REPORT OF AN INVESTIGATION INTO THE DEATH OF JOHN DOE

Disability Rights Maine
160 Capitol Street, Suite 4
Augusta, ME 04330

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Introduction

Disability Rights Maine (DRM) is an independent, private, nonprofit agency that protects and advocates for the rights of Maine citizens with disabilities. Under both state and federal law DRM has the authority to investigate allegations of abuse and neglect involving people with disabilities if the incident is reported to DRM or if DRM determines there is probable cause to believe that the incident occurred. This authority comes from the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. §§ 10801 et seq.; 42 C.F.R. §§ 51.1 et seq. and the Maine Protection and Advocacy for Persons with Disabilities statutes, 5 M.R.S.A. §§ 19501 et seq.

This is a report of the DRM's investigation of the death of John Doe[1], an individual with mental illness. Mr. Doe died on May 5, 2018 in his apartment. At the time of his death he was receiving mental health services from a non-profit mental health agency that maintained an office in the apartment complex where he lived ("Residential Provider") as well as with a different agency's Assertive Community Treatment ("ACT") Team.

Investigative Methodology

On May 8, 2018, Mr. Doe's guardian contacted Disability Rights Maine reporting that Mr. Doe had passed away in his supported apartment the weekend before. She reported that Mr. Doe, who was 40-years-old and appeared to be in good health at the time of his death, had been found nonresponsive in his apartment by staff of the Residential Provider. She also

[1] All names in this report have been de-identified.

reported to DRM staff that approximately one month prior to Mr. Doe's death the residential provider reduced the level of observation it was providing to Mr. Doe in his apartment from 24 hours seven days a week eyes on observation to observation of Mr. Doe every fifteen minutes and then reducing it further to observations occurring every thirty minutes.

The guardian also reported that this 24 hour level of observation had been required under the terms of a Progressive Treatment Program ("PTP") Court order which had lapsed on March 24, 2018, seven weeks prior to Mr. Doe's death. She reported that a court hearing had been scheduled to take place two weeks after the expiration of this court order in which the court was going to be asked to issue a new PTP order with a treatment plan that contained the same level of observations. She reported that this hearing had been continued and the request for the new PTP order had been withdrawn. She also reported that it was her opinion that the PTP had been withdrawn due to the Residential Provider no longer wanting to provide services to Mr. Doe under the terms of a PTP that had been previously in force.

DRM requested records related to Mr. Doe's treatment from the Residential Provider, the ACT Team serving Mr. Doe, and the State of Maine, which filed the petition for the PTP at the request of the ACT Team.[2] The records requested primarily covered the period from January 1, 2018 through May 5, 2018 (the date of Mr. Doe's death).

[2] Although the ACT Team could apply to the court for the PTP order without the state filing the application, in this case the records and interviews indicated that the state was filing the application on behalf of the ACT Team.

The documents reviewed included the following types of records:

Medical Records/Court Records
Agency Investigatory Records
Documents Provided by the Guardian
Agency Policies

DRM attorneys interviewed the following individuals:

From the State of Maine:

- State Employee # 1, an employee responsible for managing admissions to the state portfolio of residential programs.
- State Psychiatrist responsible for overseeing the State's capacity to accept involuntary admission of patients from a PTP.
- State Employee # 2, State Social Worker responsible for coordinating the State's involvement in the PTP.

From the ACT Team, serving as the PTP Administrator:

- ACT Psychiatric Provider responsible for prescribing and monitoring Mr. Doe's psychiatric medications.
- ACT Program Manager responsible for overseeing the ACT Team staff, communicating with the psychiatric provider, and coordinating the PTP application with the State, residential provider, and the guardian.
- ACT Case manager.

From the Residential Provider, responsible for services attached to a supervised apartment with the ability to provide around the clock 1-to-1 staffing:

- Director of Program Operations.
- Director of Behavioral Health Services.
- Former Program Manager.

- Residential Program Clinician.
- 7 Residential Staff.
- 1 Residential Staff who served in the positions of Assistant Program.

Manager and Program Manager over the course of Mr. Doe's PTP.

Additionally, DRM interviewed Mr. Doe's guardian, who was Mr. Doe's mother.

Independent Clinical Review of Records

Dr. Beth Gouse, PHD is a licensed psychologist and former Chief of Staff, Chief Clinical Officer, and former interim chief executive of St. Elizabeth's Hospital in Washington DC, Washington's public psychiatric hospital.

Dr. Gouse reviewed records and transcripts of the interviews conducted by DRM. Dr. Gouse summarized her findings and recommendations into a written report for DRM.

The Progressive Treatment Program: Involuntary Outpatient Treatment Services

The Maine District Court has the statutory authority to involuntarily order individuals into a "Progressive Treatment Program" or "PTP". Participation in this court ordered program is limited under this statute to individuals who have a serious mental illness who are unlikely to follow an individualized treatment plan, but the compliance of which would help protect them from interruptions in treatment, relapses or deterioration of their mental health and

enable them to survive more safely in a community setting without posing a likelihood of serious harm to themselves or others.[3]

After notice and an opportunity to be heard the court may issue an order effective for a period of up to 12 months directing the person to follow such an individualized treatment plan. As part of the order the court may identify incentives for compliance and potential consequences for noncompliance. Any party may move to dissolve, modify or extend the PTP for good cause. These PTP orders can be extended for an additional term of up to one year.

