Chairwoman Rotundo, Chairwoman Sachs, Chairman Baldacci , Chairwoman Meyer and distinguished members of the Appropriations and the Health and Human Services committees:

My name is John Nutting and as a state senator in 2003 and 2010, I sponsored the Progressive Treatment Plan bills that became law. My lead co-sponsor was Senator Peter Mills. Forty-eight states now have similar statutes.

I'm also a member of the National Shattering Silence Coalition (NSSC), a group made up of parents and family members of those with the most severe form of brain diseases, and having Anosognosia – Which is a total lack of awareness of their disease. NSSC has chapters in all 50 states – and that allows us to talk to parents in other states and see what other states are doing!

The supplemental budget proposes millions in new spending to create a series of walk-in centers; which will be a help to those **with awareness** of their diseases. But, it will do absolutely nothing to help those and their families, struggling with the most severe forms of mental illness, and having **no awareness** of it! In Maine in the last few months we've had tragedies in Freeport, Turner, Poland, Yarmouth, South, Portland, Lewiston, and Topsham. From talking to family members, Everyone of these individuals had absolutely no insight into their disease. If we are going to prevent these type of tragedies in the future, we need to do more than just walk-in centers that are for those who do have awareness of their disease. "I don't need to be in a treatment plan." – "You need to be on a treatment plan!" I've heard these statements many times from the parents and clinicians testifying here today. The question you're facing today is, are we going to increase our help for those that need it the most?

Last week NSSC members received devastating news that DHHS is not going to apply for extra federal mental health funding for almost 2 years – even though LD 445 passed unanimously in the legislature.

The MANATT report points out that states who use these extra federal mental health funds use it to also build up their community supports thru more act teams and intensive case managers in the community so they can help with more Court orders.

(OVER)

So what can this state do to prevent these types of things from happening in the future?

1) Adding an ACT team in Western Maine, serving the Oxford and Franklin County areas.....Adding an ACT team in Aroostook County and replacing the recently eliminated ACT team in Augusta.....And adding some intensive case managers in Aroostook and Washington county.....would allow District Court judges to place many more people in the PTP program, so that the numbers could approach what they were in other states our size.

2) NSSC members have been trying to get DHHS to train law enforcement in what statues are out there, what mental health statutes that they can initiate (PTP) , and who they could contact in DHHS if the family brought them concerns over a loved one. After our press conference in November, Sheriff Merry was asked why he didn't put Mr. Card in the PTP program, incidentally, Mr. Card did qualify for it, his response was shocking: "I've never heard of it!" When the young man in Richmond burned his parents house down, that sheriff pointed out to the media that they had had 183 medical health touches with this individual, and yet he was not put in the PTP program. A similar situation just happened in Minot with the gentleman that shot the Androscoggin County Sheriff deputy. After a press conference on November 8th, the department put out a press release, saying they were willing to train law-enforcement. Twenty-four hours later when the spotlight was not on them they said they did not want to train Law enforcement. The wall between DHHS and law enforcement must come down!

It is been so gratifying of the last 21 years to hear the numerous cases of loved ones on the PTP program now having successes in their lives, whereas before they had none. It is also been incredibly frustrating to realize that this state is not using the statute anywhere near as much as other states are. New York, Michigan, California come to mind. Schizophrenia with Anosognosia is a very very serious brain disease. The serotonin levels in the brain are not normal, and someone's thought process is not normal. You don't cure other diseases by talking to people, hoping. Or giving them a pat on the back. Those things may help, but those diseases are are cured by a treatment plan. This disease is no different. We can and should learn from other states that we can do a better job helping more people have successes in their lives, and having fewer tragedies as a result.

Thank-you, I'd be happy to answer any questions.

