U.S. Department of Justice

Civil Rights Division

Disability Rights Section – 4CON
950 Pennsylvania Ave, N.W.
Washington, D.C. 20530

June 22, 2022

By First Class Mail and Electronic Mail

Governor Janet Mills
1 State House Station
Augusta, ME 04333

Attorney General Aaron Frey
Office of the Maine Attorney General
6 State House Station
Augusta, ME 04333
oag.generalcivil@maine.gov

Re: United States' Investigation of Maine's Behavioral Health System for Children Under Title II of the Americans with Disabilities Act

Dear Governor Mills and Attorney General Frey:

We write to report the findings of our investigation into Maine's behavioral health system for children.[1] In response to a complaint submitted on behalf of children across the state, we assessed Maine's compliance with Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131–12134, as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), which requires public entities to administer services to individuals with disabilities in the most integrated setting appropriate to their needs. The U.S. Department of Justice (the Department) is authorized to seek a remedy for violations of Title II of the ADA. 42 U.S.C. § 12133; 28 C.F.R. §§ 35.170–174, 190(e).

We have determined that Maine is violating the ADA by failing to provide behavioral health services to children in the most integrated setting appropriate to their needs. Instead, the State unnecessarily relies on segregated settings such as psychiatric hospitals and residential treatment facilities to provide these services. As a result of these violations, children are separated from their families and communities. This letter describes the Department's findings, including steps the State should take to meet its legal obligations and remedy the violations the Department has identified.

Before proceeding to the substance of our findings, we want to acknowledge the professionalism and courtesy of all the State officials and counsel involved in this matter. We

[1] In this context, "behavioral health system" refers to State-administered long-term care services provided to Maine children with mental health or developmental disabilities who have behavioral health needs, up to 21 years of age. We refer to these children throughout as "children with behavioral health needs."

hope to continue our collaborative and productive relationship as we work toward an amicable resolution of the violations described below.

I. Summary of Findings

A troubling picture emerged from our investigation: Maine's community-based behavioral health system fails to provide sufficient services. As a result, hundreds of children are unnecessarily segregated in institutions each year, while other children are at serious risk of entering institutions. Children are unable to access behavioral health services in their homes and communities—services that are part of an existing array of programs that the State advertises to families through its Medicaid program (MaineCare), but does not make available in a meaningful or timely manner. This failure is evident in the following ways: first, Maine maintains lengthy waitlists for community-based behavioral health services for children that significantly delay necessary treatment and support. Often forced to wait for hundreds of days to receive services at home, families have no option but to turn to law enforcement and hospitals for help during a mental health crisis, triggering lengthy or repeated institutionalizations. Second, contributing to the waitlists problem, even as Maine approves children and families for community-based services, it fails to sustain a network of providers to meet demand, especially to serve children in rural areas and children with the most significant needs. Third, Maine's crisis services are understaffed and under-resourced. A call to the State's crisis hotline frequently is not answered at all, or families are told that no services are available. Crisis staff may recommend that families take children to hospital emergency rooms or call the police. Fourth, Maine's dearth of Treatment Foster Care providers—a specialized service in which foster parents are trained, supervised, and supported by qualified staff to meet the needs of children in their care who have behavioral health needs—subjects young people in the child welfare system to prolonged institutionalization.

Maine has long been on notice of these problems.[2] As one State-commissioned report concluded, "children's behavioral health services are not available immediately (or at all)."[3] For years, the State has acknowledged that a lack of community-based services for children with behavioral health needs leads to their unnecessary institutionalization.[4] Despite this recognition,

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[2] *See, e.g.*, Erin Rhoda, *Hundreds of Children Wait for Mental Health Help, even after Maine Pledged to Follow the Law*, BANGOR DAILY NEWS (June 4, 2018), https://bangordailynews.com/2018/06/04/mainefocus/hundreds-of-children-wait-for-mental-health-help-even-after-maine-pledged-to-follow-the-law/; Vivien Leigh, *Lists to Nowhere: Mainers with High Needs Waiting Years for Services*, NEWS CENTER MAINE (Nov. 8, 2019), https://www.newscentermaine.com/article/news/families-say-the-lack-of-services-is-setting-up-their-loved-ones-to-be-more-not-less-dependent-on-the-system/97-c082f8a0-c24c-45d3-a217-05449b297c01; Matthew Stone, *Maine's history of serving—and not serving— children with mental health needs*, BANGOR DAILY NEWS (June 4, 2018), https://bangordailynews.com/2018/06/04/mainefocus/maines-history-of-serving-and-not-serving-children-with-mental-health-needs/ ; Vivien Leigh, *State Commission Hopes to Shorten Waiting Lists for Kids in Need of Services: Nearly One Thousand Children Are Waiting for Mental and Behavioral Health Care Services in Maine*, KTVB7 (Aug. 30, 2019), https://www.ktvb.com/amp/article/news/local/as-seen-on-tv/state-commission-hopes-to-shorten-waiting-lists-for-kids-in-need-of-services/97-859a7a32-f974-4f89-968e-3f767166ee43.

[3] PUBLIC CONSULTING GROUP, CHILDREN'S BEHAVIORAL HEALTH SERVICES FINAL REPORT 4 (Dec. 2018), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/cbhs/documents/ME-OCFS-CBHS-Assessment-Final-Report.pdf [hereinafter CBHS ASSESSMENT 2018].

[4] *Id.* at 22–33.

the day-to-day experiences of many families struggling to get off a waitlist or bring their child home from an institution remains unchanged. As discussed further below, Maine can and must make changes to its service system to ensure that children receive the support and treatment they need in their communities and with their families.

II. Overview of Maine's Behavioral Health System for Children

After receiving a complaint on behalf of children with behavioral health needs, the Department notified the State in January 2021 that we were opening an investigation into whether Maine serves children in the most integrated setting appropriate to their needs, in accordance with Title II of the ADA. During the course of our investigation, we conducted interviews with children and families and visited various institutions in the State. We also interviewed service providers, medical professionals, children's attorneys, and advocates. We reviewed publicly-available reports and data, and documents produced by the State in response to our requests for information.

