Maine

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

FY 2025
PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS
Short Title: 2025 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	Heather Dubord
Title	Chief Financial Officer
Phone Number/Extension	207-626-2774
Email Address	hdubord@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	13	12	9
	Ethnicity Unknown	0	0	0
Race				
	American Indian/Alaska Native	0	1	0
	Asian	0	0	0
	Black/African American	1	0	0
	Native Hawaiian/Pacific Islander	0	0	0
	White	12	11	0
	Two or more races	0	0	9
	Some other race	0	0	0
	Race Unknown	0	0	0
Sex				
	Female	7	9	3
	Male	6	3	6

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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	13	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 9/30/2025	13
Total vacancies on 9/30/2025	2
Term of appointment (number of years)	4
Term maximum	2
Meeting Frequency	5
Number of meetings held this fiscal year (2025)	5
Percentage of members present at meetings during the 2025	89 %

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	10
Total	**13**

Footnotes:

A. PAIMI Program Information

Executive Director

Intial Appointment Date	12/10/1996 (mm/dd/yyyy)
Recent performance evaluation completed	09/25/2025 (mm/dd/yyyy)
Date of previous performance evaluation	07/25/2024 (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	0
6-10	2
11-22	13
23-64	158
65+	20
Prefer not to say	0
Total	**193**

Sex of PAIMI-eligible Individuals Served

Sex	Number
Female	103
Male	90
Total	**193**

Ethnicity and Race of Individuals Served

Ethnicity	Number	PAIMI %	State %
Hispanic/Latino (of any race)	1	0.52	2.08
Non-Hispanic/Latino	153	79.27	97.92
Ethnicity Unknown	39	20.21	0.00
Total	**193**		

Race	Number	PAIMI %	State %
American Indian/Alaska Native	3	1.55	0.45

Asian	0	0.00	1.11
Black/African American	11	5.70	1.68
Native Hawaiian/Other Pacific Islander	0	0.00	0.02
White	144	74.61	91.34
Two or more races	9	4.66	4.70
Some other race	0	0.00	0.70
Race unknown	26	13.48	0.00
Total	**193**		

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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.		32
2. Number of new PAIMI-eligible individuals served during the reporting year.		161
3. Total number of PAIMI-eligible individuals served during this FY (Add lines 1 and 2).		193
4. Individuals with more than one (1) intervention opened/closed during the reporting year.		37
5. Individuals with a co-occurring mental illness and Intellectual and Developmental Disability (IDD).		9
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.	248
	b. non-priority areas.	192
7. Individuals served as of September 30 and will be carried over to next reporting year (This should equal ≤ item 3 above).		19

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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.	3
Community Residential Home for Adults	26
Non-Medical Community-Based Residential Facility for Children/Youth	0
Foster Care	0
Nursing homes, including skilled nursing facilities	3
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 b. Private	 74 8
Jails	0
State Prison	0
Federal Detention Center	0
Federal Prison	0
Veterans' administration hospital/Clinic	0
Other Federal Facility	0
Homeless	13
Independent (in the community & PAIMI-eligible)	43
Parental or Other Family Home & PAIMI-eligible	9
Unknown	0
Total	193

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	0	1	0	0	0	0	0	0	0	0	1
c. Involuntary medication	0	0	2	0	0	0	0	0	0	0	0	2
d. Involuntary Electric Convulsive Therapy (ECT)	0	0	0	1	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	3	0	0	0	0	0	0	0	0	3
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	1	0	0	0	0	0	0	0	0	1
j. Coercion	0	0	1	0	0	0	0	0	0	0	0	1
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	0
C. Number of complaints/problems resolved in the client's favor	10
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	**11**

At least 1 case required.

Case of Alleged Abuse

DRM intervened on behalf of a 65-year-old PAIMI-eligible woman who, after being discharged from her mental health group home, was taken to the emergency room and denied re-entry to the facility. A DRM attorney collaborated with the state's Complex Case Unit to prevent a prolonged stay in the emergency room, and our client was transferred to a regular hospital bed. Working closely with the state and hospital, DRM sought a suitable community residence for the client. A suitable placement initially denied her admission because of behaviors related to her disability. Recognizing that these behaviors could be managed with proper support, the attorney submitted a reasonable accommodation request, which prompted a meeting with the facility's admission director, leading to the client's acceptance into the residence. After enduring nearly four months in the hospital, the client was successfully discharged to her new community placement, where she expressed satisfaction with this outcome.

Case of Alleged Abuse

A 48-year-old PAIMI-eligible individual, held involuntarily in a behavioral health emergency department, was forced to change into hospital scrubs despite disclosing a trauma history and offering alternative safety measures. Staff indicated that refusal would result in forcibly removing their clothing. DRM's investigation found no evidence that an individualized safety assessment had been conducted, even though the client posed no imminent risk. DRM assisted the individual in raising the issue with hospital administrators and filing a formal complaint. The hospital issued a written apology acknowledging that its actions were inconsistent with trauma-informed care standards and committed to substantial staff re-education to ensure future searches and clothing changes are based on individualized assessments and conducted with respect for patient dignity.

Case of Alleged Abuse

A 32-year-old PAIMI-eligible involuntary patient at a psychiatric hospital reported that male staff on the night shift had physically assaulted him. DRM responded immediately after a nurse made the initial report. A physical exam by medical staff showed no visible injury, but DRM ensured that the allegations were formally reported to both hospital administration and the State DHHS. Safety protocols on the unit were reviewed and updated, including assigning an additional staff member to the night shift. DRM's involvement ensured that the individual's safety concerns were taken seriously, properly documented, and addressed without delay.

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	3	0	0	0	1	0	0	0	0	4
b. Failure to provide necessary or appropriate mental health treatment, including access to prescribed medication	0	0	3	0	0	0	0	0	0	0	0	3
c. Failure to provide necessary or appropriate personal care and safety	0	0	1	0	0	0	0	0	0	0	0	1
d. Failure to provide appropriate discharge planning or release from a residential care or treatment facility	0	0	17	0	0	0	0	1	1	0	0	19
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

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	0
B. Number of complaints/problems withdrawn or terminated by client	0
C. Number of complaints/problems resolved in the client's favor	24
D. Number of complaints/problems not resolved in the client's favor	0
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	1
H. P&A withdrew due to conflict of interest or other reasons	1
I. Lost Contact	1
J. Outcome Unknown	0
K. Lack of Resources	0

Total number of Neglect complaints/problem addressed from closed cases	27

Case of Alleged Neglect

A 39-year-old PAIMI-eligible woman, involuntarily hospitalized in a psychiatric facility, sought help after months of unanswered requests for an eye exam and dental appointment. Her glasses were broken and an updated prescription was required. DRM contacted her provider, prompting immediate action. The facility confirmed a dental appointment was already scheduled and arranged the long-delayed eye exam. DRM continues monitoring access to necessary medical care to help ensure patients' basic health needs are met.

Case of Alleged Neglect

A 72-year-old PAIMI-eligible man involuntarily hospitalized in an inpatient psychiatric facility reported that excessive heat in his room was preventing him from sleeping. He had previously been allowed to open his window slightly, but staff had recently prohibited this. DRM contacted unit staff and the facilities department, resulting in a safe modification of the window and screen to allow adequate airflow. The environmental adjustment improved the client's comfort, and DRM continues monitoring similar concerns to ensure livable conditions within the hospital.

Case of Alleged Neglect

A 36-year-old PAIMI-eligible individual was discharged from a psychiatric hospital with no mental health follow-up services and no access to prescribed medication. DRM intervened to ensure proper discharge planning occurred and that barriers to obtaining medication were addressed. As a result, the client secured case management services and received the prescribed psychiatric medication necessary to maintain stability in the community.

Case of Alleged Neglect

A 64-year-old PAIMI-eligible involuntary psychiatric hospital patient requested assistance regarding ongoing medication side effects. Although a titration adjustment had been ordered by his primary psychiatric provider, the change had not been implemented. The order was not conveyed because the primary provider was away, and the covering provider was not aware of the titration plan. DRM contacted the covering provider, who reviewed the chart, evaluated the patient, and initiated the medication adjustment. The patient later reported significant improvement. DRM's involvement ensured timely coordination and proper follow-through on an essential treatment modification.

Case of Alleged Neglect

A 20-year-old PAIMI-eligible involuntarily hospitalized man was experiencing severe wisdom-tooth pain that was worsening his mental health symptoms. His guardian contacted DRM after the hospital's medical clinic declined to make a dental referral. DRM raised the concern with the treatment team and emphasized the medical necessity of addressing the source of pain. The clinic subsequently issued a referral for dental care, allowing the client to receive appropriate treatment.

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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	0	2	0	0	0	0	0	1	0	0	3
b. Failure to provide written discharge plan including a description of mental health services needed upon discharged from such program or facility	1	0	6	2	0	0	1	0	1	0	0	11
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	0	9	0	0	0	0	0	0	0	0	9
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	6	0	0	0	0	0	0	0	0	6
g. Guardianship/Conservator problems	1	1	4	0	0	0	0	0	0	0	0	6
h. The denial of rights protection information or legal assistance, including adequate and appropriate representation during commitment hearings	0	0	26	0	0	0	0	0	0	0	0	26
i. The denial of privacy rights (e.g., congregation, telephone calls, receiving mail)	0	0	8	0	0	0	0	0	0	0	0	8
j. The denial of recreational opportunities (e.g., grounds access, television, and smoking)	0	0	9	1	0	0	0	0	0	0	0	10
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	0	9	1	0	0	0	0	0	0	0	10
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	4	0	0	0	0	0	0	0	0	4
o. Advance directives issues	0	0	4	0	0	0	0	0	0	0	0	4
p. The denial of parental/family rights	0	0	0	0	0	0	0	0	0	0	0	0
q. Housing Discrimination	1	0	19	1	0	1	0	0	1	0	0	23
r. The denial of access to administrative or judicial process	0	0	5	0	0	0	0	0	0	0	0	5
s. Failure to provide educational services in the least restricted environment for PAIMI-eligible individuals	0	0	2	0	0	0	0	0	0	0	0	2
t. The denial of access to community-based rehabilitation services and/or treatment	2	1	28	1	0	0	1	0	2	2	0	37

u. The denial of access to transportation	0	0	2	0	0	0	0	0	0	0	0	2
v. Employment Discrimination	0	0	2	1	0	0	0	0	0	0	0	3
w. The denial of access to personal possessions	0	0	26	0	0	0	0	0	0	0	0	26
x. Failure to comply with commitment regulations	0	0	1	0	0	0	0	0	0	0	0	1
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	0	0	0	0	0	0	0	0	0	0	0

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	5
B. Number of complaints/problems withdrawn or terminated by client	2
C. Number of complaints/problems resolved in the client's favor	174
D. Number of complaints/problems not resolved in the client's favor	7
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	2
H. P&A withdrew due to conflict of interest or other reasons	0
I. Lost Contact	5
J. Outcome Unknown	2
K. Lack of Resources	0
Total number of Rights Violation complaints/problems addressed from closed cases	**198**

Cases of Alleged Rights Violations

A 73-year-old PAIMI-eligible involuntary patient at a psychiatric hospital reported she was unable to obtain a specific Bible and believed that spiritual materials had been removed from the unit library. DRM contacted the hospital chaplain, who promptly met with her, provided the requested Bible and additional resources, and ensured the library was restocked. DRM continues to monitor patients' ability to exercise their religious rights during hospitalization.

Cases of Alleged Rights Violations

A 33-year-old PAIMI-eligible involuntary psychiatric hospital patient sought assistance after being informed that his guardian could not contact the Assistant Attorney General's (AAG) office regarding his required Progressive Treatment Program (PTP). Although he had been awaiting discharge home, the hospital required a court-ordered PTP—implemented in the community to ensure post-discharge treatment compliance—as a condition of release. DRM determined that an

administrative exchange between the hospital and the AAG's office had stalled the process and delayed submission of the necessary paperwork. After the advocate contacted the hospital social worker and clarified the status of the case, the reviewed PTP was forwarded to the AAG's office within a day, resolving the bottleneck. The PTP order was subsequently granted, and the client was discharged home. DRM ensured the client remained informed and did not continue to shoulder the burden of administrative miscommunication.

Cases of Alleged Rights Violations

A 46-year-old PAIMI-eligible involuntary patient at a psychiatric hospital had been denied all visitation, including visits from his mother. DRM reviewed the records and raised the issue with both the ordering psychiatrist and the hospital superintendent. The superintendent agreed that the restriction violated the patient's rights because required procedures had not been followed. Visitation was reinstated immediately.

Cases of Alleged Rights Violations

A 36-year-old PAIMI-eligible involuntary patient at a psychiatric hospital sought assistance after repeated, unanswered requests to attend church services, either virtually or in the community. DRM raised the concern with staff, and her treatment team subsequently approved religious accommodations and arranged for her to participate in services virtually. The hospital's actions affirmed her right to practice her faith while hospitalized.

Cases of Alleged Rights Violations

DRM assisted a 36-year-old PAIMI-eligible man living in a supported apartment whose Medicaid benefits through MaineCare had been terminated, placing him at immediate risk of losing housing and essential services. DRM notified MaineCare of his intent to appeal and formally filed the appeal on his behalf, entering an appearance as his legal representative—thereby triggering his right to a hearing. Within days of the filing, MaineCare revisited the case and reinstated his eligibility, preventing a loss of services.

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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.	81
2. Case or investigation lacked merit.	5
3. Case withdrawn or terminated by the client.	2
4. Issue favorably resolved.	127
5. Issue not favorably resolved.	8
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.	3
9. P&A withdrew due to conflict of interest or other reasons (i.e., client would not cooperate).	1
10. Appeal(s) unsuccessful.	0
11. Other appropriate entity investigating.	0
12. Lost Contact.	6
13. Lack of Resources.	2
Total	**236**

At least 1 case required.

Case of Closing an Individual Advocacy Case File

Issue Favorably Resolved: A 46-year-old PAIMI-eligible woman, involuntarily hospitalized at a psychiatric facility, contacted DRM after reporting that a staff member had eavesdropped on a private phone call with a family member, violating her right to confidential communication. Recognizing the seriousness of the allegation, DRM promptly raised the concern with unit staff, the Director of Nursing, and the hospital Superintendent. DRM emphasized the facility's obligation to safeguard patient privacy and reminded leadership of the hospital's own policies guaranteeing confidential telephone access for involuntarily hospitalized individuals. In response, the hospital reaffirmed the policy, addressed the issue with relevant staff, and took steps to reinforce expectations regarding patient rights. The intervention ensured the client's complaint was formally acknowledged and that protections for confidential communication were upheld moving forward.

Case of Closing an Individual Advocacy Case File

Client's Objective was partially or fully met: A 35-year-old PAIMI-eligible man, involuntarily hospitalized in a psychiatric hospital after being discharged involuntarily from his supported apartment program and becoming homeless, sought services to address his mental health needs. DRM attorneys collaborated with state and hospital staff through weekly meetings to explore

viable housing and treatment options. Although the client wished to return to a supported apartment, no openings were available. A more structured mental health residential program was offered instead, and the client agreed to the transfer. He was subsequently discharged to a mental health group home and was also referred to an Assertive Community Treatment (ACT) team to support his ongoing treatment needs.

Case of Closing an Individual Advocacy Case File

Case Withdrawn or Terminated by Client: During outreach at the state's juvenile detention facility, DRM met with a PAIMI-eligible teenage resident who shared concerns about interruptions and gaps in his education. After reviewing available information, DRM identified that he was not receiving certain services and supports necessary to ensure an appropriate educational program. DRM discussed the findings with the youth and offered assistance in addressing the issues. He ultimately chose not to pursue further advocacy at that time.

Case of Closing an Individual Advocacy Case File

Issue Favorably resolved: DRM assisted a 50-year-old PAIMI-eligible woman who was facing eviction from her community mental health group home after the state's Medicaid Managed Care Organization (MCO) denied her coverage. A request from her case manager to evaluate her for a different group home triggered an MCO review that resulted in a denial of services. DRM identified due process violations in the MCO's handling of her case and filed an administrative appeal, including pre-hearing motions and subpoenas. Before the hearing occurred, the MCO reversed its decision, allowing her to remain in the group home and be waitlisted for alternative placements. With continued DRM support, she worked with her case manager to pursue independent housing, mental health services, and rental assistance.

Case of Closing an Individual Advocacy Case File

Issue Favorably Resolved: A 56-year-old PAIMI-eligible woman, involuntarily hospitalized on a psychiatric unit, sought assistance after being prohibited from accessing her cell phone. She relied on the device to pay bills and manage essential financial tasks, and prolonged inability to do so placed her at risk of missed payments, account defaults, and potential damage to her credit—consequences that can have long-term impacts on housing stability and overall financial security. Although patients are generally not permitted to use personal cell phones on the unit, DRM worked with the treatment team to secure an appropriate exception. Hospital security then allowed the phone to be temporarily removed from secure storage and brought to the unit, enabling the patient to complete her necessary financial transactions. This accommodation helped prevent avoidable financial harm.

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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	1	1	30	0	0	1	2	1	5	0	0	41
2. Limited Advocacy	4	1	56	6	0	0	1	0	1	0	2	71
3. Administrative Remedies	0	0	5	0	0	0	0	0	0	0	0	5
4. Litigation	0	0	1	1	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	0	0	0	0	0	0	0	0	0	0
7. Negotiation	0	0	116	1	0	0	0	0	0	0	0	117
Total	**5**	**2**	**208**	**8**	**0**	**1**	**3**	**1**	**6**	**0**	**2**	**236**
Neglect	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	
1. Self Advocacy Assistance	0	0	0	0	0	0	0	0	0	0	0	0
2. Limited Advocacy	0	0	0	0	0	0	0	0	0	0	0	0
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	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Rights Violations	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	
1. Self Advocacy Assistance	0	0	0	0	0	0	0	0	0	0	0	0
2. Limited Advocacy	0	0	0	0	0	0	0	0	0	0	0	0
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	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

At least 1 case required.

Case of Intervention

Limited Advocacy: A 41-year-old PAIMI-eligible man contacted DRM while hospitalized in a private psychiatric facility because he was receiving food that violated his religious dietary restrictions. Once DRM became involved, the hospital promptly adjusted his meals to comply with his religious requirements. DRM continued to follow up for several days to ensure the issue did not reoccur.

Case of Intervention

Self Advocacy Assistance: A 58-year-old PAIMI-eligible individual was being held in the psychiatric unit of a general hospital when DRM staff met with him during a monitoring visit. He reported that his electricity had been shut off at home. DRM asked whether his social worker had helped him apply for WRAP funds to restore service; he reported that no assistance had been offered. DRM facilitated a meeting with the social worker, who promptly agreed to help. DRM confirmed that the WRAP application was printed and observed the social worker and the individual calling the power company together to negotiate the outstanding bill and pursue restoration of service.

Case of Intervention

Administrative Remedies: DRM represented a 29-year-old PAIMI-eligible man in a housing discrimination complaint before the State Human Rights Commission against the agency operating his former community mental health group home. The client sought recognition of his fair housing rights after two reasonable accommodation requests had been denied, with the agency asserting it was not a housing provider and therefore not subject to federal or state fair housing laws. DRM assisted the client through every stage of the administrative process including filing objections to the investigator's no reasonable grounds finding that discrimination had occurred and representing him at the Commission hearing. Although the Commission ultimately upheld the finding of no reasonable grounds and the client did not obtain the individual relief he sought, the case resulted in a significant system-wide outcome. In its final report, adopted by the Commission, the investigator concluded that the agency is a "housing provider" subject to federal and state fair housing laws. This determination now extends to all 24 agencies operating community mental health group homes in Maine, clarifying that these programs are covered by fair housing protections. As a result, individuals living in these residences now have stronger, enforceable housing rights.

Case of Intervention

Litigation: A 72-year-old PAIMI-eligible man sought DRM's assistance an eviction proceeding that threatened both his housing and his housing voucher. DRM entered its appearance in the litigation and represented him in the forcible entry and detainer (FED) action. Through counsel-to-counsel negotiation, DRM submitted and secured a reasonable accommodation agreement allowing the client additional time to relocate safely and retain his housing stability. The parties presented the agreement to the court, which accepted it, and the landlord agreed to dismiss the eviction action upon the client's timely move. The client relocated before the hearing, and the FED was dismissed with prejudice, fully preserving his housing voucher and preventing the severe collateral consequences of an eviction judgment.

Case of Intervention

Abuse/Neglect Investigation: During outreach, DRM identified a PAIMI-eligible resident who reported a concerning practice at a mental health group home. According to the resident, staffing limitations led the home to require all residents to make a forced choice whenever another resident needed transportation in the agency van: either ride along on the trip—despite having no personal need to go—or remain outside while the house was locked. DRM initiated

an investigation and filed formal complaints with both the state licensing authority and the state mental health authority. Both agencies ultimately determined that the practice did not violate their respective standards and declined to take corrective action.

