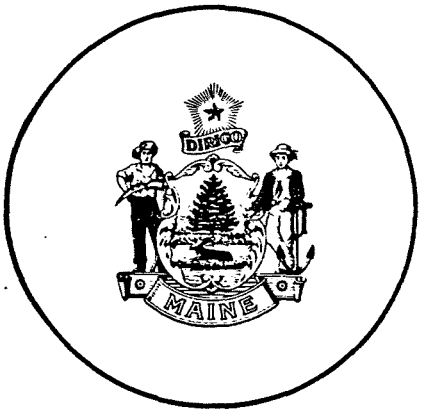
MENTAL HEALTH SERVICES IN MAINE: A SYSTEMS APPROACH TO REDUCE OVERCROWDING AT AMHI AND BMHI



Maine Department of Mental Health and Mental Retardation

John R. McKernan, Jr.
Governor

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JULY, 1988

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EXHIBITS

INTRODUCTION

Mental Health Services in the State of Maine, Summer 1988, exist unevenly. That is, depending on an individual's problem type and place of residence, they could well experience frustration in locating the needed service. The situation is particularly dire for people with long term and severe mental illness and their families. Maine HAS NEVER SYSTEMATICALLY built and maintained services for people with long term mental illness, despite actively moving people out of the state hospitals during the early 1970's. In a nutshell, mental health policy itself has developed unevenly, not according to either a short, mid-range, or long-term plan.

Federal mental health policy developed in the mid to late 1960's has driven service development in Maine. Specifically, the Comprehensive Community Mental Health Centers Act (CCMHCA) carved each state into "catchment areas" determined by population and mandated the provision of a large service menu. Typically, the amount of service dollars did not match the menu requirements. Reduction of the Augusta Mental Health Institute and the Bangor Mental Health Institutes' census from 2,600 adults to 900 in 1974 occurred despite the fact that community services adequate to the delivery challenge had not been created. They still have not. Service development in the community has played catch up since the mid-seventies. One of the most visible and pressing signs of the community's services' failure to catch up, is the increasing number of people going into the institutes.

The realization by the Federal Government that, indeed, the mandated services called for in the late sixties had never materialized was well and loudly documented by the Government Accounting Office's report on deinstitutionalization titled Returning the Mentally Disabled to the Community: Government Needs To Do More. The significant findings of that report:

1) A fragmented and unclear responsiblity for community coordination and services for people with psychiatric disabilities.

2) A lack of coordination and support at the administrative level for state and local agencies providing services.

3) Inadequate financing for needed community services and supports.

4) Poor planning and implementation of an individual's move from hospital to community.

Response at the Federal level included the National Institute' of Mental Health's building of the Community Support Program with its attendant development grants designed to assist states in developing needed services. Maine in 1978 recognized itself in that description, and applied for an NIMH Community Support Program Grant which envisioned a regionally organized community system with a State of Maine Department of Mental Health and Mental Retardation presence at the local level. The REAL contributions of five plus years of federal funding were:

1) The development of family and consumer support and advocacy groups.
2) The development of new community rehabilitation programs.
3) The acknowledgement by the Department of Mental Health and Mental Retariation that adults with severe and disabling mental illness were the highest priority for services and new resources.

Maine has never embarked upon comprenensive development of mental health services incorporating systems thinking that acknowledged the roles of the AMHI and BMHI, the interplay of community services and the institutions, the relationship of institutionally-based staff with community agency staff, the role of families of people with long term and severe mental illness in the care and treatment of their members, and relationships of general hospitals (private sector) with the publicly-supported inpatient facilities. In order to responsibly and comprehensively map out a service development and maintenance strategy, the Department began a year-long planning effort in July 1987. The task is to assess what works, evaluate the function, in light of stated and unstated need, and determine the location of deficiencies.

THIS DOCUMENT IS A PROPOSAL OUTLINING HOW THE STATE OF MAINE COULD BEGIN TO SYSTEMATICALLY ADDRESS THOSE DEFICIENCIES.

Other cues from outside the Department of Mental Health and Mental Retardation reinforce the need to plan comprehensively. The Federal government and the State of Maine each passed a statute which stipulated that comprehensive planning should occur. Further, the Maine State Legislature established a Commission to Study Overcrowding Existing at BMHI and AMHI. Since 1984, AMHI has been adding nearly two patients per month to its base population; at the close of fiscal year 1988, it will have admitted an all-time record number of patients. Adding to the pressure is the fact that the Veteran's Administration Hospital (Togus), located in proximity to Augusta, closed off a thirty bed ward to potential patients showing acute symptoms. AMHI must pick up the slack created by this June, 1988, administrative action.

BMHI's problems with overcrowding may also be viewed as 1) too many patients - or potential patients - asking for inpatient services; or 2) too few staff to handle the demand. Either perspective results from a paucity of services strategically located in communities across Maine. The increased patient load has created a shortage of staff in the medical, therapeutic, clerical, and housekeeping areas. THE ULTIMATE RESULT OF SUCH SHORTAGES IS THAT PATIENTS ARE INADEQUATELY PREPARED FOR THE TRANSITION TO LIVING IN THE COMMUNITY.

Different regions throughout the State have developed their community services to greater and lesser degrees, mirroring the patchwork policy development described earlier. Components in a service system must be developed consistently to insure that:

1) Each psychiatrically disabled person in the State of Maine can have access to the appropriate treatment, support and rehabilitation.

2) Each person's treatment will be determined based on the need of the individual, and not limited by inadequate service capacity.

3) Each psychiatrically disabled person can receive the appropriate support and rehabilitation, wherever possible, within his/her community, in order to maximize their potential for becomming fully functioning citizens as quickly as possible.

Clearly, what is needed for Maine's mental health future is a true systems approach to both build and maintain services. What is needed today is an immediate correction of the various imbalances in our institutions and in the community to serve the present needs of Maine citizens.

CONCEPTUAL MODEL FOR THE SERVICE SYSTEM

The overriding goal of an effective mental health system is to make services and supports available and accessible to a person while encouraging or maintaining independence and a decent quality of life. While this does not preclude needed periods of in patient care, it minimizes unnecessary hospitalizations by assuring timely and appropriate interventions and efforts to provide needed basic supports.

There are four rather discrete functions in a community system for persons with psychiatric disabilities. The interaction of these four functions and their complementary components determine the degree to which psychiatrically disabled men and women can achieve and maintain an adequate quality of life. Exhibit A illustrates the relationship of these functions and signifies that an effective system of services and supports for rehabilitation and treatment is person-centered, is consistent and comprehensive and provides long term continuity of care.

