PINELAND CONSENT DECREE

TABLE OF CONTENTS

Vol. 1

Vol. 2

SOUTHERN DIVISION

MARTTI WUORI, et al., Plaintiffs	)	
v.	)	CIVIL NO. 75-80-SD
GEORGE A. ZITNAY, et al., Defendants	)	App. A: Pineland Standards App B: Community Standards

CONSENT JUDGMENT

Upon the joint motion of plaintiffs and defendants, it is hereby ordered, adjudged and decreed:

1. Plaintiffs are mentally retarded citizens of the State of Maine either involuntarily confined to Pineland Center, a state institution, or conditionally released by Pineland Center authorities to state-approved community placements. They bring this action, pursuant to 42 U.S.C. §1983, claiming violations of their constitutional and statutory rights to be free from harm and to receive habilitative services necessary for helping them achieve their maximum potential.

2. This Court has jurisdiction of the subject matter, and plaintiffs' complaint states a cause of action pursuant to 42 U.S.C. §1983. On October 7, 1975, this Court certified plaintiffs' motion to proceed as a class action, and proper notice to the class issued.

3. Without admission of liability and prior to submission of this case on the merits, the parties have agreed to entry of a consent judgment detailing a comprehensive plan designed to bring about speedy and meaningful relief. This plan is attached hereto and incorporated herein as Appendices "A" and "B."

4. Notice to the class, pursuant to Rule 23(e) of the Federal Rules of Civil Procedure, of the proposed settlement of this case by consent having been given on July 5, 1978; and a hearing having been held on the proposed consent decree on July 14, 1978; and no

objections to the terms of the proposed decree or reasons why the decree should not be approved having been brought to the Court's attention; and the Court having determined that the class has been fully and adequately represented by counsel; the Court hereby approves this judgment and Appendices "A" and "B."

5. Within their lawful authority, defendants are hereby ordered and enjoined to take all actions necessary to secure implementation of this judgment, including Appendices "A" and "B," in a prompt and orderly manner.

6. Defendants shall delegate among themselves and their subordinates responsibility for the appropriate and relevant actions necessary to implement this judgment, including coordination with other State agencies as is necessary and proper to the full implementation of this decree. Defendants shall take all steps necessary to ensure the full and timely financing of this judgment, including, if necessary, submission of further appropriate budget requests to the legislature.

7. This judgment and Appendices "A" and "B" shall be applicable to and binding on the defendants and their successors, their agents, servants and employees. In addition, defendants shall include in every future contract requiring an agent or independent contractor to perform duties that would otherwise be performed by defendants or their employees, a clause requiring the agent or independent contractor to perform these duties in accordance with the requirements of this judgment and Appendices "A" and "B" insofar as they are relevant to said contracts.

8. Defendants shall post in each and every building at Pineland Center, and shall either post in each community facility where members of the class reside or deliver to members of the class in the community, a notice that the Court has issued a judgment setting forth standards and procedures to be applicable to plaintiffs, and shall ensure that a copy of that judgment is available for inspection during regular business hours by employees and agents of defendants, as well as by parents, relatives,

legal guardians, and interested members of the public, at the administration building at Pineland Center and in each regional office.

9. Defendants agree to make available to individuals and local agencies and consumer organizations upon request copies of the decree including the Appendices.

10. The Court has determined that a Master should be appointed to monitor the implementation of this decree. The appointment shall be made by separate order after consultation with the parties.

11. The Court hereby retains jurisdiction over this matter for two years, at which time the Court shall consider whether to retain jurisdiction for an additional period of time. Any party may, at any time, apply to this Court for such orders as may be necessary or appropriate.

12. Plaintiffs reserve the right to request such costs and attorneys' fees as this Court deems appropriate. Defendants reserve the right to oppose such motions.

Dated at Portland, Maine, this 14th day of July, 1978.

Edward T. Gignoux
UNITED STATES DISTRICT COURT JUDGE

Seen and Agreed to:

Jane Bloom Yohalem

Neil Wooley

Robert Plotkin (JBY)

ATTORNEYS FOR PLAINTIFFS

Richard S. Howard

William R. Stokes

ATTORNEYS FOR DEFENDANTS

George A. Zitnay

Kevin W. Concannon

Will R. Bryant

DEFENDANTS

UNITED STATES DISTRICT COURT

DISTRICT OF MAINE

SOUTHERN DIVISION

WUORI, et al., Plaintiffs	)	
v.	)	CIVIL ACTION DOCKET NO. 75-80 SD
ZITNAY, et al., Defendants	)	

I

DEFENDANTS' OBJECTIONS TO PART I OF THE MASTER'S REPORT

1. Defendants object to the conclusion of the Master that Pineland Center must be closed.

Pineland Center is a residential facility for the care, treatment, education and training of mentally retarded persons. Pursuant to State Law, 34 M.R.S.A. §2651, et seq., all persons residing in the facility have been found by the Maine State District Court to be in need of the services available at the facility. In each case the State Court has certified that no less restrictive alternative is available which would offer a more suitable living environment.

Pineland Center is an essential element of the State of Maine's system for the delivery of services to the mentally retarded. The parties to the consent decree negotiated, and the Court agreed to entry of the decree on the premise that Pineland Center would remain open and continue to serve the citizens of Maine as a residential facility. At no time has it been contemplated that Pineland would be closed or converted to an educational institution. The Master apparently disagrees with the part Pineland Center plays in the State's system for the delivery of services to

the mentally retarded. The conclusions he has drawn in Part I of his report flow solely from his perception of the appropriate role for Pineland Center and his prepossession about the desirability of large residential facilities for the mentally retarded. The conclusions do not emanate from the established order contained in the consent decree.

2. Defendants object to the conclusion of the Master that no effort has been made to comply with the purposes of the decree.

The consent decree contains a comprehensive plan for meeting the needs of persons residing at Pineland Center and for the delivery of services to mentally retarded persons living in the community. Defendants have consented and been enjoined to meet the goals detailed in the decree. Defendants have not consented nor have they been enjoined to employ any particular means to meet these goals. The primary goals of the decree are (1) the reduction of the population of Pineland Center to 400 by July 14, 1979, and to 350 by July 14, 1980; (2) an increase in the hours of programming at Pineland Center; and (3) the development of suitable placements for mentally retarded persons living in the community. In the first year of the decree, defendants have (1) reduced the population of Pineland Center to 390; (2) increased programming hours over 40 per cent; and (3) developed over 200 community placements. The Master has not given due consideration to these achievements of defendants. He has not given any consideration to the fact that Maine, of all the State's now subject to consent decrees arising from suits brought to enforce the rights of the mentally retarded, is the only State to have met its placement goals; that Maine has the lowest percentage of institutionalized mentally retarded citizens in New England; and that Maine is among the leaders in the country in providing community based services.

3. Defendants object to the conclusion of the Master that non-party State officials have obstructed compliance.

The defendants before the court in this action are the Commissioner of Mental Health and Corrections, the Director of

the Bureau of Mental Retardation, and the Superintendent of Pineland Center. The Court's decree runs against these officials of the State of Maine, their successors, their agents, servants and employees. Contrary to the contentions of the Master, it does not run against those officials of the State of Maine not made parties to the litigation by plaintiffs and not subject to the control of or legally identified with the parties. Nevertheless, defendants have agreed to work actively to ensure compliance with the decree of all persons, facilities, programs and departments whose cooperation is necessary for successful implementation. To this end the Office of the Governor of Maine, the leaders of the State Legislature, the Commissioners of Finance and Administration, Education and Cultural Affairs, Transportation, and Human Services have met with the Master, listened to his requests for cooperation and, in fact, have agreed to work actively to assist in securing full compliance, within and without the framework of the decree.

Defendants consider unfair the Master's characterization of State agencies as obstructionist. The essence of the Master's complaint concerning state officials is that they are reluctant to adopt without question his ideas on the appropriate methods to achieve compliance and his interpretation of complex federal rules and regulations. State agencies have made every effort to facilitate compliance with consent decree:

1. The Department of Finance and Administration has worked closely with the Department of Mental Health and Corrections to amend statutory funding mechanisms to ensure money is available to meet the needs of the decree;

2. The Department of Human Services has worked with the Department of Mental Health and Corrections to certify Pineland Center as an Intermediate Care Facility for the Mentally Retarded;

3. The Department of Personnel has developed new job descriptions and new classifications, held interviews, and reclassified numerous positions within a few weeks to meet the staff qualification requirements of the decree;

4. The Department of Personnel has given priority to position requests from defendants, including development of a driver-custodian position to resolve transportation problems at Pineland Center;

5. The Department of Personnel has waived hiring procedures for lower level staff;

6. The Department of Personnel and the Department of Finance and Administration have approved the filling of any vacant authorized position with a Mental Health Worker;

7. The State Purchasing Agent has expedited bidding procedures and facilitated the purchase of many articles including an ambulance, draperies, dressers, carpeting, and clinical equipment;

8. The State Budget Office has supported the request for 50 new positions for July 1, 1979, and has made commitments for full funding of institutional and community services; and

9. The Bureau of Public Improvements has waived bidding procedures and given architectural assistance in developing group homes.

4. Defendants object to the advocacy role assumed by the Master.

Defendants are concerned with the Master's interpretation of his role and responsibilities as reflected in his report. The Court ordered, and the parties consented to the appointment of a Master to monitor implementation of the decree. The Master was appointed to serve the Court and the interests of justice. He was to stand between the plaintiffs and the defendants; he was to be the bridge between the advocates and the actors. Part I of the Master's report clearly shows that the Master has abdicated his impartial judicial office and become an advocate for those who wish to close all institutions for the mentally retarded.

The Master's Order of Appointment directed him to develop evaluation systems to measure the extent of compliance. The Order guaranteed him full access to all persons, facilities,

records and documents for the purpose of gathering information relevant to enforcement. It was anticipated the Master would use the evaluation systems developed and the information gathered to render a balanced report to the Court. The Master failed to develop any evaluation systems. Instead, he has taken the information gathered by his assistants and provided to him by defendants and used it to develop an argument for the closing of Pineland Center.

The Master's Order of Appointment granted him broad powers to make informal suggestions and to make recommendations with regard to implementation of the decree. The only limitation on these powers was that the recommendations be within the framework of the decree and consistent with the intent of the decree. The Master failed to make any recommendations in the first year of the decree. Even when requested by plaintiffs in the spring of 1979 to make recommendations regarding staff at Pineland Center, the Master did not act. On occasion the Master has consulted informally with defendants to achieve compliance. But the tactic most frequently employed by the Master to bring defendants into compliance has been direct confrontation. For example:

1. He demanded defendants rescind the appointment of a program director at Pineland Center;

2. He directed defendants and other State officials to ignore federal regulations regarding architectural accessibility in the construction of the Freeport Town Square; and

3. He has lectured the Commissioner of the Department of Human Services on that Department's duties and short-comings in administering various federal programs as the Master views them.

It must be concluded from the Master's Report that the Master considers his efforts to achieve compliance a failure and that the only appropriate way to remedy this failure is the closing of Pineland Center as a residential facility. To the extent this remedy may be considered a recommendation of the Master, it is considerably outside the framework of the decree and certainly inconsistent with the intent of the decree.

Defendants have made substantial efforts to achieve compliance with the intent and letter of the consent decree. They have made every effort to assist the Master fulfill his role as an impartial monitor of defendants' progress towards compliance. The Master has made only a token reference to these efforts in his report. It appears from the report that the Master believes the consent decree will never be implemented. It can also be inferred from the report and the overall approach of the Master that the Master wants to close Pineland Center. He has structured his report to advance this interest. A serious question is thus raised as to the ability of the Master to continue serving effectively in the role assigned to him by the court.

II

DEFENDANTS' OBJECTIONS TO PART II OF THE MASTER'S REPORT

5. Defendants object to the conclusion of the Master that residents have been relocated for the convenience of the administration.

Appendix A of the consent decree sets forth an ambitious plan to remodel and refurbush Pineland Center to create an attractive, suitable and appropriate residential facility for approximately 350 mentally retarded persons, most of whom will be profoundly retarded. The realization of the plan within the time frames contained in the decree would be a major accomplishment if there were not residents at the center, given the complexity of the task, the cost involved, and the essential dependence of defendants on the cooperation and support of other state agencies and other branches of state government. But renovations at Pineland are being undertaken with close to 400 residents, ninety percent of whom are profoundly retarded. These people have numerous medical, physical, social and behavioral problems which must be addressed every day. Wholesale, institution wide renovations therefore cannot be undertaken without careful planning for the daily life of these people.

Defendants have expended approximately $1.5 million to improve the quality of life of the residents of Pineland Center since July 1975 when this case was initiated. An additional $518,000 has been budgeted for the current fiscal year. Defendants have renovated buildings, have purchased furniture, toys, clothing and special equipment, have acquired vans for transportation, and have developed programs and activities to enrich the lives of the residents at Pineland Center. They are implementing a plan to renovate or abandon those residential units which do not now meet the requirements of the decree. In some instances defendants will not meet the time frames set forth in the decree, but even the Special Master at a meeting of the parties in the spring of 1979, has acknowledged that the time frames in the decree are unrealistic. An amendment to the decree, therefore, may be in order.

Defendants have contributed to the improvement of the quality of life for the residents of Pineland by:

1. Providing privacy in bathrooms, bedrooms and living areas;

2. Making bathrooms accessible to all residents and installing specialized equipment;

3. Providing all residents with new, firm, washable mattresses;

4. Providing every resident with a dresser or other storage space;

5. Decorating living areas;

6. Making, providing and repairing curtains and bedspreads;

7. Investing in comfortable, attractive leisure-time furniture;

8. Ensuring most residents share a room with no more than 2 other residents;

9. Furnishing residents with sufficient and appropriate personal toys, games, and recreational items;

10. Hiring ten additional housekeeping staff and issuing a contract for housekeeping services in non-residential buildings

to improve building cleanliness and relieve direct care staff of housekeeping duties;

11. Establishing and equipping a beauty salon; and

12. Redecorating and refurnishing a leisure center for residents.

Defendants efforts to meet the demands of the decree are continuing. They have enlisted and received the support of the State Legislature as well as other state agencies. The Department of Human Services, in particular, has assisted defendants in securing certification of Pineland Center as an Intermediate Care Facility, thus ensuring an improvement in the standard of living as well as an increase in available revenues.

6. Defendants object to the conclusion of the Master that no effort has been made to meet staffing needs of the residents.

Staffing ratios at Pineland Center are directly related to population goals established in Appendix B of the consent decree. Defendants have worked diligently to meet the staffing requirements of the current population at Pineland Center. All additions to the staff have been made with due consideration being given to establishment of the staff required to serve the needs of a resident population of 350 or less. Defendants cannot justifiably employ a permanent staff large enough to serve a population in excess of 400 when the projected population is 350. This is a projection with which even the Master agrees. (Pt. II, p. 138). Pineland Center has an authorized staff of approximately 780 permanent positions. This is a sufficient staff to serve a population of 350. This is a dramatic change from 1975 when Pineland had a staff of 585 to serve a population of 471.

Defendants have recruited extensively and aggressively to fill vacant positions at Pineland Center. Defendants have offered nationally competitive salaries to attract qualified professional staff. The State has negotiated and agreed to a labor contract which guarantees to entry level non-professional staff salaries competitive with the private sector labor market. Defen-

dants efforts in recruitment are continuing. It must be acknowledged, nevertheless, that it is difficult to keep filled all available positions: (1) There is a nationwide demand for nurses and physical therapists; (2) Pineland Center is not attractively located geographically; (3) work with the profoundly retarded is physically exhausting and mentally demanding, with few rewards, resulting in a high turnover of lower level staff; and, (4) the pressure of the consent decree and constant fault finding of the Master have had a chilling effect on recruitment. (In the summer of 1979 the Master met with groups of employees and told them Pineland was out of compliance and receivership was imminent).

Recent planning of defendants to meet the staffing needs of Pineland Center must be assessed in light of a request by plaintiffs in February 1979 that the Master make certain staffing recommendations. These recommendations were based primarily on a report prepared by Bert Schmichel, a consultant employed by defendants. The Master took no formal action on the request of plaintiffs, thereby failing in his responsibility to assist the parties in achieving compliance with the decree.

Defendants responded to the recommendations of the plaintiff by implementing a counter recommendation developed by defendants. It was assumed this plan met with the Master's approval since he failed to object to it at the time. This recommendation included the addition of 50 new positions as of July 1, 1979; the addition of up to 30 positions through the CETA program; the development of a team of 21 floating Mental Health Workers to cover absences; and the filling of up to 30 authorized personnel lines with Mental Health Workers. (The Master fails to mention these actions of plaintiffs and defendants in his report. He notes, however, that defendants did acquire and fill the positions recommended by Mr. Schmichel. [Pt. II, p. 93]).

7. Defendants object to the Master's methodology and conclusions regarding program development.

Defendants' success in meeting the programming goals and requirements of Appendix A will probably be the true measure of their success in achieving full compliance with the consent decree. Partial success is already apparent: defendants have met the placement goals of the decree. Only residents who have been appropriately and adequately prepared can be placed in the community. Yet, programming remains the critical challenge of the consent decree. It is the major area where defendants and the Special Master have not reached agreement on the proper way to measure quantitatively and qualitatively the extent of defendants compliance. The Court imposed upon the Master the duty to "develop evaluation systems to measure the extent of defendants' compliance", (Appointment of a Master, ¶6.c.), but the Master failed to develop such systems.

In addition, the Special Master in his report erroneously judges defendants' performance in the first year of the decree by a standard to be met at the end of the second year: the decree requires 5 hours of programming each weekday in the first year, not 6. This basic error renders suspect and colors all his other conclusions regarding programming. But this is not the only objection that must be made to the Master's report on programming. His report is deficient also in the following respects:

a. The Master refuses to count programs in residential areas, including training in Activities in Daily Living (ADL), contrary to intent of the decree which is to include all planned activity in the term programming;

b. The Master bases his program statistics on a concept of "Core Program", a term not employed in the decree or accepted by the parties, but fabricated by the Master; and

c. The Master arbitrarily deducts from his statistics 205 hours each week for medical and dental appointments, a practice not validated by the decree or accepted by the parties.

Defendants have made a substantial effort to provide some programming to all residents and to upgrade the programming process. In particular:

a. They have established eight program centers at Pineland Center--Berman School, Work Activity Center, Adult Day Activity Center, Recreation, New Gloucester Learning Cooperative, Open Classroom (Kupelian Hall), Perry Hayden Hall Day Activity Center, and Residential Training;

b. They have placed residents in the Woodsford School and the Friends of the Retarded Activity Program;

c. They have developed the Freeport Town Square as a community group home and as an off-campus work activities center;

d. They have employed a consultant, Marvin Rosenblum, to train program coordinators and to assist staff in understanding the proper function of the interdisciplinary team process;

e. They have adopted a detailed Program Guide to assist staff in training techniques;

f. They have employed a consultant, Carolyn Cherington, to assist in staff development, the use of the Program Guide, and the development of a media center;

g. They have established an active Task Force to study, upgrade and reorganize as necessary the interdisciplinary team process;

h. They have established a specialized living unit for residents requiring intensive training in non-verbal communication skills (staff and residents in the unit use signing to communicate);

i. They have employed a consultant, Jacqueline Giasson, M.Ed., Eden Institute, Princeton, New Jersey, to assist in improving the education program at the Berman School;

j. They have accepted for instruction at the Berman School children from surrounding communities and have provided community based education program for residents of Pineland Center;

k. They have maintained a gymnasium, a bowling alley, a

swimming pool, a resident leisure center, and a five acre camp for the recreation of Pineland residents;

l. They have established an on-grounds transportation system to facilitate program attendance;

m. They have developed a comprehensive health services program including daily medical clinics, specialty clinics such as orthopedics and seizure control, and medical service to all residents at the clinic;

n. They have established programs in medication, basic nursing and medical terminology, and have begun development of a 100 hour State Certified Nurses' Aide Program;

o. They have systematically reviewed and studied the use of psychotropic medications, initiated drug holidays, discontinued the use of medication such as an anticonvulsants when appropriate, and employed an independent psychiatric consultant to evaluate and document the use of antipsychotic, antianxiety, antidepressant, and antimanic medication;

p. They have established a modern dental clinic which undertakes quarterly check-ups and cleaning, training in oral hygiene, and evaluations for mouth restoration, as well as providing the services of an oral surgeon; and

q. They have initiated establishment by the University of Maine of an associate degree program in developmental disabilities for Pineland staff, tuition and faculty to be paid by the State.

Independent of the Master and prior to his becoming interested or involved in the counting of program hours, defendants undertook to measure their own performance under the decree. John L. Hoffman, Ph.D., Research Scientist at Pineland, has worked since September 1978 to collect, analyze and report program hours provided to residents at Pineland.

Dr. Hoffman's work shows that in September 1978, approximately 240 residents were receiving less than 25 hours per week of program activity. By March 1979 this figure had dropped to 98. In this period there was a 46% increase in the number of scheduled program hours and a 37% increase in the number of actual program hours.

Statistics developed by defendants in August 1979 show that 10% of the residents were receiving 6 hours of program daily; 62% were receiving 5 hours; 16% were receiving 3-4 hours of programming; and 12% were receiving less than 3 hours.

The extent of defendants compliance with the program goals of the decree cannot be measured by bare statistics. Statistics do not take into account changes in daily routine (attendance at a local fair or summer camp); individual tolerance for extended programs; or, personal problems of a resident which affect attendance at a program. Defendants are committed to meeting actual program and activity needs of every resident of Pineland, whether this means a full daily program or some variation dictated by the individual resident.

Conclusion

For all the foregoing reasons the defendants respectfully object to the content and bias of the Master's report.

RICHARD S. COHEN
ATTORNEY GENERAL

WILLIAM H. LAUBENSTEIN, III
ASSISTANT ATTORNEY GENERAL

DATED: January 7, 1980

APPENDIX "A"

PINELAND CENTER STANDARDS

JULY 14, 1978

Table of Contents

Definitions

For the purposes of this Appendix, the following terms are defined as follows:

1.	"Plaintiffs" and "Defendants"	refer to the parties named as plaintiffs and defendants in the caption hereof.
2.	"Department"	refers to the Department of Mental Health and Corrections.
3.	"Commissioner"	refers to the Commissioner of the Department.
4.	"Bureau"	refers to the Bureau of Mental Retardation.
5.	"Director"	refers to the Director of the Bureau.
6.	"Pineland"	refers to Pineland Center, Pownal, Maine.
7.	"Superintendent"	refers to the Superintendent of Pineland.
8.	"The class"	refers to all persons who were involuntarily confined residents of Pineland on or after July 3, 1975, or who were conditionally released from Pineland and in community placements on or after July 3, 1975, exclusive of those individuals admitted to Pineland for a specific medical service at Benda Hospital or for respite care for less than 21 consecutive days.
9.	"Resident"	refers to a member of the class who resides at Pineland.
10.	"Competent resident"	refers to a resident 18 years or older not adjudged incompetent by a court nor determined to be incapable of making a particular decision as set forth herein. A determination that a resident is incapable of making a particular decision requires a finding by the resident's interdisciplinary team and an independent finding by the appropriate advocate that the resident does not understand the nature and consequences of the decision in question. Such a finding or determination shall have no effect on legal competence or on competence or capacity for any other purpose.

11.	"Professional"	Except as specifically provided otherwise in this appendix, "professional" refers to a person possessing appropriate licensure, certification or registration to practice his discipline in the community; and where licensure, certification or registration is not required, "professional" shall mean a person possessing a Master's Degree in the appropriate discipline or a person possessing a Bachelor's Degree in the appropriate discipline and three years' experience in treating the mentally retarded or three years' experience in a related human services field.
12.	"Interdisciplinary team" or "IDT"	refers to a team of persons established, and whose meetings are conducted, in accordance with professionally accepted standards, and whose purpose is to evaluate a resident's needs and to develop an individual prescriptive program plan.
13.	"Prescriptive program plan" or "PPP"	refers to a detailed written plan outlining a resident's specific needs for education, training, treatment and habilitation services, along with the methods to be utilized in providing treatment, education and habilitation to the resident. A prescriptive program plan shall be formulated by an appropriately constituted interdisciplinary team.
14.	"Contraindicated by a resident's prescriptive program plan"	means a specific considered recommendation by an IDT with supporting reasons stated clearly in writing that a decree standard should not be followed in the habilitation program of a given resident because a concrete risk of physical, mental or emotional harm is posed or because the resident's habilitation program will suffer if the standard is followed. Whenever the IDT reaches this conclusion it shall set out the steps to be taken such that the resident's program can be governed by the standard at the earliest possible time.
15.	"Programming" or "Program activity"	refers to any activity specified in the resident's prescriptive program plan that is individually designed and structured to increase the resident's physical, social, emotional or intellectual growth and development.
16.	"Document," "Documented," or "Documentation"	means a current written record kept of all activities bearing on the relevant decree standard in a form that is readily understandable to all persons concerned with the enforcement of this decree.

17.	"Consultant"	refers to a person, agency, firm, or organization that is independent of the Department and of Pineland though not necessarily independent of other state agencies or departments.
18.	"Correspondent"	In the first instance, a correspondent is the resident's legal guardian. If the resident does not have a legal guardian, the correspondent is the resident's parent. Where parents are deceased or their whereabouts cannot, with due diligence, be ascertained, and they have failed to designate an appropriate representative and there is no guardian, then the correspondent shall be defined as the relative, if any, in closest relationship with the resident who has, at least once within the previous year, manifested interest in the resident by communication with the Department regarding the resident or by visiting the resident. If there is no legal guardian, parent or relative, as defined above, or if such person is unable to exercise his rights hereunder because of age, illness, distance, or some other compelling reason, the correspondent shall be a person designated by the Consumer Advisory Board (see Appendix A, Section T this decree). The notices required by this decree to be sent to a correspondent shall inform the correspondent of his right to designate the Consumer Advisory Board to act for him if for the reasons stated above he is unable to exercise his rights. Any designation by the Consumer Advisory Board shall remain in effect until revoked by the legal guardian, parent or relative, as defined above.
19.	"Persons concerned with the enforcement of this decree"	refers to counsel for plaintiffs and defendants, any person designated by the Court to monitor enforcement and his agents.
20.	"Day" or "Days"	Time periods referred to shall not include the day of the act or decision involved. If the last day of such a time period falls on a Saturday, Sunday or legal holiday, the period shall extend to the end of the next day which is neither a Saturday, Sunday nor legal holiday. When written notice of a decision is required, the notice shall be mailed within the specified time period.

A. Resident Rights

1. Residents have a right to habilitation, including medical treatment, education, training and care, suited to their needs, regardless of age, degree of retardation or handicapping condition. Each resident has a right to a habilitation program which will maximize his human abilities, enhance his ability to cope with his environment and create a reasonable expectation of progress toward the goal of independent community living.

2. Residents shall be provided with the least restrictive and most normal living conditions possible. This standard shall apply to dress, grooming, movement, use of free time, and contact and communication with the outside community, including access to educational, vocational and recreational therapy services outside of the institution. Residents shall be taught skills that help them learn how to manipulate their environment and how to make choices necessary for daily living.

3. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, Pineland shall make every attempt to move residents from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residences; (5) segregated to integrated community living; (6) dependent to independent living.

4. No person shall be admitted to Pineland unless a prior determination is made that residence at Pineland is the least restrictive habilitation setting feasible for that person. No mentally retarded person shall be admitted to Pineland if services and programs in the community can afford adequate habilitation to such person.

5. Unless contraindicated by the resident's PPP, residential units shall house both male and female residents; unrelated residents of grossly different ages, developmental levels and social needs shall not be housed in close physical proximity; and residents who are nonambulatory, deaf, blind, epileptic, or otherwise physically handicapped shall be integrated with peers of comparable social and intellectual development.

6. Pineland's rhythm of life shall conform with practices prevalent in the community. For example, older residents ordinarily shall not be expected to live according to the timetable of younger children.

7. Multiply handicapped and nonambulatory residents shall, except where otherwise indicated by a physician's order, spend a major portion of their waking day out of bed, and out of their bedrooms, have planned daily activity, and

be rendered mobile by suitable methods and devices. Residents shall not stay in beds, cribs, wheelchairs or orthopedic carts all day long, except on the order of a physician, which must be in writing if the order is to remain in effect for more than four hours.

8. Any violation of residents' rights guaranteed by this decree shall be promptly reported to the resident advocate who shall investigate and document the complaint.

9. A comprehensive summary of residents' rights in lay language shall be prepared for distribution to residents, guardians, parents and other interested persons. The summary shall be submitted for comment to all persons concerned with the enforcement of this decree within 60 days of the signing of this decree.

B. Environment

1. Defendants shall provide living facilities which afford residents privacy, dignity, comfort and sanitation. This shall include, but not be limited to:

(a) accessible, private and easily usable toilets and bathing facilities, including specialized equipment for the physically handicapped;

(b) accessible and easily usable sinks and drinking facilities;

(c) adequate supplies of toilet paper, soap, towels, linen and bedding;

(d) individual bed and dresser or other storage space;

(e) attractive, comfortable and spacious living and sleeping areas;

(f) attractive and normalizing furnishings and leisure equipment, including materials to reduce noise level;

(g) normal temperature and adequate ventilation;

(h) separate clean and dirty linen storage areas.