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	1
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	**1**

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.).	1
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]	**1**

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.

DRM conducted a death investigation following the passing of a PAIMI-eligible patient who died from choking while eating lunch in the common dining room of a psychiatric hospital. The individual collapsed during the meal, and staff initiated an emergency response while awaiting EMS. He was later pronounced deceased, and the medical examiner determined the cause of death to be choking on food. As part of the investigation, DRM obtained and reviewed the patient's complete hospital records, including treatment notes, supervision levels, dietary information, and the hospital's internal incident documentation. DRM also secured and reviewed video footage capturing the period leading up to the choking event, the incident itself, and staff response until EMS and, subsequently, the coroner arrived. DRM further met with the state officials responsible for oversight of the facility to gather additional information regarding hospital policies, staff training, and any corrective actions taken. Following a comprehensive review, DRM found no evidence to substantiate that the patient was subjected to abuse or neglect by hospital staff. While the death was sudden and tragic, the investigation did not reveal deviations from established supervision levels or any failure by staff to respond to the medical emergency. The case was therefore closed with a finding of no substantiated abuse or neglect.

Footnotes:

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, 2023 to 2024. (Carried over from prior FY (s))	20
2. New group cases/projects opened during the year.	112
3. Total group cases/projects worked on during the year (Add lines 1 & 2)	132
4. Total group cases/projects as of September 30, 2024 to 2025. (Carry over to next FY)	11
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	30	0	4
Abuse and Neglect Investigations (non-death related)	20,000	2	0	0
Facility Monitoring Services	20,000	26	0	7
Community Based Monitoring Services	20,000	37	0	0
Court Ordered Monitoring	0	0	0	0
Systemic Litigation	20,000	1	0	0

Educating Policy Makers	20,000	5	0	0
Other Systemic Advocacy	20,000	20	0	0
Total	**140,000**	**121**	**0**	**11**

In the second form, the Potential # of Individuals Impacted should match the number for Question 3. Total group cases/projects worked on during the year (Add lines 1 & 2). The total number of cases Concluded Successfully, Concluded Unsuccessfully, and On-going should match the number for Question 6. Total # of individuals potentially impacted by line 3.

Case of Intervention on Behalf of a Group

Abuse and Neglect Investigation. Non-Death Related.: A 32-year-old PAIMI-eligible involuntary patient at a psychiatric hospital reported that male staff on the night shift had physically assaulted him. DRM responded immediately after a nurse made the initial report. A physical exam by medical staff showed no visible injury, but DRM ensured that the allegations were formally reported to both hospital administration and the State DHHS. Safety protocols on the unit were reviewed and updated, including assigning an additional staff member to the night shift. DRM's involvement ensured that the individual's safety concerns were taken seriously, properly documented, and addressed without delay.

Case of Intervention on Behalf of a Group

Facility Monitoring Services : DRM provides contract advocacy services at both of Maine's state psychiatric hospitals and conducts regular in-person outreach and monitoring at the eight private psychiatric hospitals located across the entire state—from the southernmost facility in Sanford, Maine to the northernmost in Fort Kent, Maine (roughly 350 miles apart). These hospitals together include more than 500 inpatient beds. Several of the private facilities operate children's units, and DRM's monitoring encompasses both adult and youth psychiatric populations. Through onsite visits, meetings with patients, and direct engagement with facility leadership, DRM works to identify and address concerns and ensure that the rights of individuals receiving inpatient psychiatric care are protected throughout Maine's geographic expanse. DRM also monitors the Long Creek Youth Development Center, Maine's only juvenile correctional facility. In doing so, DRM covers the full geographic scope of the state, ensuring that youth detained in any region have access to oversight. Monitoring includes meeting with detained youth, assessing conditions and services, and raising systemic or individual concerns with facility administration as needed.

Case of Intervention on Behalf of a Group

Educating Policy Makers Access to Justice Day: Each year, the Hall of Flags at the State House is reserved for a range of legal service organizations to host information tables so Legislators, state officials, and visitors can learn about available legal resources and interact directly with staff. Disability Rights Maine is among the participating organizations, providing lawmakers with information about disability rights issues, our services, and the systemic barriers faced by the people we serve. The event, held from 8 a.m. to 12 p.m., offers an important opportunity to educate policy makers and strengthen relationships that support access to justice.

Case of Intervention on Behalf of a Group

Systemic Litigation Bates v. Glover class action. (AMHI Consent Decree): For more than three decades, DRM served as class counsel in Bates v. Glover, the institutional reform lawsuit commonly known as the AMHI Consent Decree. The case sought comprehensive relief for thousands of individuals with serious mental illness, including current and former residents of AMHI/Riverview and community members entitled to services under the settlement. The 1990 Consent Decree established statewide obligations in key service areas such as access to community mental health services, limits on hospital length of stay, provider acceptance requirements, and the availability of community housing supports. As part of the settlement, the State contracted with DRM to provide independent advocacy and to monitor the implementation of several core service protections, ensuring the rights and needs of adults with serious mental illness remained central to system oversight. On December 3, 2024, the Superior Court terminated the Consent Decree, bringing the longstanding litigation to a close. For a summary of the final proceedings and the legislative action that now establishes permanent statewide advocacy, see the Major Accomplishments section.

Case of Intervention on Behalf of a Group

Community Based Monitoring Services: DRM, as Maine's Protection & Advocacy system, is

contracted by the State to provide community-based outreach and advocacy for adults who have been determined, or are eligible to be determined, to have a significant mental illness or emotional impairment. The program is designed to meet individuals where they are, ensuring that people living in the community—not only those in institutional settings—have meaningful access to rights protection and advocacy. DRM conducts outreach across Maine, monitoring locations such as mental health crisis units, group homes, homeless shelters, public libraries, peer recovery centers, clubhouses, tent encampments, and community mental health agencies. Through these visits, advocates identify and address rights violations, support individuals in treatment and planning meetings, and help people navigate barriers to services, including access to community supports and discharge planning from inpatient settings. This statewide program reflects DRM's commitment to ensuring that adults with significant mental health conditions receive advocacy, information, and rights protection wherever they live, gather, or seek support in the community.

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Footnotes:

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;	50
b) PAIMI-eligible individuals who access benefits or services or are better able to advocate to do so;	6
c) PAIMI-eligible individuals who live in a healthier, safer, improved, or more integrated settings or are better able to advocate to do so;	21
d) PAIMI-eligible individuals are able to stay in their own home or better able to advocate to do so;	12
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;	2
g) PAIMI-eligible individuals who go to school in safe and more humane conditions;	0
h) PAIMI-eligible children (individuals) who receive appropriate services in the most integrated settings;	1
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;	9
j) PAIMI-eligible individuals who were not subject to abuse, neglect, or rights violations or are better able to advocate for to do so;	63
k) PAIMI-eligible individuals who can make their own decisions to the maximum extent feasible or are better able to advocate to do so;	76
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	80
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.	726

2. State Mental Health planning activities
DRM regularly meets with the Director of the Office of Child and Family Services to exchange updates and discuss service issues affecting children with disabilities. • DRM serves on the MaineCare Advisory Committee, a stakeholder body advising the state's Medicaid agency. • Oversight of Consent Decree Compliance: As class counsel, DRM participates in meetings with the Court Master and state mental health officials regarding system operations and compliance matters. (note this case was ended in FY 25. See Major Accomplishments section). • Transportation Advisory Committee Membership: DRM participates on the MaineCare Transportation Advisory Committee, offering input on non-emergency transportation services. • Collaboration with the Department of Education: DRM meets with the Maine Department of Education to discuss issues affecting students with disabilities and implementation of state and federal requirements. • Engagement with the Department of Corrections: DRM participates in meetings with the Maine Department of Corrections to discuss disability-related issues impacting incarcerated individuals. • Commission for Disability Employment: DRM serves on the Commission for Disability Employment, contributing to statewide efforts to improve employment outcomes for people with disabilities. • Collaboration with the Bureau of Rehabilitation Services: DRM meets quarterly with the Bureau of Rehabilitation Services to discuss shared initiatives and disability-related service delivery. • Advisory Committee on Probate Procedure: DRM participates on the Advisory Committee reviewing and updating the Maine Rules of Probate Procedure. • Meetings with Children's Residential Licensing: DRM meets with Children's Residential Licensing and OCFS to discuss oversight and monitoring of children's residential programs. • Participation in the State Health Improvement Plan Advisory Committee: DRM participates in the Maine CDC's SHIP Advisory Committee to support statewide health-planning initiatives. • Partnership with the Office of Behavioral Health: DRM meets with OBH staff to share information and discuss topics related to the adult mental health system. • Membership on the Maine Statewide Independent Living Council (SILC): DRM participates in SILC meetings. • Commission on Disability Employment (CDE): DRM attends meetings of the CDE as part of the State Workforce Board structure, supporting statewide employment planning for people with disabilities. • Quarterly Meetings with MMC Benefits Counseling (WIPA): DRM meets with Maine's Work Incentives Planning and Assistance program to exchange information on Social Security–related benefits and statewide trends. • Participation in IDEA State Advisory Panel: DRM attends meetings of the IDEA State Advisory Panel to stay informed about statewide IDEA implementation. • Public Transit Advisory Council: DRM participates in the Public Transit Advisory Council to support transit planning that includes the needs of people with disabilities. • Monthly Meetings with Superintendents of both state Hospitals, Dorothea Dix Psychiatric Center and Riverview Psychiatric Center.

3. Education, Public Awareness Activities, and Events	
1. Number of public awareness activities or events.	203
2. Number of education/training activities undertaken.	101
3. Number (approximate) of persons trained in 2.	1,600

4. Technical Assistance	
Provide the number of PAIMI Program TA services.	103

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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	0
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:

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.

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.
All clients are provided 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 psychiatric hospitals. Every patient at these hospitals are, as part of their discharge packet, given a DRM satisfaction survey upon discharge. These advocates also distribute DRM materials residential facilities we hand out copies of our brochures and solicit input and comment. 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 a provision for providing public comment on our website. These documents are attached.

b. ( ) No, (if no, briefly explain, limit to 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. (●) If **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's website is accessible. Surveys sent to clients are sent in the format identified as needed at the time of the initial intake with the client. Interpreters are present at the general public events. We have a program that converts any written document to voice, which we use as needed. Our brochure and agency publications are available in alternative format upon request.

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)]
Acadia Psychiatric Hospital Aroostook Mental Health Center Bangor Area Homeless Shelter City of Portland Homeless Services Center Consumer Council System of Maine (CCSM) Consumers for Affordable Health Care (CAHC) Dorothea Dix Psychiatric Center Eagles Nest Club House G.E.A.R. Parent Network High Hopes Club House Kennebec Behavioral Health (KBH) Legal Services for Maine Elders (LSE) LINC Club Peer Center Long-Term Care Ombudsman Program (LTCOP) Looking Ahead Clubhouse Maine Association for Community Service Providers (MACSP) Maine Association of Mental Health Services Maine Behavioral Health Maine Board of Overseers of the Bar Maine CareerCenters Maine Children's Alliance Maine MaineHealth Maine Housing Authority Maine Medical Association (MMA) Maine School of Law 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) NAIMI-Maine Northern Maine Medical Center Pine Tree Legal Assistance (PTLA) Riverview Psychiatric Center (RPC) State of Maine Bureau of Veteran Services Spring Harbor Hospital St. Mary’s Regional Medical Center Spurwink State Independent Living Council (SILC) State of Maine Judicial Branch State of Maine Legislative Branch The League of Women Voters (LWV) 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) Unlimited Solutions Club House Village Club House Volunteer Lawyers Project Wabanaki Public Health and Wellness .

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]

Outreach to racial and ethnic minority communities is incorporated into our ongoing PAIMI outreach activities wherever PAIMI-eligible individuals are likely to be located. This includes routine presence in psychiatric hospitals and other treatment settings, as well as outreach in community-based environments. Through these efforts, individuals are informed about their rights and about the availability of PAIMI advocacy services. Additional information regarding outreach conducted through broader advocacy initiatives is included in the section on advocacy on behalf of groups.

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 9. Maine has a very small minority population

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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

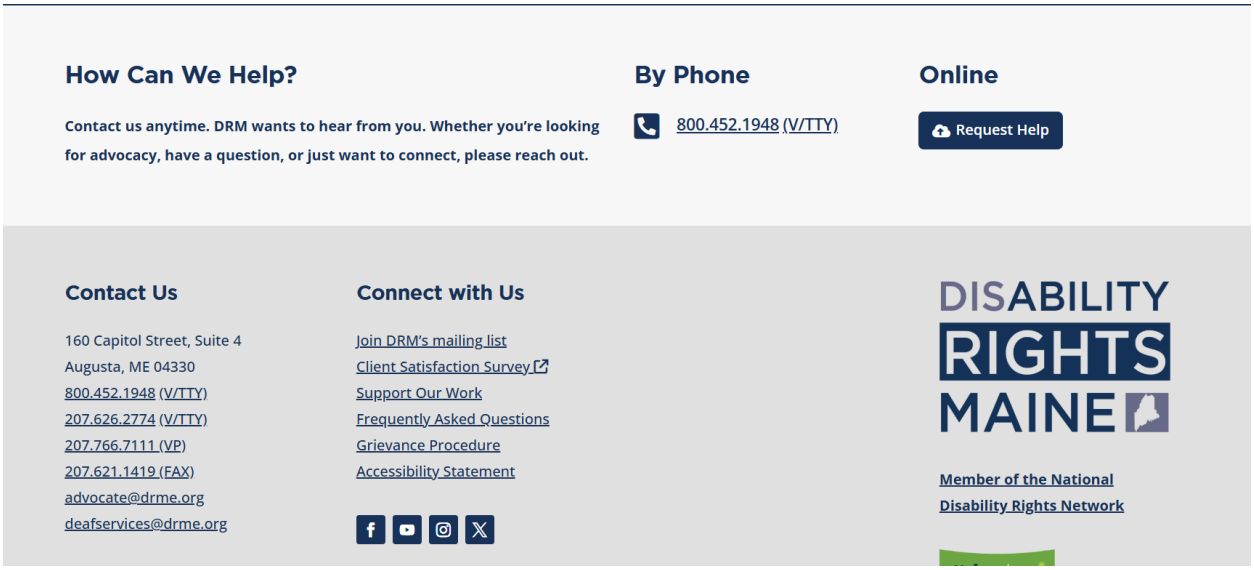
DRM is always seeking public input on the priorities of our legal and advocacy work. You can view our priorities on our website, www.drme.org, and provide us your input:

- 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.).
The most significant barrier to full implementation of PAIMI activities is that PAIMI funding has not kept pace with inflation or with the real cost of carrying out the Act. In 2004, our PAIMI grant was $410,000. Using the Consumer Price Index (CPI) that 2004 funding level would need to be approximately $700,000 in 2025 simply to have the same purchasing power. Instead, the 2025 award was $473,700. As a result, the program is required to meet the same statutory obligations with significantly diminished purchasing power. Routine operating costs such as salaries, benefits, technology, travel, insurance, and office expenses have risen much faster than the grant. When PAIMI funding does not keep pace with inflation, the lack of adequate funding, by definition, becomes the primary impediment to implementation.
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.

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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. Conclusion of the AMHI Consent Decree and Establishment of Permanent Independent Advocacy

On December 3, 2024, the Maine Superior Court dismissed the 34-year AMHI Consent Decree, ending the longest-running mental health class action in Maine history. As class counsel, DRM helped bring the case, monitored compliance over decades, and participated in the final proceedings leading to its conclusion.
In his final report, Court Master Daniel Wathen found that Maine's adult mental health system had made "enduring improvements... supported by robust advocacy." That finding reflected the State's agreement requiring DHHS to contract with the Protection and Advocacy system to provide

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)].

The most important activity needed to improve the PAIMI program is restoration of adequate funding. As explained in the section on barriers to implementation, our PAIMI grant has not meaningfully increased in more than two decades, while costs have continued to rise. Although we continue to carry out our statutory responsibilities, stagnant funding significantly limits how many individuals we can serve and the range of issues we are able to address. Increasing PAIMI funding to inflation-adjusted levels would allow us to respond to more requests for help, address emerging issues more effectively, and strengthen advocacy for individuals with mental illness across the state.

Training Needs

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

If PAIMI funding remains level or is reduced, additional technical assistance would be helpful in the form of SAMHSA-developed self-advocacy materials that can be provided to individuals referred for information and assistance. As programs are required to do more I&R when direct representation is not possible, having more high-quality materials to supplement those we already produce would help ensure individuals still receive useful guidance and support.

Upload supporting documents for Accomplishments here

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Footnotes:

APPROVED
JUNE 17, 2025
BY GOVERNOR

CHAPTER
349
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-FIVE

S.P. 736 - L.D. 1866

An Act to Amend the Laws Regarding the State-designated Agency Advocating for Individuals with Serious Mental Illness

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

Sec. 1. 34-B MRSA §3012 is enacted to read:

§3012. Advocacy services for individuals with serious mental illness

1. Legislative intent. It is the intent of the Legislature to effectuate the State's commitment to protecting the rights of individuals with serious mental illness, as demonstrated by the successful resolution and dismissal of the Augusta Mental Health Institute Consent Decree, issued on December 3, 2024, by the Superior Court, Kennebec County, Civil Action Docket No. 89-88. Independent advocacy was a key component of the system improvements that supported that resolution, and the Legislature seeks to ensure that those protections continue through the ongoing delivery of advocacy services in both institutional and community settings.

2. Contract for protection and advocacy services. The department shall contract with and make a good faith effort to obtain sufficient appropriations to fund the agency designated under Title 5, section 19502 to carry out the duties related to protecting the rights of individuals with serious mental illness in both institutional and community settings. The contract must be consistent with the scope of authority and protections provided in Title 5, chapter 511 and must ensure that advocacy services are provided statewide through a presence in at least 5 geographically dispersed areas.

3. Access to state mental health institute records. In addition to the agency's authority to access records under Title 5, chapter 511 and notwithstanding subsection 1207, the agency contracted under subsection 2 may access medical records of individuals with serious mental illness who are hospitalized in a state mental health institute as defined in section 3801, subsection 9 when necessary to provide advocacy services as authorized under Title 5.

4. Medical advice. Advocates providing services in accordance with this section are prohibited from providing medical advice.

UNITED STATES DISTRICT COURT
DISTRICT OF MAINE

UNITED STATES OF AMERICA,

Plaintiff,

v. Case No. 1:24-cv-00315-SDN

STATE OF MAINE,

Defendant.

SETTLEMENT AGREEMENT BETWEEN THE UNITED STATES OF AMERICA AND THE STATE OF MAINE

I. INTRODUCTION

A. This matter involves the services that the State of Maine (the "State") administers and delivers to children with behavioral health disabilities.

B. As a result of complaints, including a September 17, 2019 complaint, on January 27, 2021, the United States Department of Justice (the "United States") opened an investigation under Title II of the Americans with Disabilities Act (the "ADA"), 42 U.S.C. §§ 12101 et seq. and its implementing regulation, into the State's service system for children with behavioral health disabilities. Maine responded, providing information about its children's behavioral health services ("CBHS") system.

C. On June 22, 2022, the United States issued a letter with its findings ("Letter of Findings") that the State does not comply with the integration mandate of Title II of the ADA. The State disputes the United States' findings. This Settlement Agreement (the "Agreement") resolves the United States' investigation of the State.

D. The United States and the State (collectively, the "Parties") agree that it is in their interests, and the United States believes that it is in the public interest, to resolve this matter without litigation. The Parties have therefore voluntarily entered into this Agreement. In consideration of and through the terms of this Agreement, the Parties have agreed to address the issues that gave rise to the Letter of Findings and settle and fully resolve the claim in the United States' Complaint.

E. The Parties are committed to full compliance with the ADA. This Agreement is intended to memorialize the commitment of the State to furnish its behavioral

health services, programs, and activities to children with a disability in the most integrated setting appropriate to meet their needs, as required by Title II of the ADA. *See* 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d).

F. This Agreement is intended to prevent individuals with disabilities under the age of 21 with behavioral health needs from unnecessarily entering or remaining in an Out-of-Home Placement, and to support the transition of Children back to a Family Home if they have entered or remain in an Out-of-Home Placement unnecessarily. Implementation of this Agreement will strengthen the array of Community-Based Services available to Children, ensure Timely access to those services, and furnish to Children and their families service planning and Care Coordination. *See* 28 C.F.R. § 35.130(b)(7)(i). "Children" are defined at Section II. Community-Based Services," "Out-of-Home Placement," "Timely," "Family Home," "Care Coordination," and other terms used in this Agreement are defined in Appendix A: Definitions.