Exhibit B charts the key functions. They are:

1) Integrating Services
2) Basic Supports Services
3) Treatment Services
4) Rehabilitation Services

It also lists the specific components which are essential parts of a complete and effective system. This model, developed in 1986 by DeSisto and Ridgway, and copyrighted by DMH&MR lends itself to a range of organizational structures and program designs. In Maine, local systems have developed very differently from one another, a few have nearly all the components, many have great gaps. The recent comprehensive planning process undertaken by the Department in conjunction with the Governor's Mental Health Advisory Council began with assessments by local teams of the systems across the state to compare what is in place with the ideal comprehensive mental health system to "meet the needs of psychiatrically disabled persons for treatment, support and rehabilitation." (Bureau of MH, 1986, Ridgway and DeSisto.)

This process has resulted in an extensive picture of what specifically is needed to build a mental health system across the state.

As part of this process, the Subcommittee on Persons with Severe and Prolonged Mental Illness has completed an initial review of the work of eight regional Local System Assessment and Planning Teams. They sought to derive statewide priorities and themes consistent across the eight mental health service areas. One major theme was the need to specify responsibility for services to people with mental illness. This translates into a designation of a lead agency for integrating services, ie. case management. The clearly articulated need was for a local entity to have authority and adequate resources to perform the full range of integrating functions so that persons with mental illness can be linked and maintained in needed services and supports. This need was echoed in the 10 public forums held through out the state during the month of May 1988.

The Subcommittee also synthesized the 80+ priorities from the 8 Local Teams into nine statewide priorities for service system development. Following is a list with definitions of these. Within these nine areas, the specific local system needs will be expressed in the Action Plans being developed by the Subcommittee.

In addition, workforce development strategies were highlighted as key ways to bring existing services to functional capacity and guide the creation of new services. These strategies include staff development and training, clearer standards for performance and supervision, and competitive salary scales for community providers.

To support the designation of single focus of local responsibility for integrating services and system coordination, the Subcommittee identified a need for local quality assurance and system monitoring linked to a state level process for accountability for service delivery.

Much of what is characterized as functions and components in the exhibits translate in practice to programs and facilities. Implicit in the model is the designation of responsibility for integrating services on a client level. This single focus assures that each person with mental illness has the best opportunities to use supports and services as needed, while on the systems level the designated entity is responsible for assuring the delivery and coordination of all services and opportunities for all persons with severe and disabling mental illness in the local system.

Exhibit A

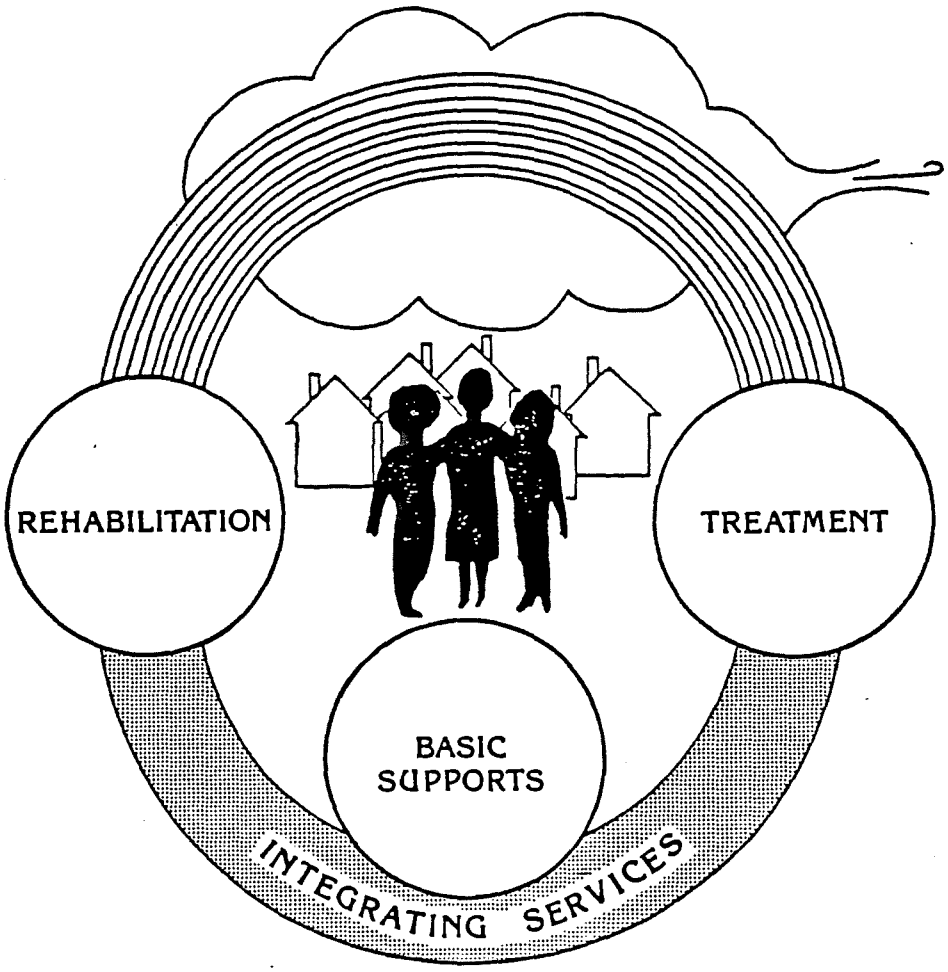
REHABILITATION
TREATMENT
BASIC SUPPORTS
INTEGRATING SERVICES

Exhibit B

FUNCTIONS IN A COMMUNITY SYSTEM FOR PERSONS WITH PSYCHIATRIC DIFFICULTIES

INTEGRATING FUNCTIONS

- OUTREACH AND CASEFINDING
- COMPREHENSIVE INDIVIDUALIZED ASSESSMENT
- COMPREHENSIVE INDIVIDUALIZED PLANNING
- FACILITATING LINKAGES, COORDINATION AND ADVOCACY
- MODIFYING AND CREATING RESOURCES AND SUPPORTS
- TRANSPORTATION
- MONITORING, EVALUATING, REASSESSING, REVISING
- MEETING SPECIAL NEEDS

BASIC SUPPORT FUNCTIONS

- INCOME AND ENTITLEMENTS
- HOUSING
- SUPPORTIVE CARE AND SUPERVISION
- RIGHTS PROTECTION

TREATMENT FUNCTIONS

- PSYCHIATRIC ASSESSMENT AND MEDICATION
- PSYCHOTHERAPEUTIC SERVICES
- CRISIS SERVICES
- DRUG AND ALCOHOL SERVICES
- HEALTH CARE SERVICES

REHABILITATION FUNCTIONS

- DAILY LIVING SKILLS DEVELOPMENT
- SOCIAL SKILLS DEVELOPMENT
- VOCATIONAL AND EDUCATION SERVICES
- SOCIAL SUPPORT NETWORK DEVELOPMENT
- SOCIAL AND RECREATIONAL ACTIVITIES
- PUBLIC INVOLVEMENT AND EDUCATION

THE PLANNING PROCESS

The Department of Mental Health and Mental Retardation has, since July of 1987, moved forward dramatically and involved hundreds of Maine citizens in a broad based participatory process to assess the community system of mental health care and plan for the needed future developments. Unlike years past when planning meant documenting current activities and receiving comments from the public, the Department is inviting interested and involved individual citizens to help it chart the course and transform the plan into a new and vital service system.