To ensure compliance with treatment the court may order the individual to be committed to the care and supervision of an ACT Team or other outpatient facility with such restrictions or conditions as may be reasonable and necessary to ensure compliance with the treatment plan including a process for involuntary emergency psychiatric hospitalization that is triggered by a medical

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[3]34-B M.R.S.A. § 3801 (4-A) defines "Likelihood of serious harm' as follows:

> D. For the purposes of section 3873-A, [Progressive Treatment Program] in view of the person's treatment history, current behavior and inability to make an informed decision, a reasonable likelihood that the person's mental health will deteriorate and that the person will in the foreseeable future pose a likelihood of serious harm as defined in paragraphs A, B or C.

Paragraph A, B, or C read as follows:

> A. A substantial risk of physical harm to the person as manifested by recent threats of, or attempts at, suicide or serious self-inflicted harm;
> B. A substantial risk of physical harm to other persons as manifested by recent homicidal or violent behavior or by recent conduct placing others in reasonable fear of serious physical harm;
> C. A reasonable certainty that the person will suffer severe physical or mental harm as manifested by recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury[.]

A copy of the Progressive Treatment Program statute is attached to this report as Exhibit 1.

practitioner's certificate that the person has failed to comply with an essential part of the treatment plan. This certificate is commonly referred to as a "green paper." [4]

Summary of Events

At the time of his death Mr. Doe was receiving mental health residential services from a private non-profit mental health agency ("Residential Provider"). On May 5, 2018 John Doe was found dead in his apartment by staff of the Residential Provider. He was a 40 year old man with mental illness. Mr. Doe's mother was his legal guardian.

The Residential Provider provided on-site mental health services to Mr. Doe. It also provided mental health services to other individuals with mental illness who lived in other apartments. The Residential Provider maintained an office on site at this complex, with around the clock staff available to provide these services.

Approximately 13 months prior to Mr. Doe's death, on March 24, 2017, the Maine District Court issued an order committing Mr. Doe to the "care and supervision" of a nonprofit mental health agency's Assertive Community Treatment Team or "ACT Team." This agency was different than the Residential Provider Agency. The ACT Team consists of a team of mental health professionals.[5] These teams are designed to have the ability to provide

[4] An example of this certificate is attached to this report as Exhibit 2.
[5] 34-B M.R.S.A. § 3801(11) provides, in part, as follows: "Assertive community treatment is provided by multidisciplinary teams who are on duty 24 hours per day, 7 days per week; teams must include a psychiatrist, registered nurse, certified rehabilitation counselor or certified employment specialist, a peer recovery specialist and a substance use disorder counselor and may include an occupational therapist, community-based mental health rehabilitation

intensive outpatient mental health services on a 24 hour, seven day a week basis. Mr. Doe's order was a result of the filing of an application with the District Court under Maine's Progressive Treatment Program or "PTP" laws, to have Mr. Doe committed to the care and supervision of the ACT Team while in the community.

The PTP order required that Mr. Doe follow an individualized treatment plan of care, recommended by the ACT Team (PTP Plan). In the event that the ACT Team did not believe that Mr. Doe was adequately following his PTP Plan of care they could seek immediate involuntary psychiatric hospitalization of Mr. Doe. This PTP order was to remain in effect for one year, expiring on March 24, 2018.

As part of this PTP Plan, the Residential Provider was responsible to "provide 24 hour one to one Residential treatment including medication administration to Mr. Doe...." This one-on-one status required that someone be in Mr. Doe's apartment at all times.

The plan as to the Residential Provider required them to communicate with the ACT Team on Mr. Doe's "current status, treatment compliance, level of stability and safety" as well as to "notify ACT of any changes in [Mr. Doe's] mental status that may require a psychiatric appointment."

Mr. Doe's PTP order expired on March 24, 2018. Three days after the expiration of the order on March 27, 2018 the Program Manager for the ACT Team, a licensed clinical social worker acting in his capacity as the "ACT Team

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technician, psychologist, licensed clinical social worker or licensed clinical professional counselor."

director or designee", signed a document that was then filed the next day with the Maine District Court concerning a new application for Mr. Doe to be admitted into the PTP.[6] In this March 27, 2018 document the ACT Team Program Manager represented to the court that Mr. Doe met the requirements for the PTP, including having a "suitable individualized treatment plan" and that "licensed qualified community providers are available to support the plan." The ACT Team Program Manager represented the following:

2. The basis for seeking an order admitting this proposed client to the progressive treatment program is as follows:

   A. The proposed client suffers from a severe and persistent mental illness;
   B. The proposed client poses a likelihood of serious harm;
   C. The proposed client has a suitable individualized treatment plan;
   D. Licensed qualified community providers are available to support the plan;
   E. The proposed client is unlikely to follow the plan voluntarily;
   F. Court-ordered compliance will help to protect the proposed client from interruptions in treatment, relapses, or deterioration of mental health; and
   G. Compliance will enable to proposed client to survive more safely in the community without posing a likelihood of serious harm.

The above is an actual copy of an excerpt from the court filing. The ACT Team Program Manager who signed this document began his role with the ACT Team in January of 2018. In his interview with DRM he outlined his lack of training in the PTP process and the specifics of Mr. Doe's PTP plan that was in effect at the time.

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[6] According to information supplied by the state to DRM the application was filed with the court by state hospital staff on March 28th 2018, that same day the Court issued a Notice of Hearing appointing counsel, ordering an independent examiner and setting the hearing date for April 6th 2018. Subsequent to this court filing and notice:

- The state hospital filed two motions, one to correct clerical oversights on April 3rd 2018, and one for telephonic testimony on April 4th 2018. Counsel for Mr. Doe did not object to either motion.
- Around April 4th 2018 the court-appointed examiner filed a report with the Court (Dated April 2nd).

With regards to training, the ACT Team Program Manager stated:

DRM: Can I ask, when you came onto this role did you get any training or information regarding the PTP specifically?