Maine's Office of Child and Family Services (OCFS)[5] administers behavioral health services for children up to age 21,[6] primarily funded by MaineCare. Maine has several institutional settings that serve children, including two psychiatric hospitals and two general hospitals with children's psychiatric units. Maine also contracts with a number of private providers that operate residential treatment facilities. Residential treatment facilities are multi-bed facilities for children with behavioral health needs. Maine's residential treatment facilities have up to 93 beds. During each month between January 2019 and September 2021, OCFS's public dashboard reported that an average of nearly 290 children lived in in-state residential treatment facilities. Faced with a shortage of beds in-state, Maine increasingly sends children with behavioral health needs to out-of-state residential facilities all over the country. At any given month during the past two years, over 250 children were living in residential treatment facilities in- and out-of-state.[7] According to data provided by the State, children sent to in-state residential treatment facilities stayed there for an average of 246 days in Fiscal Year (FY) 2020[8] even though the State describes residential treatment as intended to last one to four months.[9] Additional children each month enter hospital emergency rooms and psychiatric units because they cannot access services in the community, some remaining hospitalized for months after they are found ready for discharge because services at home remain unavailable. To address some of

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[5] OCFS is situated within Maine's Department of Health and Human Services.

[6] *Children's Behavioral Health*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., https://www.maine.gov/dhhs/ocfs/support-for-families/childrens-behavioral-health (last visited June 16, 2022).

[7] *Children's Behavioral Health Data Dashboard*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/childrens-behavioral-health (last visited June 16, 2022) [hereinafter CBHS DATA DASHBOARD].

[8] Supplemental Narrative Response to Req. for Information No. 24 from the State of Me. 1 (Dec. 3, 2021) (on file).

[9] CBHS DATA DASHBOARD, *supra* n.7.

these problems, OCFS has prioritized building one or more long-term psychiatric residential treatment facilities, and is in search of a provider to run these in-state institutions.[10]

In theory, MaineCare provides a wide range of supports in the community. However, many of the services described below are only available in some regions due to Maine's failure to maintain a statewide network of providers for certain programs, while other services are not available in sufficient quantity, as detailed further in Section III. Furthermore, families may not be aware of the full extent of the State's offerings because there is no centralized process for assessing eligibility for services.

Maine's community-based programs include assistance with daily activities and behavior management for children with developmental disabilities,[11] and outpatient counseling for children with mental health diagnoses, including those who may also have a developmental disability.[12] For example, a teenager with a mental health diagnosis and autism may need assistance with everyday activities, behavior management such as supervision and redirection to prevent the teen from wandering, and individual counseling. MaineCare offers higher-intensity behavioral health services to children who are diagnosed with serious emotional disturbance, including children who also have a developmental disability. Such services include individual or family counseling, and support from trained staff in the home and community. This counseling and support helps children manage their mental health needs and learn social skills and behaviors necessary to be independent and interact with the community.[13] For example, trained staff can come to the home and work with a family on strategies to reduce behaviors such as running away from home due to a serious emotional disturbance.

Assertive Community Treatment (ACT) is another intensive program ostensibly available to children with higher needs in Maine. ACT is a service model where a team of behavioral health professionals provide ongoing support to a child in the child's home and community,

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[10] OFF. OF CHILD AND FAMILY SERVS., STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., CHILDREN'S BEHAVIORAL HEALTH: AN UPDATE ON SYSTEM IMPROVEMENT EFFORTS 3–4 (Dec. 2020), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/cbhs/documents/CBHS%20Annual%20Report%202020%20FINAL.pdf [hereinafter CBHS UPDATE 2020].

[11] Ch. 101, MaineCare Benefits Manual, Ch. II § 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (Sept. 23, 2019), https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s028.docx; *see also Rehabilitative and Community Support (RCS)*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS. (Sept. 30, 2021), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/RCS%20Information%20Sheet%20-%209.30.21.pdf; *Specialized Rehabilitative and Community Support (Specialized RCS)*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS. (Sept. 30, 2021), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Specialized%20RCS%20Information%20Sheet%20-%209.30.21docx.pdf.

[12] Ch. 101, MaineCare Benefits Manual, Ch. II § 65, Behavioral Health Services, at § 65.06-3 (Aug. 19, 2020), https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s065.docx [hereinafter MAINECARE SECTION 65 SERVICES]. Services also include family therapy programs such as Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST). MAINECARE SECTION 65 SERVICES, at §§ 65.02-22, 65.02-29.

[13] MAINECARE SECTION 65 SERVICES, *supra* n.12, at § 65.06-9; *see also Home and Community Treatment (HCT)*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS. (Sept. 30, 2021), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/HCT%20Information%20Sheet%20-%209.30.21.pdf.

including assistance during a crisis.[14] But according to OCFS's website, the State currently has no identified ACT providers actively serving children.[15] Finally, MaineCare also offers case management services to coordinate children's care and treatment.[16]

Notably, Maine previously operated a statewide wraparound program that prevented children from being institutionalized, saving money and resources that would have been spent on institutional care. Wraparound programs are a best practice that go beyond coordinating services to identifying and building a wider net of resources for youth, including family and community supports.[17] Children who participated in Maine's statewide wraparound program greatly improved their day-to-day functioning[18] with a 43% reduction in the use of psychiatric hospitals and a 29% reduction in the use of residential treatment facilities.[19] But after 2013, Maine discontinued the statewide wraparound program. The State now limits wraparound services to children already in the juvenile justice system, with only a subset of those children receiving services because the program is under-resourced.

In addition to the community-based programs detailed above, OCFS administers the State's foster care system for children who have been removed from their homes due to abuse or neglect.[20] For foster children with behavioral health needs, Maine offers a specialized service known as Treatment Foster Care where foster parents are trained, supervised, and supported by qualified staff to meet the needs of children placed in their care.[21] OCFS licenses private placement agencies that contract with Treatment Foster Care parents to match children with

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[14] MAINECARE SECTION 65 SERVICES, *supra* n.12, at § 65.06-8.

[15] *Assertive Community Treatment (ACT)-MaineCare Provider List*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., https://www.maine.gov/dhhs/ocfs/support-for-families/childrens-behavioral-health/services/find-a-provider/act-district1-2 (last visited June 16, 2022) [hereinafter ACT PROVIDER LIST]. A recent memorandum from the Department of Health and Human Services states that an ACT provider has been identified for Southern Maine, but OCFS's website provides no further information about the name of the provider or how children can access ACT services. Memorandum from the Off. of Child and Family Servs., Me. DHHS to the Joint Standing Comm. on Criminal Justice and Public Safety re: Availability of treatment beds for youth 5 (Sept. 22, 2021) (on file) [hereinafter DHHS MEMORANDUM].

[16] Ch. 101, MaineCare Benefits Manual, Ch. II § 13, Targeted Case Management Services (Mar. 20, 2014), https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s013.docx.