Encouraged and empowered by recent state and federal legislation, the Governor and the Department along with the Mental Health Advisory Council have established a mechanism to 1) look comprehensively at the full range of mental health service needs in Maine and 2) develop a state level action plan to create a coordinated community based service system. The Mental Health Advisory council designated a Plan Development Committee nearly a year ago to organize and implement efforts. To do this, they have formed eight subcommittees focusing on different mental health population groups.

The Subcommittee on Persons with Severe and Prolonged Mental Illness and its eight Local System Assessment and Planning Teams (LSAPTS) began its work in August of 1987. Since that time, nearly 1,250 different people have been involved directly as part of the process to assess the system and put together an Action Plan. In addition to people with mental illness and their families, these 1,250 people comprised a variety of interests. These include:

local agency providers;
private practitioners;
other state agency staff;
local government officials;
nursing and boarding home personnel;
health care providers;
state legislators;
law enforcement.

The 11 member Subcommittee is comprised of four major constituencies. These are:

1) Consumers of mental health services;
2) Families of persons with mental illness;
3) Providers of mental health services, and
4) Mental Health Advisory Council Members.

The subcommittee is staffed by the Bureau of Mental Health's Office of Community Support Systems. The membership of the core LSAPTS mirrors the Subcommittee and includes other interested persons. The regional efforts were chaired by local providers or family members and staffed in five instances by local BMH/OCSS staff, in the remaining instances by CMHC staff, Maine Council of Community Mental Health Services staff, or Maine State Alliance for the Mentally Ill staff.

Each LSAPT each completed a four stage process, culminating in a System Assessment and Plan tailored to their region. The process included:

1st Stage - Assessment of the existing service system using the Community Systems Workbook as a tool.

2nd Stage - Development of a "Service System Description" of what is and is not in place. The initial draft of this was developed by the core Local Team and widely disseminated for review and comment. Comments were incorporated in the final draft.

3rd Stage - Determination of the ten highest priorities for service system development. These were identified through the use of data gathered from a survey sent to a wide range of people. The survey asked them to rank 60 - 80 service need statements draw from the assessment and service system description.

4th Stage - Development of an Action Plan. Each of the highest ranked priority needs was addressed by the core team and an action plan involving several levels of community participation was developed.

The products of all four stages of the eight LSAPTS were submitted to the Subcommittee for review. The Subcommittee on Persons with Severe and Prolonged Mental Illness has used these results to formulate statewide priorities for service system development (Exhibit C). The Plan Development Committee has used these priorities and the work of the other seven Subcommittees to craft priorities for a state level action plan based on a coordinated community service system for all mental health population groups. Exhibit D demonstrates the array of Subcommittees, their relationship to the Council and the Department.

As a counterpoint to this planning process, during the month of May 1988, the Department hosted mental health forums in ten locations across the state from Presque Isle to Sanford, Waterville to Rockland. Nearly 700 people to heard reports from the Subcommittees, made their comments, and shared their perspectives. Key Departmental staff, Mental Health Advisory Council Members, and Subcommittee representatives were available to hear public response to planning initiatives and additional unique local service system service problems. The results of these forums have been compiled and made available to the planning groups.

EXHIBIT C

STATEWIDE PRIORITIES FOR PERSONS WITH
PROLONGED AND SEVERE MENTAL ILLNESS

1. Case Management Services - In the community systems workbook these are called Integrating Services those services that bring psychiatrically disabled people into contact with the helping system and provide comprehensive assessment and planning, linkage to other services, resource development, and long-term monitoring and continuity of care. Integrating services coordinate the other three service areas: basic supports, treatment services, and rehabilitation services.

2. Development of a range of specified community residential programs - The CSW views housing as a basic support. A stable living environment with services that match a persons skills, resources, and goal is essential for successful treatment and rehabilitation. Adequate supportive care and supervision throughout the range of residential options are key elements.

3. Funding to assure the availability of an adequate range of professional services. The CSW section on treatment services refer to those services and supports which aid a person with psychiatric disabilities to achieve and maintain health and to ameliorate the signs and symptoms of mental and physical illnesses. Treatment services include Psychiatric Assessment and Medication, psycho therapeutic services, crisis services, substance abuse services and health and dental care services.

4. Increase vocational rehabilitation services, including prevocational and supported employment. Rehabilitaiton Services are those services and supports intended to increase the psychiatrically disabled person's capacity for healthy personal, social, and vocational functioning. These services include daily living and social skills development, vocational and educational services, social support network development, social and recreational activities, and stigma reduction activities.

5. Improved access to transportation to services. An aspect of Integrating Services, transportation or the ability of an individual to get to where services are is a necessary component of a viable system.

6. Increased local inpatient capacity. Psychiatric inpatient care is a treatment service which the Workbook characterizes as an aspect of crisis services. Acute psychotic episodes may often be dealt with successfully in the local community with appropriate psychiatric services and a sheltered environment.

7. Increased funding for existing services. Current services across the four functions are adversely affected by funding levels that have not kept pace with market values. Quality of those programs now in place is hurt by long standing staff vacancies and the necessity to hire less experienced persons be cause of salary level. Staff turnover is increased when workers' years of employment do not result in increased salaries.

8. Increased accessibility of crisis intervention. Once again, a component treatment service, crisis intervention with a full range of functions can lead to fewer hospitalizations, more locally based care, and less disruption to a persons life. The function of crisis services include 24 hour/7 day telephone service, rapid face to face assessment, short term hospitalization, 24 hour/7 day outreach to homes, etc., short term supported/supervised housing, crisis counseling, and linkage to long term services and supports.

9. Increased advocacy and lobbying activities. These activities are represented in both basic supports and integrating services. It implies mobilization at all levels and among all constituencies to focus on the need for system improvement and the impact of human lives of the failure to make those improvements.

