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S.P. 721 In Senate, May 30, 1991

Reported by Senator CONLEY of Cumberland for the Systems Assessment Commission pursuant to Public Law 1989, chapter 501, Part BB, section 8.

Reference to the Committee on Human Resources suggested and ordered printed pursuant to Joint Rule 18.

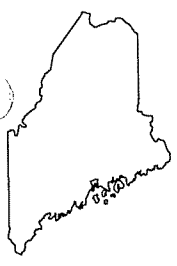
JOY J. O'BRIEN
Secretary of the Senate

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

An Act to More Clearly Define the Role and Responsibilities of the Department of Mental Health and Mental Retardation.

(EMERGENCY)



Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the Systems Assessment Commission, established by Public Law 1989, chapter 501, Part BB, section 8, was charged with making recommendations to reform Maine's mental health system; and

Whereas, the Systems Assessment Commission recommended the immediate modification of several aspects of the system as necessary to the system's ability to provide appropriate and adequate services to persons affected by mental illness and with mental health needs; and

Whereas, the involvement of community and government leaders in designing these modifications is needed; and

Whereas, there is a need for immediate action to bring together coalitions of individuals to implement the recommendations of the Systems Assessment Commission; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

PART A

Sec. A-1. 5 MRSA §12004-G, sub-§28-A is enacted to read:

28-A. Mental Health	Mental Health Advancement Program Board of Trustees	Expenses Only	34-B MRSA §10005

Sec. A-2. 34-B MRSA §1001, as amended by PL 1985, c. 506, Pt. A, §70, is further amended to read:

§1001. Definitions

As used in this Title, unless the context otherwise indicates, the following terms have the following meanings.

1. Chief administrative officer. "Chief administrative officer" means the head of a state ~~institution~~ facility or the head of any other institution ~~which~~ that provides services ~~which~~ that fall under the jurisdiction of the department.

1-A. Agent. "Agent" means a person, firm, association or corporation providing services under an agreement with the Department of Mental Health and Mental Retardation.

1-B. Agreement. "Agreement" means a legally binding document between 2 parties, including documents commonly referred to as accepted application, proposal, prospectus, contract, grant, joint or cooperative agreement, purchase of service or state aid.

2. Client. "Client" means a person receiving services from the department, ~~from the Bureau of Mental Health,~~ from the Bureau of Mental Retardation, from any state ~~institution~~ facility or from any ~~agency~~ agent licensed or funded to provide services falling under the jurisdiction of the department.

3. Commissioner. "Commissioner" means the Commissioner of Mental Health and Mental Retardation or ~~his~~ a designee, except that when the term "commissioner and only the commissioner" is used, the term applies only to the person appointed Commissioner of Mental Health and Mental Retardation and not to any designee.

3-A. Community-based services. "Community-based services" means diagnosis, evaluation, treatment, rehabilitation, care support or other services provided to a client as near as possible to the locality in which the consumer resides, in the least restrictive setting appropriate, and includes substantial community social support and involvement.

3-B. Community support services. "Community support services" means those services that assist an individual in gaining access to and making effective use of the range of medical, psychological and other available related services.

3-C. Community support system. "Community support system" means the entire complex of mental health, rehabilitative, residential and other support services provided in the community to ensure community interaction and the maintenance of a decent quality of life for consumers.

3-D. Consumer. "Consumer" means an individual with mental health needs or mental illness who is or has been a primary consumer of mental health services, from any source, including the Bureau of Health.

4. Department. "Department" means the Department of Mental Health and Mental Retardation.

4-A. Funds. "Funds" means money from the General Fund, a dedicated fund, fees, a special revenue fund, 3rd-party reimbursements, vendor payments or other funds available for expenditure by the department to provide a human service.

4-B. Human service. "Human service" means any service provided to a person affected by mental illness or with mental health needs or to a person with developmental disabilities under an agreement financially supporting the service, wholly or in part, by funds authorized for expenditure by the department.

4-C. Individual support plan. "Individual support plan" means a written document prepared by a team of persons including the consumer and health and social service professionals, which includes an assessment of the consumer's strengths and needs and describes the consumer's goals and objectives and the services needed to meet those goals.

4-D. Interdependence. "Interdependence" means the interaction and mutual dependence of consumers, natural support systems and the community.

4-E. Mental health services. "Mental health services" means outpatient counseling, inpatient counseling, or other psychological, psychiatric, rehabilitative, diagnostic, therapeutic or other allied services.

4-F. Mental illness. "Mental illness" means a mental or emotional disorder such as organic brain syndrome, schizophrenia, recurrent depressive and manic-depressive disorders and paranoid and other psychoses that erode or prevent the capacities in relation to the primary aspects of daily life.

4-G. Natural support system. "Natural support system" means a family member or other significant person who is involved in the life of a consumer.

4-H. Nonprofit organization. "Nonprofit organization" means any agency, institution or organization that is, or is owned and operated by, one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual and that has a territory of operations that may extend to a neighborhood, community, region or the State.

5. Parking area. "Parking area" means land maintained by the State at the state ~~institutions~~ facilities under the jurisdiction of the department, which may be designated as parking areas by the heads of the state ~~institutions~~ facilities.

6. Public way. "Public way" means a road or driveway on land maintained by the State at the state ~~institutions~~ facilities under the jurisdiction of the department.

7. Resident. "Resident" means a person residing in a state ~~institution~~ facility or in any other institution ~~which~~ that

provides services ~~which~~ that fall under the jurisdiction of the department.

7-A. State agency client. "State agency client" has the same meaning as in Title 20-A, section 1, subsection 34-A.

8. State facility. "State ~~institution~~ facility" means: any facility operated and staffed directly by the department or the Mental Health Advancement Program.

~~A.--The Augusta Mental Health Institute;~~

~~B.--The Bangor Mental Health Institute;~~

~~C.--The Pineland Center;~~

~~D.--The Elizabeth Levinson Center;~~

~~E.--The Aroostook Residential Center; or~~

~~F.--The Military and Naval Children's Home.~~

9. Written political material. "Written political material" means flyers, handbills or other nonperiodical publications ~~which are~~ subject to the restrictions of Title 21-A, chapter 13.

Sec. A-3. 34-B MRSA §1201-A is enacted to read:

§1201-A. Principles

In the provision of services for persons affected by mental illness or mental health needs the department must be guided by the following principles.

1. Availability of services. Comprehensive mental health services should be available for all population groups, from the very young to the very old. Those affected by mental illness and those with mental health needs should have available to them appropriate mental health, physical health, psycho-social rehabilitation, career counseling, education and training, supported employment, housing, transportation and other services that are generally available to society as a whole. Mental health, health, psycho-social rehabilitation, career counseling, education, vocational and other support services should be coordinated so that there is continuity in their availability to consumers.

2. Flexibility. The mental health system should be flexible in its approach to the needs of individual consumers, flexible in adjustments to different geographic and demographic areas and flexible over time in adapting to the lessons of

program evaluations and the acquisition of new knowledge and understanding of mental illness, its diagnosis and treatment.

3. Consumer focus. Mental health services should focus on the consumer, emphasize consumer choice and recognize individual rights. There should be individuality of treatment and care directed at maximum functional achievement and built on individual strengths.

4. Consumer involvement. Those persons affected by mental illness and those who are part of natural support systems for those persons should participate in system and care planning and delivery.

5. Community-based services. Diagnosis, evaluation, treatment, rehabilitation, care and support should be provided by state-operated and public or private facilities or programs as near as possible to the locality in which the consumer resides. Care and services should be provided in the least restrictive settings and as community-based as possible, with substantial community social support and involvement.

6. Fostering interdependence. Treatment, care and other services should foster interdependence, involving meaningful reciprocal relationships between individual consumers and natural support systems whenever possible.

