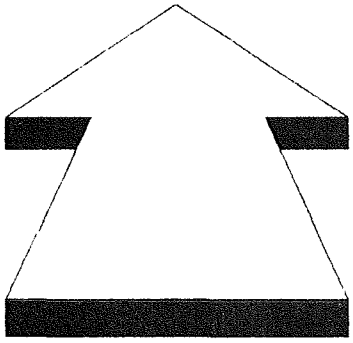
MENTAL HEALTH AND A HEALTHY SOCIETY:

TRANSFORMING MAINE'S MENTAL HEALTH SYSTEM BY THE YEAR 2000



FINAL REPORT

of the

State of Maine

SYSTEMS ASSESSMENT COMMISSION

January 25, 1991

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Governor John R. McKernan, Jr.
Senate President Charles P. Pray
House Speaker John L. Martin

Dear Governor McKernan, President Pray and Speaker Martin:

We are pleased to submit the final report of the Systems Assessment Commission. We hope that you and your colleagues will find it useful in launching a substantial effort to transform Maine's Mental Health System between now and the year 2000.

The report represents a consensus of our Commission and reflects, we believe, a substantial consensus among those most closely concerned with those who are affected by mental illness or have mental health needs. We intend the report as a framework of our vision of a mental health system for a healthy society and we hope it will be a stimulus to debate, discussion, improvements, planning and action.

We appreciate the privilege you gave us in appointing us to the Commission. We thank you and your associates and staffs for the assistance we have received from and the cooperation we have received from both the Executive and Legislative branches of state government. We would like to take this opportunity to say special thanks to our staff, Joan Lawson and Bruce Thomas, for their contributions to our work. Most of all, we want to express our gratitude for the time, thought, effort and interest shown by consumers, families, advocates, providers, state employees, representatives of various groups, and community leaders in their testimony, correspondence, advice and criticism. We hope their participation in our work is just the beginning of a determined effort to reform and improve our approaches and our performance in making available mental health and related services worthy of a caring society.

Sincerely,

Donald Nicoll, Chair

Victor Perreault, Vice Chair

Robert Clarke

George Davis, M.D.

Richard Estabrook, Esq.

Kerry Kimball, Ed.D.

William Sullivan, M.D.

Kenneth Allen, ex officio

Carol Carothers, ex officio

Robert Glover, Ph.D., ex officio

State House Station 115, Room 434, Augusta, Maine 04333 • (207) 289-3123

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A government has something more to do than to govern, and levy taxes to pay the governors. It is something more than a police to arrest evil and punish wrong. It must also encourage good, point out improvements, open roads of prosperity and infuse life into right enterprises. It should combine the insight and the foresight of the best minds of the State for all the high ends for which society is established and to which man aspires. That gives us much to do.

* * * *

Independence, if it is genuine is no evil, but a good. The great requisite, indeed, on the part of those who make or administer laws, is moral courage. We cannot expect much that is good from laws enacted under clamor to meet some crisis, nor from statesmen who are chiefly concerned in continuing to keep their place and power. One thing we may be sure of, -- the virtue in the hearts of the people. That instinct may be deceived, but it will not be defeated. It demands honesty; and will pardon us if in that cause we are over bold.

--Governor Joshua L. Chamberlain
Address to the Legislature
January 1870

FOREWORD

When Governor Chamberlain addressed the Legislature one hundred and twenty-one years ago, Maine had not recovered from the losses it suffered in the Civil War and it was facing an uncertain economic future as the United States entered a period of tremendous westward expansion, industrial change and shifting political-economic alliances. The proper role of government was much on his mind in relation to civic order, economic development and human services. Maine was, in many respects, different from what we know, but there are similarities. Governor Chamberlain's vision and wisdom still ring true.

In Governor Chamberlain's words, this Commission is endeavoring in its report to "encourage good, point out improvements, open roads of prosperity and infuse life into right enterprises," public and private, in support of those who need mental health and related services. We believe the transformation of our mental health system will require, in Governor Chamberlain's words, "the insight and foresight of the best minds of the State." For us, the "best minds of the State" include consumers of mental health services, families and other members of natural support systems, service providers, civil servants, elected officials, and concerned citizens in all regions of our state and at every level of society.

We have endeavored to prepare a report that offers a vision of what might be and a framework to help our state achieve that vision. We have tried to look beyond our present troubles to avoid recommending laws "under clamor to meet some crisis." Our vision is not the last, nor is it the best word on the issues of mental health services. The insights and the ideas are not the sole property of the members of the Commission. Insofar as we could, we have tried to reflect consensus where it exists, identify differences of opinion, and challenge ourselves and our society to begin the work of transforming our public and private mental health system. And, as we note in our report, that transformation must be a long term commitment in which we are willing to change to meet new conditions and to respond to new knowledge and insights.

The heart of our recommendations is the view that decision-making about mental health programs and services must involve broad participation, especially by consumers and those who provide them natural support. Closely related to that view is the recommendation that more power and authority over the planning, development and implementation of mental health services be moved to communities and regions, within the context of statewide commitments to equal access and quality. Those shifts will entail

substantial risks. They will unsettle current relationships. They will require changes in attitudes and behavior among those directly concerned with mental health services and those who have viewed the problems of mental illness and mental health with anxiety and fear.

One of the obstacles to approaching and achieving those changes will be the problem of language. The discussion of mental illness and mental health is fraught with difficulties. Some of these difficulties are based on genuine differences of opinion over the causes of mental illness and mental health problems and the appropriate courses of treatment, care and support required. Some are related to the development of professional jargon. Some are rooted in ideological convictions. Some stem from deep-seated and unsettling attitudes that undermine therapeutic goals. Some reveal unrecognized prejudices. Some reflect suspicion. All of us need to work very hard, and with great humility, to understand and to overcome the problems of language and the underlying difficulties they signal. We need to listen more, explore more with each other and seek clarity in our goals, our means and our priorities.

The Commission has tried to follow those precepts. We have not always succeeded. Our membership was limited, because it did not include any consumer or natural support system members, although several members are deeply involved in direct mental health services or support for those needing such services. We have been helped enormously by those from the consumer, family, natural support system, provider, government and community service communities who have shared their knowledge, experience and insights with us. We have tried to be honest and objective, with a strong commitment to our objectives, and we hope they "will pardon us if in that cause we are over bold."

We intend, as we have said before, for our report to provide a framework for transformation of our mental health system. We expect and want it to stimulate debate and action. The test of our success will not come on whether the shape or structure of the system matches our recommendations, but on whether the values we advocate are incorporated into our mental health system and whether action is taken and sustained to make real improvements in the lives of those who are affected by mental illness or need mental health services. The ultimate test of our success will be the degree to which our society demonstrates a strong and continuing commitment to the cause of helping those who are affected by mental illness or mental health needs to grow and achieve their potential as interdependent, functioning members of society, with healthy relationships and the sense that they are contributing to the health of their community and state.

Given the limitation on resources, given the unsettling changes in the mental health system that will be needed, given the shifts in decision-making power that must be undertaken, given the new alliances that need to be developed, and given the strong differences of opinion that exist, the task of building on this report will be long and demanding. The work of this Commission ends with this report and the submission of legislation based on its recommendations. Members of the Commission, as individuals, are committed to continue their contributions, but the main burden of undertaking the ongoing tasks will fall to other organizations and individuals who share our vision and our conviction.

In undertaking those tasks it will be essential for those involved to "keep their eyes on the prize," not getting diverted by disagreements over detail or the difficulties of establishing new relationships. It will also be necessary to be resourceful and persistent, to "hold on" in the effort to transform our mental health system within the next ten years.

Keep Your Eyes on the Prize

Paul and Silas bound in jail
Had no money for to go their bail.

Keep your eyes on the prize, hold on!
Hold on.
Hold on! Hold on!
Keep your eyes on the prize, hold on!

Paul and Silas began to shout;
The jail door opened and they walked right out.

Keep your eyes on the prize, hold on!
Hold on.
Hold on! Hold on!
Keep your eyes on the prize, hold on!

The only chain a man can stand
Is that chain of hand in hand.

Keep your eyes on the prize, hold on!
Hold on.
Hold on! Hold on!
Keep your eyes on the prize, hold on!

The only thing that we did was wrong
Was stayin' in the wilderness too long.

Keep your eyes on the prize, hold on!
Hold on.
Hold on! Hold on!
Keep your eyes on the prize, hold on!

- American Civil Rights/Freedom Song

II. EXECUTIVE SUMMARY

The Systems Assessment Commission recommends development of a comprehensive public and private mental health system by the year 2000, based on clearly stated values and assignment of responsibilities to state, regional and subregional bodies for leadership, planning, development, implementation, evaluation and revision. The Commission's recommendations would shift the emphasis in program directions to grass roots, community and regional participation, with significant roles for mental health service consumers, family and other natural support system members.

Under the Commission's proposals, mental health services would be consumer-focused, emphasizing consumer choice and recognizing individual rights. Diagnosis, evaluation, treatment, care, rehabilitation and support would be provided in the least restrictive settings possible and in locations as near as possible to the place the consumer regards as home base.

The Commission calls for making available comprehensive mental health, physical health, psycho-social rehabilitation, career counselling, education and training, supported employment, housing, transportation and other services for those affected by mental illness or with mental health needs. Some of the services would be provided by or through funding by the Department of Mental Health and Mental Retardation; some would be provided by or through other state agencies and institutions; all would be coordinated.

The aim of comprehensive services would be to give individuals affected by mental illness or with serious mental health needs the opportunity to grow in self-knowledge, regain function, achieve their potentials as interdependent, contributing members of society, enjoying healthy relationships.

The Commission recommends

- a flexible system, regionally diversified, adapted to community and individual needs and changing over time
- extensive participation by mental health service consumers, families and other natural support system members in planning, priority setting, program development, governance, evaluation and education programs at subregional, regional and statewide levels; that participation would be supported by specific membership requirements on advisory organizations and government boards associated with state supported mental health programs
- substantial, coordinated efforts aimed at broader education, recruitment and retention of mental health professionals and para-professionals; expanded community education programs aimed at increasing community involvement in mental health service programs and the elimination of stigma attached to those affected by mental illness or with mental health needs

- considerably expanded and improved mental health service planning, based on broad participation, local and regional needs assessments and priority setting, with quantified goals and objectives and target dates

- expanded and improved information systems to support planning, evaluation, quality assurance and program oversight

Specific Commission recommendations include the following:

- creation of regional mental health boards, elected by subregional boards, to plan, set priorities, allocate resources and oversee delivery of mental health services in a system adapted to local and regional needs

- establishment of a Maine Mental Health Advancement Program, governed by a broad based board of directors, to develop and oversee diagnostic, treatment, care, rehabilitation, research and teaching programs in response to serious mental health problems; the program would be responsible for services for high risk groups requiring care in protected settings, forensic patients and individuals in corrections institutions requiring mental health services; the board of directors would have immediate responsibility for the Augusta Mental Health Institute and the Bangor Mental Health Institute and for development of plans for their replacement

- a pilot project for a targeted detection, evaluation, intervention and treatment program for individuals in environments where serious sexual, emotional or physical abuse is occurring

- coordinated steps to strengthen and integrate the state's substance abuse program and improve collaboration between substance abuse and mental health service programs through education and training, reimbursement reforms and quality assurance

- the appointment of task forces to undertake detailed analyses and to make recommendations on reimbursement, health insurance, provider liability and other mental health service and related funding issues that affect the availability of, access to and continuity of mental health services in the community

- increased support for families and other natural support systems through education, respite services, crisis intervention services, and financial assistance, where needed

- special studies to develop program plans for improved mental health services for children, adolescents and elderly individuals

The Commission recommends that legislation be enacted to implement a number of its proposals.