MAINE DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
MENTAL HEALTH PLANNING PROCESS

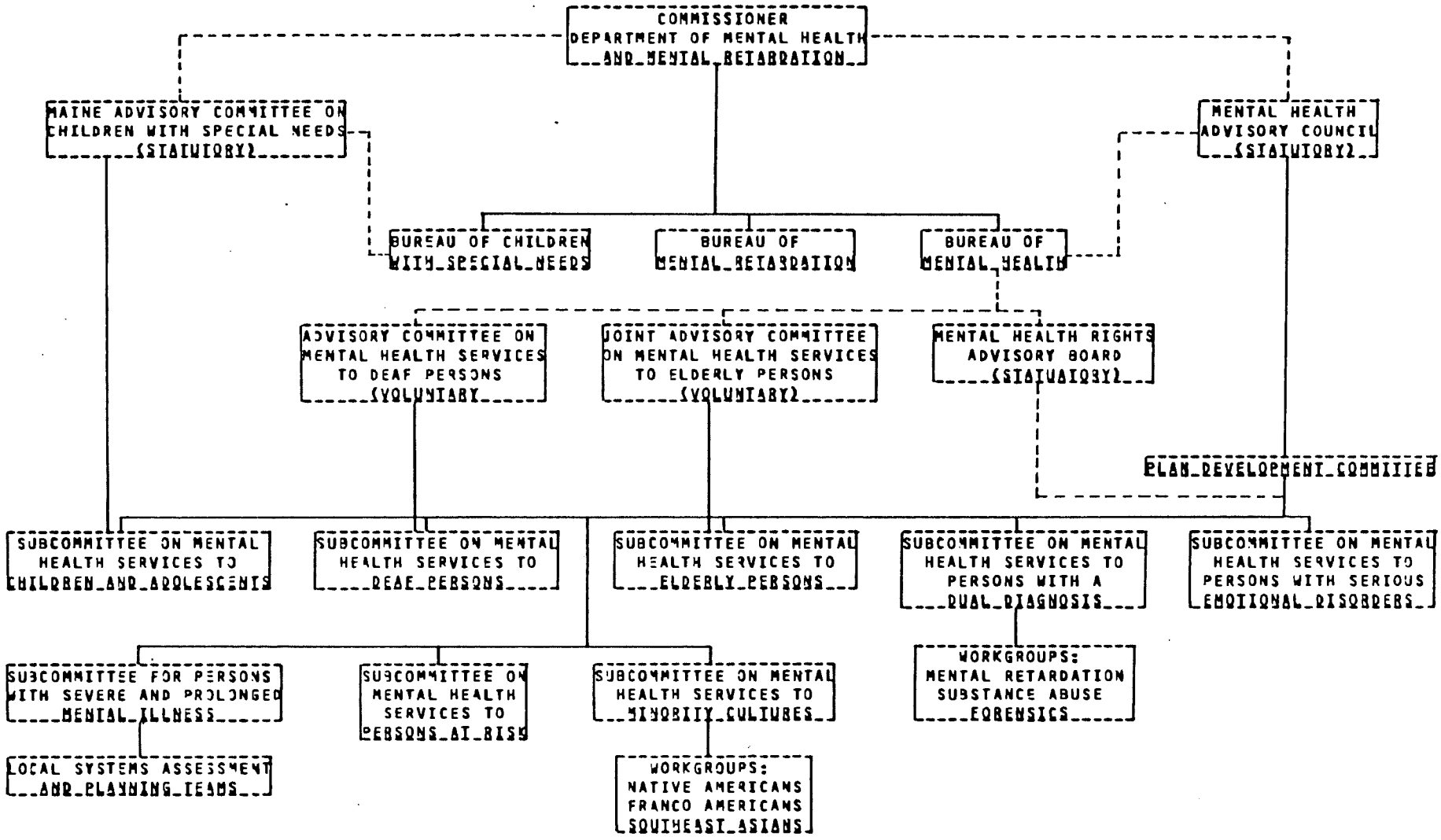

EXHIBIT D

THE PAST YEAR (8/87 - 8/88)

During the past year, the Department of Mental Health and Mental Retardation has made a concerted effort to place at the forefront of its efforts two major agenda items for the development of mental health in Maine. First, the establishment of a top quality planning effort that would systematically combine local and regional concerns raised by citizens with the professionalism of a technically proficient central planning department. Second, the construction of a comprehensive system approach to mental health services that would build on the unique strength of the various local communities in Maine and provide quality services for all Maine's citizens regardless of location.

These operational philosophies of planning and systems analysis have shaped the actual make-up and structure of the department itself. A new Commissioner and Bureau Director with extensive backgrounds in planning have already been hired; new director of planning and quality assurance are being interviewed. These steps combined with a new department structure to include an office of planning, quality assurance, program development and administrative fiscal control have set the pace for this past year.

Now is the time to build on these first steps and use the opportunity provided by the most extensive and comprehensive citizen planning effort in the history of the Department of Mental Health and Mental Retardation. Now is the time to implement the basics of a system of community mental health services.

As a first step, we have developed the following proposals to immediately address several deficiencies in our existing network of mental health care which directly impacts on the overcrowded conditions at AMHI and BMHI. In the biennial budget process, we will extend this process to reflect the entire state system of community mental health service needs through a five year plan.

HOW TO GET THERE

FROM HERE

How to Get There from Here

This proposal is a design for optimizing the availability of services in a variety of facilities in order to benefit all citizens in need of psychiatric care. Ultimately its intent is to provide quality care within a community structure which includes both inpatient and outpatient services. The operationalizing of such a process however, cannot occur overnight. The full implementation will take several years. How can we then bridge the period between the full implementation of a state plan (the future) and the dire circumstances we have determined exist right now (today)? Following are proposals for Today and Tomorrow, the Future will be proposed in the Department's Biennial Budget using the completed state plan prepared during this past year.

PROPOSALS FOR TODAY

AUGUSTA MENTAL HEALTH INSTITUTE

STAFFING RELIEF PROPOSAL

CURRENT STATUS

Since 1984, AMHI has been adding nearly two patients per month to its base population. Many of these patients are restricted to wards due to their acute mental disorders and with overcrowding, there is little physical or therapeutic space on the units. Medical staff are frequently in the position of covering as many as 50 to 60 patients while working in a context in which HCFA requires clear demonstration of medical leadership in directing treatment. Therapeutic Activity staff have been spread to cover evening and weekend programming. Direct care staff are extremely stressed due to the pure numbers of patients and resulting needs for overtime work (both voluntary and mandatory) and frequently direct care staff must be "floated" to provide adequate coverage on other areas in acute need. It is not uncommon for direct care staff to work several 16 hour stretches in a week. This severely compromises alertness and capacity to respond to crises.

Overwhelming demands are placed upon physicians, physician extenders, Therapeutic Activity staff, ward staff, clerical staff and staff in other areas due to the large numbers of patients who must be served, along with the medical record documentation needed.

We have been using extensive overtime (77 shifts hired for the weekend of June 17, 1988 - June 19, 1988) to provide safe coverage for all hospital areas. The overtime demands result from a combination of sheer numbers of patients plus those patients who require intensive levels of observation.

