach visit to a Crisis Stabilization Unit (CSU) DRM assisted a 28-year-old man, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, in resolving issues with his social security benefits. The client, who was homeless, had not received his retroactive benefits check, which had been sent to an inaccessible address. With DRM's help, the client contacted the Social Security Administration (SSA) to advocate for the cancellation of the original check and the deposit of the funds into his bank account. The SSA complied, enabling the client to access his benefits and achieve greater financial stability necessary for his success in the community.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

During outreach to a psychiatric hospital DRM met with a 44 year old patient. While the client was still hospitalized, DRM uncovered that he lacked any plans for community-based case management post-discharge—an oversight that could have jeopardized his recovery and reintegration. DRM stepped in, assisting the client in contacting agencies, navigating the often complex assessment process, and successfully securing his acceptance into a case management program ensuring he had this critical resource necessary he transitioned back into the community

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 63-year-old involuntary psychiatric hospital patient abruptly lost access to his community case management services when his provider terminated support during his inpatient psychiatric hospitalization, leaving him without essential advocacy and coordination of care necessary for discharge. DRM promptly intervened, contacting the agency to underscore the critical importance of maintaining continuity of care for patients in vulnerable situations.
Following DRM's advocacy, the agency reinstated the client's case management services, ensuring he received the necessary support to navigate his hospitalization effectively and safeguarding his access to essential resources and care planning.

Objective: OBJECTIVE 2.2 DRM, in coordination with the PAC and other organizations will conduct projects that promote community inclusion for PAIMI-eligible individuals.

Strategies Used: Collaboration,Educating Policy Makers,Other Systemic Advocacy,Training/Outreach

Target Measures

Target Population:	PAIMI-eligible individuals living in unnecessarily restrictive facilities or at risk of entering such facilities. PAIMI-eligible individuals who receive less than adequate service or treatment and discharge planning, such that achievement of community integration is compromised. PAIMI-eligible veterans with mental health needs who are excluded from or having difficulty obtaining community mental health related services
Expected Target:	6
Expected Outcome:	6
Actual Outcome:	8
Achieved: (●) **Not Achieved:** ( )	

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

Maine regulations governing the rights of adults and children receiving mental health services have remained largely unchanged for over 30 years. The legislature tasked the Office of Behavioral Health with modernizing these rights, and the state initiated a stakeholder engagement process to gather input. However, the process primarily relied on digital platforms such as Zoom, email, and internet-based tools, creating significant barriers for many consumers of mental health services in a rural state like Maine.
DRM filed objections to this process, highlighting that many individuals directly impacted by these regulations lack reliable internet access. Moreover, individuals under the control of providers—such as those committed to psychiatric hospitals—may face restrictions preventing their participation in virtual meetings or email correspondence, particularly if they are on unit restrictions or in restraints. DRM argued that these limitations skewed the process toward comments from providers and individuals with easy access to technology, excluding the voices of those most affected by the proposed changes.
DRM recommended the state conduct robust in-person listening sessions throughout Maine to ensure equitable participation. While the state acknowledged DRM's comments, it ultimately chose not to act on them, maintaining that the existing process was sufficient. This decision left concerns about the inclusivity of the engagement process unresolved

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

In Maine, community mental health case managers and staff at residential mental health providers are required to obtain the Mental Health Rehabilitation Technician (MHRT) certification, which includes training in multiple essential domains. DRM contributes to this process by delivering the training module for Domain 5: Policy Knowledge, focusing on understanding regulations and fostering effective self-advocacy within Maine's health and human services system.
The DRM training covers key topics, including Understanding the legal protections afforded to individuals receiving mental health services, an overview of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, key provisions of the Civil Rights Act, the Maine Human Rights Act and identifying organizations like DRM that support consumer rights and connecting individuals with appropriate resources.
By equipping mental health professionals with a deep understanding of these critical areas, DRM ensures a more informed and effective

workforce. This training promotes the protection of consumer rights, supports self-advocacy, and contributes to better outcomes for individuals receiving mental health services across the state.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

As part of a local college's psychology curriculum, DRM delivered a presentation to students in the "Mental Health and Society" course. The session provided an in-depth look at the day-to-day experiences of individuals navigating Maine's mental health system, highlighting the systemic challenges and barriers faced by those the system is intended to support.

DRM helped students contextualize these challenges within the broader framework of mental health services, fostering a deeper understanding of how systemic issues impact individuals' lives. The presentation also emphasized the importance of protecting clients' rights and introduced students to the resources and advocacy strategies available to future mental health providers. This engagement aimed to equip students with a more holistic perspective, empowering them to think broadly and effectively support the rights and needs of their future clients.

Priority/Goal Description: PRIORITY 3 – Housing: PAIMI-eligible individuals will live in safe, accessible, affordable housing

Objective: OBJECTIVE 3.1 DRM will assist PAIMI-eligible individuals in obtaining or maintaining housing when they are being discriminated against. DRM will also represent PAIMI-eligible individuals at risk of becoming or remaining homeless or at risk of entering or remaining in a facility when their rights pertaining to housing are otherwise being violated or they are at risk of losing a disability related housing subsidy. This assistance may include assisting individuals in obtaining reasonable accommodations

Strategies Used: Collaboration,Rights-Based Individual Advocacy Services,Educating Policy Makers,Other Systemic Advocacy,Monitoring,Training/Outreach

Target Measures

Target Population:	Target Population: PAIMI-eligible individuals who experience discrimination in housing or whose rights relating to housing otherwise need protection in order to avoid homelessness or entering or remaining in a facility. Target: 1. Represent at least 15 PAIMI-eligible individuals.
Expected Target:	15
Expected Outcome:	15
Actual Outcome:	25
Achieved: (●) **Not Achieved:** ( )	

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

A 49-year-old man, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, was denied permission to have an emotional support dog due to restrictive policies at his mobile home park. DRM determined that the policies violated state and federal housing laws. After negotiating with the landlord's attorney, an agreement was reached that allowed the client to obtain and keep a dog within the legal parameters. The client subsequently acquired an emotional support dog, improving his well-being and quality of life..