G. Nothing in this Agreement is intended to require the parent, guardian, or legally responsible party of a Child ("Family" or "Families") or Child to accept services furnished by the State that they choose not to accept. 28 C.F.R. § 35.130(e)(1). Families and Children who choose not to accept a particular service under this Agreement will not be barred from receiving other services under this Agreement.

H. Children will be assumed capable of having their needs met with a family, in a Family Home. A Family Home means an integrated, non-disability-specific setting in which Children live with a family who help the Child go to school, recreate, and receive services. A Family Home generally means a parental home. A Family Home also includes: (1) a kinship home, which is the home of an individual who is related to the Child by blood, marriage, or adoption; or who is a family friend whose close relationship is acknowledged by the Child's parents or by the Child; or who is unrelated to the Child but has an emotionally significant relationship with the Child or Child's Family; (2) a guardian's home; (3) a foster care home in which a foster care parent lives full-time; (4) a Therapeutic Foster Care Home (defined at Section IV.E.5), for Children in the child-welfare system; or Therapeutic Intensive Home (also defined at Section IV.E.5), for Children both in and out of the child-welfare system; or (5) a house or apartment owned or rented by the Child, if the Child has reached the age of majority or is an emancipated minor.

I. The State will furnish all services this Agreement describes. The State will furnish these services in an individualized manner consistent with the preferences, goals, needs, and abilities of each Child and their Family. The State will provide information about the services and requirements in this Agreement in a manner that is accessible to Children, Families, and other Stakeholders, including those with limited English proficiency or with disabilities that impair their communication skills. *See* 28 C.F.R. § 35.160. "Stakeholders" is defined in Appendix A. The United States agrees and acknowledges that this Agreement is not, and is not to be construed as, an admission of liability on behalf of the State

or any of its agencies, subdivisions, officers, or employees, by whom liability is expressly denied. The Parties have entered into this Agreement for the sole purpose of avoiding the burden, expenses, delay, and uncertainties of litigation. The Parties understand that this Agreement resolves certain disputes between the Parties which, if pursued, would be contested, and that this Agreement will not be construed as a precedent, admission, or agreement concerning any factual or legal questions arising from the underlying dispute.

J. Nothing in this Agreement will be construed to affect or limit the authority of: (1) Maine courts with respect to juvenile justice; or (2) the Maine Department of Corrections under Titles 15 and 34-A of the Maine Revised Statutes.

K. The "Effective Date" of this Agreement will be the date on which the U.S. District Court for the District of Maine (the "Court") enters an order, under Federal Rule of Civil Procedure 41(a)(2), retaining jurisdiction to enforce this Agreement in accordance with its terms and for its duration, as set forth in Section XII. In the event the Court declines to do so, this Agreement shall become null and void and the United States will have the right to revive any claims that may be otherwise barred by operation of this Agreement.

L. This Section I includes the goals of this Agreement. The Parties agree that the State's substantial compliance with Sections II to XV of the Agreement and its Appendices will satisfy the purposes and goals of this Agreement. The following sections of this Agreement will be interpreted consistent with the goals recited in this Section I.

II. CHILDREN COVERED BY THIS AGREEMENT

A. The Children covered by this Agreement ("Child" or "Children") are individuals up to their 21st birthday who have Behavioral Health Disabilities and:

1. Are eligible for, and, as applicable, are enrolled to receive behavioral health services offered, paid for, and/or administered by the Maine Department of Health and Human Services; and

2. Are at serious risk of an Out-of-Home Placement, are in an Out-of-Home Placement, or have an Emergency Department Stay during the pendency of this Agreement.

"Behavioral Health Disabilities" and "Emergency Department Stay" are defined in Appendix A. The Children covered by this Agreement meet this paragraph and at least one of the categories defined in Sections II.B.1–4.

B. The Children covered by this Agreement are those who meet the requirements of Section II.A and who also meet at least one of the following categories:

1. Children who, up to one year prior to the Effective Date or at any point during the pendency of this Agreement, received behavioral health services in an Out-of-Home Placement or during an Emergency Department Stay;

2. Children who, up to one year prior to the Effective Date, have been discharged from a Crisis Stabilization Unit (defined at Ch. 101, MaineCare Benefits Manual ("MBM"), Ch. II § 65.06-8.A), where they received behavioral health services;

3. Children who, at any point during the pendency of this Agreement, have been referred to or are on the waitlist to receive behavioral health services in a Crisis Stabilization Unit, emergency department, or Out-of-Home Placement due to a behavioral health need; or

4. Children who, at any point during the pendency of this Agreement, were detained in a Maine juvenile correctional facility pending adjudication or committed to such a facility post-adjudication pursuant to a criminal juvenile court order but have been released by the Maine Department of Corrections for placement outside that facility during the period of detention or commitment.

C. The presence of a co-occurring disability (such as a physical disability or brain injury) will not exclude a Child from being covered by this Agreement.

D. An Out-of-Home Placement is a setting other than a Family Home. "Out-of-Home Placement" and other terms used in this Agreement are defined in Appendix A.

E. Individuals under the age of 21 with behavioral health needs who are found not to be covered by this Agreement, and Children who are covered but then exit the population due to their failure to meet the criteria at Section II.A, will be referred and linked to other relevant services they may be eligible for as needed.

III. IDENTIFICATION OF STRENGTHS, NEEDS, AND SERVICES

A. Single Assessment.

1. Children who meet the criteria at Section III.A.3 will be offered a Single Assessment for all Medium or High Intensity Behavioral Health Services as of January 1, 2026. "Medium or High Intensity Behavioral Health Services" is defined in Appendix A.

2. The Single Assessment will include, when feasible, review of the Child's diagnoses and current and former treatment records; an interview of the Child and the Child's Family; and an interview of the Child's current

and/or former service provider(s) and educator(s). The Single Assessment will:

i. Include an instrument from the Level of Care Utilization System ("LOCUS") suite of instruments;

ii. Determine the clinically-appropriate level of care and services needed to meet the Child's behavioral health needs; provided, however, that the service planning process and Child and Family Team, defined in Appendix A, determines the service setting;

iii. Determine the Child's eligibility for High-Fidelity Wraparound Services ("HFW"), defined in Appendix A; and

iv. Inform the service planning process described below.

3. A Child will be offered a Single Assessment if:

i. A Family requests assistance from a school, medical provider, clinician, crisis services provider, or responsible State employee to: (1) address a Child's behavioral health needs that would be appropriate for Medium or High Intensity Behavioral Health Services (regardless whether the Family uses the term "Medium or High Intensity Behavioral Health Services" or identifies a specific service); or (2) place their Child in an Out-of-Home Placement;

ii. A school, medical provider, clinician, crisis services provider, or responsible State employee recommends that a Child be placed in an Out-of-Home Placement;

iii. A Child has an Emergency Department Stay;

iv. A Child has been arrested and referred to the Maine Department of Corrections pursuant to 15 M.R.S.A. § 3203-A; or

v. A Child is admitted for in-patient psychiatric care.

4. Absent emergency or other exigent circumstances, the Single Assessment will be the only assessment to determine a Child's eligibility for Medium or High Intensity Behavioral Health Services. Children periodically may be re-assessed by their provider or Care Coordinator to assure they are receiving appropriate services. Children can be reassessed through the Single Assessment at any time at the request of the Family, Child, or Care Coordinator. Where not otherwise specified, "Care Coordinator" is an umbrella term inclusive of "HFW Care Coordinators." Both "Care Coordinator" and "HFW Care Coordinator" are defined in Appendix A.

5. The State will take appropriate steps so that schools, medical providers, clinicians (including emergency departments), crisis services providers, and responsible State employees refer Children for Single Assessments.

6. For Children who meet the criteria in Section III.A.3 but who have had a recent Single Assessment and their needs have not changed, the State will furnish the Child with Care Coordination or require their existing Care Coordinator to take appropriate steps to address the Child's need for services.

B. Service Planning – Care Coordination, including High-Fidelity Wraparound Services ("HFW").

1. Care Coordination. All Children covered by this Agreement will have access to Care Coordination services guided by the Wraparound Planning Principles. Care Coordination is a service planning and coordination process provided to individuals under the age of 21 for selecting and organizing services that a Child may need to live in a Family Home, based on the Wraparound Planning Principles. Care Coordination includes but is not limited to HFW. The State will furnish the appropriate type of Care Coordination and Care Coordinator to all Children the Maine Department of Health and Human Services assesses to need Community-Based Services. "Wraparound Planning Principles" are defined in Appendix A.

2. In crisis or urgent situations, the goal of service planning will be to stabilize the Child and divert the Child whenever possible from receiving services in an Out-of-Home Placement or making an emergency department visit due to a behavioral health need by identifying and furnishing appropriate Community-Based Services.

3. Children will receive Care Coordination guided by the Wraparound Planning Principles effective as of January 1, 2027. The Wraparound Planning Principles, which are based on those established by the National Wraparound Initiative, are:

   i. Family Voice and Choice;

   ii. Family and Team Based;

   iii. Involvement of Natural Supports;

   iv. Collaboration;

   v. Community-Based;

   vi. Culturally Competent;

   vii. Individualized;

viii. Strengths-Based;

ix. Persistence; and

x. Outcome-Based.

4. High-Fidelity Wraparound Services ("HFW"). HFW, to be offered effective as of the date set forth in the Implementation Plan, but no later than January 1, 2026, is an intensive, team-based type of Care Coordination. HFW is available to those Children receiving Behavioral Health Home ("BHH") services under MBM 10-144 C.M.R. ch. 101, for selecting and organizing the services that an eligible Child needs to address their behavioral health challenges when involved in multiple child-serving systems and at risk of or in an Out-of-Home Placement, based on the Wraparound Planning Principles. HFW is a structured approach to service planning for Children that encourages flexibility and creativity in determining how to meet the Child's behavioral health needs and is intended to offer individualized, coordinated, family-driven care to meet the complex needs of Children in need of Medium or High Intensity Children's Behavioral Health Services (and their Families) who are at risk of placement in, or while preparing for Community Return from, Out-of-Home Placements, and who may experience emotional, behavioral, safety, or mental health difficulties. "Community Return" is defined in Appendix A.

5. Individualized Service Plan ("ISP"). All Care Coordination will result in a written ISP that:

i. Identifies the Child's strengths, goals, needs, and desired outcomes;

ii. States the frequency and intensity of the services needed to address the Child's behavioral health needs, based on the individualized needs assessment; as well as: (1) whether the Child is authorized to receive each service (including the amount, duration, and frequency authorized); (2) whether the Child is actually receiving each service, whether the service is working effectively, and the name of the Community Provider(s) delivering or who will deliver each service; (3) whether there are any barriers to receiving a particular service, including any issues in terms of fulfilling all authorized hours of a particular service and if so, how those barriers will be addressed; and (4) whether adjustments are needed;

iii. Documents the Informed Choice, defined in Appendix A, as to service setting;

iv. Includes a crisis plan;

v. Includes a Return Plan, defined in Appendix A and as explained in Section VIII, if the Child currently is receiving services in an Out-of-Home Placement;

vi. Anticipates and appropriately plans for significant transitions in the Child's life, including a transition to a new school and the transition to adult services; and

vii. References and coordinates with other written plans relevant to a Child's disability needs, such as an Individualized Education Plan, 504 Plan, Individualized Plan for Employment, behavioral health treatment plans, or positive behavioral support plans.

6. Child and Family Team. A Child and Family Team is a group of people, chosen with the Child and Family and connected to them through natural, community, and formal support relationships, that develops and implements the ISP. The Child and Family Team includes the Child, the Family, Natural Supports chosen by the Child and Family, service providers, and, as appropriate, representatives of the Child's school and other community contacts. The Child and Family Team is led by a Care Coordinator.

7. Care Coordinator. Care Coordinators support obtaining access for Children to Community-Based Services and have specialized knowledge and training in Care Coordination that is informed by the Wraparound Planning Principles, which are based on those developed by the National Wraparound Initiative. Care Coordinators, including but not limited to HFW Care Coordinators, deliver Care Coordination. "Care Coordinator" and "HFW Care Coordinator" are defined in Appendix A. Care Coordinators are responsible for:

i. An individualized needs assessment to identify all necessary services to meet the Child's behavioral health needs;

ii. This individualized needs assessment includes, at a minimum, a visit to the Child's home, as appropriate, observation of Family interactions, interviews with the Child, Family, and Natural Supports, and a detailed social history to identify behavioral health risk factors, child welfare involvement, and developmental trauma;

iii. Meeting in places and at times convenient for and preferred by the Child and Family;

iv. Utilizing the appropriate type of Care Coordination;

v. Liaising and coordinating with the Child and Family Team and with Natural Supports to complete and implement an ISP that addresses all necessary Community-Based Services for the Child and enables the

Child to remain in or safely return to a Family Home based on the Informed Choice of a Family or Child;

vi. Planning to ensure services are received Timely, advocating for the Child and Family, and notifying the State if necessary services are not received Timely;

vii. A process to ensure that decisions can be made in the event that the Child and Family Team cannot reach consensus. The Child should be part of decision-making, unless clinically contraindicated;

viii. Coordinating with other relevant entities, including school staff, medical providers, juvenile justice staff, and other State service program staff or contractors to ensure those programs support the ISP and Community-Based Services provided;

ix. Identifying any risks leading to a potential Out-of-Home Placement or, for a Child in an Out-of-Home Placement, individual barriers to the Child living in a Family Home;

x. Meeting the following timelines:

a. Working with the Child and Family Team to develop an ISP within 30 days of the first meeting with the Care Coordinator; and

b. Working with the Child and Family Team to repeat the individualized needs assessment and review and update the ISP and its implementation on a regular basis, but not less than every six months. The re-assessment and review will be undertaken at the request of the Child and Family and after any significant change in circumstance, including but not limited to a crisis event, a hospitalization as a result of the Child's behavioral health needs, the Child's arrest and referral to the Maine Department of Corrections pursuant to 15 M.R.S.A. § 3203-A, an admission for in-patient psychiatric care, a child welfare placement, a placement in an alternative school, or an incident endangering self or others at the Child's school; and

xi. Ensuring that Children and Families understand how to raise issues with existing services or lack of services.

8. Outcomes of the Service Planning Process.

i. The Child and Family Team, through the service planning process, addresses the services identified for the Child and how those services would be furnished to the Child, subject to Section III.B.8.iii. The service planning process will include, as appropriate, discussion of how to furnish services in a Family Home other than a parental home,

such as a kinship home or a Therapeutic Intensive or Therapeutic Foster Care Home. Each Family and/or Child will, with the assistance of the Care Coordinator and the Child and Family Team, have the opportunity to make an Informed Choice whether the otherwise eligible Child will receive services in a Family Home, including a Family Home other than a parental home. If the Child is currently eligible for an Out-of-Home Placement, a Family and/or Child may make an Informed Choice for the Child to receive services in an Out-of-Home Placement. The Informed Choice will be documented in the ISP.

ii. If the Family or Child chooses not to accept services in a Family Home, including in a Family Home other than a parental home, the refusal will be documented in the ISP. The ISP will include measures taken to afford the Family or Child with Informed Choice and address the Family or Child's concerns about the Child receiving services in a Family Home. Once a Family or Child's choice is documented, the Child and Family Team will reconvene at least annually to invite the Family and Child to re-engage with Care Coordination to furnish the Child with Community-Based Services. A Family or Child may change their mind and request Community-Based Services by contacting their Care Coordinator at any time.

iii. In the event that, despite the assumption that Children can be served in a Family Home, the Child and Family Team determines that the Child needs one or more services that are currently only available in an Out-of-Home Placement, this will be documented in the ISP. The Care Coordinator will inform the Family and Child of the option to submit a request for a reasonable modification to the Maine Department of Health and Human Services' ADA Coordinator. The Family and/or Child may submit a reasonable modification request on their own; or may request the Care Coordinator to assist them or submit it on their behalf. The ADA Coordinator will follow the Maine Department of Health and Human Services' then existing reasonable modification process to determine whether reasonable modifications are necessary to furnish the Child with Community-Based Services.

iv. If the ISP documents that a Family or Child has chosen not to accept services in a Family Home in accordance with Section III.B.8.i–ii, or the State has determined that necessary service(s) cannot be furnished to the Child in a Family Home through a reasonable modification in accordance with Section III.B.8.iii, then that Child will not count against the State for the purpose of the benchmarks and timelines required by this Agreement.

v. Every six months of the Agreement's term, the State will report the number of Children whose ISPs state that (1) a Family or Child has

chosen not to accept services in a Family Home, or (2) the Child needs one or more services that cannot be provided in a Family Home through reasonable modifications.

vi. If, during any reporting period of the Agreement, more than 10% of all ISPs for Children include (1) a choice not to accept services in a Family Home and/or (2) a need for services that Maine only offers in an Out-of-Home Placement, then the Independent Reviewer will review ISPs that include such choice or need for Out-of-Home Placement and may interview Families, Children, Care Coordinators, providers, treating professionals, and Natural Supports. The Independent Reviewer will provide technical assistance to the State about its service planning and reasonable modification processes each reporting period that this 10% threshold is exceeded. The goal of this technical assistance is to ensure that the State is: (1) proceeding from the assumption that Children can be served in a Family Home; (2) providing all Families and Children with the opportunity to make an Informed Choice; and (3) making reasonable modifications consistent with Section III.B.8.iii to serve Children in Family Homes.

vii. The Independent Reviewer will repeat the review described in Section III.B.8.vi annually. The Independent Reviewer will provide continued technical assistance so long as the 10% threshold is exceeded, until Children receive services in a Family Home in all circumstances except: (1) where a Family or Child has chosen not to accept services in a Family Home; or (2) in the event that a Child's service needs cannot be met in a Family Home through reasonable modifications.

viii. Notwithstanding Sections III.B.8.v–vii above: (1) the fact that the 10% threshold is exceeded; and/or (2) the extent of the State's compliance with technical assistance offered by the Independent Reviewer, alone, is insufficient to establish non-compliance with this Agreement.

IV. COMMUNITY-BASED SERVICES

A. Array, Intensity, and Duration. The State will include all services listed here in Section IV in its full array of Community-Based Services. The State will ensure that Children have access to the full array and intensity of Community-Based Services for which they are authorized.

1. Specific services must continue for as long as the Child remains eligible and the service continues to be included in the Child's ISP. In other words, there will not be automatic termination dates or calendar limitations on services.

2. Children will not be excluded from or denied Community-Based Services due to: (a) complex behavioral health needs; (b) significant physical or

medical needs in addition to behavioral health needs; or (c) the need for behavioral health assistance for up to 24 hours per day.

B. Statewide Availability. The State will develop and ensure sufficient statewide availability of the services listed here in Section IV.

C. Timeliness. The State will furnish Community-Based Services that Children need in a Timely manner. To be Timely, services must be available in time to prevent Children from unnecessarily: (1) entering an Out-of-Home Placement for the purpose of receiving behavioral health services; (2) remaining in an Out-of-Home Placement; or (3) having an Emergency Department Stay. For purposes of Timeliness, a Child "unnecessarily" enters or remains in an Out-of-Home Placement when the Child and/or Family are eligible for Home and Community-Based Services and are awaiting the start of such services and the delay is the primary reason the Child enters or remains in an Out-of-Home Placement. For purpose of Timeliness, a Child "unnecessarily" remains in an emergency department when the stay extends because of the Childs's unmet behavioral health needs. "Timely" is defined in Appendix A.

D. Crisis Services. The State will include the following components in its statewide crisis response system:

1. A 24/7 crisis hotline staffed with trained workers who are able to communicate with children experiencing crisis and appropriately dispatch mobile crisis intervention teams for face-to-face response as needed. The crisis hotline will assist with immediate stabilization. For all in-person responses, either the crisis hotline or a member of the mobile crisis intervention team will be available to provide telehealth stabilization support as needed to Children and their Families during the mobile crisis intervention travel time; and

2. Stand-alone mobile crisis intervention services. Mobile crisis services will serve Children who are in crisis, employing a team-based mobile response for Children experiencing a mental health or substance use crisis, including both clinical and para-professional staff available, statewide, to promptly respond to and help resolve crises, consistent with Section IX.H.4.

