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Testimony of the Department of Health and Human Services

Before the Joint Standing Committee on Criminal Justice and Public Safety

In support of LD 2046, *An Act to Continue Allowing the Department of Corrections to Accept Placement of Certain Defendants Found Incompetent to Stand Trial*

Hearing Date: January 17, 2024

Senator Beebe-Center, Representative Salisbury, and Members of the Joint Standing committee on Criminal Justice and Public Safety, I'm Dr. Matthew Davis, I am proud to be a Distinguished Fellow of the American Psychiatric Association, and I serve as the Clinical Director at Riverview Psychiatric Center (RPC) in Augusta, one of two State psychiatric hospitals operated by the Department of Health and Human Services. I'm here to speak in support of LD 2046, *An Act to Continue Allowing the Department of Corrections to Accept Placement of Certain Defendants Found Incompetent to Stand Trial.* Thank you to Representative Salisbury for providing the opportunity to DHHS and the Maine Department of Corrections to introduce this bill.

LD 2046 is very straightforward; it repeals the sunset provision on 34-A MRSA §3069-C. DHHS and DOC are appreciative of the collaborative work done in 2021 with this Committee to develop the statute to allow the transfer of an adult defendant who is found incompetent to stand trial (IST) to a mental health unit of a correctional facility only under the approval of the Court when patient's behaviors are too dangerous to safely manage within a psychiatric hospital and the violence is not primarily driven by symptoms of a major mental illness or other disability. Importantly, there must also be no other, less restrictive alternative for this provision to be utilized.

When the Departments and the Committee worked on the proposal in 2021 (LD 769, later PL 2021, Ch. 259), we collectively acknowledged that the proposal was novel and some expressed concern that it could lead to the incarceration of individuals with mental illness. Together, we crafted guardrails to protect patients, and further included a sunset of this authority to provide the Legislature with an opportunity to review the provision after a short time piloting this authority.

In the report on this provision provided to the Committee on January 8, you will see that this process has only been used with four individuals who presented risks too significant to manage at Riverview Psychiatric Center for both the safety of other patients and staff. This represents approximately just 6.5% of IST referrals since the statute was enacted in October 2021 and is even less than our initial conservative estimates prior to the bill being passed. Clinicians and staff at Riverview work closely with the Intensive Mental Health Unit (IMHU) to support patient care. Of the 4 patients referred to the IMHU, 3 had their competence restored and were able to resolve their legal situations and the fourth is currently in the process of doing so.

This authority has been critical to maintaining safe and effective care at Riverview Psychiatric Center and ensuring that the inpatient admissions pipeline can remain open. Indeed, we have seen a year-over-year 20-25% increase in admissions since this statute was enacted. Patients with behaviors that meet the criteria in 34-A MRSA §3069-C who remain at RPC can require an entire unit to be cleared, which means other individuals (including defendants) who are in need of care and/or competence restoration are unable to access those services.

I am attaching to my testimony copies of the testimony from myself and now-retired Dr. Debra Baeder of the Office of Behavioral Health submitted to the committee in 2021. These better outline the need for this authority and the limited situations in which these transfers are necessary.

This provision has allowed me and my colleagues to provide better, safer care to all defendants found IST, importantly including those who are transferred to the IMHU as it best matches the right treatment setting for their treatment needs. I am glad to have the opportunity to discuss this limited by critical provision of statute, and I hope you will support passage of this bill.

Testimony of the Office of Behavioral Health
Department of Health and Human Services

Before the Joint Standing Committee on Criminal Justice and Public Safety

In Support of LD 769
An Act To Increase the Availability of Mental Health Services for a Defendant
Who Has Been Found Incompetent To Stand Trial

Sponsored by: Representative Holly Stover
Hearing Date: April 9, 2021

Senator Deschambault, Representative Warren and Members of the Joint Standing Committee on Criminal Justice and Public Safety, I am Dr. Debbie Baeder, Board Certified Forensic Psychologist and Clinical Director of the Office of Behavioral Health (OBH) in the Department of Health and Human Services. I am here today to introduce and speak in strong support of LD 769, An Act To Increase the Availability of Mental Health Services for a Defendant Who Has Been Found Incompetent To Stand Trial. The Department thanks Representative Stover for introducing this bill on our behalf.
LD 769 seeks to authorize the Commissioner of the Department of Corrections (DOC) to accept placement of an adult defendant in a mental health unit of a correctional facility when prior to trial the adult defendant has been found Incompetent to Stand Trial (IST), is committed to the custody of the Department of Health and Human Services, and that defendant's behavior is deemed too dangerous to safely manage at one of the State's psychiatric hospitals.