PROBLEM DEFINITION

The problem is that staffing in the physician, therapeutic activities, mental health worker, clerical and housekeeping areas is insufficient to manage the patient load with which AMHI is faced. Inability to provide the level of active treatment needed by both acutely and chronically ill individuals reduces the capacity to adequately prepare patients for transition to community living. Staff insufficiencies result in a focus on providing basic patient care, while active treatment suffers, as does medical record documentation.

PROPOSED ACTION

Fund additional staff in the following areas:

1. Psychiatry
2. Therapeutic Activities
3. Mental Health Workers
4. Nursing (RN/LPN)
5. Clerical
6. Housekeeping
7. Psychology
8. Pharmacy
9. Food Service

ANTICIPATED RESULTS

It is anticipated that additional staff will 1) improve active treatment measures; 2) relieve some of the overcrowding in three critical programming areas; 3) reduce stress; 4) provide more capacity to conduct vital quality of care audits to maximize compliance with JCAHO medical staff/Quality Assurance Standard; 5) enhance the ability to maintain Medicare reimbursement; and 6) better prepare patients for the transition to community living.

BANGOR MENTAL HEALTH INSTITUTE

INPATIENT NEEDS PROPOSAL

CURRENT STATUS

BMHI anticipates difficulty meeting accreditation and/or certification standards. BMHI has been cited for inadequate psychology coverage on the admissions ward which will be changed by the next review in February 1989. There is insufficient RN coverage in the admissions unit, minimum staffing standards for each ward Monday-Friday and safety only needs on weekends.

PROBLEM DEFINITION

Based on too few staff, inequities of the career ladder for Mental Health Workers, JCAHO standards for direct patient care, and Dietary and Sanitation, BMHI is in need of additional staff as soon as possible.

PROPOSED ACTION

BMHI needs to employ:

- additional RN's
- Mental Health Workers
- Physician III (Psychiatrist)
- Food Services Workers
- Custodial Worker I's

ANTICIPATED RESULTS

Bangor Mental Health Institute will be in compliance with Medicare and JCAHO standards pertaining to Psychiatric, Psychological, Nursing, Mental Health, Dietary and Sanitation needs.

BANGOR MENTAL HEALTH INSTITUTE

DAY HOSPITAL/OUTPATIENT SERVICE

CURRENT STATUS

The overcrowding phenomenon at BMHI continues to tax and stretch thin the resources available. Although BMHI has maintained a relatively constant number of beds over the past three years, the way they are used has changed dramatically. Patients are sent out on Trail Visit and Leave status earlier than previously and are maintained on an outpatient basis by the treating team. The average number of patients on leave from the Skills Learning Program has risen from nine in April 1986 to 28 in April 1988.

PROBLEM DEFINITION

A sample study undertaken in May 1987, revealed that nearly 200 (197) persons received outpatient services in one form or another from BMHI during that month. The services received are provided by all direct care and several ancillary service departments, thus compromising and diluting the direct service available to our inpatient population.

PROPOSED ACTION

Add an official outpatient/partial hospitalization component to the continuum of service offered at BMHI. The addition of 21 positions will provide a day hospital service for both the Adult Psychiatric Program and the Program on Aging and relieve the pressure ion inpatient providers.

ANTICIPATED RESULTS

- o A reconcentration of BMHI staff focus on the inpatient population
- o An increased ability to transfer people to community living situations while still providing sufficiently structured day programming.
- o A mechanism for ensuring medication compliance in community and prevent rehospitalization
- o Provision of focused transitional services to facilitate utilization of resources available in the community for those able to take advantage
- o a reduction in the inpatient census at BMHI

PROPOSALS FOR TOMORROW

COMPREHENSIVE COMMUNITY MENTAL HEALTH SYSTEM

INTENSIVE CASE MANAGEMENT

CURRENT STATUS

In most of the state, case management activities are performed in conjunction with other types of services, and usually are limited to coordination around a particular service such as residential programs or psychotherapy. No single agency/entity or worker is deemed as having responsibility for assuring the delivery and coordination of all necessary services and supports for BMH clients. The model, developed for the Cumberland County system and reflected in the Medicaid mental health case management rules, creates this single focus of responsibility. The program in the Portland area is operational, but due to initial problems with Medicaid reimbursement, it will not be at full capacity until FY '89. This model, however, embodies the key components which meets the needs defined by the Subcommittee on Persons with Severe and Prolonged Mental Illness and heard across the state at the Mental Health Community Forums.

PROBLEM DEFINITION

Many people with severe and disabling mental illness, especially those with a history of state hospitalization, have a complex and demanding array of needs for services and living supports. To effectively bring a very fragmented system to bear on behalf of a client is extremely challenging and time-consuming, and a full time job. While not every person who has mental illness requires what is often referred to as "intensive" case management, there are many that do. These persons often gravitate to the more populous urban areas where they have to compete against serious odds for housing, food, jobs, clothing, as well as treatment and rehabilitation services. Failure to access any of these things can precipitate a crisis and lead directly to hospitalization. There are currently over 560 identified clients, without intensive case management.

PROPOSED ACTION

- o Designate an agency in each of the most populous mental health regions to be responsible for client and system coordination across the array of service and supports. Areas where new case management agencies will be designated are: 1) York County, 2) Lewiston-Auburn, 3) Kennebec County, and 4) Bangor. In addition, services to Cumberland County will be increased.

- o Intensive Case Management agencies will provide comprehensive and intensive case management to persons with mental illness who have difficulty accessing services and supports and staying connected so that they can avoid unnecessary hospitalization. Focus will be on the population of people going into and coming out of AMHI and BMHI.

- o Build the staff capacity of those local entities to create a workable client/case manager ratio. This will be done by developing contracts with local providers, either directly or in a RFP, and using the Medicaid case management reimbursement option. The anticipated case load size will be 20-25 persons.

Numbers and Locations of Needed Intensive Case Managers

York County	4 ICMs
Cumberland County	4 ICMs
Lewiston-Auburn	5 ICMs
Kennebec County	4 ICMs
Bangor	4 ICMs

ANTICIPATED RESULTS

Intensive case management focuses on the most difficult clients, with the most complex problems. These are the people who make the most demands on the system. It is expected that this type of service will assist the client in getting what he/she needs to integrate more successfully into community living and avoid the external crisis situations which can lead to frequent hospitalizations. The number of admissions to AMHI and BMHI will be reduced by meeting people's needs more in their own community.

RESIDENTIAL PROGRAMS

CURRENT STATUS

The Bureau of Mental Health contracts for programs providing 130 residential beds in the community. This number represents residential programs of all types for adult mentally ill persons, from supported apartments to intensive group homes.

PROBLEM DEFINITION

The number of available community residential programs is seriously inadequate, and this inadequacy pervades all types of programs. The need for additional numbers and types of residential programs is supported by public testimony from the Department's ten community forums held in May of 1988. Forty-five persons at those forums expressed the need for more residential programs, and those needs were expressed in all areas of the state. Further, data from the Augusta and Bangor Mental Health Institutes suggest that a large number of patients could be placed in the community if appropriate residential services were available.