2. More specifically, the following standards shall apply: All toilets shall have toilet seats and toilet paper, and all toilet stalls shall have doors or other appropriate visual barriers. At least one source of drinking water shall be available to residents on every ward of every resident building. Clean towels and bed linens shall be provided at least twice weekly. All showers shall have curtains and all bathtubs shall be screened for privacy. Mattresses shall be fire and urine resistant and without appreciable sag. Blankets with holes or stains shall be cleaned, repaired or replaced. Sufficient padded chairs shall be provided in living areas so that every resident desiring to do so might sit in one. An adequate number of lamps and age-appropriate wall decorations shall be provided in every living area. The standards specified in this paragraph shall be met within three months, or in the case of items which must be purchased, within six months of the signing of this decree.

3. Every resident shall be provided with appropriate and attractive living and sleeping space.

(a) No resident shall share a bedroom with more than two other residents and at least 75 percent of residents will be provided single or double bedrooms.

(b) All bed areas shall have outside windows, be above ground level and meet ICF-MR standards in terms of space and provisions for individual privacy.

(c) Walls.

(1) Unless impracticable for structural or safety reasons, the walls of bedrooms shall extend from floor to ceiling. Where impracticable, walls shall be at least six and one-half feet high.

(2) Newly constructed walls shall be of a permanent nature (studded and insulated, concrete block or comparable construction).

(3) Wall units installed or to be installed in Vosburgh and Staples Halls shall be exempted from the requirements of (1) and (2) above.

(d) Doors.

(1) Bathrooms shall be provided with doors or other suitable visual barriers. Bedrooms shall be provided with doors but where the safety or security of a resident would be jeopardized by having a door on his bedroom, the resident's PPP may specify that the door be removed, provided the resident's program includes steps to be taken for placement of a door on the resident's bedroom as soon as feasible.

(2) No more than 10 percent of residents shall have bedrooms without doors.

(3) Vosburgh and Staples Halls shall be excepted from the requirements of (1) and (2) above.

(e) Resident living areas shall provide ample space and opportunity for socialization, relaxation and activity normally conducted in living areas (e.g., games, crafts, listening to music).

(f) The provisions of this paragraph shall be met within six months from the signing of this decree for 230 residents, for an additional 60 residents by May 1, 1979, and an additional 60 by January 1, 1980.

4. Perry Hayden Hall shall be abandoned for residential purposes within two years from the date of this decree.

5. Each resident desiring such shall have locked storage space for personal belongings and each resident shall have adequate individual storage space. Each resident shall have ready access to the Pineland grounds unless contraindicated by the resident's PPP. Each resident shall have access to his bedroom except during programming. Within three months of the signing of this decree all windows in resident bedrooms shall have curtains and all beds shall have bedspreads.

6. Living, programming and working areas shall be quiet, appropriately designed and conducive to programming. Acoustical ceiling tile shall be installed wherever noise levels remain high. Architectural barriers which impede living and programming for handicapped residents shall be corrected or removed. Residents shall be encouraged to decorate their living and bedroom areas.

7. Every building shall be kept clean, odorless and insect free, and sufficient equipment shall be provided to housekeeping staff for this purpose. In particular, lavatory areas are to be cleaned as often as necessary every day, and bathtubs shall be cleaned after the bath of each resident. The smell of harsh disinfectants shall be eliminated.

8 . Residents shall ordinarily sit or be on the floor only for therapeutic reasons (e.g., physical therapy positioning). If placed on the floor for play or other purposes, they shall shall be on mats, a sufficient number of which shall be provided so that residents are not crowded together.

9. Residential life shall be structured so that it is possible for residents to wear and use glasses, hearing aids, crutches, braces, rolling walkers, and similar aids in their living units.

10. Toys, games and other recreational or learning equipment of good quality shall be readily accessible to residents on their living units during waking hours. In addition, each resident shall be provided with at least three such items as his own. An adequate budget for such equipment and materials shall be maintained so that items which are lost, broken or stolen can be replaced within a reasonable time.

11. A phone providing privacy to a resident shall be accessible in each resident building and a mailbox shall be available to residents on the grounds.

12. A concerted effort will be made to provide residents affected by renovation or temporary placement in a residence with accommodations meeting the requirements of this section.

C. Staff Responsibilities, Staff Ratios

1. The primary responsibility of the living unit staff shall be the proper care, habilitation, and development of each resident. In addition, living unit personnel shall insure that the rights of residents set out in this decree are respected. In particular they shall:

(a) develop and maintain a warm, home-like environment conducive to the habilitation of each resident and consistent with the normalization principle;

(b) facilitate enjoyment by each resident of a "rhythm of life" consistent with the cultural norms for the resident's nonretarded peers;

(c) respect and promote each resident's right to freedom of movement and unrestrained communications both within and without the facility;

(d) encourage each resident to assume responsibility for daily needs and wants commensurate with the resident's interests, abilities and program plan in order to enhance the self-esteem and independent living skills of each resident;

(e) protect and uphold each resident's rights to keep and enjoy personal possessions and money;

(f) train each resident in appropriate activities of daily living, self-help, social and communication skills consistent with the resident's PPP;

(g) manage behavior problems in a consistent, humane manner calculated to maximize resident safety and to facilitate the learning of more adaptive behavior;

(h) permit and encourage each resident to select and enjoy a variety of constructive, pleasurable activities within and without the institution consistent with each resident's PPP;

(i) respect and promote each resident's right to privacy including physical modesty, the right to be alone at times, private communications and the confidentiality of resident records; and

(j) respect each resident's preferences with regard to living conditions, food, dress, grooming, religion, personal associations, and visitations.

2. Direct care staff shall not perform routine housekeeping chores during residents' waking hours. Routine housekeeping shall include such chores as laundering services; the cleaning of an entire floor, wall or window area; the making of beds; the cleaning of bathrooms; the cleaning of furniture and the sorting of linen. Separate housekeeping staff shall be provided from 6:00 a.m. to 1:00 a.m.

3. For each shift, a specific direct care employee shall be designated to have continuing primary responsibility for each resident's safety, and for the resident's progress in daily living skills. Records shall be maintained listing such employees and the residents for whom they are responsible. Such records shall be available to persons concerned with the enforcement of this decree and to each resident's correspondent. Professional IDT members shall be responsible for training, supervising and evaluating therapy aides and direct care staff who implement any part of a resident's program. Each professional IDT member shall consult with direct care staff at least monthly. Professional staff shall respond to requests by living unit personnel for consultation.

4. The participation of the direct care staff member on each shift primarily responsible for a resident will be sought in the resident's IDT meeting, and staff members will be compensated for attendance at any IDT meeting scheduled when the staff person is off duty. When personal participation cannot be accomplished, the concerned direct care staff member shall be requested to provide relevant written input to the IDT including regular progress notes and shall be provided a copy of the resident's PPP.

5. Pineland shall employ and maintain sufficient living unit staff to ensure that the following numbers are present and on duty:

(a) During the hours of the day and evening when residents are awake:

(1) One direct care worker for every four residents in buildings primarily for residents who are children, nonambulatory, multiply handicapped or have behavior problems (e.g., persons residing in Kupelian Hall at the time the decree is signed).

(2) One direct care worker (or psychological aide) for every resident receiving an intensive behavior modification program.

(3) One direct care worker for every six residents for all residents and buildings not covered above.

(b) During sleeping hours, one direct care worker for every 12 residents; but in no event less than one staff person on each floor of each building.

6. Day ratios shall apply when residents are waking and preparing for breakfast and when residents are bathing and going to bed.

7. In no living unit except as provided in 5(b) above shall the staff to resident ratio actually within the unit ever be lower than one to eight.

8. The direct care staff to resident ratios specified above shall be achieved and maintained as promptly as possible and in no event later than twelve months from the date of the signing of this decree.

9. Sufficient living unit supervisors, at at least the Mental Health Worker II level, shall be employed to ensure that there is one such person present and on duty per 24 residents on both the first (day) and second (evening) shifts. At least three supervisory persons shall be on duty during the third (night) shift. Such ratios shall be achieved within three months of the date of the signing of this decree. Supervisors who are primarily involved in the direct care of residents may be counted in determining living unit staffing ratios. Such supervisors shall be responsible for assuring that paragraphs 1-4 of this section are complied with by all staff under their supervision.

10. Sufficient PPP coordinators at the Mental Health Worker V level shall be employed such that the PPP of every resident will be appropriately prepared, coordinated, implemented and carefully monitored. The ratio of PPP coordinators to residents shall be at least 1 to 35. PPP coordinators shall not personally conduct, on a routine or ongoing basis, resident programs.

11. The level of training and experience of staff shall be substantially similar between all halls and wards. For example, the level of training and experience of staff at Kupelian Hall 1 and 2 shall be substantially equal to that of staff at Cumberland Hall. The level of training and experience of all staff shall be substantially similar for residents of differing developmental levels.

12. Qualified professional staff in numbers sufficient to develop and implement adequate habilitation programs shall be provided. Pineland shall establish and maintain an overall ratio of professional staff to residents of 1 to 3. Within existing disciplines the minimum ratios shall be established as indicated below. Remaining professional positions will be divided among disciplines so as to best meet the needs of the residents. Compliance with staffing ratios may be accomplished through either direct employment or service contract. Ratios do not include staff with exclusive supervisory or administration functions.

Discipline	Ratio Staff to Residents
Social Service	1:50
Psychology	1:80
Occupational Therapy	1:100
Physical Therapy	1:100
Speech Therapy	1:100
Special Education	1:40
Vocational Training	1:50
Recreational Therapy	1:100
Dentistry	1:400
Medicine (physicians)	1:100
Medical Support (pharmacist, medical technicians)	1:134

Qualified medical specialists of recognized professional ability shall be available for specialized care and consultation.

13. Vocational training instructors employed at Pineland as of October 1, 1977, may be counted as professional staff for purposes of this decree. However, any vocational training instructor hired after October 1, 1977, must have a Bachelor's Degree in an appropriate discipline and three years' experience in teaching the mentally retarded in order to be considered part of the professional staff for purposes of this decree.

14. A minimum of 40 percent of social service professionals shall have a Master of Social Work degree from an accredited school.

15. A sufficient number of registered nurses and licensed practical nurses shall be provided to meet the medical and habilitation needs of the residents. The ratio of nurses (both registered nurses and licensed practical nurses) to residents shall not exceed 1 to 9.5.

16. Each professional department or major program area shall maintain an adequate number of program aides to carry out the recommendations of the PPP for each resident. To this end, paraprofessional staff performing services in programs shall be maintained at a ratio of at least 1 to 5 while programs are in operation. Paraprofessional staff shall receive training appropriate to their assignments. Professional supervision shall be provided to all paraprofessional personnel.

17. A sufficient number of clerical staff shall be available to administrative and professional staff, program coordinators and living unit personnel such that memoranda dealing with emergency problems shall be typed and distributed within four hours of submission to the clerical staff, so that memoranda needed to assure adequate resident care shall be typed within 24 hours of submission and so that other routine matters will be typed within 10 working days of submission to clerical staff. For this purpose, a ratio of 1 clerical staff to 15 residents shall be maintained.

D. Programming

1. Each resident shall have an individual plan of care, development and services, referred to hereafter as a prescriptive program plan. The prescriptive program plan shall be prepared and re-evaluated at least annually by an interdisciplinary team which shall include a direct care staff member who is primarily responsible for the resident (see Appendix A, Section C, paragraph 4, supra) and appropriate professionals. The makeup of the interdisciplinary team shall be sufficiently broad such that each habilitation need of a resident can be professionally assessed and appropriate remedial recommendations can be made. The resident shall be asked to attend the interdisciplinary team meeting and shall be consulted in the development of his prescriptive program plan. Each resident's correspondent, unless a competent resident objects, shall be asked to attend the team meeting. Notification shall be sent at least two weeks in advance of the meeting. Minutes of each team meeting shall be kept in the resident's file and the minutes shall include the names of persons present and in the case of professional staff members, their respective disciplines.

2. A PPP coordinator, identified by name in the prescriptive program plan, shall be responsible for reviewing and supervising the resident's program progress, including his progress toward community placement, and coordinating the input and assignments of other professionals and disciplines in the interdisciplinary team process.

3. The PPP shall be reviewed by a minimum of three members of the interdisciplinary team, including the PPP coordinator, at least quarterly. At the quarterly review, minor modifications in the plan may be made, and progress as well as problem areas shall be noted. The quarterly review team may reconvene the entire interdisciplinary team if they find that re-evaluation of the resident is necessary.

4. Each program plan shall describe the nature of the resident's specific needs and capabilities, his program goals, with short-range and long-range objectives and timetables for the attainment of these objectives. The prescriptive program plan shall address each resident's residential needs, medical needs, ADL skill learning needs, psychological needs, social needs, recreational needs, and other needs including educational, vocational, physical therapy, occupational therapy, and speech therapy, as appropriate. The individual program plan shall include a clear explanation of the daily program needs of the resident for the guidance of those responsible for daily care. The recommendations included in each resident's prescriptive program plan, both as to residential and programming placements, shall in all cases be the least restrictive placements suited to the resident's needs. The recommendations of the prescriptive program plan shall be based on the interdisciplinary team's evaluation of the actual needs of the resident rather than on what programs are currently available. In cases where the services needed by a resident are unavailable, the IDT shall so note in the prescriptive program plan and shall recommend an interim program based on available services which meet, as nearly as possible, the actual needs of the resident. The number of residents in need of a service which is not currently available and the type of program each needs shall be compiled and these figures shall be used to plan for the development of new services and programs.

5. Each resident's prescriptive program plan shall include an analysis of the community placement best suited for that resident and a projected date for the resident's progress to a community setting. There shall be at least an annual review of each resident's progress toward community placement.

6. Each prescriptive program plan shall be carried out pursuant to a written service agreement. Each service agreement shall include at least the following information:

(a) It shall specify the respective responsibilities of the resident, the family, correspondent or legal guardian of the resident, of Pineland Center, of the regional office, and each public and private agency which intends to provide services to the resident.

(b) It shall identify by job classification or other specific description each individual who is responsible for carrying out each portion of the prescriptive program plan.

7. At the first interdisciplinary team meeting held on behalf of a resident under the terms of this decree, any regressive or self-abusive behavior which has been exhibited by the resident will be noted. The prescriptive program plan shall address in detail the programs and services which must be provided to the resident so that such behavior can be eliminated as quickly as possible. One-to-one training shall be an option considered by the interdisciplinary team.

8. The prescriptive program plan shall provide in the first year following the signing of this decree, for a minimum of five scheduled hours of program activity per weekday for each resident and in the second year following this decree for at least six hours of program activity per weekday for each resident. Each resident shall receive these scheduled hours of programming. This program activity shall be designed to contribute to the achievement of objectives established for each resident in his prescriptive program plan. In exceptional cases, residents may receive fewer hours of program activity per weekday if a physician certifies in writing that such activity would be medically harmful to the resident.

9. Residents shall not be sent back to their living units from programming activity as punishment or because of toileting problems, and programming shall not be withdrawn from any individual except as part of an approved behavior modification program. Programming shall be regularly scheduled for both the day and evening shifts.

10. Each resident's correspondent shall be kept informed on a quarterly basis of the resident's educational, vocational and living skills progress, and medical condition, and shall be allowed access to the resident's records, unless a competent resident objects. Each resident shall have access to his own records, unless the IDT determines that serious harm to the resident will result and in such cases access may be denied to harmful portions of the record.

11. Pineland shall provide the programming recommended by the resident's prescriptive program plan within 30 days of the preparation of the plan. If the recommended programs are not available within the 30-day period set out herein:

(a) the resident shall be placed in the interim program recommended by the resident's prescriptive program plan; and

(b) Pineland shall submit to the master for his approval, either a plan, including a time schedule, for the development of an appropriate program, or a statement that the program will not be developed with accompanying documentation demonstrating that the service or program is not required by professionally accepted standards of habilitation or care.

12. Any resident, either independently or with the aid of an advocate or his correspondent, may invoke the procedures set forth in paragraphs 15-17 of this section when he disagrees with his prescriptive program plan. Subject to objection to such representation by a competent resident, the resident's correspondent may invoke the procedures set forth in paragraphs 15-17 of this section when the correspondent disagrees with the resident's prescriptive program plan.

13. All residents and their correspondents shall receive notice of their right to object to and to appeal the prescriptive program plan, in connection with all quarterly reports required by paragraph 10 of this section. The notice shall explain the procedure for objection and appeal and shall identify, giving name, address and telephone number, an advocate whom the resident or correspondent may contact for assistance.

14. The new prescriptive program plan shall be implemented while an objection is being pursued unless the Superintendent and the objecting resident or correspondent agree otherwise.

15. Informal objections

(a) Informal objections to the prescriptive program plan, which need not be in writing, shall be conveyed to the PPP coordinator identified in the resident's prescriptive program plan (see paragraph 2 of this section), who shall immediately attempt to resolve such objections. Such objections shall be noted in the resident's permanent record.

(b) If the PPP coordinator is unable to resolve the objection to the resident's or correspondent's satisfaction, the PPP coordinator shall explain to the resident or correspondent his right to invoke the formal objection and appeal mechanism outlined herein, and shall inform the resident or correspondent of his right of access to the resident's program plan and other relevant records and to all papers submitted at all stages of the proceedings. The PPP coordinator shall notify the appropriate advocate of any unresolved objections.

16. Formal objections

(a) Formal objections may be made only after the informal procedure set forth in paragraph 15 above has been exhausted. The informal procedure shall be deemed to be exhausted if no resolution has been reached within 20 days after an informal objection is made.

(b) All formal objections must be in writing, must state the basis for the objection, and must be addressed to the Superintendent.

(c) Upon receipt of a formal objection, the Superintendent, after notice to the resident, correspondent, and advocate's office, shall call a conference with the resident's PPP coordinator and the objecting resident or correspondent. This conference shall be called within 10 days. The conference shall be conducted in an informal manner, in such a way as to receive all relevant written and oral evidence. The particular procedure to be used shall be determined by the Superintendent. The resident shall in all cases have the right to be present and to be represented by an advocate. Persons who do not desire to participate in this conference may submit papers in support of their position.

(d) Within five days, the Superintendent shall issue a written decision with regard to the formal objection which shall fully state the basis therefor, and shall (if the decision upholds the objection) recommend a resolution of the issues presented.

(e) If the decision of the Superintendent upholds the objection, it shall allocate responsibility to named individuals for carrying out the recommended resolution within 45 days of the date of the decision.

(f) The decision of the Superintendent shall be communicated in writing to the resident, the resident's correspondent, the resident's PPP coordinator, and the advocate. Notice of the decision to the resident and the correspondent shall include notice of their right to appeal to the Director.

17. Appeals

(a) Notice of an appeal shall be filed with the Director within ten days of receipt of the decision of the Superintendent. The Director shall cause copies of this notice to be sent out to the resident, the resident's correspondent, the resident's PPP coordinator, the advocate and the Superintendent. Within ten days of the filing of the notice of appeal, persons receiving notice of the appeal shall submit to the Director and to each other all information deemed pertinent to the Director's review. The Director shall render a decision solely on the basis of the papers so submitted. In the event that the Director requires further information, the Director may call a conference with notice to all persons receiving notice of the appeal. The resident shall in all cases have the right to be present and to be represented by an advocate.

(b) Within ten days of receipt of all information necessary to a decision, and in no case more than 20 days after receipt of the notice of appeal, the Director shall consider the appeal and make a decision either upholding the decision of the Superintendent, recommending a new or different resolution, or dismissing the objection.

(c) If any resolution is recommended, the decision shall allocate responsibility to named individuals for carrying out the recommended resolution within 45 days of the date of the decision.

E. Personnel - Recruitment, Screening, Training, Qualifications, Termination

1. Defendants shall actively recruit qualified staff. Active recruitment of nonprofessional staff shall consist at a minimum of placing highly visible ads in the major papers in Portland and Lewiston, and of professional staff, in addition, in relevant professional journals, in the Boston Globe, in the Maine Times and other sources as appropriate. Salaries and benefits offered shall be adequate to attract qualified staff.

2. All job applicants shall be carefully screened. At least three existing professional staff at Pineland Center will interview each candidate for professional jobs. At every level of employment every attempt will be made to screen out those individuals who might pose a danger to residents or fail to work in their best interests.

3. Any employee charged with the physical abuse of a resident shall be relieved of duties during the pendency of a comprehensive and speedy investigation into the alleged abuse. Subject to the State personnel grievance proceedings, any employee found to have abused a resident shall be terminated immediately from employment at Pineland and shall not again be rehired in any capacity at Pineland. Every job applicant shall, before being hired, be informed of this rule and shall sign a statement that he understands the rule and will abide by it.

4. (a) There shall be full staff orientation and training programs to increase employees' skills and interest in achieving the program goals of the residents. Within 60 days of the signing of this decree, defendants shall prepare and submit for comment to all persons concerned with the enforcement of this decree a plan to improve Pineland's orientation and in-service training programs, which plan shall specify the proposed staffing, curricula and duration of such programs.

(b) Orientation training for all new employees shall consist at a minimum of the following: Within two weeks of being hired, each new employee shall receive 90% of a 20-hour orientation. At least the following areas shall be addressed: introduction to mental retardation, principles of normalization and developmental growth, human and legal rights, fire protection, safety, growth-oriented programming, behavior shaping, function of each professional department, and role of staff in implementing the philosophy of care and training of residents at Pineland. In addition, all new resident care and programming staff shall receive within two months at least the following training: eight hours of practical training in resident programming including the interdisciplinary team process, twelve hours of practical training in behavior influencing techniques and the utilization of the Program Guide, two hours of practical training in proper oral hygiene for residents, and two hours of training in the requirements of this decree.

(c) All current employees will have the equivalent of orientation training within six months of the signing of this decree and the additional 24 hours of training within one year.

(d) Each professional department at Pineland shall prepare and implement an inservice training program for all new departmental employees. Such programs shall emphasize creative and professional approaches to working directly with residents and shall be as comprehensive as necessary for the competent functioning of departmental employees and in no case less than 50 hours in duration. Professional employees who have at least one year of experience in working with retarded persons in the capacity in which they are employed at Pineland shall be exempt from the training requirements of this subparagraph, but shall attend relevant sections of the orientation training.

(e) At least annually staff training programs in the following areas will be provided: basic nursing, gesture language development, behavior influencing techniques, records and reports, supervisory training, skill development and other appropriate courses. To the extent appropriate, closely supervised practical experience shall be emphasized in such programs. A sufficient number of intermediate and advanced training courses shall be offered such that each staff person desiring to do so could receive 50 hours of training in any six-month period. Fifty hours of appropriate training shall be a prime requisite for advancement for nonprofessional resident care staff.

(f) Hour-for-hour credit may be given for a staff member's completion of relevant course work at a university or relevant training received from any other source provided that such instruction or training is approved in advance by a professional department head in the case of departmental employees or by the director of residential services in the case of other employees, and in either case with the approval of the Director of Staff Development.

(g) All key supervisory personnel and PPP Coordinators shall be thoroughly familiar with the provisions of this decree.

5. The personnel records of every Pineland employee shall indicate all training received by the employee and such training records shall be available to all persons concerned with the enforcement of this decree.

6. A staff member shall not do any resident programming without assistance from a qualified staff person until such staff member has completed 90% of the training required in paragraph 4(b) of this section (for non-professionals) or paragraph 4(d) of this section (for professionals).

7. Staff shall be actively involved by the administration in the development and assessment of Pineland policies and programming.

8. Every member of the Pineland professional staff shall be entitled to attend annually at least one conference in the New England region of relevance to his work or to visit another facility or program which will provide him with new ideas relevant to his needs. The name of each staff member taking advantage of the provisions of this paragraph and the place of the conference attended or visit made shall be documented. Attendance at such conferences or such visits shall be approved by the staff members' immediate supervisor, by the Director of Staff Development, and by the Superintendent.

9. Supervisors shall be responsible for the regular review and assessment of the performance of their subordinates, including their success in meeting program objectives. According to the procedures established by the state personnel department, an evaluation report shall be prepared at least annually emphasizing concrete ways in which the staff person can improve performance and shall be given to the person evaluated. The administration shall be responsible for pursuing every procedure and requirement provided by law, regulation or contract, in the termination or reassignment of employees whose performance is found unsatisfactory.

10. Personnel policies shall be designed to maximize use of individual employees' skills and to enhance effective programming for residents and working conditions for employees. In order to improve personnel policies, personnel terminating employment shall be interviewed if the employee consents. Summaries of these interviews shall be reviewed by the Superintendent and by other appropriate persons, to determine any causes of employee dissatisfaction and instances of dehumanizing or abusive practices and other relevant information, including the determination of appropriate criteria for hiring and screening new employees. Such summaries shall be made available to all persons concerned with the enforcement of this decree.

11. Volunteers at Pineland Center will be eligible to receive appropriate in-service training on terms identical to those of regular staff. Volunteers will be encouraged to make use of these opportunities by their supervisors. Each volunteer will be provided a person who will provide direct supervision to the volunteer on a regular basis. One person shall be assigned the responsibility of recruiting volunteers, scheduling volunteers and seeing to the maximum effective utilization of volunteers.

F. Food, Clothing, Hygiene

1. Consistent with their capabilities and handicaps, residents shall be taught to feed themselves and shall be fed both hot and cold foods and beverages in a normal fashion, in cheerful dining room surroundings, with regard for personal hygiene (including washing hands of residents before and after every meal). Meal schedules shall correspond to normal community standards, with no less than 30 minutes allocated for each resident's meal. To the extent possible, residents shall be taught to eat in leisurely family style, to use utensils, and to choose appropriate quantities of food according to individual tastes and preferences. Direct care staff shall be trained in and shall utilize proper feeding techniques. Significant individual feeding problems shall be addressed in the PPP and the recommendations of the PPP shall be followed.

2. A nourishing, well-balanced, nutritionally adequate diet shall be provided. Residents shall be given liquids at appropriate intervals during each meal, not just at the end of the meal. The food and nutrition needs of residents shall be met in accordance with the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, adjusted for age, sex, activity, disability and special therapeutic needs of individual residents. There shall be a mechanism for ensuring that residents who require special diets receive them.

3. A medical order shall be required if residents are to be fed a diet of other than solid foods, are to be fed in any setting other than a suitable dining area, or are to be fed in a prone position, and any such orders shall be reviewed quarterly by the resident's physician.

4. Dining areas and food storage, preparation, and distribution shall be in compliance with state and local sanitation requirements. There shall be sufficient dishes and utensils for all residents, which shall be thoroughly cleaned between uses.

5. Food shall be prepared by methods that preserve nutritive value, served at normal temperatures, and protected from contamination in transport and storage.

6. Denial of a nutritionally adequate diet shall not be used as punishment, or as part of a behavior modification program.

7. At least one serving of fresh or frozen fruit and one serving of a fresh or frozen vegetables shall be provided each resident each day. Every effort shall be made to provide fresh fruit and fresh vegetables on a daily basis in season. A wide variety of breads will be available to be served daily.

8. Processed meats will be served no more than twice a week. A concerted effort will be made to restrict a

resident's intake of refined sugar. Each resident will receive daily supplemental vitamins if recommended by the resident's physician.

9. All residents will be provided training at a level appropriate to the resident's functional abilities in the purchase, preparation and eating of food.

10. Residents shall be provided with clean, adequate and seasonably appropriate clothing which is comparable in style and quality with clothing worn by persons of similar age and sex in the community. An inventory of clothing owned by each resident shall be maintained on a current basis and every resident shall have a summer and winter compliment of dress clothing, daily wear clothing, recreational clothing and sleepwear. Each resident shall also be provided with sufficient clothing for rainy weather, snow and extreme cold. Whenever a resident's clothes are lost, damaged or stolen, the affected items shall be repaired or replaced to maintain the resident's currently needed wardrobe. Special or adaptive clothing shall be provided to all residents who need it, such that the standards of this paragraph will be met for all residents. Every resident will be provided with an adequate supply of undergarments such that he will have clean underclothing of his own. Clothing will not be taped or tied onto a resident unless the resident's PPP specifies the conditions upon which it may be done. Each resident shall be provided specific habilitative services to teach the proper use and maintenance of clothing. Unless contraindicated by a resident's PPP, each resident shall be involved in the selection of his clothing and shall have ready access to it. All clothing worn by a resident shall be his own, shall be noted on the resident's clothing inventory and shall be inconspicuously marked with the resident's name.

11. Each resident shall receive assistance in learning normal grooming and personal hygiene practices. Individual toilet articles shall be available to each resident unless contraindicated by the resident's PPP. Residents shall receive a bath or shower at least every other day. Hair styling and finger and toe nail cutting shall be regularly scheduled for all residents.

12. There shall be a sufficient number of qualified personnel to fulfill the objectives of this section.

G. Education

1. The educational philosophy shall be that all residents are presumed to be capable of benefitting from education. Education services shall be provided to adult residents upon recommendation of the resident's PPP. The education staff shall consult on at least a monthly basis with those individuals and teams responsible for the daily care and programming of each resident.

2. Educational services at Pineland shall, at a minimum, be equivalent to the special educational services provided in the community in accordance with Maine law in terms of:

(a) Staff qualifications and competencies, in-service training, and diagnostic or prescriptive teachers;

(b) Program hours per student;

(c) Nature, content and quality of programs;

(d) Curriculum guides, equipment, resource materials and diagnostic, testing and screening procedures.

3. There shall be no more than ten residents in a class. Each class of more than five students shall be staffed by a paraprofessional in addition to the teacher.