Defendants found IST who exhibit highly aggressive and predatory violence to staff and patients at Riverview Psychiatric Center are very difficult to behaviorally manage and therefore clinically treat. Given their relatively long lengths of stay and the high staffing requirements to safely manage their care, admitting these defendants often places a hold on other forensic and civil clients needing an admission to Riverview and/or Court-Ordered to be admitted. The ripple effects of admitting defendants with highly dangerous behaviors to Riverview include greater at-risk patient mixes, staff shortages due to injury, civil unit staffing disruptions, and Special Care Unit (SCU) bed vacancies due to IST clients with highly dangerous behaviors needing intensive staffing and low patient interaction. The ripple effects within the larger forensic system include longer wait times in jail for defendants awaiting an inpatient admission and longer times for legal case resolutions.

The number of defendants found IST and referred to state psychiatric facilities has grown somewhat since 2015, but generally represent a relatively small number of defendants when compared with all defendants for whom the competence question is raised. For example, 57 defendants were found IST in 2018. The average waiting time, almost always in jail, for a defendant found IST prior to inpatient hospital admission was approximately 16 days (pre-COVID). That wait time has increased significantly since the beginning of the pandemic. Between 2015 and 2018, there were 345 documented incidents of verbal and/or physical aggression against either staff or peers, property destruction, self-injury, and attempted elopement perpetrated by 40 separate IST patients. That relatively low number of IST patients

highlights the fact that a relatively small number of patients with dangerous behaviors can cause significant harm.

A significant gap in our current competence restoration services is the inability to both keep the inpatient admissions pipeline open *and* safely manage defendants with highly dangerous behaviors. Several other states have allowed defendants with highly dangerous behaviors found IST to be restored to competence either in jail, or on a specialty mental health/competence restoration unit within an incarcerated setting. For example, a jail-based, specialized competence restoration program in Atlanta, Georgia functions much like the operation of an inpatient forensic unit in a state psychiatric hospital. It was reported that in the seven years of their study period, the rate of dangerous incidents was much lower than rates reported by the state forensic hospital.

The Intensive Mental Health Unit (IMHU) at the Maine State Prison utilizes an approach which is consistent with a multidisciplinary hospital approach in terms of psychiatric care, a focus on recovery, individualized interventions, and tailored interventions to address the reported competence-related deficits. It is a unit separated from the general population and staffed by a contracted full-time team of mental health professionals. Specifically, mental health treatment at the IMHU aligns with the care provided at Riverview in that they employ a multidisciplinary team of providers including a psychiatrist, 2 psychologists, a nurse, a Unit Coordinator, behavioral health technicians, and an Intensive Case Manager to facilitate community reintegration. Individual and group treatment modalities are offered on a weekly basis. There is undeniably a higher level of security and specially trained correctional officers (e.g. mental health training, de-escalation training) are placed on the unit as well. Functionally, this separate Unit operates more similarly to a psychiatric unit than it does to a prison.

Currently, the IMHU statute prohibits placing defendants found IST at the IMHU. This bill would fill the gap in competence restoration services in Maine by allowing for the placement of pretrial defendants found IST with behaviors deemed too dangerous for placement at the state hospitals to be placed at the IMHU for competence restoration and treatment. This is envisioned as a multi-directional option, where individuals with behaviors that cannot be safely managed at Riverview can receive care and competence restoration at the IMHU until their behaviors are addressed to a point at which they can be safely reintegrated into the milieu at Riverview. It is proposed that placing an IST defendant at the IMHU would have both a judicial safeguard and require a clinical recommendation regarding the most appropriate placement.

Filling the gap in competence restoration services would complete a continuum of care for pretrial defendants in Maine found IST by the Court. The continuum of care would include community-based competence restoration and treatment for low-risk, amenable defendants; hospital-based restoration and treatment for defendants with exacerbated symptoms of major mental illness; and IMHU-based restoration and treatment for defendants deemed by a Court too dangerous for initial placement at Riverview. Movement between the levels of care allows treatment teams to meet the needs of these defendants at the most appropriate level of care and, ultimately, in the least restrictive environment necessary. Having a fully functioning, multi-directional continuum of care for defendants found IST by the Court would significantly assist in diverting defendants from longer jail stays, properly triaging forensic admissions, ensuring

treatment, improving safety, and effectively processing difficult criminal cases through to completion.

Thank you for your time and attention. Dr. Matt Davis and Superintendent Rod Bouffard will also be testifying to this bill from their perspectives at Riverview. I would be happy to answer any questions you may have and to make myself and other team members available for questions at the work session.