III. INTRODUCTION

The State of Maine 114th Legislature created the Systems Assessment Commission (Sec. 8, Part BB, Sec. 2, Ch. 50, P.L. 1989) to perform several tasks:

> (1) "to review the costs of the Augusta Mental Health Institute and the Bangor Mental Health Institute and to formulate specific proposals for alternative systems of care. The commission is authorized to determine how best to use state money in providing the most appropriate treatment for persons with severe long-term illness." [par. C.]
>
> (2) to "develop a long-range plan for the Augusta Mental Health Institute and the Bangor Mental Health Institute. The plan shall include consideration of the creation of smaller acute care facility or facilities to take the place of the current facilities and any other option for humane, safe and cost-effective delivery of services to Maine's mentally ill citizens. Following the development of a long-range plan for the Augusta Mental Health Institute, the commission shall develop a plan for the Bangor Mental Health Institute. Any plans developed shall also include an assessment of the need for and delivery of community services, including consideration of the drafting of model legislation governing the delivery of mental health services statewide." [par. G.(1)]
>
> (3) to prepare a final report that "shall include a complete plan for the Augusta Mental Health Institute and the Bangor Mental Health Institute, including a full assessment of an alternative facility or facilities, community resources which are needed, costs, time frames and necessary implementing legislation." [par. G.(2)]

Early in its deliberations the commission concluded that any plans for the Augusta Mental Health Institute, the Bangor Mental Health Institute, alternative facilities, or community services must be developed within the context of a state mental health system that includes state government, and other public and private services focused on the needs of defined populations. Some of those services would be within the purview of the Department of Mental Health and Mental Retardation. Others (e.g., housing, health care, income maintenance, vocational rehabilitation, education, substance abuse services, etc.) would be provided or supported by other state agencies and institutions, such as the Department of Human Services, Department of Education, Department of Labor, Maine Housing Authority, Department of Corrections, Office of Substance Abuse, University of Maine System, and Maine Technical Colleges.

The Commission decided that it should, to the maximum extent possible, make use of the experience and initiatives of other states that have undertaken reforms in their mental health systems. Twelve states were examined in a special study that accompanies this report. The Commission reviewed reports, studies, professional journal articles and news accounts. Members sought advice from consumers, family and other members of the natural support system, advocates,

providers, educators, civil servants, and community leaders, as individuals and as members of advisory groups, advocacy organizations, professional committees and associations.

The Commission met first on September 15, 1989. It has met a total of 32 times, including three sets of public hearings, two site visits to the Augusta Mental Health Institute and one site visit to the Bangor Mental Health Institute. Individual members attended more than 12 additional sessions with a variety of organizations. Individuals attending Commission meetings were invited to and did participate in Commission deliberations. Individuals attending those sessions and the public hearings, which included participation from Fort Kent, Machias, Bangor, Farmington, Augusta and Portland on the University of Maine System's interactive television system, included consumers, family members, advocacy groups, community mental health clinic staff and board members, social club staff, individual mental health practitioners, social workers, nurses, physicians, hospital administrators, nursing home and residential facility administrators, substance abuse counsellors, educators, students, state department heads, legislators, members of state advisory boards and committees, state employees, trade union staff, and professional and trade association leaders and staff.

The Commission realized that it could not, for a variety of reasons, provide detailed plans for the future of the Augusta Mental Health Institute and the Bangor Mental Health Institute. A series of events, including the Augusta Mental Health Institute Consent Decree and the current State budget crisis, introduced complications into an already complex picture. Some information essential for the kind of planning contemplated in the legislation that created the Commission is not available. Most important, the Commission felt that much of the planning related to State in-patient facilities and community services should be developed in a broadly participatory, grass roots planning effort. The report does offer the Commission's findings and recommendations for courses of action aimed at transforming Maine's mental health system by the year 2000. The report includes a number of references to proposed legislation. Individual members of the Commission are prepared to work with legislators, legislative staff and departmental staff in developing proposed statutory language.

A Vision for Maine's Mental Health System

The Commission believes significant and meaningful reform in Maine's mental health services, including changes in the State's mental health institutes, can only take place within the context of a broad view of a mental health system worthy of a caring society -- a society whose members are involved with those who are affected by mental illness or who have mental health needs. That involved caring is essential not only to promote the mental health of individuals; it is vital to the health and well-being of the society as a whole. When we care, when we respect and support each other, we contribute to our own dignity and worth as well as to those we seek to help. The goal of our society's values, as expressed in our mental health system should be to achieve for all of us the condition of mental health that, in the words of Sigmund Freud, is the "ability to love and to work." Mental health is based on healthy relationships and the ability to function and contribute to a free society.

The Commission has, therefore, developed a vision of a mental health system that relates to more than state statutes, institutions and programs. Its vision covers public and private responsibilities. It aims at giving each of society's members the opportunity to grow in self-knowledge, interdependence and contributing participation in the community at large. The Commission's findings and recommendations for State and other public and private actions are derived from that vision and offered in a framework that is intended to transform the way we as a society deal with issues of mental illness and mental health.

The Commission recognizes that implementation of its recommendations will require substantial public and private investments over time, significant changes in organizations and operations, and changes in public attitudes. The Commission also recognizes that financial and other resource limits will restrict our capacity to achieve all the goals of an ideal mental health system. As noted in its findings and recommendations, priorities must be set, changes must be incremental and programs must be flexible. It is absolutely essential, however, that the incremental changes we undertake in reforming our mental health system be carried out in a purposeful way, aimed at achieving clear and definitive goals that have broad public support and remain consistent over time.

We hope this report will help crystallize opinion on the goals we need to set in reforming our mental health system. We hope its specific recommendations will be implemented as the first steps toward those goals. And we hope community, regional and state leaders from all segments of society -- from the public and private sector, from provider groups, from consumers, and from those who form the natural support systems for those affected by mental illness or with mental health needs -- will be stimulated by this report to engage in the sustained and determined effort that will be required to achieve a mental health system worthy of a caring society.

IV. FINDINGS

Broad Reforms, Specific Goals

Reform of State of Maine institutional and other services for those affected by mental illness and those with mental health needs must be undertaken within the context of revised approaches to the problems that affect them. True reform will require development of integrated and mutually supportive public and private efforts that span the wide range of mental health needs. The focus must be on the needs of individual consumers rather than those of the system or system providers. Reform must also be based on shared values. And reform efforts must be carried out in pursuit of specific goals and objectives that can be evaluated.

The goals of reform will not be achieved overnight, but it is imperative that we be clear in our goals and consistent in the development and implementation of our policies before we launch new investments or tinker with pieces of what has been called our "mental health system". There will be emergency needs to protect the health and safety of consumers, but great care must be taken to insure that actions to meet those needs will not create obstacles to broader reforms. In other words, corrections of existing, urgent problems should be consistent with longer term goals and objectives.

Reforms and the avoidance of harmful changes are also imperative in health, income maintenance, employment, education and training, career counselling, housing, social services and corrections programs, where program eligibility, practices, policies and funding (or lack of funding) can have profound consequences for those affected by mental illness or with mental health needs. Responses to budget difficulties and other exigencies in those areas should avoid creating obstacles to or undermining mental health reforms.

Variety of Mental Health Needs

All of us are subject to stress from time to time and need assistance in retaining or regaining our mental health. For most of us, natural support from family, friends or counselors is sufficient to overcome those difficulties and to help us learn and grow in the process. Some of us encounter more severe problems that require more intensive intervention, support, guidance and, sometimes, treatment. Some of us have more serious and longer lasting problems, the product of genetic or congenital factors, injury or disease, sexual or other abuse, dependence on drugs or alcohol, or a combination of factors that may result in mental illness or mental health needs. While a number of us are affected by mental illness or mental health difficulties at some time, relatively few have very serious, long lasting conditions that impair our ability to function in society and can result in our being dangerous to ourselves or others.

Those of us who are most severely affected, most seriously dysfunctional, are frequently disaffiliated from natural support systems, and are stigmatized and

excluded from participation in many activities of daily life. As a consequence, a number of us affected by those problems have become most dependent on intervention and continuing or intermittent care in protective environments. The goals of intervention and care planning in those cases, as in others, should be to offer a variety of treatment, care and support options, based on careful assessment or diagnosis and consumer-defined needs and aspirations, to alleviate severe dysfunction, foster growth in realization of potential, restore interdependent and healthy relationships, and give the individual an opportunity to contribute to society.

Variety of Mental Health Services

Individuals needing help from our mental health system, public and private, must be able to obtain and integrate a broad variety of care, support and assistance services. Those include a full range of biological, psychological, social, and spiritual services, including diagnosis, treatment, counseling, care and support, psycho-social rehabilitation, career counselling and development, education (including post-secondary education), vocational training, supported employment, housing, transportation and other public and private services. Our understanding of the breadth of mental health services must be expanded, and our education, training and compensation policies and programs must reflect that expanded understanding.

It is imperative that there be continuity in the provision of mental health and related services in each individual's case so that the mix of services is effective in meeting that individual's needs. Special attention must be given to insuring access to services for those affected by mental illness. Access to services should not be conditioned on consumer behavior that providers find acceptable. Treatment, care and support plans should be adapted over time to respond to individual development as well as changing professional knowledge.

No Integrated Mental Health System

Maine has a wide variety of mental health services, many of them excellent, but it does not have an integrated Mental Health System. In too many cases, mental health and related health, social, psycho-social rehabilitational, educational, vocational and support services are segmented and fragmented. Too many times consumers experience extraordinary difficulty in trying to find their way through the system.

Statutes Unclear

Maine's laws relating to mental health are a hodge-podge of statutes enacted in response to particular issues. They do not provide a direction for mental health policies, and they do not define the responsibility of State government in the provision of mental health programs and services. They do not provide broad policy guidance for community and regional providers to respond to those affected by mental illness or having mental health needs.

State Government Activities Undirected and Uncoordinated

Narrowly focused program grants, contracts and reimbursement policies, coupled with uncoordinated departmental programs and policies (especially between the Departments of Mental Health & Mental Retardation, Human Services, Corrections, Education, and the Office of Substance Abuse) and turf battles contribute to the fragmentation of services and a lack of continuity of care and support for consumers of mental health services. State funding of mental health and related services is tied to programs and not to consumers.