[17] *Wraparound Basics or What is Wraparound: An Introduction*, NATIONAL WRAPAROUND INITIATIVE, https://nwi.pdx.edu/wraparound-basics/ (last visited June 16, 2022).

[18] Trish E. Knight, *The Characteristics, Experiences and Outcomes of Youth Involved with the Child Welfare System and Receiving Wraparound Services* (2011), https://www.acf.hhs.gov/sites/default/files/documents/cb/es2011_poster_17.pdf.

[19] Sheila A. Pires, *Human Service Collaborative, Customizing Health Homes for Children with Serious Behavioral Health Challenges*, at 16 (March 2013), https://nwi.pdx.edu/pdf/CustomizingHealthHomes.pdf.

[20] *Child Welfare*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., https://www.maine.gov/dhhs/ocfs/support-for-families/child-welfare (last visited June 16, 2022).

[21] Treatment Foster Care Section I: Program, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/cw/section1-program.pdf (last visited June 16, 2022).

families.[22] The State lacks a sufficient number of Treatment Foster Care parents, resulting in foster children with behavioral health needs languishing in psychiatric hospitals and other segregated settings. Faced with lengthy delays in receiving community-based services, Treatment Foster Care parents may have to stop serving children with disabilities when children in their care go without services due to the State's waitlists.

Maine also purports to offer a range of crisis services to all children, regardless of whether they are enrolled in MaineCare. The State runs a crisis hotline available 24 hours per day, seven days per week, where a trained professional speaks with callers and directs them to crisis services in their area.[23] However, the Department learned that the hotline is consistently understaffed. Families either cannot immediately connect with a crisis worker or they are told that a mobile crisis team will be unable to arrive for hours.[24] Data shared by the State showed that in 2020, there were 8,236 calls to the crisis line for children 17 years and younger.[25] Only 37% of those calls were referred to mobile crisis services.[26] For calls where a mobile crisis team responded, the average wait time according to the State was over an hour in both 2019 and 2020.[27] Maine also has Crisis Stabilization Units, which are intended to be an alternative to hospitalization, where children can receive short-term, in-patient care during a mental health crisis and return home.[28] Again, there is often no space available in these units, or no willing providers.[29] When families request crisis services and none are available, caseworkers and other State contractors often direct families to emergency rooms or law enforcement.

Contact with law enforcement can mean a child enters the juvenile justice system.[30] By the State's own account, juvenile justice interventions are part of Maine's behavioral health system.[31] Long Creek Youth Development Center, the State's sole juvenile justice facility,

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[22] Treatment Foster Care Section II: Foster Parents, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/ocfs/cw/section2-program.pdf (last visited June 16, 2022) [hereinafter TREATMENT FOSTER PARENTS].

[23] *See Hotlines/Crisis Numbers*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., https://www.maine.gov/dhhs/about/contact/hotlines (last visited June 16, 2022).

[24] CBHS ASSESSMENT 2018, *supra* n.3, at 31.

[25] Narrative Response to Req. for Information No. 13 from the State of Me. 1 (Jan. 28, 2022) (on file).

[26] *Id*.

[27] *Id*.

[28] *See, e.g.*, MAINECARE SECTION 65 SERVICES, *supra* n.12, at § 65.06-2; *Crisis Stabilization Units*, Sweetser, https://www.sweetser.org/programs-services/services-for-children-families/crisis-services/crisis-stabilization-units/ (last visited June 16, 2022).

[29] CBHS ASSESSMENT 2018, *supra* n.3, at 32.

[30] *Id.* at 25, 32.

[31] Supplemental Narrative Response to Req. for Information No. 41 from the State of Me. 1 (Nov. 5, 2021) (on file) ("Children's behavioral health services in Maine are provided through a large, interconnected system of care that includes early childhood providers, medical providers, the public school system, juvenile justice interventions, and substance use disorder providers.").

currently fills a gap left by Maine's community-based behavioral health system.[32] Even though Maine law requires that juvenile justice rehabilitative services be provided in the least restrictive setting, many children with mental health disabilities are sent to or remain in Long Creek because of the insufficient behavioral health services available to them in the community. The overwhelming majority of children at Long Creek have behavioral health needs. In 2016, Maine's Department of Corrections reported that 84.6% of youth arrive at Long Creek with three or more mental health diagnoses.[33] In a recent State-commissioned assessment of the juvenile justice system, the Center for Children's Law and Policy (CCLP) found that nearly 70% of young people committed or sentenced to Long Creek in 2018–19 had received behavioral health services through MaineCare within the year prior to their incarceration.[34] Various state officials reported to CCLP that many young people should not be incarcerated at Long Creek but remain there because of a lack of other treatment options, and that Maine is improperly using detention to deal with its failure to provide behavioral health services in the community.[35]

Our meetings with children at Long Creek, facility staff, and attorneys representing young people similarly echoed that the State's lack of community-based behavioral health services leads to unnecessary and prolonged incarceration. In fact, CCLP found that 73% of children detained longer than 30 days were awaiting placement in the community or in a different setting, and approximately 53% were detained so the State could "provide care."[36] These numbers underscore that Maine is using Long Creek as a de facto children's psychiatric facility instead of providing more integrated treatment options. A 2019 report by the United States Commission on Civil Rights on the criminalization of people with mental illness in Maine

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[32] *See*, *e.g.*, *State of Maine v. J.R.*, 191 A.3d 1157, 1167–68 (Me. 2018) (Saufley, C.J., concurring) (decrying the lack of alternatives to incarceration for children with mental illness in Maine, the Chief Justice of the Maine Supreme Judicial Court stated that the government "must find . . . enhanced mental health treatment services . . . within or near the communities of [children's] families"); *A.I. v. State of Maine*, 223 A.3d 910 (Me. 2020). The Maine Department of Corrections Commissioner has acknowledged that "some of our youth are at Long Creek because there are no other options[.]" Joint Comm. on Criminal Justice and Public Safety, *Testimony of Dep't of Corrections Comm'r Liberty*, YOUTUBE (Mar. 8, 2021), https://www.youtube.com/watch?v=PJKEu6NTYVk [hereinafter COMMISSIONER LIBERTY TESTIMONY].

[33] ME. DEP'T OF CORRECTIONS, PROFILE OF YOUTH COMMITTED AT LONG CREEK YOUTH DEVELOPMENT CENTER AS OF JULY 1, 2016 4 (Jan. 2017), https://www.documentcloud.org/documents/3475813-Long-Creek-Profile-FINAL-Jan-19-2017-Copy.html.