ACT PROGRAM MANAGER: Not specifically to the PTP. You know, and I think, and I certainly don't want to speak out of turn, but I think it was a new thing for us to work with PTPs that we were still trying to get an understanding of it other than we have it, here's what it is, let's hope we never have to implement it. We'll figure it out, but -- so no, nothing too specific to other than this is what it is. These are -- who's responsible for what, so let's just make sure that we're all on top of it.

Regarding Mr. Doe's specific PTP plan the ACT Team Program Manager stated:

DRM: Okay. Yeah. If you'll turn to what is titled -- down at the bottom it says page 2 of 4; do you see that?

ACT PROGRAM MANAGER: Uh-huh.

DRM: In the middle of the page there's a heading that says [ACT Team] Responsibilities.

ACT PROGRAM MANAGER: Uh-huh.

DRM: And then the third point on -- under that says "The ACT team assigned case manager for Mr. [Doe] with oversight by the ACT program manager will provide Mr. [Doe]'s guardian with biweekly email –

ACT PROGRAM MANAGER: Uh-huh.

DRM: -- with psychiatry updates included." Was that something that you were aware of at the time you took over in your position?

ACT PROGRAM MANAGER: That was not.

Additionally he would state:

DRM: Did any -- so -- when you said when you came on in January, so there was no handoff of your, you know, "Here's a person, [Mr. Doe], he's in a PTP and these are his (indiscernible)"?

ACT PROGRAM MANAGER: I think -- I can't -- there was never like a sit-down like "Let's crack the books and talk about this case." But I think

that it was more of a on my way out the door, "By the way, there's a PTP." And that was off the cuff.

As part of this March 28, 2018 filing with the Court the ACT Team Psychiatric Provider, a certified Psychiatric Mental Health Nurse Practitioner signed a document entitled "Certificate of Medical Practitioner to Support PTP Application". In that document the certified Psychiatric Mental Health Nurse Practitioner represents the following;

1. The proposed client suffers from a severe and persistent mental illness; specifically, the proposed client is diagnosed with Schizophrenia Paranoid Type;
2. In view of the proposed client's treatment history, current behavior, and inability to make an informed decision, it is reasonably likely that the proposed client's mental health will deteriorate and that the proposed client will in the foreseeable future pose a likelihood of serious harm, specifically [check all that apply]:
   - [ ] A substantial risk of physical harm to the proposed client as shown by recent attempts at suicide or serious self-inflicted harm;
   - [X] A substantial risk of physical harm to others as shown by recent homicidal or violent behavior or by recent conduct placing others in reasonable fear of serious physical harm;
   - [X] A reasonable certainty that the proposed client will suffer severe physical or mental harm as shown by recent behavior demonstrating an inability to avoid risk or to protect the proposed client adequately from impairment or injury;

The above is an actual copy of an excerpt from the court filing. In his interview with DRM, the individual who signed this in support of the PTP application stated the following regarding his familiarity with the PTP process and Mr. Doe's plan in particular:

DRM: Okay. As a provider, do you play a role in the progressive treatment program, or PTP as it's known? Are you familiar with that term?

ACT Psychiatric Provider: Yes. Yeah, I have a role in that.

DRM: Can you describe that role?

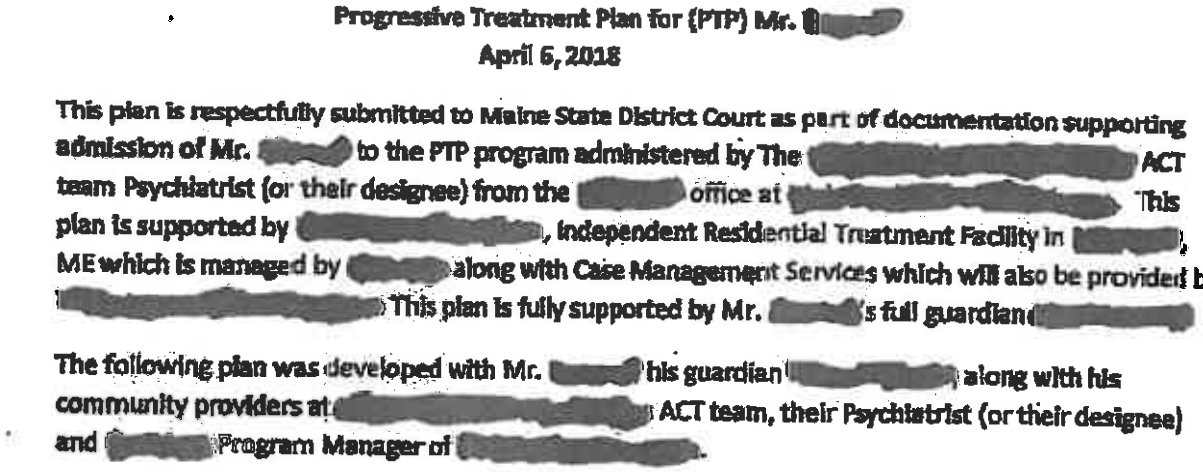
ACT PSYCHIATRIC PROVIDER: I'm not super-familiar with it. I've had two or three patients in the seven years that I've been working having a PTP.