Planning Inadequate

The Department of Mental Health and Mental Retardation has developed plans in response to federal mandates under P.L. 99-660. The Mental Health Planning Council, created in response to P.L. 99-660 requirements, has involved a large number of interested parties from consumer and provider constituencies, but planning has suffered in several respects. There are serious discrepancies between local priorities and those found in the State Mental Health Plan. The State Plan has limited information and an almost exclusive focus on process goals. The absence of measurable, programmatic goals and objectives makes it virtually impossible to use the plans for a cohesive sense of direction in our mental health system or to determine meaningful achievements in mental health and related services.

Community Services Overloaded, Uncoordinated and Undirected

Overloading of individual providers and agencies, public and private, professional and institutional "turf" concerns, lack of effective communication, spotty collaboration, limitations on interdisciplinary education and training, and lack of cooperation and collaboration between professional providers, natural support system members and consumers compound the problems of fragmentation and discontinuity.

Experience in Other States

The Commission has reviewed the experience of twelve other states that have been involved in mental health system reform efforts. Bruce Thomas, comprehensive health planner for the Maine Health Policy Advisory Council, was retained by the Commission to gather documentation and interview participants in the states of Arkansas, Connecticut, Michigan, Minnesota, Nebraska, New Hampshire, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont and Wisconsin. A copy of the complete study, "Mental Health Systems Reform in Selected States", accompanies this report.

Agreement and Continuity of Vision Crucial

Findings from the twelve state study suggest that some of the most important factors in achieving meaningful reform include continuity of executive leadership, agreement on shared concerns and values, incremental planning and development, and concrete rewards for participation in systems reform.

Deinstitutionalization: Limited Success

States have had only modest success with reducing the size of their state mental hospitals, although Vermont provides an excellent model for successfully reducing the size of its institution. Vermont's program has been distinguished by an historically consistent statement of the role of the state hospital and integration with vocational rehabilitation services. Barriers to reducing dependency on the state institutions and achieving an integrated approach to managing the whole range of mental health services identified in our study include: lack of resources to support community services attuned to individual consumer needs; lack of progress in overcoming community hospital resistance to absorbing the risks associated with involuntary inpatient care; lack of professionals oriented toward "public psychiatric care;" disputes over collective bargaining agreements; dogma; stigma; and fear of change on the part of community providers who have become accustomed to State care for the most seriously ill and dysfunctional individuals.

Limited Community Support

A common theme, stemming from the experience with the lack of community supports for the chronically mentally ill in the 1980s and the emergence of younger people with serious mental illness who were never institutionalized, is the need for real housing, real jobs, education and continuity of care and support. Virtually all states are involving consumers in helping to reorient the system toward "consumer directed" models of care and support, with efforts ranging from formal participation on community planning bodies, to operating direct mental health services, to training in case management, to statewide advocacy efforts. The states are also working to develop family supports and education strategies as well as supporting advocacy by families in planning and evaluating mental health programs.

The Commission's Broad Framework

The Commission suggests a broad framework for a mental health system and recommends priorities, with some specific goals. Because the current, fragmented mental health system has never been consumer driven, and because information linked to reimbursement for services is focused on limited diagnoses or narrowly defined eligible services, there is no documented base for concrete, detailed, programmatic and budget estimates. The Commission offers, therefore, a broad framework for the values on which the system should be founded, the specific roles for State government, desirable initiatives in the society as a whole, and the system changes that should be undertaken.

The Commission has concluded that the development of such a system will require consensus on values, agreement on priorities and leadership by the State, all carried out through formal, intensive planning at the community, regional and state level.

Planning Process Important

Initiation of a Mental Health System Development Planning Process is essential to the program of reform that the Commission recommends. The "how" of the planning is as important as the "what". Broad based, participatory planning, is the essential ingredient. It must address the needs of all those in need of mental health services in all geographic areas of the state, whether or not individuals have been patients in the State's mental health institutes, and whether or not their needs will be met by the provision of State funded services. Community participation, understanding and support are necessary for consumer driven, community based mental health services. That participation, understanding and support can only be achieved through active, broad-based involvement in planning for mental health services reform.

Community Based

System reform must start with planning at the community and regional level. The Department of Mental Health and Mental Retardation and the Mental Health Planning Council can and should provide leadership, support and technical assistance, including essential information about existing programs and estimated needs, but true planning for reform cannot be carried out by the department or the council with only some assistance from those outside the department. Participants in the planning process must include consumers, family members and other natural support persons, public and private providers and agencies, educators and researchers, legislators and representatives from the general community. Commissioner Glover has made a substantial step in this direction by convening representatives from many of the above mentioned groups in his "Vision Conferences", but much more needs to be done in extending the process and participation at the local and regional levels. Planning must be community based and derived from the identified needs of consumers in the region for which the plan is being developed. All planning must result in goals and objectives that can be reviewed and evaluated on a regular basis. Those efforts will require support at the highest levels of the Executive Branch and from the Legislature in structure, funding and interdepartmental collaboration and cooperation.

Downsizing and Diversion Are Not the Purpose

The most visible step taken in recent attempts to reform Maine's mental health system has been the AMHI Consent Decree, aimed at providing individualized support plans and services for past, present and future AMHI patients. The Decree is also directed toward care and support services delivered in the least restrictive settings, preferably in consumers' home communities. The Decree sets out a schedule for reducing the number of AMHI beds as the focus of services shifts to community settings. In this sense the Consent Decree and the recommendations of this Commission are consistent.

The Commission is concerned, however, that the existence of reduced AMHI bed number targets and State budget constraints may result in a limited and distorted view of the purposes of the Decree and the ways in which it is to be applied. The Commission is also concerned that the Consent Decree not be misinterpreted as the end of the reform process. It is a significant effort to correct existing

deficiencies, but it is not the blueprint for more fundamental and far-reaching reforms.

Reform of the mental health system and redirection to community based, client oriented and responsive services cannot proceed from "downsizing" State institutes to force change. First, clear decisions must be made about the future role of State institutions or service programs in the mental health system. Changes are needed in the nature, scope and direction of State services and the size and purpose of the State institutes, and those changes must be based on a clear and consistent view of the role of State government in providing inpatient or outpatient care.

The process of restructuring the mental health system so as to eliminate the current reliance on inpatient, protected setting care, especially in State institutions, for those individuals with severe and persistent mental illness, should focus on the identified needs, wishes and aspirations of current institute residents and community consumers, and the availability of community programs, so the cycle of re-entry to State institutes that is caused by lack of appropriate community programs can be broken. Even for those patients who appear to need care in protected settings, we should never assume a need for permanent sequestration. Treatment, care and support should be appropriate to the individual's needs, wishes and aspirations at different times in her/his life, and not designed simply to control symptoms.

Community and regional programs must be adapted to the philosophy of individualized services enunciated above and resources must be in place before patients are discharged from or refused admission to the State institutes on the basis of mandated downsizing or budget cuts. Programs and resources that will be necessary to provide care and support in communities and regions for individuals affected by mental illness or with mental health needs run the gamut from medical, nursing and psychological services, to crisis intervention, support systems, psycho-social rehabilitation, career counselling and development, education (including post-secondary education), vocational services, housing and transportation. Wherever possible, those services should be provided independent of, but coordinated with, the mental health system.

The goal should not be downsizing and diversion, but the provision of more appropriate services in more desirable settings, based on the needs, wishes and aspirations of individual consumers. The plans developed by the Department of Mental Health and Mental Retardation in connection with the AMHI Consent Decree and any proposals to limit or reduce occupancy at BMHI must include firm timetables, quantified service objectives, and resource commitments to meet the needs of affected consumers.

The Commission cannot stress enough the importance of goals aimed at building on the strengths of individuals who require mental health services, helping them to meet needs they have identified and to achieve levels of function that equal or exceed what they had experienced prior to the onset of their mental health problems. In this connection, rehabilitation, habilitation, career counselling and development, education (including post-secondary education), and vocational rehabilitation services will be essential adjuncts to the mental health system.

During this period of budget limitations, every proposal to modify, reduce or eliminate the availability of those services must be tested against the potential adverse effects on consumers of essential mental health services provided or funded by the State.

Strengthening the Sense of Community

The achievement of a healthy society that promotes mental health for its members will, in the Commission's view, depend on strengthening the sense of community. That stems from shared community values about individual rights and responsibilities, care and support for individuals in need, respect for individual differences, and the importance of helping members of the community become productive participants in the public and private business of the society. It also relies on the collaborative efforts of mental health service consumers, families, churches, social organizations, businesses, public agencies, health and social service organizations, and all parts of the natural support system.

Regional Diversity Is Needed

Attention must be given to regional organization of mental health services, including the composition of the State's designated regions, planning and advisory functions at the regional level, and responsibilities for delivery and oversight of services within regions. The State should encourage and support diversity in regional organization structure and operation, responding to regional and local needs and priorities, consistent with statewide values. The object of changes in regional and subregional systems should be the achievement of true partnerships between the State, regional and local organizations.

The Commission believes that decision- and policy-making that is removed from local control and design, results in stigma, loss of community participation and involvement, and excessive reliance on the State. The role of local citizens and organizations in the planning, program development, needs identification and overall design and control of services for those affected by mental illness and those with mental health needs should be expanded. The State must reduce its centralized control over community-based programs and foster a locally controlled and designed mental health system, while fulfilling its responsibilities in quality assurance, public information, public safety, funding public programs, and providing leadership in the articulation of societal values. The State must also continue to play the central role in insuring equal access to mental health services, including those provided in State in-patient facilities.

Ongoing Flexibility Will Be Needed

Development of a mental health system will take time. The system, and its components, should never be considered as "complete". Nor should a monolithic system be considered ideal. As components change, care must be taken to insure

continuity and to avoid creation of gaps in the system. The system must be adaptable and flexible across geographic areas and over time. It must be adaptable to individual and community needs, variations in demography, changes in knowledge and treatment, and the lessons of experience.

The ideal of a seamless, but not monolithic system, is a goal we do not expect to achieve, particularly if we intend that system to be adaptable and flexible. As we attempt to approach the ideal, always striving to reduce barriers and gaps for consumers, we should make use of techniques that overcome those problems and foster healthy change. The technique most often cited is that of using the "case manager," an assertive community or consumer support person, advocate and facilitator who, while not necessarily a mental health professional, understands the systems, is responsive to consumer wishes, and is effective in making the collection of systems work for the consumer in the context of the consumer's environment. The effectiveness of such a support person could be enhanced with some authority to approve expenditures, start care plans, institute crisis intervention or other gap filling actions. The Commission does not like the impersonal "case manager" label, and recommends change to "community support person." It believes the State and other agencies should strengthen and expand "community support person" services as they are described above. As noted elsewhere in this report, the Commission recommends including mental health consumers among those employed as community support persons.