E. Intensive In-Home Behavioral Treatment Services. The State will ensure statewide availability of MaineCare intensive in-home behavioral treatment services, including (without limitation) Section 65 Home and Community Based Treatment ("HCT"), and Section 28 Rehabilitative and Community Supports for Children with Cognitive Impairment and Functional Limitations ("RCS"). All Children must be considered for intensive in-home behavioral treatment services through the Single Assessment, and, if eligible, offered those services during the service planning process. The Child and Family Team will, through the service planning process, determine the combination and intensity of services that will

best meet the Child's needs. Intensive in-home behavioral treatment services include:

1. Behavioral Services. Behavioral services address challenging behaviors that interfere with a Child's functioning. Behavioral services also educate the Child's family about, and train the family in managing, the Child's behavioral health disability. A qualified paraprofessional under appropriate supervision, including clinical supervision, as required by the model of treatment, will assist the family and Child in implementing the behavioral interventions. Behavioral services include:

   i. Implementation of skill-based interventions for the remediation of behaviors or improvement of symptoms, including the implementation of a positive behavior plan and modeling interventions for the Child's family for the benefit of the Child to assist them in implementing the strategies;

   ii. Development of functional skills to improve self-care, self-regulation, or other functional impairments by intervening to decrease or replace non-functional behavior that interferes with daily living tasks;

   iii. Family psychoeducation of the Child and their family about how to manage the Child's behavioral health symptoms; and

   iv. Support to address behaviors that interfere with the achievement of a stable and permanent family life and educational objectives in an academic program in the community.

2. Therapy Services. Therapy services help to ameliorate the Child's behavioral health symptoms and strengthen family structures and supports. Therapy services are situational, working with the Child and family for the benefit of the Child, preferably in their natural environment, to foster understanding of family dynamics and teach strategies to address stressors as they arise. Therapy services will improve the family's capacity to improve the Child's functioning in the home and community. Licensed therapists or otherwise certified therapists practicing under supervision of a licensed clinician will provide intensive individual and family therapy as clinically indicated. Qualified paraprofessionals working under the supervision of the licensed or certified therapist will assist the Child and family in achieving the therapy goals set by the Child and Family Team and the licensed or certified therapist.

3. Family and Youth Peer Services. Family and youth peer services include developing and linking Family and Children with peers who have personally faced the challenges of coping with behavioral health disabilities, either as a person with a behavioral health disability or as a caregiver. Peer services are family centered and help families develop

skills in managing and coping with behavioral health disabilities, become self-advocates, and identify and use Natural Supports. These services will enhance community living skills, community integration, rehabilitation, resiliency, and recovery. Peer services will be provided one-on-one, either parent-to-parent or youth-to-youth. The State will maximize the use of peer services in accomplishing the goals of this Agreement.

4. Family Supports. Services that assist and support Children's families and Natural Supports in their role as caregivers, including respite and family psychoeducation of the Child and their family about how to manage the Child's behavioral health symptoms, and family peer supports offered under BHH.

5. Therapeutic Foster Care Homes and Therapeutic Intensive Homes. Services provided to Children that meet the requirements of 22 M.R.S. § 8101(5). A Therapeutic Foster Care Home is a foster care home for children in the child-welfare system in which a specially trained parent lives full-time. A Therapeutic Intensive Home is also referred to in Maine statute or rule as "Treatment Foster Care," "Specialized Treatment Foster Homes," and "Specialized Children's Home." A Therapeutic Intensive Home is a Family Home for Children either in or outside of the child-welfare system who need to live with a specially trained parent. The specially trained parent lives in the Therapeutic Intensive Home full-time.

6. Individual Planning Funds. Individual Planning Funds are designed to provide flexible, short-term, and time-limited support to fill in gaps in services that cannot be addressed through any other funding source, for example to help the Child transition to a new service. The State will prioritize the use of Individual Planning Funds for the purpose of ensuring that Children are able to remain in or return to a Family Home. Care Coordinators will help Children access Individual Planning Funds for this purpose.

V. OUTREACH, ENGAGEMENT, AND INTERAGENCY COORDINATION

A. Outreach and Engagement About Community-Based Services.

1. Outreach Materials. Within six months of the Effective Date, the State will publish and effectively provide information for Families, Children, and other Stakeholders about Community-Based Services, how to access them, and the rights of Children under this Agreement. The State will ensure that it uses a variety of publication methods, including print and digital publications and social media, to reach Families, Children, and other Stakeholders. The State will update this information as needed and disseminate it to appropriate State agencies and Stakeholders. These materials will describe the various Community-Based Services available to Children, including how to request a Single Assessment for a Child.

These materials will direct Children, Families, and the public to the State's website and include a phone number to call for additional information.

2. Outreach. Within six months of the Effective Date, the State will begin providing outreach to Families, Children, and other Stakeholders about Community-Based Services, how to access them, and the rights of Children under this Agreement.

   i. For the first two years that this Agreement is in effect, the State will provide at least six outreach events in varied geographic regions of the State, in places and at times likely to be convenient for Families, Children, and Stakeholders, as detailed in the Implementation Plan.

   ii. For each year that this Agreement is in effect after the first two years, the State will provide at least three outreach events in varied geographic regions of the State, in places and at times likely to be convenient for Families, Children, and Stakeholders.

   iii. For each year that this Agreement is in effect, the State will leverage existing, relevant outreach programs, committees, commissions, events, and meetings to communicate relevant information about Community-Based Services, how to access them, and the rights of Children under this Agreement, including to juvenile justice entities.

   iv. The State will track and, upon request, report on the number and types of attendees at each event (e.g., Families, Community Providers, etc.), to the extent such attendees choose to disclose their affiliations or roles.

B. Interagency Cooperation. The State will take steps to ensure interagency cooperation among the Maine Department of Health and Human Services (including the Office of Behavioral Health, the Office of Child and Family Services, and the Office of MaineCare Services), the Maine Department of Corrections, and the Maine Department of Education to accomplish the requirements of this Agreement. This collaboration may include: allocation of responsibility, funding commitments, and authority for conducting and ensuring the quality of all efforts to meet requirements of this Agreement, including the provision of Community-Based Services; outreach; Community Provider training and sufficiency; Community Return; ensuring quality services; and data collection, sharing, and reporting.

VI. COMMUNITY PROVIDER SUFFICIENCY AND TRAINING

A. Match Children with Community Providers. The State will furnish Timely access to Community-Based Services by providing real-time information to Children and their Families and Care Coordinators about the location and types of services in their search area, which Community Providers have immediate availability, and

how to contact Community Providers to secure Community-Based Services for the Child. The State will continue to onboard Community Providers to its provider directory(ies), train providers to utilize the directory(ies), and promote the provider directory(ies) to community members.

B. Skilled Community Provider Workforce Recruitment. The State will take immediate steps to review, develop, implement, and update a plan to address any current or future workforce shortages of Community Providers, including Therapeutic Intensive Home parents and Therapeutic Foster Care Home parents. The State will make reasonable modifications to ensure that the number and quality of Community Providers are sufficient to enable Children to remain in, or successfully transition back to, Family Homes with necessary Community-Based Services, if consistent with their ISPs, and to have long-term stability in Family Homes throughout the State.

C. Skilled Community Provider Workforce Training. The State shall redesign its curriculum for training behavioral health professionals ("BHPs"), mental health and rehabilitation technicians ("MHRTs"), and other select Community Providers, to streamline upskilling and allow "stackable" credits as workers advance their training and certification levels. The State, through a contracted vendor, shall make such training available at no cost to appropriate individuals seeking to become Community Providers. In developing and expanding the availability of no cost training opportunities for such Community Providers, the State shall partner with provider agencies, make training opportunities available statewide, and reduce barriers to accessing training.

D. Rulemaking. The State will amend its rules governing MaineCare Community Providers to specifically describe performance expectations, and desired outcomes and ensure provider accountability for the Timeliness of services described in this Agreement.

E. Provider Flexibility and Contingency Planning. The State will ensure its rules and processes allow multiple Community Providers to be authorized to serve a Child where no one Community Provider is able to fully meet the Child's assessed need. The State will ensure that Community Providers deliver Community-Based Services with sufficient flexibility to address fluctuations in: (a) a Child's needs; or (b) a Community Provider's availability. Within one year of the Effective Date, the State will require Community Providers to develop contingency plans so that Children have access to back-up Community Providers and receive all authorized Community-Based Services on days when an individual Community Provider is unavailable. The State will provide support to Community Providers in developing contingency plans and will ensure the contingency plans are shared with the Child and Family Teams.

F. Support for Self-Direction. The State will support Children and Families who self-direct Community-Based Services and support the use of telehealth, as

appropriate. Regardless of self-direction, all Children will be offered a Care Coordinator.

G. Reporting. As part of its Implementation Plan (Section IX.B), Data Collection and Analysis Plan (Section IX.B.4), the State will report to the United States and Independent Reviewer semi-annually with reporting and data on workforce shortages affecting services required under this Agreement, steps the State has taken to increase the workforce, and whether those steps have enabled the State to furnish Care Coordination and Community-Based Services to Children, as required by Sections III and IV.

H. Communication with Provider Network.

1. Communication. The State will communicate with Community Providers and providers of Children's behavioral health services in Out-of-Home Placements, on issues related to implementation of this Agreement, including: (a) working with Community Providers to ensure Community Providers connect Children and Families to appropriate resources, including Single Assessments; (b) engaging Community Providers and providers of Children's behavioral health services in Out-of-Home Placements so that the State learns about any challenges in offering the services described in this Agreement; (c) soliciting feedback on proposed policy changes consistent with the Maine Administrative Procedure Act; and (d) offering technical assistance related to State policies, billing, and service development.

2. Quarterly Meetings. Beginning no later than three months after the Effective Date, the State will hold meetings at least quarterly with Community Providers and Out-of-Home Placement service providers to discuss issues related to State policies, reimbursement, billing, and service provision, and to gather feedback on issues such as providing services consistent with this Agreement, addressing unmet needs, and training staff. These meetings may include topics unrelated to this Agreement.

I. Training.

1. Within 14 months of the Effective Date, the Maine Department of Health and Human Services will implement training policies and mandatory, competency-based curricula to ensure Community Providers and Care Coordinators are trained in evidence-based practices sufficient to provide the services required under this Agreement pursuant to the curricula and certification processes for those evidence-based practices. The training policies and curricula will meet the requirements set forth at Appendix C: Training.

2. Within one year of the Effective Date, the State will provide joint specialized training on Care Coordination according to the Wraparound Planning Principles to all juvenile community corrections officers.

VII. FUNDING

A. The State will establish MaineCare provider reimbursement rates, pursuant to 22 M.R.S. § 3173-J, that reimburse Community Providers for the costs of providing Community-Based Services to enable Children to return to or remain in a Family Home long-term.

B. The State will provide annual cost-of-living adjustments for Community-Based Services and conduct rate determinations at least every five years for Assertive Community Treatment ("ACT") and HCT services, consistent with 22 M.R.S. § 3173-J.

VIII. RETURN FROM OUT-OF-HOME PLACEMENTS TO THE FAMILY HOME

A. Return Plan. When the Child and Family Team decides that, with planning and services, a Child in an Out-of-Home Placement can return to a Family Home, the Care Coordinator will work with the Child and Family Team to develop a Return Plan. The Return Plan is part of the ISP and lists the specific steps that will be taken so the Child can return to a Family Home and continue to receive necessary services. The Child and Family Team sets a planned discharge date in the Return Plan.

B. Community Return. Community Return is the successful process of discharging a Child from an Out-of-Home Placement to a Family Home and furnishing Timely Community-Based Services accepted by the Child and/or their Family to maintain the Child in a Family Home long-term. Preparation for Community Return begins on a Child's first day in an Out-of-Home Placement.

C. Assignment of Care Coordinators. The State will furnish Care Coordination to all Children, both in in- and out-of-State Out-of-Home Placements. Care Coordinators will facilitate Community Return for each Child in an Out-of-Home Placement, working directly with the Child and Family Team.

D. Pursuant to 14-472 C.M.R. ch. 1, the State will review complaints that are not requests for a reasonable modification from Children, Family, or Care Coordinators and make all reasonable efforts to resolve barriers identified in the complaints.

E. The State will seek, through Timely Community-Based Services, to prevent each Child who achieves Community Return from unnecessarily (1) having an Emergency Department Stay or (2) entering or remaining in in an Out-of-Home Placement. For purposes of this paragraph, "unnecessarily" has the same meaning as in Section IV.C and the definition of "Timely" in Appendix A.

IX. IMPLEMENTATION

A. Children's Behavioral Services Integration Coordinator. Within 120 days of the Effective Date, the State will appoint or hire a Children's Behavioral Services Integration Coordinator ("Coordinator"). The Coordinator will: (1) coordinate the State's efforts to comply with the terms of this Agreement; (2) have sufficient authority to direct State staff to the extent necessary to implement the terms of this Agreement; (3) have experience in program management, program implementation, and tracking of program implementation; and (4) coordinate the State's Agreement-related activities and its communications with the United States and the Independent Reviewer. The role of the Independent Reviewer is defined at Section XI. The State's Implementation Plan (Section IX.B) will address the responsibilities and role of the Coordinator. If the Coordinator position becomes vacant for any reason, the State will appoint or hire a replacement as soon as possible.

B. Implementation Plan. Immediately after the Effective Date, the State will begin developing an Implementation Plan due to the United States within 120 days of the Effective Date or within 1 week of the retention of the Independent Reviewer, whichever is later, to be updated and resubmitted at least 6 months before the end of the second full State fiscal year within the Agreement's term, and at least biennially thereafter. The Implementation Plan will:

1. Assign to the relevant State offices or employees responsibility for achieving each initiative and timeline until the development and submission of the next Implementation Plan update;

2. Establish clear strategies to achieve Agreement initiatives and outcomes;

3. Describe evaluation metrics and methods for each proposed strategy to assess efficacy and effectiveness;

4. Include a Data Collection and Analysis Plan to measure progress and completion of Agreement initiatives and outcomes. The plan will create a data collection and analysis system that:

    i. Records and maintains data on Children covered by this Agreement and numeric requirements of this Agreement to enable the Parties and Independent Reviewer to analyze data to measure whether Agreement outcomes are being achieved. The data will be available on both an aggregate and individual basis. The Parties will jointly seek a confidentiality order from the Court so that individually identifiable data will be made available to the United States pursuant to the confidentiality order. The State will provide the Independent Reviewer full access to personally identifiable or confidential information related to this Agreement and so need not be limited by the confidentiality order. The Data Collection and Analysis Plan will

enable the State to, beginning within one year of the Effective Date, produce the data to the Independent Reviewer and the United States annually;

ii. Collects and analyzes valid, reliable, trustworthy, and credible quantitative and qualitative data relevant to assessing compliance with this Agreement;

iii. Enables identification of trends, patterns, strengths, barriers, and problems at the individual, provider, and system levels, including, but not limited to, service gaps, accessibility of services, serving individuals with significant or complex needs, the discharge and transition processes; and provision of Community-Based Services to maintain Children in Family Homes long-term; and

iv. Meets the Minimum Data Elements found at Appendix B: Minimum Data Elements.

5. Outline the reasonable modifications the State will make consistent with 28 C.F.R. § 35.130(b)(7), as described in Section III.B.8.iii;

6. Consider offering therapies that are recommended for Children with developmental trauma; and

7. State the date that each of the services described in this Agreement reasonably are expected to be implemented.

C. Biennial Updates to the Implementation Plan. At least six months before the end of the second full State fiscal year within the Agreement's term, and at least biennially thereafter, the State will update the Implementation Plan. The State may consult with the United States or the Independent Reviewer. These updates to the Implementation Plan will focus on implementation for the upcoming two State fiscal years, including:

1. Assigning to the relevant State offices or employees responsibility for achieving each initiative and a timeline for the relevant time-period;

2. Challenges encountered by the State to date and strategies to resolve them;

3. Refinement of previous strategies or development of new strategies to achieve Agreement initiatives and outcomes; and

4. Development of preventative, corrective, and improvement data collection and analysis to identify and address identified challenges, and to build on successes and positive outcomes.

D. Consultative Process and Approval. Within 120 days of the Effective Date, or within 1 week of the retention of the Independent Reviewer, whichever is later,

the State will present to the United States and the Independent Reviewer its completed Implementation Plan. Within 30 days of receipt, the United States and the Independent Reviewer will provide comments to the State regarding the Implementation Plan. Within 30 days of receiving comments, the State will promptly revise its Implementation Plan to address comments from the United States and the Independent Reviewer that the State concludes are reasonably necessary to assure compliance with this Agreement. The Parties will meet and consult as necessary. The State must continue to revise its Implementation Plan until the United States approves it, provided however that the State cannot be required to include in the Implementation Plan any undertaking that is inconsistent with this Agreement or, where relevant, the Medicaid Act.

E. Publication. The State will make the Implementation Plan and biennial updates publicly available by posting them on the State's website and relevant social media accounts.

F. Outreach. The State will seek insight into the needs of Children and their Families and receive feedback on the State's progress in strengthening the array and Timeliness of Community-Based Services through the State's engagement with various Stakeholders, including: quarterly meetings with Disability Rights Maine; quarterly meetings with all CBHS providers; bi-monthly provider meetings on the Continuum of Care with the Child and Family Network; monthly discussions with the System of Care Steering Committee; monthly meetings of the Juvenile Justice Advisory Group; monthly discussions with the Quality Improvement Committee; quarterly working groups with BHH and Opioid Health Home providers; regular meetings of the MaineCare Advisory Committee; and discussions regarding the development of Certified Community Behavioral Health Clinics. The State will continue to seek such insight and feedback throughout the duration of this Agreement and may also seek such insight and feedback during the outreach and communications described in Sections V(A) and VI(H).

G. Juvenile Justice Transitions and Reporting.

1. The State will transition Children, if appropriate and eligible, out of a Maine juvenile correctional facility in accordance with the requirements of the Maine juvenile court and Titles 15 and 34-A of the Maine Revised Statutes. For Children committed to a Maine juvenile correctional facility, the State shall begin community reintegration planning at the point of admission. The case plan of each committed Child shall include whether community reintegration is appropriate and, if so, steps to be taken toward community reintegration.

2. Beginning six months after the Effective Date, and every six months thereafter, the State shall provide the United States: (1) de-identified copies of written periodic review reports of juvenile dispositions created in the prior six months pursuant to 15 M.R.S. § 3315; (2) a de-identified list of juveniles detained for more than 30 days at a Maine juvenile

correctional facility, including information on whether the Maine State District Court has provided the Maine Department of Corrections with discretion to release the juvenile; and (3) a de-identified list of juveniles committed to the custody of the Maine Department of Corrections, including information on the status of those community release efforts. The State will provide the Independent Reviewer access to the personally identifiable or confidential information in the documents referred to in this paragraph.

H. Implementation Timelines. The State's Implementation Plan and biennial updates will address how it will meet, in addition to benchmarks and timelines found throughout this Agreement and its Appendices, the following required benchmarks and timelines:

1. Care Coordination Timelines.

i. No later than January 1, 2026, the State will furnish HFW and HFW Care Coordinators to Children meeting clinical criteria through the Single Assessment as described in this Agreement.

ii. No later than January 1, 2026, the State will train 50% of Care Coordinators in the Wraparound Planning Principles.

iii. No later than January 1, 2027, the State will train all Care Coordinators in the Wraparound Planning Principles and furnish Care Coordinators and Care Coordination to all Children as described in this Agreement.

iv. The State will continue thereafter to provide training in the Wrap Around Planning Principles annually to Care Coordinators.

v. The State will continue thereafter to furnish to all Children Care Coordination that meets the requirements of this Agreement and as determined by the Child's needs.

2. Single Assessment Benchmarks.

i. No later than January 1, 2026, 50% of Children who receive a Single Assessment and engage in Care Coordination will have an ISP that meets the requirements at Section III.B.5 within 30 days of their first meeting with their Care Coordinator.

ii. No later than January 1, 2027, all Children who receive a Single Assessment and engage in Care Coordination will have an ISP that meets the requirements at Section III.B.5 within 30 days of their first meeting with their Care Coordinator.

3. HFW Ratios. Each HFW Care Coordinator will work with small numbers of Children and their respective Child and Family Teams, as specified by the ratios below. If an HFW Care Coordinator serves additional individuals other than Children covered by this Agreement, the ratio still applies to the HFW Care Coordinator's total caseload of individuals served. Children will be offered HFW with a ratio of one HFW Care Coordinator to no more than 10 Children, and will count towards the benchmarks and timelines below. If State law or policy for HFW requires a smaller ratio than listed below, that smaller ratio must apply.

   i. By January 1, 2026, 30% of eligible Children will be provided HFW with a ratio of 1 HFW Care Coordinator to no more than 10 Children.

   ii. By January 1, 2027, 60% of eligible Children will be provided HFW with a ratio of 1 HFW Care Coordinator to no more than 10 Children.

   iii. By January 1, 2028, 90% of eligible Children will be provided HFW with a ratio of 1 HFW Care Coordinator to no more than 10 Children.

   iv. By July 1, 2028, all eligible Children will be provided HFW with a ratio of 1 HFW Care Coordinator to no more than 10 Children.