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 40-year-old man, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, was denied the opportunity to apply for subsidized housing due to his criminal history—a legally permissible reason for such denials. His criminal history, however, was tied to behaviors stemming from his disability during periods of psychiatric hospitalization. Without housing, the client faced a heightened risk of cycling back into the hospital due to homelessness. DRM represented the client at an internal administrative hearing, presenting testimony from his treatment providers to demonstrate his progress and readiness for stable housing. The housing provider reversed its decision, not only allowing the client's application to proceed for the specific complex but also granting him eligibility for other properties within its large portfolio. This decision provided the client with significant housing options and created a crucial document he can present to other property management agencies as evidence of his acceptance by a reputable peer, further expanding his opportunities for stability and reducing the risk of future hospitalizations.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 44-year-old involuntary psychiatric hospital patient faced the imminent expiration of his community housing voucher while still hospitalized. Individuals in psychiatric hospitals cannot actively search for apartments, and without an extension, the client risked losing his voucher. This would not only leave him homeless upon discharge but also significantly increase the likelihood of cycling back into the hospital, as waitlists for these vouchers can extend for years.

Recognizing the critical implications, DRM intervened, contacting the housing authority managing the voucher and successfully negotiating an extension. The housing authority issued a letter confirming the extension, preserving the client's access to stable housing upon discharge and supporting his successful reintegration into the communit

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 44-year-old PAIMI-eligible woman, who had lived in her apartment for six years and been under the care of a psychiatrist and therapist for years, experienced a mental health crisis that resulted in behaviors prompting a Notice to Quit from her landlord. The client's home had been a stabilizing factor, allowing her to avoid psychiatric hospitalization since moving in. Facing homelessness, she was at high risk of returning to the hospital without intervention.

DRM advocated on her behalf, requesting a reasonable accommodation to rescind the notice, contingent upon her engaging with community case management and continuing her healthcare services. DRM supported her in self-referring to Section 17 Community Integration Case Management, assisting with calls and follow-ups to ensure she began receiving services. Through negotiations with the landlord's attorneys and a facilitated Zoom meeting with all parties, DRM finalized a reasonable accommodation agreement. The agreement rescinded the Notice to Quit, preserved her lease, and ensured she could remain in her home, maintaining the stability critical to her mental health recovery.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 20-year-old woman, previously diagnosed with a significant mental illness or emotional impairment by a qualified Maine mental health professional, was experiencing homelessness and residing in a mental health Crisis Stabilization Unit (CSU) in which DRM met her during outreach. She was eligible for admission to a more stable mental health group home, however, due to her providers' unfamiliarity with the system, she faced discharge back to homelessness instead of transitioning to the group home. Without stable housing, she was at a significantly higher risk of psychiatric hospitalization.
DRM stepped in, working closely with the client's case manager to navigate the system, providing guidance, and persistently following up to ensure the necessary paperwork was completed and submitted. As a result of DRM's intervention, the client successfully moved into the group home, securing the stability needed to prepare for independent living and significantly reducing her risk of future hospitalization

Objective: OBJECTIVE 3.2 DRM, in coordination with the PAC and other organizations, will conduct projects that: promote the protection of PAIMI-eligible individuals from rights violations in housing or that promote the availability of housing options

Strategies Used: Collaboration,Educating Policy Makers,Other Systemic Advocacy,Monitoring,Training/Outreach

Target Measures

Target Population: PAIMI-eligible individuals who experience difficulty in obtaining and maintaining decent, safe and affordable housing. DRM will conduct at least 5 projects that promote the protection of PAIMI-eligible individuals from discrimination in housing or that promote the availability of housing options.

Expected Target: 5

Expected Outcome: 5

Actual Outcome: 7

Achieved: (●) **Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

In response to the housing crisis, DRM engaged in outreach and advocacy for individuals with serious mental health disabilities affected by the dismantling of a tent encampment in a local city. Following the city's actions to clear the encampment—issuing no-trespass orders and removing tents and belongings—a private organization rapidly established a shelter for those displaced. DRM staff partnered with this new program to conduct an outreach visit, connecting directly with affected individuals. Staff provided information about their rights, educated them on how to access community services, and explained the support DRM could offer. This effort ensured that vulnerable individuals were equipped with the knowledge and resources needed to navigate the challenges of displacement and secure necessary services.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

DRM has launched a statewide project to address significant inconsistencies in policies, costs, tenancy terms, and services across over 110 mental health group homes, which serve more than 800 individuals with severe and persistent mental illness. These group homes, designed as the most intensive treatment setting outside of inpatient psychiatric hospitalization, are often mismanaged due to the lack of a uniform policy framework. This has created a systemic bottleneck, where individuals are left "stuck" in group homes, unable to progress to independent community living because they are not receiving the proper services and supports to prepare them for that transition. This bottleneck has broader implications for the mental health system. When group home residents cannot move to less restrictive settings, it prevents individuals in psychiatric hospitals who are ready for discharge from transitioning into group homes, leaving them unnecessarily hospitalized. This creates a cascading backlog, reducing access to appropriate care at all levels.
To address these systemic issues, DRM's project began by mailing letters to all 110 group homes to collect their written policies and procedures, as required by state regulations. DRM is now reviewing the responses to identify inconsistencies, gaps, and systemic failures in service delivery across homes. The findings will culminate in a detailed report, to be completed in FY 2025, with actionable recommendations aimed at ensuring consistent, equitable services. By resolving these disparities, the project aims to improve residents' ability to transition to independent living and free up group home spaces for individuals transitioning out of psychiatric hospitalization

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

DRM identified a critical barrier in the state's housing voucher program designed for individuals with severe and persistent mental illness who are homeless or transitioning from correctional or psychiatric facilities. The program's application process requires a form signed by a licensed clinician verifying a mental health diagnosis. This creates a "catch 22" for many homeless individuals, including chronically homeless individuals who, by the program's design, are its intended beneficiaries. Many of these individuals may have had minimal contact with the mental health system, making it unlikely they could find a clinician to provide the required certification.
This disproportionately affects chronically homeless individuals whose challenges are related to this insurmountable service barriers they encounter relating to the required clinical justification form which then contribute to their homelessness. Without access to housing, they remain at heightened risk of psychiatric hospitalization which costs the system substantially more than the cost of a monthly housing voucher.
In response, DRM submitted formal comments to the state when the application process was opened for review. DRM highlighted the systemic flaws in the process and emphasized how this requirement undermines the program's purpose. Recommendations were provided to address this "catch 22," such as implementing alternative methods for verifying eligibility that do not rely on existing clinical relationships.
DRM anticipates the state will assess and address these concerns in 2025, creating a more accessible application process that ensures the voucher program can fulfill its mission of preventing homelessness and reducing psychiatric hospitalizations for vulnerable individuals.