Although all types of programs are needed, there is a particularly pressing need, in light of institutional overcrowding, for intensive psychiatric group homes to provide community alternatives for persons who would otherwise remain for long periods of time in hospital. In addition to the overall scarcity of such residential programs, there is also a disparity in geographic availability of these resources, with there being in excess of 25 beds available in three service regions and none available in two regions.

PROPOSED ACTION

- Two intensive group homes will be developed in the Augusta Mental Health Institute service area. These programs will be expected to come on line in the winter and spring of 1989. The programs will provide secure residence, quality care, and active programming to our most severely ill clients. The homes will be placed in those areas where lack of residential alternatives impacts most heavily on admissions and readmissions to the Augusta Mental Health Institute. The homes will be designed with adequate resident staffing and intensive programming to assure care to adults with serious and persistent mental illness.

- Thirty supported, semi-independent living options will be established throughout the state. These programs will range from supported apartment living with minimal personal care services to congregate housing programs. The emphasis in these models will be on imported clinical and supportive services, rather than resident staffing.

- To provide necessary professional support for the development of the above programs, as well as to provide a firm basis for future residential program development, we will contract to secure experts in zoning law, real estate development, architecture, and residential programming.

ANTICIPATED RESULTS

The intensive group homes will serve 12 persons annually. These persons will be chosen directly out of AMHI, resulting in a direct bed reduction. The supported living programs will serve 30 persons annually after development. These programs will directly benefit some persons presently in the institutes, but they will also have a more indirect benefit in preventing recidivism among the population of chronically mentally ill adults in the community. Clients in supported living will receive intensive case management services to assure that they receive necessary treatment and supportive services in the community.

STAFF RETENTION, SALARY EQUITY, HUMAN RESOURCE DEVELOPMENT

CURRENT STATUS

Current salaries for clinical staff in mental health programs funded by the Bureau of Mental Health reflect historically low levels of compensation. There has been an unfortunate attitude that social service professionals, including those in the mental health field, altruistically choose their field. While positive, unselfish motivation among mental health clinical staff is evident everywhere, it is also clear that these individuals must earn an adequate salary in order to keep up with today's economy. As opportunities in other fields appear more attractive, mental health staff are drawn away from our community agencies. In some cases, higher-degreed personnel may choose private practice, frequently isolating themselves from low-income, highest need clients. In other cases, staff are leaving the mental health field altogether. Finally, there is a future shock to this, situation as more and more young people look away from a community mental health career, in light of low salaries.

PROBLEM DEFINITION

The major problems currently being caused by salary inequity are in the areas of staff recruitment and retention. Community agencies are reporting long vacancies in many clinical positions, with some positions remaining vacant for a year or more. Staffing of group homes and other residential programs has been very problematic, as the current wage rates for care staff, at least in the southern part of the state, are easily being matched by even the fast-food industry. Agencies under contract with the Bureau of Mental Health are having problems providing contracted service units as they cannot hire staff to provide those services. Waiting lists of 6-8 weeks are being experienced in several areas as a result of intractable direct care vacancies. Agencies are experiencing the costs of training new staff on an ever more frequent basis, only to find that those staff leave in a short time for more remunerative employment. Morale problems exist in some agencies, attributable to the instability of staffing. Quality issues arise in the Bureau as a result of the unavailability of stable, trained staff in some programs.

PROPOSED ACTION

- The Bureau will implement a program to adjust community direct care salaries to more closely parallel those offerred for similar work in both state employment and the private sector. The amount of salary increase will differ with the clinical discipline and with market conditions in each area, but on average will approximate a 10% base salary enhancement. None of this increase will go to administrative or other non-clinical personnel.

ANTICIPATED RESULTS

As a result of the salary adjustment for direct care mental health staff in community agencies, client services should improve in quantity, quality, and cost-effectiveness. Quantity would improve as agencies are both able to recruit staff for current vacancies and also as they are able to retain the trained staff they now have. Quality should improve as agencies build a stable, long-term staffing for their programs. Cost-effectiveness will improve as necessary administrative and other non-personnel costs are spread over a larger base of delivered services.

The Bureau has committed itself to staff training and other human resource development efforts in the upcoming biennium. In order to make those plans operational and meaningful, we must continue to be able to attract intelligent, dedicated people to a difficult, though fulfilling field of work. Salary equity is a necessary base step to human resource development efforts in the community mental health area.

EMPLOYMENT OPPORTUNITIES FOR PSYCHIATRICALLY DISABLED PERSONS

CURRENT STATUS

In its first report to the Legislature, the Commission to Review Overcrowding at the two state hospitals identified the need to develop and expand community vocational services for persons with psychiatric disabilities. Seven of the ten statewide mental health forums received testimony specifically encouraging the development of more vocational opportunities, and more specifically supported employment services.

In FY87, community programs funded by the Bureau served at leasT 3,600 persons with psychiatric disabilities. 65% of that number had annual incomes of less than $5,000, most likely from government assistance, and 55% had previous hospitalizations. In that year, about 100 persons were served in community vocational programs for persons with psychiatric disabilities. With the advent of SUPPORTED EMPLOYMENT, as a major focus for getting persons with psychiatric disabilities into work, employment is being viewed by the mental health system as a viable treatment approach, building interpersonal skills, confidence and job specific skills, along with increasing taxable income.

Relationship Between Work and Hospitalization

Studies examining the rehabilitation of patients in psychiatric hospitals identified employment as a significant factor in avoiding rehospitalizations A research project, specific to Maine, found that participation in real work resulted in better individual outcomes (the Maine-Vermont Longitudinal Project, 1988). Data pertaining to the Augusta Mental Health Institute in FY87, indicates that of the 600+ patients discharged that year, only 15% had jobs, and 67% had no plans of pursuing any work related activities. This can be attributed to the shortage of vocational programming for persons with psychiatric disabilities within the community.

PROBLEM DEFINITION

Employment opportunities for persons with psychiatric disabilities are grossly underfunded. To date, within the Maine mental health system, employment opportunities have not been a priority for the limited resources available to serve this population. The Bureau of Mental Health in collaboration with the Bureau of Rehabilitation have co-sponsored a number of programs geared to get persons with psychiatric disabilities into the workforce. Despite the limited resources, these services/programs have demonstrated significant success serving 100 persons at any time, and have successfully placed individuals into competitive employment every year. However, compared with the figures represented above, only a fraction of the total number capable of some degree of competitive employment, are being served.