7. Assistance for those who support. Assistance, including crisis intervention, respite arrangements and financial assistance, should be available as appropriate to those providing support for individuals affected by mental illness or emotional disturbance. Developing family supports and education strategies and supporting advocacy by families in planning and evaluating mental health programs should be emphasized.

8. Fostering community support. There should be continuing public education on mental illness that is aimed at fostering supportive community attitudes and eliminating stigma so that those affected by mental illness will have greater opportunities to achieve interdependence and realize their potential as productive members of society. Consumers of mental health services, families and other natural support system members should be active participants in the design, development and delivery of such public education programs.

9. Quality standards. High quality standards of diagnosis, care and support are essential to all mental health services. Those standards must be improved and adjusted constantly in response to new knowledge and the lessons of experience. Care givers must be held accountable for quality of services. Research, education and evaluation must be an integral part of the mental health system.

10. Continuity of comprehensive services. Those having mental health needs and those affected by mental illness should be able to obtain a comprehensive range of services across professional lines in an integrated system that fosters continuity of care and overcomes gaps in services and barriers to care and support. Collegiality and team approaches should be the dominant characteristics of service delivery. Service providers should foster the exchange of needed information to meet the needs of individual consumers, consistent with the protection of patient confidentiality. Consumers and family members should be involved in those kinds of exchanges.

11. Holistic approach. Individuals with multiple needs, for example, individuals with mental health needs or affected by mental illness and also affected by substance abuse, head injuries or other trauma, the aftermath of psychological trauma or sexual or other abuse, should have access to mental health services as an integral and coordinated part of all forms of needed care and support, regardless of their source or location. High quality, integrated and coordinated care and support services for persons with multiple problems will be possible only if providers of mental health and other health and social services receive education in different areas of expertise and there is ongoing communication and consultation among professionals and paraprofessionals from different disciplines. Different disciplines must also be involved at senior levels in program management and planning.

12. Consumer and natural support participation. All advisory, planning and governance bodies associated with mental health programs should include significant numbers of consumer and natural support system members.

13. Financial resource commitments. Mental health system program initiatives must be accompanied by adequate financial support, whether obtained from state, federal, other public or private funding.

14. Personnel. Recruitment, development, training and retention of highly qualified mental health and related service professionals and paraprofessionals are essential to the achievement of an effective mental health system. Cooperation and coordination among professional licensing boards and organizations, the State, the University of Maine System, the University of New England, the Maine Technical College System and other educational institutions are crucial to an integrated system of care.

15. Reimbursement for services. Reimbursement and support for mental health and related service agencies and individual providers should be set at levels designed to recognize a variety

of professionals and paraprofessionals and to encourage high standards of performance. Such compensation and support policies should be accompanied by clear expectations and mechanisms to ensure high quality performance and commitment to eliminating obstacles to obtaining appropriate care. Reimbursement should be related to the multiple needs of individual consumers and not to narrow programs or diagnostic categories.

16. Access to services. Special attention must be given to ensuring access to services for those affected by mental illness. Access to services should not be conditioned either on consumer behavior that providers find acceptable or on ability to pay.

Sec. A-4. 34-B MRSA §1204, sub-§9 is enacted to read:

9. Regional offices. The commissioner may establish regional offices as necessary to carry out the responsibilities of this Title.

Sec. A-5. 34-B MRSA §1208, as amended by PL 1989, c. 432, is repealed.

Sec. A-6. 34-B MRSA §§1208-A and 1208-B are enacted to read:

§1208-A. Agreements with agents

1. Commissioner's powers. The commissioner's powers are as follows.

A. The commissioner may disburse funds to an agent for the purpose of financially supporting a human service only if the disbursement is covered by a written agreement between the department and the agent specifying at least the following:

(1) The human service to be provided by the agent within the context of individual plans of service;

(2) The method of payment by the department to the agent;

(3) The criteria for monitoring and evaluating the performance of the agent in the provision of the human service under a regional plan;

(4) That the agent will not discriminate because of ability to pay;

(5) That the limitations on executive and administrative compensation are fixed under the terms of the contract;

(6) Unless the award is for a pilot project of limited duration, the establishment of at least 3-year but no more than 5-year contract agreements and the terms for requesting contract renewal; and

(7) By March 1992, an acceptable description of how continuity of care and integration of community services for individuals served, consumer and community input and choice will be ensured.

B. The commissioner may disburse funds to any agent that applies for the funds to be used in the provision of mental health services to persons affected by mental illness or with mental health needs or in the promotion of community understanding and involvement in the provision of mental health services to persons affected by mental illness or with mental health needs.

(1) The programs administered by the agent must comply with standards of professional services as defined by the Bureau of Mental Health.

(2) The commissioner shall ensure that the programs administered by the agent specify how consumers and natural support members participate in the provision of services and how the services are integrated and coordinated to meet the full range of service needs of the consumers served.

(3) The commissioner shall ensure that grant awards include support for programs designed to reduce stigma, to provide crisis intervention, to provide acute-community-based inpatient services, to educate professional, paraprofessional and nonprofessional community members, to support members of natural support systems and to provide respite services.

(4) When disbursing funds for the provision of mental health services, the commissioner shall ensure that model in-patient and ambulatory programs that incorporate state-of-the-art research, education, diagnosis, treatment, rehabilitation and support are included in the mix of contract awards relative to services for persons affected by mental illness or with mental health needs.

(5) The commissioner is responsible for establishing and monitoring licensing requirements for agents providing mental health services. Licensing requirements must be measurable, clear and related to consumer rights, safety and quality assurance.

(6) The commissioner may require the agent applying for funds to produce evidence that appropriate local, governmental and other funding sources have been sought to assist in the financing of its mental health services.

(7) After negotiation with the agent applying for funds, the commissioner may execute an agreement for the provision of mental health services that reflects the commitment by the agent of local, governmental and other funds to assist in the financing of its mental health services.

(8) Beyond the commissioner's ensuring through program monitoring and auditing activities that an equitable distribution of the funds committed by contract or agreement to assist in the financing of mental health services is actually provided, the agent providing services may apportion other nonstate funds in an appropriate manner in accordance with its priorities, service contracts and applicable provisions of the law.

2. Commissioner's duties. The commissioner's duties are as follows.

A. The commissioner shall adopt rules consistent with and necessary for the effective administration of this section.

B. When making agreements with agents for the provision of a human service, the commissioner shall use agreement forms and shall use uniform procedures developed by the commissioner.

C. When disbursing funds pursuant to an agreement, the commissioner shall require uniform accounts payable forms or uniform accounts supporting documentation and information.

D. When accounting for funds disbursed under an agreement, the commissioner shall use uniform accounting principles, policies and procedures.

E. When making agreements with agents for the provision of a human service, the commissioner shall provide incentives for efficient, cost-effective and high-quality service delivery.

F. When making agreements with agents for the provision of a human service, the commissioner shall ensure that mental health services are available from a variety of sources for individuals affected by severe and chronic long-term mental

illness who require emergency, short-term inpatient or outpatient services.

G. The commissioner is responsible for ensuring that professional quality standards and practices are in place and enforced and that appropriate monitoring of quality performance in facilities and by agents providing a human service occurs.

4. Payment for state agency clients. The commissioner shall authorize payment of approved mental health treatment costs for state agency clients who are placed for educational purposes with the recommendation of an employee of the Bureau of Children with Special Needs in an in-state residential treatment center, as identified in Title 20-A, section 1, subsection 24-A, paragraph D, subparagraph (3), to the extent of the amount of funds appropriated by the Legislature for this purpose. The commissioner may authorize payment of mental health treatment costs for similar placements in out-of-state residential placements on a case-by-case basis within the limits of available funds. The commissioner shall authorize payment of approved board and care and mental health treatment costs for state agency clients who are placed for other than educational purposes with the recommendation of an employee of the Bureau of Children with Special Needs in any residential placement, as defined in Title 20-A, section 1, subsection 24-A, to the extent of the funds appropriated by the Legislature for this purpose. Payments authorized under this section may not exceed the funds appropriated by the Legislature for the purposes referred to in this subsection. Payment from these funds may be made only when other appropriate state or federal funds to which the department has access have been exhausted.