[34] CENTER FOR CHILDREN'S LAW AND POLICY, THE JUVENILE JUSTICE RESEARCH AND REFORM LAB AT DREXEL UNIVERSITY, AND THE CENTER FOR THE STUDY OF SOCIAL POLICY, MAINE JUVENILE JUSTICE SYSTEM ASSESSMENT 47 (Feb. 2020), https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/Maine%20Juvenile%20Justice%20System%20Assessment%20FINAL%20REPORT%202-25-20_2.pdf [hereinafter JUVENILE JUSTICE SYSTEM ASSESSMENT 2020]. In addition to highlighting the disproportionate number of children with disabilities at Long Creek, the report also underscored that youth of color and LGBTQ+ children experience worse outcomes in Maine's juvenile justice system. *Id.* at 68. For example, Black children are detained at eight times their share of the population, and are committed or sentenced to Long Creek at five times their share of the population. *Id.* at 117.

[35] *Id.* at 82.

[36] *Id.* at 50; *see also id.* at 59 (Long Creek staff reports that "the lion's share of kids in detention are waiting for programming in the community.").

discussed how a lack of investment in behavioral health services has made Long Creek "a de facto treatment facility for youth with acute care needs."[37]

III. Maine's Behavioral Health System for Children Violates the ADA's Integration Mandate

Maine violates Title II of the ADA because it fails to serve children with behavioral health needs in the most integrated setting appropriate to their needs. While children wait—sometimes for over a year—for counseling and other community-based services such as crisis services or Treatment Foster Care, their health deteriorates and they either enter institutional settings or remain at serious risk of institutionalization. Children who are already separated from their families in hospitals and residential treatment facilities struggle to transition back to the community because of the State's waitlists for community-based services.

Under Title II of the ADA, no qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. 42 U.S.C. § 12132; 28 C.F.R. § 35.130(a). Congress has explicitly identified unjustified "segregation" of persons with disabilities as a "for[m] of discrimination." 42 U.S.C. §§ 12101(a)(2), 12101(a)(5). Title II's implementing regulation therefore requires, in what is known as the "integration mandate," that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The "most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, app. B, at 711 (2020).

The Supreme Court has held that unjustified isolation is a form of discrimination prohibited by the ADA. *Olmstead v. L.C.*, 527 U.S. 581, 597 (1999). Public entities must provide community-based services to individuals with disabilities when (a) such services are appropriate, (b) the affected persons do not oppose community-based treatment, and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. *Id.* at 607. The ADA's integration mandate applies to Maine children with behavioral health needs who are currently in institutions and who are at serious risk of institutionalization. *See, e.g.*, *Waskul v. Washtenaw Cty. Cmty. Mental Health*, 979 F.3d 426, 460 (6th Cir. 2020); *Steimel v. Wernert*, 823 F.3d 902, 912 (7th Cir. 2016).[38]

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[37] *See* ME. ADVISORY COMM. TO THE U.S. COMM'N ON CIVIL RIGHTS, THE CRIMINALIZATION OF PEOPLE WITH MENTAL ILLNESSES IN MAINE 44 (May 2019), https://www.usccr.gov/pubs/2019/07-30-Maine-Criminalization-Mental-Health.pdf.

[38] *See also Davis v. Shah*, 821 F.3d 231, 263 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d 307, 321–22 (4th Cir. 2013); *M.R. v. Dreyfus*, 663 F.3d 1100, 1116–17 (9th Cir. 2011), *amended by* 697 F.3d 706 (9th Cir. 2012); *United States v. Mississippi*, 400 F. Supp. 3d 546, 553 (S.D. Miss. 2019) (holding valid a claim on behalf of adults with serious mental illness at risk of institutionalization for lack of community-based mental health services); *Kenneth R. v. Hassan*, 293 F.R.D. 254, 260 (D.N.H. 2013).

A. Maine Is a Public Entity, and Its Hospitals and Residential Facilities Housing Children with Behavioral Health Needs Are Segregated Settings.

The State of Maine is a "public entity" subject to the ADA. 42 U.S.C. § 12131(1). As a public entity, Maine is prohibited under Title II from discriminating on the basis of disability, and must administer services in the most integrated setting appropriate to the needs of qualified children with disabilities. 28 C.F.R. § 35.130(d). Maine retains responsibility for children's Medicaid behavioral health services, even though it contracts and funds private facilities for those services, such as psychiatric hospitals, psychiatric wards of general hospitals, and private residential treatment facilities. These institutions qualify as "segregated settings" for Title II purposes. Although Maine describes its residential treatment facilities[39] for children as "community-based" placements,[40] these facilities have all of the usual hallmarks of segregated institutions.[41] Children residing in these facilities are separated from their families and communities, and have few interactions with people without disabilities other than paid staff. Children's movements and daily activities are restricted and regimented.

Long Creek is also a segregated setting under Title II for incarcerated children with behavioral health needs who could be supported in their families' homes or Treatment Foster Care if community-based behavioral health services were available to them. Maine's juvenile code prioritizes treatment and rehabilitation,[42] and provides that both pre- and post-adjudication, i.e., before and after trial, children in the juvenile justice system should be placed in the least restrictive setting, typically the family home, with few exceptions.[43] However, even when juvenile justice system actors recommend placement outside of Long Creek, children are frequently confined at Long Creek due to Maine's failure to provide more integrated behavioral health services. Long Creek is a secure facility and the majority of its young residents have multiple mental health diagnoses.[44] As noted above, children with behavioral health needs are routinely incarcerated at Long Creek solely to receive behavioral health care.[45] Children who are

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[39] MaineCare describes these facilities as "Private Non-Medical Institutions (PNMIs)." CBHS ASSESSMENT 2018, *supra* n.3, at 12.

[40] Narrative Response to Req. for Information No. 16 from the State of Me. 10 (Sept. 10, 2021) (on file).

[41] *See* 28 C.F.R. § 35.130(d); 28 C.F.R. pt. 35, app. B, at 711 (2020); U.S. DEP'T OF JUSTICE, STATEMENT OF THE DEPARTMENT OF JUSTICE ON ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND OLMSTEAD V. L.C., Q. 1 (Feb. 25, 2020), https://www.ada.gov/olmstead/q&a_olmstead.htm.