He went on to state the following regarding Mr. Doe's PTP plan:

> DRM: Okay, thank you. Turning back to the first page of the document, it's titled Progressive Treatment Plan for [Mr. Doe], is this a document that you're -- that you've seen before?
>
> ACT PSYCHIATRIC PROVIDER: Not to my recollection, no.
>
> DRM: Okay. Do you -- I think going back to the beginning, we did discuss the progressive treatment program and you understand the (indiscernible-paper shuffling). Do you know in the [ACT team] would have responsibility for knowing about this document and what's in it?
>
> ACT PSYCHIATRIC PROVIDER: I would assume the people that signed it.
>
> DRM: Okay. Could you turn to the next page. At the bottom it says page 2 of 4. And in the middle of the page there's a heading that says [the ACT Team] Responsibilities?
>
> ACT PSYCHIATRIC PROVIDER: Yes.
>
> DRM: Were you aware of the responsibilities assigned in sub-part 1 and 2 to the psychiatrist? Were you aware of those responsibilities? (PAUSE)
>
> ACT PSYCHIATRIC PROVIDER: Not specifically. I have a general understanding that the patient had to comply with medications, treatment recommendations, but not those specific statements

After the filing of the PTP application dated March 27, 2018, the court scheduled a hearing for Friday, April 6, 2018. The proposed 2018 PTP plan, which was signed on March 27, 2018, bears a date of April 6, 2018 which was the date of the hearing. The PTP plan was primarily the same as the previously expired 2017 plan, including 24 hour one to one Residential Treatment.

Below is a redacted excerpt of the beginning of the 2018 plan outlining that it was developed with Mr. Doe, the ACT Team, the Residential Provider and Mr. Doe's guardian.



Progressive Treatment Plan for (PTP) Mr. [redacted]
April 6, 2018

This plan is respectfully submitted to Maine State District Court as part of documentation supporting admission of Mr. [redacted] to the PTP program administered by The [redacted] ACT team Psychiatrist (or their designee) from the [redacted] office at [redacted]. This plan is supported by [redacted], independent Residential Treatment Facility in [redacted], ME which is managed by [redacted] along with Case Management Services which will also be provided by [redacted]. This plan is fully supported by Mr. [redacted]'s full guardian [redacted].

The following plan was developed with Mr. [redacted] his guardian [redacted] along with his community providers at [redacted] ACT team, their Psychiatrist (or their designee) and [redacted] Program Manager of [redacted].

Sometime after the March 28th filing but before the April 6th hearing the residential provider informed the ACT team it no longer wished to have its name on the PTP plan. On April 3rd the Residential Provider's program manager sent an email out to the residential provider's staff who were working with Mr. Doe that his observation status was being reduced from 1:1 supervision twenty four hours a day to 15 minute checks. The email to residential staff working with Mr. Doe informed them as follows: "Mr. Doe will no longer have staff in his apartment 24/7. He has been reduced to 15 minute safety checks throughout the day/night...."

April 4th, the ACT Program Manager replied in writing to a request from the residential provider confirming that the Residential Provider had informed the ACT Team that they would no longer provide one to one monitoring but rather 15 minute checks of Mr. Doe and wanted their name removed from the PTP

Plan. In that written confirmation the program manager stated that "[t]his request was passed on to [State Employee # 2] at the [State Hospital] on April 4th 2018.

During its investigation the Residential Provider provided DRM with a written summary stating that they had had a conversation with State Employee # 1 of the state of Maine who gave them authorization to reduce the level of Mr. Doe's observation from 1:1 twenty four hours a day to 15 minute checks.

A redacted excerpt of this summary is as follows:

[redacted] spoke with [redacted] on 4/3/18 to inform her of the concern of staff and client safety due to the above stated incidents. [redacted] approved and was in agreement that the [redacted] staff would complete 15-minute eyes on check of [redacted] and no longer staff him 24/7. It was agreed that staff would still take him to all appointments and store needs.

In her interview with DRM this State Employee # 1 disputes that she ever gave such authorization to the Residential Provider, because it is a clinical decision and she is not a clinician. Stating as follows:

> DRM: And what are your credentials, professional credentials?
>
> STATE EMPLOYEE: I'm an MHRTC[7].
>
> DRM: And what clinical training did that involve?
>
> STATE EMPLOYEE: None.

And:

> DRM: So, [State Employee # 1], do you have the authority of experience to approve clinical decisions for a community mental health provider?

[7] MHRTC is an abbreviation for Mental Health Rehabilitation Technician/Community. It is a certification issued by the Muskie School. According to the Muskie website there are three types of MHRT.

STATE EMPLOYEE: No.

DRM: What sort of response would you give a community mental health provider requesting your clinical opinion regarding two levels of monitoring of an individual in a group home environment?

STATE EMPLOYEE: That they need to be speaking to their clinical team and supervisor.

On April 6, 2018 Mr. Doe's PTP hearing was continued until April 20, 2018. The Court stated that the reason for the continuance was that it was;

> "[c]ontinued by agreement 4/20/18 8:15. State needs more time to monitor patient's housing to make sure it is appropriate. Atty. [Mr. Doe's Attorney] will continue as counsel for patient."

On April 18, 2018 State Employee # 2 a State Social Worker sent an e-mail to Mr. Doe's guardian, the ACT Program Manager, the residential provider's Assistant Program Manager, the Residential Provider's Director of Behavioral Health Services, the State Psychiatrist, and the Assistant Attorney General who represents state psychiatric facilities. The email contained the following first paragraph:

> After careful consideration along with conversations with the AAG, the PTP hearing will not take place on Friday April, [sic] 20 and a motion to withdraw is being sent to the court.[8]

[8] The full body of the email reads: After careful consideration along with conversations with the AAG, the PTP hearing will not take place on Friday April, [sic] 20 and a motion to withdraw is being sent to the court. At this time [Mr. Doe] is aware that his PTP has expired and continues to remains [sic] voluntarily compliant with his psychiatric medications and treatment plan. As for housing, although his placement remains in question, [Mr. Doe] is still residing at his supported [Residential Provider Name] apartment in [Maine Town]. [Residential provider's Director of Behavioral Health Services] continues to explore alternative and appropriate housing options for [Mr. Doe]. Also given [Mr. Doe] is a Consent Decree member, [Residential Provider Name] cannot end his placement without prior approval from DHHS. At this time [Mr. Doe's] providers and guardian should continue with open communication and meetings. Once housing is secure and [Mr. Doe's] community providers are in agreement that there is a need for a new PTP, one can be filed with the courts.