Priority/Goal Description: PRIORITY 4 – Education: PAIMI eligible children and young adults are entitled to a Free and Appropriate Public Education in the least restrictive environment without threat of inappropriate discipline.

Objective: OBJECTIVE 4.1 DRM will assist PAIMI eligible students who have been suspended, expelled or otherwise excluded from school, who are harassed or bullied and not protected by the school, or who are placed in unnecessarily noninclusive environments. DRM will also assist in obtaining appropriate transition plans and services for students residing in facilities who are between the ages of 16-19 and who have not yet graduated from school.

Strategies Used: Collaboration,Rights-Based Individual Advocacy Services,Educating Policy Makers,Investigations of Abuse and Neglect,Other Systemic Advocacy,Monitoring,Training/Outreach

Target Measures

Target Population: PAIMI-eligible students who are excluded from school, who are not being protected from harassment or bullying, who are being educated in unnecessarily non-inclusive environments or who are between the ages of 16 and 19, live in facilities and have inadequate transition plans

Expected Target: 28

Expected Outcome: 28

Actual Outcome: 41

Achieved: (●) **Not Achieved:** ( )

Reason why priority/goal was not achieved or was partially achieved:

Results narratives of P&A activities and accomplishments related to above priority:

A caller sought DRM's help for her nine-year-old son with ADHD and PTSD after his school district refused to allow his return to in-district

programming, citing lack of behavioral support. DRM filed a due process complaint and reached a settlement that included a 60-day diagnostic period, a revised IEP, independent behavioral evaluation, and compensation for a behavioral aid. Following advocacy through spring and summer IEP meetings, the student transitioned to an age-appropriate general education class with peers and a fitting curriculum. By June, the student was attending full-time and thriving, with the caller expressing satisfaction with his progress

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A caller sought DRM's help for her 15-year-old son with ADHD, a communication disorder, and clinical depression, citing repeated suspensions and failure to implement his IEP. DRM determined that the school district had not conducted required manifestation determination reviews (MDRs) for his suspensions. Following another suspension for a behavioral incident, DRM filed a State Complaint Investigation Request with the Maine Department of Education (MDOE) for multiple IDEA violations. MDOE's investigation confirmed the district violated the student's rights, including failing to conduct MDRs, improperly changing his placement, not implementing his IEP, and denying a free appropriate public education (FAPE) in the least restrictive environment. MDOE issued a Corrective Action Plan (CAP) mandating an IEP meeting to review his placement, plan his return to school, and assess his compensatory education needs. DRM's advocacy secured accountability and ensured the student's educational rights were upheld.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

DRM assisted a 13-year-old student with a trauma-related mental health disability who was excluded from school for disability-related behaviors. A due process hearing led to the student's immediate return to school. A settlement agreement provided compensatory education through tutoring and summer camp, mental health provider consultation for school staff, and payment of DRM's fees, ensuring the student's educational and emotional needs were addressed

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A caller sought DRM's assistance for her nine-year-old child, who was missing school and being repeatedly restrained due to a lack of appropriate supports. The DRM attorney provided advocacy strategies, including obtaining a medical letter for accommodations and helping file a "Chapter 33" complaint against the district for improper restraint use. After the complaint was filed, the caller reported a dramatic reduction in restraint incidents, indicating progress in addressing the student's needs.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A caller contacted DRM regarding her 13-year-old daughter, placed on an indefinite "abbreviated day" schedule, limiting her to two hours of instruction daily due to behavioral concerns. With DRM's support, the caller advocated in a Section 504 meeting, successfully negotiating the student's return to school. DRM also assisted in filing a disability discrimination complaint with the U.S. Department of Education's Office for Civil Rights, ensuring accountability for the district's actions.

0930-0169 Approved: 07/27/2023 Expires: 07/31/2026

Footnotes:

Advisory Council Report

Advisory Council Report (Required)

Advisory Council Report (ACR)

The Advisory Council Report (ACR) section of the annual PAIMI Program Performance Report, to the Secretary of the U.S. Department of Health and Human Services, **is due by January 1**. The ACR is mandated under the PAIMI Act at 42 U.S.C. 10805 (a) (7). The ACR is the PAIMI Advisory's Council's (PAC) **independent assessment** of their protection and advocacy system's for the previous fiscal year. **The ACR must be prepared by the PAC and signed and dated by the PAC Chairperson.**

Please use the box below to indicate areas of technical assistance needed related to this section.

0930-0169 Approved: 07/27/2023 Expires: 07/31/2026

Footnotes:

OMB Approval: 0930-0169
Expiration Date: 07/31/2026

THE ADVISORY COUNCIL REPORT (ACR) SECTION OF THE ANNUAL PAIMI PROGRAM PERFORMANCE REPORT (PPR)

STATE	FISCAL YEAR

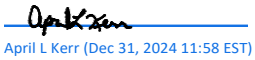
The Advisory Council Report (ACR) section of the annual PAIMI Program Performance Report, to the Secretary of the U.S. Department of Health and Human Services, **is due by January 1**. The ACR is mandated under the PAIMI Act at 42 U.S.C. 10805 (a) (7). The ACR is the PAIMI Advisory's Council's (PAC) **independent assessment** of their protection and advocacy systems for the previous fiscal year. **The ACR must be prepared by the PAC and signed and dated by the PAC Chairperson.**

For ACR assistance, please contact the PAIMI Program Coordinator.

Please read and follow the instructions in each section and use the attached glossary in to complete the form.