5. Annual report. The department shall prepare an annual report on services contracted with agents. The department shall deliver its report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs by January 31st of each year. The report must include:

A. A listing by agent of all funds received from the State and a summary of the purposes for which those funds were expended;

B. A summary of the most recent year's allocations of all funds by bureau or office, service area, region and, if available, county;

C. An evaluation of additional funding needed to equalize funding among all regions by individual service area, presented in prioritized order;

D. The department's assessment, by individual service area, of the outstanding service needs of the State. The assessment must identify the funding source projected by the department to be available for the expansion of service, presented in prioritized order; and

E. Recommendations for changes in funding resulting from the department's planning and evaluation system presented in the following order of priority: the greatest service need within the existing funding scheme; the equalization of regional funding within each service area; and the new or outstanding needs.

6. Rules. The commissioner may not issue requests for proposals for agreements with agents until the commissioner adopts rules in accordance with the Maine Administrative Procedure Act to ensure:

A. That the reasons for which existing services may be placed out for bid and the performance standards and manner in which compliance will be evaluated are specified;

B. The protection of the consumer of mental health or mental retardation services in such a way that any change in provider will be accomplished in a manner that fully protects the consumer;

C. The verification of the nonservice revenue portion of proposed budgets submitted by current and prospective providers; and

D. The reasonable financial protection for providers who have made capital investments in the fulfillment of contract responsibilities.

§1208-B. Commission membership; mental health

All boards and commissions established to advise, oversee or make recommendations to the Bureau of Mental Health must include at least 51% consumer and natural support system representation. This representation must include at least 25% primary consumers of mental health or mental retardation services.

Sec. A-7. 34-B MRSA §1209-A, sub-§1, as amended by PL 1989, c. 503, Pt. B, §161, is further amended to read:

1. Establishment. The Mental Health Rights Advisory Board as established pursuant to Title 5, section 12004-I, subsection 63, ~~shall consist~~ consists of 11 members, at least 25% of whom must be primary consumers and at least 51% consumers and natural support system members as follows:

A. Six persons who are consumers of mental health services, including clients, at least 3 of whom have received services from a state ~~institution~~ facility or a community mental health agency, and their families; and

B. Five persons concerned with the quality of the delivery of mental health services, at least 4 of whom are providers of services in a hospital pursuant to subchapter IV or in a program or facility administered or licensed by the department under section 3606.

Members ~~shall be~~ are appointed by the commissioner for staggered terms not to exceed 2 years.

At least 3 nominations to the commissioner ~~shall~~ must be made by majority vote of the board 30 days before the expiration of a member's term. If the initial nominations are unacceptable, the board shall submit 3 alternative nominations. If a member's term expires and the commissioner has not appointed a successor, the member may be reelected by majority vote to continue as a member until the commissioner appoints a successor.

Sec. A-8. 34-B MRSA c. 1, sub-c. III, as amended, is repealed.

Sec. A-9. 34-B MRSA §3001, as enacted by PL 1983, c. 459, §7, is amended to read:

§3001. Establishment

There is established, within the Department of Mental Health and Mental Retardation, the Bureau of Mental Health, which is responsible for the direction of ~~the~~ state mental health programs ~~in the state institutions~~ and for the promotion ~~and guidance~~ of mental health programs within the several communities of the State.

Sec. A-10. 34-B MRSA §3001-A is enacted to read:

§3001-A. Responsibilities

The Bureau of Mental Health, with the cooperation and assistance of the Legislature and other departments and agencies of State Government, is responsible for undertaking the following actions on behalf of persons affected by mental illness or with mental health needs:

1. Further mission and goals of system. Providing leadership, facilitating and serving as a catalyst in defining and advocating the mission and goals of a mental health system, including the range of services that should be available through various public and private entities and the legal framework for

individual rights, equal access, liability and quality assurance related to mental health services;

2. Prevent discrimination. Providing leadership, facilitating and serving as a catalyst to ensure that individuals with mental health needs and those affected by mental illness are not discriminated against as they try to obtain services available to the general public;

3. Model programs. Operating, directly or through contracts, model inpatient and ambulatory programs for persons affected by mental illness or with mental health needs that incorporate state-of-the-art research, education, diagnosis, treatment, rehabilitation and support;

4. Contracts and grants. Offering contract and grant reimbursement programs that provide incentives for efficient, cost-effective and high-quality service delivery;

5. Emergency or short-term services. Providing, through reimbursement or contracts, mental health services from a variety of sources for individuals affected by long-term, severe and chronic mental illness who require emergency, short-term inpatient or outpatient services;

6. Licensing oversight. Establishing and monitoring licensing requirements for individuals, facilities and agencies providing mental health services;

7. Enforce standards. Ensuring that professional quality standards and practices are in place and enforced in facilities providing services for those with mental health needs or affected by mental illness and monitoring quality performance in facilities and agencies providing care under state contracts;

8. Education. Engaging in consumer and general public education that helps consumers make informed judgments on mental health services;

9. Quality assurance. Being involved in quality assurance through participation in the licensing of mental health professionals, monitoring the delivery of contracted mental health services, collecting information on professional quality assurance programs, providing public education on the evaluation of mental health services quality and collecting information on consumer opinions and the perspectives of other lateral support system members;

10. Indigency. Funding, within available resources, the range of services determined necessary for those indigent and medically indigent individuals with mental health needs and those affected by mental illness;

11. Coordination and continuity. Ensuring that services funded by the Bureau of Mental Health are coordinated, offer continuity in the availability of care and eliminate the fragmentation of services;

12. Education and research funding. Assisting in the funding of clinical research, professional education, public education, natural support system education, selected services in the community mental health system and risk-reduction programs related to mental health services;

13. Information bases. Developing, maintaining and making available, directly or through grants and contracts, information bases that will support needed research, planning, evaluation and program development for mental health services. These information bases should be consistent over time, include consumer need and demand, service, quality assurance, expenditure and revenue sources and other pertinent information;

14. Regional and community-based systems and services. Fostering, through leadership in planning, technical assistance, education and incentive grants, the development of regional and community-based mental health systems and services that address a broad spectrum of needs, including the promotion of mental health, support for those in emotional difficulty, intervention, diagnosis, treatment, rehabilitation, care and support for those affected by mental illness;

15. Crisis intervention. Assisting in the creation of regional and community crisis intervention services designed to reduce risks for those who may be a danger to themselves or others. These services must be designed to resolve crises and provide stabilization and a transition to appropriate levels of care. Services must be mobile and include crisis beds and related services;

16. Role as lead agency. Acting, with the cooperation and assistance of the Department of Corrections and the Executive Department, Office of Substance Abuse, as the lead agency of State Government with responsibility for offering mental health services to those convicted of crimes and inmates of state and county correctional institutions;

17. Community-based services; priority. Making community-based services a funding priority;

18. Needs assessment. Developing a mental health system based on the identified needs of consumers and natural support systems using needs assessments to plan services. At a minimum, the department shall maintain an inventory of existing and planned services at the community and regional level, conduct

regular assessments of consumer need and potential demand for services, conduct ongoing corrections in existing services and levels based on identified needs and use this information to plan financial and other resource needs required to support the future needs of individuals affected by mental illness or with mental health needs;

19. Proposals to Legislature. Establishing task forces and work groups to develop recommendations and proposals for system improvements to be reported to the Legislature and the Governor;

20. Consumer information clearinghouse. Informing consumers of the range of services available by establishing, no later than September 1991, a consumer information clearinghouse and assistance program with a toll-free number so that consumers and their natural support systems, community support persons, case managers and service providers may obtain the information needed to identify and make judgments on existing services and programs and receive assistance from the department in gaining access to selected services;

21. Respite programs. Ensuring the establishment of respite programs for families of persons affected by mental illness by creating respite programs in each county of the State by 1995; and

22. Regional support systems. Developing regional support systems and integrating them into the structure of services available in the community.