Mr. Doe's mother, his guardian responded as follows:

> I am opposed to the withdrawal of the pto [sic] request. I fail to understand why if the medical experts...both the court appointed and ACT psychiatrist feel this is warranted the whole situation should be at the disposal of his residential caretakers. I feel [Mr. Doe] and I are being jerked around by [Residential Provider]. They now have him on 15 min checks because they are worried about the safety of staff. Something does not compute here. I want the present filing to be postponed until my return May 4th. To dateno one [sic] at [Residential Provider] has responded to me despite numerous calls and e-mails since I last saw you. Thisisnot [sic] acceptable. [Residential provider] is being paid to do [a] job....make them do it.

The State Psychiatrist involved in the PTP filing in the State Hospital would state:

> DRM: So why did [State Psychiatric Hospital] decide to withdraw its application for the PTP two days before the hearing, the continued hearing?
>
> STATE PSYCHIATRIST: So what I recall is that not all participants on the -- what I recall is that where he -- the group home that he was living in couldn't commit to the PTP, and you need an address and they were a major part of his outpatient commitment, and so that's my understanding. That's my recall of that.
>
> DRM: Okay.
>
> STATE PSYCHIATRIST: So we couldn't submit it because we didn't have all the information that we needed to provide the treatment that he had had.

Following the email from Mr. Doe's guardian an Assistant Attorney General would respond to her concerns:

> Good Afternoon,
>
> Please find attached the Notice of Withdrawal filed with the Court today on behalf of [the State Psychiatric Hospital]. The Office of the Attorney General does not believe this application meets the legal criteria required for the PTP, and does not believe a Court – at this time – would grant this application. Here is the relevant excerpt from the statute (34-B M.R.S. sec. 3873-A):

§3873-A. Progressive treatment program
1. Application. The superintendent or chief administrative officer of a psychiatric hospital, the commissioner, the director of an ACT team, a medical practitioner, a law enforcement officer or the legal guardian of the patient who is the subject of the application may obtain an order from the District Court to admit a patient to a progressive treatment program upon the following conditions:
A. The patient suffers from a severe and persistent mental illness; [2009, c. 651, §29 (NEW).]
B. The patient poses a likelihood of serious harm; [2009, c. 651, §29 (NEW).]
C. The patient has the benefit of a suitable individualized treatment plan; [2009, c. 651, §29 (NEW).]
D. Licensed and qualified community providers are available to support the treatment plan; [2011, c. 492, §1 (AMD).]
E. The patient is unlikely to follow the treatment plan voluntarily; [2009, c. 651, §29 (NEW).]
G. Compliance will enable the patient to survive more safely in a community setting without posing a likelihood of serious harm. [2009, c. 651, §29 (NEW).]
[2011, c. 492, §1 (AMD) .]

As noted in [State Employee # 2][9] email below, the withdrawal of this PTP application does not preclude a new PTP application from being filed in the future. This would be contingent upon all providers agreeing to the plan and [Mr. Doe] meeting the other criteria in the statute.

The PTP application was withdrawn from the court on April 18, 2018.[10]

Below is the language of the actual withdrawal:

[9] The full text of this email is contained in footnote 8.
[10] It should be noted that under Title 34-B M.R.S.A § 3873-A(1) all of the cited conditions cited in the email from the Assistant Attorney General must be met in order to meet the legal criteria for a PTP to be granted. This includes a willing residential provider when that is part of the required treatment. In Mr. Doe's case as outlined above, the ACT Team would state in writing that the residential provider had asked to have its name removed from the PTP.

NOW COMES [redacted], by and through [redacted] attorney, and hereby withdraws the Application to District Court for an Order of Admission to the Progressive Treatment Program for [John Doe], filed with this Court on March 28, 2018, and amended by order on April 3, 2018. The matter was originally scheduled to be heard on April 6, 2018, but was continued for two weeks by agreement of the parties so that the applicant could monitor Mr. [Doe's] housing to make sure it remained appropriate. Since that time, Mr. [Doe's] housing situation has not been fully resolved Additionally, Mr [Doe] has been voluntarily complying with his treatment. It is both premature and unnecessary to proceed with the application at this time.

The [redacted] is therefore withdrawing this application.

Nine days later, on April 27, 2018 the Residential Provider further reduced Mr. Doe's checks to every 30 minutes. The following week, on May 5, 2018, Mr. Doe was found dead in his apartment.

Summary of Independent Psychologist Review of Records

Dr. Beth Gouse Ph.D., a licensed psychologist and the former Chief of Staff, Chief Clinical Officer and Interim Chief Executive Officer at St. Elizabeth's Hospital in Washington, D.C. conducted a review of Mr. Doe's records and transcripts of DRM's interviews, and issued the following observations and opinions regarding Mr. Doe's case:

The Progressive Treatment Program

First, regarding Mr. Doe's PTP and the decision to withdraw the PTP, Dr. Gouse stated, "Despite the above documentation, which appears to have been completed consistent with PTP guidelines, Mr. Doe's application for PTP was continued and then withdrawn."[11]

Further, regarding events before, during, and after the time period where

[11] As stated above the state would file the withdrawal on April 18th 2018.