Additional Assessment Studies

There are several areas where additional, detailed planning efforts must be undertaken. These include the issues of mental health services for children and adolescents, services for the elderly affected by mental illness or with mental health needs, services for individuals with multiple problems (such as those affected by mental illness or having mental health problems, and also affected by substance abuse, sexual or other abuse, those affected by mental retardation and mental illness, and those with head injuries), and services for forensic patients (those found not guilty of crimes by reason of insanity) and individuals accused or convicted of crimes and affected by mental illness or having mental health needs. Attention should also be given to areas where there are gaps in services, as in the case of children, adolescents and the elderly. Those planning efforts require priority attention, but because of time constraints could not be examined in sufficient detail by the Commission to warrant extensive findings and recommendations in this report. It should be noted that those areas are identified in this report for State action on public policies and programs and not for the development of responses to individual consumer service needs.

Prevention Through Intervention

One of the areas offering the most substantial opportunities for prevention of some kinds of long term mental health problems is the detection, evaluation, intervention and treatment of individuals in a variety of settings, including families, where serious sexual, emotional or physical abuse is occurring. This

would require significant allocation of resources and important changes in the ways state departments, the courts, and public and private agencies deal with perpetrators and victims of abuse. The need for early intervention and treatment is clearly indicated for all ages, from the very young to the very old, and reports from other states suggest some effective strategies.

Clearly Defined Roles Are Needed

There should be clarity in the assignment of responsibilities for different components of the mental health services system. The roles and responsibilities of the State and each component of the system should be clear.

Insuring Accountability

Accountability must be tied to responsibilities. The State should use a combination of appropriate support, incentives, rewards, contract policies and requirements, sanctions, case review and quality assurance to insure accessibility, quality of services, and elimination of obstacles to services placed in the way of some consumers. That is essential if we are to overcome what J. A. Talbott has described as "the shunning of some populations (for example, the chronically ill) by almost all facilities, and destructive competition for desirable populations between certain facilities."[1] Maine's mental health system must no longer be one in which State inpatient facilities are the only option for the chronically and acutely mentally ill.

Informed Consumer Choice

Informed consumer choice is essential to the responsiveness of the system. Program policies, reimbursement mechanisms, consumer information services and consumer support mechanisms should foster the availability of choices and include assistance in understanding the system.

Supply of Appropriate Personnel Crucial

Education, recruitment, development and retention of mental health, health and social service personnel working with those affected by mental illness or having mental health needs is essential to the development and maintenance of a high quality mental health system. The problem of recruiting clinical professionals, especially for public agencies and in rural areas, is particularly serious.

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[1]Talbott, J.A., Editor's Notes, in Unified Mental Health Systems: Utopia Revisited, New Directions for Mental Health Services, No. 18, J.A. Talbott, ed., San Francisco, Jossey-Bass, 1983.

Education and Training Should Be Broad Based

Education and training for mental health and social service professionals and para-professionals, including program managers, should include entry level (technical, associate degree or baccalaureate), continued or graduate education, continuing education, training, and supervision. All education or training programs should include interdisciplinary components. Consumers of mental health services, their families and other members of the natural support system should be participants in programs to educate and train mental health professionals, para-professionals and other workers. Such training programs should be based on planning efforts designed to insure the availability of appropriate mental health and related personnel in the several mental health regions of the state, especially in more rural areas. Education and training should also address the professional challenges of providing care or support for those with multiple problems and different age groups, from the very young to the very old. The State should work with the University of Maine System, the University of New England, the State Technical Colleges and other educational institutions in Maine and beyond to foster coordination and integration of education programs and to support the education of appropriate professionals, para-professionals and other personnel, trained to meet the needs of those affected by mental illness or in need of mental health services. Education programs related to mental health should be provided for primary care physicians, nurses and other health and social service professionals and para-professionals.

Retention Key

Retention of mental health and related personnel will depend on continuing education opportunities, adequate compensation for services, and support mechanisms that provide professional back-up, peer interaction and respite arrangements. Those needs are general, but they are particularly important in rural areas. Coordination and cooperation with institutions of higher education will be an essential element in insuring the success of such efforts. It is also important to broaden the definition of types of professional and para-professionals that are qualified and suitable for providing such services and thus reimbursable under State and private programs.

Consumer and Natural Support Education

Education, training and support are also essential for consumers and those who are part of natural support systems for individuals affected by mental illness or having mental health needs.[2] Consumers, families and other members of the

[2] The term "natural support systems" refers to families, friends, health service professionals, employers, social clubs, educational, religious, public safety and other sources of support generally available to all members of society. Those systems are important to the well-being of those affected by mental illness or having mental health needs, but are not considered part of the formal mental health therapeutic system.

natural support system should be involved in education and training for professionals and para-professionals.

Care in Protected Settings

There are two groups of individuals affected by mental illness that, at present, require diagnosis, treatment and care in a protected setting: (1) forensic patients (those accused of crimes and found "not guilty by reason of insanity") and correctional institution inmates requiring mental health services; and (2) those whose illness is acute in its intensity and chronic in its duration, who are not functioning consistently in society, have frequent readmissions for care, and, in many cases, are at times an imminent danger to themselves or others.

Access to an appropriate level of inpatient care for those who are mentally ill and an imminent danger to themselves or others, should be assured for all Maine citizens on a 24 hour basis 365 days a year and should not be the sole responsibility of a State facility or facilities.

Forensic Patients and Correctional Institution Inmates Requiring Mental Health Services.

The Commission expects that the forensic patients and correctional institution inmates requiring mental health services will continue to be the sole responsibility of the State. Those services should be provided by the Department of Mental Health and Mental Retardation.

Patients Needing Care in Protected Settings.

As noted above, the Commission recognizes that there currently exists a population of individuals affected by mental illness with acute symptoms of chronic duration, who are not functioning consistently in society, have frequent re-admissions to State institutes, and are considered at times an imminent danger to themselves or others.[3] At the present time, the State Institutes are the primary source of care for those patients. They are a group of consumers that has been generally shunned by private community or psychiatric hospitals. Commission members believe the long term goal with respect to those patients should be to assist them to become functioning, interdependent members of society, able to participate in life outside institutional, inpatient settings. That goal cannot be over-emphasized. That population of consumers should be a

[3] At present there appear to be about 120 AMHI or BMHI patients at any one time who match the that description. That represents about 0.01% of the total population of the state and 0.4% of those in the state who are affected by mental illness. The estimate of patient numbers is based on the work of Dr. Walter Lowell at the Augusta Mental Health Institute, which indicates that the group described has been characterized by more than three admissions to the Institute in two years or 180 days of hospitalization in a ten year period.

priority for treatment services. They will require consistent and carefully designed assistance in making the transition away from institutional, custodial care and a significant commitment of resources and structured program planning.

Transforming the State's Role in Providing Services to Individuals at High Risk as a Consequence of Mental Illness or Mental Health Service Needs

The Commission is offering a vision of a mental health system for society as a whole that is broad and inclusive. At the same time, the Commission is conscious of the need to avoid putting the State in the position of trying to be "all things to all people." There are genuine concerns that the State cannot dilute its responsibilities to those who are at high risk as a consequence of mental illness or mental health service needs. In addressing the needs of high risk consumers, the Commission has worked toward a goal of a flexible, adaptable service system that is responsive to the concerns and interests of consumers and families, and accountable to society as a whole. High on the list of Commission priorities, especially when considering the needs of those individuals who appear to require high levels of treatment and care in protected settings, is the avoidance of a conscious or unconscious dependence on a permanent, institutional form of treatment for a population that is labeled as a permanent problem. As noted elsewhere in this report, the only permanent problem in which sequestration is appropriate is a forensic service for those individuals considered dangerous and found not guilty by reason of insanity or imprisoned as a result of criminal conviction and affected by mental illness or having mental health service needs.

Developing a transformed program for high risk consumers that will insure focused attention on their needs, continuity over times exceeding legislative and gubernatorial terms and the service of individual department commissioners has led the Commission to recommend creation of a Mental Health Advancement Program (MHAP) that is closely linked with the Department of Mental Health and Mental Retardation and regional mental health programs, but directly charged with responsibility for programs designed to meet the changing demands for services for those at high risk from mental illness or mental health needs. The proposed board of directors for MHAP is designed to insure continuing public policy debate and a responsive, responsible and accountable governance structure. We believe that structure can assure continuity and consistency of purpose, coupled with flexibility and adaptability in program development and implementation.

Information Needs

Effective planning, program development, implementation, review and evaluation of mental health services will require much improved and accessible information bases. With the exception of the ten year patient data base developed at the Augusta Mental Health Institute, information on mental health service needs, populations receiving services or at risk, program scope, quality of service, and resource requirements is spotty and generally inadequate. Efforts to gather

information on mental health service needs over the years have been fitful, with sporadic, intensive projects resulting in shelved reports[4]

Last year the department undertook an Adult Mental Health Census that provided a snapshot of adult populations receiving mental health services in State institutes or community programs funded by the department. The department and the University of Southern Maine's Human Services Development Institute are engaged in an analysis of the data collected under the State of Maine-University of Maine System Partnership Program.

As noted earlier in this report, reimbursement programs and policies tend to undermine and block the collection of meaningful information related to consumer service needs. Without adequate information about the needs of consumers, planning and program management cannot be realistically conducted. The development of accurate, relevant and usable information bases and the availability of expertise in interpretation and analysis of the information are critical to any meaningful reform efforts.

In undertaking information base development, priority attention should be given to developments in information technology that can enhance the effectiveness of quantitative analysis. For example, one approach to discovering the patterns of successful psychiatric treatment plans would be to apply a relatively new computer technology: neural networking. That technique functions through a neural network emulator, which actually has the capacity to learn and to be retrained with new data as they become available. Neural networking can identify the most useful parameters in large data sets, de-emphasizing less meaningful data. As a consequence, the system may be able to streamline the data collection process in hospitals and communities, by identifying the most important data to be collected. This may be the most practical way to obtain information that will be useful in statistical analyses aimed at predicting trends, supporting needs analyses, and evaluating programs in individual practices, community agencies and psychiatric facilities.

The Department of Mental Health and Mental Retardation should make use of talent within the department and in academic institutions and should seek grant funding to make use of expertise and newer technologies in building a dynamic information collection, storage, retrieval and analysis system that will support local, regional and state-wide planning.

The acquisition and analysis of quantitative information are, as the Commission has noted, essential in planning, managing and evaluating programs. They are not, however, a substitute for responses to individual consumer needs and capacities in developing and delivering services.

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[4] For example, in 1984 the Northern Tier Planning Group (Aroostook, Penobscot, Piscataquis, Hancock and Washington Counties), convened by then Bureau of Mental Health Director Michael DeSisto, prepared a planning report that included extensive information on service needs that were identified in a Functional Services Questionnaire. That was a one-time effort that did not, so far as the Commission can determine, result in on-going, organized data collection and related planning.