PROPOSED ACTION

Build the capacity of the mental health service system to get more persons with psychiatric disabilities into the workforce. This is consistent with both the Governor's SUPPORTED EMPLOYMENT initiative, and the MAINE HUMAN RESOURCE DEVELOPMENT PLAN. The following system components are recommended:

- o Develop pre-vocational training opportunities geared to development of job readiness skills (finding a job, appropriate work behaviors, etc.) and matching career interests with jobs in order to prepare persons who have had a limited work history for work. ALL OF THE MENTAL HEALTH REGIONS WILL BE TARGETED TO DEVELOP THIS CAPACITY.

- o Increase the number of individual assessments and as a result increase the number of jobs matched to them. Development of new job sites, increase the amount of job coaching and support services. Based on the MAINE HRD PLAN, 150 additional persons will be placed in supported employment annually.

- o Contract for regional supported employment coordinators who would work with existing vocational and mental health resources to coordinate existing service with new opportunities, and function as brokers of supported employment services.

ANTICIPATED BENEFITS

Implementation of these requests would result in the placement of 150 persons with psychiatric disabilities in competitive work annually. There would be a direct impact in the short and long term hospitalizations in the state psychiatric facilities. The economic benefits of placing persons into the workforce will be multiple, resulting in decreased government subsidies, increased contribution to the state tax base, and reduction of state costs for lengthy and frequent hospitalizations.

COMMUNITY INPATIENT SERVICES

CURRENT STATUS:

The need for increased inpatient services at the community level has been well documented throughout the mental health planning process (Community Mental Health Forums, Planning Committee Prioritization of Needs). Other than the two state-run psychiatric hospitals, only the Jackson Brook Institute will accept involuntary admissions of persons with mental illness (persons whose psychiatric condition is so severe that a danger exists to themselves or others). Currently, there exists seven general hospitals in the community that operate distinct psychiatric units with capacities of ten beds or less each. Based on recent research, community inpatient units have experienced consistent increases in unit occupancy and the average length of stay. This is due to the overall increase in persons needing inpatient psychiatric services, and is negatively impacting on the state hospitals 'over crowding' and their ability to treat longer-term patients, as they are forced to admit the 'overflow' from community units.

PROBLEM DEFINITION:

Other components of a comprehensive mental health system included within this package will assure that appropriate care is administered at the community level and unnecessary admissions into state psychiatric hospitals will be avoided. Nevertheless, because mental illnesses are cyclical in nature (extended periods of stability interrupted by short-term severe episodes), a number of these persons will experience crisis situations that will call for them needing to be hospitalized for less than 30 days. In addition, the physical uprooting of these individuals, when admitted to either of the two state hospitals outside of their community of residence, adds to difficulties in reintegrating them back into the local community once the acute crisis is over.

Local options must be made available at existing medical facilities. In order to do this, the issues of liability and funding must be addressed, both for voluntary and involuntary admissions.

PROPOSED ACTION:

- Prepare and submit legislation to limit the tort liability of general hospitals for involuntary/voluntary admissions.
- Establish a DMH/MR account to purchase up to 20 inpatient beds.

ANTICIPATED BENEFITS:

There would be an immediate reduction in admissions at the two state psychiatric hospitals as a greater number of involuntary/voluntary patients will be diverted to expanded community inpatient psychiatric units. In addition, treatment would be provided closer to the patients home and community supports, and therefore, facilitate re-entry into community life.

CRISIS STABILIZATION SERVICES

CURRENT STATUS

Crisis Stabilization Services, to be comprehensive, combine elements from treatment services and basic supports. The components include 24 hour/7 day availability of telephone crisis intervention, face-to-face and mobile outreach services, professional evaluation for hospitalization, and alternative supported and supervised short-term residential services. As with virtually every other service in Maine, the existence of such components varies widely, from region to region. In York County, Cumberland County, Lewiston-Auburn, and Kennebec County, comprehensive services do exist, though the capacity is often exceeded by the demand. Throughout the remainder of the state, there are no residential components. There is telephone crisis intervention in Aroostook and soon to be in Hancock, Washington, Piscataquis, and Penobscot counties. Franklin County has face-to-face crisis services in the Farmington hospital. In the remaining areas, after hours, on weekends and holidays there is only professional evaluation for hospitalization. The quality of this is relative to the availability of psychologists and psychiatrists in the local area.

PROBLEM DEFINITION

Many psychiatrically disabled persons are acutely susceptible to stress and face recurrent acute episodes of psychosis. Others face serious social crises due to poverty, recurrent unemployment, loss of housing, or loss of their support network. Many episodes of hospitalization can be avoided with appropriate crisis services. Such services have the most effective impact when linked to ongoing integrating services and basic supports. Acute psychosis may often be dealt with successfully in the community with appropriate psychiatric services and a sheltered environment. While it is impossible to estimate accurately, active crisis workers judge that between 30 and 40% of AMHI and BMHI admissions could be prevented if the full array of services were in place.

PROPOSED ACTION

- Convert the three current successful state operated models of crisis stabilization services to contracted services through RFP. This would establish contracted crisis stabilization programs in Kennebec, Cumberland and York counties. These programs should be closely linked with the Intensive Case Management Services to be developed in those areas.

ANTICIPATED RESULTS

As with case management services, it is expected that the availability of comprehensive crisis stabilization service will provide, in many instances, local alternatives to psychiatric hospitalizations. Subjective estimates by people in crisis work currently are that between 20% and 40% of people seen in crisis would avoid admission if the full spectrum of services were available. The three BMH programs serve approximately 1,200 different psychiatrically disabled people each year. Staff estimate that they now deflect approximately 240 admissions. With improved service options, especially intensive case management and residential programs, this number could go as high as 440. (New programs when operational could deflect an additional 400 bringing the total to 840 differed admissions per year, statewide.)

MENTAL HEALTH SERVICES FOR ELDERLY PERSONS

CURRENT STATUS

The Department of Mental Health and Mental Retardation funds one community support program for elderly persons with mental and emotional disorders. The program, which operates primarily in Penobscot and Piscataquis counties, is funded through a demonstration grant from the National Institute of Mental Health and has a client capacity of 45. Apart from this special project, there are no comprehensive community-based alternatives to institutional care for elderly persons with serious disabling mental illnesses.

PROBLEM DEFINITION

An estimated 18% of the general population suffers from mental illness, but because of natural life changes, multiple personal losses, and other factors that characterize advanced age, an even higher proportion of the elderly population, 20-25%, is in need of intervention for mental and emotional disorders.

Despite the prevalence of mental illness among older persons, the elderly continue to receive less publicly funded mental health care than any other age group. Between 1984 and 1987 persons aged 65 and older received less than 9% of all services provided by community mental health agencies in Maine even though they accounted for over 13% of the total state census.