4. A resident shall be seen several times during the day where the PPP determines that continuous hours of education would be inappropriate for a resident. In exceptional cases, residents may receive fewer hours of educational activity per weekday if a physician certifies in writing that such activity would be medically harmful to the resident. All such certifications shall be collected and made available to persons concerned with the enforcement of this decree.

5. The Department and the Superintendent shall actively seek out, develop and utilize educational services in the community for residents.

6. Those residents with specialized needs, such as the blind, deaf and multiply handicapped, shall receive programs of special education and development specifically designed to meet those needs, and special education staff shall receive specialized training or consultation from qualified professionals in the appropriate specialized field.

7. Toilet training or any other level of competency shall not be a prerequisite to receiving educational services.

8. All necessary classroom materials and equipment shall be on hand and reordered as necessary. Teachers shall have a major voice in deciding what is needed. All necessary diagnostic equipment shall be ordered immediately. Teachers shall be trained to use such equipment.

9. Education shall be provided to school age children on a year-round basis unless a resident's PPP specifies otherwise and states in full why such year-round schooling is inappropriate. Modification of school age children's educational program will be made as necessary during the activities and camp experiences scheduled through the summer months.

H. Recreation

1. There shall be a recreational program at Pineland which meets the recreational needs of each resident as set forth in his PPP. There shall be enough recreational equipment to provide adequate recreational services to all residents. There shall be a special effort to find equipment appropriate for multiply handicapped and profoundly retarded residents. The recreation program shall conform as closely as possible to normal community recreation activities, in particular in terms of equipment, age and sex grouping, facilities and surroundings. A minimum of five hours of recreational program activity shall be provided to each resident each week.

2. Recreation may be considered a part of programming if it consists of organized and structured activity related to the achievement of PPP goals.

3. Recreation shall be conducted in developmentally appropriate groups.

4. Whenever possible, recreation shall take place in the community. Additional vehicles shall be provided to ensure adequate transportation for residents, regardless of handicap.

5. Recreation staff shall receive appropriate in-service training. Recreation shall be conducted primarily during evening and weekend hours.

6. In addition to recreational program activity, developmentally appropriate opportunities shall be provided all residents for use of their leisure time. Unless contra-indicated by the resident's PPP, at least one major and two minor evening or weekend recreational activities shall be available to each resident each week. A major activity is one which takes the resident off the campus or occupies most of a resident's morning, afternoon or evening. A minor activity is one which involves the resident for at least one hour. Weather permitting, and unless inappropriate for the activity, it shall take place outdoors.

7. Developmentally appropriate reading materials, coloring books, film strips, special toys, games and records shall be available to residents in places which are comfortable and conducive to resident use.

8. An attractive area conducive to residents' enjoyment of outdoor leisure time, including equipment designed to meet the residents' needs for unstructured physical activity and appropriate to the residents' developmental levels shall be accessible to residents. Chairs shall be available to residents who wish to sit outdoors.

9. Every ambulatory resident shall have the opportunity for a minimum of four hours of outdoor activity each week for seven months of the year and a minimum of eight hours of outdoor involvement each week for five months of the year, weather permitting.

I. Dental Services

1. A dental clinic shall be maintained at Pineland which will provide twice-yearly examination, cleaning and repairing of all residents' teeth. Residents without teeth shall be seen at least annually. More frequent examinations or treatment shall be provided when necessary.

2. As a part of the PPP of each resident who is without teeth or missing teeth or who has visibly crooked teeth or swollen gums, a concrete plan shall be developed by the dental clinic for maximum feasible restoration of the resident's mouth. All such plans shall be available to persons concerned with the enforcement of this decree.

3. Oral hygiene shall be maintained at a level that will adequately assure the oral health of each resident and that will allow all professionally recommended prosthodontic, orthodontic, endodontic and oral surgery work to be performed.

4. All nursing and direct care staff shall receive the practical training necessary to fully implement the oral hygiene standard specified in the preceding paragraph.

5. A concerted effort shall be made to train each resident in the proper care of his or her teeth, and all residents shall brush their teeth (or have their teeth brushed) every morning and every evening before bedtime. Plaque detector shall be used under the supervision of nursing staff as necessary to ensure that proper brushing of teeth is accomplished. All reasonable steps shall be taken to eliminate mouth odors.

6. Emergency dental care shall be available on a 24-hour, seven-day-a-week basis. Appropriate specialists, including anesthesiologists, shall be provided whenever needed.

J. Psychological Services

1. These services shall include at least annual psychological evaluations which shall be conducted as part of each resident's PPP pursuant to Appendix A, Section D. Such evaluations shall include personal interaction with the resident. In addition, evaluation, consultation, the preparation of a program plan, therapy and behavior modification shall be provided, where necessary or appropriate, by sufficient qualified psychologists.

2. All PPP recommendations by psychology professionals intended to be carried out in whole or in part by direct care staff will be monitored by the psychology staff on a weekly basis during the month following the recommendation, and monthly thereafter, unless closer monitoring continues to be required.

3. When appropriate, psychologists shall instruct parents and relatives in the techniques of behavior management specified in the resident's PPP.

K. Physical Therapy Services

1. Individualized physical therapy services on a regular basis shall be provided to those residents who can benefit therefrom, including all residents suffering from cerebral palsy and all non-ambulatory residents, and shall include positioning, feeding programs, self-ambulation programs, intervention and activation. Each physical therapist shall keep evaluation and progress records for each resident under his care, in accordance with the requirements of Appendix A, Section D.

2. Sufficient numbers of qualified staff shall promptly evaluate all non-ambulatory and physically handicapped residents to determine the number of wheelchairs (including electric wheelchairs), braces, orthopedic shoes, walkers, crutches, positioning equipment, bolsters, helmets, adaptive chairs and any other adaptive equipment that is needed. Such equipment shall be ordered and/or constructed and issued as quickly as possible. Staff shall be employed to make adaptive equipment, tailored to the physical needs of individual residents.

3. There shall be immediate physical therapy follow-up on residents who have undergone orthopedic surgery.

4. All PPP recommendations made by physical therapy professionals and intended to be carried out in whole or in part by direct care staff will be monitored by physical therapy staff on a weekly basis in the month following the recommendation, and monthly thereafter unless closer monitoring continues to be required.

5. When appropriate, physical therapists shall instruct parents and relatives in the proper techniques of physical therapy specified in the resident's PPP.

L. Speech Pathology and Audiology Services

1. The purpose of speech pathology and audiology services shall be to improve the verbal or non-verbal communications skills of all residents. For this purpose, it shall be presumed that all residents can benefit from such services. Speech pathology and audiology services shall be provided as specified in each resident's PPP.

2. To this end, there shall be available sufficient appropriately qualified staff and necessary supporting personnel to carry out speech pathology and audiology services and communication skills development in accordance with goals and stated objectives in residents' PPP's. Staff who assume independent responsibilities for clinical services shall possess the educational and experience qualifications required for a Certificate of Clinical Competence issued by the American Speech and Hearing Association (ASHA) in the area (speech pathology or audiology) in which they provide services, or equivalent qualifications.

3. All PPP recommendations made by speech and hearing professionals and intended to be carried out in whole or in part by direct care staff shall be monitored weekly in the month following the recommendation, and monthly thereafter unless closer monitoring continues to be required. When a resident is being trained in a non-verbal or gesture language system, that resident's primary aides on the day and evening shifts and primary program provider shall be similarly trained in that system.

4. Every resident shall receive a speech, language, and hearing screening once every two years, administered by a speech and hearing professional to identify speech, language, or hearing problems. In addition, every resident under ten years of age and those residents requiring closer monitoring or who are high-risk residents (i.e., those with progressive hearing loss or diminishing speech or language functions due to physical/neurological factors) shall be evaluated annually by a speech and hearing professional. In addition, residents referred by the IDT process as requiring additional diagnostic work will be evaluated as necessary. Speech and hearing professionals shall develop PPP's for those residents who may require such services as appropriate to their developmental needs. Speech and hearing professionals will participate in the IDT meetings of residents receiving direct treatment services and IDT's of other residents as appropriate. As part of the PPP for each non-verbal resident, a specific communication skills training program calculated to meet the resident's need to communicate will be prescribed.

5. Speech therapists shall teach parents and relatives how to stimulate language and train them in using an alternative communication system, when appropriate.

6. Residents who require hearing aids are to wear the aid as the therapist recommends. Such aids are to be maintained at all times in good working order.

7. Speech therapists shall consult with physicians if they believe surgery is appropriate.

8. Speech therapists' recommendations as to ENT, dental referrals and continued programming shall be considered by the IDT described in Appendix A, Section D.

9. Where appropriate, deaf residents, hearing impaired residents, and residents with neurological or physical damage precluding the acquisition of speech will be taught sign language or an alternate communicative system.

10. A speech or hearing professional shall at least semiannually observe and measure with appropriate equipment the noise levels in all resident living and program areas and make concrete recommendations for the elimination of unacceptable noise levels. All such recommendations shall be provided to persons concerned with the enforcement of this decree.

M. Medical and Nursing Services

1. Pineland shall have a comprehensive program of health services for residents which provides quality, continuity and accessibility of care. Each resident shall have at least annually a comprehensive medical examination. A full range of preventive, acute, and specialized medical services and resources shall be available to residents as needed. In keeping with Appendix A, Section D, medical services and diagnosis shall be closely coordinated with each resident's PPP.

2. Residents not requiring specialized medical or nursing care shall not be kept in Benda Hospital. Residents who remain in the hospital for more than ten days shall receive a level of programming comparable to their regular programming, unless the written order of a physician certifies that such programming would be medically harmful.

3. A full-scale immunization program shall be maintained so that all residents receive all necessary immunizations except as exempted by Maine statute.

4. There shall be regular training sessions for direct care staff on the identification and reporting of medical problems, with particular emphasis on seizure control, aspiration, prevention of bed sores, and other common health problems of Pineland residents.

5. Physicians' schedules shall include adequate provision for medical coverage, including care for medical emergencies on a 24-hour, seven-day-a-week basis.

6. Pineland shall maintain a contract for acute medical care with one or more accredited hospitals. In addition, service agreements with backup medical facilities shall be developed, where appropriate.

7. The comprehensive medical evaluations specified in paragraph 1 above shall include evaluation of the need for comprehensive eye examination which shall be provided if indicated. Glasses shall be provided when indicated and promptly replaced if broken.

8. As part of the PPP for each bedridden or non-ambulatory resident, consideration shall be given to providing orthopedic surgery to correct or allay further degeneration.

9. Nurses shall be considered part of the care service team. Residents shall be provided with nursing services in accordance with their needs. Such services shall include:

(a) Provision of skilled nursing care as needed;

(b) Control of communicable diseases and infections through:

(1) Identification and assessment;

(2) Reporting to medical authority; and

(3) Implementation of appropriate protective and preventive measures; and

(c) Responsibility for attaining the standards set for oral hygiene and care in accordance with Appendix A, Section I.

N. Restraints and Abuse

1. Mistreatment, neglect or abuse in any form of any resident shall be prohibited. The routine use of all forms of restraint shall be eliminated. Physical or chemical restraint shall be employed only when absolutely necessary to prevent a resident from seriously injuring himself or others. Restraint shall never be employed as punishment, for the convenience of staff, or as a substitute for programs. In any event, restraints may only be applied if alternative techniques have been attempted and failed (such failure to be documented in the resident's record) and only if such restraints impose the least possible restriction consistent with their purposes. Pineland shall have a written policy defining (1) the use of restraints, (2) the professionals who may authorize such use, and (3) the mechanism for monitoring and controlling such use.

2. Only professionals designated by the Superintendent may order the use of restraints. Such orders shall be in writing and shall not be in force for over 12 hours. A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints and a written record of such checks shall be kept.

3. Mechanical restraints shall be designed for minimum discomfort and used so as not to cause physical injury to the resident. Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which restraint is employed.

4. The use and duration of all restraints, including mittens, tying devices, and camisoles shall be documented in daily reports made to the Superintendent by those professionals ordering such use.

5. Straitjackets shall never be used, nor shall any resident be tied, spread-eagled to a bed, or subjected to either corporal punishment, degradation, or seclusion, which is hereby defined as placing a resident alone in a locked room, living unit or area, which he cannot leave at will, without constant visual surveillance.

6. Alleged instances of mistreatment, neglect or abuse of any resident shall be reported immediately to the Superintendent and to the advocate, and there shall be a written report that the allegation has been thoroughly and promptly investigated (with the findings stated therein). Such written reports shall be made available to persons concerned with the enforcement of this decree, and their confidentiality shall be maintained.

7. A resident's correspondent shall be notified in writing whenever restraints are used and whenever an instance of mistreatment, neglect or abuse occurs.

O. Medication

1. No prescription medication shall be administered except upon order of a physician. Such orders shall be confirmed in writing by a physician within 48 hours.

2. Notation of each resident's medication shall be kept in his medical records. At least every 30 days the physician shall review the drug regimen of each resident under his care. All prescriptions shall be written with a termination date, which shall not exceed 60 days. The chief medical or pharmacological professional shall provide a monthly statement listing the number of residents receiving (1) phenothiazines, (2) tranquilizers, and (3) anticonvulsants.

3. Residents shall have a right to be free from unnecessary or excessive medication and a continuous, concerted effort shall be made to reduce unnecessary medications.

4. Psychotropic drugs shall be used only as an integrated part of an individualized habilitation plan that is designed to lead to a less restrictive way of treating, and ultimately to the elimination of, the behaviors for which the drugs are employed. Before any new psychotropic medication is prescribed, the attending physician shall ascertain, consider and record in the resident's medical record the following information:

(a) the diagnosis and the specific behaviors and other signs and symptoms which indicate a need for the medication;

(b) the reasons for the choice of medication, including such matters as careful balancing of expected therapeutic effects and potential adverse effects, the history of the resident's response to the same or similar medication, and why techniques other than medication are not deemed adequate or appropriate treatment for the resident;

(c) the method for assessing the resident's progress or response to the treatment, including adverse effects; and

(d) the fact that the physician or nurse has explained in lay terms to the resident and to the resident's correspondent the reasons for the treatment and possible benefits and consequences of the medication.

5. During a course of administration of psychotropic medication, the physician shall ensure that the resident's progress or response to the treatment, including adverse effects, are carefully monitored and recorded. Pursuant to this requirement, the physician shall:

(a) ensure that appropriate persons responsible for the resident's habilitation, education, care and other treatment are informed as to the significant potential effects of the medication and record their observations

thereof, including effects on the resident's progress in habilitation and education programs and his participation in other activities; and

(b) ensure that appropriate laboratory tests are performed and analyzed.

6. Repeated administration of a psychotropic medication, including substitution of a medication of the same class, shall never cumulatively exceed one year without the attending physician effecting a carefully monitored withdrawal of the medication. This periodic drug withdrawal shall be used to determine the need for continuing the medication and the prescribed dosage. During such withdrawal the results shall be noted in the resident's medical record. Withdrawal should proceed as long as the patient's condition is not worsened. Medication may be resumed only if there is clear documentation of benefit derived from its use. Such a drug withdrawal program shall be repeated on an annual basis. The physician shall be responsible for making all decisions regarding individual withdrawal programs.

7. Any resident subjected to the following medication regimens shall have his medical record reviewed by a consultant in psychopharmacology at least annually:

(a) concurrent use of more than one antipsychotic medication or concurrent use of an antipsychotic medication with an antianxiety, antidepressant or antimanic medication;

(b) use of any anticonvulsive or anti-Parkinson medication in the absence of current indications that the resident suffers from convulsions or Parkinson-like effects;

(c) use of any antipsychotic medication in the presence of evidence of serious side effects, including, but not limited to, tardive dyskinesia;

(d) use of any psychotropic medication regimen when any pharmacist, physician, pharmocologist, professional or staff member states in writing with reasons therefor to the pharmacist that such regimen constitutes a hazard of serious adverse effects not warranted by the therapeutic benefit to the resident. The pharmacist shall send a copy of all such reports to the attending physician.

8. Medication shall not be used as punishment, for the convenience of the staff, as a substitute for program, or in quantities that interfere with the resident's habilitation.

9. Pharmacy services at the institution shall be directed by a full-time professionally competent and licensed pharmacist. Such pharmacist shall be a graduate of a school of pharmacy accredited by the American Council on Pharmaceutical Education.

10. The pharmacist shall perform duties which include, but are not limited to, the following:

(a) receiving the original or direct copy, of the physician's drug treatment order;

(b) reviewing the drug regimen, and any changes, for potentially adverse reactions, allergies, interactions, contraindications, rationality, and laboratory test modifications, and advising the physician of any recommended changes, with reasons and with a proposed alternate drug regimen;

(c) maintaining for each resident an individual record of all medications (prescription and nonprescription) dispensed, including quantities and frequency of refills.

11. Only appropriately trained persons shall be allowed to administer drugs. Injectable drugs shall be administered by a registered nurse or licensed practical nurse.

12. Written policies and procedures that govern the safe administration and handling of all drugs shall be developed by the responsible pharmacist, physician, nurse, and other professional staff.

(a) The compounding, packaging, labeling, and dispensing of drugs, including samples and investigational drugs, shall be done by the pharmacist, or under his direct supervision, with proper controls and records. Each drug shall be identified up to the point of administration. Procedures shall be established for obtaining drugs when the pharmacy is closed.

(b) There shall be a written policy regarding the administration of all drugs used by the residents, including those not specifically prescribed by the attending practitioner. There shall be a written policy regarding the routine of drug administration, including standardization of abbreviations indicating dose schedules. Medications shall not be used by any resident other than the one for whom they were issued.

13. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

(a) All drugs shall be kept under lock and key except when authorized personnel are in attendance.

(b) The security requirements of federal and state laws shall be satisfied in storerooms, pharmacies, and living units.

(c) Poisons, drugs used externally, and drugs taken internally shall be stored on separate shelves or in separate cabinets, at all locations.

(d) Medications that are stored in a refrigerator containing things other than drugs shall be kept in a separate compartment with proper security.

(e) A perpetual inventory shall be maintained of each narcotic drug kept in the pharmacy, and on each unit in which such drugs are kept, and inventory records shall show the quantities of receipts, and issues and the person(s) to whom issued or administered.

(f) If there is a drug storeroom separate from the pharmacy, there shall be a perpetual inventory of receipts and issues of all drugs by such storeroom.

14. Discontinued and outdated drugs, and containers with worn, illegible, or missing labels, shall be returned to the pharmacy for proper disposition.

15. Medication errors and drug reactions shall be recorded and reported immediately to the practitioner who ordered the drug, if he is available, and otherwise to a physician on duty. A report shall also be made to the pharmacist.

P. Behavior Modification, Research, and Hazardous or Experimental Treatment

1. Residents who require, in addition to regular programming, services for psychiatric problems shall be treated in their living units or in small groups within a living unit of no more than four residents. Any transfer of a resident to a psychiatric facility or unit shall occur only in compliance with the procedures set forth in Maine admission and commitment law.

2. The use of aversive conditioning shall be permitted only after positive reinforcement procedures and other less drastic alternatives have been tried and failed (this failure shall be documented) and approval has been obtained:

(a) from the resident's interdisciplinary team; and

(b) from the resident, if he is capable of giving informed consent, or from the resident's correspondent if the resident cannot give informed consent; and

(c) from a three-person special committee on aversive conditioning, designated by the Superintendent, which shall include the advocate, and two designees from the Consumer Advisory Board.

3. The Superintendent, the Director and Commissioner shall be advised when a decision has been reached and approved to utilize such aversive conditioning. Aversive conditioning techniques shall be employed only under the supervision of a psychiatrist or psychologist licensed to practice in Maine who has had proper training in the use of such techniques, and who is specifically authorized by the Superintendent to conduct such aversive conditioning.

4. Research or experimentation shall be conducted only after approval has been obtained as set forth in paragraph 2 above, except research limited to review of resident records, provided that confidentiality is adequately protected.

Q. Maintenance, Safety and Emergency Procedures

1. All necessary steps shall be taken to correct health and safety hazards, including covering radiators and steam pipes in a manner to protect residents from injury, repairing broken windows, and removing insects and vermin.

2. Pineland shall comply with the provisions of the Life Safety Code of the National Fire Protection Association. Staff and residents shall be trained in emergency procedures. Procedures to be followed in case of fire, medical, missing person, or other emergencies, shall be promulgated by the Superintendent. Special attention shall be paid to the needs of physically handicapped residents. There shall be quarterly fire drills for each shift except the night shift, and periodic fire drills for the night shift.

3. Outside windows shall be provided with screens. Doors shall be provided with screens except where their installation would create a violation of fire safety standards.

4. Floors in living or sleeping areas other than dining or bathroom areas shall be provided with carpets or rugs, consistent with a pleasant, clean, quiet and safe residential environment.

5. Defendants shall establish and maintain a program of adequate maintenance of buildings and equipment which shall include prompt elimination of existing maintenance backlogs.

R. Labor

1. Institution Maintenance: No resident shall be required to perform labor which involves the operation and maintenance of the institution or for which the institution is under contract with an outside organization. Privileges or release from the institution shall not be conditioned upon the performance of labor covered by this provision. Residents may voluntarily engage in such labor if the labor is compensated in accordance with paragraph 4 of this section. No resident shall regularly be involved in the care, feeding, clothing, training, or supervision of other residents.

2. Training Tasks and Labor:

(a) Residents may be required to perform vocational training tasks which do not involve the operation and maintenance of the institution, subject to a presumption that an assignment of longer than four months to any specific task is not a training task, provided the specific task or any change in assignment is:

(1) an integrated part of the resident's PPP and has been approved as a program activity by a professional responsible for supervising the resident's program; and

(2) supervised by a staff member.

(b) Residents may voluntarily engage in labor during non-program hours for which the institution would otherwise have to pay an employee, provided the type of labor or any change in the type of labor is:

(1) approved by the IDT;

(2) supervised by a staff member; and

(3) compensated in accordance with paragraph 4 of this section.

3. Personal Housekeeping: Residents may be required to perform tasks of a personal housekeeping nature such as the making of their own beds.

4. (a) Residents who are employed to perform work of economic benefit to the employer shall be paid wages which are commensurate with those paid nonhandicapped workers at Pineland or at businesses in the vicinity for essentially the same type, quality and quantity of work. The applicability of this standard does not depend on whether or not the work is of therapeutic value to the resident.

(b) Pineland shall maintain for each resident who is employed, and have available for inspection, records of:

(1) the productivity of each resident, to be reviewed at quarterly intervals;

(2) the prevailing wages paid nonhandicapped workers in Pineland or in businesses in the vicinity for essentially similar work to that performed by residents; and

(3) production standards for an average nonhandicapped worker for each job being performed by a resident.

5. Residents shall be allowed to keep amounts earned under this section.

6. Every effort shall be made to provide compensated employment for residents who are willing and able to work and sufficient funds will be made available for the implementation of this paragraph.

S. Records

1. There shall be a system of records for each resident developed and maintained under the supervision of a competent records technician. Each resident's records shall be readily available to all professional staff. Direct care staff involved with a particular resident shall have access to those portions of an individual's records relevant to programming. Information shall be incorporated in the resident's record in sufficient detail to enable those persons involved in ther resident's program to provide effective, continuing services. All entries in the resident's record shall be legible, dated, and have the signature and identification of the individual making the entry.

2. These records shall include:

(a) identification data including the resident's legal status;

(b) relevant family data, including family visits and contacts, educational background, and employment record;

(c) prior medical history, both physical and mental, including prior institutionalization;

(d) an inventory of the resident's life skills;

(e) a record of each physical examination, psychological report, and any other evaluations, including all those required by this decree;

(f) a copy of the individual's PPP, and any modifications and evaluations thereof, with an appropriate summary to guide direct care staff in implementing such plan;

(g) the findings made in periodic (at least quarterly) reviews of the individual's response to his PPP, with directions as to modifications, prepared by a professional involved in the resident's program;

(h) a copy of the post-institutionalization plan and any modifications thereof, a summary of the steps that have been taken to implement that plan, and all social service reports;

(i) a medication history and status, as required by Appendix A, Section O;

(j) a signed order by authorized personnel for any physical restraints, as required by Appendix A, Section N;

(k) a description of any extraordinary incident or accident in the institution involving the resident, to be entered by a staff member noting personal knowledge of the incident or accident or other source of information, including all reports of investigations of resident mistreatment, as required by Appendix A, Section N;

(l) a summary of the extent and nature of any work activities and the effect of such activity upon the resident's progress;

(m) all team minutes relating to the resident;

(n) all other orders and certifications specifically required by this decree.

3. Defendants shall employ an adequate number of appropriately qualified staff, and necessary supporting personnel, to facilitate the prompt and accurate processing, typing, checking, indexing, filing and retrieval of records and record data.

T. Consumer Advisory Board

1. A nine-member Consumer Advisory Board shall be established, and its responsibilities shall include evaluation of alleged dehumanizing practices, promotion of normalization, and examination of violations of individual rights. The Board shall submit written reports on at least a quarterly basis to the Superintendent and to the Commissioner, and shall make such reports available to persons concerned with the enforcement of this decree.

2. Membership on the Consumer Advisory Board shall include parents or relatives of residents, community leaders, the advocate from Pineland, the chaplain from Pineland, and residents or former residents. Membership shall be nominated from but not limited to the following organizations: the Maine Committee on the Problems of the Mentally Retarded, the Protection and Advocacy System, the Developmental Disabilities Council, the Pineland Parents and Friends, and the Maine Association for Retarded Citizens. The members shall be appointed by the Commissioner for terms not to exceed two years. Such terms shall be staggered so as to afford appropriate overlap.

3. The Consumer Advisory Board shall have direct access to all living and program areas and to all records directly related to resident care, other than personnel records.

4. Members of the Consumer Advisory Board shall be reimbursed by defendants for their reasonable expenses involved in carrying out their responsibilities as stated in this section.

U. Management

1. A meaningful table of organization shall be maintained, clearly defining areas of responsibility and accountability by position and name. A means for resolving disputes between units and professional departments, including disputes concerning the deployment or supervision of staff, shall be provided.

2. Pineland shall maintain an up-to-date manual for employees including all policies, regulations and procedures required by this decree. The manual shall be submitted for comment to all persons concerned with the enforcement of this decree within 60 days of the signing of this decree.

3. Consultants shall periodically evaluate management and all major program elements covered by this decree. Whenever consultants or outside evaluators are utilized, reports shall be forwarded to the Superintendent and be made available to persons concerned with the enforcement of this decree.

4. At least one person shall be employed who shall be familiar with all sources of federal and private monies for which Pineland or any of its programs might be eligible and who shall make application whenever appropriate.

5. Pineland shall make a concerted effort to maintain mutually beneficial contact and liaison with the various campuses and departments of the University of Maine, as well as other colleges, with the goal of providing students practical experience in working with retarded citizens, involving outside professionals in contributing to program and research needs of Pineland residents, and developing such other cooperative efforts as may be of benefit to Pineland's residents.

6. The Commissioner shall prepare a budget request which is calculated to meet all deficiencies in meeting the terms of this decree. A copy of all portions of the governor's budget applicable to this decree shall be sent to all persons concerned with the enforcement of this decree when the budget is sent to the legislature, and a copy of the final budget approved by the legislature shall be sent to persons concerned with the enforcement of this decree immediately following approval of the budget. This section shall apply to any supplemental budget requests.

7. The services of a resident advocate shall be maintained throughout the term of this decree.

8. Within 90 days of the signing of this decree, defendants shall hire an Assistant Superintendent at Pineland.

V. Integration with the Community

1. Pineland shall utilize existing services and resources in the community to the maximum extent possible. When needed services and resources in the community are unavailable to Pineland residents. Pineland shall systematically work toward the development of those services and resources and shall document these efforts.

2. Unless specifically contraindicated by a resident's PPP, each resident shall be provided the opportunity:

(a) to shop in the community at least monthly;

(b) to eat in a public place in the community at least monthly;

(c) to participate in a major recreational activity in the community at least monthly;

(d) to attend a public event in the community at least four times annually.

Implementation of this standard shall be documented in each resident's record.

3. Subject to guidelines established by the Pineland chaplain, residents shall have the opportunity to worship in the community as frequently as possible.

4. Transportation shall be provided once each morning and afternoon to Gray, Maine, and periodically to Portland at times convenient for residents' trips for their private purposes. Residents and staff shall be informed regularly of opportunities for trips into the community in compliance with this paragraph and with paragraph 2 of this section.

5. In order that the residents of Pineland be provided adequate opportunity to go into the community and to utilize available community resources and recreational opportunities, sufficient vehicles, including vehicles capable of accommodating handicapped residents, shall be maintained in good operating order.

W. Miscellaneous

1. Unless otherwise specified herein, all steps, standards and procedures contained herein, including those relating to staffing, programming, clothing, housekeeping, recreation, education, food and maintenance, shall be achieved, and thereafter maintained within 12 months of the signing of this decree.

2. Any resident's parent residing in Maine who is desirous of visiting the resident but who, on account of poverty, is unable to accomplish the visitation will be provided the opportunity to do so at least three times annually. Every effort will be made to facilitate such visitation on the resident's birthday and at Christmas. The number of visits made in accordance with the provisions of this paragraph will be recorded and made available to all persons concerned with the enforcement of this decree.