Pg. 3+4

June 18, 2021

States Are Leveraging Medicaid Waivers to Transform Their Behavioral Health Systems

Jocelyn Guyer, Ashley Traube

Manatt, Phelps & Phillips, LLP

+ Follow Contact

manatt

Introduction

As the nation experiences unprecedented levels of behavioral health needs—even further exacerbated by the COVID-19 pandemic—state Medicaid programs have increasingly looked for flexibility to craft services and payment models that support improved access and outcomes. As the single largest payer for behavioral health services nationwide, Medicaid is in a unique position to impact millions of Americans' access to quality behavioral health care. To engender this effort, the Centers for Medicare & Medicaid Services (CMS) has waived historical restrictions on inpatient substance use and mental health services and permitted states to leverage Section 1115 demonstrations to support broad-based reform.

Background on Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbances Waivers

Institutions for Mental Disease Waivers for Substance Use Disorders

Over the last five years, 32 states (see Figure 1) have obtained federal waivers of the institutions for mental disease (IMD) exclusion—the historical prohibition on using federal Medicaid funds to pay for treatment delivered to individuals ages 21 to 6 beds—for individuals receiving substance use disorde released a state Medicaid director (SMD) letter—repla of the opportunity to design Section 1115 demonstrati CMS advised states that they could apply to waive the including providing access to SUD treatment across c evidence-based SUD treatment and placement criteri appropriate level of care, introducing SUD provider q coordination for individuals with SUDs. These demon

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the largest source of coverage and funding for substance use prevention and treatment in the country, covering nearly 40 percent of adults with an opioid use disorder (OUD) and 17 percent of adults experiencing any type of addiction. Since the first state waivers were approved in late 2015 and 2016, expanding access to evidence-based SUD treatment across all levels of care remains a critical need due to continued rise in drug use and overdose deaths.

IMD Waivers for Serious Mental Illness & Serious Emotional Disturbance

In recent years, CMS and states have taken an integrated approach to treating mental illness and SUD to effectively address rising behavioral health (BH)—mental health (MH) and SUD—needs. Nearly half of the 19.3 million adults with SUD have a co-occurring mental illness, and 18 percent of adults with mental illness have a co-occurring SUD. In November 2018, CMS released another SMD letter notifying states of the opportunity to design Section 1115 demonstrations focused on adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). In the SMD letter, CMS advised states that they could similarly apply to waive the IMD exclusion for individuals obtaining care for serious MH conditions if they ensure the quality of inpatient and residential care; improve care coordination and care transitions; improve access to a continuum of care for MH treatment; and promote earlier identification of and engagement in MH care. To prevent over-institutionalization of individuals with SMI/SED, states must meet additional requirements, including maintaining their current funding for outpatient community-based MH services and adhering to a 30-day average length of stay in IMDs.[1] A growing number of states—seven with approved waivers and three with pending waivers as of May 2021—are pursuing waivers of the IMD exclusion for SMI/SED.