The ACR Section of the ANNUAL PAIMI PPR

TABLE of CONTENTS

The ACR Section of the Annual PAIMI PPR	
SECTION A. GENERAL INFORMATION	
Fiscal Year:	2024
State:	Maine
Name of P&A system:	Disability Rights Maine
PAC Report Prepared By: Provide the name [Print First, Middle and Last Name] Title of the Preparer: Phone Number:	April Kerr & PAC members PAC Chair Aprillkerr2020@gmail.com (207) 491-0381
Name of PAC Chair: [Print First, Middle and Last Name] Provide updated contact information if the PAC Chair is different than the person listed on the most recent PAIMI Application.	April Kerr aprillkerr2020@gmail.com
Telephone Number:	(207) 491-0381
E- Mail Address:	aprillkerr2020@gmail.com
Date Submitted:	12/31/2024
By signing this document, the Chair certifies that this report reflects the consensus of the PAC members.	 April L Kerr (Dec 31, 2024 11:58 EST)

SECTION B. The PAIMI ADVISORY COUNCIL (PAC)		
*Under Primary ID, select *ONLY ONE* (1) primary identity for each PAC member position **[B.1.b. - B.1.h.] that** is mandated per the PAIMI Act & Rules).		**Primary Identification**
B.1.a. The TOTAL number of seats on the PAC.		**Total 13**
B.1.b. Individuals who are recipients/former recipients (R/FR) of mental health services.		9
B.1.c. Family members of individuals who are recipients/former recipients (R/FR) of mental health services.		1
At least one (1) PAC member shall be a B.1.d.		

B.1.d. Family members of a minor child or youth (under 18 years old) who has received or is receiving mental health services.	0
B.1.e. Mental health service providers.	1
B.1.f. Mental health professionals:	
B.1.f.1. Social Workers	
B.1.f.2. Psychologists	1
B.1.f.3. Psychiatric Nurses	
B.1.f.4. Psychiatrists	
B.1.f.5. Psychiatric Nurse Practitioners	
B.1.f.5. Peer Support Specialists	
B.1.g. Attorneys.	1
B.1.h. Individuals from the public knowledgeable about mental illness.	
B.1.i. Others (please identify by position held).	
B.1.j. Vacancies as of 9/30. [identify each vacant position & the date it was vacated].	0
B.1.k. TOTAL number of PAC members serving on 9/30.	**Total 13**
B.1.l. Number of PAC members who are either R/FR of MH services or family members of these individuals (count each PAC member only once).	10
B.1.m. Percentage of PAC members who are either R/FR of MH services or family members of these individuals [B.1. k. divided by B.1.l.]	76%

B. 2. REPRESENTATION OF THE PAC CHAIRPERSON		
B.2. Is the PAC Chair an individual who has received or is receiving mental health services, or a family member of an individual who has received or is receiving mental health services?	**Yes** **X**	**No**

B. 3. PAC TERMS of Appointment	
B.3.a. Term of Appointment (number of years)	4
B.3.b. Maximum Number of Terms a Member May Serve	2
B.3.c. Frequency of Meetings	6 per yr
B.3.d. Number of Meetings Held in the FY [3 is the mandated minimum].	6
B.3. e. Number (%Average) of PAC members present at Meeting.	84%

SECTION C. PAC ETHNICITY & RACIAL DIVERSITY

Please refer to the **GLOSSARY** for definitions. The following information is self-reported or self-identified and uses two separate questions. The data on race and ethnicity are collected SEPARATELY; provision shall be made to report the number of respondents in each category who are Hispanic or Latino. Collection of greater detail is encouraged; however, any collection that uses more detail shall be organized in such a way, that the additional information can be aggregated into these minimum categories for data on race and ethnicity.

C. A. ETHNICITY	**Number of PAC Members**
C. A. 1. Hispanic or Latino	0
C. A. 2. Not of Hispanic Origin	13
C. A. 3. Ethnicity Unknown	0
(Add C.A.1 through C.A.3., the total should be the same as the one listed in B.1.k. (members serving as of 9/30).	**Total 13**

C. B. RACE	
C. B. 1. American Indian or Alaska Native	**1**
C. B. 2. Asian	**0**
C. B. 3. Black or African American	**0**
C. B. 4. Native Hawaiian/Other Pacific Islander	**0**
C. B. 5. White	**12**
C. B. 6. Two or more races	**0**
C. B. 7. Some other race	**0**
C. B. 8. Race unknown	**0**
C. B. 9. = C.B.1 through C.B.8.	**Total 13**
Members may select as many racial identifications as they want.	
C. C.1. Total Number of PAC member vacancies on September 30.	**Total PAC Vacancies**
	0

SECTION D. Gender of PAC Members	
D.1 FEMALE 10	D.2 MALE 3
D.3 TRANSGENDER (Trans Woman)	D.4 TRANSGENDER (Trans Man)
D.5 TWO-SPIRIT (if AI or AN)	D.6 GENDER NON-CONFORMING
D.7 OTHER (if use a different term)	D.8 PREFER NOT TO SAY
D.3. TOTAL	

SECTION E. GOVERNING BOARD INFORMATION		
E. 1. FOR STATE-OPERATED P&A SYSTEMS ONLY:		
E.1.a. Is this a State-operated P&A system?	Yes	No X
E.1.b. Does this State-operated system have a Governing Board/Authority authorized by State statute? If the answer is NO, proceed to Section F.	Yes	No
E.1.c. If the answer to item E.1.b. is YES, does the PAC Chair sit on the Governing Board/Authority as a full voting member?	Yes	No
E.1.d. If the answer to item E.1.c. is no, briefly explain (e.g., State statute determines Governing Board/Authority composition, etc.).		
E.2. For PRIVATE, Not-for Profit P&A SYSTEMS only		
E. 2.a. Does the P&A system have a multi-member Governing Board?	Yes X	No

If you answered YES to E.2.a., please answer the questions E.2.b. 1. - 3.		
E.2.b.1. Number of Governing Board members.	Total 9	
E.2.b.2. Is the PAC Chair a full voting member of the Governing Board?	Yes X	No
E.2.b.3. If you answered No to E.2.b.2., then explain why the PAC Chair is not a full voting member of the Governing Board as mandated by the PAIMI Rules at 42 CFR 51.22(b)(3).		
E.2.b.4. Do any other PAC members hold seats on the Governing Board? If Yes, how many seats? 1	Yes X	No