In 1984 the Task Force on Mental Health Services to Elderly Persons, a 25-member panel convened by the Bureau of Mental Health, DMH&MR, and the Bureau of Maine's Elderly, DHS, sited as one of its primary recommendations "...reimbursement which will enable community mental health agencies and private practitioners to provide in-home assessments of older persons." Also in its report, the Task Force recommended the development of "A solid funding base to insure availability of treatment programming, in-home counseling, and psychiatric emergency services for the elderly and their families."

In 1988 the need for in-home mental health services for the elderly remains a high priority. The planning sub-committee on mental health services to elderly persons has recommended as its first priority "The development of a flexible funding base which will be used for the purchase of outreach, in-home mental health treatment services for elderly persons." In addition, the sub-committee has recommended as its second priority, "The deployment of individuals who will act in each service area as aging and mental health resource persons." Finally, during the Department's community forums held in May, the need for outreach, in-home mental health assessment and treatment services for elderly persons were articulated in ten areas of the state.

PROPOSED ACTION

- The Department will establish 10 geriatric mental health specialists in six regions the state. These individuals will be employed as resource persons who will be available to elderly persons and their families, community-based organizations, and other providers who are involved with the care of elderly persons (with particular emphasis on area agencies on aging) for the following:

    1) Individual client assessments;

    2) Case consultation; and

    3) Caregiver training and development

  These individuals will not provide on-going treatment, but will be responsible for working with agencies, organizations and individuals to access and advocate for needed treatment and supportive services for mentally ill elderly persons.

- The Department will establish a funding base for the purchase of outpatient mental health services for elderly persons with mental and emotional disorders. These funds will be used to purchase counseling and other therapeutic services which will be provided in settings that are most appropriate for the client (eg. in-home). They will also be used to purchase mental health services from a variety of community-based providers (i.e., mental health centers, regional health agencies, home health agencies and private practitioners). Funds will be allocated on the basis of the percentage of each service area's census over 65.

ANTICIPATED OUTCOMES

The 10 aging and mental health resource persons will help to ensure a much needed focus on mental health and aging issues, which will ultimately lead to expanded programs and services in each of these service areas. It is estimated that these ten resource persons will provide said services to approximately 1,000 elderly persons in the community annually.

In addition, the establishment of a flexible funding base, designed specifically to address the treatment needs of elderly persons in the community, will help to ensure that treatment services are available to those elderly persons in need, regardless of their ability to pay, and their location. It is estimated that an approximate 300 individuals statewide will be served with these funds, annually.

Finally, the integration of both budget requests will help to ensure that a multi-disciplinary approach is employed in the assessment and treatment of all mentally ill elderly persons living in the community throughout Maine.

FAMILY SUPPORT LIAISON POSITION

CURRENT STATUS

In recent years Maine has experienced continued growth in the development of family support groups for persons who have a family member with mental illness. Currently there are eleven such organizations located across the state, from Madawaska to York. These groups offer regular meetings to provide up-to-date information about mental illness, and ways that families can participate in the treatment process. Although there have been efforts to coordinate locally between mental health service providers and family groups, a liaison function with the central office is needed to insure family input about new initiatives. In addition, because these family groups represent only a fraction of Maine families effected by mental illness, the Department is committed to broadening the opportunities for families to receive support and information on a statewide basis.

PROBLEM DEFINITION

Families can provide the Department with first-hand assistance by identifying new priorities and implementing current service opportunities. In order to facilitate the necessary two-way communication for this to occur, a staff state employee position will need to be established as a state line, that will function as direct liaison to all family support groups throughout the state. This is critical in order to assure that these groups and the Department have the opportunity to be fully informed about each others plans, prior to embarking on new major initiatives. The Department currently lacks adequate capacity to respond to needs of individual family cases.

PROPOSED ACTION

- This request is for a staff position, within the Department, that will function as a direct link between the Director of the Bureau of Mental Health and family support groups. In addition to regular participation at group meetings, this position will be responsible for assisting in the resolution of difficulties that families might encounter regarding services for their mentally ill family member, on a case by case basis.

ANTICIPATED BENEFITS

Staffing the liaison position would assure that Department initiatives address significant problem areas, and would obtain the necessary support of families towards implementation. Also, this position would work to 'pull together' all parties thereby reducing the potential for fragmentation of the service system for persons with mental illness, while at the same time, formally recognizing family members as important parts of the overall treatment of their effected members.

PUBLIC EDUCATION INITIATIVES

CURRENT STATUS

Although the Department, over the past 10 years, has conducted various activities related to delivering factual information about mental illness to families, providers and the community at large, there has not been to date an organized campaign designed to increase the acceptance of persons with psychiatric disabilities as equal, participating members of local communities. Studies in this area consistently indicate that public stigma against persons who have mental illness is one of the primary barriers to integration into every aspect of community living, i.e. work and leisure. Ignorance about affected persons results in a great deal of blame directed at them, when in reality, causes are primarily biological. More importantly, the capabilities of persons with psychiatric disabilities are grossly underestimated. Significant research has demonstrated that the majority of these persons can have productive lives, holding down jobs, and contributing economically and otherwise to the future of Maine.

PROBLEM STATEMENT

Service opportunities for greater participation in the community, by persons with psychiatric disabilities, will have limited success unless a well-planned effort is made to inform the Maine public about the misconceptions towards these persons' capabilities. It has been well documented, by this Department, that individuals who have objected the most to a particular community program have, in short time, become the strongest supporters. This has occurred because their concern has focused their attention on this population, and they have come to realize that the threat that they have felt to their normal way of life, is not substantiated. This phenomena has become our strongest tool towards de-institutionalization. Now the Department needs to take an aggressive step to educate the public at large. We realize that de-institutionalization goes beyond the establishment of community group programs, and touches the daily routines of all Maine citizens. We must help the community realize it too.

PROPOSED ACTION

- This recommendation is to initiate and support, as an ongoing Departmental function, an anti-stigma campaign directed toward Maine citizens at-large, about mental illness. This campaign will facilitate the successful and complete implementation of every recommendation in the total request package. Funds will be utilized to organize a task force, comprised primarily of persons whose lives have been directly effected by mental illness, and community leaders. The Task Force will identify specific activities the Department should undertake to reduce the stigma around mental illness. We anticipate utilizing a wide range of media options available, as well as, employing strategies at the local level that will have direct impact on the lives of persons effected (Chambers of Commerce, Rotary Clubs, Local and County Government, etc.).

ANTICIPATED BENEFITS

Without question, the cost benefit of a successful anti-stigma campaign will be considerable. This is evidenced by new resources outside of traditional service programs, that offer new opportunities (ie. hiring persons, participation by private non-profits) as well as by greater acceptance of all Department initiatives concerning community integration.

PROPOSAL FOR THE FUTURE

The Governor's Biennial Budget will evolve from a systems plan for mental health based on the year long planning process and the mental health service needs of Maine's citizens.