Consequences of Reforms

The reforms contemplated by the Commission will offer substantial benefits to consumers of mental health services and those most directly affected by their problems, but the reforms will also have substantial consequences for institutions and individuals now engaged in providing services to those affected by mental illness or in need of mental health services. It is imperative that every effort be made by the State and by others in positions of responsibility to reduce and, wherever possible and appropriate, alleviate adverse consequences for those at risk because of the reforms. This is particularly important with respect to those employed in and residing in the State's mental health institutes, where reductions in size and scope of services are mandated by the AMHI Consent Decree or contemplated by the Department of Mental Health and Mental Retardation.

In undertaking reductions in institutional facilities and programs and in shifting the locations of services every effort should be made to take advantage of the skills and experience of talented mental health workers who have provided services in those institutions. Their expertise should also be used in planning for community services and for future developments of State inpatient facilities or their replacements.

V. VALUE STATEMENTS

The Commission's recommendations are based on its findings and the following value statements:

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 counselling, 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 counselling, education, vocational, and other support services should be coordinated so that there is continuity in their availability.

Flexibility

The mental health system should be flexible in its approach to the needs of individual clients, 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.

Consumer Focus

Mental health services should be consumer focused, 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.

Consumer Involvement

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

Community Based Services

Diagnosis, evaluation, treatment, rehabilitation, care and support should be provided as near as possible to the place the consumer regards as home base. Care and services should be provided in the least restrictive settings and as community based as possible, with substantial community social support and involvement.

Fostering Interdependence

Treatment, care and other services should foster interdependence, involving families and other natural support systems wherever possible.

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.

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 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.

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.

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.

Holistic Approach

Individuals with multiple needs (for example: those 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, sexual or other abuse, etc.) 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 para-professionals from different disciplines. Different disciplines must also be involved at senior levels in program management and planning.

Consumer and Natural Support Participation

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

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.

Personnel

Recruitment, development, training and retention of highly qualified mental health and related service professionals and para-professionals 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 State Technical Colleges and other educational institutions are crucial to an integrated system of care.

Reimbursement for Services

Reimbursement and support of mental health and related service agencies and individual providers should be set at levels designed to recognize a variety of professionals and para-professionals and to encourage high standards of performance. Such compensation and support policies should be accompanied by clear expectations and mechanisms for assurance of high quality performance and commitment to the elimination of obstacles to access to appropriate care. Reimbursement should be related to the multiple needs of individual consumers and not to narrow program or diagnostic categories.

VI. RECOMMENDATIONS

A. ***State Statutes*** State government should, through the Legislature and the Executive Branch, including the Department of Mental Health and Retardation and other departments and agencies:

1. **provide leadership, facilitate and serve as a catalyst in:**

a. 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 institutions, agencies, organizations and individual providers for those affected by mental illness. The statutes should provide the legal framework for individual rights, equal access, liability and quality assurance related to mental health services. They should insure that those individuals having mental health needs and those affected by mental illness are not discriminated against as they try to obtain services available to the general public.

State statutes governing the role of the State in providing mental health services should be amended to include a clear statement of policies, roles and responsibilities of the Department of Mental Health and Mental Retardation, and goals for the State's mental health system. They should insure the existence and continuing improvement of quality mental health services through:

(1) ***Model Programs*** The state should operate, directly or through contracts, model in-patient and ambulatory programs that incorporate state of the art research, education, diagnosis, treatment, rehabilitation and support;

(2) ***Contracts and Reimbursement*** The State should offer contract, grant and reimbursement programs that provide incentives for efficient, cost effective and high quality service delivery. The State has a direct responsibility to provide, through reimbursement (including Medicaid, other insurance mechanisms and direct funding, as appropriate) or contracts, mental health services from a variety of sources for individuals with mental illness who require emergency, short term in-patient, or out-patient services. Contracts with individuals or agencies for general management and delivery of mental health services should be written for terms of not less than three and not more than five years. Contracts should include reasonable financial protection for service providers in connection with capital investments required to fulfill contracts, in the event a contract is not renewed for reasons other

than failure to comply with the terms of the contract. Contract renewals should not be guaranteed.

(3) ***Licensing Requirements*** The State is responsible for establishing and monitoring licensing requirements for individuals, institutions and agencies providing mental health services. Those requirements should be measurable, clear and related to consumer rights, safety and quality assurance.

(4) ***Standards*** The State is responsible for assuring that professional quality standards and practices are in place and are enforced.

(5) ***Performance Evaluation*** The State is responsible for monitoring quality performance in institutions and agencies providing care under State contracts; and

(6) ***Community Education*** The state is responsible for engaging in consumer and general public education that will help consumers make informed judgements on mental health services.

(7) ***Quality Assurance*** The State is responsible for involving the Department of Mental Health and Mental Retardation in licensing mental health professionals, monitoring the delivery of contracted mental health services, collection of information on professional quality assurance programs, and public education on evaluation of mental health services quality; the department's performance in those areas should be audited by other appropriate departments or agencies; monitoring of contracted services should include collection of information on consumer opinions and the perspectives of other stakeholders.

(8) ***Funding*** The State is responsible for funding for indigent and medically indigent individuals the range of services the State has determined should be available for those having mental health needs and those affected by mental illness, and for insuring that those services are coordinated to assure continuity in the availability of care and to eliminate the fragmentation of services. The State is also responsible for helping to fund priority infrastructure and program activities in clinical research, professional education, public education, natural support system education, and risk reduction programs related to mental health services. The State should also help fund or provide selected services in the community mental health system.

(9) ***Information Base*** The State is responsible for developing and maintaining, directly or through grants and contracts, information bases that will support needed research, planning, evaluation and program development for mental health services. Those information bases should be comprehensive and consistent over time, including consumer need and demand, service, quality assurance, expenditure and revenue source, and other pertinent information. Data should be collected in a cost-effective way and should be stored and retrieved in ways that protect consumer privacy.

B. ***Fostering Community Services*** The State should foster, 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, from promotion of mental health, to support for those in emotional difficulty, to intervention, diagnosis, treatment, rehabilitation, care and support for those affected by mental illness. The Commission is not making any assumptions about the most appropriate sources of those services, whether State or other public agencies, non-profit agencies, for-profit agencies, or individual providers. Experience suggests the wisdom of having a mix of services available, with effective State leadership and oversight through the Department of Mental Health and Mental Retardation and the several advisory bodies, coupled with the regional and subregional boards. By 1995, at least 60% of State mental health spending should be for community system based services. The following actions should be taken to foster the development of additional community services:

1. ***Planning Regional and Community Services*** Planning for improved regional and community mental health systems should address the full range of settings where organized mental health services may be provided, including community hospitals, specialty hospitals, nursing homes, boarding homes, group homes, individual homes or living units, day care centers, social clubs and clinics. Those locations, especially housing, should be considered independent of mental health programs, so that services can move in or out as consumers need or do not need them. Regional and community mental health systems plans should aim to insure that individuals who require long term physical care and support in institutional settings and are affected by mental illness receive that care in facilities in or near their home communities.

   It is essential, if the State is to comply with the spirit, as well as the letter, of the AMHI Consent Decree, and if we are to achieve a statewide, consumer centered mental health system in which appropriate care and support are provided in appropriate settings, as close to consumers' homes as possible, that the State concentrate first on building community and regional capacities to provide those services. That will require early attention to:

a. assessment of consumer need and potential demand for services at the community and regional level;

b. inventory of existing and planned services at the community and regional level;

c. estimate of required corrections in existing services and levels and additions to those service capacities; and

d. planning for and commitment of financial and other resources to support the required services.

2. *Regional Planning and Program Direction Structure*

One of the major objectives of the Commission's recommendations is to shift the center of gravity in mental health program planning, development and implementation as much as possible from a central office to the community and regional level, placing responsibility for subregional and regional programs in accountable and responsive boards, with substantial representation of consumers, families and other natural support system members. The recommendations dealing with planning and program direction structure suggest the allocation of responsibilities and address the question of geographic regions. The areas of structure, roles and responsibilities, and geographic configurations all need intensive deliberations, with broad participation, partially because of the substantial changes in relationships suggested and partially because there are a number of trade-offs and balances to be considered, especially in the geographic configurations of the regions.

The Commission recommends that a minimum of three and a maximum of four regional mental health boards be established and assigned responsibility for mental health planning (including long range planning, priority setting, regional program budgets, review and evaluation). The regional mental health boards should also be responsible for liaison with the Department of Mental Health and Mental Retardation and the Mental Health Advancement Program, approval of regional and local contracts and funding allocations. We recommend against having those boards operate programs or deliver services, other than ombudsman and community support person services. The Commission recommends consideration of appointment of a senior regional staff member, with ex officio board membership, in each region as Regional Ombudsman, with responsibility for supervising the work of the region's "community support persons." Those "community support persons" would be employed by the regional mental health board.

The Commission recommends that each of the regions include several counties and that each county or group of smaller counties, where existing multi-county regions are functioning well, constitute a subregion with a board. The subregional boards would be responsible for electing regional board members, for local and subregional needs assessment and planning, priority setting, and making recommendations to the regional board on policy matters.

Board membership at both levels (county or sub-regional and regional) should include consumers, family or other natural support system members, providers, community leaders, educators, and representatives of the department, as outlined in the detailed recommendations below. Consumer and family or other natural support system members should constitute at least 51 percent of the subregional and regional board members, with primary consumers being at least 25 percent of total board membership in each case. Staffs for the boards should be small, avoiding creation of another layer of bureaucracy. Where appropriate regional or subregional organizations exist, they could be adapted to assume the responsibilities contemplated in this report.

In considering the geographic configuration of the regions, the Commission examined the regional organization of Department of Mental Health and Mental Retardation programs, giving particular attention to concerns expressed about the existing regional configurations. We did so in the context of the Commission's recommendations that more leadership and responsibility for planning, priority setting, resource allocation and program oversight be given to the regions and subregions. We have considered several possible configurations and tested them in Commission sessions and in report drafts. None of the configurations met universal approval, although each developed some support. The following alternatives are presented to stimulate discussion and further thinking. We believe it is important that discussion of regional configurations focus first on the development of criteria appropriate to the values and responsibilities of the proposed regional organizations, such as: assurance of strong local voices in regional planning and policy implementation, commonality of interest, adequate infrastructure support for regional policy and planning boards, efficient use of resources, continuity of services during transition, and relationships with other State human service regions.