3. Each resident shall have his birthday celebrated and shall receive suitable birthday presents valued at at least $10.

4. Defendants shall make every effort to insure that a person in the governor's office will be responsible for being knowledgeable about the terms of this decree and for lending all appropriate assistance of that office to the full implementation of the decree.

5. A copy of this decree shall be available in each living unit and in each professional or program area.

6. The resident advocate at Pineland, the chief advocate within the Department and the Consumer Advisory Board shall, upon request, have access to any information made available to persons concerned with the enforcement of this decree.

7. All correspondents, advocates and persons concerned with the enforcement of this decree shall have an obligation to keep all records and other personally identifiable information concerning residents confidential consistent with the provisions of the relevant Maine law on confidentiality.

8. This decree shall be interpreted in a fair and reasonable manner so as to attain the object for which it was designed and the purpose to which it is applied.

APPENDIX "B"
COMMUNITY STANDARDS
JULY 14, 1978

TABLE OF CONTENTS

Definitions

For the purposes of this Appendix, the following terms are defined as follows:

1.	"Plaintiffs" and "Defendants"	refer to the parties named as plaintiffs and defendants in the caption hereof.
2.	"Department"	refers to the Department of Mental Health and Corrections.
3.	"Commissioner"	refers to the Commissioner of the Department.
4.	"Bureau"	refers to the Bureau of Mental Retardation.
5.	"Director"	refers to the Director of the Bureau.
6.	"Regional office"	refers to the appropriate regional office of the Bureau.
7.	"Regional Administrator"	refers to the professional who heads the appropriate regional office.
8.	"Pineland"	refers to Pineland Center, Pownal, Maine.
9.	"Superintendent"	refers to the Superintendent of Pineland.
10.	"The class"	refers to all persons who were involuntarily confined residents of Pineland on or after July 3, 1975, or who were conditionally released from Pineland and in community placements on or after July 3, 1975, exclusive of those individuals admitted to Pineland for a specific medical service at Benda Hospital or for respite care for less than 21 consecutive days.
11.	"Resident"	refers to a member of the class who resides at Pineland.
12.	"Client"	refers to a member of the class who does not reside at Pineland.
13.	"Competent client" or "competent resident"	refers to a client or a resident 18 years or older not adjudged incompetent by a court nor determined to be incapable of making a particular decision as set forth herein. A determination that a resident or client is incapable of making a particular decision requires a finding by the client's interdisciplinary team and an independent finding by the appropriate advocate that the client does not understand the nature and consequences of the decision in question. Such a finding or determination shall have no effect on legal competence or on competence or capacity for any other purpose.

14.	"Professional"	Except as specifically provided otherwise in this appendix, "professional" refers to a person possessing appropriate licensure, certification or registration to practice his discipline in the community; and where licensure, certification or registration is not required, "professional" shall mean a person possessing a Master's Degree in the appropriate discipline or a person possessing a Bachelor's Degree in the appropriate discipline and three years' experience in treating the mentally retarded or three years' experience in a related human services field.
15.	"Community service worker"	refers to a person qualified in social work, psychology, or other relevant human services field. At least 75 percent of community service workers shall have professional qualifications.
16.	"Interdisciplinary team" or "IDT"	refers to a team of persons established, and whose meetings are conducted, in accordance with professionally accepted standards, and whose purpose is to evaluate a client's needs and to develop an individual prescriptive program plan.
17.	"Prescriptive program plan"	refers to a detailed written plan outlining a client's specific needs for education, training, treatment and habilitation services, along with the methods to be utilized in providing treatment, education and habilitation to the client. A prescriptive program plan shall be formulated by an appropriately constituted interdisciplinary team.
18.	"PPP coordinator"	refers to a prescriptive program plan coordinator.
19.	"Programming" or "Program activity"	refers to any activity specified in the client's prescriptive program plan that is individually designed and structured to increase the client's physical, social, emotional or intellectual growth and development.
20.	"Community placement"	refers to a residence in the community in a group home, foster care home, natural home, apartment, boarding home, or similar residential facility coupled with a program element adequate to meet the client's individual needs.
21.	"Group home"	refers to a community residence for no more than eight clients.

22.	"Consultant"	refers to a person, agency, firm, or organization that is independent of the Department and of Pineland, though not necessarily independent of other state agencies or departments.
23.	"Day" or "Days"	Time periods referred to shall not include the day of the act or decision involved. If the last day of such a time period falls on a Saturday, Sunday or legal holiday, the period shall extend to the end of the next day which is neither a Saturday, Sunday nor legal holiday. When written notice of a decision is required, the notice shall be mailed within the specified time period.
24.	"Correspondent"	In the first instance, a correspondent is the client's legal guardian. If the client does not have a legal guardian, the correspondent is the client's parent. Where parents are deceased or their whereabouts cannot, with due diligence, be ascertained, and they have failed to designate an appropriate representative and there is no guardian, then the correspondent shall be defined as the relative, if any, in closest relationship with the client who has, at least once within the previous year, manifested interest in the client by communication with the Department regarding the client or by visiting the client. If there is no legal guardian, parent or relative, as defined above, or if such person is unable to exercise his rights hereunder because of age, illness, distance, or some other compelling reason, the correspondent shall be a person designated by the Consumer Advisory Board (see Appendix A, Section T this decree). The notices required by this decree to be sent to a correspondent shall inform the correspondent of his right to designate the Consumer Advisory Board to act for him if for the reasons stated above he is unable to exercise his rights. Any designation by the Consumer Advisory Board shall remain in effect until revoked by the legal guardian, parent or relative, as defined above.
25.	"Persons concerned with the enforcement of this decree"	refers to counsel for plaintiffs and defendants, any person designated by the Court to monitor enforcement and his agents.

A. Community Placement and Client Movement

1. By July 1, 1979, Pineland shall be reduced to an institution of 400 or fewer beds to serve the needs of individuals who require institutional care. Within two years of the signing of this decree, Pineland shall be reduced to a maximum of 350 beds, and shall be maintained at that level or smaller.

2. Movement of residents

(a) As part of the individual evaluation required by Appendix A, Section D of this decree, each resident's Pineland interdisciplinary team shall determine whether placement in the community is appropriate, and, if so, shall make a community placement recommendation. Community placement decisions shall be based on a determination that the placement will offer the individual a better opportunity for personal development and a more suitable living environment, and will result in placement in the least restrictive alternative appropriate for the resident.

(b) Following a determination, made in conformance with (a) above, that placement in the community is appropriate for a resident, a community service worker shall be assigned to that resident and the community service worker's name shall be recorded in the resident's file. The community service worker shall then locate and/or develop, in consultation with the resident and with the resident's correspondent (unless a competent resident objects to the correspondent's involvement), a community placement that is in conformance with the recommendations of the interdisciplinary team.

(c) Each resident shall be placed in a placement located as close as practicable to the area in which his correspondent lives. However, if the resident's interdisciplinary team specifically recommends in writing a placement in an area other than as described in this subparagraph and records its reasons therefore, the team's recommendations shall be followed.

(d) Any community placement located or developed by a community service worker must be reviewed by the Superintendent, and no resident shall be placed in a community placement unless and until the Superintendent finds that such placement complies with the criteria set forth in (a) above. The Superintendent shall note his finding in the resident's record.

(e) The procedures set forth in paragraphs 4-8 of this section shall apply to any movement of residents from Pineland into a community placement or into any other living arrangement.

3. Movement of clients.

(a) For clients in a community placement, as part of the individual evaluation required by Appendix B, Section B of this decree, each client's community interdisciplinary

team shall determine whether movement to any other living arrangement is necessary to meet the client's needs. If so, the team shall make a placement recommendation. Placement decisions shall be based on a determination that the placement will offer the individual a better opportunity for personal development and a more suitable living environment, and will result in placement in the least restrictive alternative appropriate for the client.

(b) For clients in community placements for whom movement to another living arrangement is recommended, the client's community service worker in consultation with the client and the client's correspondent (unless a competent client objects to the correspondent's involvement) shall locate or develop a placement that is in conformance with the recommendations of the interdisciplinary team.

(c) For clients in the community, the placement must be reviewed by the appropriate Regional Administrator, and no client shall be moved unless and until the Regional Administrator finds that the placement complies with the criteria set forth in (a) above. The Regional Administrator shall note this finding in the client's record.

(d) The procedures set forth in paragraphs 4-8 of this section shall apply to any movement of clients from a community placement to any other living arrangement.

4. After an appropriate placement has been found and approved by the Superintendent/Regional Administrator, and prior to the resident's/client's transfer to that placement the Superintendent/Regional Administrator shall notify the resident/client, the correspondent and the appropriate advocate, of the proposed placement. No resident/client shall be transferred to any other living arrangement without prior notice and prior opportunity to challenge that placement pursuant to the procedures set forth in paragraphs 4-8 of this section, except:

(a) If the Superintendent/Regional Administrator states in writing with supporting reasons that an immediate placement is required to avoid serious harm to the health or welfare of the resident/client, the resident/client may be moved and opportunity to challenge may be given after such an emergency placement is effected, but in no case more than 10 days after such placement.

(b) If a community residence provider refuses to continue services to a client, or if a placement is otherwise terminated by other than Bureau action, the client may be placed in respite care, while a new placement is arranged.

(1) Before a client placed in respite care pursuant to this paragraph is relocated, the procedures set out in this section, including a team conference and a new or revised placement plan, shall be followed.

(2) No client shall be placed in respite care for longer than 30 days without movement being initiated and notice sent pursuant to this paragraph.

(3) The time limits governing the filing of an objection and time limits governing the procedures set forth in paragraph 8 of this section shall be reduced by half for clients to whom this paragraph is applicable.

5. The notice required by paragraph 4 of this section shall specify: (a) the standards (see paragraphs 2(a) and 3(a) of this section) pursuant to which all placements are made; (b) the date the placement is to be made; (c) a detailed description of the placement; (d) the resident's/client's and correspondent's right on a continuing basis to have access to all data on which the placement is based; (e) the name, address, and telephone number of a staff member at Pineland (when appropriate) and at the appropriate regional office who can be contacted to respond to questions from the resident/client or his correspondent or advocate; (f) the procedure for indicating agreement or disapproval of the proposed placement; (g) the procedures for challenge set forth in paragraph 8 of this section; (h) the name, address, and telephone number of an advocate whom the resident/client or correspondent may contact for assistance; and (i) the date by which any response must be received.

6. (a) Prior to placement, residents/clients shall have a right to a preplacement visit to the new residence. Unless a competent resident/client objects, his correspondent and advocate shall be invited to accompany the resident/client on this visit. A record of the preplacement visit shall be kept in the resident's/client's file. Exceptions to this requirement may be made: (1) if a visit to the placement would require the resident/client to ride more than two hours each way; or (2) if the placement is an emergency placement as provided for in paragraph 4(a) of this section.

(b) The Bureau shall offer to make arrangements for a visit to the placement by the correspondent, even in those cases in which a visit by the resident/client is not required.

7. Agreement to movement.

Following the provision of the notice required by paragraph 4 of this section:

(a) Competent residents/clients agreeing to the move may move immediately. Agreement need not be written, nor need it be verbal, in the case of a nonverbal resident/client.

(b) Incompetent residents/clients may move immediately if the resident's/client's correspondent agrees and if the appropriate advocate, after consultation with the resident/client, agrees that a challenge is not appropriate.

8. Procedures for challenges to placement.

(a) Any challenge to the proposed placement must be made in writing to the Superintendent/Regional Administrator or his designee within 10 days of the sending of the notice required by paragraph 4. Each resident/client shall be provided all necessary assistance in preparing his challenge.

(b) Residents/clients have a right to obtain all information on which the proposed placement is based. When such information is requested by the resident/client, his correspondent or advocate, the Superintendent/Regional Administrator's office shall furnish same within five days of receipt of the request. Requests for information need not be made in writing. If a request for information is made, the 10-day limit for challenging the placement shall be extended to five days following the date on which the requested data is furnished. If there is any disagreement about the data furnished, a hearing shall nonetheless be scheduled within 20 days of the receipt of the initial request for information.

(c) Upon receipt of challenge pursuant to paragraph 8(a), the Superintendent/Regional Administrator shall schedule a hearing to be held within 10 days. Notice of the time and place of the hearing shall be given to the resident/client, his correspondent and the advocate's office no less than eight days prior to the hearing. Such notice shall also specify the parties' rights and the procedures at the hearing.

(d) The hearing shall be held at or near the placement in which the resident/client is located at the time the challenge is made. The hearing shall be before an impartial hearing officer who has professional experience in developmental programs for the mentally retarded, and who is not employed either at the resident's/client's facility or placement or at the proposed new facility or placement. At this hearing the resident/client and/or correspondent shall have the right to be represented or assisted by a person of his choice, to present evidence, to question and cross-examine witnesses and, if necessary, to compel the attendance of employees of the Department. The resident/client shall in all cases have the right to be present. The Superintendent/Regional Administrator or an appropriate representative shall attend the hearing and shall be prepared to answer any questions from the hearing officer or from the parties.

(e) The hearing officer shall have the authority to require the presence of any Department employee determined by the hearing officer to have relevant evidence.

(f) A record of the hearing shall be made and kept on file in the Superintendent/Regional Administrator's office for 12 months. It shall be available to any party for purposes of appeal.

(g) The hearing officer must determine if the Superintendent/Regional Administrator has proved, by a preponderance of the evidence presented at the hearing, that the placement challenged will offer the individual a better opportunity for personal development and a more suitable living environment and will result in placement in the least restrictive alternative appropriate for the resident/client.

(h) Within five days of the hearing, the hearing officer shall issue a written decision, setting forth the conclusion reached and the reasons therefor.

(i) The decision shall be communicated in writing to the resident/client, his correspondent and the advocate's office. Notice of the decision shall include notice of the right to appeal to the Director.

(j) An appeal by a resident/client, advocate, or correspondent shall be made in writing to the Director within five days of receipt of the decision of the hearing officer. The Director shall notify the resident/client, his correspondent and the advocate's office of the pendency of an appeal and the date by which a decision will be reached.

(k) The Director shall decide all appeals within ten days after receipt of the notice of appeal and base the decision exclusively on the hearing record. The Director shall decide only whether the decision of the hearing officer is supported by substantial evidence and whether proper procedures have been followed.

9. Request for resident/client movement.

(a) A resident/client or, unless objected to by a competent resident/client, his correspondent may at any time initate a request for transfer to a less restrictive setting. Following the receipt of such a request for transfer the appropriate interdisciplinary team shall meet pursuant to the procedures set out in paragraphs 2 and 3 of this section. Within 30 days after receipt of such a request, the Superintendent/Regional Administrator shall respond in writing, accepting or rejecting the request and stating the reasons for any rejection. A request for transfer shall be rejected only because:

(1) Continuation in the current placement will offer the individual a better opportunity for personal development and a more suitable living environment and will offer the individual placement in the least restrictive alternative appropriate for that resident/client.

(2) Placement is not currently available because of space limitations. In this case, the resident/client shall be moved as soon as an appropriate placement can be found or developed.

(b) If the request for transfer is accepted, the procedures set out in paragraphs 4-8 of this section shall be followed.

(c) A letter of refusal must advise the person making the request that that person may within ten days demand in writing a hearing which shall be conducted pursuant to the procedures set out in paragraph 8 of this section. The letter of refusal shall comply with the notice requirements set forth in paragraph 5 of this section. If a hearing is sought, the hearing officer shall determine the validity of the reason for refusing the transfer.

10. Within 60 days following any resident/client movement, the resident's/client's interdisciplinary team shall meet and develop a new or amended prescriptive program plan as appropriate. If the transfer is from one community placement to another, the PPP coordinator shall decide whether a team meeting is necessary.

B. Programming

1. Each client shall have by February 1, 1979, an individual plan of care, development and services referred to hereafter as a "prescriptive program plan". By September 1, 1978 half of the clients in the community shall have prescriptive program plans. The prescriptive program plan shall be prepared and re-evaluated at least annually by an interdisciplinary team which shall include the resident home operator, foster parent or other person responsible for the daily care of the client, the person responsible for the client's programming activities outside the residence, the client's community social worker and other appropriate professionals. The makeup of the interdisciplinary team shall be sufficiently broad such that each habilitation need of the client can be professionally assessed and appropriate remedial recommendations can be made. The client shall be asked to attend the interdisciplinary team meeting and shall be consulted in the development of his prescriptive program plan. Each client's correspondent and the client's advocate, unless a competent client objects, shall be asked to attend the team meeting. Notification shall be sent at least two weeks in advance of the meeting. Minutes of each team meeting shall be kept in the client's file and the minutes shall include the names of persons present; and in the case of professional team members, their respective disciplines.

2. The client's community service worker, identified by name in the prescriptive program plan, in conjunction with the PPP coordinator, shall be responsible for reviewing and supervising the client's program progress, for ensuring service delivery and coordinating the input and assignments of other professionals and disciplines in the interdisciplinary team process.

3. The prescriptive program plan shall be reviewed by the client's community service worker and by those responsible for the daily care of the client at least quarterly. At the quarterly review, minor modifications in the plan may be made, and progress as well as problem areas shall be noted. The quarterly review team may reconvene the entire interdisciplinary team if they find that reevaluation of the client is necessary.

4. Each program plan shall describe the nature of the client's specific needs and capabilities, his program goals, with short-range and long-range objectives and timetables for the attainment of these objectives. The prescriptive program plan shall address each client's residential needs, medical needs, ADL skill learning needs, psychological needs, social needs, recreational needs, transportation needs, and other needs including educational, vocational, physical therapy, occupational therapy, and speech therapy, as appropriate. The prescriptive program plan shall include a clear explanation of the daily program needs of the client for the guidance of those responsible for daily care. The recommendations included in each client's prescriptive program plan, both as to residential and programming placements, shall in all cases be the least restrictive placements suited to the client's needs. The recommendations of

the prescriptive program plan shall be based on the interdisciplinary team's evaluation of the actual needs of the client rather than on what programs are currently available in the community. In cases where the services needed by a client are unavailable, the IDT shall so note in the prescriptive program plan and shall recommend an interim program based on available services which meet, as nearly as possible, the actual needs of the client. The number of clients in need of a service which is not currently available and the type of program or residential placement each needs shall be compiled and these figures shall be used to plan for the development of new programs and residential placements. See Appendix B, Section C, paragraph 14.

5. Each prescriptive program plan shall be carried out pursuant to a written service agreement. Each service agreement shall include at least the following information:

(a) It shall specify the respective responsibilities of the client, the family, correspondent or legal guardian of the client, the regional office, the facility, and each public and private agency which intends to provide services to the client. It shall include a specific description of the client's daily activities with an explanation of how they will contribute to the achievement of the client's program goals.

(b) It shall identify by job classification or other specific description each individual who is responsible for carrying out each portion of the prescriptive program plan.

6. At the first interdisciplinary team meeting held on behalf of a client under the terms of this decree, any regressive or self-abusive behavior which has been exhibited by the client shall be noted. The prescriptive program plan shall address in detail the programs and services which must be provided to the client so that such behavior can be reduced, controlled or eliminated as quickly as possible. One-to-one training shall be an option considered by the interdisciplinary team.

7. (a) It is the goal of the Bureau to provide the programming recommended by the client's interdisciplinary team and, to encourage integration with the community, to provide such programming outside the client's residential setting.

(b) Each client's prescriptive program plan shall provide for a minimum of four scheduled hours of program activity per week day, and each client shall receive this programming. This program activity shall be designed to contribute to the achievement of objectives established for each client in his prescriptive program plan.

(c) In addition to the four hours of programming required by subparagraph (b) above, each client shall receive training in his residential setting in everyday living skills, including, as appropriate:

(1) care of individual living area;

(2) management, preparation and service of well-balanced meals;

(3) selection, purchase and appropriate use of clothing;

(4) development of grooming and hygiene skills;

(5) preventive health and dental care;

(6) use of telephone;

(7) safety skills; and

(8) use and management of money.

Such training shall be monitored by the appropriate regional office staff.

(d) Each client shall receive the programming required by subparagraph (b) outside the client's residential setting with the following exceptions:

(1) clients who at the time of the signing of this decree reside in ICF-MR facilities (Klearview, Pinkham, Northland and Houlton Residential Facility);

(2) in the first year following the signing of this decree, 100 clients;

(3) in the second year following the signing of this decree, 50 clients.

(e) In cases where programming outside the residential setting is unavailable and moving the client would be inappropriate, the interdisciplinary team shall develop an interim plan pursuant to paragraph 4 of this section. This interim plan shall include an alternative plan for integration into the community which shall require frequent participation in social functions, shopping trips, athletic events, meals out or other similar activities in the community. Activities of this sort shall take place at least twice weekly. In reporting to the master pursuant to paragraph 9(b) of this section the defendants shall cite this provision.

8. A client may receive programming in the residence and/or receive fewer than four hours of program activity per week day if:

(a) a physician certifies in writing that four hours of activity outside the residential setting would be medically harmful to the client. Any such decision shall be reviewed quarterly and shall be subject to challenge as part of the client's prescriptive program plan.

(b) A client who is competent for the purpose of making this decision shall be permitted to choose to engage in fewer hours of programming a day or to engage in programming in his residence. The client shall be asked to reaffirm this decision quarterly.

9. The defendants shall provide or insure that each client is provided the services recommended by the client's prescriptive program plan within 45 days of the client's placement in the community, or for those class members already in community residences, within three months of the

preparation of the client's first prescriptive program plan, and for subsequent plans within 45 days. If the recommended services are not available in the community within the applicable period set out herein:

(a) the client shall be placed in the interim program recommended by the client's prescriptive program plan; and

(b) the Bureau shall submit to the master for his approval either a plan including a time schedule, for the development of an appropriate program or a statement that the program will not be developed with accompanying documentation demonstrating that the service or program is not required by professionally accepted standards of habilitation or care.

10. Each client's correspondent shall be kept informed on a semi-annual basis (unless the correspondent requests quarterly reports) of the client's educational, vocational and living skills progress, and medical condition, and shall be allowed access to the client's records, unless a competent client objects. Each client shall have access to his own records, unless the IDT determines that serious harm might result and, in such cases, access may be denied to harmful portions of the record.

11. The Bureau shall offer those clients who are living independently or with their family (natural or adoptive) all services under this decree.

12. Any client, either independently or with the aid of an advocate or his correspondent, may invoke the procedures set forth in paragraphs 15-17 of this section when he disagrees with his prescriptive program plan. Subject to objection to such representation by a competent client, the client's correspondent may invoke the procedures set forth in paragraphs 15-17 of this section when the correspondent disagrees with the client's prescriptive program plan.

13. All clients and their correspondents shall receive notice of their right to object to and to appeal the prescriptive program plan, in connection with all reports required by paragraph 10 of this section. The notice shall explain the procedure for objection and appeal and shall identify, giving name, address and telephone number, an advocate whom the client or correspondent may contact for assistance.

14. The new prescriptive program plan shall be implemented while an objection is being pursued unless the Bureau and the objecting client or correspondent agree otherwise.

15. Informal objections

(a) Informal objections to the prescriptive program plan, which need not be in writing, shall be conveyed to the client's community service worker, who shall immediately attempt to resolve such objections. Such objections shall be noted in the client's permanent record.

(b) If the community service worker is unable to resolve the objection to the client's or correspondent's satisfaction, the community service worker shall explain to the client or correspondent his right to invoke the formal objection and appeal mechanism outlined herein, and shall inform the client or correspondent of his right of access to the client's program plan and other relevant records and to all papers submitted at all stages of the proceedings. The community service worker shall notify the appropriate advocate of any unresolved objection.

16. Formal objections

(a) Formal objections may be made only after the informal procedure set forth in paragraph 15 above has been exhausted. The informal procedure shall be deemed to be exhausted if no resolution has been reached within 20 days after an informal objection is made.

(b) All formal objections must be in writing, must state the basis for the objection, and must be addressed to the Regional Administrator.

(c) Upon receipt of a formal objection, the Regional Administrator, after notice to the client, correspondent, and advocate's office, shall call a conference with the client's community service worker and the objecting client or correspondent. This conference shall be called within 10 days. The conference shall be conducted in an informal manner, in such a way as to receive all relevant written and oral evidence. The particular procedure to be used shall be determined by the Regional Administrator. The client shall in all cases have the right to be present and to be represented by an advocate. Persons who do not desire to participate in this conference may submit papers in support of their position.

(d) Within five days, the Regional Administrator shall issue a written decision with regard to the formal objection which shall fully state the basis therefor, and shall (if the decision upholds the objection) recommend a resolution of the issues presented.

(e) If the decision of the Regional Administrator upholds the objection, it shall allocate responsibility to named individuals for carrying out the recommended resolution within 45 days of the date of the decision.

(f) The decision of the Regional Administrator shall be communicated in writing to the client, the client's correspondent, the client's community service worker, and the advocate. Notice of the decision to the client and the correspondent shall include notice of their right to appeal to the Director.

17. Appeals

(a) Notice of an appeal shall be filed with the Director within ten days of receipt of the decision of the Regional Administrator. The Director shall cause copies of this notice to be sent out to the client, the client's correspondent, the client's community service worker, the advocate and the Regional Administrator. Within ten days of the filing of the notice of appeal, persons receiving notice of the appeal shall submit to the Director and to each other all information deemed pertinent to the Director's review.

The Director shall render a decision solely on the basis of the papers so submitted. In the event that the Director requires further information, the Director may call a conference with notice to all persons receiving notice of the appeal. The client shall in all cases have the right to be present and to be represented by an advocate.

(b) Within ten days of receipt of all information necessary to a decision, and in no case more than 20 days after receipt of the notice of appeal, the Director shall consider the appeal and make a decision either upholding the decision of the Regional Administrator, recommending a new or different resolution, or dismissing the objection.

(c) Notice of the decision shall be communicated to the client, the client's correspondent, the client's community service worker, the advocate and the Regional Administrator.

(d) If any resolution is recommended, the decision shall allocate responsibility to named individuals for carrying out the recommended resolution within 45 days of the date of the decision.

C. Development of Community Placements

1. The Bureau of Mental Retardation shall maintain at least six regional offices which shall be responsible for the development of appropriate residential and program placements to meet the needs of the plaintiff class.

2. (a) Each of the regional offices shall be staffed by at least one full-time person specializing in the development of foster, adoptive and natural homes, group homes, sheltered workshops, vocational training programs and other day activity programs. The Regional Administrator in each region shall also devote substantial time to the development of community placements. If at the end of one year the minimum goals set forth in this decree for the creation of community placements have not been met, and other causes explaining this failure cannot be documented, at least one additional full-time person shall be hired in each region where needed to develop such placements.

(b) One full-time professional who possesses the skills, knowledge and demonstrated ability to oversee planning and development of community resources shall be hired at the central office to coordinate the staff described in (a) above. This professional should have a graduate degree and two to three years' experience running a successful program for developing community placements for the mentally retarded or other disadvantaged groups.

3. A staff member in the Central Office shall spend at least two-thirds of his time preparing public education materials and working with the media to encourage the development and acceptance of community facilities and programs for the mentally retarded.

4. The Bureau shall take all steps necessary to develop community placements including regular advertising; distributing appropriate pamphlets in libraries, schools, town offices, and other public places; speaking to community groups for the purpose of encouraging their involvement; displaying appropriate posters in public places; and making appropriate radio announcements and public service announcements on television. The Bureau shall prepare a booklet discussing the need for group homes and describing the availability of funding and services to help in establishing a group home. A similar booklet shall be prepared for potential foster families. These booklets shall be completed within three months of the signing of this decree. Copies shall be provided to counsel for the plaintiffs.

5. The regional office staff and Bureau staff shall provide technical assistance in the following areas to local groups, agencies or individuals interested in developing community programs or community facilities: selecting, acquiring and preparing a facility; identifying sources of funding and applying for funding; budgeting; assessing zoning requirements and requesting rezoning or exemptions if necessary; obtaining fire, health and building inspections; completing the licensing process; coordinating services provided by various agencies; training staff and preparing required proposals, forms and records. Legal assistance shall be provided where zoning or other legal difficulties arise.

6. Start-up funds shall be available in sufficient amounts and shall be utilized to fund construction or renovations of existing facilities, equipment purchasing costs, program implementation costs and other expenses necessary to set up a viable facility or program. The Bureau shall promulgate written guidelines detailing the process and criteria for the application and awarding of these funds. Records shall be kept of the Bureau's decisions and shall be made available to those concerned with the enforcement of this decree.

7. When a community agency, group or individual first expresses interest in developing a community facility or program, a specific individual in the regional office shall be assigned the responsibility for coordinating the development of the program or facility. In most cases, this person shall be the resource developer.

8. (a) By July 1, 1979 the defendants shall cause to be developed and operated at least 130 residential placements in group homes (6-8 bed homes), boarding homes, foster homes, natural or adoptive homes, and independent or semi-independent apartment placements. Approximately 70 of these placements shall be in group homes (6-8 bed homes), 20 in foster homes, 10 in apartments and 30 in boarding homes. At least 100 of these placements shall be provided to members of the class.

(b) Each year after July 1, 1979 the Bureau shall maintain the level of newly created community placements and, as the needs of the class demand, shall develop a minimum of 62 new community placements every six months until the needs of the class are met. The type and number of placements developed shall be dictated by the needs of the class and the provisions of this decree, and shall be consistent with the principles of normalization and least restrictive alternative. Quarterly progress reports will be provided to those persons concerned with the enforcement of the decree.

