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*Maine People Living  
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**REPORT TO THE JOINT STANDING COMMITTEE ON  
HEALTH AND HUMAN SERVICES**

**ON THE**

**THE PROGRESSIVE TREATMENT PROGRAM**

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**Prepared and Submitted by:**

**Department of Health and Human Services**

## **Introduction**

The Department of Health and Human Services (DHHS) is submitting this report to the Joint Standing Committee on Health and Human Services documenting the implementation and progress of the legislatively mandated Progressive Treatment Program (PTP). The Progressive Treatment Program (PTP) was made possible through the passage of Chapter 519, BBBB 1-19, during the 2<sup>nd</sup> Session of the 122<sup>nd</sup> Legislature. A statutory change was made to the PTP during the first session of the 124<sup>th</sup> Legislature which reduced the age of eligibility from 21 to 18 and provided for an extension of the period of participation from 6 months to a possible 12 months. The relevant statutes are included in [Appendix 1](#).

The development of the PTP came about through the work of many stakeholders over a period of many months. Numerous concerns, issues, and strong feelings arose during this period, as stakeholders struggled with the complex issues of mandated community treatment. The PTP program design was reached through consensus of this stakeholder group.

The legislation establishing the Progressive Treatment Program authorizes the two public hospitals, Dorothea Dix Psychiatric Center (DDPC) in Bangor and Riverview Psychiatric Center (RPC) in Augusta, to apply to district court to request a judge to order a commitment of six months of court ordered community-based treatment using the Assertive Community Treatment (ACT) program to provide the service. Moreover, the legislation authorized the creation of ACT programs to provide the services, one to be associated with RPC organized through reallocation of State positions, and the other to be associated with DDPC.

The PTP is now fully operational and the related ACT services exist in both areas; one under the operation of RPC and the other operated by Community Health and Counseling Services (CHCS) in Bangor. The RPC ACT Team accepts both PTP clients and RPC forensic clients. The ACT Team at CHCS accepts PTP clients as well as ACT clients from DDPC and the community.

This report describes activities that have taken place or are ongoing to carry out the mandates of the legislation, including the following:

1. Requirements of the Statute
2. Development of Progressive Treatment Program Guidelines
3. Education and Training
4. Consumer Eligibility
5. Riverview Psychiatric Center – Riverview ACT Team
6. Dorothea Dix Psychiatric Center – Community Health and Counseling Services ACT Team
7. No Reject Provisions
8. Evaluation
9. Next Steps

## **Requirements of the Statute**

The enabling legislation contained a number of requirements to be undertaken by DHHS. These included:

- The development of two PTP-ACT teams to serve eligible individuals from each of the two public psychiatric hospitals;
- An analysis of the current costs to provide service to individuals eligible to participate in the PTP program;
- Development of a funding proposal to sustain the PTP program with existing resources;
- The development of education and training materials with input from a variety of appropriate groups;
- Amendments to MaineCare rules to prohibit any provider of ACT from rejecting any person participating in the PTP.

Each of these requirements is addressed in this report. DHHS has closely monitored the implementation of PTP and has tracked the number of individuals served by the program and the number who have completed the program. An evaluation of cost effectiveness would yield little valid information because of the small number of individuals served by the two PTP - ACT teams to date. The small number of participants is attributed to the requirement in the statute which narrowly defines those who are eligible to participate in the program.

## **Development of Progressive Treatment Program Guidelines**

The Office of Adult Mental Health Services (OAMHS) recognized that a key element of implementing the PTP within the two public hospitals would be the joint development of the guidelines which would be followed by the two hospitals. OAMHS convened a work group of representatives from RPC and DDPC, OAMHS, and an Assistant Attorney General. The group included Superintendents, Medical Directors, the RPC Deputy Superintendent and the Riverview ACT Team Program Director. The guidelines were completed in draft form in late October, 2007 and were approved for use by early November, 2007 with the initiation of the Riverview ACT Team. In addition to the guidelines, the associated forms for the commitment hearings and other necessary documents were also developed. The guidelines are included in [Appendix 2](#).