Testimony of Riverview Psychiatric Center
Department of Health and Human Services

Before the Joint Standing Committee on Criminal Justice and Public Safety

In Support of LD 769
An Act to Increase the Availability of Mental Health Services for a Defendant
Who Has Been Found Incompetent to Stand Trial

Sponsored by: Representative Holly Stover
Hearing Date: April 9, 2021

Senator Deschambault, Representative Warren, and Members of the Joint Standing Committee on Criminal Justice and Public Safety, we are here today to speak in strong support of LD 769, An Act to Increase the Availability of Mental Health Services for a Defendant Who Has Been Found Incompetent to Stand Trial. We are grateful to Representative Stover for working with us on this bill. Before we begin, we would like to provide some brief background on ourselves.

Rodney Bouffard is the Superintendent at Riverview Psychiatric Center (RPC). His professional career has been built on helping Mainers at the most critical and challenging times in their lives. In addition to his current position at RPC, his service to the state includes top leadership positions at the Pineland Center, Augusta Mental Health Institute, Long Creek Youth Development Center, and the Maine State Prison. He managed each of these facilities through challenging/difficult times (litigation, closure, gaining/regaining certification, etc). As an example, under his leadership, Riverview regained full Centers for Medicare and Medicaid Services (CMS) certification. Given his work history, he has the unique ability and perspective on how multiple systems function and the critical importance of collaboration. Throughout the years he has been recognized for his work by the Governor's Office, the National Alliance on Mental Illness (NAMI), the American Academy of Medical Administrators, and several other private organizations.

Matthew Davis, MD, DFAPA, is the Clinical Director at Riverview Psychiatric Center, a position he has held since August 2018. Prior to that, he served as Medical Director of Behavioral Health Services at Portsmouth Regional Hospital in New Hampshire. He also worked as a staff psychiatrist for a number of years at the state psychiatric hospital in New Hampshire. He is a Distinguished Fellow of the American Psychiatric Association and the current President of the Maine Association of Psychiatric Physicians (MAPP).

We strongly support LD 769 for two primary reasons—access to care and patient and staff safety—which we discuss in detail below. By way of background, RPC admits patients through several different legal mechanisms, broadly categorized as civil and forensic. Civil referrals include patients admitted on an Emergency Involuntary Commitment (EIC), commonly referred to as a "Blue Paper" and those admitted on a District Court Commitment. In these instances, a patient poses a risk of engaging in dangerous behaviors—self-harming, suicidal, aggression towards others, or inability to care for oneself—that are due to a mental illness diagnosis. Forensic referrals include patients admitted for competency evaluation, those who have already been found Incompetent to Stand Trial (IST), or those who have been adjudicated as Not

Criminally Responsible (NCR) after being charged with a crime--usually something serious such as murder, aggravated assault, sexual assault, or arson. Regardless of the legal mechanism that generates an admission, our duty is to evaluate, treat, stabilize, and ultimately discharge patients to a lower level of care as soon as safe and practicable.

This bill seeks to address the small proportion of patients admitted on IST status who pose a significant risk of dangerous, aggressive, violent, and assaultive behaviors. The root cause of this aggression and violence usually is from one of three symptom domains: psychotic, impulsive, or predatory/instrumental:

> Psychotic aggression is driven by symptoms including hallucinations (a patient perceives a stimulus that is not present, such as hearing voices that no one else does) and delusions (a patient has a belief that is inconsistent with reality, e.g., fearing that all their loved ones have been replaced by evil imposters). In such cases, a patient may respond to their external environment with aggression, typically because they are fearful and feel they must protect themselves. Individuals with psychotic disorders, such as schizophrenia and schizoaffective disorder, are at risk for engaging in this type of violence.
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> An individual engages in impulsive aggression typically as a response to an external stimulus that triggers them and is not preplanned. Some examples include kicking a hole in the wall after hearing bad news or punching someone in the face after being called a derogatory name. Individuals with impulse control disorders, traumatic brain injuries, or even some mood disorders such as bipolar disorder, are at risk of engaging in impulsive aggression.
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> Predatory/instrumental aggression is planned, methodical, volitional, and not directly in response to a mental illness diagnosis. Individuals typically engage in predatory acts for some type of gain, e.g., money or status, as retribution or retaliation for a perceived past slight, or, for example, to induce fear in someone, perhaps an individual who might testify against them in a criminal proceeding. Usually these individuals have sociopathic or psychopathic personality traits, meaning that they have little regard for the rights or well-being of others and no remorse for their actions. According to Drs. Warburton and Stahl, psychiatrists and international experts on violence in psychiatric patients, "a moderate proportion of all violent acts and a high proportion of the most severe violence acts are due to" this type of violence. Predatory violence is typically not responsive to medication or treatment, and, in fact, Drs. Warburton and Stahl indicate that individuals who engage in this type of violence likely require placement in a restrictive, custodial housing with a high degree of security, as opposed to a psychiatric hospital or ward that is geared toward providing treatment and therapy to improve symptoms of a mental illness. These patients require *management* of their dangerous behaviors with high-security environments, low staffing ratios, and access to tools that are not available at a psychiatric hospital. Unlike with psychotic and impulsive etiologies, this type of violence and aggression cannot be clinically treated.

