Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Riverview Psychiatric Center
11 State House Station
250 Arsenal Street
Augusta, Maine 04333-0011
Tel.: (207) 624-4674; Fax: (207) 287-6123
TTY: Dial 711 (Maine Relay)

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.