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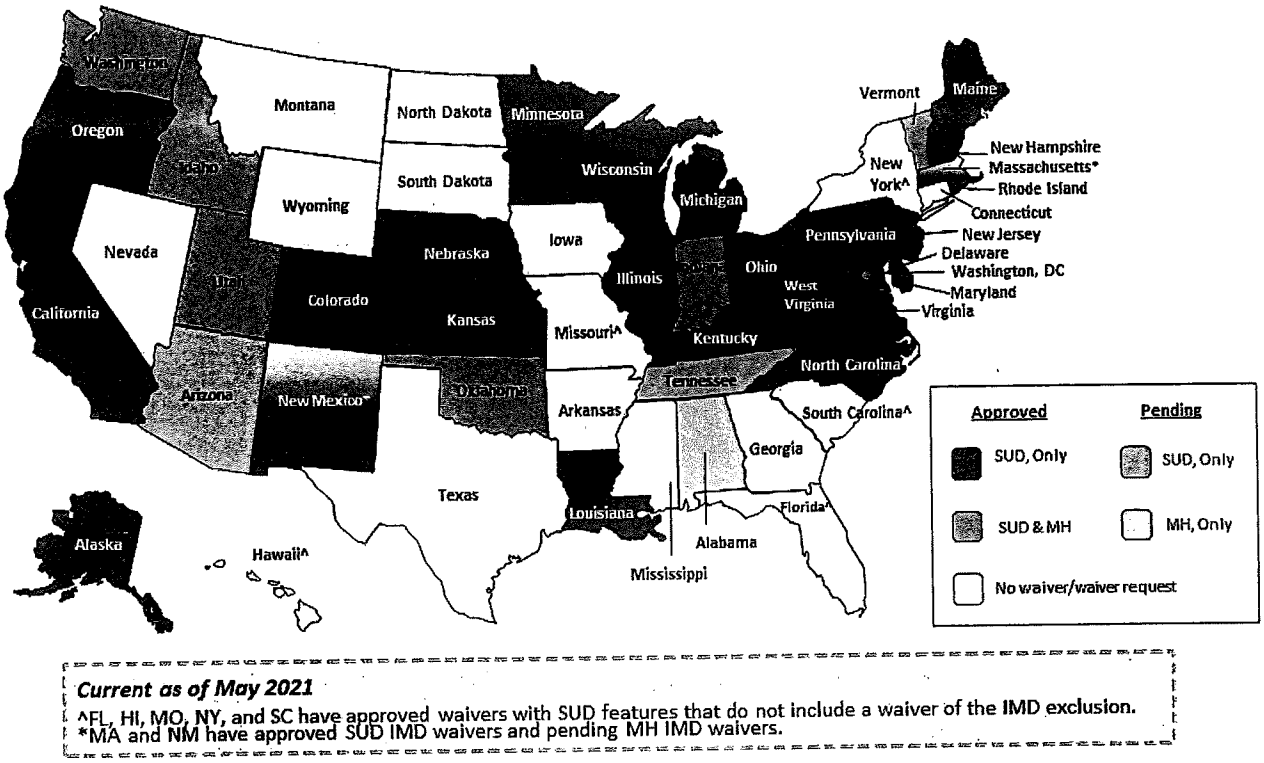
Figure 1. States With Approved or Pending Waivers of the IMD Exclusion



Current as of May 2021

^FL, HI, MO, NY, and SC have approved waivers with SUD features that do not include a waiver of the IMD exclusion.
*MA and NM have approved SUD IMD waivers and pending MH IMD waivers.

Key Features of SUD and SMI/SED Section 1115 Demonstrations

In addition to waiving the IMD exclusion for SUD and MH treatment, states are using Section 1115 demonstrations to implement a range of strategies to improve care for Medicaid enrollees with BH needs.

Additional Treatment and Recovery Services

A number of states are using waiver authority to cover or pilot a range of BH treatment and recovery services, many of which can be covered via Medicaid State Plan authority, and link these services to waivers of the IMD exclusion. States commonly use Section 1115 IMD-focused waivers to cover SUD and MH treatment and detoxification services, particularly residential levels of care that are often provided in IMDs. Other states like Illinois and Washington, D.C., are using their Section 1115 demonstrations to cover or pilot crisis int[illegible] mobile crisis response services—a move that may become increasingly more Rescue Plan (ARP) Act community mobile crisis inter to cover qualifying services using Medicaid State Plan authorities—becomes effective in April 2022.[2]

A significant number of states with Section 1115 BH-f[illegible] waivers to cover peer support services, which use the [illegible] from SUD to support others in treatment and recover[illegible] the 37 states covering peer supports for individuals wi[illegible]

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using Medicaid State Plan authority. Peer support services can be provided in a range of clinical and non-clinical settings, and as a complement to or replacement for clinical treatment, including for crisis response services.