## **Education and Training**

OAMHS, through the Office of Consumer Affairs, brought together a Peer Advisory Group to assist in the preparation of a program description for the PTP to be used for educational purposes. It is geared to anyone who is interested in learning more about the PTP, how it works and what is intended to accomplish. The Program Description developed by this group is attached ([Appendix 3](#)).

In addition to the development of the program description there have been several other initial training and educational activities which included:

- On October 2, 2006, NAMI-Maine sponsored a panel open to the public to provide information about community commitment and the progress in Maine toward implementation of the Progressive Treatment Program. The panel was held at the University of Maine in Augusta, and included Mary T. Znadowicz J.D., Executive

Director of the Treatment Advocacy Center in Arlington, VA and Donald Chamberlain, Director, Community Systems, OAMHS, DHHS.

- Guidelines were developed for use by RPC and DDPC and forms were created by the Assistant Attorney General (AAG) who works with DHHS and with the District Court for commitment hearings. This AAG worked with court personnel to introduce them to the role of the court in the PTP, and to acquaint them with the new forms. The AAG has also offered court personnel the opportunity to participate in using in vivo cases for training as the law is implemented for the first time.
- The Assistant Attorney General assigned to OAMHS arranged training sessions for RPC and DDPC medical staff regarding PTP and the new standards for commitment and rehospitalization that had been created.

### **Consumer Eligibility**

The legislation allowed for up to 25 persons to be served by each of the ACT teams but the number of persons who were eligible and agreed to the PTP have been substantially less. Moreover, the original projection was done prior to the finalization of the legislation which defined more specifically and narrowly who would be eligible. To be eligible for District Court commitment to the PTP and individual must:

- (1) Be 21 years of age or older originally; and 18 as of the fall of 2009;
- (2) Have a clinical diagnosis of a Severe and Persistent Mental Illness;
- (3) Have an order of involuntary commitment to Dorothea Dix Psychiatric Center or Riverview Psychiatric Center at the time of filing of the application for PTP; and
- (4) Have a clinical determination that PTP is appropriate in order to prevent interruptions in treatment, relapse and deterioration of mental health and to enable the person to live safely in a community setting in the reasonably foreseeable future without posing a likelihood of serious harm. This determination must be based on current behavior, treatment history, documented history of positive responses to treatment while hospitalized, relapse and deterioration of mental health after discharge and inability to make informed decisions regarding treatment;
- (5) Be able to live within a 25 mile radius of the referring state public psychiatric hospital without undue disruption of the person's natural support system for the duration of the PTP.

### **Riverview Psychiatric Center – Riverview ACT Team**

In November, 2006 the Riverview ACT team was licensed and ready to accept PTP referrals from RPC.

Beginning with the effective date the legislation, July 1, 2006, the Department reassigned personnel from within RPC and the DHHS Office of Adult Mental Health Services Region II Office to staff the new Riverview ACT Team which would operate as a community based outpatient program of RPC. These changes were made in accordance with Chapter 519, BBBB-19. The ACT Team is designed, as its mission statement reads, to provide “a broad array of community-based, individualized rehabilitative services delivered by a multi-disciplinary team of medical, mental health, administrative and social and human services professionals.”

The Riverview ACT Team was created to serve two populations:

- (1) RCP civil patients who are committed to the PTP
- (2) RCP forensic patients on Non Criminally Responsible (NCR) status who are returning to the community

### Staffing

The Riverview ACT Team serving RPC consists of State employees and contract employees and is overseen by RPC. This Team not only serves PTP clients as noted above but also forensic clients who are in the custody of the DHHS Commissioner and have been discharged from RPC. The current total staffing is 9 direct service full time equivalents (FTEs) and consists of the following positions:

- 0.5 Psychiatrist
- 1.0 Nurse Practitioner
- 1.0 Program Director
- 1.0 Team Leader
- 1.0 Substance Abuse Specialist
- 1.0 Vocational/Employment Specialist
- 1.0 Case Manager
- 1.0 Peer Support Specialist
- 1.0 Psychologist
- 0.5 Program Specialist

Of the above positions, the OAMHS Region 2 office contributed 2 FTEs – 1 FTE Consent Decree Coordinator who became the Team Leader of the ACT Team and 1 FTE ICM who is the case manager on the Team.