[42] The Maine Juvenile Code states that its overall purpose includes securing "care and guidance, preferably in the juvenile's own home" and "preserv[ing] and strengthen[ing] family ties whenever possible, including improvement of home environment." 15 M.R.S. §§ 3002(1)(A)–(B).

[43] *See* 15 M.R.S. § 3203-A(4)(C) ("Detention, if ordered, must be in the least restrictive residential setting that will serve the purposes of the Maine Juvenile Code as provided in section 3002."); 15 M.R.S. § 3313(1) ("The court shall enter an order of disposition for a juvenile who has been adjudicated as having committed a juvenile crime without imposing placement in a secure institution as disposition" unless, inter alia, "[t]he juvenile is in need of correctional treatment that can be provided most effectively by the juvenile's commitment to an institution.").

[44] ME. DEP'T OF CORRECTIONS, PROFILE OF YOUTH COMMITTED AT LONG CREEK YOUTH DEVELOPMENT CENTER AS OF JULY 1, 2016 4 (Jan. 2017), https://www.documentcloud.org/documents/3475813-Long-Creek-Profile-FINAL-Jan-19-2017-Copy.html.

[45] JUVENILE JUSTICE SYSTEM ASSESSMENT 2020, *supra* n.34, at 50; *see also id.* at 59.

held at Long Creek have few—if any—opportunities to see their families and friends or engage with the community. If behavioral health care services were available in the community, children who are appropriate for such services could await trial or serve their sentences at home with their families.

B. Community-Based Services Are Appropriate for Maine Children with Behavioral Health Needs, and Families Prefer Such Services.

Maine children with behavioral health needs are eligible and appropriate for the range of community-based services the State offers, but either remain in segregated settings or are at serious risk of institutionalization.[46] Both institutional and community providers consistently told us that children in institutional settings could be appropriately served in the community if services were available to them. Children's attorneys similarly shared that their clients had successfully lived in the community and could continue to do so with appropriate supports. Families and children in Maine are overwhelmingly open to receiving services in integrated settings. In fact, parents indicated a strong preference that their children receive services at home due to trauma, neglect, and abuse that their children reportedly endured in residential facilities within and outside of Maine.

C. Maine Does Not Ensure Access to the Community-Based Services it Offers, Resulting in Needless Institutionalization and Risk of Such Institutionalization.

Although children with behavioral health needs are eligible and appropriate for community-based services, they frequently cannot access the very services that are part of Maine's existing array of programs. The State's failure to provide sufficient services through its community-based behavioral health system drives unnecessary institutionalization and risk of institutionalization in the following ways.

1. Maine Has Lengthy Waitlists for Community-Based Services.

Many children in Maine are unable to access community-based behavioral health services due to the State's lengthy waitlists. According to OCFS, as of October 2020, youth had been put on waitlists for 3,642 requested community-based behavioral health services.[47] The waitlists operate on a first-come-first-served basis by town, with priority given to children discharged from hospitals, residential facilities, or crisis stabilization units.[48] As of February 2022, the

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[46] *See, e.g.*, *Olmstead*, 527 U.S. at 602, 607; *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 994 (N.D. Cal. 2010) (appropriateness prong satisfied where plaintiffs' individual plans of care documented their need for specific community services, which were "critical to their ability to avoid institutionalization, and to remain in a community setting"); *see also* U.S. DEP'T OF JUSTICE, STATEMENT OF THE DEPARTMENT OF JUSTICE ON ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND OLMSTEAD V. L.C., Q. 4 (Feb. 25, 2020) (listing types of evidence an individual can rely on to establish that an integrated setting is appropriate), https://www.ada.gov/olmstead/q&a_olmstead.htm.

[47] CBHS UPDATE 2020, *supra* n.10, at 2. Some children were waiting for more than one service.

[48] Narrative Response to Req. for Information No. 19 from the State of Me., at 2 (Sept. 10, 2021) (on file).

average amount of time children spend on waitlists is several months to over a year.[49] Maine provided data showing that in FY 2020, children waited on average 328 days for a community-based service known as targeted case management, with some children waiting more than twice that time. Similarly, children waited on average 121 days for Home and Community Treatment services, an intensive program for children with mental health diagnoses, with wait times as high as 954 days (2.61 years).[50] By contrast, during that same period, children waited on average only 30 days to enter residential treatment facilities.[51]

All of the providers of institutional and community-based services whom we interviewed identified waitlists as a barrier to children living in the community. We interviewed families who also identified waitlists as a reason why their children had been or were currently institutionalized, or might have to be institutionalized in the future. For some parents, the strain of going months without necessary services in place has reached a breaking point, forcing them to quit their jobs to provide care for their children's escalating needs or to send their children to institutions.

2. Maine Fails to Maintain a Network of Providers to Meet the Demand for Community-Based Behavioral Health Services.

Even after children come off the waitlist or move to the top of the list, they may continue to go without services for a number of reasons. No provider may actually exist for an advertised MaineCare service or, when there is an available provider, children and families may receive only minimal or infrequent services. These gaps exist because the State does not provide necessary support to ensure sufficient capacity of community-based services. In 2018, OCFS commissioned an assessment of its service system which concluded that among the root causes of the lack of providers are Maine's low payment rates[52] as well as burdensome administrative requirements.[53]

Maine fails to ensure that a provider is promptly assigned that is willing and able to serve each child with behavioral health needs who is eligible for community-based services.[54] Children in rural areas or who have more intensive needs may technically come off a waitlist only to be

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[49] CBHS DATA DASHBOARD, *supra* n.7.

[50] Waitlist Data Set, Response to Req. for Information No. 18 from the State of Me. (Sept. 10, 2021) (on file) (listing mean and highest wait times for community-based services). Home and Community Treatment is a team-based approach that includes a therapist and a behavioral health professional who work with the child's entire family in the child's home and community. *Home and Community Treatment (HCT)*, STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS. (Sept. 30, 2021), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/HCT%20Information%20Sheet%20-%209.30.21.pdf.

[51] Waitlist Data Set, Response to Req. for Information No. 18 from the State of Me. (Sept. 10, 2021) (on file) (listing mean and highest wait times to enter residential treatment facilities or private non-medical institutions). The longest wait time a child waited for treatment in a private non-medical institution in 2020 was listed as 310 days.

[52] CBHS ASSESSMENT 2018, *supra* n.3, at 22–23.

[53] *Id*. at 25.