SECTION F. PAC ACTIVITIES [See, PAIMI Act - 42 U.S.C. 10805(7)]		
F.1. Are P&A program staff invited to attend PAC meetings?	Yes X	No
F.1.a. Did any of the invited program staff attend?	Yes X	No
F.2.a. If the answer to F.1. is Yes, please identify the positions of staff (e.g., PAIMI Coordinator, Mental health advocate, etc.) usually invited to attend. Executive Director, PAIMI Director, Attorneys and Advocates are invited to attend and many do.		
F.2.b. If the answer to F.1.a. is Yes, please identify the positions of the program staff in attendance (e.g., one advocate, one attorney) and their role at the meetings, e.g., information sharing, etc. Information is shared about the organization, financial condition, cases, projects, and priorities. A standing item on the PAC agenda is something called PAC-TION. They are specific projects that are designed with PAC members and DRM staff that address issues in the community and institutions. We have also added a standing agenda item to hear from PAC members about what is going on in their communities etc., so the PAIMI staff become aware of issues from the members		
F.2.c. If the answer to F.1. is No, you *MAY* provide a brief explanation.		
F. 3. a. Were governing board members, excluding the PAC Chair, invited to PAC meetings?	Yes X	No

F.3.b. If you answered Yes to F.3.a., which governing board members were invited, for what purpose (e.g., informational, etc.) and did they attend? There is a standing invitation for Board members to attend. The PAC chair restates this invitation at the Board meetings		
F.3.c. Did any of the invited governing board members attend?	Yes	No X
F.4. Did the PAC work jointly with the governing board to develop the annual PAIMI priorities? [42 CFR 51.23(a) (2)].	Yes X	No*
F.4.a. If Yes, briefly describe these joint activities. The PAC chair and another PAC member are members of the governing board and participates in all board meetings.		

SECTION F. PAC ACTIVITIES [See, PAIMI Act - 42 U.S.C. 10805(7)]		
F.4. b. If No, PAC's affiliated with private, non-profit P&A systems must provide a brief explanation.		
F.5. Did PAC members attend any in-state or out-of-state trainings or educational presentations related to PAIMI Program activities? *[42 CFR 51.27 - payments for PAC and Governing board/authority members by a State P&A system are optional]*.		
F.5.a. In-State Trainings/Educational Activities.	Yes	No
If Yes, list each activity by number and provide a brief description of PAC involvement, e.g., Activity 1 – Attendance at local NAMI training.	X	
F.5.b. Out-of-State Trainings/Educational Activities.	Yes	No
If yes, list each activity by number and provide a brief description of PAC involvement, e.g., Activity 1 – Attendance at NDRN annual conference.	X	
F.6. Does the P&A system have established written policies and procedures for reimbursing PAC members for expenses that takes into account the needs of the individual council members, available resources and applicable restrictions on use of grant funds, including the restrictions cited in and the restrictions in 51.31(e) and 51.6(e)? [See, 42 CFR 51.23 (d) (1)].		
F.6.a.1. Yes	F.6.a.2. No*	F.6.a.3. Don't Know.*

F.6.b. Brief explanation needed for F.6.a.2. or F.6.a.3. responses].

SECTION F. PAC ACTIVITIES [See, PAIMI Act - 42 U.S.C. 10805(7)]

F.7. If the answer to F.6. was Yes, were PAC members reimbursed for expenses incurred for PAIMI Program related activities, consistent with the P&A system's policies and procedures.

F.7.a.	1.Yes X	2. No*	3. Don't Know*

F.7.b. *Brief explanation required for either F.7.a. 2. No *or F.7.a*. 3. Don't Know responses.

All PAC meetings were held virtually so there was no mileage reimbursement.
DRM paid the registration, travel, and lodging (including meal stipend) for 2 PAC members to attend the National Association of Rights Protection and Advocacy Conference that was held in Portland, Oregon this year.

F. 8. REIMBURSEMENT OF EXPENSES – If PAC member expenses were reimbursed, please complete the following chart. [42 CFR 51.23(d) (1)]. Under the Activity column, list the activity by the number used in above F.5.a. – In-State or F.5.b. – Out-of-State. Example: F.5.b. Out-of-State activity # 1, – 5 PAC members attended the NDRN annual meeting, 2 members reimbursed by the P&A; 2 self-paid, 1 NDRN scholarship.

a. ACTIVITY	b. # ATTENDING	c. P&A	d. SELF	e. OTHER
NARPA Conference Out of State Portland, OR.	2 PAC Members	2 P&A staff		
SAMSHA/PAC Webinar	1+	0		

Disability Rights Mississippi Webinar: Monitoring Justice at Miss. Correctional Facilities.	2+	2 P&A staff		
PAIMI Advisory Council Empowerment Project.	2+			

SECTION F. PAC ACTIVITIES [See PAIMI Act at 10805(7)]		
F.9. Did the P&A system provide the PAC with reports, materials, & fiscal data to enable review of the following: [42 CFR 51.23(c)].		
F.9.a. Existing program policies, priorities, and performance outcomes.	Yes X	No*
F.9.b. If Yes, were the submissions (of P&A system documents referenced in F.9.a.) made at least annually and (shall) report expenditures for the past two (2) FISCAL *YEARS?*	Yes X	No*
*F.9.c. If the answer to F.9. a. or F.9.b. is 'No", a brief explanation is required.		
F.9.d. If you answered Yes in F.9.a., did the P&A system documents referenced also *INCLUDE THE PROJECTED EXPENSES FOR THE NEXT FISCAL YEAR (FY) IDENTIFIED BY BUDGET CATEGORY*, e.g. salary & wages, contracts for services, administrative expenses, including, the amount allotted for training of the PAC, the governing board and staff?	Yes X	No*
F.9.d.1. If No*, a brief explanation is required].		

SECTION F. PAC ACTIVITIES [See, PAIMI Act at 10805(7)]
F.9.e. The PAIMI Rules mandate that members of the public shall be given an opportunity, on an annual basis, to comment on the priorities established by and the activities of the P&A system. Procedures for public comment must provide for notice in a format accessible to individuals with mental illness, including such individuals who are in residential facilities, to family members and representatives of such individuals with disabilities. [42 CFR at 51.24(b)].

F.9.e. Does the P&A have procedures established for public comment?		
F.9.e. 1. Yes X	F.9.e. 2. No*	F.9.e.3. Don't Know*
F.9.e.4. *Brief explanation required for F.9.e.2. No or F.9.e.3. Don't know responses.		
F.9.f. Was the PAC provided a copy of these procedures?		
F.9.f.1. Yes X	F.9.f.2. No*	F.9.f.3. Don't Know*
F.9.f.4. *Brief explanation required for F.9.f.2. No or F.9.f.3.Don't know responses.		