Additionally, states use their Section 1115 BH demonstrations to provide enhanced home and community-based services (HCBS) to individuals with SMI, SED and/or SUD. In recognition that individuals with BH needs account for approximately one-third of all homeless individuals, states like Washington, Illinois, Florida and Hawaii are providing supportive housing benefits to adults with SUD and/or SMI who are or at risk of becoming homeless. In addition to Section 1115 waiver authority, states can cover supportive housing services through Section 1915(c) or 1915(i) authority. These supportive housing and tenancy support services assist beneficiaries with a range of services including securing appropriate housing, building relationships with landlords and neighbors and obtaining the skills necessary to manage a household.

Targeted Delivery System Reform With Behavioral Health Components

Several states also use waiver authority to obtain Medicaid funding to pursue delivery system and payment reforms targeted to specific populations, including those with BH needs. A shrinking number of states operate Delivery System Reform Incentive Payment (DSRIP) programs with BH components, which provide states with significant funding to help providers, especially hospitals, invest in delivery system reform.[3] For example, Washington's DSRIP program, authorized through a Section 1115 demonstration in 2017, includes waivers of the IMD exclusion for SUD and SMI/SED, as well as projects targeted toward the integration of physical and behavioral health services and strategies to address SUD and projects focusing on SUD and projects focusing on physical health and BH integration. It will be critical to watch whether the Biden Administration reverses the course set out by the Trump Administration, which was gradually phasing down DSRIP programs in an effort to shift Medicaid programs toward more sustainable value-based purchasing integrated into Medicaid delivery systems. Under the Trump Administration, states were still able to leverage Medicaid funding for and pursue BH-focused delivery system and payment reforms using 1115 waivers other than DSRIP waivers. For example, Hawaii, Massachusetts and North Carolina obtained 1 1115 demonstrations for health-related initiatives add specific populations, including those with BH needs.

Coverage Expansion for Individuals With

Select states also use Section 1115 authority to extend adults and children with SED, SMI or SUD who are ot example, Rhode Island uses its 1115 demonstration to

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SED who require treatment in a psychiatric residential treatment facility and do not meet income requirements for Social Security Income. The state also provides a limited benefit package to uninsured adults with incomes from 133–200 percent of the federal poverty level who have a mental illness or SUD.

Looking Ahead

As the first state-focused IMD demonstrations come up for renewal and more than 60 percent of states gain experience operating these demonstrations, federal and state governments have an opportunity to take stock of these demonstrations. Key questions to watch in the months ahead include:

- How effective have SUD demonstrations been at increasing SUD treatment and leading to reductions in overdose deaths?
- Will CMS accelerate approval of SMI waivers?
- What pressures may emerge for additional protections against over-institutionalized care as more states begin to seek such waivers?
- What efforts will be made to integrate MH and SUD treatment via Section 1115 demonstrations?
- Will states integrate child-focused BH reforms into these waivers that have long focused on adults with BH needs?
- How will CMS bring its strong focus on equity into these waivers going forward?

As BH care needs among Americans change, it is essential that CMS and state Medicaid agencies remain nimble and innovative.

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1 States may not claim Medicaid matching funds for any part of an IMD stay for mental health that exceeds 60 days.

2 The ARP Act enacted on March 11, 2021, establishes mobile crisis intervention services for a five-year peri to state adoption, the law provides for an 85 percent e qualifying services for the first three years of state cov

3 Thirteen states originally had DSRIP waivers with 1: and one—Washington—approved by the Trump Admi

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SAMHSA

Substance Abuse and Mental Health Services Administration

Notice of Funding Opportunity

Assertive Community Treatment

Application Due Date: Monday, April 10, 2023

The purpose of this program is to establish or expand and maintain ACT programs for transition-aged youth and adults with a serious mental illness (SMI) or serious emotional disturbance (SED). Recipients are expected to implement an ACT program to fidelity and provide ACT services to the population of focus. With this program, SAMHSA aims to improve behavioral health outcomes for individuals by reducing rates of hospitalization, mortality, substance use, homelessness, and involvement with the criminal justice system.