It is important to note that an individual with a mental illness diagnosis might engage in violence and aggression due to any one or combination of these etiologies. Someone may have a mental

illness diagnosis that is adequately treated and stable but still engages in predatory violence. In other words, individuals with a mental illness diagnosis can knowingly and volitionally participate in violent and aggressive acts that their mental illness diagnoses have no direct bearing on. To further complicate the picture, sometimes, especially at the outset, it may be difficult--even for the most seasoned clinicians--to ascertain the root cause of violence and aggression for a given clinical presentation. During initial stages of an evaluation, an individual may appear to manifest signs and symptoms of mental illness or appear to engage in treatable forms of aggression (psychotic and impulsive). A prolonged, thorough, and expert clinical assessment ultimately reveals the absence of a mental illness diagnosis and treatable forms of aggression. RPC is equipped to treat patients with psychotic and impulsive aggression. On the other hand, we are not an appropriate or safe venue to manage predatory aggression, especially in the absence of any treatable mental illness diagnosis.

From January 1, 2019 through December 31, 2020, RPC admitted 49 patients on IST status, eight of whom either directly transferred from the Intensive Mental Health Unit (IMHU) or were there within two weeks of RPC admission. Almost all of them posed some risk of violence and aggression, but of these, only approximately five each year were unsafe or inappropriate for state hospital placement due to the severity and type of violence in which they engaged.
The significance to the State of RPC having to manage these patients is two-fold:

1. **Access to care**. Individuals referred on an IST status have lengths of stay nearly double that of patients admitted through civil mechanisms. From January 1, 2019 through December 31, 2020 the average length of stay (ALOS) for an IST admission was 116 days vs. 69.5 days for civil admissions. This is further compounded by the fact that IST patients who pose a significant risk of predatory violence are highly staff-intensive, meaning that they often necessitate that fewer beds can be utilized in order to ensure that there is adequate staff present to manage their dangerous behaviors. The upshot is that these individuals effectively consume multiple beds for extended periods of time. Further, the presence of these individuals also has the effect of overstimulating the therapeutic milieu that the hospital works diligently to cultivate. When the milieu is overstimulated, treatment and safety inevitably become compromised resulting in increased assaultive and self-abusive behaviors and prolonged stays for patients we can otherwise safely and effectively treat. The end result is patients languish in emergency departments, medical hospitals, or houses of incarceration, while awaiting admission.

2. **Patient and staff safety**. During our time at RPC—and in spite of our work leading to regaining CMS certification, safely discharging dozens of long-term patients to the community who previously languished here, and having seclusion and restraint rates consistent with state and national averages even while we have admitted many of the most ill and dangerous patients in the entire State—we have witnessed a small handful of patients who engage in predatory aggression and violence partake in seriously dangerous behaviors. In all these cases, these individuals engaged in these behaviors *not* due to symptoms of mental illness but with the intention of obtaining

some type of secondary gain. Superintendent Bouffard will provide some (anonymized) specific examples.

LD 769 addresses these challenges and ensures patient and staff safety by allowing the DHHS Commissioner to place IST patients with highly dangerous behavior, particularly those prone to predatory/instrumental aggression and violence, at the IMHU. One need look no further than New Hampshire to see that this is exactly how one of our peer states manages these issues. Most IST patients who cannot undergo community-based competency restoration are ordered for commitment at the Secure Psychiatric Unit (SPU) at the New Hampshire State Prison, which is akin to the IMHU. In New Hampshire, courts have the option of directly committing individuals who exhibit dangerousness that is felt to supersede the capacity of their state hospital, to the SPU, which is part of the New Hampshire Department of Corrections. They are then eligible for transfer to the state hospital once their dangerousness is adjudicated and diminished to the point that they can be safely cared for in a hospital setting.

In summary, cutting-edge research, common sense, fiscal responsibility, other state practices, and, above all, a duty to provide Mainers with the safest, most timely, efficient, and effective mental health treatment in the most appropriate setting leads to our strong support of LD 769. I urge the committee to pass this bill.

Superintendent Bouffard is prepared to speak to these challenges from his perspective. Both of us an members of our team will gladly answer any questions you have now and participate in the work session. Thank you for the opportunity to discuss this bill with you today.