Mr. Doe's PTP was withdrawn; Dr. Gouse cited and commented on notes related to Mr. Doe from ACT and the Residential Provider from March 6, 2018 to May 1, 2018.[12] Dr. Gouse stated as follows:

> Notes below capture Mr. [Doe's] functioning in the weeks prior to submission of the PTP application and following the withdrawal of the PTP application.
>
> 3/6/18: Pushed a staff person on 3/5/18 and receives a summons
>
> 3/12/18: Described as 'at baseline'
>
> 3/15/18: Note by [Psychiatric Provider] references 2 recent incidents-1 involving pushing staff and I involving unwanted sexual discussions with staff
>
> 3/16/18: Psychosocial update references possession of several burnt spoons but he denies any substance use issues currently or historically
>
> 3/20/18: Note indicating mother has informed staff that he is also smoking e-cig as well as cigs and is snorting talcum powder. Also informs staff of expiring PTP
>
> 3/29/18: Note by [ACT Psychiatric Provider] references "recent exacerbation of agitation, irritability, and odd behaviors, the patient had been smoking an increased amount of cigarettes which may be inhibiting his antipsychotics from working effectively that also been slightly decreased over the past six months". "I do advocate that the patient continue to be on a PTP as he has little to no insight into his symptoms...."
>
> 4/2/18: Note indicates appt. with ACT team cancelled because he is in Bangor to meet with (Court Independent Examiner) and attorney for evaluation for PTP extension.
>
> 4/6/18: Note at 1:30pm-Had been up all night and unable to wake him up...shouted close the door...unwilling to engage
>
> 4/9/18: 1:58pm...unwilling to answer door no contact
>
> 4/10/18: Not home for appt
>
> 4/10/18: Note indicates "found a disposable razor in his bathroom without the blades in it"
>
> 4/12/18: Pt. informed his checks have been changed to 15 minute checks

[12] These notes include the time period from April 6th 2018 to April 18th 2018 when the PTP was being continued and then ultimately withdrawn.

4/16/18...ACT staff (ACT Case Manager) observed powder all over floor though he denied snorting anything

4/19/18: No show for appt

4/23/18: 3:47pm...unable to wake him

4/27/18: 11:00am...pt reports he is doing good

4/30/18: No contact...would not answer door

5/1/18: Did not show up for apt with [ACT Psychiatric Provider][13]

After documenting the above in her report Dr. Gouse stated that the Residential Providers decision to reduce Mr. Doe's observation levels appeared to be based on concerns for the safety of their staff and without consultation with the ACT Team. Dr. Gouse observed the following:

> Clearly, these notes reflect aggressive behaviors, self-harming behaviors, the possibility that his increased nicotine use was reducing efficacy of antipsychotic medication, and noncompliance with appointments. Despite these behaviors, there is no evidence that a risk assessment was conducted to either review his levels of observation or inform the decision to withdraw the PTP application. Rather, the decision to reduce his levels of observation appeared to be due to concern about staff safety and this decision was made without consultation with the ACT team.

Dr. Gouse further noted:

> .... [T]he reliance upon the hospital to initiate these extensions, when the individual has been residing in the community and that evaluator is either not familiar with recent events or not reviewing recent records, does not lend itself to an informed process.

Dr. Gouse observed, with respect to the parties' understanding of the PTP and the roles played by the staff of the agencies the following:

> Based on the transcripts of the interviews with [ACT Psychiatric Provider], [ACT Program Manager], [Residential Program Clinician], [Residential staff], etc., many staff were not even aware of the presence of the PTP, most staff were not sufficiently familiar with the specific roles

and responsibilities identified in the PTP, and most were not familiar with the related options of initiating a green paper or blue paper for evaluation for hospitalization when behaviors or symptoms warrants such an evaluation.

Treatment Planning

Regarding treatment planning, Dr. Gouse observed the following:

> [Mr. Doe's] PTP, dated 3/24/17, identified the chief responsibilities of [The ACT Team] and [Residential Provider]. It appears that [The ACT Team] was responsible for monitoring his psychiatric symptoms and related medication management, while [Residential Provider] was responsible for providing his 1:1 staffing, daily medication administration, and transportation to appointments. However, the treatment planning process that identifies specific goals and associated interventions to assist [Mr. Doe] was confusing at best. For example, there appeared to be two treatment plans (one by [The ACT Team] and one by [Residential Provider]) and not only were these inconsistent with one another, there was no evidence that there were changes in either the goals or interventions in response to progress or lack thereof.

Communication

Dr. Gouse observed problems with communication between the parties to the PTP, as well as between the psychiatric provider prescribing Mr. Doe's psychiatric medications and his primary care physician, stating:

> ....[C]oncerns were raised with [the Primary Care Provider's] staff about gastritis, vomiting, diet, and dental issues but treatment planning did not incorporate any interventions associated with these issues. For example, his guardian related concerns by [Residential Provider] staff about increased vomiting, as often as 2-3 times per week in a visit on 1/12/18....[The Primary Care Provider] concluded that a trial of medication could be helpful, which he refused, as well as changes in his diet and amount of smoking. It does not appear that these recommendations were relayed to the ACT Team or [the residential provider] for inclusion in his treatment plan."

Levels of Observation

Dr. Gouse observed, regarding the decision-making related to Mr. Doe's observation status:

> The factors precipitating [Mr. Doe's] placement on 15 minute checks just prior to the expiration of his PTP and 30 minute checks soon after the expiration of his PTP are of significant concern....[T]he decision to change his levels of observation was not made either in conjunction with his [ACT Team] nor guided by a specific risk assessment process.