Anticipated Total Available Funding: $5,135,688

Anticipated # of Awards: 7

Learn More

Substance Abuse and Mental Health Services Administration

5600 Fishers Lane Rockville, MD 20857 USA

1-877-SAMHSA-7 (1-877-726-4727) | www.samhsa.gov | Privacy

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TREATMENT ADVOCACY CENTER

21st Century Cures Act

December 2016

On December 13, President Obama signed HR 34, the 21st Century Cures Act, which incorporates monumental bipartisan reform of our nation's mental health system. These reforms include a host of Treatment Advocacy Center priorities, including provisions to increase the number of psychiatric beds nationwide, elevate the federal focus on mental illness by creating a federal position of assistant secretary for mental health and substance use disorders and to address the criminalization of untreated mental illness.

The full bill is more than 300 pages, with more than 100 pages dedicated to mental health reform. Below is a selected summary of some of the most significant changes. The full 21st Century Cures Act can be found here.

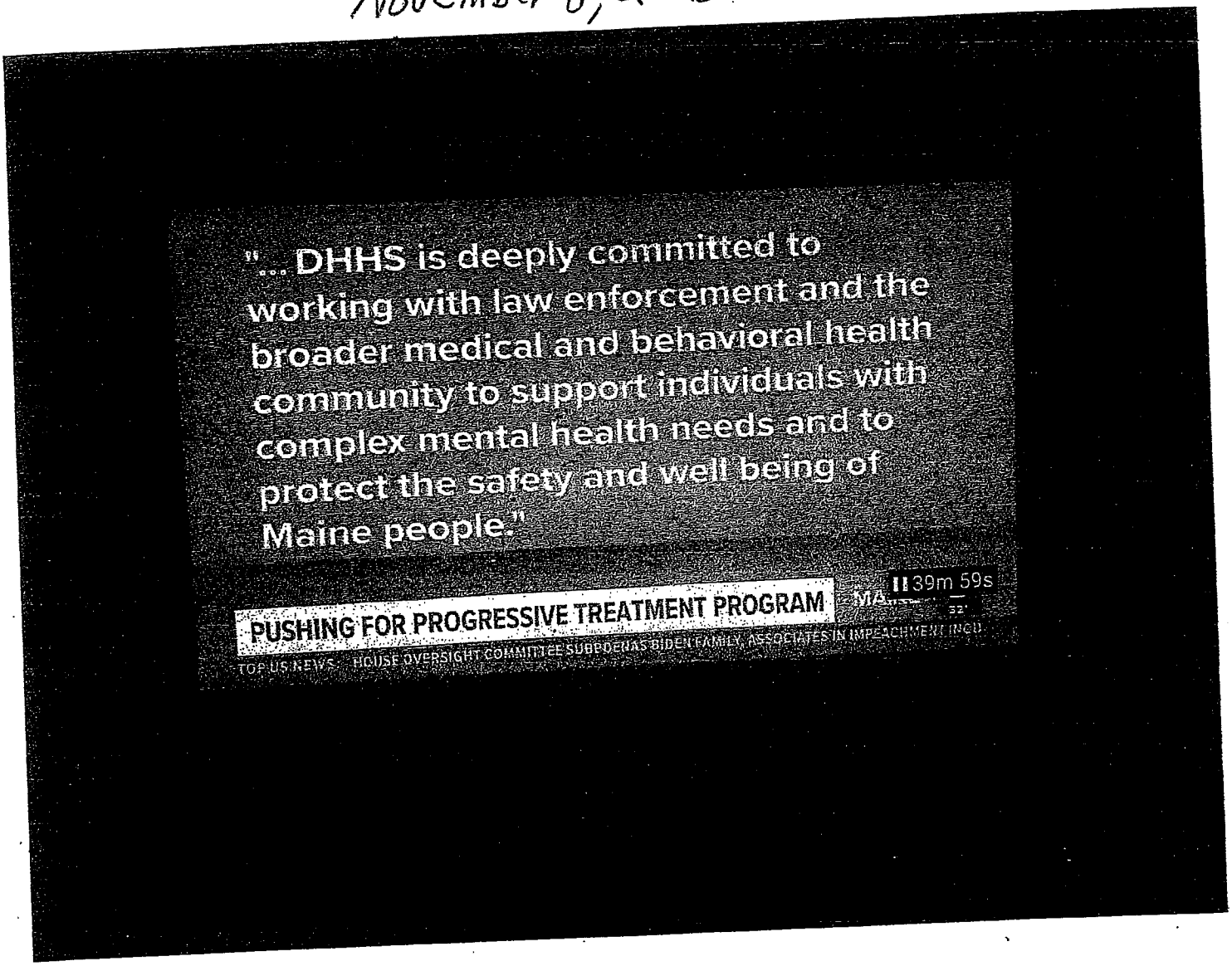
Reforming SAMHSA

- Creates a new Assistant Secretary for Mental Health and Substance Use Disorders to be presidentially appointed with Senate confirmation, who will oversee SAMHSA and coordinate related programs and research across the federal government, with emphasis on science and evidence based programs, and with the aid of a newly established Chief Medical Officer.
- Establishes a new federal policy laboratory for mental health and substance use, to elevate and disseminate policy changes and service models that work based on evidence, research, and science.

Funding and Strengthening Evidence-Based Treatment Programs for Severe Mental Illness (SMI)

- Strengthens and expands critical Assisted Outpatient Treatment (AOT) programs to help break the revolving-door cycle through a grant reauthorization and funding increase for states to implement AOT and permits states to use Department of Justice grant funding for AOT in civil courts as an alternative to incarceration.
- Establishes, hand in hand with AOT, a grant program for Assertive Community Treatment (ACT) teams to provide critical wrap-around services in the community to people with SMI. (up to 1 mil./st./yr.
- Provides states with new innovative opportunities to deliver much-needed care in IMDs to adult Medicaid patients with SMI.
- Requires states to expend not less than 10 percent of their community mental health services block grant funding each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset.