(c) The community placements in (a) and (b) of this paragraph refer to newly created beds in newly developed facilities or to beds not previously used for the mentally retarded. Placements created by increasing the population of existing facilities to over eight clients will not be counted for purposes of this paragraph.

9. No residential facility shall be developed for more than 15 clients, except facilities which meet ICF-MR standards, limited to a maximum of 20 beds each.

10. Defendants shall not place clients in and shall remove clients from those facilities that fail substantially to meet the environment, care and programming standards included in this decree or set by the defendants by contract or in statutes, regulations or guidelines.

11. For any client who resides in a facility of over 15 beds, except for (1) independent apartments clustered together where the total population does not exceed 20 clients, (2) 20-bed ICF facilities and (3) the Houlton Residential Facility, the interdisciplinary team shall give

special scrutiny to the continued appropriateness of the client's residential placement and shall note their findings and the reasons therefor in the prescriptive program plan. The Regional Administrator shall review these findings.

12. Community facilities shall be integrated into the community.

(a) Community residences -- Sites shall be chosen in residential settings normal for the community in which they are located and with ample opportunity for interaction with the community. Preferably placements shall have easy access to shopping facilities and be within a reasonable commuting distance from programs attended by clients during the day.

(b) Program facilities -- Sites shall be chosen in or close to a population center. Programs shall be located in areas appropriate to the training purposes of the program. For example, workshop programs should be developed in business areas.

13. Defendants shall prepare a directory of all available day and residential programs whose principal client population is the mentally retarded in the state, which shall include a brief description of each program and of the procedures for obtaining services from each program. The initial volume shall be prepared and distributed before October 1, 1978, and the directory shall be updated annually thereafter.

14. Defendants shall develop a data system of client needs and of availability of services in the community. An annual report shall be prepared listing the number and type of placements made during the year, the number of clients currently in need of service and the type of program each needs, the total number of clients served in each type of program and the number of openings available in each program, if any. The needs of residents of Pineland for community services or placement shall be included in these totals. The confidentiality of records identifying individual clients shall be protected.

D. Professional Services

1. General

(a) Two resource centers shall be established, fully staffed, and in operation by September 1, 1978. The professional staff of each resource center shall include, at a minimum, one psychologist, one physical therapist, one occupational therapist, one registered nurse, one speech pathologist, one special education teacher, one social worker, one advocate, and four mental health workers. A director and appropriate clerical and secretarial staff shall also be provided. Where area conditions dictate, staffing patterns may vary provided that there is no reduction in the number of professional level staff.

(b) The resource center staff shall provide diagnosis and evaluation services and prepare prescriptive program plans for community clients. The resource center professional staff, in addition to their diagnosis and evaluation and prescriptive program plan duties, shall provide a crisis intervention team, shall help identify and evalute professional services available in the community, link clients with the professional services appropriate to meet their needs, and monitor the services provided. They shall also serve as consultants to professionals and programs which are providing treatment.

(c) The Bureau shall provide the services of at least one half-time qualified professional physical therapist, occupational therapist, psychologist, and speech therapist in each of the six regions, in addition to the professionals at the resource centers. The qualified professionals who provide these services need not be employees of the defendants. Additional professional services shall be obtained as necessary to provide the habilitation, programming and therapy specified in each client's prescriptive program plan.

(d) One PPP Coordinator shall be employed in each of the Bureau's six Regional Offices.

2. Medical and Dental Services

(a) Each client who has not had a complete medical and dental examination within the past year shall have such examinations during the first year after the signing of this decree. Subsequently, each client shall have at least annually a medical and dental review. Each client shall have included in his prescriptive program plan a medical and dental plan which may require, based on need, a medical examination, including an eye examination, on an annual basis. Complete medical and dental examinations shall be provided, at a minimum, every three years.

(b) Glasses shall be provided if a client cannot pay.

(c) Medical and dental services and diagnosis shall be closely integrated with the client's prescriptive program plan.

(d) The interdisciplinary team shall monitor the quality of medical and dental care the client receives and where continuing problems arise, shall seek a second professional opinion or take other appropriate action.

(e) Psychotropic medication shall be used only as an integrated part of the client's prescriptive program plan. Continued use of psychotropic medication shall be reviewed by the client's interdisciplinary team.

(f) When a regimen of psychotropic medication is approved, the interdisciplinary team shall ensure:

(1) that appropriate persons responsible for the client's habilitation, education, care and other treatment are informed as to the significant potential effects of the medication and record their observations thereof, including effects on the client's progress in habilitation and education programs and his participation in other activities and any significant adverse effects; and

(2) that appropriate laboratory tests are performed and analyzed; and

(3) that repeated administration of an antipsychotic or antianxiety medication, including substitution of a medication of the same class, does not cumulatively exceed one year without the attending physician effecting a carefully monitored withdrawal of the medication. This periodic drug withdrawal shall be used to determine the need for continuing medication and the prescribed dosage. During such withdrawal the results shall be noted in the client's medical record. Medication may be resumed only if there is a clear documentation of benefit derived from its use. Such a drug withdrawal program shall be repeated on an annual basis.

(g) Defendants shall maintain or require home operators to maintain written agreements for the provision of acute medical care with accredited hospitals. Emergency treatment by a physician on a 24-hour, seven-day-a-week basis shall be available.

(h) Emergency dental care shall be available on a 24-hour seven-day-a-week basis.

(i) The client's need for training or assistance in tooth brushing and oral hygiene shall be considered by the interdisciplinary team. Any necessary training or assistance shall be provided under the supervision of the registered nurse at each resource center.

3. Crisis Intervention

The defendants shall provide crisis intervention services in emergency situations which threaten a client's program or residential placement. Resource center staff with skills in crisis intervention and behavior programming shall provide intensive intervention at the community placement. Only if intervention at the community placement fails or if the crisis intervention team, after seeing the client, determines that immediate movement is necessary shall the client be moved to a respite care facility or other appropriate treatment facility. Any time crisis intervention services are required, an interdisciplinary team meeting shall be convened as soon as possible thereafter to review the client's prescriptive program plan, and in no event more than 10 days after the event requiring the crisis intervention.

4. Respite Care

(a) Respite care or temporary residential assistance shall be available to clients by December 1, 1978. When respite care is reasonably needed, it shall be provided in community facilities. Pineland may be used for respite care purposes of a specialized nature only.

(b) Before a client is provided with respite services, a written agreement with the client's family or guardian specifying length of stay shall be reached. The maximum length of stay agreed to by defendants shall be 21 days at a time and shall not exceed 60 days during any twelve months.

(c) Clients receiving respite care shall, whenever possible, continue to attend day programs they have been attending. They shall be involved in appropriate recreational and program activities in the respite care facility as well.

5. Education

(a) Defendants shall attempt to ensure and shall advocate for the provision of appropriate education to all members of the class. Defendants shall document their efforts in this regard and shall submit this documentation to persons concerned with the enforcement of this decree.

(b) Defendants shall, by July 5, 1978, advise the appropriate public school systems of the number of persons under the age of 21 who are members of the class and who currently are out of school or who are inappropriately placed. This information also shall be provided to the Commissioner of the Department of Education and Cultural Services.

(c) In addition, defendants shall advise the appropriate public school systems of the number of school-age Pineland residents being prepared for transfer to their community, and shall supply the appropriate public school with a projected timetable for the transfer of such residents to the jurisdiction of such schools. This information also shall be provided to the Commissioner of the Department of Education and Cultural Services.

(d) Defendants shall offer consultation services, offer training programs, and in general assist the public schools to provide appropriate education services to mentally retarded children.

(e) Defendants shall assist parents, guardians and/or advocates in enrolling class members in appropriate education programs.

6. Transportation

The defendants shall ensure that sufficient transportation is available so that clients can attend all recommended program activities and professional services, and so that recreation, shopping and other community activities are reasonably accessible to each client. School transportation shall be provided by the appropriate school district, as required by state and federal law.

7. Family Support Services

(a) Defendants shall provide by October 1, 1978, a full range of support services for the families of all those clients living with their natural, adoptive or foster family.

(b) All services available to residents of group homes or other community placements shall be available to clients living at home.

(c) The Bureau shall provide the services of child development workers and community service workers for every client, adult or child, who needs such services. The worker shall regularly visit clients' homes and assist the family in meeting the developmental needs of the mentally retarded family member. Child development workers shall teach self-help skills, communication skills, motor development, socialization skills, and/or other skills as appropriate. Community service and child development workers shall be provided support by the professional staff of the resource centers.

(d) The Bureau shall assist in securing homemaker services to a client's family when needed to enable the family to adequately care for the client. The homemaker shall assist with and teach health care, meal planning, marketing, budgeting, and housekeeping. Assistance shall be provided, when appropriate, with the training program of the client.

(e) The Bureau shall make available training in caring for the retarded for sitters and homemakers. The Bureau will facilitate the provision of these services where needed.

(f) Defendants shall provide counseling and instruction which will enable a family to better care for the mentally retarded client at home.

8. Psychology Services

(a) Psychology services shall be provided and shall include at least a psychological evaluation every three years and in years when no evaluation is performed, a psychological review conducted as part of each client's prescriptive program plan pursuant to Appendix B, Section B. Such reviews and evaluations shall include personal interaction with the client.

(b) One-to-one training programs supervised or administered by a qualified psychologist shall be available, where appropriate, to treat chronic or aggravated behavior problems which are a potential threat to the client's program or residential placement or which prevent the client from moving to a less restrictive placement.

(c) When appropriate, psychologists shall instruct care providers in the behavior management techniques specified in the client's prescriptive program plan.

9. Speech and Hearing Services

(a) Speech and hearing services shall include a hearing screening once during the first two years of this

decree which shall be conducted as part of each client's prescriptive program plan pursuant to Appendix B, Section B. Treatment and/or further evaluation shall be provided to those clients who require such services by sufficient qualified speech and hearing professionals.

(b) Hearing aids will be provided as needed and shall be maintained in good working order.

(c) Where appropriate, deaf, hearing impaired, and/or clients with neurological or physical damage precluding the acquisition of speech will be taught sign language or an alternate communication system. The Bureau shall make available to parents, relatives, and other persons working with the client, training in language-stimulation skills or in the use of an alternative communication system.

10. Social Work Services

(a) Each regional office shall employ an adequate number of community services workers to perform the following types of services for each member of the class residing in the community:

(1) Case management - The coordination of service provision to each client including insuring that the services recommended in the client's prescriptive program plan are being provided.

(2) Follow-up and Follow-along - The maintenance of regular contact with each client and the provision of social work services as needed by each client.

(3) Record-keeping - See paragraph 10(e), (f) and (g) below.

(b) In addition, there shall be one community service work supervisor for each regional officer. Supervisors shall be qualified professionals.

(c) The standards in subparagraphs (a) and (b) of this paragraph shall be met within 60 days of the signing of this decree.

(d) All program and residential facilities shall be visited by a community service worker or other designee with regular responsibility for the clients at least once a month and more frequently when necessary.

(e) There shall be a uniform system of records kept by the regional office for each client, developed and maintained under the supervision of the community service worker assigned to each client. The community service worker shall review the records at least monthly. The client's residential facility and program placements shall have a copy of those portions of an individual's records relevant to the programming and the health and safety of the client. Information shall be incorporated in the client's record in sufficient detail to enable those persons involved in the client's program to provide effective, continuing services. All entries in the client's record shall be legible, dated, and have the signature and identification of the individual making the entry. The confidentiality of any records identifying individual clients shall be respected.

(f) These records shall include:

(1) Identification data, including the client's legal status;

(2) Relevant family data, including family visits and contacts, educational background, and employment record;

(3) Complete medical record, including medication history and status;

(4) An inventory of the client's life skills;

(5) A copy of the individual's prescriptive program plan, and any modification and evaluations thereof, with an appropriate summary to guide facility and program staff in implementing the plan;

(6) The findings made in periodic (at least quarterly) reviews of the individual's response to his prescriptive program plan, with directions as to modifications, prepared by a professional involved in the client's program;

(7) A record of activities outside the residential facility and the amount of time each client spends outside the residential facility;

(8) A physical description of the client.

(g) Progress toward prescriptive program plan goals, observations on the quality of the program being provided, and any problems identified shall be noted in the client's records by the community service worker at each monthly visit.

(h) Regulations and forms for use in regional offices, and community facilities and programs incorporating the requirements of subparagraphs (e), (f) and (g) of this paragraph, shall be developed by the Bureau within three months of the signing of this decree.

E. Program Administration

1. Defendants are responsible for monitoring the quality of services delivered to all clients in the community.

2. Employees of the defendants or a consultant retained by defendants shall be responsible for monitoring the provision of services at each community placement facility. Defendants shall evaluate the quality of prescriptive program plans, assess the extent to which recommended services are being provided, and evaluate the adequacy of services, facilities and programs. Records of such evaluations shall be forwarded to the Director.

3. (a) Prior to placement of class members in any facility or program, defendants shall reach a written agreement with the operator of the facility or program. This agreement shall:

(1) require that the facility or program comply with all the applicable terms of this decree and with all applicable statutes, rules and regulations promulgated by the United States, the State of Maine, the Department, and the Bureau;

(2) reserve the right of employees and contractees of the Bureau to have reasonable access to the facility or program and to its records to audit the facility or program, to provide services to clients, and for other reasonable purposes;

(3) specify all charges and the sources of payment for a client's program, room and board and any other expenses;

(4) require the participation of the facility or program operator (or an appropriate representative) in the prescriptive program plan process for each client placed in the facility or program;

(5) require compliance with the requirements of each client's service agreement.

(b) Sanctions for failure to comply with the provisions of the agreement shall be included in the agreement. Sanctions shall include, but are not limited to, the termination of the agreement and the removal of the client from the placement.

(c) The agreement shall be limited to one year. Prior to renewal, the defendants shall audit the service provider's compliance with the terms of the agreement.

F. Standards for Community Residences

1. Daily living and clients' rights

(a) Clients have a right to habilitation, including medical treatment, education, training and care, suited to their needs, regardless of age, degree of retardation or handicapping condition. Each client has a right to a habilitation program which will maximize his human abilities, enhance his ability to cope with his environment and create a reasonable expectation of progress toward the goal of independent community living.

(b) Each client shall be provided with the least restrictive and most normal living conditions appropriate for that client. This standard shall apply to dress, grooming, movement, free time, personal funds, and contact and communication with the outside community, including access to educational, vocational, recreational and therapy services in the community. Clients shall be taught skills that help them learn how to manipulate their environment and how to make choices necessary for daily living. Restrictions on client activities shall be noted in the client's records with the reasons therefor stated.

(c) Clients shall be prepared to move from: (1) living and programming segregated from community to living and programming integrated with the community; (2) more structured living to less structured living; (3) larger living units to smaller living units; (4) group residences to individual residences; (5) dependent living to independent living, as appropriate for the individual client.

(d) Living groups shall not ordinarily contain unrelated residents differing widely in age level (e.g., young children and adults) or developmental level or social needs. Exceptions shall be recommended by the IDT, accompanied by written reasons, and approved by the Regional Administrator. Blind or deaf clients shall not be grouped with lower functioning clients solely because of their blindness or deafness. To the maximum extent possible, physically handicapped clients shall be integrated with their nonphysically handicapped peers.

(e) The facility's activities, routines and rhythms shall conform with practices prevalent in the community and the client's age. For example, older clients ordinarily shall not be expected to live according to the timetable of younger children; meals shall be served at hours typical for the community.

(f) No client shall be denied the right to vote because of mental impairment, unless the client is under guardianship.

(g) Clients shall have the right to religious freedom and practice.

(h) Clients have a right to private communications.

(1) Each client shall be allowed to receive, send and mail sealed correspondence. Mail shall not be delayed, censored or opened without the consent of the client or, where appropriate, his legal guardian.

(2) Clients shall have an unrestricted right to visitations during reasonable hours. This provision shall be implemented with sensitivity to other clients' right to privacy.

(3) Clients shall be afforded a reasonable opportunity to use a telephone.

(i) Each client has the right to the possession and use of his own clothing and personal effects. When necessary to protect the client or others from imminent injury, the director of a day program or a residential facility may take temporary custody of clothing or personal effects, provided they are immediately returned when the emergency ends.

(j) Clients shall be assisted in obtaining, and, if necessary, provided with adequate, fashionable and seasonally appropriate clothing, including shoes and coats. Each client shall have sufficient clothing for rainy weather, snow and extreme cold. Where necessary special or adaptive clothing shall be provided. Each client shall be involved to the extent possible in the selection of his clothing.

(k) Unless otherwise ordered by a court, each client shall have the right to manage and spend personal funds, including the right to maintain an individual bank account.

(l) Any funds deposited with the head of a community program or residence shall be subject to the following provisions: Such custody shall be promptly recorded in the client's record; a receipt shall be given; a record shall be kept of every deposit or withdrawal of funds, including the date and the amount received or disbursed; an accounting shall be provided on demand; deposited funds shall be used in accordance with the client's desires.

(2) Where the client has deposited funds in excess of $200 with the head of a community program or residence, an individual interest-bearing bank account shall be maintained. Interest shall be property of the client. Withdrawal of funds shall require the authorization of the client or the client's guardian. The requirements of (1) above shall apply.

(3) The head of the client's community residence or program shall not act as representative payee for the client. A representative payee independent of the residence or program shall be designated, and shall be required to make at least an annual accounting of the client's funds. A copy of this accounting shall be kept in the client's record.

(l) A summary of the clients' legal and civil rights shall be available in all community programs and residences. For this purpose, the Director shall prepare a comprehensive summary of clients' rights in lay language. This summary shall be submitted for comment to all persons concerned with the enforcement of this decree within 60 days of the signing of the decree.

2. Environment

(a) Defendants shall ensure that community living facilities afford clients privacy, dignity, comfort, sanitation and a home-like environment. This shall include, but is not limited to:

(1) individual bed, dresser and storage place;

(2) attractive, comfortable and spacious living and sleeping areas;

(3) privacy in bathroom areas;

(4) normal temperatures and adequate ventilation, comparable to that found in private homes.

(b) Each facility must provide for all the functions characteristic of a normal home, including a kitchen, living room, dining area, bedrooms and bathrooms of normal residential design.

(c) The dining area shall be of sufficient size to permit staff and clients to eat meals together.

(d) Hallways and circulation space must be comparable to that found in typical private homes and apartments.

(e) Exceptions to (b), (c) and (d) may be made only when necessary to meet special needs of clients.

(f) No more than three clients shall occupy one bedroom. No facility developed after January 1, 1978 shall have more than two clients in any bedroom.

3. Food and Nutrition

(a) There shall be at least three meals a day provided at normal times, and in a manner as close to normal family-style dining as possible. Clients shall be taught to eat in leisurely family style and to choose their own quantities and items according to individual tastes and preferences.

(b) A nourishing, well-balanced, nutritionally adequate diet shall be provided. Clients shall have liquids available throughout each meal.

(c) There shall be sufficient dishes and utensils for all clients, which shall be thoroughly cleaned between uses.

(d) A medical order shall be required for clients served other than a normal variety of foods. Such orders shall be reviewed quarterly by the client's physician.

(e) Denial of a nutritionally adequate diet shall not be used as punishment, or as part of a behavior modification program.

4. Staffing

(a) All community residences -- Sufficient staff shall be on duty in each residential placement to meet each client's programming needs as set out in the client's prescriptive program plan.

(b) Group homes -- In group homes, the staff-to-client ratio of direct care staff actually present and on duty during hours when clients are awake and at home shall be 1:8. During sleeping hours, at least one staff person shall be at the facility.

(c) Facilities with more than 8 beds

(1) These facilities shall comply with the staffing ratios included in the relevant Maine licensing regulations and with applicable federal law or regulations.

(2) Staffing shall be scheduled so that maximum staffing levels occur during the hours clients are in the residence and awake.

5. Medication

(a) No prescription medication shall be administered except upon written order of a physician. Behavior-modifying medication shall be administered only as an integrated part of the client's prescriptive program plan.

(b) Notation of each individual's medication shall be kept in records available in the client's community placement.

(c) Clients shall have a right to be free from unnecessary or excessive medication.

(d) All drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.

(e) All drugs shall be stored in secure and locked areas.

(f) Poisons, drugs used externally, and drugs taken internally shall be stored on separate shelves or in separate cabinets within the locked areas.

(g) Medications that are stored in a refrigerator containing things other than drugs shall be kept in a separate compartment with proper security.

(h) A perpetual inventory shall be maintained of each narcotic drug in the facility.

(i) Discontinued and outdated drugs, and containers with worn, illegible, or missing labels, shall be returned and properly disposed of.

(j) During the course of administration of psychotropic medication, the staff of the client's community placement shall carefully monitor and record the client's progress and response to the treatment. Persons responsible for the client's habilitation, education, care and other treatment regularly shall record their observations of the effects of the medication, including effects on the client's progress in habilitation and education programs and his participation in other activities.

(k) Medication errors and drug reactions shall be recorded and reported immediately to the physician who ordered the drug.

(l) Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the client's program or work.

6. Labor

Client labor in privately-operated community facilities shall be governed by the requirements of the Fair Labor Standards Act, 29 U.S.C. section 201 et seq. and the regulations promulgated thereunder. Client labor in State-operated community facilities shall be governed by the standards set out in subparagraphs (a)-(e) herein or by the provisions of the Fair Labor Standards Act, 29 U.S.C. section 201 et seq. and the regulations promulgated thereunder at the option of the Director.

(a) Operation and maintenance of program or facility: No client shall be required to perform labor which involves the operation and maintenance of the program or facility or the regular care, treatment or supervision of other clients. Clients may voluntarily perform any work available to them, provided they are compensated in accordance with sub-paragraph (d) below.

(b) Training tasks: A client may be required to perform vocational training tasks not involving the operation or maintenance of a program or facility, subject to a presumption that an assignment of longer than four months to any task is not a training task, and provided that the specific task or any change in assignment:

(1) does not involve the operation and maintenance of the facility or program;

(2) is an integrated part of the client's prescriptive program plan and has been approved as a program activity by a professional responsible for supervising the client's program; and

(3) is adequately supervised.

(c) Personal housekeeping: Clients may be required to perform tasks of a personal housekeeping nature such as the making of their own beds.

(d) Clients who are employed to perform work of economic benefit to the employer shall be paid wages which are commensurate with those paid nonhandicapped workers at the facility or at businesses in the vicinity for essentially the same type, quality and quantity of work. The applicability of this standard does not depend on whether or not the work is of therapeutic value to the client.

(e) Each workshop or other employer shall maintain, and have available for inspection, records of:

(1) the productivity of each client to be reviewed at quarterly intervals;

(2) the prevailing wages paid nonhandicapped workers in the facility or in businesses in the vicinity for essentially similar work to that performed by clients; and

(3) the production standards for an average nonhandicapped worker for each job being performed by a client.

(f) Every effort shall be made to find compensated employment for clients who are willing and able to work.

(g) Clients shall be allowed to keep amounts earned under this paragraph.

7. Restraints and Abuse

(a) Mistreatment, neglect or abuse of clients in any form shall be prohibited. The routine use of all forms of restraint shall be eliminated. Restraint shall be employed only when absolutely necessary to prevent a client from seriously injuring himself or others. Restraint shall never be employed as a punishment, for the convenience of staff, or as a substitute for programs and shall be applied only after other means of controlling behavior have been tried and have failed. Documentation of the failure of these alternative techniques shall be included in the client's records and be available for inspection.

(b) The permissible forms of restraint thereafter shall be physically holding the individual for a maximum of one hour, placing the individual in a room with an attendant for a maximum of one hour, or placing the individual alone in an unlocked room with an attendant outside for a maximum of one hour. If these types of restraint prove inadequate, chemical restraint may be used. Each use of a chemical restraint shall be ordered by a physician. Such order shall be reviewed by the physician as soon as possible after use of the drug and the physician's findings shall be noted in the client's record. Straitjackets and camisoles shall never be used, nor shall any resident be tied to a bed or subject to corporal punishment, degradation, or seclusion (seclusion is hereby defined as placing a client alone in a locked room, which he cannot leave at will).

(c) Use of restraints by the crisis intervention team shall be governed by the provisions of Appendix A, Section N, rather than by the provisions of this section. The duties of the Superintendent shall be performed by the Regional Administrator.

(d) Alleged instances of mistreatment, neglect or abuse of any client shall be reported immediately to the Regional Administrator and the advocate's office, and there shall be a written report documenting that the allegation has been thoroughly and promptly investigated (with the findings stated therein). Copies of such reports shall be made available to persons concerned with the enforcement of this decree along with a report indicating the action taken.

(e) A client's correspondent shall be notified in writing whenever an instance of mistreatment, neglect or abuse occurs.

(f) The use of aversive conditioning shall not be permitted unless positive reinforcement procedures and other less drastic alternatives have been tried and failed (this failure shall be documented) and approval has been obtained:

(1) from the client's interdisciplinary team; and

(2) from the client, if he is capable of giving informed consent or from the client's correspondent if the client cannnot give informed consent; and

(3) from a three-person special committee on aversive conditioning, designated by the Director, which shall include the client's advocate and one designee from the Consumer Advisory Board.

(g) The Director shall be advised when a decision has been reached and approved to utilize such aversive conditioning. Aversive conditioning techniques shall be employed only under the supervision of a psychiatrist or psychologist licensed to practice in the State of Maine who has had proper training in the use of such techniques, and who is specifically authorized by the Director to conduct aversive conditioning. The Director shall at all times maintain a list of all persons authorized to conduct aversive conditioning.

(h) Research or experimentation of any sort shall be conducted only after approval has been obtained as set forth in paragraph (f) above except research limited to review of client records, provided that confidentiality is adequately protected.

8. Recordkeeping

(a) Each facility shall keep a record of the client's progress toward the prescriptive program goals for which the facility is responsible, recorded at least monthly, and recorded on a weekly basis for skill acquisition programs.

(b) Each facility shall cooperate with the Bureau in collecting other necessary data.

(c) These records shall be available to regional office staff and to all persons concerned with the enforcement of this decree.

G. Standards for Day, Social, Pre-vocational and Work Training Programs.

1. Clients' Rights

Clients shall be treated with dignity and respect. Programming shall be provided consistent with the requirements of the client's prescriptive program plan and in the least restrictive and most normal setting possible.

2. Staffing

(a) Sufficient staff shall be on duty in each program placement to meet each client's programming needs as set out in each client's prescriptive program plan.

(b) Social/prevocational programs: In Social/prevocational programs, there shall be at a minimum the following staff:

(1) a full-time or part-time Director who has professional qualifications in a relevant field or experience in a relevant field including administrative experience;

(2) one full-time staff member for the first 10 (or fewer) clients and an additional half-time staff member for each additional 15 clients.

(3) Where neither the Director nor a full-time staff member is a professional, the Bureau shall semi-annually provide the services of a professional consultant who shall make recommendations to the program and to the Bureau for improving client services. A copy of these reports shall be made available to persons concerned with the enforcement of this decree.

(c) Work training programs: In work training programs there shall be at a minimum the following staff:

(1) a full-time or part-time Director who has professional qualifications in a relevant field or experience in a relevant field including administrative experience;

(2) a full-time professional staff member for the first 20 (or fewer) clients;

(3) one half-time staff member for each 10 additional clients.

3. Food and Nutrition

Where a meal is provided by a program facility, the meal shall be nourishing, well-balanced and of normal variety unless medically contraindicated for specific clients.

4. Recordkeeping

(a) Each program shall keep a record of each client's progress toward the prescriptive program plan goals for which the program is responsible, recorded on a weekly basis.

(b) Each program shall cooperate with the Bureau in collecting other necessary data.

(c) These records shall be available to the regional office staff and to all persons concerned with the enforcement of this decree.

5. Restraints and Abuse

Community programs shall comply with Appendix B, Section F, paragraph 7 (Restraints and Abuse).

6. Labor

Community programs shall comply with Appendix B, Section F, paragraph 6.

7. Medication

Those programs which administer medication shall comply with the standards set forth in Appendix B, Section F, paragraph 5.

H. Management

1. The Bureau shall maintain a meaningful table of organization, clearly defining areas of responsibility and accountability by position. There shall be regular outside evaluation of management and of all major program elements covered by this decree.

2. A current and meaningful policies and procedures manual shall be developed by defendants for community service workers and staff and for resource center and regional office personnel incorporating policies and procedures to be followed in providing client care. It shall include all relevant provisions of this decree. At least one copy of the manual shall be readily available at each regional office, resource center and at each State-operated facility or program serving clients of the Bureau.

3. Consultants shall be used purposefully and on a regular basis. Whenever consultants or outside evaluators are utilized, they shall prepare written reports and evaluations which shall be forwarded to the Director and made available to persons concerned with the enforcement of this decree.

4. The Director's office shall be familiar with all sources of government and private monies for which community programs are eligible and shall, when appropriate, apply for such funding.

5. The Commissioner shall prepare a budget request which is calculated to meet all deficiencies in meeting the terms of this decree. A copy of all portions of the governor's budget applicable to this decree shall be sent to all persons concerned with the enforcement of this decree when the budget is sent to the legislature, and a copy of the final budget approved by the legislature shall be sent to persons concerned with the enforcement of this decree immediately following approval of the budget. This section shall apply to any supplemental budget requests.

I. Personnel

1. Defendants shall actively recruit qualified staff. Salaries and benefits offered shall be adequate to attract qualified staff.