4. Community-Based Services Benchmarks and Timelines.

   i. Within three months after the Effective Date, the State will submit a State Plan Amendment to CMS to implement the CMS-qualifying mobile crisis service. Upon CMS approval of a State Plan Amendment and the Maine Department of Health and Human Services adopting rules implementing the CMS qualifying mobile crisis service, 50% of face-to-face mobile crisis intervention team responses will occur within 120 minutes in rural settings, and 60 minutes in urban settings; and

   ii. Within 3 years of the Effective Date, 95% of face-to-face mobile crisis intervention team responses will occur within 120 minutes in rural settings, and 60 minutes in urban settings.

5. Community Return Benchmarks and Timelines.

   i. Within 1 year of the Effective Date, the State will accomplish Community Returns for a total of 40 Children in an Out-of-Home Placement whose ISP/Return Plan states that Community Return is a goal according to the processes at Section III.B.8;

   ii. Within 2 years of the Effective Date, the State will accomplish Community Returns for an additional 55 Children in an Out-of-Home Placement, whose ISP/Return Plan states that Community Return is a

goal according to the processes at Section III.B.8, for a total of 95 Community Transitions;

iii. Within 3 years of the Effective Date, the State will accomplish Community Returns for an additional 70 Children in an Out-of-Home Placement whose ISP/Return Plan states that Community Return is a goal according to the processes at Section III.B.8, for a total of 165 Community Transitions;

iv. Within 4 years of the Effective Date, the State will accomplish Community Returns for 80% of Children in an Out-of-Home Placement whose ISP/Return Plan states that Community Return is a goal according to the processes at Section III.B.8; and

v. Within 5 years of the Effective Date and thereafter, the State will accomplish Community Returns for 92% of Children in an Out-of-Home Placement whose ISP/Return Plan states that Community Return is a goal according to the processes at Section III.B.8. Such Community Returns will occur on or within 30 days of the date identified in the ISP/Return Plan for discharge.

vi. Each Child the State transitions from an Out-of-Home Placement may only be counted for the purposes of the benchmarks to accomplish Community Returns so long as they live in a Family Home. A previously returned Child will no longer count towards the benchmarks if they reenter an Out-of-Home Placement during the pendency of this Agreement, but will count once more if and when they achieve Community Return again.

vii. The State will track Children who achieve Community Returns but who later enter an emergency department related to a behavioral health need, or re-enter an Out-of-Home Placement. The State will analyze available data to determine contributing factors and take steps to prevent future unnecessary Emergency Department Stays and re-entry to Out-of-Home Placements.

X. ENSURING QUALITY SERVICES

A. The State will assess the adequacy of each Community Provider agency's services in terms of quality (e.g., the services are provided with fidelity to the relevant service, with appropriate training and safety protocols in place) and quantity (e.g., the total amount of authorized services are fulfilled, and appropriate steps are taken to ensure backup staff in the event of a staff member's absence).

B. Beginning 180 days after the Effective Date, the State will annually assess at least 10% of Community Provider agencies in each category of services described in Section IV. Where only one Community Provider agency offers a particular

category of services and the State does not have concerns regarding that agency's performance, an assessment of adequacy of that agency's services shall not be required in consecutive years. If the assessment reveals that a Community Provider agency's services are inadequate, then the State will give the agency technical assistance, and, when appropriate, ensure that the agency remediates the inadequacy.

C. The State will coordinate the annual assessments of Community Provider agencies under this section with other applicable licensing activities of the Maine Department of Health and Human Services and will consider recent licensing reviews in prioritizing Community Provider agencies for annual assessment.

XI. INDEPENDENT REVIEWER

A. Selection of the Independent Reviewer.

1. Independent Reviewer. The Parties will select an Independent Reviewer within four months of the Effective Date. The State will use its request for proposal ("RFP") process. The RFP will be mutually developed by the Parties to comply with the State's competitive bidding process and the United States' process for selecting an independent reviewer. The RFP will specify the criteria for selecting the Independent Reviewer. Those criteria will include that the Independent Reviewer must have expertise and experience in the provision of Home and Community-Based Services for children with Behavioral Health Disabilities, including facilitating and overseeing: (1) administration, funding, and delivery of such services; and (2) transitions to Community-Based Services from Out-of-Home Placements. The United States will participate in review and evaluation of the RFP and applications for the Independent Reviewer. Both Parties must agree on which applicant will be selected pursuant to the RFP process. The initial term of the contract with the Independent Reviewer will be three years, which will be renewed for the remainder of the duration of the Agreement unless or until the Independent Reviewer resigns or the Parties agree not to renew. If the Independent Reviewer resigns or the Parties agree not to renew, the Parties will replace the Independent Reviewer.

2. Replacement of the Independent Reviewer. If the Independent Reviewer resigns or their contract is terminated or not renewed, then the Parties will jointly select a new Independent Reviewer within four months of the prior Independent Reviewer's last day, in conformance with Section XI.A.1.

B. Independent Reviewer's Powers and Responsibilities.

1. Independent Reviewer's Role. Throughout the term of this Agreement, the Independent Reviewer will gather, analyze, and report on information and data reflecting the State's progress in complying with all sections of this Agreement. The Independent Reviewer will pursue a problem-solving

approach to resolve amicably any disagreements that arise between the Parties so the Parties can focus on the State's compliance with the Agreement.

2. Assessment Methodology Plan. The Independent Reviewer will consult with the Parties and submit to them a written plan on the methodologies the Independent Reviewer will use to assess compliance with and implementation of the Agreement. The Parties will provide the Independent Reviewer with any comments on the plan before its implementation. The Independent Reviewer's methodologies will include on-site inspection of Children's residences and programs; detailed review of relevant documents, records, and data collected by the State and behavioral health service providers, including ISPs; may include interviews with Families, Children, school administrators, providers, Natural Supports, Care Coordinators, Stakeholders, and relevant State staff; individual case reviews, including the quality and sufficiency of ISPs, by regularly reviewing sufficient samples of Children, including through first-person interviews; and other methodologies as agreed to by the Parties. The plan will also identify data elements the Independent Reviewer will request from the State.

C. Written Annual Reports. The Independent Reviewer, in every fiscal year within the term of this Agreement, will submit to the Parties a comprehensive public report on the State's compliance with the terms of the Agreement during the preceding State fiscal year. Additionally, nine months prior to the date that the Agreement is otherwise intended to terminate, the Independent Reviewer will prepare a final report on compliance. These reports must include recommendations for facilitating or sustaining compliance. The reports must specify how the State is or is not in compliance with each of its obligations in the Agreement; for future obligations in the Agreement, the Independent Reviewer will report on whether the State is progressing at an appropriate pace toward achieving compliance when the obligation takes effect. These reports may contain personally identifiable or confidential information when provided to the Parties. Such information will be redacted from the public version of the reports. At least 45 days before finalizing any of these reports, the Independent Reviewer must provide a draft of the report to the Parties for comment. The Parties have 30 days to comment, and the Independent Reviewer has 15 days to finalize the report after receiving comments from both Parties. After the Independent Reviewer submits a report to the Parties, the State shall publish the public version of the report on its website. The finalization or publishing of any report shall not constitute agreement by a Party to its contents or conclusions.

D. Technical Assistance. The Independent Reviewer may provide the State with technical assistance relating to any aspect of this Agreement.

E. Impact of Technical Assistance on Compliance. The State's implementation or non-implementation of the technical assistance of the Independent Reviewer, as

documented in the Independent Reviewer's reporting, will be a factor in evaluating non-compliance with this Agreement, but is insufficient to establish non-compliance.

F. Independent Reviewer's Authority. In completing these responsibilities, the Independent Reviewer may:

1. Hire staff and consultants as necessary to assist in carrying out the Independent Reviewer's duties and responsibilities.

2. Require the State and its behavioral health service providers to produce records and data, including Children's individual patient or client files to which the State has access, as requested, pursuant to the confidentiality order, per Section IX.B.4.i.

3. Enter, with or without advance notice, any part of any Out-of-Home Placement or program providing services to Children and interview individuals with knowledge pertinent to compliance with this Agreement. Staff and consultants of the Independent Reviewer must also have this authority. The State will facilitate the Independent Reviewer's access if an Out-of-Home Placement or program denies entry.

4. Communicate *ex parte* with a Party, counsel, agents or staff of the Parties, or anyone else the Independent Reviewer deems necessary for completing their responsibilities. The State may require that the Independent Reviewer copy its counsel on any written communications with any responsible State employees or staff.

5. Conduct interviews of Families, Children, school administrators, providers, Natural Supports, Care Coordinators, Stakeholders, and relevant State staff. The State may require that its counsel be present when the Independent Reviewer interviews any responsible State employees or staff.

6. Testify in any case between the Parties regarding any matter relating to the implementation, enforcement, or dissolution of the Agreement, including, but not limited to, the Independent Reviewer's observations, findings, and recommendations in this matter.

7. Limitations. The Independent Reviewer, and any staff or consultants retained by them, will not:

   i. Be liable for any claim, lawsuit, or demand arising out of their activities under this Agreement. This paragraph does not apply to any proceeding for payment to the Independent Reviewer or their consultants or staff required in connection with their work under the Agreement.

ii. Enter, while serving as the Independent Reviewer, into any new contract with the State or the United States, unless the other Party consents in writing.

iii. Be subject to formal discovery involving the services or provisions reviewed in this Agreement, including, but not limited to, depositions, requests for production of documents, requests for admissions, interrogatories, or other disclosures.

iv. Absent a subpoena, testify in any other litigation or proceeding with regard to any act or omission of the State or any of its agents, representatives, or employees related to this Agreement, nor testify regarding any matter or subject that they may have learned as a result of their performance under this Agreement, nor serve as a non-testifying expert regarding any matter or subject that they may have learned as a result of their performance under this Agreement.

G. Independent Reviewer's Budget.

1. The Independent Reviewer will submit a budget providing a detailed breakdown of expenses in performing the services required of the Independent Reviewer under this Agreement through the end of the first full State fiscal year within this Agreement, as well as subsequent years. This requirement may be in addition to any requirements of the RFP process.

2. Reimbursement and Payment.

i. State to Bear Costs. The State will bear the cost of the Independent Reviewer, including the cost of any staff or consultants to the Independent Reviewer, pursuant to a contract between the Independent Reviewer and the State. However, the Independent Reviewer and their staff or consultants are not State agents except to the extent necessary for the State to share personally identifiable or confidential information.

ii. Reimbursement. The State will reimburse the costs and reasonable expenses of the Independent Reviewer pursuant to a contract between the State and the Independent Reviewer up to the limits of the contract, which shall not exceed $900,000 for three years.

H. Monthly Statements. The State's contract with the Independent Reviewer will require the Independent Reviewer to submit monthly statements to the State, detailing all expenses the Independent Reviewer incurred during the prior month.

XII. JURISDICTION AND ENFORCEMENT

A. The U.S. District Court for the District of Maine (the "Court") has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331, 1345.

B. The Agreement will be interpreted in accordance with federal law and the laws of the State of Maine.

C. Upon execution of this Agreement, the Parties shall file a joint motion with the Court pursuant to Federal Rule of Civil Procedure 41(a)(2), requesting that the Court retain jurisdiction over the case for purposes of enforcing the Agreement in accordance with its terms and for its duration.

D. This Agreement will become effective only upon the Court's approval of the Agreement and entry of an order under Federal Rule of Civil Procedure 41(a)(2), retaining jurisdiction over this case for the purposes of enforcing the Agreement in accordance with its terms and for its duration. In the event the Court declines to enter an order retaining jurisdiction to enforce this Agreement in accordance with its terms and for its duration, this Agreement shall become null and void and the United States will have the right to revive any claims that may be otherwise barred by operation of this Agreement.

XII. TERMINATION

A. The Agreement shall terminate six years from the Effective Date if the State is in substantial compliance with the Agreement, without further action of the Court, unless otherwise terminated, canceled, or extended. Therefore, the Agreement, unless otherwise terminated, canceled, or extended, shall terminate six years after the Effective Date unless:

1. The Parties jointly ask the Court to terminate the Agreement before the termination date, provided that the State has substantially complied with the Agreement and maintained substantial compliance for one year; or

2. The United States disputes that the State is in substantial compliance with the Agreement as of six months prior to the termination date. Both parties may present briefing and exhibits to the Court before the Court rules on the United States' motion. The burden shall be on the State to demonstrate that it has substantially complied with the Agreement and maintained substantial compliance for at least six months.

XIV. GENERAL PROVISIONS

A. Binding Agreement. This Agreement is binding on the Parties, by and through their officials, agents, employees, and successors for the term of this Agreement. To the extent that the State decides to contract with or otherwise assign a third party to implement any actions relating to compliance with this Agreement, the

third party's actions or inactions do not constitute a defense to non-compliance. 28 C.F.R. § 35.130(b)(1). The State will align the terms of any such contracts with its obligations under this Agreement and will ensure that contracted parties and agents take all actions necessary for the State to comply with the provisions of this Agreement.

B. Protections Against Retaliation for Complainants, Witnesses, and Whistleblowers. The State will not retaliate against any individual who (1) opposes any act or practice that violates this Agreement, (2) has made or may make a complaint related to this Agreement, or (3) has testified or may testify, has assisted or may assist, or has participated or may participate in any manner in an investigation, proceeding, or hearing related to this Agreement. The State will timely and thoroughly investigate any allegations of such retaliation and take any appropriate corrective actions. The State will promptly report to the United States these allegations of retaliation.

C. Protections Against Coercion and Retaliation for Children. The State will refrain from, and take reasonable steps to prevent Out-of-Home Placement staff, hospitals, Community-Based Service providers, or State contractors from: (1) pressuring any Child or their Family to choose to receive behavioral health services outside of a Family Home and/or to decline Community-Based Services, or (2) subjecting any Child or their Family to any form of retaliation by out-of-home staff, hospitals, State staff, or State contractors for seeking alternatives to behavioral health services outside of a Family Home. The State will timely and thoroughly investigate any allegations of such pressure or retaliation by State staff or a provider of covered services and take any appropriate corrective actions. Supporting the Informed Choice of a Family or Child for the Child to receive services outside of a Family Home shall not constitute "pressure" under this section.

D. Voluntary Settlement. The Parties represent and acknowledge that this Agreement is the result of extensive, thorough, and good-faith negotiations. The Parties further represent and acknowledge that the terms of this Agreement have been voluntarily accepted, after consultation with counsel, for the purpose of making a full and final compromise and settlement of any and all claims or allegations set forth in the Complaint in *United States v. Maine*, case number 1:24-cv-00315. Each Party to this Agreement represents and warrants that the person who has signed this Agreement on behalf of a Party is duly authorized to enter into this Agreement and to bind that Party to the terms and conditions of this Agreement. No other group, individual, or agency of the United States government, is bound by or waives or resolves any claims related to this Agreement.

E. Amendment of Programs. The State reserves the right to amend its programs, including children's behavioral health services, so long as the State timely apprises the United States and Independent Reviewer of any and all proposed amendments that are relevant to this Agreement, and provide assurances that the amendments, if adopted, will not hinder the State's compliance with this

Agreement. The continued receipt of services under the MaineCare Program by any Child shall be contingent upon the Child's remaining a Maine resident eligible for MaineCare services.

F. Ex Parte Communications. Neither Party may engage in *ex parte* communications with the Court.

G. Modifications. This Agreement may be modified only by consent of the Parties in writing, signed by both Parties and approval of the Court except that the Parties may extend any time limit or deadline in this Agreement, other than the termination date, by mutual written consent without Court approval.

H. Third-Party Challenges. The Parties will promptly notify each other of any judicial or administrative challenge to this Agreement or any portion thereof, and both Parties must defend against any challenge to the Agreement.

I. No Third-Party Beneficiaries. No person or entity is intended to be a third-party beneficiary of the provisions of this Agreement for purposes of any civil, criminal, or administrative action, and accordingly no person or entity may assert any claim or right as a beneficiary under this Agreement in any civil, criminal, or administrative action. This Agreement is not intended to expand the right of any person or entity to seek relief against the State or their officials, employees, or agents.

J. Failure to Enforce Not a Waiver. The United States' failure to enforce any benchmark, timeline, or other provision of this Agreement will not be construed as a waiver of any enforcement rights.

K. Entire Agreement. This Agreement constitutes the entire agreement between the United States and the State in this matter. No other statement, promise, or agreement, either written or oral, made by any Party or agents of any Party, that is not contained in this Agreement, including its Appendices, is enforceable.

L. Reviewing Compliance. The Independent Reviewer and the United States may review compliance with this Agreement at any time. The State will cooperate with efforts to monitor compliance with this Agreement. The Independent Reviewer, any staff/consultants hired by the Independent Reviewer, and the United States will have full access to the people, places, and documents that are necessary to assess the State's compliance with and implementation of this Agreement, consistent with the Parties' confidentiality order, Section IX.B.4.i. Access will include departmental or individual medical and other records pursuant to the confidentiality order, Section IX.B.4.i. Other than to carry out the express functions as set forth herein, both the United States and the Independent Reviewer will hold information received to monitor compliance with this Agreement in strict confidence and to the greatest extent possible under federal and state law.

M. Impossibility. Noncompliance with this Agreement due to circumstances outside of the State's control that are unanticipated, unpreventable, and unavoidable and

make it impossible to perform the Agreement's requirements will not constitute a breach of this Agreement.

N. Litigation Holds. For purposes of the Parties' preservation obligations under Federal Rule of Civil Procedure 26, as of the Effective Date, litigation is not "reasonably foreseeable" about the matters described in the findings letter the United States issued to the State on June 22, 2022. To the extent that either Party previously implemented a litigation hold to preserve documents, electronically stored information, or things related to the matters described in this findings letter, the Party need not maintain the litigation hold.

O. Severability. If any provision of this Agreement is found to be invalid, unenforceable, or otherwise contrary to applicable law after the Effective Date, the other terms of the Agreement shall nonetheless remain in effect.

P. Notice. Any notices or responses necessary under this Agreement will be sent by electronic mail to the recipient's counsel of record.

XV. DISPUTE RESOLUTION

A. Informal Dispute Resolution. The Parties agree to work collaboratively to achieve the purpose of this Agreement and will attempt to resolve informally any disagreements that may arise. If a dispute arises over the language or construction of this Agreement or its requirements, the Parties agree to meet and confer in an effort to achieve a mutually agreeable resolution before seeking a judicial remedy. The Parties may seek the assistance of the Independent Reviewer in resolving any disputes.

B. Formal Dispute Resolution.

1. If the United States believes that the State is failing to fulfill any obligation of this Agreement during the pendency of the Agreement, then the United States will notify the State in writing of the alleged non-compliance, and request that the State correct the non-compliance, before initiating any court proceeding. The State will have 30 days to respond to the United States in writing. If the United States believes that any alleged non-compliance poses an immediate and serious risk to the life, health, or safety of a Child, the United States will notify the State and request that the State correct the non-compliance within a shorter time proposed by the United States or will seek a judicial remedy.

2. In such written response, the State will, for each allegation of non-compliance, either: (a) accept (without necessarily admitting) the allegation of non-compliance and propose a curative action plan describing all steps that the State will take to cure the non-compliance and the dates by when it will take these steps; or (b) deny non-compliance.

3. If the State fails to respond within 30 days, or a shorter time proposed by the United States in the event of immediate and serious risk to the life, health, or safety a Child, or proposes a curative action plan that the United States deems insufficient, then the United States may seek a judicial remedy.

4. If the State responds in a timely manner and proposes a curative action plan, then the United States may accept the State's proposal or offer a counterproposal for a different curative action plan. If the Parties reach an agreement that varies from the Agreement's provisions, the new agreement must be in writing, signed by the Parties, and subject to Court approval per Section XIV.G. If the Parties fail to reach agreement on a curative action plan, the United States may seek a judicial remedy.

C. The processes described in this Section are not required prior to seeking a judicial remedy when the United States believes that any alleged non-compliance related to conditions or practices poses an immediate and serious risk to the life, health, or safety of a Child. In that event, the United States may immediately seek a judicial remedy.

D. The processes described in this Section are not required if the United States believes that the State has failed to fulfill any obligation of this Agreement as of six months prior to the Agreement's termination date.