- Strengthens community response systems with a grant program to create databases on psychiatric beds, crisis stabilization units, and residential treatment facilities.
- Directs CMS to outline for states innovative opportunities to use Medicaid 1115 waivers to provide care for adults with serious mental illness

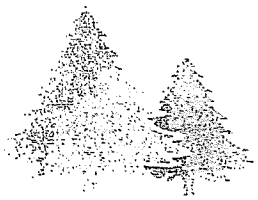
November 8, 2023



Date: November 9, 2023
To: John Nutting <jnutting2020@gmail.com>
Subject: Re: Nice work!

Good morning John,

I spoke with Jackie Farwell a minute ago and brought up some of these concerns. She basically - [redacted] said PTP would not have applied in Mr. Card's case because he wasn't engaged in mental health treatment at the time of the shooting. A sheriff could have stepped in earlier in the year when he was in New York for that brief hospitalization, which Jackie acknowledged is probably why you all want there to be greater awareness around PTP. She also said DHHS does not train law enforcement, so it's up to the Department of Public Safety to handle any training on PTP.



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December 2, 2019

Dear Senator Breen, Representative Warren, and members of the Mental Health Working Group,

First, we would like to thank the entire group for your commendable efforts to improve Maine's mental health system. We are at a critical juncture with regards to the provision of mental health services in the State and we welcome your work. We write to note our continued support for Progressive Treatment Plans (PTPs) and Assisted Outpatient Treatment (AOT).

By way of background, approximately 5% of American adults--approximately 50,000 Mainers--live with serious mental illness (SMI). Many of these people suffer from anosognosia, an inability to recognize their illness, the severity of their symptoms and the functional impairment they cause. This lack of awareness is a contributing factor to individuals discontinuing treatment and relapsing. Every relapse causes brain injury and worsens an individual's prognosis. PTPs and AOT are valuable options to support individual's treatment adherence. Importantly, they also serve as a less restrictive option. They foster adherence to treatment and help prevent relapse, allowing individuals with serious mental illnesses to spend more time living in the community and less time involuntarily hospitalized or, worse, incarcerated. This maximizes patient autonomy and dignity while also helping ensure humane treatment in an appropriate setting.