SECTION F. PAC ACTIVITIES [See, PAIMI Act at 10805(7)]		
F.9.g. The PAIMI Rules, at 42 CFR 51. 24(b), mandate that the public shall be given an opportunity, on an annual basis, to comment on the priorities established by and the activities of the P&A system. *WAS THE PUBLIC PROVIDED AN OPPORTUNITY FOR PUBLIC COMMENT?*		
F.9.g. 1. Yes# x	F.9.g. 2. No*	F.9.g.3. Don't Know*
F.9.g 4. #If the answer to F.9.g.1. is Yes, briefly describe activities the P&A system used to obtain public comment.		
F.9.g. 5. *If the answer to F.9.g.2. is NO, explain why public comment was not obtained.		
F.9.g. 6. *If the answer to F.9.g.3. is DON'T KNOW, please explain (e.g., PAC needs training, etc.)		
F.10. ***COMPLETION OF THIS SECTION (F.10 a. –e.) IS OPTIONAL.*** However, if you choose to respond, please describe in the spaces below any other PAC activities, *other than* mandated PAC membership meetings.		
F.10.a. Briefly describe, governing board or PAC committee work. The Agency solicits input through its web page, newsletter, in surveys, PAC members are asked to solicit input through their constituencies, This year DRM presented at a statewide HOPE conference, that was organized by the Consumer Council System of Maine which some members are also members of the PAC. PAC has decided to meet regularly, independently of DRM staff (so far 3 times in 2024 and aiming to be 6 times ins subsequent years, adjusted based on availably and need.)		

F.10.b. Briefly describe any training or educational presentations to either constituency groups or the general public.

SECTION F. PAC ACTIVITIES [See, PAIMI Act – 42 U.S.C.10805(7)]

F.10.d. Briefly describe any special projects (e.g., institutional monitoring).

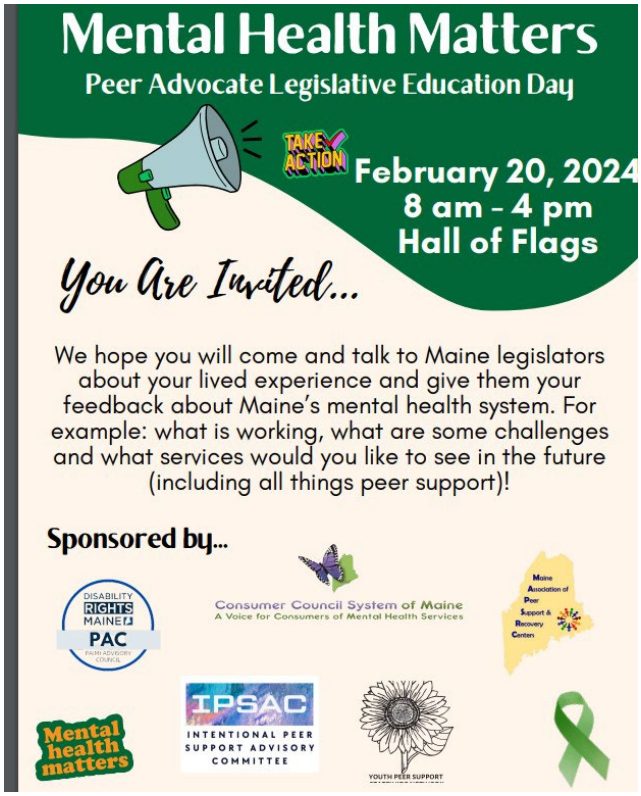
HOPE Conference The Consumer Council System of Maine holds an annual event called the HOPE conference. It is held at the Augusta Civic Center. The HOPE conference was created to help participants gain a greater understanding of what recovery/wellness is from the many paths and different perspectives on the journey of life. This conference is designed by consumers and allies, in conjunction with the Maine Office of Behavioral Health

There are several members of the PAC who are part of the CCSM. This year's HOPE conference was in person.

National Association of Rights and Protection and Advocacy (NARPA) Annual Conference. NARPA held their annual conference in Portland, Oregon. PAC members Jenny McCarthy and Kelly Staples attended. Including attending the Pre Conference Institute for PAIMI Advisory Council Members entitled: PAIMI Councils as Leaders for Systemic Reform. The agenda is attached.

EMERGENCY ROOM BROCHURE: : DRM is working on a project to develop with the PAC a brochure for Emergency Departments regarding individuals' rights and how to contact DRM. There are ongoing efforts and discussions regarding rights of recipients in EDs with hopes to form relationships with leadership of hospitals and EDs.

DISABILITY AWARNESS DAY: PAC members attended Disability Awareness Day. Which advocates and organizations participated at the State House to educate legislators about critical issues impacting Maine people with disabilities including mental health disabilities.



PAC Chair April Kerr

Peer Advocate Legislative Education Day. Hall of Flags, Maine State House.

The PAC staffed a table at the annual Peer Advocate Legislative Education Day at the Hall of Flags Many Legislators and staff stop at these tables for information during their day.

F.10.e. Briefly describe any other activities, e.g., fund raising, public relations, etc.

See above

SECTION G. PAC ASSESSMENT OF PAIMI PROGRAM OPERATIONS

G.1. ***Please provide a NARRATIVE SUMMARY of the PAC'S ASSESSMENT of the PAIMI priorities (goals) and objectives included in the PPR for this Fiscal Year.***

Include in the narrative an assessment of the following items:

G.1.a. The PAIMI Priorities (Goals) and Objectives selected.

G.1.b. The activities conducted towards achieving these priorities (goals) and objectives.

G.1.c. The outcomes.

G.1.d. Examples of individual or systemic cases, applicable legislative activities, and participation in State mental health planning activities.

G.1.e. Any recommendations regarding future priorities (goals) and objectives.

The current priorities are 1. Abuse, Neglect & Rights Violations, 2. Community Inclusion, 3. Housing, and 4. Education. We are satisfied with the priorities that we have developed. We believe these priorities continue to represent the highest need for individuals with mental illness in Maine.