[54] *See, e.g.*, CBHS Wait Lists, Narrative Response to Req. for Information No. 50 from the State of Me. (Mar. 25, 2022) (on file).

turned away by a provider, or they may rise to the top of a waitlist but remain there indefinitely. Under the Medicaid Act's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provision, states must provide access to providers so that children can get required services, yet Maine fails to provide such access.[55] As a result, children enter institutions or are at serious risk of institutionalization.

3. Maine's Lack of Crisis Services Leads to Hospitalization and Law Enforcement Contact.

Maine's failure to make crisis services available to families causes children to enter institutions or to be at serious risk of institutionalization. The State's crisis hotline, staffed by contracted private providers, is understaffed, and mobile crisis providers are often unable to respond in a timely manner or reach parts of the State.[56] Maine also fails to invest in more intensive programs like ACT or wraparound that can prevent crises from escalating. Although MaineCare lists ACT, an evidence-based program where a team of social workers, clinicians, and other staff are available to families 24 hours a day, seven days a week,[57] children cannot actually access this service because there appear to be no ACT providers that are actively accepting clients.[58] Absent intensive services such as ACT and timely mobile crisis response, children experiencing frequent or protracted crises have no alternative but to turn to hospitals or law enforcement for help.

In fact, several families we interviewed said that after reaching the crisis hotline, staff told them there was no available service in their area and suggested taking children to the emergency room or calling law enforcement.[59] Because of a shortage of Crisis Stabilization Units, which are designed to provide short-term inpatient treatment and care, hospital staff described children remaining in emergency rooms for weeks or even months, even though the emergency rooms were ill-equipped to meet their needs. Although families wanted their children to return home with community-based services, often their only options were to bring their child

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[55] *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, EPSDT – A GUIDE FOR STATES: COVERAGE IN THE MEDICAID BENEFIT FOR CHILDREN AND ADOLESCENTS 28 (June 2014) ("Access to covered services is of course a critical component of delivering an appropriate health benefit to children. Accordingly, a number of Medicaid and EPSDT provisions are intended to assure that children have access to an adequate number and range of pediatric providers. For example, states are required to make available a variety of individual and group providers qualified and willing to provide services to children. States must also take advantage of all resources available to provide a broad base of providers who treat children. Some states may find it necessary to recruit new providers to meet children's needs.") (citing 42 C.F.R. § 441.61; CMS, State Medicaid Manual § 5220) (internal quotation marks omitted), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.

[56] CBHS ASSESSMENT 2018, *supra* n.3, at 31–32.

[57] MAINECARE SECTION 65 SERVICES, *supra* n.12, at § 65.06-8.

[58] ACT PROVIDER LIST, *supra* n.15 (showing no available children's ACT providers). A recent memorandum from the Department of Health and Human Services states that an ACT provider has been identified for Southern Maine but OCFS's website provides no further information about the name of the provider or how children can access ACT services. DHHS Memorandum, *supra* n.15, at 5.

[59] *See also* DISABILITY RIGHTS MAINE, ASSESSING THE USE OF LAW ENFORCEMENT BY YOUTH RESIDENTIAL SERVICE PROVIDERS 3 (Aug. 2017), https://drme.org/assets/uncategorized/Law-Enforcement-08.08.17.pdf [hereinafter DRM REPORT ON LAW ENFORCEMENT].

home without services or to discharge their child to a residential treatment facility. Even hospitals and residential facilities rely inappropriately on law enforcement for children experiencing behavioral health crises due to difficulty accessing crisis services.[60]

Law enforcement responses to mental health crises are not only ineffective, they increase the likelihood that children whose needs could be met with behavioral health services will instead enter the juvenile justice system.[61] In the worst situations, children end up incarcerated at Long Creek.[62] Maine's Department of Corrections Commissioner has acknowledged that despite efforts to reduce detention solely to provide care to children, "some of our youth are at Long Creek because there are no other options[.]"[63] In recent years, several children in acute crisis and struggling with thoughts of suicide spent weeks or months at Long Creek isolated on suicide watch due to a lack of appropriate treatment options for them.[64]

4. Maine's Lack of Support for Treatment Foster Care Parents Results in Unnecessary and Prolonged Institutionalizations.

Maine is responsible for administering training, supports, and services to Treatment Foster Care parents to meet the behavioral health needs of children in their homes.[65] But young people with behavioral health needs in the child welfare system are especially at risk of institutionalization because Maine fails to recruit, train, and support sufficient numbers of Treatment Foster Care parents. Treatment Foster Care parents struggle to get support and services to maintain children in their care, or to take on future children. As a result, few Treatment Foster Care placements are available.

Instead, children who need this service frequently remain in psychiatric hospitals and other segregated settings long after they are ready for discharge. Both hospital staff and advocates told the Department that some foster children with behavioral health needs are discharged from hospitals to hotels and homeless shelters because OCFS has not secured homes for their long-term care, placing them at risk of re-institutionalization. Maine's own Child Welfare Services Ombudsman recently reported on cases of foster children with behavioral health needs being sent to homeless shelters, including one teenager who went from an

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[60] *See* JUVENILE JUSTICE SYSTEM ASSESSMENT 2020, *supra* n.34, at 103; DRM REPORT ON LAW ENFORCEMENT, *supra* n.59, at 5, 7.

[61] DRM REPORT ON LAW ENFORCEMENT, *supra* n.59, at 3–4.

[62] *Id.* at 4; *see also* JUVENILE JUSTICE SYSTEM ASSESSMENT 2020, *supra* n.34, at 75 (discussing interviews where law enforcement officers indicated need for alternatives to arrest, such as mobile crisis response).

[63] COMMISSIONER LIBERTY TESTIMONY, *supra* n.32.

[64] *See, e.g.*, *Transgender teen's suicide raises concerns about Maine youth corrections center*, BANGOR DAILY NEWS (Nov. 13, 2016), https://bangordailynews.com/2016/11/13/news/transgender-teens-suicide-raises-concerns-about-maine-youth-corrections-center/; Letter from the American Civil Liberties Union of Maine and GLBTQ Legal Advocates & Defenders to the Maine Office of the Attorney General re: Suicide at Long Creek 3–4 (Nov. 10, 2016), https://www.aclumaine.org/sites/default/files/11.10.16_letter_to_ag_re_l.c._investigation_final.docx.pdf.