FOR PLAINTIFF UNITED STATES OF AMERICA

KRISTEN CLARKE
Assistant Attorney General
Civil Rights Division

REBECCA B. BOND
Chief
ANNE S. RAISH
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Dated:

FOR DEFENDANT STATE OF MAINE

_____

SARA GAGNÉ-HOLMES
Commissioner
Maine Department of Health and Human Services

Dated:

_____

AARON M. FREY
Maine Attorney General
Office of the Maine Attorney General

Dated:

APPENDIX A: DEFINITIONS

This Agreement references the following defined terms throughout:

A. **Behavioral Health Disabilities**: Children with Behavioral Health Disabilities are individuals up to their 21st birthday with mental health and/or developmental disabilities, as defined at 28 C.F.R. § 35.108(a)(1), who have behavioral health needs.

B. **Care Coordination**: A service planning and coordination process provided to individuals under the age of 21 for selecting and organizing services that a Child may need to live in their Family Home, based on the Wraparound Planning Principles described below. HFW is a type of Care Coordination, defined below. Where not otherwise specified, "Care Coordination" is an umbrella term inclusive of HFW.

C. **Care Coordinator**: Care Coordinators support obtaining access for Children to Community-Based Services and have specialized knowledge and training in Care Coordination that is informed by the Wraparound Planning Principles, which are based on those developed by the National Wraparound Initiative. Care Coordinators that deliver HFW are referred to as HFW Care Coordinators, defined below. Where not otherwise specified, "Care Coordinator" is an umbrella term inclusive of HFW Care Coordinators.

D. **Child/Children**: Individuals who are covered by this Agreement because they meet the requirements at Section II.

E. **Child and Family Team**: A Child and Family Team is a group of people, chosen with the Child and Family and connected to them through natural, community, and formal support relationships, that develops and implements the ISP. The Child and Family Team includes the Child, the Family, Natural Supports chosen by the Child and Family, service providers, and, as appropriate, representatives of the Child's school and other community contacts. The Child and Family Team is led by a Care Coordinator.

F. **Community-Based Services**: Individualized, person-centered, flexible, and culturally and linguistically competent behavioral health services provided to individuals under the age of 21, delivered in integrated settings, with an emphasis on positive behavioral supports, to help Children live in Family Homes. These services are available statewide and help recipients lead integrated lives with participation in community life consistent with their preferences and needs, and those of their Family. Community-Based Services are delivered at times and locations that a Child and their Family selects. They may be defined in the State's Medicaid State Plan, defined in a Medicaid waiver, or State-funded. They include, but are not limited to: identification of strengths, needs, and services, defined at Section III; and the Community-Based Services included in Section IV.

G. **Community Provider**: A behavioral health service provider who, through an agency or on an individual basis, provides Community-Based Services to individuals under the age of 21.

H. **Community Return**: Community Return is the successful process of discharging a Child from an Out-of-Home Placement to a Family Home and furnishing Timely Community-Based Services accepted by the Child and/or their Family to maintain the Child in a Family Home long-term. Preparation for Community Return begins on a Child's first day in an Out-of-Home Placement.

I. **Emergency Department Stay**: An Emergency Department Stay occurs when a Child: (1) enters an emergency department primarily because of a behavioral health need, and (2) remains unnecessarily in an emergency department because of a behavioral health need. A stay is unnecessary for purposes of this definition when the stay extends because of the Childs's unmet behavioral health needs.

J. **Family/Families**: The parent, guardian, or legally responsible party of a Child. When referring more generally to a family, to include, for example, foster family members, extended family, and siblings, this Agreement uses lowercase "family."

K. **Family Home**: An integrated, non-disability-specific setting in which Children live with a family who help the Child go to school, recreate, and receive services. A Family Home generally means a parental home. A Family Home also includes: (1) a kinship home, which is the home of an individual who is related to the Child by blood, marriage, or adoption; or who is a Family friend whose close relationship is acknowledged by the Child's Family or by the Child; or who is unrelated to the Child but has an emotionally significant relationship with the Child or Child's Family; (2) a guardian's home; (3) a foster care home in which a foster care parent lives full-time; (4) a Therapeutic Foster Care Home (defined at Section IV.E.5), for Children in the child-welfare system; or Therapeutic Intensive Home (also defined at Section IV.E.5), for Children both in and out of the child-welfare system; or (5) a house or apartment owned or rented by the Child, if the Child has reached the age of majority or is an emancipated minor.

L. **HFW Care Coordinator**: HFW Care Coordinators connect Children to Community-Based Services and have specialized knowledge and training to provide HFW.

M. **High-Fidelity Wrap Around Service (HFW)**: An intensive, team based type of Care Coordination available to those Children receiving Behavioral Health Home ("BHH") services under MBM Chapter II, Section 92 for selecting and organizing the services that an eligible Child needs to address their behavioral health challenges when involved in multiple child-serving systems and at risk of or in an Out-of-Home Placement, based on the Wraparound Planning Principles. HFW is a structured approach to service planning for Children that encourages flexibility and creativity in determining how to meet the Child's behavioral health needs and is intended to offer individualized, coordinated, family-driven care to meet the complex needs of Children in need of Medium to High-Intensity Behavioral Health Services (and their

Families) who are at risk of placement in, or while preparing for Community Return from, Out-of-Home Placements, and who may experience emotional, behavioral, safety, or mental health difficulties.

N. **Informed Choice**: A choice that a Family and/or a Child make about the setting where the Child will live and receive services, after receiving information about and being considered for all of the behavioral health services offered, paid for, and/or administered by the State for which the Child is eligible under the Single Assessment, and with the assumption that the Child's service needs can be met in a Family Home, with reasonable modifications if appropriate. To ensure the Child and their Family can make an Informed Choice, the State must provide information about services the Child would receive in a Family Home; including, for example, educating the Child and their Family about the benefits of the Child living in a Family Home; facilitating, when possible and appropriate, meetings with Community Providers, Therapeutic Foster Care Home parents, and Therapeutic Intensive Home parents who could serve the Child in a Family Home; and providing opportunities, when available, to meet other Children and Families who are receiving services in a Family Home. The State must identify and address, when possible, any concerns or objections that the Child or their Family may have about living and receiving services in a Family Home. A Child and Family's Informed Choice can and may change.

O. **Medium or High Intensity Behavioral Health Services**: These are services provided to individuals under the age of 21 and include Section 28 Rehabilitative and Community Support Services for Children with Cognitive Impairment and Functional Limitations ("RCS"): Standard Services, Specialized Services, and BCBA Services; Section 65 Behavioral Health Services: Intensive Outpatient Programs, Assertive Community Treatment ("ACT"), Children's Home and Community Based Treatment ("HCT"); Multi-Systemic Therapy; Functional Family Therapy; Hi-Fidelity Wraparound for Behavioral Health Homes under Section 92; Section 97 Private Non-Medical Institutions: Children's Residential Care Facility Services; Therapeutic Foster Care Homes; Therapeutic Intensive Homes; and Section 107 Psychiatric Residential Treatment Facility Services.

P. **MaineCare Benefits Manual ("MBM")**: As of the Effective Date, MBM can be found at 10-144 Code of Maine Rules, ch. 101.

Q. **Natural Supports**: A Natural Support is a person who (1) is not employed by a provider agency; (2) knows a Child personally; and (3) helps the Child live in and engage with the community.

R. **Out-of-Home Placement**: An Out-of-Home Placement is a residential setting other than a Family Home, whether within Maine or out-of-state, where a Child receives services primarily based on a behavioral health need. An Out-of-Home Placement is not a violation of this Agreement if a Family or Child, through the service planning process or otherwise, makes an Informed Choice that the Child will receive services in an Out-of-Home Placement. An emergency department is not an Out-of-Home Placement.

S. **Return Plan**: When the Child and Family Team decides that, with planning and services, a Child in an Out-of-Home Placement can return to a Family Home, the Care Coordinator will work with the team to develop a Return Plan. The Return Plan is part of the ISP and lists the specific steps that will be taken so the Child can return to a Family Home and continue to receive necessary services. The Child and Family Team sets a planned discharge date in the Return Plan.

T. **Stakeholders**: Stakeholders include Children, Families, and individuals who provide any services to Children such as advocates, advocacy organizations, attorneys, Care Coordinators, children's counselors, child welfare leadership and staff, service providers, foster families, family court judges, juvenile justice leadership and staff, juvenile criminal court judges, law enforcement personnel, Natural Supports, peer service providers, pediatricians, child psychologists, child psychiatrists, social workers, school staff, and therapists.

U. **Timely/Timeliness**: To be Timely, services must be available in time to prevent Children from unnecessarily: (1) entering an Out-of-Home Placement for the purpose of receiving behavioral health services; (2) remaining in an Out-of-Home Placement; or (3) remaining in an emergency department. For purposes of Timeliness, a Child "unnecessarily" enters or remains in an Out-of-Home Placement when the Child and/or Family are eligible for Community-Based Services and are awaiting the start of such services and the delay is the primary reason the Child enters or remains in an Out-of-Home Placement. For purpose of Timeliness, a Child "unnecessarily" remains in an emergency department when the stay extends because of the Child's unmet behavioral health needs.

V. **Wraparound Planning Principles**: The Wraparound Planning Principles are based on those established by the National Wraparound Initiative. These ten principles are:

1. Family Voice and Choice: Family and Child perspectives are gathered and prioritized throughout the ISP development and Care Coordination processes.

2. Child and Family Team Based: The Child and Family Team consists of individuals agreed upon by the Family and Child and committed to them through informal, formal, and community support and service relationships.

3. Involvement of Natural Supports: The Child and Family Team actively seeks out and encourages the full participation of Child and Family Team members drawn from the Child's Family and others in the Child's networks of relationships chosen by the Child.

4. Collaboration: Child and Family Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single ISP.

5. Community-based: The Child and Family Team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and most integrated settings appropriate for the Child's needs

possible, and that safely promote the Child and Family integration into home and community life.

6. Culturally competent: Wraparound service delivery demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the Child and Family, and their community.

7. Individualized: To achieve the goals laid out in the ISP, the Child and Family Team develops and implements a customized set of strategies, supports, and services.

8. Strengths-based: Wraparound identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the Child and Family, their community, and other Child and Family Team members.

9. Persistence: Despite challenges, the Child and Family Team persists in working toward the goals included in the ISP.

10. Outcome-based: The Child and Family Team ties the goals and strategies of the ISP to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

APPENDIX B: MINIMUM DATA ELEMENTS

A. The Data Collection and Analysis Plan will include the following minimum data elements:

1. Tracking the number of individual calls to the crisis hotline requesting crisis services for Children, the response time for providing requested services, and any follow-up after the call;

2. For each Child identified for a Single Assessment—

   i. The Child's date of birth, city of residence, referral source, and services recommended by the individualized needs assessment to identify all necessary services to meet the Child's behavioral health needs;

   ii. Status of Care Coordination, including the length of time between the Single Assessment and the first meeting between the Family, Child, and Care Coordinator, and additional data such as date of the initial ISP development, the date of the last update to each Child's ISP, and the list of members on the Child and Family Team;

   iii. The Child's current address, designating the type of setting;

   iv. Whether the Child has been identified for Community Return, the date they were so identified, and the current status;

   v. Single Assessment referral source;

   vi. In a randomized sample of cases, comparison of authorized services to received services, by type and quantity; and

3. The number of Community Providers available to provide Community-Based Services, including peer supports, and number of Therapeutic Intensive Homes and Therapeutic Foster Care Homes.

B. Performance Indicators. These measures will be included in the State's evaluation of the effectiveness of its Implementation Plan, i.e., process evaluation, as required by Section IX. In developing measures, the State and the Independent Reviewer will include the following, non-exhaustive, list of examples related to Community-Based Services:

1. Overall prevalence and incidence of Children in Out-of-Home Placements;

2. Average length of stay of Out-of-Home Placement;

3. Review of random sample of ISPs for detailed contingency plans in the event of Community Provider unavailability. The State will determine sample size in concert with the Independent Reviewer;

4. Child and Family service satisfaction and experiences with Community-Based Services;

5. All-cause hospital admission or emergency department visits for Children with ISPs;

6. Degree and frequency of follow-up by Community Providers and Care Coordinators after hospitalization or an emergency department visit for behavioral health;

7. Time between the Single Assessment and the individualized needs assessment to identify all necessary services to meet the Child's behavioral health needs;

8. Changes in cultural competence competency levels within the organizations delivering services outlined in this Agreement regarding infrastructure and services provided;

9. Percent of parents/guardians who found paperwork to receive or retain services to be clearly written and straightforward;

10. Partnerships with advocacy groups;

11. Number and quality of trainings provided across Stakeholders; and

12. Other performance indicators needed to gather actionable, meaningful, useful, and informative data that specifically serves necessary to demonstrate compliance with the Agreement.

APPENDIX C: TRAINING

A. As required by Section VI, the mandated training policy and curriculum of select, appropriate State staff, Community Providers, Care Coordinators, and service providers will:

1. Incorporate training implementation evaluation measures to assess fidelity to and impact of the curricula;

2. Incorporate measures related to changes in knowledge, changes in attitude, development of multiple training modalities, and feedback from those taking the training; and

3. Establish training curricula tailored to training audience, which will address: the core requirements of this Agreement; cultural competency; motivational interviewing, an evidence-based, person-centered approach to facilitate behavioral change; Family engagement; and the values of community integration and having a Child live in a Family Home. The curricula will include initial and continuing training. The State will seek input from Children and their Families on the curriculum and will involve Children and their families/guardians in preparing and conducting the training, as appropriate. Training will be offered with sufficient frequency and intensity to adequately train all Community Providers, Care Coordinators, and other service providers. Curriculum development will include provisions for evaluating the quality of the training program, changes to or acquisition of competencies, and impact of training on person-centered service delivery consistent with this Agreement.

B. Review. No later than 12 months following the Effective Date of the Agreement, the State will send its proposed training policy and curricula to the Independent Reviewer for review and comment. The Independent Reviewer may provide technical assistance on the State's proposed training policy and curricula and its consistency with this Agreement. The State will provide annual updates to the United States and Independent Reviewer about any modifications to the training policy or curricula.

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. Conclusion of the AMHI Consent Decree and Establishment of Permanent Independent Advocacy

On December 3, 2024, the Maine Superior Court dismissed the 34-year AMHI Consent Decree, ending the longest-running mental health class action in Maine history. As class counsel, DRM helped bring the case, monitored compliance over decades, and participated in the final proceedings leading to its conclusion.

In his final report, Court Master Daniel Wathen found that Maine's adult mental health system had made "enduring improvements… supported by robust advocacy." That finding reflected the State's agreement requiring DHHS to contract with the Protection and Advocacy system to provide independent advocacy for adults with serious mental illness in hospitals and community settings. Within six months of the decree's dismissal, the Legislature acted to ensure those protections did not disappear. It enacted 34-B M.R.S. §3012, requiring DHHS to contract with DRM, as the P&A, to continue statewide independent advocacy. The end of court oversight—paired with permanent statutory advocacy—marks a major structural milestone. Maine now has a lasting state framework to protect the rights of adults with serious mental illness, regardless of whether a court remains involved.

A copy of the statute is attached.

2. Federal Settlement to Reform Maine's Children's Behavioral Health System

In 2024, DRM achieved a major systemic result stemming from a complaint filed with the U.S. Department of Justice (DOJ) in 2019 regarding Maine's failure to provide appropriate community-based behavioral health services for children. DOJ's investigation concluded that gaps in the system led to unnecessary institutionalization, including prolonged stays in emergency departments, residential facilities, and Long Creek Youth Development Center.

In September 2024, DOJ filed suit against the State. By November 2024, the parties reached a comprehensive, enforceable settlement. The agreement requires Maine to build and maintain a system that allows children with behavioral health needs to remain in their homes whenever possible. Key requirements include timely assessments, effective care coordination, expanded community services, mobile crisis response, stronger oversight, workforce development, and monitoring by an independent reviewer with potential court enforcement. This settlement grew directly from DRM's original complaint and sustained advocacy on behalf of Maine families. It creates a roadmap to reduce unnecessary institutionalization and ensure children receive appropriate services close to home.

A copy of the settlement agreement is attached.

3. DRM'S Provision of Contract Advocacy Services in the two Maine State Psychiatric Hospitals.

DRM provides advocacy service to 2 state psychiatric hospitals through contracts with the state Department of Health and Human Services.

The state contract supports the services of 1 full time employee (FTE) advocate at the southern institution and 1 (FTE) advocate at the northern institution. The state institutions do not admit anyone under the age of 18.

The southern state institution has 4 units housing civil and forensic patients. The northern state institution has 4 units housing civil and forensic patients. DRM staff advocates spend a significant portion of each day on the units, meeting with patients and staff. During those meetings DRM advocates provide informal advocacy, referral to resources, and information about patient rights.

In addition to the advocacy provided above, some problems require a more formal approach, such as filing a complaint or grievance. The advocates meet with the clinical directors and superintendents at the two state institutions on a periodic basis to report on, and request action regarding, specific issues. Below are a few of the areas that the advocates provide consistent and quality advocacy services to protect individual rights and effect change in the institutions.

TRAINING

At both of the state institutions the advocates conduct weekly groups for patients to provide instruction on self-advocacy skills, especially on how to make the most of one's treatment planning meetings, including advocating for additional resources for themselves. Additionally, the advocates provide information on rights and discuss issues facing the individuals in the hospital and the community. Further, the advocates at both hospitals look for training topics for hospital staff trainings when rights related issues come up.

Through the groups and interactions with hospital staff at both of the facilities, advocates frequently identify systemic issues that are then presented to hospital administration. In some of those situations what occurs are hospital staff trainings that target specific rights related issues. In addition to any targeted trainings on rights related issues the advocates in both state hospitals provide regular new employee orientation training for all incoming staff on patient rights. This is to ensure patient rights are at the forefront of new employee’s minds coming into the institutions.

MONITORING

Monitoring for rights related issues is an integral part of the advocates role in both facilities. In both state institutions the advocates monitor the process leading up to the weekly civil commitment hearings looking for any issues of concern. The advocates in one state institution regularly attend hospital unit community meetings with patients to monitor for rights related issues. The advocates in both state hospitals attend morning round reports for each unit to monitor for rights related issues that come up in those staff only meetings. All hospital advocates also participate in treatment planning meetings for patients, in addition to a variety of other in-hospital meetings.

In one of the state institutions, the advocate monitors in-hospital clinical review panels that make decisions about medication-over-objection. The advocate in the other state hospital monitors the process involving treatment over objection hearings that occur in the context of civil commitment. Further, the advocates in both state hospitals monitor all reports of seclusion, restraint, and medication given over patient objection for any rights issues.

ADVOCATING FOR COMMUNITY RESOURCES

At both state institutions individuals can face barriers to discharge despite a determination that they are clinically ready for discharge.

The staff advocates frequently are involved in negotiating solutions with community providers and the state mental health authority in order to effectuate appropriate discharges.

In both state institutions, the advocates attend a weekly discharge planning meeting with the social work departments and representatives from the state mental health authority. Many issues are discussed, including barriers to discharge facing individual clients. The advocates are a consistent voice in this meeting: promoting the rights of individuals and the mandate that individuals receive adequate mental health treatment.

PROTECTING INDIVIDUAL RIGHTS THROUGH ADVOCACY

At both the state institutions, the advocates are frequently involved in resolving some seemingly minor issues, which, if left unattended, can escalate. Advocates assist clients on everything from environmental conditions to medical and medication issues to restrictions on basic rights. Additionally, the advocates are continuously watching for issues regarding the use of seclusion and restraint.