Dr. Gouse further noted the following:

> Finally, email exchanges regarding Mr. [Doe]'s changes in levels of observation suggest a lack of clarity about the responsibilities of the state. Specifically, the gatekeeper role as far as assignment to levels of supervised housing is critical from an oversight perspective. The state provides this service to ensure available resources are used appropriately and to advocate through the budgetary process when there is a mismatch between resources and needs. However, while staff safety is certainly a concern from a programmatic standpoint, the decision to change levels of observations **must** be a clinical decision, informed by a formal risk assessment process." (emphasis in original)

ACT Team

With respect to the ACT Team, Dr. Gouse stated as follows:

> Notes indicate frequent visits by ACT Team members to Mr.[Doe] in his residence; however, the contact was typically very brief (e.g., lasting a few minutes and entailed a few questions ascertaining whether he had everything he needed, had been sleeping and eating, and how much he had been smoking) or at times nonexistent (e.g., Mr. [Doe] would be asleep and he would not respond to a knock on his door). Furthermore, the transcript of the interview with [the ACT psychiatric provider] indicated that he was not formally involved in all of the treatment planning and that his involvement was not necessarily or always integrated with the rest of the ACT team as far as case management[.]

Recommendations

As a result of this investigation, and given Dr. Gouse's opinion as outlined in this report, DRM recommends that (1) the State of Maine ensure that all mental health providers involved in any PTP plan are in compliance with all clinical, ethical, regulatory and statutory standards prior to such plan being submitted to the court; and that (2) The State of Maine develop an effective means to oversee that the provisions of these services are being delivered by the mental health providers according to these standards while the PTP plans are in force; and (3) Prior to filing on behalf of a community agency for a PTP the State of Maine ensure that recommendations 1 and 2 are being adhered to.

§3873-A. PROGRESSIVE TREATMENT PROGRAM

1. Application. The superintendent or chief administrative officer of a psychiatric hospital, the commissioner, the director of an ACT team, a medical practitioner, a law enforcement officer or the legal guardian of the patient who is the subject of the application may obtain an order from the District Court to admit a patient to a progressive treatment program upon the following conditions:

A. The patient suffers from a severe and persistent mental illness; [2009, c. 651, §29 (NEW).]

B. The patient poses a likelihood of serious harm; [2009, c. 651, §29 (NEW).]

C. The patient has the benefit of a suitable individualized treatment plan; [2009, c. 651, §29 (NEW).]

D. Licensed and qualified community providers are available to support the treatment plan; [2011, c. 492, §1 (AMD).]

E. The patient is unlikely to follow the treatment plan voluntarily; [2009, c. 651, §29 (NEW).]

F. Court-ordered compliance will help to protect the patient from interruptions in treatment, relapses or deterioration of mental health; and [2009, c. 651, §29 (NEW).]

G. Compliance will enable the patient to survive more safely in a community setting without posing a likelihood of serious harm. [2009, c. 651, §29 (NEW).]

[2011, c. 492, §1 (AMD) .]

2. Contents of the application. The application must be accompanied by a certificate of a medical practitioner providing the facts and opinions necessary to support the application. The certificate must indicate that the examiner's opinions are based on one or more recent examinations of the patient or upon the examiner's recent personal treatment of the patient. Opinions of the examiner may be based on personal observation and must include a consideration of history and information from other sources considered reliable by the examiner when such sources are available. The application must include a proposed individualized treatment plan and identify one or more licensed and qualified community providers willing to support the plan.

The applicant must also provide a written statement certifying that a copy of the application and the accompanying documents have been given personally to the patient and that the patient and the patient's guardian or next of kin, if any, have been notified of:

A. The patient's right to retain an attorney or to have an attorney appointed; [2009, c. 651, §29 (NEW).]

B. The patient's right to select or to have the patient's attorney select an independent examiner; and [2009, c. 651, §29 (NEW).]

C. How to contact the District Court. [2009, c. 651, §29 (NEW).]

[2011, c. 492, §1 (AMD) .]

3. Notice of hearing. Upon receipt by the District Court of the application or any motion relating to the application, the court shall cause written notice of hearing to be mailed within 2 days to the applicant, to the patient and to the following persons if known: to anyone serving as the patient's guardian and to the patient's spouse, a parent or an adult child, if any. If no immediate relatives are known or can be located, notice must be mailed to a person identified as the patient's next of kin or a friend, if any are known. If the applicant has reason to believe that notice to any individual would pose risk of harm to the patient, notice to that individual may not be given. A docket entry is sufficient evidence that notice under this subsection has been given. If the patient is not hospitalized, the applicant shall serve the notice of hearing upon the patient personally and provide proof of service to the court.

[2011, c. 492, §1 (AMD) .]

4. Examinations. Examinations under this section are governed as follows.

A. Upon receipt by the District Court of the application and the accompanying documents specified in subsection 1 and at least 3 days after the person who is the subject of the examination is notified by the applicant of the proceedings and of that person's right to retain counsel or to select an examiner, the court shall cause the person to be examined by a medical practitioner. If the person under examination or the counsel for that person selects a qualified examiner who is reasonably available, the court shall give preference to choosing that examiner. [2009, c. 651, §29 (NEW).]

B. The examination must be held at a psychiatric hospital, a crisis center, an ACT team facility or at another suitable place not likely to have a harmful effect on the mental health of the patient. [2009, c. 651, §29 (NEW).]

C. The examiner shall report to the court on:

(1) Whether the patient is a mentally ill person within the meaning of section 3801, subsection 5;

(2) Whether the patient is suffering from a severe and persistent mental illness within the meaning of section 3801, subsection 8-A; and

(3) Whether the patient poses a likelihood of serious harm within the meaning of section 3801, subsection 4-A. [2009, c. 651, §29 (NEW).]

[2009, c. 651, §29 (NEW) .]