PAC is excited to begin to establish more autonomy in our involvement with the PAIMI program & as a result being more able to provide a more robust assessment of PAIMI program operations to DRM during the upcoming.

SECTION G. PAC ASSESSMENT OF PAIMI PROGRAM OPERATIONS

G.2. OTHER COMMENTS CONCERNING PAIMI SYSTEM OPERATIONS:

Briefly describe any special initiatives, problem solving techniques, or innovative practices that may help other State P&A systems.

We would like to highlight the outstanding work that the Community Advocates continue to do out in the community in the State of Maine they have helped more individuals in Maine than can be counted. We also want to point to the excellent work being done by attorneys and advocates who work in Maine's various psychiatric facilities. They have been very dedicated to doing education around rights training with both staff and patients, as well as helping patients file grievances, and help problem solve in the moment when issues arise between staff and patients. PAC members are kept informed of the work that has been done by the members of the PAIMI team through extensive reports and ongoing in-person conversations with them. This has been helpful in the collaborative work of the PAC. The DRM website and social media interaction have also helped reach out to the people.

G.3. Please list any training & technical assistance needs identified by the PAC.

SECTION H. GRIEVANCE PROCEDURES [42 CFR Section 51.25]

Pursuant to the PAIMI Rules at 42 CFR 51.25, the P&A systems shall establish procedures to address grievances from: individuals at 42 CFR 51.25*(a)(1) – clients or prospective clients . . . ; and systemic complaints at 42 CFR 51.25(a)(2) – individuals who have received or are receiving mental health services in the state, family members or representatives of such individuals . . . .*

H.1. Is the PAC aware of and knowledgeable of the above referenced policies and procedures?	Yes X	No*

H.1.a. If you answered No to H.1. provide a brief explanation.

H.2. The number of grievances filed by PAIMI-eligible clients, including representatives or family-members of such individuals receiving services during this fiscal year.	Total 0
H.3. The number of grievances filed by prospective PAIMI-eligible clients (those who were not served due to limited PAIMI Program resources or because of non-priority issues).	Total 0
H.4. Add H.2 & H.3 **[42 CFR Section 51.25(a)(1),(2)]**	Total 0
H.5. The Number of Grievances Appealed to:	
H.5. a. The Governing Board (the PAC Chair of a private, non-profit P&A system should have this information).	Total 0
H.5.b. The Executive Director	Total 0
H.5 c. The number of Grievances appealed [H.5.a. + H.5.B = H.5.c.].	Total 0
H.6. The number of reports sent to the Governing Board AND the PAC (*at least one annually*) that describe the grievances received, processed, and resolved.	Total 1

SECTION H. GRIEVANCE PROCEDURES [42 CFR Section 51.25]		
H.7. Please identify all individuals, by name & title, responsible for P&A system grievance reviews. Kimberly Moody, Executive Director Lauren Willie, Litigation Director Mark Joyce, PAIMI Director		
H.8. What is the timetable (in days) used to ensure prompt notification of the grievance procedure process to clients, prospective clients or persons denied representation, and ensure prompt resolution. **[42 CFR 51.25(B)(4)]**		Days 10
H.9. Were written responses sent to all grievants?	Yes X	No*
H.9.a. *If you answered No, to H.9, briefly explain.		

H.10. Was client confidentiality protected?_____. If not, explain below. **[42 CFR 51.25(B)(6)]**	Yes X	No*
H.10.a. *If you answered No, to H.10, briefly explain.	Yes	No*

GLOSSARY

Closed Case - is when the advocate/attorney closes the client record or case file after providing advocacy interventions on behalf of a client and determining that the client either has no need of further intervention services or that the agency has no other services available to address the issue(s) or complaint(s) for which the case was initially opened.

Grievance Procedures - are policies and procedures developed by the P&A system to ensure that its clients and prospective PAIMI-eligible clients, their family members, or representatives have full access to the system services and that the system is fully compliant with the provisions of the PAIMI Act and Rules.

Information and Referral (I&R) Services - is the provision of brief written or oral information, such as generic information about the P&A, including information about additional programs and resources external to the P&A that relate to the individual's service needs and statutory or constitutional rights as a person with a disability. I &R services are generally of short duration, typically range from a few minutes to an hour, do not involve direct advocacy intervention by staff, and any type of staff follow-up. I&R services may include mailing generic agency information. Individuals receiving I &R services are not counted as PAIMI clients.

Intervention Strategies:

Abuse/Neglect Investigations - a systemic and thorough examination of information, records, evidence, and circumstances surrounding an allegation of abuse and neglect. Investigations are undertaken to determine if there is a basis for administrative or legal action on behalf of the client. Investigations require a significant allocation of time to interview witnesses, gather factual information, and to issue a written report of findings.

Administrative Remedies - includes the use of any systems for appeal within an agency or facility, or between agencies, which does not involve adjudication by a court of law.

Legal Remedies - the legal representation of clients in litigation in court processes concerned with rights, grievances, or appeals of such rights or grievances.
Legislative/Regulatory Advocacy - activities involve monitoring, evaluating, and commenting upon the development and implementation of Federal, State, and local laws, regulations, plans, budgets, taxes and other

actions which may affect individuals with mental illness. [The PAIMI Rules at 42 FCR at 51.24 mandates that legislative activities shall also be addressed in the development of program priorities].

Negotiation/Mediation - is an informal, non-legal intervention by a PAIMI representative, attorney or case manager used to resolve problems with facility staff or other agency representatives; (does not involve a formal appeal).

Objectives - are activities undertaken to achieve annual program priorities (goals). All objectives required to have measurable outcomes and the use of numerical targets is encouraged. Each objective must clearly state why the activity was undertaken, who will benefit from the objective (the target population), how the activity will be accomplished, and what is the expected outcome for the activity? Generally, with the exception of litigation, legislative or regulatory activities, objectives shall be attainable within the fiscal reporting period (within one (1) fiscal year).

Open Case - is when a PAIMI-eligible individual with a complaint is accepted as a client by the P&A system. A case record or case file is opened for that individual. System staff maintain all intervention services provided to the client and other information t are maintained in this case record/file.

Outreach - is an activity that targets information on PAIMI Program activities to specific populations (e.g., cultural, ethnic, and racial minorities, and other underserved or un-served populations, etc. The activity is linked to an objective of a specific annual priority.