G. PAIMI Budget - Actual

PAIMI Budget

Planning Period From **10/1/2024** to **9/30/2025**

In this section, provide actual expenditures for the FY 2025. 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, including program income. 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
Administration	$ 26,476.60	$ 3,719.25	14.0 %	Susan Adams
Attorney	$ 63,000.08	$ 13,584.38	21.6 %	Christina Blake
Administration	$ 24,327.07	$ 175.00	0.7 %	Bridget Campbell - admin/advocate
Administration	$ 56,038.60	$ 5,711.95	10.2 %	Harper Chance - Operations Director
Director of Finance	$ 106,153.82	$ 7,174.86	6.8 %	Shannon Crocker
Administration	$ 61,310.78	$ 7,401.61	12.1 %	Tammy Cunningham
Director of Finance	$ 8,115.39	$ 771.48	9.5 %	Heather Dubord DOH 8/11/25
Other (List title in the Comments box)	$ 65,800.28	$ 6,889.91	10.5 %	Julia Endicott - Communications Director
Advocate/Case Manager	$ 39,410.40	$ 160.08	0.4 %	Casey Escobar
Advocate/Case Manager	$ 53,878.19	$ 2,156.52	4.0 %	Mary Green
Administration	$ 29,071.92	$ 3,087.17	10.6 %	Sheila Hansen
Senior Staff Attorney	$ 98,600.06	$ 68,218.92	69.2 %	Mark Joyce
Administration	$ 50,412.60	$ 6,313.67	12.5 %	Linda Leighton
Advocate/Case Manager	$ 50,758.97	$ 308.13	0.6 %	Carlene Mahaffey
Director of Finance	$ 6,057.69	$ 610.31	10.1 %	Julie Montefesco
Executive Director	$ 175,000.28	$ 29,732.49	17.0 %	Kim Moody
Advocate/Case Manager	$ 20,452.95	$ 889.53	4.3 %	Jane Moore
Attorney	$ 65,000.00	$ 45,449.66	69.9 %	Emily Mott
Intake Specialist	$ 61,631.81	$ 8,569.90	13.9 %	Fernand Nadeau
Attorney	$ 65,153.84	$ 6,633.75	10.2 %	Jessica Payson
Attorney	$ 65,153.84	$ 17.19	0.0 %	Jeanette Plourde
Attorney	$ 89,856.00	$ 238.90	0.3 %	Atlee Reilly
Other (List title in the Comments box)	$ 81,997.61	$ 13,226.89	16.1 %	Katrina Ringrose - Deputy Director
Administration	$ 14,669.95	$ 1,951.57	13.3 %	Susan Schroeder
Intake Specialist	$ 70,696.08	$ 12,939.17	18.3 %	Sara Squires
Attorney	$ 48,500.14	$ 36,560.16	75.4 %	Kevin Voyvodich
Attorney	$ 90,000.04	$ 1,560.72	1.7 %	Lauren Wille Legal Director
Attorney	$ 13,494.30	$ 161.44	1.2 %	Peter Rice
	$ 1,601,019.29	$ 284,214.61		

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)	$ 27,857.00	$ 2,026.35	7.3 %	Cash Benefit in lieu of Health Insurance
FICA/Medicare	$ 210,345.92	$ 21,046.46	10.0 %	FICA
Other (Describe the line item in the Comments box)	$ 334,254.28	$ 39,364.20	11.8 %	Healthcare
Dental Insurance	$ 22,125.18	$ 1,984.28	9.0 %	Dental Insurance
State Unemployment Insurance	$ 10,482.11	$ 850.24	8.1 %	Unemployment Insurance

Other (Describe the line item in the Comments box)	$ 1,505.52	$ 145.27	9.6 %	Life Insurance
Workers Compensation	$ 10,232.42	$ 971.67	9.5 %	Workers Compensation
Employer Match-Retirement	$ 116,646.65	$ 15,107.67	13.0 %	Retirement - Employer Match
Long Term Disability Insurance	$ 8,762.81	$ 836.27	9.5 %	Long Term Disability Insurance
Other (Describe the line item in the Comments box)	$ 162.12	$ 18.99	11.7 %	CBU Health Tax Benefit
Other (Describe the line item in the Comments box)	$ 4,372.00	$ 423.79	9.7 %	PFMLA
	$ 746,746.01	$ 82,775.19		

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
Mileage	$ 61,624.16	$ 3,806.14	6.2 %	5811 miles for staff listed above Rate of $0.655 per mile
Lodging for Meetings	$ 15,567.52	$ 1,587.75	10.2 %	NARPA and other overnights as necessary
	$ 77,191.68	$ 5,393.89		

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)	$ 38,791.98	$ 5,815.82	15.0 %	Repair & Maintenance
Equipment Rental	$ 22,744.53	$ 3,132.79	13.8 %	Copier and postage machine through Pitney Bowes
	$ 61,536.51	$ 8,948.61		

** 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	$ 30,246.02	$ 3,170.35	10.5 %	Supplies
Other (Describe the line item in the Comments box)	$ 6,724.39	$ 532.25	7.9 %	Printing
Network/Computer	$ 18,927.92	$ 2,288.03	12.1 %	Telephone
Internet Services	$ 6,308.39	$ 728.66	11.6 %	Internet/Email
Postage	$ 7,327.52	$ 1,343.62	18.3 %	Postage
Other (Describe the line item in the Comments box)	$ 3,655.46	$ 929.45	25.4 %	Library Books & Services
	$ 73,189.70	$ 8,992.36		

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		$ 210,943.01	$ 32,069.70	15.2 %	Miscellaneous vendors - There are no contracts with the people and companies who are billed to this budget line. Included is PAIMI's share of movers, storage unit for file, administrative/financial consulting and human resource consulting. Only one vendor was paid more than $25,000 in FY25 - Berry, Dunn, McNeil and Parker LLC accounting firm for financial consulting.
Misc		$ 18,217.98	$ 911.94	5.0 %	Admin payroll expenses
Interpreters		$ 45,628.47	$ 606.51	1.3 %	Interpreters
		$ 274,789.46	$ 33,588.15		

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 * (explain costs in the comment field i.e number of meetings and number of participants)	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)	$ 34,360.34	$ 4,416.16	12.9 %	Staff Trainings
Advisory Council meetings	$ 325.16	$ 276.92	85.2 %	Advisory Council Expenses. Including meetings, travel, trainings, etc as needed.
Other (Describe the line item in the Comments box)	$ 36,424.00	$ 6,979.06	19.2 %	Audit
Governing Board meetings	$ 2,032.58	$ 320.94	15.8 %	Board Expenses
	$ 73,142.08	$ 11,993.08		

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	$ 137,058.40	$ 17,822.73	13.0 %	Occupancy 160 Capitol St., Suite 4 Augusta, ME 04330 41 Campus Dr. New Gloucester, ME 04260
Other (Describe the line item in the Comments box)	$ 10,869.58	$ 1,210.12	11.1 %	Janitorial
Other (Describe the line item in the Comments box)	$ 18,560.90	$ 2,852.83	15.4 %	Utlities
Other (Describe the line item in the Comments box)	$ 6,692.80	$ 3,797.76	56.7 %	Litigation/Client Expense
Other (Describe the line item in the Comments box)	$ 12,867.78	$ 2,298.38	17.9 %	Payroll/Banking Services
Dues and Memberships	$ 73,140.77	$ 17,407.99	23.8 %	Dues and Memberships, DAD, Westlaw, MIP, etc
Insurance	$ 27,458.90	$ 3,115.74	11.3 %	Insurance - business
Other (Describe the line item in the Comments box)	$ 10,711.70	$ 486.91	4.5 %	Legal Expenses
Other (Describe the line item in the Comments box)	$ 60,201.38	$ 1,122.67	1.9 %	Agency Development
Other (Describe the line item in the Comments box)	$ 13,734.46	$ 1,305.44	9.5 %	Admin Fees
Other (Describe the line item in the Comments box)	$ 31,315.79	$ 3,881.25	12.4 %	Annual Meeting
Other (Describe the line item in the Comments box)	$ 8,217.26	$ 979.53	11.9 %	Recruitment
	$ 410,829.72	$ 56,281.35		

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 2024	$	5,925.80

Please upload your budget plan for 2024 carryover funds

	Total Actual Cost	Total PAIMI Share
Total PAIMI Costs	$ 3,318,444.45	$ 492,187.24

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Footnotes:

$ 62,218.92

1	Personnel	Annual Salary	FULL PAIMI Share	APPORTIONED	%	Comment	Remainder Carryover
	Senior Staff Attorney	98,600.06	68,218.92	62,218.92	69%	Mark Joyce	5,925.80
			68,218.92				
			68,218.92				
			68,218.92				
	Carryover for FY2024	$ 5,925.80					

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	$492,187
Total	**$492,187**

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**

Please note in the second form that Question 2. Program Income (PAIMI only) is not the current FY PAIMI allotment. Program income is defined as gross income earned that is directly generated by a federally supported activity or earned as a result of the federal award.

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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 2025 PAIMI Application. The strategies used for each Objective must be completed. The reason why priority/goal was not achieved or was partially achieved must be completed.

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: 149

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 36-year-old PAIMI-eligible individual wanted to create a mental health advance directive after repeated, distressing encounters with law enforcement during psychiatric crises. With support from a police mental health liaison, they contacted DRM for assistance. DRM helped the individual draft an advance directive reflecting their specific treatment preferences and, at their request, met with the mental health provider to review and incorporate the directive into treatment planning. DRM then convened a meeting with the individual and local law enforcement so officers would understand the directive and be prepared to follow it during future crises. The individual successfully completed and implemented a mental health advance directive aimed at reducing unnecessary police involvement.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 49-year-old PAIMI-eligible man involuntarily hospitalized at a state psychiatric hospital, contacted DRM because he lacked a winter coat and was therefore unable to go outside for fresh air during the winter months. DRM brought the issue directly to the hospital superintendent, who confirmed that coats were available for patients. Staff promptly provided the man with a winter coat, allowing him to participate fully in outdoor activities.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 36-year-old PAIMI-eligible woman, involuntarily hospitalized in a psychiatric hospital, was placed on a call restriction limiting her to three calls per day. She was told that this restriction applied even to calls to DRM and her appointed attorney, which is a clear violation of her rights. DRM intervened by providing rights education and direct advocacy with the hospital clinician. As a result, staff confirmed that the restriction did not apply to calls with DRM or legal counsel and clarified that she could contact both without limitation. Hospital staff also printed and provided her with her commitment hearing paperwork so she had ready access to her attorney's contact information

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 41-year-old PAIMI-eligible woman hospitalized in a psychiatric unit had spent a decade cycling in and out of hospitals and experiencing homelessness. She expressed a strong desire to live in a mental health group home, and hospital staff supported the referral. When her application was denied, she sought help from DRM. DRM worked closely with the hospital social worker to ensure a timely appeal and a request for reconsideration. As a result of this coordinated advocacy, the denial was overturned and she was approved for placement in a mental health group home, positioning her to transition from the hospital to the community with needed stability and services.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 36-year-old PAIMI-eligible woman, involuntarily hospitalized at a psychiatric hospital, contacted DRM after being denied access to religious books and materials she had legally purchased during a community outing. Security had already approved the items, and they were not considered contraband, yet staff told her she could keep only one book. DRM quickly raised the issue with the treatment team and hospital security. Within a few hours, the hospital acknowledged the error and returned all approved religious materials to her, reinforcing her right to access spiritual resources while hospitalized.

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,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, exploitation, or restriction of their rights. Target: DRM will conduct at least 5 projects.
Expected Target:	5
Expected Outcome:	5
Actual Outcome:	21
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:

Level I Grievance Training:
The Maine Department of Health and Human Services administers the Certified Intentional Peer Support Specialist (CIPSS) program, a credential requiring completion of the DHHS Office of Behavioral Health curriculum and ongoing continuing education. CIPSS workers play an important role within MaineCare-covered treatment teams, offering peer support grounded in shared experience, mutual respect, and recovery-oriented principles.As part of the program's continuing education offerings, the Maine CIPSS Training Program invited DRM to provide a specialized training focused on the Level I Grievance Process outlined in the Rights of Recipients of Mental Health Services. The training was designed specifically for CIPSS participants to strengthen their understanding of recipient rights and to equip them with the knowledge needed to support individuals navigating the grievance process within mental health settings.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

DRM, in its role as Maine's Protection & Advocacy system, filed a systemic complaint concerning a licensed mental health group home after identifying significant concerns about the services residents were receiving. Through review and monitoring, DRM determined that the facility was billing Medicaid for rehabilitative and personal care services that did not appear to be delivered at the level or frequency expected for residents with serious mental health needs. The complaint documented patterns showing that residents were not consistently receiving meaningful mental health treatment, rehabilitative supports, or adequate assistance with daily living, and that treatment planning practices were not sufficiently individualized. DRM submitted extensive supporting materials demonstrating that the services being funded did not align with what Medicaid dollars are intended to support in this type of program.
The State ultimately denied the complaint. Because the existing complaint process provides no right to a hearing and no clear way to challenge

that decision, DRM is developing additional strategies to address these systemic failures and to help ensure that Medicaid funds are used appropriately — and that residents in community mental health group homes receive the services they are being funded to receive.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

ADA Training Jail Board of Visitors
Maine law requires county jail Boards of Visitors to receive annual training on the Americans with Disabilities Act (ADA). At the request of the Franklin County Jail Board of Visitors, DRM delivered a presentation titled "Overview: Americans with Disabilities Act and County Jails." The session covered core ADA obligations in correctional settings, including nondiscrimination standards, reasonable modifications, and effective communication for people with disabilities.
The Board of Visitors, appointed by the Governor, provides independent oversight of Maine's correctional facilities through inspections, meetings with staff and incarcerated individuals, and recommendations to the Department of Corrections and the Legislature. DRM's training supported the Board in carrying out its statutory duties and reinforced the importance of ADA compliance within Maine's correctional oversight system.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

The PAIMI Director served as a featured presenter for Judi's Room, a national webinar series focused on mental health advocacy and named in honor Judi Chamberlin. The session, "Building Effective PAIMI–PAC Relationships," highlighted DRM's approach to working with its federally mandated PAIMI Advisory Council (PAC). The presentation described how DRM meets statutory responsibilities while fostering a collaborative, engaged, and accountable relationship with the PAC.This webinar provided an opportunity to share best practices with a national audience and to contribute to ongoing discussions about strengthening PAIMI programs and supporting effective P&A–PAC relationships.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

DRM attorneys were invited to participate in a legal training hosted by the Board of Overseers of the Bar addressing the ethical rules that apply when representing clients who may be perceived as having "diminished capacity," including individuals with mental illness. The presentation focused on how attorneys should carefully assess capacity, avoid assumptions based on diagnosis, and ensure that clients with mental illness are provided the support necessary to participate meaningfully in their representation. DRM attorneys emphasized the obligation to maintain, to the greatest extent possible, a typical attorney-client relationship and to provide reasonable accommodations when needed. Approximately 50 lawyers attended the training.

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: 37

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:

DRM assisted a 38-year-old PAIMI-eligible woman, who lost access to her community mental health case manager after losing her State Medicaid insurance. DRM provided information about grant-funded case management agencies in her area, supported her in making self-referrals, and advocated to ensure she was correctly listed in the state system as awaiting case management services. Throughout the process, DRM also supported her in self-advocacy efforts, which contributed to her eventually regaining State Medicaid coverage. As a result, she remains eligible for services through providers accepting both grant funding and Medicaid.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 63-year-old PAIMI-eligible man living in a post-acute skilled rehabilitation and nursing facility expressed a desire to move out. DRM met with him at the facility and collaborated with staff and state representatives to identify appropriate community-based options. Although his preference was for a supported apartment and availability was uncertain, he chose to move to a mental health group home so he could leave the facility and reenter the community. He successfully transitioned to the group home with the option to pursue more independent housing when it becomes available.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

DRM assisted a 50-year-old PAIMI-eligible woman staying at a homeless shelter who was seeking case management and a housing voucher. During regular outreach at the shelter, DRM helped her contact case management agencies, resulting in her being accepted for services. DRM also assisted with a BRAP (state funded housing voucher for individuals with mental illness) application, including advocacy with the homeless shelter to verify her homelessness for eligibility and accompanying her to the housing authority to obtain proof of a Section 8 application. With this documentation, she was able to submit a complete application for the voucher, moving closer to stable housing.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 57-year-old PAIMI-eligible man experiencing homelessness contacted DRM from the hospital seeking assistance with discharge planning to ensure his needs would be met. DRM collaborated with the client and the hospital social worker to follow up on the discharge process and confirm that the
services the client requested were arranged. As a result, the client was successfully discharged to a newly opened assisted living facility, aligning with his goals.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 29-year-old Paimi-eligible man, who was an involuntary patient at a psychiatric hospital, requested help from the patient advocate regarding out-of-state criminal charges and an upcoming virtual court hearing. He was also unsure whether he currently had a public defender. The advocate contacted his treatment team, who were aware of the charges but lacked information about the hearing and had not received a response from the defender's office. With the client's consent, the advocate reached out to the public defender's office and learned that his assigned defender had been removed from the case but could be reappointed if he requested this at his next hearing. The advocate secured the virtual hearing link and provided all information to both the client and his social worker, who would attend the hearing with him. As a result, the client was prepared to participate in the proceeding and to request reinstatement of his public defender.

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,Investigations of Abuse and Neglect,Other Systemic Advocacy,Monitoring,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: 20

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:

Hope Conference
DRM participated as an exhibitor at the HOPE Conference, a statewide recovery and wellness event held at the Augusta Civic Center. The conference brings together individuals in recovery from substance use and mental health challenges, along with service providers, to promote diverse perspectives on recovery and wellness. At the event, DRM staffed an informational table, sharing materials on rights, services, and

advocacy resources. Attendees engaged with DRM staff, received educational materials, and took home DRM-branded items to help increase visibility and awareness of our work.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

DRM conducts outreach to individuals with mental illness who are not yet connected to needed services. We regularly visit a drop-in center in one of the largest metro areas in Maine that serves people experiencing homelessness and meet with individuals one-on-one to discuss concerns, explain available mental health resources, and identify possible eligibility for services.

During these visits, DRM actively helps people take the next steps toward care. Staff assist with referrals, contact providers, help complete forms, and, when needed, remain with individuals while they navigate intake processes. This work helps ensure that individuals who might otherwise go without treatment are linked to appropriate mental health services.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

Veteran's Expo
DRM participated as a vendor at the Community Connections Expo, a large outreach event hosted by the Maine Bureau of Veterans Services and the Veterans Benefits Administration. The expo brings together organizations that support veterans' access to benefits, disability services, and mental health resources.
The event serves as a critical point of connection for veterans—many of whom face significant challenges navigating complex benefit systems—and highlights the importance of linking veterans with needed supports, including mental health services and community-based programs. DRM's presence ensured that veterans with mental illness were informed of their rights and aware of available advocacy services.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

DRM provided a guest training for 45 students in the University of New England's Occupational Justice Therapists program. The presentation introduced future occupational therapists to the structure of Maine's mental health system, emphasizing how individuals with mental illness might interact with the mental health system.

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,Investigations of Abuse and Neglect,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: 23

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:

DRM assisted a PAIMI-eligible patient at a psychiatric hospital who had finally received a housing choice voucher after years on a waiting list but was hospitalized before she could use it. Concerned she would lose the voucher and have to restart the process, she asked DRM for help. DRM drafted a letter to the local housing authority requesting an extension due to her hospitalization. The extension was granted, allowing her to preserve this critical opportunity for stable housing.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 27-year-old PAIMI-eligible woman was denied an assistance animal in her apartment by her landlord. DRM intervened by requesting a reasonable accommodation and securing clinical documentation from her mental health provider supporting the need for an assistance animal. DRM continued advocacy with the landlord during the interactive process. The landlord ultimately granted the accommodation, waived standard animal-related fees, and approved the assistance animal. The client was then able to obtain an animal that supports her mental health and allows her equal use and enjoyment of her housing.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 35-year-old PAIMI-eligible man had lived for about five years in a supported apartment-style mental health program when he received notice that his services were being terminated and that he would be expected to leave his apartment. He reported that, without another option, he would become homeless at the end of the notice period. DRM reviewed the circumstances and advocated to ensure his housing status was considered separately from the decision to end services, emphasizing the serious risk of homelessness. The provider ultimately determined that he could remain in his apartment even if program services were discontinued. With his housing stabilized, he was able to transition to support from an Assertive Community Treatment (ACT) team while continuing to live safely in his home.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 49-year-old PAIMI-eligible woman experiencing homelessness achieved her goal of securing congregate housing after nearly a year in a shelter, supported by DRM's sustained advocacy. DRM worked closely with the client and her case manager to ensure that the state received all required documentation for her application. Recognizing the urgency, DRM arranged a critical call between the client and the state gatekeeper, helping her present her needs and circumstances clearly. Following this process, she was approved for her preferred placement at a mental health group home, gaining needed housing stability.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

A 31-year-old PAIMI-eligible woman in independent housing experienced a worsening of mental health symptoms whenever property management staff contacted her directly. DRM submitted a reasonable accommodation request asking that all verbal communication be directed through her mental health case manager. The property management company agreed to route verbal communication through the case manager and to avoid direct verbal contact with the tenant, helping to reduce symptom exacerbation while preserving necessary communication about her tenancy.