Three Regional Options

I. Three Regions

Northern & Eastern Region

Aroostook County
Piscataquis County
Penobscot County
Hancock County
Washington County

Southern Region

Sagadahoc County
Cumberland County
York County

Central & Mid-Coast Region

Somerset County
Kennebec County
Tri-County
- Oxford County
- Franklin County
- Androscoggin County

Mid-Coast
- Waldo County
- Knox County
- Lincoln County

II. Four Regions (A)

Northern Region

Aroostook County
Washington County

Western Region

Tri-County
- Oxford County
- Franklin County
- Androscoggin County

Sagadahoc County
Cumberland County
York County

East-Central Region

Piscataquis County
Penobscot County
Hancock County

Central & Mid-Coast Region

Somerset County
Kennebec County
Mid-Coast
- Waldo County
- Knox County
- Lincoln County

III. Four Region (B)

Northern Region

Aroostook County
Piscataquis County
Somerset County

Southern Region

Oxford County
Androscoggin County
Sagadahoc County
Cumberland County
York County

Eastern Region

Penobscot County
Washington County
Hancock County
Waldo County

Central Region

Franklin County
Kennebec County
Knox-Lincoln Counties

3. ***The Commission recommends the following initial steps***:

a. ***Development of Regional Structures*** We recommend that the Commissioner of Mental Health and Mental Retardation create a task force with appropriate and balanced geographic and constituency membership, including at least 51 percent consumers, family and other natural support system members, that would, working with the Commission on Mental Health, the Mental Health Planning Council, participants in the Commissioner's Visions Conference and other interested parties, develop by December 1991, for consideration in the Second Regular Session of the 115th Legislature, recommendations for legislation establishing regional and subregional mental health boards, including geographic designations, scope of responsibilities and accountability, and governing board membership requirements.

b. *Accountable Community Input* Increased support for the development of accountable local, regional and statewide mental health services planning processes and plans. Planning for development of local and regional systems must be carried out by representative bodies that include consumers, support persons, clinical and social service providers (including direct care providers), community leaders, educators and State personnel. We believe the kinds of boards and regional-subregional structures we are recommending would be the appropriate kinds of bodies to carry out that planning. It should be supported and coordinated by the Mental Health Planning Council.

c. *Consumer, Family and Other Natural Support System Members Input* Consumer, and family input on service delivery, quality assurance and planning is crucial and must be sought. By December 1991, membership on regional and subregional mental health boards, planning or program governance committees or boards in existence or proposed to be created should include consumers, family and other natural support system members, community leaders, mental health and social service providers, educators, and department representatives. Fifty-one percent of the total membership of such boards and committees should be consumers and natural support system members, with a minimum of 25 percent of the total membership being primary consumers.

c. *The Mental Health Planning Council* The Mental Health Planning Council is the appropriate body to lead in the planning effort, developing recommended processes for regional and local planning groups, providing technical assistance (this would require additional funds and staff resources for the Council), and integrating the results of local and regional planning with its own recommendations for statewide planning and plans; department personnel should, wherever possible, participate in (but not direct) the planning efforts; local and regional involvement is essential to insure appropriate recognition of individual and community needs and to foster local and regional support for program decisions and implementation. The responsibilities of the Mental Health Planning Council, which exists now under a federal mandate only, should be spelled out in Maine law. The Commission recommends that statutory language to implement that step be enacted in the current session of the Legislature. By December 1991, the State mental health planning process should be designed to build from local and regional planning; local, regional and State plans should articulate goals and objectives that are measurable; and the Mental Health Planning Council should have initiated technical assistance and leadership for subregional and regional mental health boards. A system of local and regional mental health planning, managed by the subregional and regional mental health boards, should be operating by December 1992.

In the long run, it may be desirable to merge the Mental Health Planning Council functions with those of the Commission on Mental

Health. During the transition period of the next four or five years, however, the Systems Assessment Commission believes both bodies will be needed to carry out their respective functions.

d. ***The Commission on Mental Health*** The Commission on Mental Health is the appropriate body to provide general oversight and targeted reviews and evaluations of the development of mental health service plans and the results of the implementation of local, regional and statewide mental health planning programs. It should continue in its present capacity, strengthening and focusing its oversight, review and comment activities. Membership on that Commission should include at least 51 percent consumers, family and other natural support system members, with a minimum of 25 percent of the total membership primary consumers. That membership goal should be achieved no later than December 1992.

e. ***Task Forces*** It is the role of the State to address reimbursement, health insurance, provider liability and other mental health service and related funding issues that affect the availability of, access to and continuity of mental health services. Special attention needs to be paid to reimbursement programs and policies that will foster and support continuity of care, expanded consumer choice of providers, and the elimination of fragmented, disjunctive service patterns.

(1) The Department of Mental Health and Mental Retardation should, directly or through the Commission on Mental Health, establish by September 1991 a task force composed of representatives of the Department of Human Services, the Maine Health Care Finance Commission, the Maine Hospital Association, the Maine Health Care Association, provider associations, consumers, insurers and others to design funding mechanisms that would 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 should 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. The task force should work closely with subregional and regional mental health planning and governance organizations. Its analysis should include examination of the issue: which mental health services and which mental health providers should be reimbursable? The task force should submit by August 1992 its findings and recommendations to the Department of Mental Health and Mental Retardation, the Mental Health Advancement Plan Board, the regional and subregional mental health boards, the Department of Human Services, the Commission on Mental

Health, the Mental Health Planning Council and the Joint Standing Committee on Human Resources.

The purpose of the task force should be to increase the available options for acute, voluntary and involuntary mental health services in the community and a decreased focus on centralized State provided involuntary mental health services. The issues addressed should include the possibility of compensating family members for services provided to those affected by severe and chronic mental illness.

(2) The Department should, directly or through the Commission on Mental Health, establish a second task force, also by September 1991, composed of consumers, family and natural support system members, community leaders, and representatives of health, mental health and social service providers, to develop recommendations for the elimination of non-economic barriers to services for acutely and chronically mentally ill persons. The task force should work closely with local and regional mental health planning and governance organizations. The task force should submit by August 1992 its findings and recommendations to the Department of Mental Health and Mental Retardation, the Department of Human Services, the Commission on Mental Health, the Mental Health Planning Council and the Joint Standing Committee on Human Resources.

(3) The Department, directly or through the Commission on Mental Health, should establish by September 1991 a task force on the elimination of barriers to housing and other essential services for persons who are acutely and chronically mentally ill. The task force should work closely with local and regional mental health planning and governance organizations. The task force should submit by August 1992 its findings and recommendations to the Department of Mental Health and Mental Retardation, the Department of Human Services, the Commission on Mental Health, the Mental Health Planning Council and the Joint Standing Committee on Human Resources.

C. ***Crisis Intervention Services*** The State should assist regional and community mental health systems to build and maintain crisis intervention services. By 1992 the Department of Mental Health and Mental Retardation should have helped establish at least two model 24 hour, 365 days per year crisis intervention programs that:

1. Reduce risks: are designed to reduce risks to individuals having mental health needs or affected by mental illness who may be a danger to themselves or others;

2. Transitional: are aimed at resolving crises and providing stabilization and a transition to appropriate levels of care and other services;

3. Mobile and residential: are designed and organized to include mobile intervention teams, community crisis beds and other related services;

4. Continuity and comprehensiveness: are developed to be a part of a comprehensive community system that insures continuity of services, to provide training to community mental health providers in crisis intervention and stabilization, and to serve as a resource to community providers on liability, commitment and other issues related to crisis intervention in community settings.

D. *Data Collection and Analysis* The Department of Mental Health and Mental Retardation, through its own staff and through the University of Maine System and other institutions with research and analysis capacity, and working with the Department of Human Services, Maine Health Care Finance Commission, Department of Education, Office of Substance Abuse and other pertinent State agencies, should obtain information and independent analyses bearing on service needs and demands, program evaluations, personnel, facilities, equipment and financial requirements and make them available to the Mental Health Planning Council, the Commission on Mental Health, regional and local mental health planning and governance bodies; those analyses will contribute to improved quality in plan development, evaluation, and revision of local, regional and statewide plans. Mental health data collection requirements for State, public and private inpatient and long term care facilities, outpatient services, counselling, psycho-social rehabilitation, career counselling and development, education, residential services and other social services should be rationalized to insure acquisition of accurate, relevant, consistent and useful information in a cost-effective way that insures protection of consumer privacy.

By December 1991, the Department should submit a report to the Legislature providing information on the status of existing departmental and related information bases, and detailing plans for implementation of a comprehensive and consistent information system by December 1992 that will support local, regional and statewide mental health service planning.

E. *Comprehensiveness, Continuity and Coordination of Services* Planning for improved regional and community mental health systems should insure comprehensiveness, continuity and coordination of services for those affected by mental illness or having mental health needs, within the context of consumer choice, through consumer need focused reimbursement, case management/support mechanisms, service teams, and support for other linkages among mental health service providers. The focus of local and regional services should be comprehensiveness, continuity and coordination of care and support that is consumer focused and includes consumer participation in decision-making. Financial support, including

compensation for provider services, must be designed to foster that continuity of care and support and to eliminate service gaps for all age groups. By March of 1992, an element of all contracts with state funded providers of mental health services should include an acceptable description of how they will assure continuity of care and integration of community services for the individuals they serve and how they will insure consumer and community input and choice.

F. ***Responsibility and Accountability*** The State should, in concert with regional and local groups, develop policies and mechanisms that result in clear assignment of responsibility and accountability for oversight and service delivery in regional and community mental health systems. It is the State's responsibility to provide support and leadership in the integration and coordination of mental health services. By December of 1992, with the assistance of community and regional and subregional mental health planning and governance boards, the Department should develop guidelines for local and regional plans that will delineate clear lines of responsibility and accountability for continuity of care, service delivery, quality assurance, and program evaluation.

G. ***Acute, Community-based Inpatient Services*** Acute, short-term voluntary and involuntary inpatient care services for individuals affected by mental illness should be provided in strategically placed community facilities. Community and regional services to support current or potential AMHI or BMHI patients whose care and support would be better provided at the community or regional level should be in place before those AMHI or BMHI patients are discharged or their admissions are prevented on the basis of mandated downsizing. It is the role of State government to facilitate and assist in the development of appropriate inpatient services in community based settings.

H. ***Community and Professional Education*** The state should foster and support greater emphasis on community and professional education related to mental health, including risk reduction and supportive attitudes coupled with the elimination of stigma associated with those affected by mental illness or substance abuse problems. It is the role of the State to serve as a catalyst in providing public education and clarification on the risks presented by some individuals affected by mental illness who are a danger to themselves and others, and distinguishing between those individuals and others who are dangerous but not affected by mental illness. The State should facilitate the establishment of strong cooperative relationships between universities, colleges, medical schools, teaching hospitals, teaching nursing homes, and other public and private mental health services institutions, agencies, organizations, and individual providers.

A community education plan should be developed in conjunction with consumers, families and other members of the natural support system, community leaders, legislators, the University of Maine System, the University of New England, the Vocational Technical Colleges, other educational facilities, and professional licensing boards. The Department of Mental Health and Mental Retardation should establish a community

education task force by March 1991, composed as indicated above. By December 1991, the task force should submit a plan, including measurable goals and objectives, timetables and financial estimates, to the Department, the Maine Commission on Mental Health, and the Joint Standing Committee on Human Resources. The plan should address the following:

1. Mental health personnel: mechanisms for improving recruitment, development and retention of high quality mental health service and related personnel and training for mental health professionals including recognition of the role played by natural support systems, the needs of multiple problem consumers, and the provision of interdisciplinary studies; mechanisms for promoting education programs for those preparing for mental health service careers and those already engaged in mental health services delivery as professional care givers, paraprofessionals, managers, and support personnel; scholarships and other financial assistance designed to reduce obstacles to those wishing to pursue mental health careers, coupled with provisions for a period of public service employment in Maine for those receiving education aid, immediately following completion of their education.