Sec. A-11. 34-B MRSA §3004, as amended by PL 1987, c. 404, §1, is repealed.

Sec. A-12. 34-B MRSA §3005, as repealed and replaced by PL 1987, c. 331, is amended to read:

§3005. Services to persons with multiple needs

1. Accommodations and services. The Bureau of Mental Health shall provide accommodations and services for persons affected by mental illness or with mental health needs who are also deaf or hearing impaired ~~persons~~, addicted to alcohol or other drugs, affected by mental retardation and mental illness or who are affected by more than one mental health need or disability by providing access to mental health programs funded or licensed by the bureau. These accommodations ~~shall~~ include, but are not limited to, the following:

A. Appropriate mental health assessments ~~for deaf clients~~;

B. Provision of interpreter services ~~for~~ in connection with diagnosis, treatment or rehabilitation services;

C. Education and training for mental health staff ~~providing treatment to deaf persons~~;

D. Placement of telecommunication devices for the deaf in comprehensive community mental health facilities;

E. Support and training for families ~~with deaf members who experience a mental health problem~~; and

F. Establishment of ~~a~~ therapeutic residence ~~program for persons who are deaf and in need of residential mental health treatment. The therapeutic residence program shall~~ be programs operated in conjunction with existing rehabilitation, education, mental health treatment and housing resources. The therapeutic residence ~~program shall~~ programs must be staffed by individuals trained in mental health treatment and proficient in deaf communication or other skills as needed.

2. Report. The Bureau of Mental Health shall prepare a biennial report ~~which~~ that describes accommodations and services available and identifies additional service needs and a plan to address these needs. The ~~Bureau~~ Director of the Bureau of Mental Health shall include representatives from deaf communities, families and public and private service agencies in the preparation of the report. The report ~~shall~~ must be submitted to the joint standing committee of the Legislature having jurisdiction over human resources by January 15th of every even-numbered year.

Sec. A-13. 34-B MRSA §3006, as amended by PL 1987, c. 887, §7, is repealed.

Sec. A-14. 34-B MRSA §3006-A is enacted to read:

§3006-A. Mental Health Planning Council and State Mental Health Plan

1. **Mental Health Planning Council.** The Mental Health Planning Council is established as a successor to the mental health planning council required under federal Public Law 99-660 and is responsible for facilitating and overseeing the development of the State Mental Health Plan mandated by federal Public Law 99-660, as amended. The council has 15 voting members appointed by the Governor for a term of 3 years; except that of those first appointed, 5 serve for a term of 3 years; 5 serve for a term of 2 years; and 5 serve for a term of one year. A member may not serve more than 2 consecutive 3-year terms. Appointments may be made to fill the unexpired terms in cases of vacancies. Members serve until the end of their terms or until their successors are appointed. Five voting members must be consumers

of mental health services, 5 must be members of the families of such individuals or members of natural support systems and 5 must be appointed from public and private entities concerned with the need, planning, operation, funding and use of mental health services and related social and rehabilitation services. The Chair of the Maine Commission on Mental Health shall appoint 2 members of the commission to serve with the executive director of the commission as nonvoting members of the council and as liaison between the council and the commission. The Commissioner of Mental Health and Mental Retardation, the Commissioner of Human Services, the Commissioner of Education, the Commissioner of Labor, the Commissioner of Public Safety, the Commissioner of Corrections, the Director of the Mental Health Advancement Program, the Director of the Maine State Housing Authority and the Director of the Office of Substance Abuse, or their successors, shall designate nonvoting members of the council who shall advise the council's voting members and serve as liaison with their respective agencies.

2. Council responsibilities. The council's responsibilities include, but are not limited to, the following:

A. Technical assistance to regional mental health boards in the development of planning processes, long-range and biennial plans and recommendations for the State Mental Health Plan;

B. Conduct of public hearings and workshops on proposals for the State Mental Health Plan;

C. Review and comment on the State Mental Health Plan; and

D. In fulfilling the foregoing responsibilities and in concert with the Maine Commission on Mental Health:

(1) Serve as an advocate for chronically mentally ill individuals, severely emotionally disturbed children and youth and other individuals who have mental health service needs or are affected by mental illness;

(2) Monitor, review and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State; and

(3) Review and evaluate the State's performance in implementing the State Mental Health Plan.

3. Council operations. The council shall adopt bylaws and elect officers, including a chair, vice-chair and secretary. The council shall share office space, equipment and support staff with the Maine Commission on Mental Health. The council shall employ, in addition, an executive director and a health planner,

who shall provide professional staff services for the council and technical assistance to the regional mental health boards and the Maine Commission on Mental Health.

4. State Mental Health Plan. The State Mental Health Plan must be prepared annually and be consistent with the requirements of federal Public Law 99-660, as amended, while serving the broader interests of the State. The Bureau of Mental Health is responsible for preparing the plan, which is derived from the regional mental health board plans, making recommendations for the plan and the Mental Health Advancement Program plan and the advice of the Mental Health Planning Council and the Commission on Mental Health. The State Mental Health Plan must include, but is not limited to, the following:

A. A 5-year forecast of mental health service needs in the State, by region and statewide;

B. An assessment of the current status of mental health services in the State, including strengths and weaknesses and an evaluation of performance in relation to the previous year's objectives;

C. Mental health service goals for the State, including public and private sectors, for the 5-year period;

D. Objectives for state mental health services in the next biennium; and

E. A plan that includes resource requirements, timetables, the expected outcome of the stated objectives in each year of the biennium and criteria for evaluating the outcome.

5. Review and revision. The commissioner, the Maine Commission on Mental Health and the Mental Health Planning Council shall review and report on the implementation of this section and submit a report to the joint standing committee of the Legislature having jurisdiction over human resources by December 15, 1995. The report must include recommendations on the possible merger of the Mental Health Planning Council and the Maine Commission on Mental Health.

Sec. A-15. 34-B MRSA §3601, as amended by PL 1987, c. 246, §3, is repealed.

Sec. A-16. 34-B MRSA §3602, as enacted by PL 1983, c. 459, §7, is amended to read:

§3602. Purpose

The purpose of this subchapter is to ~~expand~~ foster and strengthen community mental health services, encourage

participation in a program of community mental health services by persons in local communities and define the responsibilities of the Bureau of Mental Health, which are to encourage the participation of local communities in a program of community mental health services, ~~obtain~~ promote a better understanding of the need for those services and ~~secure~~ assist persons in local communities to secure aid for programs of community mental health services ~~by state aid and local financial support~~.

Sec. A-17. 34-B MRSA §3604, sub-§1, as enacted by PL 1983, c. 459, §7, is amended to read:

1. Provision of services. The commissioner may provide or encourage the provision of mental health services throughout the State and for that purpose may cooperate with other state agencies, municipalities, persons, unincorporated associations and nonstock corporations, hospitals and other facilities, organizations or agents. The commissioner shall ensure the provision of community support services for persons whose mental illness is acute in its intensity and chronic in its duration, who are not functioning consistently in society, have frequent readmission for care and are at times an imminent danger to themselves or others.

Sec. A-18. 34-B MRSA §3604, sub-§3, as repealed and replaced by PL 1983, c. 580, §8, is repealed.

Sec. A-19. 34-B MRSA §3621, as enacted by PL 1987, c. 349, Pt. H, §21, is repealed.