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: 9

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:

Legal Services for Maine Elders CLE Training
DRM conducted a legal training titled "The Reasonable Accommodation Process—A Legal Right, Not Special Treatment" for attorneys and support staff at Legal Services for Maine Elders, a nonprofit organization dedicated to providing free legal assistance to individuals aged 60 and older. The training focused on the legal framework surrounding reasonable accommodations under both state and federal disability law with a focus on accommodations relating to mental illness. Over 20 staff members attended the session, which was accredited by the Maine Board of Overseers of the Bar for 1.5 hours of Continuing Legal Education (CLE) credit

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

Homeless Shelter Monitoring.
DRM conducted monitoring at several homeless shelters across the state to assess conditions, identify rights-related concerns, and evaluate access to services for individuals with mental health disabilities. Through this monitoring, DRM identified multiple systemic issues affecting the safety, treatment, and rights of shelter residents.
DRM subsequently met with senior leadership at MaineHousing, the state agency that funds and oversees shelter operations, to raise these concerns and seek clarification on oversight mechanisms. While MaineHousing noted limits on its direct authority to regulate day-to-day shelter practices, the agency did provide DRM with the mandatory grievance policy required for all contracted shelters. This policy will assist DRM in future advocacy efforts by ensuring residents understand their rights and have a formal process for raising complaints.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

Systemic Monitoring of Mental Health Group Home Provider and Provider Collaboration

During DRM's monitoring of a large mental health provider operating group homes for individuals with mental illness, potential areas of noncompliance with state regulations were identified. In response, DRM convened a meeting with the provider's senior leadership and supplied a detailed list of relevant regulatory requirements, along with a survey tool for managers to indicate whether each area was in or out of compliance.
DRM met with management to review the materials, discuss expectations, and clarify obligations. The conversation was constructive, and the provider agreed to implement several corrective actions. DRM and the provider plan to continue meeting in the coming year to monitor progress and support ongoing compliance efforts.

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,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:	2
Achieved: ○	**Not Achieved:** ●

Reason why priority/goal was not achieved or was partially achieved:

The target for PAIMI education cases for the year was 28; however, only 2 cases were reported. This variance is the result of the decision made during FY 2025 to remove Education as a PAIMI program priority. Please note: Education no longer appears as a PAIMI priority in the FY 2026 application.

Results narratives of P&A activities and accomplishments related to above priority:

DRM was contacted by the parent of a PAIMI-eligible student who was being regularly sent home early from school for behaviors clearly related to the disability, resulting in a significant loss of instructional time. DRM provided self-advocacy assistance to the parent, including information about the affirmative steps the school should take to address behavioral concerns, and detailed guidance in preparation for a meeting with the school. Following that meeting, the school agreed to change its approach with the student, and the repeated calls to remove the student from school stopped.

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

Other qualitative narrative related to above priority (significant activity for which there were no quantifiable results go here):

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 Officer

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

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The ACR Section of the Annual PAIMI PPR	
SECTION A. GENERAL INFORMATION	
Fiscal Year:	2025
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 L. Kerr PAC Chair Aprilkerr2020@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 L. Kerr aprillkerr2020@gmail.com
Telephone Number:	207-491-0381
E- Mail Address:	aprillker2020@gmail.com
Date Submitted:	12/30/2025
By signing this document, the Chair certifies that this report reflects the consensus of the PAC members.	**Signature:** April L Kerr April L Kerr (Dec 30, 2025 11:53:50 EST) **Email:** aprillkerr2020@gmail.com

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**
B.1.b. Individuals who are recipients/former recipients (R/FR) of mental health services.		7
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.		0
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:	1
B.1.f.1. Social Workers	
B.1.f.2. Psychologists	
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.	1
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].	
B.1.k. TOTAL number of PAC members serving on 9/30.	**Total 12**
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).	8
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.]	66.67%

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 a year
B.3.d. Number of Meetings Held in the FY [3 is the mandated minimum].	5
B.3. e. Number (%Average) of PAC members present at Meeting.	67%

SECTION C. PAC DATA ON ETHNICITY & RACE

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	12
(Add C.A.1 & C.A.2., the total should be the same as the one listed in B.1.k. (members serving as of 9/30).	**Total**
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	**11**
C. B. 6. Two or More Races	**0**
C. B. 7. = C.B.1 through C.B.6.	**Total 12**
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 1**

SECTION D. Sex of PAC Members	
D.1 FEMALE 9	D.2 MALE 3
D.3. TOTAL 12	

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. (MAXIMUM 15)	Total 13	
E.2.b.2. Is the PAC Chair a full voting member of the Governing Board?	YesX	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?	YesX	No
F.1.a. Did any of the invited program staff attend?	YesX	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. 4 advocates 3 attorneys. 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 member who is also a member of the Board attends the PAC meetings regularly.		
F.3.c. Did any of the invited governing board members attend?	Yes x	No

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.	

If Yes, list each activity by number and provide a brief description of PAC involvement, e.g., Activity 1 – Attendance at local NAMI training. **HOPE Conference** The Consumer Council System of Maine holds an annual event called HOPE conference. It is held at the Augusta Civic Center. PAC members attend/participate in workshops offered to educate people on various topics, including legislative procedures and how to advocate for their rights. **Peer Advocate Legislative Education Day. Hall of Flags, Maine State House.** PAC members gathered at the statehouse to share information with legislators about disabilities , including their mental health disabilities and the challenges they face. A copy of the flyer for this event is attached. **DRM Annual Summer Event.** This is an event put on by DRM. PAC members attended and also staffed a table at DRM's annual summer event giving out information about the PAC and other resources, including letting people know that the PAC was looking to fill the seat of a family member of a minor child or youth (under 18 years old) who has received or is receiving mental health services. This is an annual event that DRM organizes where the entire community is invited to attend and celebrates and brings awareness of the people who are working within their abilities to be productive, engaging members of the community. This year's celebration brought almost 200 people to this outdoor event that featured informational booths from a wide variety of organizations. Music, face painting, games, and food and drinks were all part of the celebration. **Judi's Room Presentation on "Building Effective-PAIMI/PAC relationships"** DRM was asked to provide a presentation via webinar to "Judi's Room" a monthly forum named in honor of Judi Chamberlain. The PAC reviewed and edited the drafts of the presentation that was presented by the PAIMI director. And some PAC members attended the webinar. A copy of this PowerPoint is attached.	Yes X	No
F.5.b. Out-of-State Trainings/Educational Activities. If yes, list each activity by number and provide a brief description of PAC involvement, e.g., Activity 1 – Attendance at NDRN annual conference. One PAC member self-funded attendance at the National Association of Rights Protections and Advocacy (NARPA) conference held in New Orleans.	Yes X	No

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 X	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.

NOTE got F.7.a.: All meetings were held virtually; there was no mileage reimbursement. For activities listed in F.8 that required mileage there was mileage reimbursement.

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
Peer Advocate Legislative Education Day State House	2 PAC In state mileage paid			

DRM Annual Summer Event	2 PAC In state mileage paid			

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	No* X

*F.9.c. If the answer to F.9. a. or F.9.b. is 'No", a brief explanation is required.

DRM experienced a transition with their Chief Financial Officer. DRM's CFO, who had served in the position for 11 years, announced her resignation in February 2025, effective in March, and a full-time replacement was not hired until August 2025. The PAC received the first-quarter written financial report for FY 2025; however, due to the transition, subsequent quarterly reports were not distributed in written form. The PAC was informed that this change in reporting was related to the CFO's departure, and members were advised that they could contact the Executive Director directly with any questions regarding the organization's finances. Financial information remained available upon request, and the full FY written 2025 financial statements were provided after the close of the fiscal year and prior to the close of the calendar year. With a new CFO now in place, we do not anticipate similar delays going forward.

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	No* X

F.9.d.1. If No*, a brief explanation is required].

See answer to F.9.c above.

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. All DRM clients are provided satisfaction surveys upon the closure of their cases. The survey includes a general question soliciting suggestions for change. All callers are sent copies of DRM priorities. At all public presentations, training and monitoring visits to psychiatric hospitals and residential facilities DRM hands out copies of our brochures and solicit input and comment. DRM also has state funded advocates at the two state freestanding hospitals. Each patient upon discharge is given a DRM survey in their discharge packet. These advocates also distribute DRM materials in residential facilities including copies of DRM brochures and solicit input and comment. And there is a provision for comments to be given on DRM's website.		
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 PAC continued to meet regularly independently of DRM staff and has met as such five times in 2025. We intended to start inviting community members to these meetings to solicit more extensive input in 2026. We updated our application and application process for new PAC members.

F.10.b. Briefly describe any training or educational presentations to either constituency groups or the general public.

See F.10.d.

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. PAC members attend/participate in workshops offered to educate people on various topics, including legislative procedures and how to advocate for their rights.

Peer Advocate Legislative Education Day. Hall of Flags, Maine State House.
PAC members gathered at the statehouse to share information with legislators about disabilities , including their mental health disabilities and the challenges they face. A copy of the flyer for this event is attached.

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Judi's Room Presentation on "Building Effective-PAIMI/PAC relationships"

DRM was asked to provide a presentation via webinar to "Judi's Room" a monthly forum named in honor of Judi Chamberlain. The PAC reviewed and edited the drafts of the presentation that was presented by the PAIMI director. And some PAC members attended the webinar. A copy of this PowerPoint is attached.

F.10.e. Briefly describe any other activities, e.g., fund raising, public relations, etc.

See answer to F.10.d 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 for FY 25 are 1. Abuse, Neglect & Rights Violations, 2. Community Inclusion, 3. Housing, and 4. Education. In FY 26 Education was deleted. 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 report that this year we added a vice-chair to the PAC and worked with DRM to develop a training on how DRM and the PAC interact in a successful way. Please see Judi's room presentation.

This upcoming FY the PAC in coordination with DRM is putting together a training that includes the Judi's Room presentation, with a presentation DRM gave to the Board regarding PAIMI team activities. This combined training will be given to all PAC members and used for orientation for incoming new PAC members in the future so they have a better understanding of both who DRM is, who the PAC, is and how they interact and what kind of activities DRM is engaged in so that the PAC can advise DRM in the most effective way.

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.

Due to the budget uncertainties the PAC was unable to plan for certain PAC activities, such as an anticipated in person retreat and attendance at the National Association of Protection and Advocacy Conference (NARPA) which at least one PAC member has been able to attend for years past with the support of DRM. These activities are imperative to making sure that PAC members, who are unpaid volunteers, are able to have full access to information and resources necessary for them to effectively function. We would recommend that the funding for DRM not be reduced.

G.3. Please list any training & technical assistance needs identified by the PAC.

We would like the funding to continue at previous levels so DRM could send PAC members to the NARPA conference next year and also have an in-person retreat.

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 0 (no grievances filed)	

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, Mark Joyce, PAIMI Director, Lauren Willie, Litigation 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 42

H.9. Were written responses sent to all grievants?	Yes	No* X
H.9.a. *If you answered No, to H.9, briefly explain. Not Applicable, No grievances		
H.10. Was client confidentiality protected? ____. If not, explain below. **[42 CFR 51.25(B)(6)] Not applicable No grievances**	Yes x	No*
H.10.a. *If you answered No, to H.10, briefly explain.	Yes x	No*
Not Applicable No grievances.		

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. 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.

FY 2025_PAIMI PROGRAM_ACR final

Final Audit Report 2025-12-30

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Building Effective PAIMI–PAC Relationships

Mark C. Joyce, Esq.

DRM PAIMI Program Director

June 4, 2025

DISABILITY RIGHTS MAINE

For Education Only

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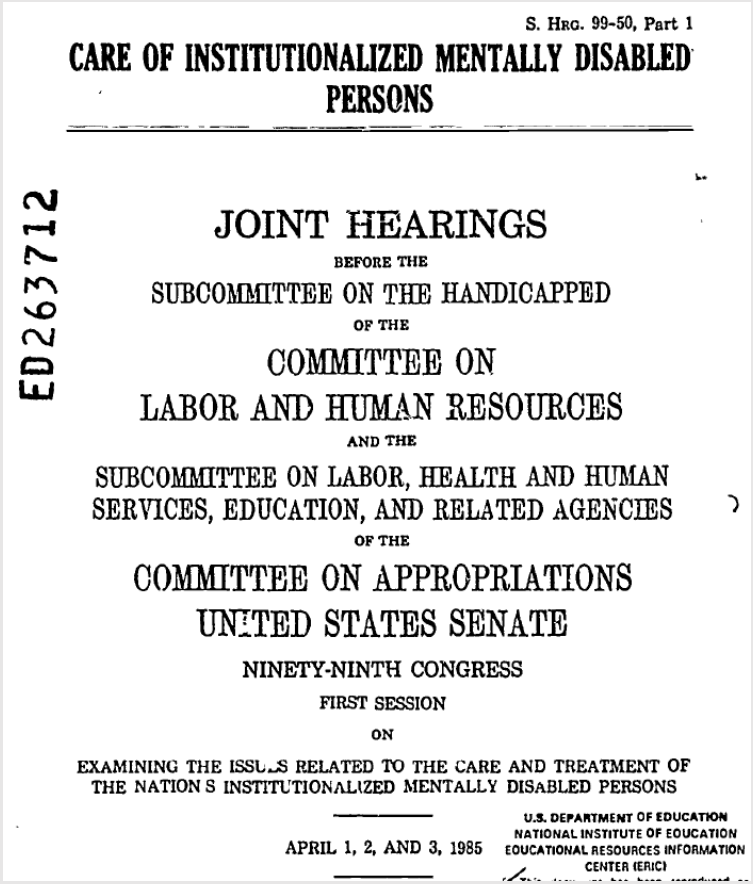
Brief History of How the Protection and Advocacy for Individuals with Mental Illness (PAIMI) law was passed.

On April 1, 2 & 3 of 1985 the Senate held hearings



S. HRG. 99-50, Part 1

CARE OF INSTITUTIONALIZED MENTALLY DISABLED PERSONS

JOINT HEARINGS

BEFORE THE

SUBCOMMITTEE ON THE HANDICAPPED

OF THE

COMMITTEE ON

LABOR AND HUMAN RESOURCES

AND THE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

EXAMINING THE ISSUES RELATED TO THE CARE AND TREATMENT OF THE NATION S INSTITUTIONALIZED MENTALLY DISABLED PERSONS

APRIL 1, 2, AND 3, 1985

Senator Weicker's description

"The 3 days of these hearings will focus on those who have been left in the backwaters of our conscience."

On May 23, 1986 President Reagan signed into law the Protection and Advocacy for Individuals With Mental Illness Act or “PAIMI”

At the time the advocacy was limited to individuals residing in institutions and residential facilities. This was expanded in 2000 to include individuals living in the community.

The purpose of the PAIMI ACT 42 United States Code Section

- “To ensure that the rights of individuals with mental illness are protected.”
- “To protect and advocate the rights of such individuals through activities to ensure the enforcement of the Constitution and Federal and State statutes.”
- “To investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.”

PAIMI Advisory Council

42 C.F.R. § 51.23 Advisory Council

Each P&A system shall establish an advisory council to:

- Provide independent advice and recommendations to the system.
- Work jointly with the governing authority in the development of policies and priorities.
- Submit a section of the system's annual report.

Provide independent advice and recommendations to the system.

42 C.F.R. § 51.23(a)(1)

Ensuring PAC's Independent Advice: The Need for Transparent Information

"Each P&A system shall provide its advisory council with reports, materials and fiscal data to enable review of existing program policies, priorities and performance outcomes."

42 CFR § 51.24(c)

How DRM Provides the PAC with This Information

DEVELOPING AGENDA

- Pre-PAC Meeting: PAIMI program director and PAC chair meet to draft agenda. Through this process identifying any information that needs to be provided to the PAC before the PAC meeting.

Standing Agenda Item: PAIMI Team Provides Updates and Information to the PAC in Advance of Each Meeting

- Written case and systemic report on current psychiatric hospital advocacy.
- Written case and systemic report on current community advocacy.
- Minutes from previous PAC meeting.
- Any other relevant information.

Staff Attendance at Meetings

At PAC meetings, staff—including the Program Director, the Executive Director, advocates and attorneys, regularly participate to provide updates, share information, and answer questions.

Accessing Information is not limited to these meetings.

PAC members are encouraged to reach out at any time between meetings. Both the PAIMI Program Director and Executive Director are always available to answer questions or provide information.

How DRM Ensures the PAC's Independence in their Advisory Role.

Time Reserved for PAC-Only Discussions

During each PAC meeting (via Zoom), time is set aside for PAC members to meet alone, without P&A staff. This allows them to discuss issues independently after hearing updates and information from staff. PAC members also meet separately outside of these formal meetings, strengthening their advisory work.

Collaborative Spirit: Working with the PAC

The PAC's advisory role is strengthened by collaborative efforts with DRM staff—like helping to organize events or providing information that supports the PAC's work. This collaborative approach was captured by a PAC member who designed the following logo:

This logo is used at PAC outreach events.

DRM PAC Chair April Kerr and
DRM PAC member Jason Goodrich

Supporting PAC Member Participation in National Conferences

- The PAC's advisory role is also strengthened by DRM sending PAC members to national conferences, such as the annual National Association of Rights Protection and Advocacy (NARPA) Conference and the Pre-Conference Institute for PAIMI Council Members. PAC members have participated in locations such as:

- Baltimore, MD
- New Orleans, LA
- Portland, OR
- Washington, DC
- Newark, NJ
- Phoenix, AZ
- Portland, ME
- Hartford, CT
- Seattle, WA

Work jointly with the governing authority in the development of policies and priorities.

42 C.F.R. § 51.23 (a)(2)

Legislative History: Affirming the PAC's Vital Role In Development of Polices and Priorities.

"…to ensure full and active participation of the advisory council in the discussion and development of the system's annual priorities."

S. REP. 100-454, 8, 1988 U.S.C.C.A.N. 3217, 3224

How DRM Creates an Environment That Enables the PAC's Full and Active Participation in Advising on Polices and Priorities.

Structural Processes that Support Full and Active PAC Participation.

- PAC meetings are held every other month, totaling six times a year—double the statutory minimum of three annual meetings.
- DRM PAIMI staff attend and DRM Board are invited to attend.
- PAC members also meet independently outside of these scheduled meetings.

Structural Processes that Support Full and Active PAC Participation. (continued)

- The PAC operates under written operating procedures to guide its work and ensure consistent practices.
- Agenda-setting: The PAC Chair and PAIMI Program Director meet ahead of each meeting to develop the agenda, which is then shared with the PAC along with all relevant information.
- PAC members can add any item during the meeting, ensuring they have control over what's discussed.

Structural Processes that Support Full and Active PAC Participation. (continued)

- Each meeting includes a dedicated PAC member-only time—no staff are present during this period, allowing for independent discussion.
- The PAIMI Program Director and Executive Director are directly available to respond to questions or requests from PAC members including outside of PAC meeting times.
- The PAC writes its own annual report assessing DRM's program, which is sent to SAMHSA. The PAIMI Program Director specifically ensures he is excluded from this process to preserve the PAC's independence.

Structural Processes that Support Full and Active PAC Participation. (continued)

While PAIMI regulations only require the PAC Chair to serve on the Board, DRM includes both the PAC Chair and an additional PAC member on its Board of Directors. This ensures that the PAC's voice is directly represented and actively engaged in the discussion and development of the system's policies and priorities.

PAC's Advisory Role in Priority Setting Amid Limited Resource

The DRM PAC's advisory role is essential in helping DRM consider which priorities to set or change—bringing critical insights and perspectives that inform our decision-making. Even when serious issues exist, we may not have the capacity to take them all on, which makes the PAC's advisory role in the development of policies and priorities even more crucial.

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Submit a section of the system's annual report.

42 C.F.R. § 51.23 (a)(3)

Advisory Council Report (ACR)

- The ACR is a report prepared annually by the PAIMI Advisory Council. It provides an independent assessment of how the P&A system is carrying out its work and priorities under the PAIMI program. This report is submitted to SAMHSA (the federal funding and oversight agency) and ensures that the PAC's voice is formally included in the reports to SAMHSA.

PAC's Independent Assessment in the ACR.

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.

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.*

DRM's Role in Ensuring the Report's Independent Nature

The PAIMI Program Director makes it clear to the PAC—both in emails and at PAC meetings—that he:

- Has no input on how the PAC writes this section.
- Does not participate in drafting or revising the content, even if he sees it before final submission.
- Does not edit it prior to submission to SAMHSA.
- This ensures that the PAC's section in the ACR is a fully independent assessment—untouched and unedited by the PAIMI Director.

Conclusion: Building Effective PAIMI-PAC relationships

An independent PAC brings together diverse perspectives to provide advice on the development of policies and priorities, working jointly with the board as required by law. DRM's role is to support and facilitate the PAC's advisory function—not to direct it.

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THE END

Mental Health Matters

Peer Advocate Legislative Education Day

April 24, 2025
8 am – 4 pm
Hall of Flags

You Are Invited...

We hope you will come and talk to Maine legislators about your lived experience and give them your feedback about Maine's mental health system. For example: what is working, what are some challenges and what services would you like to see in the future (including all things peer support)!

Sponsored by...

Consumer Council System of Maine
A Voice for Consumers of Mental Health Services

&

other Statewide Peer Organizations

Mental health matters

Mileage Reimbursement Available