[65] TREATMENT FOSTER PARENTS, *supra* n.22, 4–6.

unlicensed home to a homeless shelter where she was sexually assaulted.[66] The State's failure to meet the needs of this particularly vulnerable population is evidenced by foster children's disproportionate representation in institutional settings: youth in the child welfare system constitute less than 1% of the population of children in Maine,[67] but made up 22% of children in residential treatment facilities in State Fiscal Year 2018.[68] And in a survey of 55 youth committed to Long Creek in State Fiscal Year 2019, CCLP found that 65.5% had undergone at least one child welfare investigation.[69]

IV. Maine Can Serve Children with Behavioral Health Needs in the Community with Reasonable Modifications to Its Service System

States must reasonably modify their service systems to avoid discrimination on the basis of disability. 28 C.F.R. § 35.130(b)(7)(i); *Olmstead*, 527 U.S. at 603, 607. Maine could reasonably modify its existing community-based programs, without fundamentally altering its current system, to prevent unnecessary segregation of children with behavioral health needs in facilities. Such modifications would allow children to live and thrive in their own homes and communities instead of entering or remaining in institutions just to access appropriate care.

Maine already offers to children and families, at least in theory, a service array to meet a range of behavioral health needs and prevent institutionalization. But the reality is that because of the way the State administers its system, hundreds of children are unable to access these services. *See Olmstead,* 527 U.S at 603 n.14 ("States must adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide."). Instead, children are spending their formative years in hospitals and residential treatment facilities.

Maine could serve children in the most integrated setting appropriate to their needs and comply with Title II of the ADA with the following reasonable modifications: 1) ensure access to existing community-based services; 2) address the waitlists to ensure timely services and prevent institutionalization; 3) provide crisis services instead of law enforcement response; 4) allocate adequate resources to maintain a trained pool of community providers across the State, including Treatment Foster Care parents; and 5) implement and support a policy requiring providers to serve eligible children and prohibit refusal of services. The proposed modifications are inherently reasonable because they build on the State's existing framework for providing services and enable the State to "more fully utilize and expand that framework to make the services truly accessible." *United States v. Mississippi*, 400 F. Supp. 3d 546, 576 (S.D. Miss. 2019); *Price v. Shibinette*, 21-cv-25-PB, 2021 WL 5397864 at *12 (D.N.H. Nov. 18, 2021) ("To the extent the complaint alleges that defendants must implement new measures such as monitoring of [Medicaid] services and provider recruitment and training, plaintiffs are merely

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[66] Me. Child Welfare Servs. Ombudsman, 19TH ANNUAL REPORT 11 (2021).

[67] Census Bureau data shows that there were around 250,000 children under the age of 18 in Maine in 2018 and 2019, and approximately 2,000 or fewer of them were in the child welfare system in each of those years, constituting less than 1% of the child population. *Data by State: Maine*, CHILDREN'S BUREAU, https://cwoutcomes.acf.hhs.gov/cwodatasite/pdf/maine.html (last visited June 16, 2022).

[68] CBHS ASSESSMENT 2018, *supra* n.3, at 50–51.

[69] JUVENILE JUSTICE SYSTEM ASSESSMENT 2020, *supra* n.34, at 47.

seeking changes to the way in which the [Medicaid] program is administered to ensure that they are provided with the services that [the State] has already agreed they should receive."); *see also, e.g.*, *Henrietta D. v. Bloomberg*, 331 F.3d 261, 281–283 (2d Cir. 2003); *Messier v. Southbury Training Sch.*, 562 F. Supp. 2d 294, 344–45 (D. Conn. 2008). Moreover, the State is obligated to make these modifications under the Medicaid Act's EPSDT requirements because the services in question are medically necessary. 42 U.S.C. § 1396d(r).

V. Recommended Remedial Measures

We hope to work cooperatively with you to resolve the Department's findings in this matter.[70] We are obligated to inform you, however, that if the State declines to enter into voluntary negotiations, or if our negotiations are unsuccessful, the United States may take appropriate action, including initiating a lawsuit, to obtain redress for the State's ADA violations. We would of course prefer to resolve this matter by working with the State. To remedy these findings, the State may implement the remedial measures set forth below:

A. Ensure Access to Existing Community-Based Services.

As a threshold matter, Maine must use an evidence-based screening process to determine service needs and inform person-centered planning for children with behavioral health needs. Such a process should also ensure that families are informed of and considered for all of MaineCare's programs, and are not left to navigate the system on their own.

Second, Maine must increase the number and pace of successful transitions out of institutions by improving access to existing programs in the community to meet the needs of children who are currently unnecessarily segregated, and to prevent children from entering or re-entering institutions.

Third, preventing unnecessary segregation will also require Maine to ensure access to ongoing intensive behavioral health services such as ACT and Home and Community Treatment—programs that are already part of MaineCare's framework but are effectively unavailable.[71]

Maine has dedicated ten million dollars in American Rescue Plan Act funding to establish a "nationally recognized, evidence-based model of high-fidelity wrap-around services for youth with complex needs."[72] Since Maine announced its intent to re-establish a statewide wraparound program in July 2021, OCFS has not posted information about eligibility criteria, when services will start, or how the program will interact with existing MaineCare services. In addition to timely offering wrapround services, the State should work to sustain this program.

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[70] We will share a copy of this letter with the complaining parties. Under 28 C.F.R. § 35.172(d), a complainant may file a private suit at any time pursuant to Title II of the ADA, 42 U.S.C. § 12133.

[71] MAINECARE SECTION 65 SERVICES, *supra* n.12, at § 65.06-8; ACT PROVIDER LIST, *supra* n.15.

[72] STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., INITIAL PLAN FOR IMPLEMENTATION OF AMERICAN RESCUE PLAN ACT OF 2021, SECTION 9817 11 (July 2021), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Corrected%20FMAP%20Increase%20Initial%20Plan.pdf.

Maine's previous statewide wraparound program successfully prevented children from entering hospitals and residential treatment facilities, and was cost-saving.

B. Address the Waitlists to Ensure Timely Services and Prevent Institutionalization.

Appropriate community-based services can interrupt cycles of decompensation and institutionalization and enable young people to thrive in their homes and communities. Yet according to the State's own implementation roadmap, it plans to address its lengthy waitlists for community-based services only in the "long term," and only by reducing the waitlists by half over six years and achieving a maximum six-month waiting period for 70% of the children on waitlists.[73] Even if the State meets both of these goals, by 2025 at least one in four children will be waiting more than half a year for community-based services. One of Maine's central priorities for the future is expanding services in institutional settings by creating one or more psychiatric residential treatment facilities for children.[74] Creating or expanding institutional options without timely addressing community-based waitlists suggests that Maine's current plan will do little to decrease its reliance on segregated settings such as residential facilities and psychiatric hospitals, which are more expensive and can exacerbate trauma.[75]

C. Provide Crisis Services Instead of Law Enforcement Response.

Providing crisis services, including mobile crisis services and children's ACT services, will also prevent reliance on institutions and law enforcement. When crisis services are unavailable, families are directed to call law enforcement, putting children at serious risk of entering the juvenile justice system and Long Creek. Mobile crisis providers should be staffed by qualified clinicians and have the ability to respond to calls in a timely manner. Mobile crisis services must reach children when their families contact the crisis line, before children are institutionalized.