2. All job applicants shall be carefully screened. At least two existing professional staff will interview each candidate for professional jobs. At every level of employment every attempt will be made to screen out those individuals who might pose a danger to clients or fail to work in their best interests.

3. There shall be full staff orientation and training programs to increase employees' skills and interest in achieving the program goals of the clients. Training programs shall be mandatory for regional office and resource center employees. Operators or managers of any community facilities or programs which serve a preponderance of mentally retarded clients shall be provided training by formal program or by other means. Training programs shall be available to all on a quarterly basis.

(a) Orientation training shall consist, at a minimum, of 20 hours of training provided within three months of the hiring or contracting date. Persons who have not had such training or equivalent training shall be provided it within one year of the signing of this decree.

(b) By October 1, 1978, defendants shall prepare and submit for comment to all persons concerned with the enforcement of this decree a plan to improve orientation and in-service training programs, which plan shall specify the proposed staffing, curricula and duration of such programs.

(c) At least the following areas shall be addressed in orientation and in-service training programs: introduction to mental retardation; principles of normalization; human and legal rights; fire protection; safety; health care; emergency care; growth-oriented programming; behavior shaping; education; relationships with natural families; leisure time and recreation; administrative responsibilities; human sexuality; vocational training and counseling; and methods of insuring compliance with the provisions of this decree.

(d) Records shall be kept of all persons receiving training and such records shall be available to all persons concerned with the enforcement of this decree.

4. Supervisors shall be responsible under appropriate laws and regulations for the regular review and assessment of the job performance of their subordinates, particularly of their success in meeting program objectives. The Bureau shall be responsible for pursuing every procedure and method provided by law or regulation in the termination or reassignment of Bureau employees whose performance is found unsatisfactory. In addition, the Bureau shall terminate contracts or fail to renew them where job performance of contractees is unsatisfactory.

5. Personnel policies shall be designed to maximize use of individual employees' skills and to enhance effective programming for clients and working conditions for employees. In order to improve personnel policies, personnel

terminating employment shall be interviewed if the employee consents. Summaries of these interviews shall be reviewed by the Director and by other appropriate persons, to determine any causes of employee dissatisfaction and instances of dehumanizing or abusive practices and other relevant information, including the determination of appropriate criteria for hiring and screening new employees. Such summaries shall be made available to all persons concerned with the enforcement of this decree.

6. Staff shall be actively involved by the administration in the development and assessment of Bureau policies.

7. Volunteers will be eligible to receive appropriate orientation and inservice training on terms identical to those of regular staff. Volunteers will be encouraged to make use of these opportunities by their supervisors. Each volunteer will be provided a person who will provide direct supervision to the volunteer on a regular basis. One person in the Bureau central office shall be assigned the responsibility of recruiting volunteers and seeing to their maximum effective utilization.

J. Miscellaneous

1. Unless otherwise specified, steps, standards and procedures contained herein shall be achieved, and thereafter maintained, within 12 months from the date of the signing of this decree.

2. No care, treatment, placement, program or service necessary to implement the requirements of this decree shall be denied to any client because of the client's inability to pay.

3. All correspondents, advocates and persons concerned with the enforcement of this decree shall have an obligation to keep personally identifiable records and other information concerning clients confidential, consistent with the provisions of the relevant Maine law on confidentiality.

4. A copy of this decree shall be available in each regional office.

5. Defendants shall ensure that an advocacy system adequate to meet clients' needs is in place.

6. The Chief Advocate within the Department shall upon request have access to any information made available to persons concerned with the enforcement of this decree.

7. Defendants shall make every effort to ensure that a person in the governor's office will be responsible for being knowledgeable about the terms of this decree and for lending all appropriate assistance of that office to the full implementation of the decree.

8. This decree shall be interpreted in a fair and reasonable manner so as to attain the object for which it was designed and the purpose to which it is applied.

9. Where implementation of steps, standards and procedures contained herein requires the cooperation of persons, facilities, programs, or departments not a party to this litigation and not under the direct or indirect control of defendants, defendants shall work actively to ensure compliance within their prescribed administrative authority.

P I N E L A N D C O N S E N T D E C R E E

REPORT OF THE SPECIAL MASTER

TO THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MAINE

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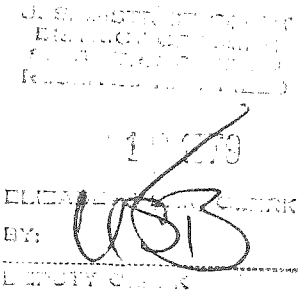
March 19, 1979



MARTTI WUORI, et al.,

Plaintiffs

v.

GEORGE A. ZITNAY, et al.,

Defendants

Civil No. 75-80-SD

REPORT OF THE SPECIAL MASTER

TO THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MAINE

This action concerns the civil and constitutional rights of mentally retarded citizens of the State of Maine. It was initiated by and on behalf of those persons who were involuntarily confined to Pineland Center, a state institution for the mentally retarded, and persons conditionally released from Pineland Center to state-approved community placements.* In July 1978 the parties to this litigation concluded a three-year period of intensive negotiation and agreed upon the terms of a decree to be entered by consent. On July 14, 1978, this Court entered the consent decree as the judgment of the Court.

Thereafter, by consent of the parties, the Court appointed a Special Master to oversee implementation of the Court's order. The Special Master is an officer of the Court and is directed to serve "solely the Court and the interests of justice." This report presents to the Court the Special Master's opinion on the implications of the Court's order and on the implementation of its provisions.

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* Not every mentally retarded citizen of Maine comes within the class described. The state defendants have taken the position that, as a matter of state policy, the benefits of the decree are to be extended to all mentally retarded citizens. I agree with that position, as a matter of both law and policy, and I will do nothing to interfere with it insofar as the State's conduct does not impede realization of the decree's benefits by members of the plaintiff-class.

I. Implications of a Federal Court Decree

Hundreds of persons have responsibilities touching upon implementation of the decree, including employees of the Department of Mental Health and Corrections, officials and employees of other state agencies, persons who provide services in cooperation with the Department, and other concerned individuals. They are not familiar with federal equity decrees, and I here address those questions which have arisen most frequently and persistently concerning the meaning of the Court's injunction.

A. Persons Bound. The named defendants in this action are the Commissioner of the Department of Mental Health and Corrections, the Director of the Bureau of Mental Retardation, and the Superintendent of Pineland Center. They are specifically enjoined to "take all actions necessary to secure implementation of this judgment, including Appendices A and B, in a prompt and orderly fashion." The decree further provides: "Defendants shall take all steps necessary to ensure full and timely financing of this judgment, including, if necessary, submission of further budget requests to the legislature." This directive is not optional; the state defendants have a binding duty to take the steps mandated.

The decree is specifically binding on the defendants and their successors in office, their agents, and their employees. Thus, each Pineland employee is personally bound by the decree; and the decree is binding on the offices of the defendants regardless of who may come to occupy those positions in the future.

Rule 65(d) of the Federal Rules of Civil Procedure provides that a federal court order granting an injunction "is binding only upon the parties to the action, their officers, agents, servants, employees, and attorneys, and upon those persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise." The defendants here represent a major state agency having primary responsibility for the care, treatment, and services for the mentally retarded. The Department of Mental Health and Corrections does not, however, now possess plenary state authority for carrying out this Court's mandate. It is presently dependent upon the cooperation of numerous other state agencies for accomplishing the objectives of the decree. Other departments of state government are necessarily in active concert and participation with the named defendants. Accordingly, Rule 65(d) would include in the class of persons bound by the decree representatives of all other state agencies having responsibilities which directly affect implementation of the Court's order. Should it become necessary to establish that this understanding is correct and to ensure that it is properly acted upon, persons who occupy positions of leadership in other state departments, bureaus, and agencies can be named as additional defendants. Moreover, this Court can exempt the Department from following normal state procedures should they prove to be obstructive or productive of delay.

B. Purported Conflicts with other Laws. By virtue of the Supremacy Clause of Article IV, Section 2, of the United States Constitution, this decree supersedes conflicting state law. State regulations, procedures,

and contracts may not be relied upon as an excuse for failing to implement the decree. While I am sensitive to the need to construe the Court's order compatibly with state law, in the event of irreconcilable conflict or delays preventing compliance with this Court's deadlines, state law must yield. All persons affected by the decree must recognize that its terms are not negotiable.

Any purported conflict between this Court's decree and other federal laws or regulations can only be authoritatively resolved by this Court. Opinions of state and federal agencies, while entitled to weight, are not final. The State may not excuse its failure to implement the Court's mandate by relying on other provisions of federal law but must bring any purported conflict to the Court's attention for final resolution. Persistent failure to implement the decree on account of conflicts, real or imagined, between the decree and state or federal law will necessitate my seeking ancillary orders directed to the state agencies responsible in order to secure the Court's judgment.

C. Entry of the Decree by Consent. The decree was entered by consent of the parties. This fact does not mean, however, that the parties can now change the decree by consent or waver in implementing its provisions. At the moment the decree was adopted by the Court, the decree became the judgment of the Court. It then became binding on the State of Maine, no longer by virtue of voluntary agreement, but as a matter of federal law.

The decree does continue to have one special quality which is derived from its having been entered by consent of the parties: Not only has the State been ordered by the Court to carry out the decree, but also the State has promised that it will do so. Individuals whose personal approval was necessary to entering the decree by consent must be especially sensitive to the present action required to fulfill their promise.

D. Retention of Jurisdiction. This Court has retained jurisdiction of the action for a period of two years. Some persons assume that the decree is, for that reason, binding for only two years and that the state will then be free to conduct its affairs without regard for the decree. This view is wrong. The decree is a perpetual injunction, which is binding on the state forever unless modified by a court of competent jurisdiction. If, at the end of two years, it appears necessary or desirable for the Court to extend its retention of jurisdiction, I shall recommend that it do so. If continuing jurisdiction is unnecessary, the Court will relinquish day-to-day supervision, but the order of the Court will remain in full effect and will continue to be enforceable, as now, through the ordinary processes of civil and criminal contempt. In making my recommendation I shall apply the following standard: If one can read the decree and find there an accurate description of conditions then existing, continuing jurisdiction will not be necessary. If the decree does not accurately describe existing conditions in terms of the actual, every day lives of the plaintiffs, then further action by the Court will be necessary.

II. The Beneficiaries of the Court's Decree

A word is in order concerning the beneficiaries of this Court's decree. It is doubtful that Maine citizens generally are aware of the condition and status in the state of persons who are mentally retarded. While occasionally one sees folks who appear as if they might be retarded, we have not generally come to know them, much less know them well. Our ignorance is embodied in hateful terms still sometimes heard.

The reason we do not know the mentally retarded is a result of the first principle of a long-prevailing philosophy: a principle of segregation. In Maine mentally retarded citizens have been segregated from the rest of us by confinement to Pineland Center. There our concern for their well-being and our information about them and their existence stopped. They were in the care of the state.*

What most of us did not know was what happened to the mentally retarded after they were committed to the state's care. Essentially they were kept. They were kept clean, kept safe, kept confined, kept bed-ridden, kept in strait-jackets and camisoles, kept away from attractive things, and kept away from us. Even so, they were not well-kept. Their care was based on a second principle of the philosophy now abandoned: that persons who are mentally retarded are incapable of learning, of growing, of having normal human experiences, of taking care of themselves, and of contributing to society. Under these conditions a person's faculties not only fail to develop to their potential but also are likely to deteriorate. The present effects of these now-abandoned practices are currently observable at Pineland Center.

The beneficiaries of this decree are interesting individuals, and individuals they are, with as diverse and varied a panoply of human emotions, interests, idiosyncracies, capabilities, and talents as anyone else. Those persons presently living in the community are often the most capable and least retarded. Most, but by no means all, of the residents of Pineland are severely or profoundly retarded. They have varying capacities for accepting education. Many are multiply handicapped, suffering blindness, deafness, mental illness, susceptibility to seizures, and physical abnormalities. Many have behavioral problems of aggression or self-abuse. Some suffer in ways which even the experts cannot comprehend. But, with rare exception, they suffer most from the failure to appreciate their affirmative capabilities. They have doubly suffered who have endured years of neglect of their intellectual and physical capacities.

Maine citizens would honor themselves by taking an interest in discovering the worth and merit of those who through no fault of their own are developmentally disabled. Many opportunities exist for both volunteer work and paid employment at Pineland, in group homes and day-activity centers, in opening new group homes, or becoming foster parents.

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* Largely because their conditions were unknown to us and outside our concerns, the responsibility for correcting their poor condition fell to the federal court. Long-standing inattention to basic human needs and worth through normal political processes itself necessitates a court's intervention to secure the rights denied or ignored.

III. Objectives of the Decree

A. Principal Decree Objectives. The operative provisions of the Court's decree are contained in two documents designated "Appendix A: Pineland Standards" and "Appendix B: Community Standards." The decree prescribes that it is to be interpreted "in a fair and reasonable manner so as to attain the object for which it was designed and the purpose to which it is applied."

There are two central objectives of the Court's decree: The first is to secure the right of mentally retarded citizens to be given training and education, designated in the decree as "programming." The second is to secure the right to live in the least restrictive environment possible. These objectives represent a reversal of the two least commendable practices of the past: segregating the mentally retarded from the rest of society and ignoring their capabilities. These objectives mean that every client in the community and every resident of Pineland has a right to be taught whatever he may be capable of learning, with an emphasis on skills of practical value to attaining or increasing personal independence. It also means that residents of Pineland have a personal and present right to leave Pineland and have a more normal home found for them outside the institution.

All other provisions of the decree revolve around these two great objectives. The decree cannot be properly understood or interpreted without resolving whatever issue may be under consideration in light of these two aims. Any failure by the state to support the objectives of programming and normal living would cut to the heart of the order of the Court.

B. Rights of Community Clients. For most class members the goal of less restrictive, more normal living means living in community residences. Pineland Center has a pressing obligation now to find or develop new community residences throughout the State of Maine.

1. Where a Client Lives. The point of community living is normalcy. Community residences are to be integrated into the community, not set apart. Homes are to be, as far as possible, usual and ordinary, like other normal homes. A person has a right to have a bed, a dresser and storage space, attractive and comfortable living areas, and privacy in bathrooms. Clients are to be taught, in their homes, to care for individual living areas, to prepare meals, to buy clothing, to use the telephone, and to care for themselves in terms of grooming and hygiene, health and dental care, safety skills, and use of money. Home operators have the teaching responsibility in these areas.

2. Where a Client Works. The essential ingredient of a successful community placement is formal education, training, or work outside the home. For children this responsibility is borne by local school districts, which cannot exclude handicapped children from public education. For adults the responsibility lies with day-activity and work centers. There the skills taught by home owners are to be reinforced, and social, pre-vocational, and compensable work programs are to be provided to clients as their capabilities and development permit.

The mechanism for implementing these program objectives is called the prescriptive program plan, a description of each individual's specific needs and capabilities, his program goals with short- and long-term objectives, and timetables for achieving those objectives. The prescriptive program plan is to be prepared and reviewed regularly by an interdisciplinary team composed of persons from various professional disciplines and persons having responsibilities for carrying out the plan's recommendations. Home operators and program directors bind themselves to provide the services specified in service agreements entered into with the Bureau of Mental Retardation.

3. Support Services. The decree requires the Bureau to operate six regional offices and two resource centers for the state. In support of community residences and programs those offices must provide or secure such services as transportation, family-support services, respite care, medical and dental care, psychological evaluations and advice, speech and hearing assistance, occupational and physical therapy, social-work services, crisis-intervention assistance, and in-service training.

C. Rights of Pineland Residents. Persons remaining at Pineland have a right to the most normal living conditions which can be provided and a right to a program of habilitation which will maximize their human abilities, enhance their abilities to cope with their environment, and create reasonable expectations of progress toward the goal of independent community living.

1. Life in a Unit. Each person at Pineland is assigned to a unit which is his home. There he has a bedroom or shares a bedroom with others; personal belongings are kept there; he takes his meals in the unit diningroom; personal records are maintained on the unit. The decree requires that living units be attractive, normal, and clean, affording residents privacy, dignity, comfort, and sanitation. Bedrooms are to be attractive and, for the most part, either single or double rooms. Residents are to be provided with personal dressers and storage space. Toilets and showers must afford privacy, and toilet paper must be provided. Common living areas must be conducive to socializing with others, relaxing, and engaging in usual leisure activities. Leisure-time and educational equipment should be handy.

Direct-care aides, who are responsible for a resident's daily care, are the primary teachers. Like the home operators in the community, the aides must teach whatever skills in daily living a resident may lack whenever there is some promise of a resident's learning to acquire those skills. The aides must organize constructive, pleasurable activities, train each resident in activities of daily living, self-help, social skills, and communication skills, and facilitate freedom of movement and communication. Specific ratios are set forth in the decree to ensure that there are enough aides to carry out their important responsibilities. To enable the direct-care staff to perform the function of teachers and helpers, they are not permitted to perform routine housekeeping chores.

Consistently with their capabilities and handicaps, residents are to be taught, by the direct-care staff, how to feed themselves both hot and cold foods in normal fashion and are to be assisted in learning normal grooming and personal hygiene practices. Residents are to be provided with clean, adequate, and seasonably appropriate clothing comparable to clothing worn by persons generally.

Direct-care aides are entitled to receive significant in-service training in order to prepare them for carrying out these new and difficult responsibilities.

2. Life Outside the Unit. The decree prescribes that the educational philosophy at Pineland shall be that every person is to be regarded as capable of benefiting from education and training (and virtually everyone is). Each person is promised by the decree a right to receive a minimum of five scheduled hours of program activity per weekday during the first year of the decree and six hours thereafter. Programming is to be keyed to whatever an individual's needs and capabilities may be. They range at Pineland from a capacity for productive, compensable work to the most basic needs for learning personal hygiene and elementary means of communication. The picture of Pineland envisioned by the decree is one of activity, stimulation, and challenge, striving for incremental improvement in mental and physical abilities.

The decree calls for Pineland to provide a variety of recreational activities both on and off Pineland grounds. Each resident has a right to five hours of recreational activity each week (which may be considered as programming if organized to contribute to achieving the goals of a resident's prescriptive program plan). Once each week each resident is entitled to participate in an activity which takes him off the Pineland grounds. Attractive outdoor areas are to be provided for unstructured physical activity.

Pineland residents have the right to be provided an opportunity to shop in the community at least monthly, to eat in a public place in the community at least monthly, to participate in a major recreational activity at least monthly, to attend public events in the community four times annually, and to attend church in the community.

The centerpiece for implementing these program objectives is, again, the prescriptive program plan prepared by a team of persons representing a spectrum of disciplines and duties. The interdisciplinary team assesses an individual's needs and capabilities and decides what goals should be set, with short-range and long-range objectives and timetables, and how Pineland can best go about achieving those goals.

3. Support services: Professional Departments. The decree calls for provision of various support services including dental care, psychological evaluations and advice, physical therapy, speech therapy, medical and nursing services, and safety and fire protection. Representatives from these specialized areas are essential to preparing the prescriptive program plans. They have the expertise to evaluate current

needs and capabilities, give advice on long-range and short-range goals to be agreed upon, and provide guidance and instruction on how those goals can best be achieved.

Two parts of the decree limit the discretion of the professional departments and set the direction for their advice and judgment. They concern the use of aversive conditioning (negative and disagreeable techniques for controlling bad behavior) and psychotropic medications (also used for controlling behavior). The decree provides that those techniques are to be employed only as a last resort after other, more agreeable alternatives have been tried and found wanting and then may be used only at the absolute minimum.

4. The Consumer Advisory Board. Finally, the decree establishes one on-going organization to preserve and protect the rights of those persons confined to Pineland Center: the Consumer Advisory Board. In addition to finding persons willing to serve as correspondents for residents who have no other interested parent, relative, or friend, the Board is commissioned to evaluate any alleged dehumanizing practices at Pineland, to promote normalization, and to examine violations of individual rights. The Board is required to submit periodic reports to the Superintendent of Pineland Center and to the Commissioner of Mental Health and Corrections.

IV. Community Programs and Residences

I have visited community residences and program centers throughout the State from York to Aroostook Counties. I have examined Bureau records and spoken with home operators, program providers, Bureau employees, and mentally retarded clients in all six Bureau regions. Bureau employees are working at high levels under intense pressure. They have completed prescriptive program plans for all of the class members in the community.

A. New Group Homes and Program Centers. Nearly the full promise of the Court's decree is now being realized by clients living in new group homes and participating in new day-activity and work programs. They live in attractive, substantial, noninstitutional group homes. Their lives are active and filled with opportunities to learn. Persons running the new homes and programs tend to be concerned for their clients and share the philosophy of self-sufficiency and independence which underlie the decree. They are working diligently to help people help themselves. Anyone who may entertain doubts about the worth of the undertaking represented by the Court's decree must see the new group homes and programs.

B. Community Residences. The principal problems in the community arise from older residential facilities. Some home operators do not understand the educational, as distinguished from custodial, function they are to perform. While that default can be corrected, the task is a delicate one. It would be self-defeating for state workers to enforce the decree against persons who have not first had a fair opportunity to understand it. The decree is not like state regulations which have been imposed. Some persons may have becomeso inured to the imposition of unreasonable or unexplained state regulations that they may fail to see the decree as an opportunity for a better life for the mentally retarded and all persons upon whom they depend.

I have seen a few community-based establishments which may be irredeemable. They are either places where the environment is too poor to expect that alterations could cure the deficiencies, places that are too large or institutional to care properly for the individuals who live there, or places where those in charge believe that they have full authority to make all decisions for persons in their care. In many cases class members living in such facilities were placed out of Pineland Center without state provision of programming which is necessary to achieving the purpose of community placement. Once residents of Pineland have been given opportunities to move out of the institution into community settings, a major emphasis must be placed on improving the conditions of persons who are now living in substandard homes. An invitation must be extended now to all community residences to implement the consent decree. If that invitation is declined, community clients may have to move.

V. Pineland Center

In keeping with attitudes of the past, Pineland Center is inaccessibly located in New Gloucester, Maine. Because the problems of Pineland are so ingrained and inter-related and because those that are minor are treated on an equal par with those that are major, it is difficult to describe Pineland without being superficial. Physically, Pineland is a complex of buildings including a school, a gymnasium, an administration building, a kitchen, a laundry, a hospital, residential units and so on. It could be like a little town, but it is not. It is also not like a hospital. Pineland personnel constitute an unwieldly bureaucracy which varies widely from one part to another in efficiency and effectiveness. Pineland residents, presently numbering more than 400 persons, are all dependent to one degree or another on Pineland employees and the services they provide. Their lives are the measure of compliance with the Court's decree.

Pineland Center is implementing the consent decree. Improvements have been made and are continuing to be made. The Pineland management (an executive committee composed of department heads and other key personnel) is committed to complying with the Court's order. Most demonstrable improvements at Pineland were made during the period of decree negotiations in anticipation of the decree's being entered by the Court. Some entire units were converted from cavernous old wards, where dozens of beds and people were once cramped in, to attractive, pleasant apartments. Medications were substantially reduced. Personal dressers, storage space, and bedspreads are being provided. Curtains and wall decorations have been hung. Normal furniture is being purchased. Screens are being installed on showers and toilets. Toilet paper is normally to be found in bathrooms (which was not the case when the decree was entered). More residents than ever are receiving some form of programming. More are seeing beyond the Pineland environment by visiting surrounding cities and towns. But all is not well at Pineland Center.

A. Residential Life. The worst-situated among the plaintiff-class are those who are presently denied even such programming, activities, interests, and pleasures as Pineland is now able to provide. Those persons pass the time, in whole or in part, left to their own devices to entertain themselves. They are still just being kept. Life for them is purposeless. Some are locked into their living units and, at the same time, locked out of their rooms. Common living areas where they are kept have no handy equipment or educational toys, and, if they did, the aides would usually be too busy to supervise their proper use. Their access to fresh air is wholly dependent on the time and willingness of direct-care aides. Some such residents become aggressors; others become their victims. The prime characteristic of those persons and others at Pineland is boredom.

The backbone of the Pineland operation is the direct-care staff, employees assigned to residential units. They are the ones who have immediate and constant, round-the-clock responsibility for persons confined to Pineland. The difficulty of tasks assigned to the direct-care staff varies enormously from unit to unit. Variations are also found in their willingness to work hard and become teachers of the retarded. Aides in some units are so overworked by the difficulties caused by their residents that they can do little more than keep the lid on, providing essentially

custodial care. As well as dealing with challenging residents (who are sometimes destructive, aggressive, self-abusive, or incontinent), the aides must accompany individual residents wherever they are required to go; they must perform routine housekeeping chores (or else leave such chores undone); and they must attend to ever-increasing paperwork demands. Precious little time is left for participating in the formulation of prescriptive program plans, for teaching daily living skills, or for being trained themselves in how best to carry out their responsibilities.

In the most difficult units the aides cannot be expected to assume the role of teachers contemplated by the decree until Pineland has an infusion of additional direct-care aides to ease the burden and a substantial increase in the number of housekeepers to remove, once and for all, housekeeping chores from the direct-care staff. It may be that a significant number of reassignments will have to be made to prevent waste in the time of staff away from the direct care of residents. Pineland is not meeting the direct-care staff ratios set forth in this Court's order. At best, those ratios are being met only in terms of authorized positions, not persons present and on duty. Vacant positions and absent employees are not the measure of compliance with the decree.

B. Programming. Most Pineland residents are scheduled into some form of programming, although not all are, and every program center has a waiting list. When viewed in terms of individual needs, the amount of time residents spend in receiving training and engaging in activities outside their units is wholly inadequate. The decree calls for constant activity. A Pineland resident should at all times have available to him the opportunity to be in a classroom learning something new or practicing an acquired skill, to be on a trip away from Pineland, to be enjoying the gymnasium or participating in other recreational activity unless he is attending to other matters which are parts of life such as eating, toileting, seeing the doctor or dentist, or getting fresh air.

To be sure, there are persons whose tolerance for stimulation is low, and everyone needs just plain rest and relaxation at times. But for many Pineland residents the colorless life they lead is attributable to nothing other than a lack of sufficient services, a failure by some staff members to understand that they are all teachers who are obligated to make life interesting, and a failure of organization.

Failure to meet residential staff ratios may be a consequence of failing to provide total programming because residents are, in substance, confined to their living quarters when they should be in programs.

C. Support Services and Prescriptive Program Plans. Professional departments at Pineland are close to being fully staffed for the first time since the decree was entered. The departments, including psychology, nursing and medicine, occupational therapy, physical therapy, speech and hearing, and fire protection, should seek to make the direct-care staff extensions of their departments. Professionals should spend about half their time teaching and working with residents and the other half teaching the direct care aides. The department of psychology especially needs to

commence an out-reach and training program to bring the direct-care staff up to that level of sophistication in psychology to enable them to provide the experts with meaningful information.

A study is now underway to examine the whole interdisciplinary process in the community. A similar study is needed at Pineland, where the process for preparing prescriptive program plans is too generalized and produces more paper than concrete objectives and specific methods for achieving them. The process is new, of course, and the persons concerned are new to it. The time for redirection, however, is now.

D. Placements out of Pineland. While the decree envisions that a community residence must be found whenever a Pineland resident is ready to live in the community, Pineland procedures do not work that way. There are persons now confined to Pineland who are capable of productive community lives but for whom no home has been found. Several instances have occurred in which residents were ready to leave Pineland and home operators were willing to provide them with homes, but Pineland delayed or obstructed the placements. Wholesale placements out of Pineland in years past without providing programming and support have caused an understandable reluctance to make placements without perfection. But too often Pineland employees fail to appreciate the scope of their own competence. They wait for the ingredients to fall into place rather than being the prime movers who make things happen.

E. The Consumer Advisory Board. The Board is organized and is operating enthusiastically in support of the Court's order. The Board is an organization whose function and importance will last beyond the period in which this Court has retained jurisdiction. Should the state defendants fail to live up to the terms or purpose of the decree after this Court has relinquished jurisdiction, the Consumer Advisory Board is likely to be the responsible mechanism for bringing any significant deviations from the decree to the Court's attention. The nature of the Board's function would necessarily make it difficult for the Superintendent or Commissioner to fail to follow Board recommendations. Should they do so, however, the Board would have access to this Court.

VI. Conclusions

Two major obstacles are impeding full implementation of this Court's decree. First, Pineland Center is insisting on implementing the decree according to old Pineland modes of procedure. Second, the Department of Mental Health and Corrections is not receiving the cooperation of other state agencies necessary to enable the Department to implement the decree with any celerity.

Pineland Center displays a worshipful devotion to foolish, cumbersome, convoluted Pineland procedures. With exceptions, it avoids imaginative problem solving and excels in producing reasons why things cannot be done. Despite the difficulty of the work of many direct-care aides, Pineland confoundingly makes life more difficult than need be. Restrictions are imposed on Pineland employees which are perceived to be repressive and necessarily based on a premise of untrustworthiness. Opportunities for fundamental change are routinely resisted. The happiness, the full-time activity, the harmony contemplated by the decree are not being realized.