Sec. A-20. 34-B MRSA §3621-A is enacted to read:

§3621-A. Crisis intervention programs

1. Program availability. The department shall ensure the availability of crisis intervention programs as a crucial element of any mental health treatment system. These programs shall serve the needs of persons affected by mental illness or with mental health needs and must be designed to reduce dependency on hospitalization.

2. Community-based. Crisis intervention programs must be community-based programs that respond to the needs of persons affected by mental illness or with mental health needs that are in or as near as possible to the locality in which these individuals reside. The programs shall provide counseling, consultation, evaluation, treatment and referral and education and training services delivered by mental health professionals specifically trained to respond to individuals in crisis. The services must be designed to reduce reliance on institutionalization or inpatient treatment services, reduce risks to persons who may be a danger to themselves or others,

must be aimed at resolving crises and providing stabilization and transition to appropriate levels of care and other services, organized to include mobile intervention teams and community crisis beds and must be part of a comprehensive community service system.

3. Regional. By December 1, 1992, the department shall establish at least 2 regional crisis intervention programs capable of responding on a 24-hours-a-day, 365-days-per-year basis to individuals affected by mental illness or with mental health needs who are in crisis. By January 1, 1996, the department shall have a system of crisis intervention programs capable of responding on a 24-hours-a-day, 365-days-per-year basis in all regions of the State to persons affected by mental illness or with mental health needs who are in crisis. These programs must be located in each region of the State and must provide the following services:

A. A range of options, including local and regional residential facilities that provide shelter and short-term treatment for persons affected by mental illness or with mental health needs who are experiencing a crisis. These facilities must include, but are not limited to, crisis intervention and psychiatric emergency services. Emergency services must provide intensive and comprehensive crisis intervention services;

B. Outreach services and crisis intervention provided by specially trained personnel who are not part of the criminal justice system, are knowledgeable in issues pertaining to mental health and mental illness, can travel to the site or locale where an individual affected by mental illness or with mental health needs is in crisis and can provide appropriate intervention services designed to prevent or reduce the need for hospitalization, can stabilize and can reduce risks to persons who may be a danger to themselves or others. These outreach services may include mobile intervention teams and community crisis beds as needed;

C. Community-based telephone crisis intervention hot lines offering 24-hour, 7-days-a-week counseling, consultation, evaluation, treatment and referral services;

D. The capability to provide training on crisis intervention to local providers of mental health services and other interested persons;

E. The capability to provide advice and individualized planning on the prevention of and planning for possible future crisis situations to local providers of mental health services and other interested persons; and

F. A link to self-help and consumer groups through the establishment, by December 1, 1992, of at least 3 extended-hour social clubs that are linked to crisis intervention programs.

Sec. A-21. 34-B MRSA §3622, as enacted by PL 1987, c. 349, Pt. H, §21, is amended to read:

§3622. Crisis intervention teams

1. Established. A ~~community-based~~ Community-based crisis intervention ~~team shall be~~ teams are established to provide crisis intervention on a 24-hour, 7-days-a-week basis, 365 days per year, to ~~mentally ill people~~ persons affected by mental illness or with mental health needs and to provide crisis intervention training for ~~emergency room~~ community personnel.

2. Qualifications. The ~~team shall~~ teams must be comprised of qualified mental health professionals with training and experience in assessment and intervention with ~~mentally ill people~~ persons affected by mental illness or with mental health needs who are in ~~a~~ crisis. In addition, the team members ~~shall~~ must have a working knowledge of ~~case management~~ community support services, the mental health system and area resources.

Sec. A-22. 34-B MRSA §3623, as amended by PL 1989, c. 163, is repealed.

Sec. A-23. 34-B MRSA §3802, sub-§1, as enacted by PL 1983, c. 459, §7, is amended to read:

1. Rules. ~~Promulgate~~ Adopt such rules, not inconsistent with this subchapter, as ~~he may find to be~~ the commissioner finds reasonably necessary for proper and efficient hospitalization of ~~the mentally ill~~ persons affected by mental illness;

Sec. A-24. 34-B MRSA §3901, sub-§2, as amended by PL 1989, c. 335, §4, is further amended to read:

2. Membership. The commission ~~shall consist~~ consists of 23 members, including 12 appointed by the Governor and 11 jointly appointed by the President of the Senate and the Speaker of the House of Representatives. ~~One of the members jointly appointed by the President of the Senate and the Speaker of the House of Representatives and one of the members appointed by the Governor shall be primary consumers of mental health services. One of the members jointly appointed by the President of the Senate and the Speaker of the House of Representatives and one of the members appointed by the Governor shall be secondary consumers of mental health services.~~ At least 25% of the members of the commission must be primary consumers of mental health services. A total of at least 51% of the members must be those consumers or members of

natural support systems of consumers. In making these appointments to the commission, the Governor shall appoint at least 7 consumer representatives, the President of the Senate and the Speaker of the House of Represenatatives shall appoint at least 5 consumer representatives and the Governor, the President of the Senate and the Speaker of the House of Representatives shall consider and appoint residents of the State who have a knowledge of problems facing persons ~~with~~ affected by mental illness in the State and who provide leadership in programs or activities ~~which~~ that are carried out to improve opportunities for persons ~~with~~ affected by mental illness. The Governor shall select a person from among the first appointees to serve as chair. Subsequent chairs ~~shall~~ must be selected by majority vote of the members of the Maine Commission on Mental Health. ~~The initial appointments to this commission shall be made within 30 days of the effective date of this subchapter.~~

Sec. A-25. 34-B MRSA c. 11 is enacted to read:

CHAPTER 11

MENTAL HEALTH ADVANCEMENT PROGRAM

§10001. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Board. "Board" means the Mental Health Advancement Program Board of Trustees.

2. Director. "Director" means the Director of the Mental Health Advancement Program.

3. Office. "Office" means the Mental Health Advancement Program Office.

4. Program. "Program" means the Mental Health Advancement Program.

§10002. Program established

The Mental Health Advancement Program is established as a body corporate and politic and a public instrumentality of the State. The exercise by the program of the powers conferred by this chapter are deemed to be the performance of essential governmental functions. The program consists of the board, the director's office and the facilities and program services authorized pursuant to this chapter.

§10003. Mission and goals

The basic mission of the program is to provide leadership in the development and implementation of high-quality clinical and related services for Maine citizens who are at high risk because of difficult and significant mental health problems, foster education and research as an integral part of those services, encourage and support the movement of services into Maine communities through joint planning with regional mental health boards established under this chapter and reduce, whenever possible, dependence on institutional care.

§10004. Tasks

The tasks of the program include, but are not limited to, the following.

1. Facilities. The program is responsible for state-operated or contracted public or private inpatient or outpatient facilities determined necessary for the treatment and rehabilitation of individuals affected by mental illness and requiring care in protected settings, including the Augusta Mental Health Institute, the Bangor Mental Health Institute, forensic services associated with those institutes and any successor facilities or programs.

A. The board shall assume all responsibilities for the Augusta Mental Health Institute and the Bangor Mental Health Institute formerly assigned to the commissioner, including, but not limited to, those contained in the consent decree issued on August 2, 1990 by the Superior Court, Kennebec County, Civil Action Docket 89-88.

B. The board shall develop plans for replacement of the Augusta Mental Health Institute and the Bangor Mental Health Institute with other facilities or contractual arrangements and submit those plans to the Governor and the Legislature by July 1, 1992. The plans must set a target date of December 31, 1997 for completion of replacements of the institutes. Any facility designed to replace the Augusta Mental Health Institute or the Bangor Mental Health Institute may not exceed 40 beds and any nursing unit in an inpatient facility may not exceed 20 beds.

C. The board shall develop plans for replacement of existing department forensic units and submit those plans to the Governor and the Legislature by July 1, 1992. The plans must set a target date of December 31, 1997 for implementation of forensic units and related psychiatric and psychosocial rehabilitation services.