COURTESY OF THE OFFICE OF STATE FIRE MARSHAL

A firefighter walks toward the debris of an Arnie Drive home that was destroyed in a suspected act of arson Jan. 4 in Richmond. Robert Jolly, 40, has been charged in connection with the incident.

Police: Richmond man attempted to flee to Kansas days before he allegedly set mom's house on fire

By Jessica Lowell
KENNEBEC JOURNAL

RICHMOND — Days before Robert Jolly was arrested for allegedly setting his mother's house on fire in Richmond, the 40-year-old was taken into custody in upstate New York for psychiatric treatment.

He had been attempting to drive to Kansas with his daughter, in a car he was not authorized to use, after sending texts threatening to kill himself or engage in a deadly confrontation with police, according to court records.

Once he returned to Maine, police say, Jolly traveled to the home of his mother on the morning of Jan. 4 to demand the return of money he said she had withdrawn from his account. When he could not speak to her, he poured gasoline over the hood of a pickup truck parked in the garage at 6 Arnie Lane and lit it on fire.

The house was destroyed in the blaze and one cat was killed, but Jolly's mother, her husband and their dogs survived.

According to the criminal complaint on file in a Sagadahoc County court, Jolly is charged with arson, assault and violating a condition of his release on bail in another criminal matter.

Attempts to reach Christopher Ledwick, Jolly's court-appointed attorney, were unsuccessful Wednesday.

Jolly had been forbidden to have contact with Richmond town employees; his mother, Laurie Boucher, is the town's finance director.

The house was destroyed in the blaze and one cat was killed, but Robert Jolly's mother, her husband and their dogs survived.

In his probable cause affidavit for the warrantless arrest and detention of Jolly, Jeremy Damren, an investigator with the Office of State Fire Marshal, recapped information from other law enforcement officials as well as his own interview with Jolly to describe what happened on the morning of the fire.

According to the affidavit, Jolly had traveled by taxi from MaineGeneral Medical Center in Augusta, where had been taken the night before for a health evaluation, to his mother's home in Richmond.

Once there, Jolly was met by his mother's husband, John Boucher, and asked him to get his mother so he could get his money back. After Boucher refused, Jolly went into the unlocked garage and started the blaze.

Jolly told Damren during the interview that Boucher knocked the gas container away from Jolly, causing more gas to be spilled in the garage. Damren wrote that Jolly said the fire grew quickly, and Jolly walked out of the garage and off the property.

Damren interviewed Jolly at the Richmond Police Department, where he had been detained by Richmond police.

A second affidavit on file, by Sgt. Aaron Skofield, details the out-of-state trip which police said also violated the conditions of Jolly's bail.

In the document, Skofield said Jolly was able to convince his mother to allow him to use her car to go to a doctor's appointment in Brunswick, while his daughter was visiting him. But rather than go to the doctor's, Jolly initially took his daughter to Boston to see a wrestling show. Instead of attending the show, they traveled west through New York state until they reached Buffalo, where they apparently ran out of gas.

New York State Police sergeants told Skofield that Jolly was taken into custody for psychiatric treatment after sending texts under his alias, Rob Todd, threatening to take his life in front of his mother or spur a fatal confrontation with police.

Attempts by the Kennebec Journal to independently confirm Jolly's detention and details of his release were unsuccessful Wednesday, as the public information officer for the Buffalo-area troop of the New York State Police was out of the office.

Skofield wrote that Boucher wanted to press charges for not returning her car, and she filled out a stolen car affidavit, which was entered into the National Crime Information Center. Skofield said Jolly was charged criminally for New York's equivalent of unauthorized use of a motor vehicle.