2. Community education: continuing education and training, provided in part by consumers and natural support system members, for clergy, family members, consumers, teachers, public safety officers, emergency medical technicians, prosecutors, judges, corrections officers, probation and parole officers, targeted population groups, and the community at large; providing public education aimed at fostering supportive community attitudes and eliminating stigma so that those affected by mental illness, including those with multiple problems, will have greater opportunities to achieve interdependence and their potential as productive members of society.

3. Continuum of education and training programs: Education and training programs for mental health and related service providers and others should include a continuum of training including vocational training, undergraduate associate, baccalaureate, graduate, continuing education, short courses, lectures, printed materials, audio visual materials, and general information delivered in a variety of ways to different sites, including those involved in geriatric care. That continuum should be linked with career ladder opportunities for mental health workers.

   In its inquiries regarding the availability of undergraduate, graduate and continuing education for health professionals and para-professionals in Maine the Commission found gaps in knowledge of programs available at the several University of Maine System campuses. Those gaps were apparent even within the University. The Commission recommends that, in addition to any broader health and social service professional education planning the University may undertake, on its own or in conjunction with Department of Mental Health and Mental Retardation planning, the departments of the colleges of the University of Maine System that provide education

and training to mental health professionals, the Maine Technical Colleges and appropriate departments from the University of New England form a task force to coordinate and, where desirable, consolidate their mental health education and training programs. The commission recommends that the University also invite the chairs of appropriate State licensing boards to be members of the task force. The Commission recommends that the task force be formed by March 1991 and report on a unified and comprehensive program by October 1991.

I. ***Natural Support Systems*** The State should encourage and support regional and community programs to develop and foster natural support systems (community systems as well as families and close associates) for those affected by mental illness and those with mental health needs. It is the role of the State to support advocacy services, including peers, families and others, and to strengthen natural support systems through education and training. The support should include at a minimum, the following:

1. **Consumer representation:** Beginning in January 1991, formal requirements should be instituted for all newly established State mental health and related program service boards, committees and commissions to insure that at least one quarter of the members are consumers and that at least fifty-one percent of the members are consumers and families or other members of natural support systems.

2. **Consumer assistance:** Consumer education and assistance on available services and choices is crucial to their ability to make informed decisions and gain access to the services they select. By September 1991, the department should have established a consumer information clearinghouse and assistance program with a toll free number, so that consumers and their families and natural support systems, community support persons, case managers, and service providers can obtain information they need to identify and make judgements on existing services and programs, and gain assistance from the department in gaining access to selected services.

3. **Support for mutual-help:** Recognition of the importance of mutual-help and support through families, social clubs, residential programs, consumer participation in crisis intervention, and other support systems should be fostered. The department should continue to support the Alliance for the Mentally Ill, consumer coalitions, and other self help groups. By December of 1992, there should be at least 3 extended-hour social clubs which are linked to crisis intervention programs and one program whose purpose is to link consumers without natural support systems with volunteers willing to serve in that capacity. By December 1991 the Department of Mental Health and Mental Retardation should submit to the Legislature a plan for providing compensation to families and other natural

support system members who need financial assistance to provide direct care and support to acutely and chronically mentally ill individuals.

4. ***Respite Services*** The State should provide assistance to regions and communities for development and maintenance of regular and emergency respite arrangements, including in-home services, to alleviate pressures on families or close associates who provide support for those affected by mental illness. By 1995, respite programs should be available in each of the sixteen counties. Subregional and regional planning goals and objectives should include targets for reduced numbers of crises requiring interventions and other improvements resulting from improved access to respite services.

J. ***Prevention through intervention*** The Commission recommends that the State undertake a targeted detection, evaluation, intervention and treatment program for individuals in environments, including family situations, where serious sexual, emotional or physical abuse is occurring.

1. The Commission heard compelling testimony that the State has an opportunity to prevent the terrible consequences of sexual, emotional or physical abuse for many potential victims if it will undertake a concentrated, comprehensive and coordinated program of detection, intervention, counseling, treatment, correction (where necessary), and rehabilitation of sexual abuse perpetrators, coupled with counselling, treatment and support for victims and their families or close associates. There are significant problems that affect all ages, from the very young to the very old. The results of such abuse can include destruction of families, mental health problems, substance abuse, disruptive and destructive behavior, and perpetuation of patterns of abuse into another generation. The human cost is terrible and the social and economic losses are substantial. There is evidence from other states that there are effective ways of dealing with the problem. It may require changes in existing statutes related to child abuse. It would require investments in education and training, reorganization of state and other services, close coordination between the Departments of Mental Health and Mental Retardation, Human Services and Corrections and the Office of Substance Abuse, and investments in personnel. Greater emphasis needs to be given to providing all families entering the Department of Human Services protective services system the opportunity to use Bureau of Mental Health family intervention and assistance services.

2. The Commission recommends that the Departments of Mental Health and Mental Retardation, Human Services and Corrections and the Office of Substance Abuse, using the Mental Health Planning Council and the Health Policy Advisory Council, initiate planning for such a program by March 1991, and report to the Legislature in December 1991, for legislative consideration in the Second Regular Session of the 115th Legislature, and implementation of the program by January 1993.

K. *Services for Individuals with Multiple Needs*

1. FINDINGS

The Commission has found that there are separate systems for providing services to individuals with mental health needs and substance abuse problems, but they are not coordinated. There is a mental health system with responsibility for services to those individuals affected by mental illness or with mental health needs, some of whom have substance abuse problems. There is another system for those identified as having a substance abuse problem, many of whom may also have mental health needs. A third type of service delivery designation has recently appeared -- facilities or programs for those persons labeled as "dually diagnosed," those with a substance abuse disorder and a mental illness. There is evidence, in addition, that responsibility for coordinating substance abuse services has not been matched by the full range of resources, authority and support required by the Office of Substance Abuse to insure collaboration, cooperation and continuity in the availability of services.

The existence of separate systems and the use of the "dual diagnosis" label create obstacles to holistic treatment, care and support. Nowhere is the need for non-fragmented approaches to the medical, physical, mental, emotional, spiritual and social needs of individuals more apparent than in the area of substance abuse and mental health. But Maine's separate systems lack an adequate level of interagency cooperation, interprofessional communication, and they focus on diagnoses rather than persons. The "dual diagnosis" label compounds the problem by imposing a stigma so significant its victims may be shunned, even by professional care givers. The absence of cross-disciplinary training, the absence of interprofessional communication, and the lack of recognition of the interaction between mental health and substance abuse problems has resulted in diminished treatment skills. Substance abuse programs have historically been designed to focus on physical detoxification, then sobriety. Psychiatrists and medical/surgical units of community hospitals tend to ignore the existence of substance abuse. Restrictions in reimbursement and segregated funding of mental health and substance abuse programs further complicate and disrupt efforts to integrate substance abuse and mental health services.

Consumers of mental health services have complained to the Commission about years of delay before the "other half" of their mental health needs -- substance abuse problems -- was assessed and addressed. Providers of substance abuse and mental health services pointed up the ways in which their work has been distorted by reimbursement policies.

The Commission has also found that the responsibilities for State regulation and evaluation of providers of mental health and substance abuse services are also divided and not fully coordinated. This fragmentation contributes to poor services, turf battles and excessive paper work for treatment professionals and agencies. Current education and training curricula for mental health professionals and substance abuse counsellors do not encourage an integrated approach to mental health and

substance abuse treatment. Psychologists, psychiatrists, counselors, social workers and other mental health professionals and para-professionals do not tend to study substance abuse, sexual and other forms of abuse recognition and treatment. Substance abuse counselors do not tend to acquire a basic knowledge of mental health issues. Professional associations, educational institutions and agencies employing mental health professionals and para-professionals and/or substance abuse counselors should take steps to broaden and improve curricula for entry level education and continuing education and training in those cross-disciplinary areas. In addition, the Department of Mental Health and Mental Retardation and the Office of Substance Abuse should take steps to insure appropriate levels of cross-disciplinary knowledge in senior leadership or consulting positions related to management and training in mental health and substance abuse programs provided or funded by the State.

2. RECOMMENDATIONS

a. ***Insure Integration and Collaboration in the Systems*** The Commission recommends that the Office of Substance Abuse be strengthened in its role as the lead and coordinating agency for substance abuse programs through appropriate levels of funding, control over funding of substance abuse activities, and ability to protect against other agencies cutting substance abuse activities. Those improvements would enable the Office of Substance Abuse to insure focus, coordination and availability of services. The Office should also be given clear primacy in its role as program coordinator through status as chairing agency for an any interdepartmental committees or task forces dealing with substance abuse issues. The Commission recommends that those moves be accomplished by June 1991. The Commission recommends that the Department of Mental Health and Mental Retardation and the Division of Substance Abuse, with advice and consultation with the Commission on Mental Health, the Mental Health Planning Council, the Maine Council on Drug and Alcohol Abuse, Prevention, Treatment, develop a plan for integrated service delivery for individuals with coexisting substance abuse problems and mental health needs, including coordination and collaboration at the regional level, and submit statutory recommendations for its implementation. That working group should consult with the task force on subregional and regional mental health boards structuring. The Commission recommends completion of the plan by July 1991 and submission of the legislative proposals in time for action in the second regular session of the 115th Legislature.

In making this recommendation the Commission is acutely aware of the different approaches, perspectives and contributions substance abuse and mental health service providers have made to the understanding, treatment and rehabilitation of individuals with coexisting substance abuse problems and mental health needs. The different perspectives of those approaches must be maintained, sustaining the healthy tension between them while fostering the advantages of cross-fertilization of ideas and skills. The Commission believes its recommendations, if implemented, will strengthen the continuity and effectiveness of the substance abuse program, by

strengthening the Office of Substance Abuse, broadening interdepartmental cooperation, and by the expanded opportunities for interrelationships between the substance abuse and mental health specialists. The Commission is particularly concerned that mental health and substance abuse agencies employ high level staff or consultants with cross-disciplinary skills to provide leadership in continuing education and training and the delivery of services. The Commission considers its recommendations consistent with the suggestions of the Maine Group, American Medical Society on Alcohol and Other Drug Dependency that substance abuse agencies, mental health and mental retardation facilities must "role model a cooperative interagency approach to case management."

b. ***Reimbursement and Regulation*** The Commission recommends that the Commission on Mental Health, the Mental Health Planning Council, the Dual-Diagnosis Task Force and the Maine Council on Drug and Alcohol Abuse, Prevention, Treatment and Education, in consultation with the Health Policy Advisory Council, develop and submit proposals for statutory reform in regulation and reimbursement structures for combined or coordinated mental health and substance abuse services in time for consideration in the second regular session of the 115th Legislature.

c. ***Interdisciplinary Continuing Education and Leadership*** The Commission recommends that the University of Maine System, the University of New England, the Maine Technical Colleges and other pertinent education institutions, working with the Office of Substance Abuse, Department of Mental Health and Mental Retardation, the Department of Human Services and appropriate professional associations and licensing boards 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 consultants in key leadership or training positions in mental health and substance abuse programs, and requirements for interdisciplinary continuing education and service support in State provided or funded mental health and substance abuse programs.