### Rate

Services for all ACT teams are reimbursed at a monthly bundled rate per consumer. The Riverview ACT Team rate is \$1,360.03 per month.

### Consumers

While the ACT Team was fully operational in November, 2006 to take on PTP consumers the first referral from RPC did not come until January, 2007. At the District Court hearing, the District Court Judge allowed the case to be dismissed. The first case was then admitted to the ACT Team on March 28, 2007. During this time period the team admitted forensic cases. This delay was the result of a lack of initial consumers who met the eligibility criteria and, if they met the criteria, were willing to accept PTP as an alternative to continued hospitalization.

For the three years of operation from January 2007 through December, 2009, there have been:

- Nineteen admissions involving fifteen individuals; one individual was admitted three times and two were admitted twice;
- Of the nineteen admissions, seven completed the PTP.

## **Dorothea Dix Psychiatric Center- Community Health and Counseling Services ACT Team**

The legislature appropriated \$115,237 for MaineCare seed in FY'07 for ACT services for the Progressive Treatment Program associated with Dorothea Dix Psychiatric Center (DDPC). The Office of Adult Mental Health Services (OAMHS) initiated a Request for Proposals (RFP) process to seek a provider of these services. However, before the RFP process was completed, DHHS decided to expedite the process and seek a provider who was licensed and qualified to provide ACT services in the DDPC services area. CHCS was the existing provider of ACT services in the area and their contract was amended to provide the PTP and a revised rate was established for the CHCS ACT Team in May, 2007. As the contract amendment was being negotiated a critical issue became the number of consumers who would be added to the existing ACT Team and what additional staffing would be needed to accommodate these consumers. After a thorough review of existing consumers at Dorothea Dix Psychiatric Center and projections of new consumers, it was decided to increase staffing to accommodate 5 PTP consumers. Should the number of consumers increase, the ACT Team staffing could be further increased to accommodate additional consumers. Since CHCS is only reimbursed based upon consumers actually receiving services, it was not financially feasible for CHCS to staff for more consumers that would likely be referred.

### Staffing

CHCS overall direct service ACT team staffing is 11.55 FTEs. The overall specific positions are as follows:

- 0.1 Psychiatrist
- 0.45 Nurse Practitioner
- 1.0 Team Leader
- 1.0 Psychiatrist Nurse
- 6.0 Case Managers
- 1.0 Vocational/Employment Specialist
- 1.0 Substance Abuse Specialist
- 1.0 Peer Specialists

Additionally, CHCS uses hourly staff for medication management administration specifically for the new PTP consumers.

### Rate

Services for all ACT Teams are reimbursed at a monthly bundled rate per consumer. The CHCS amended ACT Team rate has been set at \$1654.32 per month.

### Consumers

The first consumer entered the PTP program from Dorothea Dix Psychiatric Center in August, 2007.

As of December, 2009 there have been:

- Seventeen admissions of sixteen unique consumers; two consumers had two admissions;
- Nine persons completed the PTP.

## No Reject Provisions

Section BBBB-17 of Chapter 519 directed DHHS to amend its MaineCare rules to prohibit any provider of ACT from rejecting any person participating in the PTP. After a review of the relevant section of the MaineCare rules, DHHS determined a rule change to be unnecessary. This is true because the Riverview ACT is a DHHS program and under the auspices of OAMHS and the requirements of the CHCS program are more appropriately covered by their contract.