The affidavits in various court cases show that Jolly has a long history with police agencies.

In 2017, Jolly pleaded guilty to a charge of domestic violence criminal threatening after he stabbed the wall of his Randolph residence with a butcher knife following an argument over food.

In one document, Deputy Chad Carleton wrote that Jolly is well known to law enforcement in Sagadahoc County and noted that since 2004, police had documented 183 involvements in the county's law enforcement record keeping system having to do with his mental health.

In September, he was issued a trespass notice, preventing him from visiting the Richmond Town Office or his mother's home on Arnie Drive. The following month, he was banned from all town properties, according to Richmond police Chief James Donnell.

§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; [PL 2009, c. 651, §29 (NEW).]

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

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

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

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

[PL 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; [PL 2009, c. 651, §29 (NEW).]

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

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

[PL 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.
[PL 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. [PL 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. [PL 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. [PL 2009, c. 651, §29 (NEW).]

[PL 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. [PL 2009, c. 651, §29 (NEW).]

A-1. Prior to the commencement of the hearing, the court shall inform the patient that, if an order is entered that includes a prohibition on the possession of dangerous weapons, that patient is a prohibited person and may not possess or have under that patient's control a firearm pursuant to Title 15, section 393, subsection 1. [PL 2019, c. 411, Pt. B, §1 (NEW); PL 2019, c. 411, Pt. D, §3 (AFF).]

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. [PL 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. [PL 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. [PL 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. [PL 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. [PL 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. [PL 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. [PL 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. [PL 2009, c. 651, §29 (NEW).]

[PL 2019, c. 411, Pt. B, §1 (AMD); PL 2019, c. 411, Pt. D, §3 (AFF).]

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.
[PL 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; [PL 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 [PL 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. [PL 2009, c. 651, §29 (NEW).]

[PL 2011, c. 541, §3 (AMD).]

7-A. Dangerous weapons. If the court directs a patient to follow an individualized treatment plan pursuant to subsection 6, the court may prohibit the patient from possessing a dangerous weapon as described in Title 17-A, section 2, subsection 9, paragraph C, including a firearm as defined in Title 17-A, section 2, subsection 12-A, for the duration of the treatment plan. If the court prohibits the patient from possessing a dangerous weapon, the court shall specify the type of weapon the patient is prohibited from possessing; notify the patient that possession of such a weapon by the person is prohibited pursuant to Title 15, section 393; and direct the patient to relinquish, within 24 hours after service of the order on the patient or such earlier time as the court specifies in the order, such weapons in the possession of the patient to a law enforcement officer for the duration of the order. The duties and liability of a law enforcement agency with respect to dangerous weapons surrendered pursuant to this subsection are governed by Title 25, section 2804-C, subsection 2-C.
[PL 2019, c. 411, Pt. B, §2 (NEW); PL 2019, c. 411, Pt. D, §3 (AFF).]

7-B. Transmission of abstract of court ruling to Department of Public Safety. Notwithstanding any other provision of this section or section 1207, a court shall electronically update or transmit to the Department of Public Safety an abstract of the order issued by the court pursuant to

this section that includes a prohibition on the possession of a dangerous weapon pursuant to subsection 7-A. Implementation of this requirement is governed by section 3862-A, subsection 6, paragraph D, subparagraph (5).
[PL 2019, c. 411, Pt. B, §2 (NEW); PL 2019, c. 411, Pt. D, §3 (AFF).]

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.
[PL 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.
[PL 2009, c. 651, §29 (NEW).]

10. Limitation.

[PL 2011, c. 492, §2 (RP).]

SECTION HISTORY

PL 2009, c. 651, §29 (NEW). PL 2011, c. 492, §§1, 2 (AMD). PL 2011, c. 541, §3 (AMD). PL 2019, c. 411, Pt. B, §§1, 2 (AMD). PL 2019, c. 411, Pt. D, §3 (AFF).

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