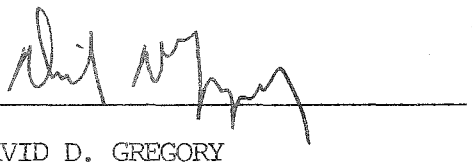
The Department of Mental Health and Corrections needs but has not received complete cooperation of other state agencies in accomplishing the decree's objectives. Hiring and upgrading employees requires approval of outside officials in charge of personnel. Obtaining federal funds to help pay for changes mandated by the decree has been blocked by another state agency. Pineland cannot purchase items required by the decree or renovate buildings without following various state procedures. Opening a new group home in Freeport and improving Pineland buildings have been subjected to unjustifiable delays from both within and without Pineland. The Department's budget must be submitted for approval to persons who are not conversant with the requirements of the Court's order. Home-licensing regulations based on a nursing-home model conflict with terms or objectives of the decree. Pineland residents have been denied their right to leave Pineland for such reasons as a school district's failure to conduct a pupil evaluation, another agency's delay in conducting a fire-safety inspection, another's failure to license a group home conceded on all sides to be a good place to live, and failure of Pineland employees to be decisive and facilitate bringing the outside processes to conclusions. All such outside procedures are inherently obstructive because the objectives of the decree are being treated as secondary or irrelevant to the agencies' functions under state law.

Pineland Center may prove itself in need of thorough-going restructuring by the Court. It may need to be emancipated from both external and internal limitations on its ability to achieve results quickly and effectively. It does need a permanent superintendent and more new blood to energize the institution to carry out its central mission of total programming for the purpose of increasing personal independence.

The lion's share of praise for those accomplishments which have occurred belongs to the Director of the Bureau of Mental Retardation. He has been tireless in his efforts to develop new community residences and programs and to spread the message of the Court's decree throughout the State. Creativity and resourcefulness have been the hallmarks of his direction of the Bureau. While the Pineland managers want to comply with the Court's decree, they seldom seek creative solutions to their problems, they fail to emulate the Bureau's direction, and they have subverted Bureau plans for reasons known only to Pineland. Plans laid by the Director and the Commissioner, however well conceived, are not reliable reflections of the Pineland reality. Pineland must awaken soon to the fact that it has only one set of supervening instructions: this Court's decree.

Specific recommendations for corrective action by the Court will be forthcoming.

Respectfully submitted,



DAVID D. GREGORY

Special Master for the United States
District Court

Dated: March 19, 1979
Portland, Maine

Professor David D. Gregory
University of Maine School of Law
246 Deering Avenue
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P I N E L A N D C O N S E N T D E C R E E

REPORT OF THE SPECIAL MASTER

TO THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MAINE

PART I: CONCLUSIONS OF THE SPECIAL MASTER

C

November 14, 1979

MARTTI WUORI, et al.,

Plaintiffs

v.

GEORGE A. ZITNAY, et al.,

Defendants

Civil no. 75-80-SD

REPORT OF THE SPECIAL MASTER

TO THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MAINE

PART I: CONCLUSIONS OF THE SPECIAL MASTER

The plaintiffs in this action are mentally retarded citizens of Maine presently or formerly involuntarily confined to Pineland Center; the defendants are officers of agencies of the State of Maine having primary responsibility for care and treatment of retarded citizens. The Court's decree describes the rights of retarded citizens of this State and imposes upon the State the duty to provide whatever may be necessary to fulfill those rights. The terms of the decree were written by both parties, and the decree was entered as the judgment of the Court with both parties' consent. The State's consent came with the personal approval of Maine's highest executive officials. The decree is binding upon the offices of the named defendants, their employees, and agents, and all persons in active concert or participation with them including all state agencies having responsibilities affecting the security of the rights of retarded citizens.

The Special Master is an officer of the Court who is directed to represent "solely the Court and the interests of justice." The Special Master is to serve in part as a witness to the State's performance in complying with the decree. The Master is directed to interpret the Court's decree "to attain the object for which it was designed and the purpose to which it is applied."

1. Compliance with the Decree. Pineland Center is not complying with the order of the Court. Noncompliance is substantial and continuing. In no major area is Pineland Center meeting the consent decree. The environment in most residential and program areas at Pineland is poor; it is neither normal nor conducive to learning. Pineland does not provide anything close to the educational opportunities or individually planned programs promised by the decree. Pineland does not have sufficient qualified staff present and on duty to deliver the services called for by the decree. Pineland fails to prepare Pineland residents for living in the community and is denying their right to noninstitutional living. These deficiencies could be partially, but only partially, cured by increased State expenditures. Part II of this report details the extent of the State's failure to implement the Court's decree at Pineland Center.

The State did meet its obligation to reduce the population of Pineland Center to 400 residents by July 14, 1979. In the first year of the decree the State did develop for members of the plaintiff-class 125 community residential placements and 156 day-program openings.* Except for persons who have been placed out of Pineland Center, the State's efforts toward compliance have had little impact on the lives of Pineland residents.

The reasons for Pineland's failure to implement the Court's order are subtle and appear to be endemic to a custodial institution. A custodial institution is inherently abnormal and is thus in the worst position to provide a normal environment conducive to learning. It is difficult to teach normal behavior and ordinary skills to persons whose affirmative capabilities have long been ignored, repressed, and contorted by living in an institution. Institutional officials and employees are not well prepared to carry out institutional reform.

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*See part II of this report, pages 5-7. Although this report does not examine in detail the State's compliance with the community aspect of the Court's decree, the Special Master has, nevertheless, visited community residences and programs in all six regions of the Bureau of Mental Retardation. The Master has examined records of class members and has interviewed employees of the Bureau, other State officials, and former residents of Pineland Center. In general, new group homes and programs for the retarded, while universally underfinanced and often understaffed, undersupported, and misregulated by the State, are proving the value of the Court's decree in terms of human capability and aspiration. The problems in the community are older boarding homes and institutions which are not complying with the Court's order, a lack of appropriate opportunities for schooling and work, including opportunities for public education and vocational rehabilitation under federally financed programs which are related in purpose to the Court's decree, and a lack of transportation and other support services.

The most gifted superintendent cannot reasonably be expected without assistance from the Court to effect fundamental change. Below the superintendent are managers who, with exceptions, do not know how to comply with the Court's order. Some do not want to comply and, hence, pronounce themselves already in compliance; others treat compliance as secondary to their own limited vision of the obligations of their offices. Representatives of direct care aides are concerned with employees, not persons who are in their direct care; they protect the few employees who abuse persons in their care; they prevent hiring the best qualified employees. Beyond the superintendent are state agencies which do and will continue to hamstring the Pineland management in a variety of matters pertaining to personnel, purchases, placements, renovations, and budget and thus impede compliance and cause needless waste.

2. The Cost of a Custodial Institution. Pineland Center, as a custodial institution, is a mental retardation facility in the sense that it is an element in the process of facilitating mental retardation. Barely a fraction of each dollar spent at a custodial institution reaches its inmates in improvements in the quality of their lives.

Taxpayers of Maine right now pay nearly ten million dollars a year, not including the costs of food and heat, to maintain Pineland as an asylum for retarded citizens. At a population of 400 inmates, Maine taxpayers are paying over $25,000 per year per person to segregate from society persons who are retarded; and the inmate receives nothing remotely close to the quality of life which $25,000 can reasonably be expected to purchase outside the institution. The figures are too plain, the contrast between community and institutional living too stark, the conclusion too inescabable for the people of Maine and their representatives long to continue to miss. Only an insidious circularity of our own ignorance protects Pineland Center in its present course: For three quarters of a century we have paid to hide retarded individuals, and now we do not know what to expect should they return to our midst because they have been hidden. Fear or misgiving, born of our own self-created ignorance, will alone permit us to continue to inflict, at extravagant cost, a custodial institution upon our mentally retarded peers.

One cannot in conscience recommend to the Court additional remedies that entail expenditure of additional millions of state dollars at Pineland Center. The Special Master here records that he has learned over the course of the last year that the center of gravity of the Court's decree is not Pineland Center but the community. If near-normalcy is to be achieved, the promise lies in normal surroundings. Pineland Center as a custodial institution is inherently abnormal. It is better to concentrate the State's resources and effort on starting and supporting new community residences and programs for Pineland residents than to put finite resources into a custodial institution to no good purpose in the faint hope of reform.

3. The Cost of Compliance. The irony concerning the limited, underfinanced opportunities now offered by the State for community living, education, and work is that federal money which is available to finance major costs of the consent decree in the community is being spurned or misapplied by the State. Approximately seventy per cent of the cost of maintaining community-based residences and programs and providing various support services could be paid for right now by the federal government. Additionally, mentally retarded citizens are excluded from fair participation in federally financed programs now being administered in Maine contrary to governing federal law. The reason that federal money is available to assist the State in implementing the Court's decree is that the purposes of federal programs enacted by Congress are identical or harmonious with the purposes of the Court's decree. Applicable federal regulatory standards are consistent with the terms and objectives of the Court's decree, and their mechanisms are often identical. If administration of federally financed programs were coordinated with the implementation of the Court's decree, Maine would bring itself into compliance with the federal law which it now violates and go far toward fully implementing the consent decree.

There is no sustainable justification for the State's maladministration of federal programs. Federal funding is not now being used to finance group homes, programs, and related services because the State has not seen fit to ask for it. Only reasons no longer tenable can account for the State's reluctance, contrary to common sense, to seek federal funds which are available to help the State in meeting its obligations under a federal court order. Officials of State agencies other than the Bureau of Mental Retardation are, like the rest of us, unfamiliar with the needs and capabilities of retarded citizens. They are unaccustomed to treating retarded persons equally with everyone else; they are content to allow Pineland Center to contain the retarded. They resent being told by a federal court order how the State's conduct affecting the retarded must be rectified. As to existing programs, typically a state agency is delegated the authority to administer a federal program. A specialized subdivision of the agency thus acquires monopoly control not only of money but also of a complex array of governing rules. A routine response to a reasonable suggestion on administration of a program is that federal regulations prohibit it, and there the matter ends because the agency has the monopoly on the law. If the agency fairly construed the law, there would be no ground for complaint, but typically the agency acts without regard to the purposes which the federal program was designed to achieve and in utter disregard of the coordinate objectives of separate federal laws and programs. The worst offender in this State on this score is the Department of Human Services. It routinely displays only the most elementary conception of law, as a regulatory, restrictive, exclusionary, and punitive device; it applies rules purposelessly.

4. Prognosis of the Future of the Decree. While the Court's decree envisions the right of all Pineland residents to enjoy noninstitutional living, the decree does not call for the closing of Pineland Center. My experience as Special Master compels me, however, to inform the Court of the following further observations.

Pineland Center's performance during the first year of the decree renders doubtful whether Pineland will ever be capable of faithfully carrying out the decree's objectives. Substantial time has been spent feigning compliance or concealing noncompliance; little regard has been given to attempting to understand the purposes of the Court's decree. To be sure, Pineland Center has been without a superintendent for the better part of a year, but the problem of Pineland at heart is not traceable to the void at the top. The problem of Pineland is that Pineland is a custodial institution. Pineland Center has no future as a custodial institution, that is, as a place where persons are consigned to live for an indefinite time.

A custodial institution, as exemplified by Pineland Center, exists for the purpose of keeping people away from the community into which they were born. As long as society is willing to pay the cost of pursuing that purpose, then a custodial institution is effectively insulated from reformation or improvement to which it does not assent; institutional residents are hostages to preservation of the status quo. Abnormalities of the persons incarcerated in the institution are only the beginning and the least of the abnormalities of the institution itself. Every single task undertaken in a custodial institution is more difficult and more expensive and produces worse results than in a more normal environment. The simplest prescriptions of the Court's decree--provide normal clothing; provide normal meals; provide a warm, home-like environment; provide privacy, dignity, and comfort; provide toys, games, and learning equipment--cannot be met by a custodial institution. They are not being met by Pineland Center.

Not only is a custodial institution incapable of meeting simple needs, but, if Pineland is exemplary, it also works a positive evil. Inmates develop uniquely institutional behavior which comes to constitute a barrier to assimilation back into society. Retarded persons become more retarded. Managers and employees exhibit their own modes of institutional behavior. Reasonable persons make unreasonable judgments in the institutional context. Harm is constantly, unintentionally perpetrated. Keys separate the keepers from the kept and are a measure of status.

Pineland could have a worthwhile destiny, if it were capable of embracing it, but not as a residential facility. There will be a need for a place to educate persons to work in community-based residences and programs. Community residences and programs will experience a constant turnover of employees and require a constantly replenished complement of well-trained persons to work with the retarded. (As matters now stand, neither Pineland nor the community direct care workers are well trained before commencing work.) There will be a need for a

place to provide short-term respite care to retarded individuals and their families. There will be a need for some place to provide short-term intensive care for persons suffering from the most perplexing medical and psychological problems. Pineland could be an educational institution. Pineland could have in residence expert teachers conversant with the most sophisticated learning on meeting the most difficult problems and needs of retarded persons. Pineland personnel could be doing the most advanced research. New parents of mentally retarded children could be educated to their children's potential and taught how they can keep their children from the present cycle of deterioration in being retarded, being institutionalized, being ignored and repressed, and becoming more retarded. Pineland Center's failure to become an educational institution wholly supportive of community-based care will leave Pineland with no reason for being.

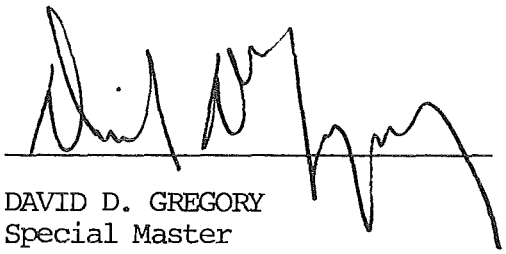
The structure of a community-based system is in place. New community residences and programs prove the worth of community placement in terms of human lives. The purpose of a small group home for the retarded is to advance a retarded individual's affirmative capabilities, those qualities which have been stifled by institutional life. Former Pineland residents now living in authentic homes are teaching us how much they are capable of learning. They are being helped to live normal lives and are being allowed to become independent, self-controlled, and productive. Those goals can be achieved only by their overcoming the continuing effects of our having consigned them to a custodial institution. A person moving from an institution to the community at large needs substantial support. Experience teaches that the success of community placement is dependent on the State's providing for each person an individually planned educational or occupational program. Just like anyone else who spends his day at school or work, a mentally retarded individual needs a productive occupation away from home. The decree guarantees and the State has promised to provide programs designed to meet the needs and test the capabilities of retarded citizens. The risks, obstacles to normalcy, and ambiguities of transition to community life which a retarded person must face are insignificant, when he is given the proper support, in comparison to the losses attending his continued institutionalization.

The people of Maine should know that the Court's decree was inevitable. We cannot justify incarcerating someone simply because he is retarded. We cannot justify confinement on a pretense of providing specialized services which do not exist or could be better provided outside an institution. The State's consenting to the decree was, therefore, sensible. There is no reason now in law or policy for Maine to fail to make every possible effort to implement the Court's decree forthwith.

One person deserves unqualified praise for his work in implementing the Court's decree: Kevin W. Concannon, Director of the Bureau of Mental Retardation.

The Court's retention of continuing jurisdiction and the term of the Special Master expire in July 1980 unless renewed by order of the Court. From the vantage of this moment, there can be no reasonable expectation that the Special Master will have any alternative other than to recommend renewal of continuing jurisdiction and renewal of the term of the office of Special Master. There is at this point no foreseeable end to this Court's decree.

Respectfully submitted,



DAVID D. GREGORY
Special Master

Dated: November 14, 1979
Portland, Maine

Professor David D. Gregory
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PINELAND CONSENT DECREE

REPORT OF THE SPECIAL MASTER

TO THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MAINE

PART II: PINELAND CENTER

November 14, 1979

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[Second printing. December 7, 1979.]

TABLE OF CONTENTS

MARTTI WUORI, et al.,

Plaintiffs

v.

GEORGE A. ZITNAY, et al.,

Defendants

Civil no. 75-80-SD

REPORT OF THE SPECIAL MASTER

TO THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MAINE

PART II: PINELAND CENTER

INTRODUCTION

1. The Decree. The objectives of the Court's decree can be summarized in two words: education and normalcy. No separate section of the decree can be properly understood or applied without considering how it relates to the decree's objectives. The standards of the decree, construed in light of its purposes, prescribe the quality and conditions of each Pineland resident's life. They are the principles which must guide the State's efforts to serve the beneficiaries of the Court's decree. The extent to which those principles are reflected in the lives of the plaintiffs is the measure of the State's compliance.*

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* See Report of the Special Master to the United States District Court for the District of Maine, p.3, March 19, 1979.

The two decree objectives are themselves interrelated. Normalcy of environment is a predicate for benefiting from education. Learning is difficult, for instance, more difficult than need be, if extraneous noise affects the senses and diverts attention. Likewise, education is necessary to facilitate adjusting to normalcy where normalcy is new. A person cannot be expected, without being taught, to use a table lamp properly, for example, when he has never seen one before.

The decree requires that living units at Pineland Center be attractive, normal, and clean, affording Pineland residents privacy, dignity, comfort, and sanitation. Living, programming, and working areas are to be quiet, appropriately designed, and conducive to learning. A standard of normalcy informs a spectrum of specifications from the condition of toilets to the furnishings and appointments of bedrooms and common living rooms to personal possessions to the rhythm of life of Pineland residents. The mission of Pineland is education. Residents have a right to "habilitation," including medical treatment, education, training and care, suited to their needs, regardless of age, degree of retardation, of handicapping condition. Each resident has a right to a habilitation program which will maximize his human abilities, enhance his ability to cope with his environment, and create a reasonable expectation of progress toward the goal of independent community living.

The mechanism for achieving these objectives in an individual case is called a prescriptive program plan, an individual assessment of a resident's specific needs and capabilities and an individually planned program to meet those needs and test those capabilities setting forth short- and long-range objectives and timetables for attaining them. The prescriptive program plan must address for each resident a wide range of needs: residential, medical, living-skill, psychological, social, recreational, educational, vocational, and therapeutic. Each individual plan must include a clear explanation of a resident's daily program requirements for the guidance of those responsible for daily care. Each plan is to specify how his needs are to be met. When services are unavailable, an interim program must be offered and a plan prepared for developing an appropriate program.

The activities of a Pineland resident's daily life should be well-considered by persons who know him well and persons from a variety of disciplines and be purposefully related to the goal of noninstitutional living. To these ends, Pineland must have sufficient equipment and supplies and sufficient well-trained staff present and on duty.

The decree's objectives of normalcy and education carry over to govern the State's obligations in the community. Persons discharged from Pineland are to live in homes as normal as possible. Just like anyone else who spends his day at school or work, a mentally retarded individual must be provided with a daily occupation outside the home. The objectives of normalcy and education here converge to point to a further purpose: to promote noninstitutional living and self-dependency.

Pineland's duty is to facilitate a person's placement out of Pineland Center to community living. It is a duty of affirmative action. Pineland cannot itself be an obstacle to placement.

2. Sources. The following report is divided into four parts: environment, programming, staffing, and placement. All of the information upon which the findings, observations, and conclusions are based comes from the State and virtually all of it comes from Pineland Center. Guidance for inquiring into the workings and management of Pineland, for examining the type and quality of various services provided, and for framing the issues in need of inquiry comes entirely from the Court's decree and the actions of the State respecting compliance. No consideration has been given to issues which are outside the decree or the State's conduct regarding implementation of the decree. Information relevant to all sections of this report has been acquired from the residents and former residents of Pineland, the Pineland management (through interviews, attendance at meetings of the Pineland Executive Management Committee and management subgroups, and official management reports), and officials and employees of the Bureau of Mental Retardation and the Department of Mental Health and Corrections.

Information concerning the environment is derived from interviews with direct care aides, teachers, program aides, maintenance men, kitchen and laundry workers, and housekeepers. As a source of information on the environment, nothing could replace personal observation of Pineland Center and new group homes and programs in the community. The section on programming is based on personal observations and information acquired from program coordinators, program directors, program professionals and aides, direct care aides, interdisciplinary team reports, and the task force on interdisciplinary teams. The fundamental information on programming is contained in Pineland's official programming statistics. As to personnel, information has been acquired by observations, interviews with members of the Pineland personnel department, officials of the Maine State Department of Personnel, union representatives, the Pineland Fire Department, and various aides and employees, and an examination of personnel records including job descriptions, records regarding allegations of abuse and neglect, advertisements and applications for employment. The fundamental information on personnel is contained in Pineland's records on daily assignment of staff. Placement information comes from observations and interviews of persons who have and have not been placed out of Pineland, reports of Pineland's social service department, interviews with social workers at Pineland and outside Pineland, resource developers, program coordinators, group home operators, and officials of the Bureau of Public Improvements, the Department of Educational and Cultural Services, and the Department of Human Services. There is no single source of fundamental information regarding placement. One must consider Pineland Center as a whole and how it fits into the state-wide network of support services of the Bureau of Mental Retardation and other state agencies having responsibilities which affect the rights of the retarded.

The reliability of information at Pineland Center is subject to judgment. There is a natural tendency among some officials at the institution to put matters in their best possible light or even a little better, while others tend to be critical whatever the subject may be. Official statistics may be misleading in the absence of analysis. Employees may be reluctant to be forthright to outsiders (and even to insiders). Manifestations of such reluctance have been anonymous communications, requests for assurances of confidentiality, and remarks expressing apprehension about the personal consequences which might follow honest disclosure. This reluctance has been fostered by directives from Pineland management to employees implying that prior management approval is required for an employee to speak with representatives of the Master's office or that the substance of all such conversations must be reported to the management. There is no way to measure the chilling effect of such directives.

3. Pineland Center. In no major area is Pineland Center meeting the consent decree. The physical environment in most residential and program areas at Pineland is poor. It is antithetical to normalcy. It is not conducive to learning. Pineland's experience seems to suggest that an institutional environment does in fact promote abnormal behavior; a person's behavior and attitude do tend to improve when he moves to a better unit. Pineland employees well know that some units, corresponding to the degree to which they approximate normalcy, are better than others. They are permitted to transfer to better units as staff vacancies occur; and as a result the worst units have the most difficulty in retaining experienced employees.* It is the staff, not the Pineland residents, who enjoy the right to move from the more restrictive to the less restrictive settings.

Pineland Center does not come close to scheduling the minimum number of hours of programming prescribed by the decree. What is scheduled is not generally individually planned by an interdisciplinary team. Pineland's programming is essentially a place where people go, not a purposeful activity devised to meet an individual's needs and to expand his personal capabilities. Of that programming which is scheduled, only about three-fourths is actually received in the sense that Pineland residents are physically present at program areas. Cancellations constantly occur for reasons having nothing to do with an individual resident. Staff absences are probably the most significant and least justifiable reason. When a resident is in actual attendance at a program area, his activity there cannot necessarily be regarded as programming received. An outside consultant hired by Pineland estimated that, of four to five hours of "actual" program time in one area, each individual resident received one half to one hour's individual attention.**

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* Sec. C.11., App. A: "The level of training and experience of staff shall be substantially similar between all halls and wards."

** See, "Recommendations Based Upon Conversations and Observations of the Berman School & Staff" by Jacqueline Giasson, M.Ed. Her report is reproduced at page 85 infra.

The little things that make life bearable, not to say enjoyable, are not readily available at Pineland Center. Well-intentioned efforts to correct deficiencies as often as not make matters worse. The food at Pineland is institutional. (One must see to appreciate a one-ounce scoop used to apportion some residents' ground meat which is the main course of a meal.) To keep food hot Pineland adopted a system of individual trays which approximates the normalcy of an airline; it does not keep the food hot. Direct care aides complain that the kitchen does not properly prepare food for individuals and that requests made to the kitchen are not followed; kitchen staff complain that doctors give too little information on individual requirements to make the instructions meaningful. Unbreakably circular complaints are commonplace at the institution. Aides complain that they have insufficient towels and linen to meet the needs of a unit; managers suspect that the aides steal towels and linen and are disinclined to supply more. The same holds true for a variety of basic supplies. Some lines of complaint point straight upward to a final decision-maker outside the Department of Mental Health and Corrections who has no understanding of retarded individuals. Direct care aides complain that they do not have enough laundry soap to keep clothes clean; the management complains that it cannot buy the type of soap needed even though it is readily available at low cost in handy stores; the Bureau of Purchases buys the soap it thinks will do by sending out huge, multi-institutional orders to bid. Painters have paint rollers which are designed to apply a different kind of paint than they have. Plumbers weld two inch bolts to four inch bolts in order to make six inch bolts which cannot be purchased through the system within a reasonable time. The forgotten man is the only one whose rights are federally guaranteed. Some obstacles to securing those rights are endemic to an institution but are not found elsewhere. The perplexing problems of staffing at Pineland fit into that category.

Pineland is not well-geared to helping people escape from its confinement. All of the major forces conduce toward continued confinement. Pineland cannot easily prepare persons for community living when preparation essentially entails ceasing and undoing the effects of being institutionalized.

4. Achievements of the State. This report, guided as it must be by the rights guaranteed to Pineland residents by the consent decree, is necessarily negative. The problems exposed are not easily susceptible of solution; they may be insoluble in the context of a custodial institution. But that is not to say that the State has done nothing toward complying with the order of the Court.

The State met its obligation to reduce the population of Pineland Center to 400 residents by July 14, 1979. The Bureau of Mental Retardation operates six regional offices and has established two resource centers. In the period of the first decree year, the State developed for members of the plaintiff-class 125 community residential placements and 156 day-program openings. (Seventy-three community clients who are members of the plaintiff-class were not enrolled in day programs at the close of the decree year.)

CLASS MEMBER RESIDENTIAL PLACEMENTS DEVELOPED July 1978 - July 1979

REGION	I	II	III	IV	V	VI	TOTAL STATE
Group Homes	12	4	19	0	14	0	49
Boarding Homes	0	4	8	0	0	15	27
Foster Homes	2	22	7	5	3	1	40
ICF Nursing Homes	0	7	2	0	0	0	9
Apartments	0	0	0	0	0	0	0
TOTALS	14	37	36	5	17	16	125

Note: Total statewide residential placements for all Bureau of Mental Retardation clients exceed 194.

NEW DAY PROGRAM SLOTS DEVELOPED FOR CLASS MEMBERS July 1978 - July 1979

REGION	I	II	III	IV	V	VI	TOTAL STATE
New program openings	20	33	46	8	22	27	156

The Commissioner of the Department of Human Services obtained a legislative appropriation to finance ten new intermediate care facilities for the mentally retarded and 72 new group home placements over the next two years. The State has recently opened a model group home in Freeport. A program center has been established as a part of the Freeport complex which will allow Pineland residents to attend a workshop away from the grounds of Pineland in a better setting in the community. Additional staff members for Pineland were authorized and actually hired in record time. The State has made honest and consistent efforts to enforce its policy of non-toleration of abuse and neglect of Pineland residents. Consultants have been brought in to work with Pineland staff, Bureau employees, and community residential and program personnel.

If one focuses on the lives of Pineland residents, the impact of these measures cannot be said to be great except in the case of persons who have been placed in authentic community homes. If one focuses, on the other hand, on the efforts required to achieve those gains -- including in every instance the personal intervention of the Director of the Bureau of Mental Retardation* -- those efforts have been monumental. They have required overcoming the resistance of Pineland Center. They have required eliciting the cooperation of a number of State agencies undisposed to cooperation. They have required vigorous efforts to oppose a few but

* Except the Human Services appropriation

important instances of resistance to allowing retarded citizens to live in Maine communities. They have required strength to withstand pressures from official representatives of Pineland employees. In this light, they merit the Court's praise.

THE ENVIRONMENT - INTRODUCTION

Defendants are enjoined to provide living facilities which afford residents privacy, dignity, comfort, and sanitation; they must develop and maintain a warm, home-like environment conducive to the habilitation of each resident. Presently, only the residents of Cumberland and Gray Halls can be considered to enjoy such living conditions.* In these buildings residents live in small "apartments," clusters of bedrooms, attractively furnished, opening into clean, visually appealing common areas. Common living areas are tastefully decorated and furnished in a normal fashion. They are suited to the types of recreation and entertainment usually enjoyed in a home setting. Each "apartment" is equipped with its own bathroom facilities and its own kitchenette. Other residential "units" do not provide a warm, home-like environment; they are not comfortable; they are not amenable to ensuring privacy or dignity; they are not always clean. These deficiencies are also characteristic of most of Pineland's major program areas.

Noise levels frequently exceed those customarily associated with living and working conditions. High noise levels deny residents effective program. Some decibel readings in Pineland buildings show that sustained exposure could cause permanent hearing loss. The problem stems from institutional architectural design and choice of building materials. Rugs, carpets, and suspended ceilings, which would contribute to normalcy and noise reduction, have not been provided in many areas.

After making the required allowances for the needs of physically handicapped residents, bathrooms should be designed, equipped, and supplied in the customary manner. They are institutional, communal bathrooms. Soap, towels, and toilet paper are often unavailable without the assistance of direct care staff. Alternative solutions to problems of misuse and destruction of these items by residents have not been attempted. Separate bathrooms for men and women are rarely found either in living or program areas.

Defendants are enjoined to keep residents' personal property and other recreational items accessible. Nevertheless, a significant number of residents must still depend upon staff for access to their money, their appliances, amusements, and clothing. Clothing and other personal property is often stored in a central locked location away from its owners.

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* Garrison House and Cottages I and II, small homes located just off Pineland's main grounds, also meet the principle of the decree. Another way to state the problem is to say that only two of Pineland's major residence halls provide plaintiffs with an approximation of the living arrangements they could expect to encounter outside the institution. The failure to provide normal living conditions affects other rights guaranteed by the decree. Residents are not systematically prepared to cope with conditions outside the institution. Their inability to negotiate a non-institutional environment becomes a rationale for keeping them at Pineland.