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[73] CBHS Implementation Roadmap: Revise the Waitlist Process, Response to Req. for Information No. 2 from the State of Me. (June 17, 2021) (on file); *see also* CBHS UPDATE 2020, *supra* n.10, at 3 (showing that addressing community-based services waitlists was moved from a short-term goal to a long-term goal, with a time horizon of 2019–2025, and addressing shortages in the behavioral health care workforce remains a long-term goal with the same respective time horizon).

[74] *See, e.g.*, CBHS UPDATE 2020, *supra* n.10, at 3–6 (describing plans to establish a psychiatric residential treatment facility in Maine and the use of Family First Prevention Services Act funding to invest in residential services in Maine); STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., Adopted Rule: Ch. 101, MaineCare Benefits Manual, Ch. II § 97, Private Non-Medical Institution Services (Nov. 1, 2021), https://www.maine.gov/tools/whatsnew/attach.php?id=5877701&an=2 (summarizing recently adopted changes to the MaineCare PNMI rules to align with the Family First Prevention Services Act).

[75] *See, e.g.*, JUVENILE JUSTICE SYSTEM ASSESSMENT 2020, *supra* n.34, at 117–18; CBHS ASSESSMENT 2018, *supra* n.3, at 16, 45–46; NATIONAL DISABILITY RIGHTS NETWORK, DESPERATION WITHOUT DIGNITY: CONDITIONS OF CHILDREN PLACED IN FOR PROFIT RESIDENTIAL FACILITIES 15, 34 (Oct. 2021), https://www.ndrn.org/wp-content/uploads/2021/10/NDRN_Desperation_without_Dignity_October_2021.pdf.

D. Allocate Adequate Resources to Maintain a Sufficient, Trained Pool of Community Providers Across the State, Including Treatment Foster Care Parents.

Maine must invest in its behavioral health system by recruiting, training, and maintaining a pool of providers that can meet the demand for community-based services, including in rural areas and for children with intense needs. This includes recruiting and supporting more Treatment Foster Care parents by providing necessary resources and services to families participating in the program. Without a concerted effort to provide home settings that can meet the behavioral health needs of foster children, the State all but guarantees that young people who are doubly vulnerable due to their child welfare involvement and behavioral health needs will live in institutions.

Furthermore, the State should reinvest in a program for children who do not have formal child welfare involvement but nonetheless require alternative-family settings, like the Multidimensional Treatment Foster Care program that the State previously ran but discontinued.[76] This alternative family setting would allow a child to live with specially trained foster parents, while maintaining all legal and social ties between the child and their own family. This option avoids institutionalization for children who are not in the child welfare system but whose families cannot currently care for the child at home, for example due to a parent's illness or the needs of other siblings in the home.

Acknowledging the lack of resources in its community-based service system, Maine has made small changes, with some additional plans for the future.[77] While welcome, these improvements and plans are not sufficient to address the systemic barriers outlined above. In contrast, the State has already dedicated considerable resources to institutional providers by significantly raising rates of reimbursement, and has plans to further expand institutional settings.[78] Maine is well-positioned to take immediate steps to invest in its community-based behavioral health system, and should take such steps to prevent the unnecessary institutionalization of its children.

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[76] *See* CBHS ASSESSMENT 2018, *supra* n.3, at 85.

[77] *See, e.g.*, CBHS UPDATE 2020, *supra* n.10, at 7 (discussing rate and other administrative changes for Multi-Systemic Therapy and Family Functional Therapy); STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., DHHS ANNOUNCES MAINECARE RATE SYSTEM IMPROVEMENTS (Sept. 30, 2021), https://www.maine.gov/dhhs/blog/dhhs-announces-mainecare-rate-system-improvements-2021-09-30 (summarizing planned rate studies for other children's behavioral health services).

[78] STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., Proposed Rule: Ch. 101, MaineCare Benefits Manual, Ch. III § 97, Private Non-Medical Institution Services (Nov. 10, 2021), https://www.maine.gov/tools/whatsnew/attach.php?id=5941853&an=2; OFF. OF CHILD AND FAMILY SERVS., STATE OF ME. DEP'T OF HEALTH AND HUMAN SERVS., CHILDREN'S BEHAVIORAL HEALTH SERVICES ANNUAL REPORT: CALENDAR YEAR 2021, at 4–5 (Jan. 2022), https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/2021%20CBHS%20Annual%20Report_0.pdf (describing "significant rate increases of 45-75%" for residential treatment providers and plans to build a Psychiatric Residential Treatment Facility.)

E. Implement and Support a Policy Requiring Providers to Serve Eligible Children and Prohibit Refusal of Services.

The State should implement an accountability policy that requires community-based behavioral health care providers to actually serve eligible children who are assigned to their caseloads. To prevent children from being matched with providers who are not equipped to meet their needs, Maine must ensure that that third parties and OCFS staff are knowledgeable about provider organizations' capabilities.

Although the concerns outlined in this letter have been ongoing, we hope you share our sense of urgency[79] to remedy these violations and support children with behavioral health needs. This letter is a public document and will be posted on the Civil Rights Division's website. Please contact Victoria Thomas, Trial Attorney at the Disability Rights Section of the Civil Rights Division, within two weeks of receiving this letter if Maine is interested in working with the United States to reach an appropriate resolution along the lines described above.

Sincerely,

/s/ Kristen Clarke
Kristen Clarke
Assistant Attorney General
Civil Rights Division

cc: Kimberly Patwardhan, Assistant Attorney General

[79] *See generally* THE U.S. SURGEON GENERAL'S ADVISORY, PROTECTING YOUTH MENTAL HEALTH (Dec. 2021), https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf (outlining growing mental health challenges among young people which have been acutely exacerbated by the COVID-19 pandemic, and the need for immediate action at local, state, and federal levels).