D. In developing its facility service plans, the board shall work with the department, the Maine Commission on

Mental Health, the Mental Health Planning Council, regional mental health boards, the Department of Corrections, the Office of Substance Abuse, the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, the Department of Human Services and the Maine Health Policy Advisory Council.

2. Model programs. The program shall, through research, consultation and cooperative planning, using information derived from other national and state programs, anticipate special mental health service needs and develop, in consultation with regional mental health boards and other pertinent agencies, model programs to alleviate or solve identified problems and implement those programs directly or through regional agencies in the least restrictive settings possible. Model programs must include provisions for review and evaluation and for procedures to determine when programs should be modified or terminated.

3. Research and education. The program shall foster education and research in the facilities and programs for which it is responsible, working with and entering into cooperative arrangements with universities, medical schools, teaching hospitals and other institutions of higher education.

4. Cooperative programs. The program shall develop cooperative programs with communities and regions of the State, including, but not limited to, education for mental health personnel, other health and social service providers, consumers, natural support system members and the community at large. The program shall work with the department, the Maine Commission on Mental Health, the Mental Health Planning Council, the Office of Substance Abuse, the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, the Department of Human Services, the Maine Health Policy Advisory Council, regional mental health boards and public and private advocacy groups and providers.

§10005. Mental Health Advancement Program Board of Trustees

The Mental Health Advancement Program Board of Trustees, as established by Title 5, section 12004-G, subsection 28-A, is the policy-making authority of the program.

1. Membership. The board consists of 14 appointed voting members, one ex officio voting member, and 3 ex officio nonvoting members as follows:

A. Eight members appointed by the Governor from nominees submitted by regional mental health boards or, in their absence, by the Maine Commission on Mental Health and the Mental Health Planning Council;

B. Six members appointed by the Governor;

C. The commissioner who shall serve ex officio with vote;

D. The Commissioner of Human Services, or the commissioner's designee, who shall serve ex officio without vote;

E. The Commissioner of Corrections, or the commissioner's designee, who shall serve ex officio without vote; and

F. The Director of the Office of Substance Abuse, or the director's designee, who shall serve ex officio without vote.

At least 4 appointed members of the board must be primary consumers of mental health services and 4 must be family members of consumers of mental health services or members of other natural support systems.

2. Appointment; terms. Members of the board are appointed by the Governor to a 3-year term of office, subject to review by the joint standing committee of the Legislature having jurisdiction over mental health and mental retardation services and to confirmation by the Legislature. A classified or unclassified employee of the State or a person who holds elected state office may not serve on the board, with the exception of an ex officio member. Notwithstanding this subsection, of those first appointed to the board, 5 shall serve a 3-year term, 5 shall serve a 2-year term and 4 shall serve a one-year term. A member of the board may not serve more than 2 consecutive terms.

3. Vacancies. Vacancies on the board must be filled for the unexpired term only. A member shall serve until a successor is appointed and qualified.

4. Compensation. Members are entitled to compensation according to Title 5, chapter 379.

5. Officers. From among the appointed members, the board shall elect a chair and vice-chair. The term for the chair and vice-chair must be established in the bylaws adopted by the board.

6. Meetings. The board shall meet at least 10 times a year and at the call of the chair or at the request of a majority of the members.

7. Quorum. A quorum consists of a majority of the members of the board. An action may not be taken without the affirmative vote of 8 members present and voting.

8. Secretary. The director shall serve as secretary of the board.

§10006. Duties and powers of the board

The powers and duties of the board include the following. The board:

1. Policies. Shall develop and adopt policies for the operation of the program, the director's office and the facilities or services under the jurisdiction of the board and approve programs and policies recommended by the director;

2. Administration. Shall oversee the administration of the program;

3. Bylaws and seal. Shall develop and adopt bylaws for the regulation of its affairs and the conduct of its business and develop and adopt an official seal and alter it as necessary or convenient;

4. Budget development. Shall prepare and adopt a biennial, line-category, operating budget for presentation to the Governor and the Legislature, incorporating all projected expenditures and all resources expected or proposed to be made available to fund the operations of the program. The budget must be used in support of any requests to the Legislature for General Fund appropriations that the board determines appropriate and necessary to supplement other resources available to the program and serve as the foundation for an annual fiscal management plan for the program;

5. Fiscal management. Shall receive, expend, allocate and transfer funds within the program, as necessary to fulfill the purposes of this chapter, in accordance with the biennial, line-category, operating budget. Cumulative transfers between line categories in excess of 10% of either the sending or the receiving category of the operating budget must be reported to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and to the joint standing committee of the Legislature having jurisdiction over mental health and mental retardation programs prior to becoming effective;

6. Receipt of loans, grants, contributions and gifts. May receive loans, grants and gifts that the board determines appropriate and necessary to carry out the purposes of this chapter, subject to the conditions upon which the loans, grants, contributions and gifts are made, including, but not limited to, loans, grants, contributions or gifts from any federal agency or governmental subdivision of the State and its agencies;

7. Fees, reimbursements and charges. May establish and collect fees, reimbursements and charges for the use of program

facilities and services, as determined necessary by the board for the efficient administration of this chapter and consistent with the mission of the program, to be credited to a separate fund and used for the purposes of this chapter;

8. Investments. Except as otherwise provided in this chapter, may invest any funds not needed for immediate use, including any funds held in reserve, in any property and securities in which fiduciaries in the State may legally invest funds;

9. Contracts and agreements. May enter into any contracts, leases and agreements and any other instruments and arrangements necessary, incidental or convenient to the performance of its duties and the execution of its powers under this chapter;

10. Legal affairs. May sue and be sued in its own name. Services of process in any action must be made by service upon the director, either in hand or by leaving a copy of the process at the Mental Health Advancement Program Office;

11. Personnel policies. Shall develop and adopt personnel policies and procedures for the program. The board, subject to applicable collective bargaining agreements, shall determine the qualifications, duties and compensation of its employees and allocate and transfer personnel within the system as necessary to fulfill the purposes of this chapter. The board shall appoint the director and the chief operating officers of any facilities under the jurisdiction of the board. The provisions of the Civil Service Law, as defined by Title 5, section 7039, do not apply to the program;

12. Purchasing. May acquire consumable supplies, materials and incidental services through cash purchases, sole-source purchase orders, bids or contracts as necessary or convenient to fulfill the purposes of this chapter;

13. Property management. May acquire, in addition to Augusta Mental Health Institute and Bangor Mental Health Institute property, lands, buildings, structures, facilities and equipment, which are hereby transferred to the board for use under this chapter, by purchase, gift, lease or rent, any property, lands, buildings, structures, facilities or equipment necessary to fulfill the purposes of this chapter. The board shall manage, rent, lease, sell and dispose of property, including lands, buildings, structures, equipment and facilities. If the board proposes to sell or permanently transfer any interest in real estate, the transaction must be approved by the Legislature before the interest is transferred. Any revenues derived from these uses must be credited to a separate fund to be used for the purposes of this chapter;

14. Facilities; construction and renovation. May authorize the construction, maintenance, renovation, reconstruction or other necessary improvements on buildings, structures and facilities;

15. Research and education. May authorize clinical research and education programs necessary to fulfill the purposes of this chapter and enter into cooperative agreements or contracts with other state agencies and with federal agencies, private hospitals, the University of Maine System, the Maine Technical College System, other universities and colleges, medical schools, and other institutions or agencies to implement this subsection;

16. Delegation; other powers. May delegate duties and responsibilities as necessary for the efficient operation of this chapter and take actions necessary or convenient to carry out the powers expressly granted or reasonably implied in this chapter; and

17. Advisory committees. May appoint or identify advisory committees to advise the board concerning policies and programs, procedures for modifying the program to meet the needs of individuals affected by mental illness and at high risk and the efficient operation of the program and the program office. These committees may include, but need not be limited to, the Maine Commission on Mental Health, the Mental Health Planning Council, the Maine Health Policy Advisory Council, the Maine Council on Alcohol and Drug Abuse Prevention and Treatment and any regional boards and committees appointed pursuant to this chapter.