## Cost

OAMHS has not mounted a study of the costs of this program given the low number of participants completing the program. We do know that the six month cost for the ACT team service is \$8,160 at RPC and is \$9,186 at DDPC, plus the housing costs for each participant. Participants would typically be in some type of supported housing (BRAP \$387 per month) to a PNMI at (\$7800 per month). Additionally, of the sixteen people completing the PTP, seven people had readmissions to either RPC or DDPC during this time. The daily hospital rate is \$870 so the days in the hospital would also need to be part of the cost calculation. A rough picture of a six month program might range from a high of \$61,050 when the housing is in a PNMI and there is a hospital readmission to a low of \$12,246 when there is BRAP housing and no readmissions. The two following examples illustrate these costs:

Scenario one....RPC PTP.....	\$ 8,160
PNMI costs.....	\$46,800
Seven days of hospitalization.....	\$ 6,090
	Total <u>                    </u>
	\$61,050 per person
Scenario two....DDPC PTP.....	\$ 9,924
BRAP/housing.....	\$ 2,322
No hospitalization.....	\$ 0
	Total <u>                    </u>
	\$12,246 per person

There are also court and assessment costs that should be considered as part of the cost calculations.

## Evaluation

The program at RPC has been in operation for three years and has had 19 admissions (15 unduplicated) and 7 completions during that three year time span. The program at DDPC has been in operation for two years and five months had has had 17 admissions (16 unduplicated) and 9 completions. OAMHS has not mounted a full evaluation of either the efficacy or the cost of the program given the low numbers for completion and the costs associated with a full evaluation. Data is being kept on each of the participants so OAMHS kept open the possibility of a retrospective study.

As of today, we do not know if the PTP is an effective option for people with severe and persistent mental illness at risk of relapse or deterioration absent mandated compliance with prescribed treatment. The numbers who have participated have been small, thirty individuals

and sixteen completions over the course of three years, and the national research on the efficacy of this option is inconclusive.

The most current national research has been done on the Assisted Outpatient Treatment (AOT) Program in New York State. The intent of AOT was to provide the resources and oversight necessary for a viable, less restrictive alternative to involuntary hospitalization. The Assisted Outpatient Treatment Program is an outpatient commitment program with three service options: enhanced voluntary services, ACT, and intensive case management. One or all three of these options may be provided at any one time to a participant in AOT. New York's AOT program was accompanied by a significant infusion of new service dollars and more comprehensive implementation, infrastructure, and oversight of the AOT process than any other comparable program in the United States according to the evaluation published in June 2009. John Monahan of the MacArthur Foundation Research Network on Mandated Community Treatment and the University of Virginia School of Law summarized the findings of this large scale effort:

- During the first six months on Assisted Outpatient Treatment (AOT), service engagement was comparable to service engagement of voluntary patients not on AOT;
- After 12 months or more, when combined with intensive services, AOT increases service engagement compared to voluntary treatment;
- During AOT, the consumer is more likely to consistently receive psychotropic medications and there are subjective improvements in many areas of functioning;
- Six months after discharge from AOT, decreased rates of hospitalization and improved receipt of psychotropic medications are sustained only if recipients receive intensive services;
- Twelve months or longer after discharge from AOT, decreased rates of hospitalization and improved receipt of medications are sustained whether or not intensive services are continued.

The summary of the New York evaluation states:

We find that New York State's AOT Program improves a range of important outcomes for its recipients, apparently without feared negative consequences to recipients. The increased services under AOT clearly improve recipient outcomes; however, the AOT court order, itself, and its monitoring do appear to offer additional benefits improving outcomes. It is also important to recognize that the AOT order exerts a critical effect on service providers stimulating their efforts to prioritize care for AOT recipients.

### **Next Steps**

The legislation for the PTP sunsets in July 2010. It is premature to end this program in July given the effort that has gone into it thus far and the possibility of improved outcomes that it may offer. OAMHS proposes:

- To consider the use of the twelve month commitment rather than the more frequently used six month term to see if there is an improvement in longer term gains;
- To do an anecdotal study of the persons who have completed the PTP with information on pre and post hospitalization and service needs at six and twelve months post discharge.
- To coordinate ongoing training and discussion with the two PTP teams to implement ongoing data collection for participants, to discuss the latest research, to understand the content of the PTP statutes and the role of the PTPs, and to provide case consultation.