5. Hearings. Hearings under this section are governed as follows.

A. The District Court shall hold a hearing on the application or any subsequent motion not later than 14 days from the date when the application or motion is filed. For good cause shown, on a motion by any party or by the court on its own motion, the hearing may be continued for a period not to exceed 21 additional days. If the hearing is not held within the time specified, or within the specified continuance period, the court shall dismiss the application or motion. In computing the time periods set forth in this paragraph, the Maine Rules of Civil Procedure apply. [2009, c. 651, §29 (NEW).]

B. The hearing must be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to harm the mental health of the patient. The applicant shall transport the patient to and from the place of hearing. If the patient is released following the hearing, the patient must be transported to the patient's place of residence if the patient so requests. [2009, c. 651, §29 (NEW).]

C. The court shall conduct the hearing in accordance with accepted rules of evidence. The patient, the applicant and all other persons to whom notice is required to be sent must be afforded an opportunity to appear at the hearing to testify and to present and cross-examine witnesses. The court may, in its discretion, receive the testimony of any other person and may subpoena any witness. [2009, c. 651, §29 (NEW).]

D. The patient must be afforded an opportunity to be represented by counsel, and, if neither the patient nor others provide counsel, the court shall appoint counsel for the patient. [2009, c. 651, §29 (NEW).]

E. At the time of hearing, the applicant shall submit to the court expert testimony to support the application and to describe the proposed individual treatment plan. The applicant shall bear the expense of providing witnesses for this purpose. [2009, c. 651, §29 (NEW).]

F. The court may consider, but is not bound by, an advance directive or durable power of attorney executed by the patient and may receive testimony from the patient's guardian or attorney in fact. [2009, c. 651, §29 (NEW).]

G. A stenographic or electronic record must be made of the proceedings. The record and all notes, exhibits and other evidence are confidential and must be retained as part of the District Court records for a period of 2 years from the date of the hearing. [2009, c. 651, §29 (NEW).]

H. The hearing is confidential and a report of the proceedings may not be released to the public or press, except by permission of the patient or the patient's counsel and with approval of the presiding District Court Judge, except that the court may order a public hearing on the request of the patient or patient's counsel. [2009, c. 651, §29 (NEW).]

I. Except as provided in this subsection, the provisions of section 3864, subsections 10 and 11 apply to expenses and the right of appeal. [2009, c. 651, §29 (NEW).]

[2009, c. 651, §29 (NEW) .]

6. Order. After notice, examination and hearing, the court may issue an order effective for a period of up to 12 months directing the patient to follow an individualized treatment plan and identifying incentives for compliance and potential consequences for noncompliance.

[2009, c. 651, §29 (NEW) .]

7. Compliance. To ensure compliance with the treatment plan, the court may:

A. Order that the patient be committed to the care and supervision of an ACT team or other outpatient facility with such restrictions or conditions as may be reasonable and necessary to ensure plan compliance; [2009, c. 651, §29 (NEW).]

B. Endorse an application for admission to a psychiatric hospital under section 3863 conditioned on receiving a certificate from a medical practitioner that the patient has failed to comply with an essential requirement of the treatment plan; and [2011, c. 541, §3 (AMD).]

C. Order that any present or conditional restrictions on the patient's liberty or control over the patient's assets or affairs be suspended or ended upon achievement of the designated goals under the treatment plan. [2009, c. 651, §29 (NEW).]

[2011, c. 541, §3 (AMD) .]

8. Consequences. In addition to any conditional remedies contained in the court's order, if the patient fails to comply with the treatment plan, the applicant may file with the court a motion for enforcement supported by a certificate from a medical practitioner identifying the circumstances of noncompliance. If after notice and hearing the court finds that the patient has been noncompliant and that the patient presents a likelihood of serious harm, the court may authorize emergency hospitalization under section 3863 if the practitioner's certificate supporting the motion complies with section 3863, subsection 2. Nothing in this section precludes the use of protective custody by law enforcement officers under section 3862.

[2009, c. 651, §29 (NEW) .]

9. Motion to dissolve, modify or extend. For good cause shown, any party to the application may move to dissolve or modify an order or to extend the term of the treatment plan for an additional term of up to one year.

[2009, c. 651, §29 (NEW) .]

10. Limitation.

[2011, c. 492, §2 (RP) .]

SECTION HISTORY
2009, c. 651, §29 (NEW). 2011, c. 492, §§1, 2 (AMD). 2011, c. 541, §3 (AMD).

STATE OF MAINE
APPLICATION FOR EMERGENCY INVOLUNTARY ADMISSION
TO A PSYCHIATRIC HOSPITAL FROM PROGRESSIVE TREATMENT PROGRAM

TO THE DISTRICT COURT, Location _____:

Application and Certifying Examination

I hereby apply under 34-B M.R.S.A. § 3873-A(7)(B) for admission of _____
Client
to _____. I certify that:
psychiatric hospital

(a) I am a licensed _____ and that I am a member of the ACT team/community provider into
MD/DO/PhD/PA/NP/RN,CS
whose care the patient was committed in a proceeding under 34-B M.R.S.A. § 3873-A.

(b) I have been seeing the patient as part of my ACT team/community provider duties, and have conferred with other team members, and it is my opinion is that the client has failed to comply with an essential requirement of the client's treatment plan. Specifically,

_____

_____

_____

_____	_____	_____	_____
Date	Time	Medical Practitioner's Printed Name	Medical Practitioner's signature

Judicial Review and Endorsement

Upon review pursuant to 34-B M.R.S.A. § 3873-A, I find this application and certificate to be regular and in accordance with the law, and I hereby authorize _____ to take
Person authorized to take client into custody
_____ into custody and transport him or her to _____
Client Psychiatric hospital

_____	_____	_____	_____	_____
Date	Time	Judicial officer's printed name	Judicial officer's signature	Judicial officer's capacity (District, Probate or Superior Court Judge or Justice; Justice of the Peace)