§10008. Director of the Mental Health Advancement Program

The board shall appoint the Director of the Mental Health Advancement Program who must be qualified by education and experience and shall serve at the pleasure of the board.

§10009. Powers and duties of the director

The director shall implement the policies of the board and is responsible for the operation of the program. The powers and duties of the director include the following. The director:

1. Leadership. Shall develop policies, procedures, goals and objectives with respect to operation of the program, to be approved by the board. The director shall meet regularly with a staff council to develop these policies and goals;

2. Staff appointment. Under procedures and standards developed by the board, shall appoint the staff of the Mental Health Advancement Program Office, including, but not limited to, professional and nonprofessional personnel, private legal counsel and financial experts;

3. Nomination of chief operating officers. Shall nominate chief operating officers of program facilities for appointment by the board;

4. Staff oversight. Shall oversee the staff of the Mental Health Advancement Program Office and the chief operating officers of the program facilities;

5. Personnel evaluation. Under policies and standards developed by the board, shall evaluate the performance of the Mental Health Advancement Program Office staff and the chief operating officers of program facilities and make personnel recommendations to the board;

6. Budget preparation. Shall assist the board in the preparation of the biennial operating budget for the program, as provided in section 10006, subsection 4;

7. Accounting system and procedures. Shall provide an accounting system and procedures that identify all appropriations, allocations, income and revenues and the expenditures of each program facility, other programs and the Mental Health Advancement Program Office;

8. Long-range planning and research. In consultation with the staff council, regional mental health boards and such other advisory bodies as may be designated by the board, shall undertake long-range planning and research, including planning for new initiatives, contracts, construction, renovation and reconstruction projects, and report those findings and recommendations to the board;

9. Interfacility cooperation and coordination. May promote cooperation among the facilities and other programs of the program and prepare plans for approval by the board with respect to the coordination of programs, activities and personnel;

10. Interagency cooperation and communication. May promote cooperation and communication with the department, the Department of Human Services, the Department of Corrections and the Office of Substance Abuse, or their designees, and with the University of Maine System, the Maine Technical College System and private educational institutions;

11. Coordination with public and private sectors. May work closely with other state, regional and local agencies, advocacy organizations and service providers that have responsibilities for or an impact on mental health services, to promote consistent and coordinated policies, procedures and programs;

12. Delegated duties. Shall undertake other duties as delegated by the board;

13. Delegate responsibility. May delegate duties and responsibilities as necessary to administer this chapter; and

14. Fulfillment of mission and goals. Shall implement the mission and goals as set forth in section 10003.

§10010. Mental Health Advancement Program Office

The Mental Health Advancement Program Office shall implement the policies of the board and provide staff and technical assistance to each unit of the program and state-level coordination and leadership to the program.

§10011. Chief operating officers of facilities

The director shall nominate the chief operating officers of the program facilities for appointment by the board. The chief operating officers must be qualified by education and experience and shall serve at the pleasure of the board.

§10012. Powers and duties of chief operating officers of facilities

The chief operating officers shall implement the policies of the board and are responsible for the day-to-day operation of the program facilities, including, but not limited to, the Augusta Mental Health Institute and the Bangor Mental Health Institute or their successors. The powers and duties of the chief operating officers include the following. The chief operating officers:

1. Administration of facilities. Are responsible for the administration of the program facilities. The chief operating officers shall cooperate to provide the care and rehabilitation services that best meet the needs of consumers served by the facilities. The chief operating officers shall administer the facilities in a manner consistent with the mission and goals set forth in section 10003;

2. Facility staff appointment. Under procedures and standards developed by the board, shall appoint the staff of the facilities, including professional and nonprofessional personnel;

3. Staff oversight. Shall oversee the administrators, professional and nonprofessional staffs of the facilities;

4. Personnel evaluation. Under policies and standards developed by the board, shall evaluate the performance of the program facility administrators and staff and make personnel recommendations to the director of the program and the board; and

5. Assist in preparation of the budget. Shall assist the board and the director of the program in the preparation of the budget for the program. Each chief operating officer shall prepare a proposed line-item budget for the facility that the officer represents. A copy of the proposed budget for each facility must be provided to the board and the director for examination. Nothing in this subsection may be construed to mean that the chief operating officers have approval authority for the budgets of the facilities.

Sec. A-26. Effective date. This Part takes effect January 1, 1992.

PART B

Sec. B-1. Mental health program; persons accused or convicted of crimes. Upon the effective date of this Part, the Department of Mental Health and Mental Retardation shall initiate a concentrated planning effort directed at development of recommendations for a combined program aimed at a meaningful and effective mental health program for those accused or convicted of crimes. The department shall be the lead agency for this planning effort and shall use the Mental Health Planning Council, consumers of mental health services and representatives from the Department of Corrections, the Department of Human Services, the Department of Public Safety, the Office of Substance Abuse, the courts and the Department of the Attorney General. The department shall submit a report and recommendations to the Legislature no later than December 31, 1991.

Sec. B-2. Task Force on Community-based Services; Department of Mental Health and Mental Retardation. The Department of Mental Health and Mental Retardation shall establish, no later than September 1, 1991, the Task Force on Community-based Services. The task force consists of representatives of consumers of mental health services, mental health services provider associations, insurers and others knowledgeable about substance abuse, acute inpatient care, long term care, ambulatory care and mental illness. The task force consists of no more than 10 members, named by the Chair of the Maine Commission on Mental Health. At least 51% of the members must be consumers of mental health services or members of natural support systems of consumers. No more than 4 members may be providers of services. The Executive Director of the Maine Health Care Finance Commission, the Director of the Office of Substance Abuse, the Commissioner of Mental Health and Mental Retardation or the commissioner's designee and the Commissioner of Human Services or the commissioner's designee shall serve as ex officio members without vote.

The task force shall design funding mechanisms to provide incentives for community-based voluntary and involuntary inpatient services for acutely and chronically mentally ill persons and disincentives for refusing services to this population of consumers. The task force shall address the issue of reimbursement for mental health services provided to older individuals and others with chronic physical problems in facilities or programs established primarily for residential or physical care and support and develop recommendations for comprehensive and holistic grants, contracts and reimbursement policies. The task force shall make recommendations for resolving the turf battles and reimbursement policies that contribute to the fragmentation of service delivery. The task force shall work closely with subregional and regional mental health planning and governance organizations in the preparation of its report, which must be submitted to the Governor, the Legislature and the Maine Commission on Mental Health no later than August 31, 1992. The task force shall consider and make recommendations about which mental health services and providers should be reimbursable, including the compensation of family members for the care they provide. The purposes of the task force are: to increase the available options for acute, voluntary and involuntary mental health services in the community; to decrease the focus on centralized state-provided involuntary mental health services; to broaden the definition of types of professional and paraprofessionals that are qualified and suitable for providing mental health services and that are reimbursable under state and private programs; and to tie state funding of services to consumer needs, not to service providers.

Sec. B-3. Task Force on Barriers to Mental Health Services; Maine Commission on Mental Health. The Maine Commission on Mental Health shall establish the Task Force on Barriers to Mental Health Services no later than September 1, 1991. The task force consists of consumers of mental health services, advocates for those consumers, family and natural support system members, community leaders and representatives of health, mental health and social service providers and consists of no more than 10 members, named by the Chair of the Maine Commission on Mental Health. The members must have expertise in problems and program requirements associated with substance abuse, stigma, housing, rehabilitation, employment and mental health.