PAIMI Clients (for purposes of this report) - are individuals who meet the PAIMI eligibility criteria as defined in the PAIMI Act [42 U.S.C. 10802(4) and its Rules at 42 CFR 51.2 Definitions, who have a complaint, for whom demographic data is collected, and for whom the PAIMI Program, or any of its subcontractors, provides an intervention (as reported under Intervention Strategies in this form).

Priorities (Goals) - are broad general descriptions of short-term activities for the P&A system to accomplish within one (1) fiscal year (FY). [The exceptions are generally regulatory, legislative, and litigation activities]. The priorities must be directly related to the purpose of the enabling Federal legislation and the requirements of the Federal-funding agency and consistent with the priorities included in the PAIMI Application for the same FY. [See PAIMI Act at 42 U.S.C. 10801, PAIMI Rules at 42 CFR 51.24 (a) – Program Priorities, and the Children's Health Act of 2000 at 42 U.S.C. at 290ii-ii-1 and 290jj-jj-2].

Public Awareness Activities - provide general information on disability rights and the purpose and mission of the P&A system. Public awareness activities include public service announcements, newsletters, radio or television, publications in legal journals, web site services, general distribution of agency brochures, etc.

Public Education and Constituency Training - is the dissemination of information to one or more persons through an interactive event, which often promotes a greater understanding of the constitutional or statutory rights of persons with disabilities. Contrasted to Public Awareness Activities, education and training must be specifically targeted to meet the unique need of the group(s) trained.

Racial/Ethnic Background - The following minimum standards shall be used for all federal administrative reporting and grants reporting or record keeping requirements that include data on race and ethnicity [http://www.whitehouse.gov/omb/fedreg_1997standards/].

CATEGORIES AND DEFINITIONS:

Ethnicity:

Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American descent.

Not of Hispanic Origin.

Race:

American Indian or Alaska Native (include tribal affiliation for the Alaska native when possible) - A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Black or African American - A person having origins in any of the Black racial groups of Africa.

Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific islands.

White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Respondents have the option of selecting one or more racial designations.

Resolution of Complaint/Problem Area – is in a client's favor when (1) the client is satisfied with the result of the intervention or (2) the expressed wish or stated goal of the client is either fully attained or negotiated to an agreeable outcome, or (3) the violation in the stated case complaint/problem area was remedied.

Systemic Advocacy Activities – are the efforts taken to implement changes in policies and practices of systems that impact persons with mental illness. These "systems" include, but are not limited to, State agencies, various public and private residential care and treatment facilities, and other service providers, etc. [The PAIMI Rules at 42 CFR 51.24 (a) PAIMI Priorities state that systemic activities shall be addressed in the development and implementation of program priorities].

Technical Assistance - assistance provided to family members, non-legal guardians, professionals, or other advocates in consultation regarding an area of the law in which the P&A has expertise. It is considered a non-client directed activity.

Pre-Conference Institute for PAIMI Council Members: PAIMI Councils as Leaders for Systemic Reform

The PAIMI Advisory Council: Advising & Guiding the future, today.

1:00 - 5:00 p.m., Wednesday, September 4, 2024

1:00 – 1:30 p.m. WELCOME

- Greetings
- Sharing and introductions from state to state

1:30 - 2:00 p.m. ADVOCACY PRIORITIES

- Personal, local community & state
- PAC strategic planning

2:00 - 2:30 IDENTIFYING PAIMI PRIORITIES

- Panel discussion with a cross-section of PAIMI chairs
- Sharing different priority input methods

2:30 – 3:00 p.m. PAC 101

- The basics of PAIMI
- SAMHSA's Roles and Responsibilities

3:00 - 3:15 p.m. Break

3:15 – 3:45 p.m. PAC 101 (continued)

- New Standards and Training

- Person-Centered Language
- Q&A with Kristina Kapp (https://narpa.org/bios/kristina.kapp) from NARPA and Raquel Rosa (https://narpa.org/bios/raquel-rosa) from NDRN

3:45 - 4:45 p.m. PAC 102

- “Best Practices“
- Highlighting & celebrating P&As with successful PAIMI Councils – Alabama, Georgia, Ohio, Oregon, and New York
- Identifying, engaging, and celebrating the natural strengths, passions, and knowledge of your PAIMI Advisory Council
- Discussing how to best utilize the assets of the PAC to fulfill our PAIMI roles and responsibilities, as council and in sub-committees
- Sharing snapshots of a few state's PAIMI Advisory Council workgroups, sub-committees and community outreach and education efforts

4:45 - 5:00 p.m. The Future of PAC

- Raquel Rosa (https://narpa.org/bios/raquel-rosa) and Kristina Kapp (https://narpa.org/bios/kristina.kapp) will discuss workgroup planning. They will conclude with a discussion of the follow up that will occur from this PAIMI Institute. They will share how all those who wish to be part of the growing community participating in this PAIMI initiative can do so through follow up Zoom meetings, listening sessions, and a post-PAIMI Institute QR Questionnaire.

Lunch Roundtable Session, Friday, September 6, 2024, 11:15 a.m. – 1 p.m. Bring your lunch and join us for an informative panel discussion hosted by the NARPA PAIMI Workgroup. PAIMI Chairpersons from several states will share how their PACs engage in community outreach and priority setting, along with a discussion about recruitment for PAC membership and other council issues. (https://narpa.org/conferences/narpa-2024/paimi-lunch-roundtable)

Resource List - Books, Documents, Websites and Links (https://narpa.org/conferences/narpa-2024/paimi-institute/PAIMI-Institute-Resources.pdf)

Special thanks to the NARPA PAIMI Workgroup and NARPA members for their hard work and commitment throughout the year to create an informative and empowering 2024 PAIMI Institute. Also, thank you to Raquel Rosa (https://narpa.org/bios/raquel-rosa), Katie Basford

(https://www.narpa.org/bios/katie-basford), George Badillo (https://www.narpa.org/bios/badillo), Charisse Rupert (https://www.narpa.org/bios/charisse-rupert), Rev. Luke Shootingstar (https://www.narpa.org/bios/luke-shootingstar), Steve Stone (https://narpa.org/bios/stone), and all the other contributors, collaborators, presenters and participants!

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