L. *Services for Forensic Patients and Inmates of Correctional Institutions*

The Commission recommends that the State, with the Department of Mental Health and Mental Retardation acting as the lead agency, undertake planning to reform mental health services for forensic patients and others charged with or convicted of crimes and requiring mental health services.

1. The Commission has concluded that an expanded mental health services program for forensic patients and others charged with or convicted of crimes should be provided by the Department of Mental Health and Mental Retardation, with the assistance and cooperation of the Department of Corrections and the Office of Substance Abuse.

Planning for such expanded services should be undertaken in conjunction with planning related to the Augusta Mental Health Institute and its existing forensic program, and in concert with reform of the organization and delivery of mental health diagnostic, treatment and rehabilitation services provided to those accused of crimes and inmates in State and county correctional institutions.

2. The Commission could not undertake a detailed review of the mental health needs in correctional institutions, but information provided to it indicated a need for substantial improvements. The Commission is recommending, therefore, 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. We believe the basic work on such a planning project could be completed by December 1991, if it were initiated by March of that year. The Department of Mental Health and Mental Retardation should be the lead agency for such a planning effort, using the Mental Health Planning Council as the planning body, supplemented by consumer representatives, and representatives from the Department of Corrections, the Department of Human Services, the Department of Public Safety, the Office of Substance Abuse, the Court System and the Attorney General's office.

3. As noted above, the Commission recommends that public safety officers, prosecutors, judges, corrections officers and probation and parole officers be provided with continuing education on mental health issues.

M. *The Maine Mental Health Advancement Program (MHAP)*

1. FINDINGS

In the course of its deliberations and exchanges with consumers, families, advocates and providers, the Commission has found a persistent pattern of becoming trapped by existing institutional arrangements and systems. All of the constituencies drift into that trap, whether they lean toward the view that there will be a permanent need for institutional care for some individuals affected by mental illness or whether they deny the long term need for any institutional settings for in-patient care. The existence of Maine's two mental health institutes, the fact that no other state has managed to eliminate its state institutions, and the current demands on states as the "last resort" for difficult patients tend to dominate thinking about the future of mental health systems. The Commission was no exception to that pattern.

We have described patients whose symptoms of mental illness are acute in their intensity and chronic in their duration. They, because of those characteristics and the fact that they are for greater or lesser periods of time a danger to themselves or others, appear to need care in protective settings. They are also individuals who have been shunned in community treatment settings. They are the individuals, along with forensic patients, for whom the State has become responsible. In our initial draft report, we suggested the need for three State mental health centers to provide care for about 120 of those patients, at least in the next ten years or so. We were criticized for such firm predictions. And we were uncomfortable with the suggestion that there was permanent population that would need institutional care. We had suggested three ways of ameliorating the problem of maintaining or creating institutions: (a) establishing a board of directors to provide governance and set policy for the centers; (b) keeping the size of the center's relatively small; and (c) making the centers teaching centers with responsibilities for education and training leadership in the community. Even that was not sufficient to eliminate our concerns or the criticisms of others. At the same time, we could not in conscience pretend that the State could in the foreseeable future, given the present state of knowledge, eliminate the need for State responsibility for in-patient services for forensic patients or for others who need care in protected settings and are a danger to themselves or others.

Our challenge was to find a way to frame a program that did not, with the exception of forensic patients and corrections inmates with mental health needs, assume a "permanent" population for whom the State would be responsible as the "last resort" of treatment. It would have to be a program that was dedicated to the primacy of individual consumer interests, within the context of protecting society's legitimate interests in public safety, a program that would be flexible over time and responsive to changing knowledge about mental health and mental illness, a program that was directed toward community involvement and community support, and a program that emphasized teaching and clinical research aimed at improving the quality of mental health services.

We have concluded that a Maine Mental Health Advancement Program (MHAP), dedicated to providing leadership in clinical and related services for those at high risk because of difficult and significant mental health problems, responsible for fostering education and research programs, and mandated to develop and implement services that move as quickly as possible into the community, offered the best opportunity to reduce our dependence on institutional patterns of the past, without being unrealistic about the need to deal with serious, troublesome and daunting mental illnesses and behavioral problems.

The underlying assumption of our proposal is that the kinds of mental health problems that are considered exceedingly difficult to treat in more routine settings will change over time. In our work we have focused on the current population of patients who appear to be dependent on long term, institutional care, stating that we should not assume that they

represent a population requiring permanent in-patient treatment. We have been confronted with the issue of young patients in the institutes who are very difficult patients. We have been reminded of the growing number of very young children who have severe behavioral problems. We know of a growing population of children damaged by chemical and other forms of abuse. We are aware of the challenges presented by the growing number of older elderly, a number of whom have serious mental health, behavioral and neurological disorders, in addition to any usual mental health needs associated with aging.

We see the Mental Health Advancement Program (MHAP) as similar to the National Institute of Mental Health as a leader in the development of programs in response to serious mental health problems. MHAP would be in a position to anticipate special mental health service needs and to develop approaches that alleviate or solve the identified problems, using lessons from other national and state programs and aiming toward solutions that are least restrictive. Part of the mandate would be to have MHAP identify problems, develop pilot projects that include review to determine when a project may be ended or modified. MHAP would also be expected to develop cooperative programs with Maine communities and regions (with public and private advocacy groups and providers). The cooperative programs would include education for mental health personnel, other health and social services providers, consumers, natural support system members, and the community at large, all carried out through consultation with [the Department of Mental Health and Mental Retardation], the Commission on Mental Health, the Mental Health Planning Council and the regional mental health boards. The Maine Mental Health Advancement Program would be charged to recognize the differences in local mental health needs and community solutions. Those differences would be valued and enhanced rather than rejected and diminished. A flow of ideas and information would work in both directions, between the subregional and regional mental health boards and the Mental Health Advancement Program, insuring attention to regional and local factors and maximum use of regional and local resources in the development of programs for high risk populations.

The Maine Mental Health Advancement Program would provide the vehicle for diversified expertise and experience so needed in a dynamically evolving system. Drawing upon the expertise of the Commission on Mental Health for special studies, oversight, and evaluation and the Mental Health Planning Council for direction, technical assistance and strategic planning, MHAP would make use of resources already in place. To establish a well defined relationship between the Board and the Bureau of Mental Health, boundaries of responsibility would need to be clear. The Bureau of Mental Health's responsibility would lie in the areas of regulation, consumer rights and quality assurance, the technical assistance for the implementation of programs established by the board and analysis and funding recommendations. The Maine Mental Health Advancement Program Board's responsibility would include planning, target populations, the identification of teaching and clinical research needs, forensic services, and services to high risk populations.

MHAP would have permanent responsibility for forensic programs and would have a significant role in reform of that system. It would have the immediate mandate to plan and oversee the transformation of AMHI and BMHI, focusing on their replacement by other facilities or other arrangements.

We are recommending that MHAP be governed by a board of directors that has more than 25 percent of its members represented by consumers and more than 50 percent represented by consumers, families and other members of the natural support community. The Commissioner of Mental Health and Mental Retardation would be an ex officio, voting member of the board. The Commissioner of Human Services and the Commissioner of Corrections would be ex officio, non-voting members of the board. We also recommend that the regional mental health boards elect the consumer and natural support system members of the board of directors of MHAP. The board would be responsible for setting policies, appointing its chief executive officer and other senior personnel, including the chief operating officers of state institutes or other mental health facilities. The board would also make recommendations to the governor and legislature on funding and other matters. In many ways the board would be comparable to the Board of Trustees of the University of Maine System or the trustees of the Maine Technical College System.

The Commission believes the MHAP, with its board of directors, would overcome one of the most serious problems encountered by other states in their efforts to reform services for individuals affected by severe and chronic mental illness: the lack of continuity and consistency in leadership over time. Legislatures change every two years. Governors may change every four years. Commissioners have uncertain tenures, especially in times of stress and change. The board of directors of MHAP would, through staggered, overlapping terms, have continuity and a tendency to think in longer terms.

B. ***RECOMMENDATIONS***

We recommend that the State of Maine create the Maine Mental Health Advancement Program, to be governed by a board of directors of 15 members. Six would be appointed by the Governor and 8 elected by the regional mental health boards and confirmed by the Senate. The fourteen members appointed by the Governor and elected by the regional mental health boards would be selected in three groups (5, 5 and 4) to three year, overlapping terms. The fifteenth voting member of the board would be the Commissioner of Mental Health and Mental Retardation. The board would elect its chairperson and other officers annually. There would be, in addition, three non-voting members: the Commissioner of Human Services, the Commissioner of Corrections and the Director of the Office of Substance Abuse, ex officio. Appointed and elected members would be eligible to serve only two consecutive terms. At least four members of the board would be consumers of mental health services, and four members of natural support systems (family members or other secondary consumers). The remaining six public members could include direct service providers as well as other community leaders. For the initial appointments to the

Board, pending organization of the regional mental health boards, the Commission recommends that the governor be authorized to appoint the consumer and support system members from a list of nominees submitted by the consumer and natural support system members of the Commission on Mental Health and the Mental Health Planning Council.

The board would be responsible for setting policies for MHAP, which would include treatment of forensic patients and correctional institution inmates requiring mental health services, and for the development and implementation of model treatment, care and support programs for individuals with high risk mental health problems. The board would be responsible for the development, operation and maintenance of any State in-patient mental health programs or facilities. The board would appoint and supervise MHAP's chief executive officer and other senior personnel, including the chief operating officers of state mental health institutes or other facilities under the direction of the board. The board would advise the Governor and the Legislature on statutory, funding and other public policy matters related to MHAP.

The initial responsibilities of the board would include policy-making and supervision of the Augusta Mental Health Institute and the Bangor Mental Health Institute.

The Commission recommends that the MHAP be created by September 1, 1991.

The Commission recommends that the legislation creating the MHAP and its board include a requirement that the board develop plans for replacing the AMHI and BMHI facilities with other arrangements (new facilities or contracts), and plans for forensic and related correctional programs, submitting its recommendations to the Governor and the legislature by July 1, 1992, and setting a target date of December 31, 1997 for completion of replacements for AMHI and BMHI and implementation of the new forensic and correctional programs. The Commission recommends that any proposed new facilities for replacement of AMHI or BMHI not exceed forty beds and that nursing units in such in-patient facilities not exceed 20 beds. The Commission also recommends that the board be directed to work with the Department of Mental Health and Mental Retardation, the Commission on Mental Health, the Mental Health Planning Council, and regional and sub-regional mental health boards, in developing and changing its program and facility plans.

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