The task force shall evaluate barriers to the provision of appropriate housing and other essential services for persons affected by mental illness or with mental health needs. The task force shall work closely with local and regional mental health planning and governance organizations. The task force shall develop recommendations for the elimination of noneconomic and economic barriers to services for persons affected by acute and chronic mental illness. At least 51% of the members must represent consumers of mental health services or other natural support systems of consumers. The task force shall submit its

report no later than August 31, 1992, to the Legislature, the Commissioner of Mental Health and Mental Retardation and the Governor.

Sec. B-4. Task Force on Regional Structure; Department of Mental Health and Mental Retardation. The Department of Mental Health and Mental Retardation shall establish the Task Force on Regional Structure. The task force consists of no more than 10 members named by the Commissioner of Mental Health and Mental Retardation. Members must reflect a broad geographic and constituency base including providers, consumers of mental health services, family members, community leaders and representatives from the Department of Human Services and the Office of Substance Abuse. At least 51% of the members must be consumers of mental health services or members of natural support systems of consumers. All members must be appointed by August 1, 1991. The task force shall work closely with the Maine Commission on Mental Health, the Mental Health Planning Council and participants in planning meetings called by the Commissioner of Mental Health and Mental Retardation to make recommendations for legislation establishing regional and subregional mental health boards, including geographic designations, scope of responsibilities and accountability, governing board membership requirements and the coordination of regional structures that are the same across government. The following issues must be considered by the task force:

1. Geographic region designations for regional and subregional mental health boards, including considerations of compatibility with other human service regions, population base, service resource base and transportation needs;

2. Scope of responsibilities and requirements for accountability of the boards, including considerations of planning for mental health services at local, regional and statewide levels; provision of community support worker and ombudsman services; prohibition of direct mental health services; and service monitoring, evaluation and reporting;

3. Governing board membership, including requirements that at least 51% of the total membership of such boards and any committees created by such boards be consumers of mental health services and natural support system members, with a minimum of 25% of the total membership being primary consumers, and including consideration of broad membership that also involves community leaders, mental health, health and social service providers, educators and department representatives; and

4. Integration of the responsibilities of the Office of Community Support Systems into the proposed regional structures system.

The task force shall issue its report no later than August 31, 1992 to the Legislature, the Commissioner of Mental Health and Mental Retardation and the Governor.

Sec. B-5. Task Force on Abuse; Maine Health Policy Advisory Council. The Maine Health Policy Advisory Council shall establish, coordinate and staff the Task Force on Abuse. The task force consists of 12 members as follows: a representative from the Department of Mental Health and Mental Retardation, named by the commissioner; a representative of the Department of Human Services, named by the commissioner; a representative from the Department of Corrections, named by the commissioner; a representative from the Office of Substance Abuse, named by the director; a member from the Maine Council on Alcohol and Drug Abuse Prevention and Treatment; a representative from the court system, named by the Chief Justice of the Supreme Judicial Court; 3 members named by the Governor representing the Mental Health Planning Council, the Maine Commission on Mental Health and providers of family intervention services; and 3 members named jointly by the President of the Senate and the Speaker of the House of Representatives representing victims of sexual abuse, victims of family violence and advocates for these populations. These appointments must be made no later than 15 days following the effective date of this Act.

The task force shall examine the existing system designed to detect, treat and prevent sexual, physical and emotional abuse and make recommendations on how to best bring effective treatment to victims and perpetrators and how to intervene in the cycle of abuse and the development of emotional and mental health difficulties. The task force shall develop a concentrated, comprehensive and coordinated program of detection, intervention, counseling, treatment, correction and rehabilitation for victims and perpetrators. The task force shall investigate the actions other states have taken to provide comprehensive services to those affected by or perpetrating abuse. The task force shall make recommendations for statutory change with particular focus on the laws related to child abuse detection, intervention, prosecution and treatment. Consideration must be given to coordinating the mental health services offered by the Department of Mental Health and Mental Retardation and the Office of Substance Abuse with the child protective services offered by the Department of Human Services. The task force shall make specific recommendations for the reorganization of state efforts through consolidation or enhanced coordination of resources and activities, including measures to strengthen the role of the Office of Substance Abuse as the coordinating agency for substance abuse programs. The task force shall convene no later than 30 days after the effective date of this Act and shall issue its final report and any statutory recommendations to the Legislature, the Maine Commission on Mental Health, the Governor

and other appropriate advisory and oversight committees and organizations no later than February 15, 1992.

Sec. B-6. Task Force on Coordination of Services; the Office of Substance Abuse. The Office of Substance Abuse shall establish the Task Force on Coordination of Services no later than August 1, 1991. The task force consists of no more than 10 members as follows: a representative from the Office of Substance Abuse, a representative from the Department of Mental Health and Mental Retardation, a representative from the Department of Corrections and a representative from the Department of Human Services named by their respective commissioners. Departmental appointees are ex officio, nonvoting members. The Chair of the Maine Council on Alcohol and Drug Abuse Prevention and Treatment shall name 6 members who must include recovering substance abusers, representatives of provider associations and others familiar with and knowledgeable about the provision of services to those with substance abuse or mental health needs.

The task force shall convene no later than September 1, 1991 and evaluate measures to ensure appropriate levels of cross-disciplinary knowledge in senior leadership or consulting positions in management and training in mental health and substance abuse programs provided by or funded by the state. The task force shall develop a plan for integrated service delivery for individuals with coexisting substance abuse problems and mental health needs including collaboration and coordination at the regional level and the reduction of barriers to the provision of integrated services which are appropriate to the needs of consumers. As part of its deliberations, the task force shall consider the development of regulatory and statutory reimbursement structures that eliminate the current lack of interdisciplinary coordination and the provision of services that respond to the many and varied needs of consumers with multiple problems. The task force shall consult with regional councils and boards involved in substance abuse or mental health planning and oversight. The task force shall issue a final report, including statutory recommendations, no later than February 1, 1992.

Sec. B-7. Task Force on Mental Health Education and Licensure; the University of Maine System. The Chancellor of the University of Maine System shall establish, organize and staff the Task Force on Mental Health Education and Licensure. The task force consists of the following members: representatives of each of the campuses of the University of Maine System knowledgeable about mental health and related educational programs and student services, named by the chancellor; a representative of the Maine Technical College System, named by the president of the system; a representative of the University of New England knowledgeable about mental health

and related educational programs, named by its president; and a representative from each of Maine's mental health licensing boards, including social workers, substance abuse counselors, professional counselors, psychologists, psychiatrists and others determined appropriate named by their chairs. The chancellor shall include representatives from associate degree programs, bachelor degree programs and graduate degree programs in making appointments. A representative from the Department of Mental Health and Mental Retardation, the Office of Substance Abuse and the Department of Human Services must be named by their respective commissioners and shall serve ex officio without vote. At least 4 members must be consumers of substance abuse services, mental health services or both.

The task force shall develop recommendations for basic interdisciplinary continuing education and training programs for Maine mental health and substance abuse professionals; recommended interdisciplinary knowledge qualifications for individuals who may be employed as staff or key consultants in key leadership or training positions in mental health and substance abuse programs; and requirements for interdisciplinary continuing education, licensure and service support in State provided or funded mental health and substance abuse programs. The task force shall convene no later than August 1, 1991 and issue its final report, with statutory recommendations, no later than February 1, 1992 to the Governor, the Legislature and the advisory boards and commissions with jurisdiction over substance abuse and mental health.

Sec. B-8. Resources utilized by task forces. The task forces established by this Act must be established, staffed and their work completed within the existing resources of the agencies charged with their operation.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved, except as otherwise indicated.

STATEMENT OF FACT

This bill clarifies the role and responsibilities of the Department of Mental Health and Mental Retardation, adds a provision defining the principles guiding the department and includes other recommendations made by the Systems Assessment Commission.