Defendants are required to provide each resident with at least three toys, games, or other recreational items of his own. These items are to be replaced as needed. Compliance is, at best, sketchy. Toys and games are usually to be found where residents live but are often locked away.* Usually, staff cannot identify any one particular recreational item as the property of a single resident. Replacement of lost, stolen, or broken items within a reasonable time is not common. Residents are not often involved in the selection of their clothing. Clothing is frequently lost or damaged and not replaced. No systematic effort is made to keep track of it. Residents are not taught proper maintenance of clothing. If a resident is hard on clothing, staff dress him in the poorest possible manner in order to minimize the loss.

As an institution, Pineland emphasizes the principle of cost-effectiveness when faced with the prospect of spending money to improve the residents' environment. Because residents, for a variety of reasons, may damage, lose, or misuse their own property and that of others, Pineland has kept such things away from them. Defendants are enjoined simultaneously to allow plaintiffs ready access to their possessions and to educate plaintiffs in the proper use and maintenance of them. Defendants have not provided many residents with either access or education.

While the decree requires defendants to provide plaintiffs with most of the decree benefits, defendants have often obtained such things for residents by invading residents' accounts. Plaintiffs have been required to purchase their own clothing, rugs, footlockers, extra bedspreads, padded chairs, and toys. Not only have residents with funds been required to finance compliance with the decree, but those without funds are often left to go without. On many "units" indigent residents have no footlockers or rugs; they are more poorly and uniformly dressed than their more fortunate peers.

The environmental provisions of Appendix A are not merely cosmetic. They are central to the overall purposes of the decree: to provide habilitation and normalcy to plaintiffs in the least restrictive setting possible; to demonstrate, for each resident, real progress toward the goal of independent community living. These objectives cannot be achieved unless Pineland acclimates residents to noninstitutional conditions, to a more normal style of life.

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* In one unit when the Master asked to see the residents' toys, games, and educational equipment, he was shown a cardboard box containing one Lincoln log, two or three tinker toys, three large plastic beads, and a few other similar items. At the same time a resident of the unit was amusing himself with a game he had invented using a cup and a paperclip.

In another unit one room is set aside for all toys and games. They are typically pre-school items of the Fisher-Price variety. The room is kept locked. In the course of a year's occasional visits to the unit, only once has a person been seen using the room.

PINELAND CENTER

Inter-Departmental Communication

TO: Dr. Burrow DATE: July 24, 1978

FROM: Cheryl Fortier, Resident Advocate

SUBJECT: Accident Reports

Of a recent batch of 21 reports I reviewed, 4 involved slipping in or around bathing areas: at PHH 2 by whirlpool, VH I in tub, KH 4 getting into shower, Bliss in tub. Several suggested non-skid materials to be put in and around bathing areas. I would like to pass along their suggestion. It would seem as though this would be a pretty easy change to accomplish. Is this something you can ask the maintenance department to do?

CF:pbt
cc - Joe Ferri
Julie Beggs

PINELAND [redacted] CENTER

Department of Administration

Office of Superintendent

TO: David Foss, Business Manager Date: October 6, 1978

FROM: Charlene Kinnelly, Acting Superintendent

SUBJECT: Attached Accident Reports

Attached please find copies of recent accident reports and please note particularly the additional comment by Cheryl Fortier. Apparently Dr. Burrow agreed to address the issue of making bath areas less slippery. I also note that the accident report regarding [redacted] indicates that bathmats have been ordered.

Would you please let me know whether this is, indeed, the case and, if so, what we might expect as the delivery date? If this is not the case, please let me know that also and I will talk with various staff involved to determine what action should be taken at this point.

Thanks very much for your cooperation.

CK/dbs

cc: Cheryl Fortier

9b

from "accident reports" file

From Cheryl Fraser

PLEASE RETURN THIS MESSAGE REPLY TO

To Joe Ferri

DATE 12/21/78

SUBJECT Bathing areas

Message

See attached copies for previous correspondence. Attached copy of accident report is example of many which are similar. According to Durwood Emery, nothing has been done to remedy the problem throughout the institution. He said he received a request for non-skid materials for one unit this week and that for supervisors to put in work orders for what they want is the appropriate way to go about getting non-skid materials installed. Would you please advise supervisors?

SIGNED

Reply

DATE

SIGNED

ORIGINATOR FOLD MARKS

ORIGINATOR-DETACH THIS PART-FORWARD BALANCE OF SET INTACT

From Cheryl Fortier

PLEASE RETURN THIS MESSAGE REPLY TO

To John Conrad

DATE 12/21/78

SUBJECT bathing areas

Message

For a long time I have been trying to get the institution to install non-skid materials around bathing areas. There are many accidents to residents due to the ~~lack~~ slipperiness in these areas. Durwood said supervisors should put in requests where necessary, but that supplies might be a problem. This is a big problem area! Would you please make sure supplies are quickly available for areas requesting them. CF

SIGNED

Reply

DATE

SIGNED

ORIGINATOR FOLD MARKS

ORIGINATOR-DETACH THIS PART-FORWARD BALANCE OF SET INTACT

THE ENVIRONMENT - FINDINGS

Finding: During the first decree year, Pineland failed to comply with the directive of sections B.1. and B.2. of Appendix A which require defendants to provide the residents with private, dignified, comfortable, and sanitary living conditions within six months of the signing of the decree. Non-compliance is continuing.

Discussion: The Business Office at Pineland conducted a unit-by-unit review of compliance with section B of Appendix A during the winter of 1978-1979. Many of the deficiencies which were, at that time, noted for corrective action are still unresolved according to the reports of direct care staff.* For example, adequate supplies of toilet paper, soap, towels, linen, and bedding, as required by section B.1.(c) are often lacking.

The quality of bathroom facilities has improved. All toilets have seats and nearly all toilet stalls have some type of visual barrier adequate to the purpose. About one-fourth of Pineland's residents must use bathrooms without doors or barriers. Section B.3.(f) requires that this privacy benefit be furnished to about three-fourths of the residents at the present time. Pineland is at the moment in compliance with this section. Bathtubs are often without screens in violation of section B.2. however.

As much as half the time soap is accessible to residents. Toilet paper is most usually found in bathrooms although often it is not accessible to residents in the manner customary to restrooms. For example, holders are installed purposely at such a height that they cannot be reached by residents, or toilet paper is stored in such a way that the average resident cannot figure out how to get it. Other, less restrictive, more normal solutions to the problems of residents' wasting and destroying toilet paper have not been adopted.

The residents' bathrooms are, as a rule, not filthy although they are not as clean as those to which most are accustomed. There are some occasionally striking exceptions. Bathrooms are usually accessible and have the specialized equipment required by section B.1.(a).

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*It should also be noted that there are some discrepancies between reports of unit staff and the reports of the various Pineland Departments which conducted the unit-by-unit reviews. For example, the Business Office reported no laundry problems at Bliss Hall. Yet, in June and again in late August, 1979, both units of Bliss Hall had serious laundry shortages that were as yet unresolved according to direct-care staff. The same was true regarding reports for Doris Sidwell and Pownal Halls.

Pineland's bathrooms for use by residents are not private enough for Pineland staff who will go out of their way to avoid using them. One is always subject to possible unannounced intrusion by members of the opposite sex, usually direct care staff.

Shortages of towels and linen continue to be problems for a substantial number of units. Other units, sometimes located in the same building, report no laundry shortages. Towel shortages are the most serious, and weekends are the most troublesome times. One supervisor, who takes pride in the increasingly normal environment afforded by his unit, was told by the Business Office that the solution to his chronic towel shortage was to keep towels locked up. Rigid Pineland laundry procedures apparently take insufficient account of unit differences. For example, on units where residents cannot feed themselves, towels must be used for bibs. These units have a greater need for towels than other units. Staff at one unit complained that towels were sometimes returned from the laundry smelling of human waste. The laundry washes towels and soiled bedding together. No other unit specifically complained of this odor although others did mention that the towels "smelled funny."

Mattresses appear to comply fully with section B.2. No beds were found smelling of urine on the morning shift after bedding had been removed or beds remade. Mattresses are new, firm, and washable.

The quantity and quality of service provided by Pineland's housekeepers have been subject to criticism by direct care workers and supervisors. The Office of the Special Master has observed that some units and program areas are routinely kept very clean and others are often filthy. Staff at New Gloucester Learning Co-op complain of continual filth and stench. They would clean the building themselves in sheer frustration, but all cleaning materials and equipment have been removed from their program area. Direct care staff report that they often must chose between leaving the residents exposed to filth and cleaning the units themselves in violation of section C.2. of Appendix A which states that unit staff are not to perform routine housekeeping chores during residents' waking hours.* To make matters worse, they are sometimes hampered in the battle to keep their unit tidy by shortages of cleaning supplies which they must order periodically from a central source. Supplies which they do receive are sometimes poor-quality substitutes for the supplies they originally ordered.

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* The purpose of this proscription is to permit direct care aides to fulfill their principal function as teachers. Some aides must still perform routine housekeeping chores. Other aides, who have been relieved of housekeeping duties, refuse to become teachers on the theory that that function is outside their job description or just out of laziness. As one aide put it, "All you're really required to do is maintenance."

Housekeepers report that some units are, by physical design, easier to keep clean than others. Since residents are often grouped together by developmental level for housing purposes, the natural consequence is that some units are more likely to be beset by toileting accidents, aggressive destruction, and, in general, a lack of attention by residents to the appearance and condition of their surroundings. Residents on some units are prevented by physical handicaps from attending to any of their basic needs and cannot, therefore, contribute to the upkeep of their surroundings. Supervisors on units which consistently violate sections B.1. and B.7.* agree that a solution would be to assign housekeepers to these areas on a full-time basis.

Finding: Pineland has nearly complied with section B.1.(d) which requires defendants to furnish residents with "individual . . . dresser or other storage space."

Discussion: The unit-by-unit compliance reports, earlier referred to in this section of the Report of the Special Master state that at least four units failed, during the first decree year, to offer this benefit. Only one residence unit now fails to provide residents individual dressers. However, a substantial number of residents on several units are without any closet or other form of storage space for clothing and personal possessions.

The Business Office also noted a substantial lack of the "attractive and normalizing furnishings" required by section B.1.(f) when it rated the units for compliance with the decree items on physical environment. Many units still lacked such furnishings at the end of the first decree year, six months after the deadline for compliance. Some of the units continue to present a drab, cheerless, institutional visage, although all units have improved and most have improved dramatically in this respect. There is a tremendous variance among units in the extent to which they provide a warm, homelike setting with appropriate furnishings and decorations. Most living areas now have the type of wall decorations contemplated by B.2., but compliance is not yet adequate. Sleeping areas are not as attractive and well-decorated as living areas in some units. On a few units, sleeping areas are afflicted with a relentless uniformity of barren walls and floors; nothing distinguishes one resident's room from that of another save a name tag over the doorway. Residents are not often encouraged to decorate their living and bedroom areas as required by section B.6. Decorations are usually the result of the effort, initiative, and creativity of staff alone.

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* "B.7. Every building shall be kept clean, odorless and insect free, and sufficient equipment shall be provided to housekeeping staff for this purpose. In particular, lavatory areas are to be cleaned as often as necessary every day, and bathtubs shall be cleaned after the bath of each resident. The smell of harsh disinfectants shall be eliminated."

Most windows in sleeping and living areas now have the curtains required by sections B.5. and B.1. Staff make an effort to repair and replace curtains damaged by residents, but a few units are totally devoid of curtains. On the whole, compliance with this feature of section B.5. has been very good, if not complete.

Not all units have sufficient padded chairs as contemplated by section B.2. Some such chairs have been purchased from funds obtained from the residents' accounts, a questionable practice in view of the requirement that "padded chairs shall be provided." *

Many sleeping and living areas are without rugs or carpets of any sort. Floors are, almost without exception, tile, terrazzo, or similar institutional, non-resilient surfaces. Such flooring is accoustically undesirable and cold to the touch in winter. It is not normal. Carpeting, large area rugs, and small scatter rugs are clearly indicated by sections B.1.(e),(f),(g), and Q.4. Scatter rugs have been purchased for most of the residents who have the money to pay for them.

Very few of the residence halls have any kind of lamp in either living or sleeping areas. One unfortunate result of this widespread non-compliance is that living and sleeping areas of the same unit must be simultaneously either brightly lit or totally dark. Thus, some residents of a unit cannot go to bed while others stay up, a choice most of us take for granted. Another result is that residents are not afforded the opportunity to learn that environmental lighting may be more precisely controlled according to individual preference, time of day, and task at hand. In general, there has been no attempt to comply with this feature of section B.2. and no solutions to the likely problem of breakage have been implemented.**

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*As the memoranda of following pages illustrate, invading residents' accounts to purchase things required by the decree apparently has become a widespread practice at Pineland. Clothing, footlockers, bedspreads, and adaptive equipment are bought with resident's funds. Those without financial resources are, in most cases, still waiting for their rugs and other such items well after the end of the first year. They should have been provided to all residents within six months after the decree was signed.

**It should be noted that one unit supervisor has, on his own initiative, undertaken to locate a type of lamp which would resist accidental breakage and even outright aggression, at least to the point of preventing injury. This type of creativity should be encouraged; however, it should also be the primary responsibility of administrative personnel.

For example, some residence supervisors explained that rugs had not been ordered for their units because residents would urinate on them, or because scatter rugs may slip causing unsteady residents to fall, or because wheelchairs could not negotiate carpets. Instead of merely failing to order such items, supervisors should be reporting to administrative personnel who could then seek common solutions to the need for furnishings: are there small, washable area rugs available? can scatter rugs be backed with non-skid material, etc.?

PINELAND CENTER

Inter-Departmental Communication

TO: David Foss DATE: March 27, 1979

FROM: Joseph Witt, Acting Resident Advocate

SUBJECT: [redacted]

As Acting Resident Advocate I have received your memo to Cheryl Fortier written 3/19/79 in which you state that $100 of the total bills for purchase and repair of R[redacted]'s helmet and face mask will be paid by Pineland. This appears to leave about $85 for R[redacted] to pay up to that point.

First let me say that I appreciate your action to, as you noted, attempt to lessen some of the drain on his account. I appreciate your efforts in this area.

However, a major problem still exists. R[redacted] continues to be violently self-abusive and in need of the helmet for protection of himself and the face mask primarily for the protection of other residents and staff due to occasional but dangerous biting. Unfortunately from both a financial and humanitarian point of view, he also continues to dislike and damage the helmet so that it is not available for his protection most of the time.

Until such time as medical and/or psychological intervention can alter R[redacted]'s behavior significantly, I feel Pineland has an obligation to protect both R[redacted] and others from harm. At this point it seems that such protection requires that he have a helmet and face mask available and in good repair at all times. It is obvious that to accomplish this at least one additional helmet and a streamlined repair mechanism is needed. Estimates from building staff as to the number of helmets needed range as high as seven. However, the speed of the repair service enters into that estimate, I assume.

It is my feeling that Pineland should be responsible for the purchase and repair of whatever number of helmets is needed for adequate protection. I base that on the fact that it is Pineland who has the responsibility for protecting R[redacted] and others and it is Pineland who must impose the wearing of the helmet on R[redacted] who is an unwilling participant. It seems unfair to also use his personal money for this project especially when he cannot connect the action of damaging the helmet with the concept of a reduction in funds and thereby learn from his mistakes.

I will anxiously await your reply on the two points of purchasing extra helmets and payment by Pineland.

JW:pbt
cc - John Conrad
Charlene Kinnelly
Rose Ricker
Jean Ross
C. M. Macgowan

David W. Foss, Business Manager I

John C. Conrad, April 19, 1979
Institutional Business Manager

I have reviewed with Charlene Kinnelly, the circumstances around which R[redacted]'s personal funds were used for the purchase and repair of his face mask. It is my understanding that R[redacted]'s personal funds have been used for a portion of the total expense.

In that the funds did not drop below $100.00 as a result of these charges, Charlene and I see no reason to alter the decision to use the resident's personal funds. It is felt that the mask is to R[redacted]'s personal benefit and personal safety and is an aid to his functioning in a "normal" environment much the same way as resident funds are used to purchase wheelchairs.

cc: C. Fortier
C. Kinnelly

/nbh

PINELAND CENTER

Inter-Departmental Communication

TO: Cheryl Fortier DATE: May 2, 1979

FROM: David Foss

SUBJECT: [redacted]

In a recent review of R[redacted]'s status as a self-abusive patient I have been advised by John Conrad that no change in treatment of R[redacted]'s financial situtation is warranted.

What this means in terms of Joseph Witt (and your own concern) for his (R[redacted]'s) ability to withstand the financial drain is this: any expenditure for face guard and helmet which would lower his funds below $100 will be born by the State.

At present 2 invoices, one for $100 and one for $75 are up for payment at our accounts payable desk. This would wipe out any and all of R[redacted]'s funds should we draw on them. As you and I briefly discussed any other purchase of personal items might keep R[redacted]'s funds balance down below $100 and thus the State would be compelled to underwrite the payment of one or more helmets as the need is determined to be. However, the benefit is still largely received by the resident himself even though as you suggest some unmet needs do persist.

This has resulted in no change in the decision to use R[redacted]s personal funds for purchase of self-protective equipment.

DF/csm

cc: John Conrad
Joseph Witt
Resident Accounts

residents' claims file

PINELAND CENTER

Inter-Departmental Communication

TO: John Conrad DATE: November 27, 1978

FROM: Cheryl Fortier, Resident Advocate CF

SUBJECT: Resident Claims

On October 31st I asked you to let me know what is happening with resident claims some of which were made in June and have not yet had a response. You have told me resident claims are difficult to process because there is no one to answer questions. I am not aware of any attempt on your part to get answers to questions. This resident claims form was showed to us about a half a year ago and to date one claim has been honored from many presented to you. I would like a response in writing by December 15, 1978.

On a unit like DAH I we have a basic problem for which the claim form is the only solution I know. A few residents rip clothes. There is no known way to completely stop them from ripping clothes. This morning none of the residents had shirts to wear to their program. This clothes shortage probably results from the extended period of time it has taken to handle the claims. The social worker has asked you via the claims form to replace the damaged clothes. Because no action has been taken, she is being forced to make the residents replace the damaged goods themselves. In many cases bills for $300 - $400 will be sent out for guardian's approval. Many of these guardians will be very upset because they may recently have been billed for similar large amounts. I am advising the social worker to refer concerned parents to you or me.

Meanwhile, I suggest, a much more responsible approach is to resupply these residents with clothes even if they have to come from the State store. That way the residents would not have to pay for the damage done by their co-residents.

CF:pbt
cc - Charlene Kinnelly
Dick Bogh
Skip MacGowan
Harriet Rogers
Attorney General's Office

Claims file

STATE OF MAINE

Inter-Departmental Memorandum

Date 26 December 1978

To Charlene Kinnelly, Act. Supt. Dept. Pineland Center

From Richard F. Howard, Assistant Dept. Attorney General

Subject Resident Claims

Pineland is clearly liable for replacement of personal items of residents destroyed by another incompetent resident. Since Pineland is also responsible for keeping residents clothed and in programming, there is clearly a need to develop a system for prompt replacement of damaged clothing, at least on a temporary basis. The costs undoubtedly may be high, which may suggest it would be cost effective to spend more programming and supervising the Doris Anderson rippers.

I see no legitimate basis for billing the families of the victims for replacement clothing, and I am sure you will agree missing programs for lack of clothing is serious. I hope some accommodation can be reached soon.

Richard F. Howard
Assistant Attorney General

RFH/vv

CC: John Conrad
Cheryl Fortier
Kevin Concannon

PINELAND CENTER

Inter-Departmental Communication

TO: John Conrad, Business Manager DATE: April 3, 1979

FROM: Joe Witt, Acting Resident Advocate JW

SUBJECT: Replacement of resident clothing, e.g. M[redacted]

As you know a claim for replacement of lost clothes belonging to M[redacted] submitted by building staff was recently denied. You will be reconsidering that claim in light of new information. Therefore, my comments here are general ones using this incident as an example.

While I recognize the need for Pineland to protect itself from fraudulent or frivilous claims and while I recognize the need for orderly and appropriate procedures to be followed in submitting claims, I have great difficulty with what appears to be present policy as exemplified in M[redacted]'s recent case. In this case the claim was denied because it had been submitted several months after the date the clothes were alledgedly lost, thus making it impossible to accurately determine the exact cause and, possibly, extent of the loss.

Please note that it was Pineland staff who failed to report the loss to the appropriate Pineland agency (i.e. business office), but it is M[redacted] who must suffer the loss, alledgedly at the hands of another section of Pineland (the laundry). All the responsibility in this matter rests with various Pineland employees and I submit that the institution as a whole should not and cannot relinquish any of its responsibilities to its residents due to the failure of some Pineland components to meet their share of that responsibility.

The current policy as exemplified here places the residents in another catch 22 situation. I suggest that some method be found that will insure that employees pass along claims properly but will not bring an adverse consequence to a resident due to the action or inaction of an employee.

JW:pbt
cc - Charlene Kinnelly
C. M. Macgowan
Cheryl Fortier ✓

pay claims file

PINELAND CENTER

Inter-Departmental Communication

TO: Charlene Kinnelly, Acting Superintendent DATE: April 4, 1979

FROM: Cheryl Fortier, CF Resident Advocate

SUBJECT: Attached unpaid claims

Enclosed are two notes received from Dave Foss which are basically uncomprehensible to me and I would appreciate comment from you. In the instances of both these claims, staff of Pineland Center admitted to being in charge of the funds of these two residents. These residents have been led to expect that they are to turn over their funds to staff members for safe keeping when not using the money. Both instances of loss were reported by staff to the Director of Residential Services. Claims were filed by me as soon as I became aware of the situation. One of these residents worked long hours each week to earn her small amount of money and the other lost a substantial amount. Doesn't it seem more than a little unfair to expect these residents to bear the loss of money which had been turned over to the staff for safe keeping because those staff also did not properly document the amount lost?

If more documentation needs to be submitted, why did the Business Office wait the good part of a year to respond? Why didn't they find out who was responsible for gathering the documentation and have it done? Is Pineland Center so callous to the needs of individual residents that this is what they can expect from an honestly submitted claim?

Pineland Center should pay these claims in full immediately. Documentation could probably be put together at this point in time if you want to do it but it would be more difficult because it happened so long ago. It is imposing an undue hardship on these individuals to make them wait any longer for repayment on their claims.

If I do not receive notification of full payment on these claims by April 9th, 1979, I will be forced to bring this matter to the attention of the Consumer Advisory Board at their April 10th, 1979 meeting.

CF:pbt
cc - Skip Macgowan
Joe Witt ✓
Dave Foss

re: claims file

PINELAND CENTER

Inter-Departmental Communication

TO: Cheryl Fortier Resident Advocate

FROM: David Foss Date March 23, 1979

Business Office

SUBJECT: Claim made on behalf of M[redacted]

Your claim for reimbursement of money un-accounted for dated June 9, 1978 is denied. In order for us to honor M[redacted]'s loss we would need documentation showing the presence of funds as described. This has not been established due to lack of record keeping.

DWF/csm

F-19

PINELAND CENTER

Inter-Departmental Communication

TO: Cheryl Fortier

FROM: David Foss Date 3/30/79

SUBJECT: Claim made on behalf of L[redacted] - Money

Your claim for reimbursement of L[redacted] for money taken from Garrison House dated 5/31/78 has been denied In order to honor this claim more documentation would have to be shown. The exact amount of money is not known . and the time frame of 6 days does not allow sufficient verification.

DWF:clv

F-19

All furnishings and decorations covered by sections B.1. and B.2. were to have been provided at the latest by January of 1979. Non-compliance is substantial and, at the present time, continuing.

Some units also lacked the leisure equipment and noise reduction materials required by sections B.1.(f) and B.6. six months after the signing of the decree. These deficiencies have not all been corrected, and non-compliance continues. In fact, a compliance report submitted by the Acting Superintendent noted that nearly half of all residence units continue to exceed acceptable noise levels as determined by the Pineland Communications Department. The fact that acceptable noise levels are frequently exceeded in the major program areas as well as in the residents' living areas has obvious implications for the efficacy of habilitative programs which may require attention and concentration by the participants, many of whom are easily distracted by competing stimuli. Bringing together for educational purposes large numbers of persons who have never before been educated is necessarily going to produce a lot of noise. The noise will interfere with the education. The solution in the institutional context is not readily apparent.

Doris Anderson Hall I, a residence unit, clearly violates the provision of section B.5. which states, "Each resident shall have access to his bedroom except during programming." The 25 residents of this unit are routinely locked out of their bedrooms during waking hours.*

Finding: Some units are not in compliance with section B.1.(g) which requires living facilities to maintain "normal temperature and adequate ventilation."

Discussion: Compliance reports indicate that six residence units are without normal temperature control or ventilation. On May 14, 1979, the Residents' Advocate notified the Business Office that three multi-unit buildings, all housing nonambulatory residents or constituting locked wards, were without any cooling system. She reported, "The residents do not have the physical ability to get up and walk outside.

*In fact, Doris Anderson I violates many of the provisions of Section B for all of its residents. It is drab, cheerless, undecorated, poorly furnished. Residents have no access to their clothing and possessions. Most have no toys, games, or recreational items of their own; they live behind locked doors. It provides, in the words of one Pineland observer, "Kennel-type" housing.

There are few windows that open in these buildings. My understanding is that they were designed originally for air conditioning. These buildings retain heat in the summer like an oven. Without a cooling system, the temperature inside rises way above the temperature outside. . . To allow such conditions to continue under a court order requiring humane care is a paradox."

Finding: Pineland fails to comply with Sections Q.3. and B.7. which, respectively, provide: "Outside windows shall be provided with screens. Doors shall be provided with screens except where their installation would create a violation of fire safety standards." "Every building shall be kept . . . insect free. . ."

Discussion: Windows often have screens. Doors rarely do, and they are very often propped wide open in the summer. Trash is left to accumulate.

Finding: Pineland fails to comply with Section Q.5. which states, "Defendants shall establish and maintain a program of adequate maintenance of buildings and equipment which shall include prompt elimination of existing maintenance backlogs."

Discussion: Maintenance backlogs are probably worse now than at the signing of the decree. Maintenance efforts are focused on ICF units* so that federal money will not be lost. Other units and program areas make repeated requests for repairs and construction of equipment needed to comply with Appendix A. These requests are met only after several months, if at all.

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* "ICF" is a designation of federal law which stands for intermediate care facility. All of Pineland could be designated as an intermediate care facility for the mentally retarded, and the effect would be to bring into the State millions of dollars of federal aid to help improve the lot of the retarded. No one knows why Pineland has not been designated as an ICF-MR before. The State is now in the process of doing so but is applying to Pineland federal regulations which are two years out of date. State regulators are requiring physical changes, some of them costly, where they are not needed and without regard to whether the changes increase the institutional character of Pineland's environment. In order to work toward the goal of creating an environment which approaches normalcy (which is a difficult task when beginning with an institution), Pineland is in the ironical position of battling State regulators who demand changes which promote an institutional environment in order to qualify for federal aid which could be used to make Pineland's institutional environment somewhat more normal.

Finding: Pineland nearly complies with the combined requirements of B.3.(a) and (f) that at least 290 residents share bedroom space with no more than two other residents.

Discussion: In late August, 1979, at least 145 residents were sleeping in areas which did not comply with this aspect of section B.3.(a).

Finding: Pineland fails to comply with the requirement of section B.3.(d) that no more than 10% of residents shall have bedrooms without doors.

Discussion: Fully one-third of all residence units fail to comply with this simple mandate even after the first decree year. Since other portions of section B.3. specify that residents shall have bedrooms, as opposed to other institutional, less normal living arrangements, the fact that some residents are without bedrooms cannot constitute a valid excuse for noncompliance with B.3.(d)(2).

Finding: Pineland failed to comply with the requirement of section B.3.(f) that the benefits of section B.3. be furnished to 230 residents within six months and to 290 residents by May 1, 1979. Noncompliance is continuing.

Discussion: Only Staples and Vosburgh Halls are exempt from the requirement of section B.3. that permanent walls shall be put in place to create bedrooms for residents on those units where, prior to the decree, there had been only open-ward sleeping arrangements. Under section B.3.(f) this benefit is now owing to 290 residents. 152 residents now have sleeping areas which do not comply with the B.3.(c) concept of a permanently constructed bedroom. Until the very recent abandonment of Kupelian Hall II and IV for renovations, well after the end of the first decree year, this figure was even higher. 152 subtracted from the present, approximate Pineland census of 390 yields a figure substantially below the 290 mark required for compliance.

Finding: During the first decree year Pineland also failed to comply with the provisions of section B.10. of Appendix A.

Discussion: B.10. declares that "toys, games and other recreational or learning equipment of good quality" shall be made readily accessible to residents on their living units. A compilation of unit-by-unit compliance with this section presented by the Acting Superintendent showed only one unit to be out of compliance. On the other hand, unit supervisors, some reporting to the Special Master's Office as late as August of 1979, well after the close of the first decree year, have indicated that at least five units are without sufficient recreational equipment.

In addition, section B.10. provides that each resident be furnished with at least three toys, games, or recreational items, as his own, and that these items be replaced within a reasonable time to compensate for breakage, theft and loss. While neither the compliance reports nor the reports of unit supervisors indicate a significant shortage of these items, it is not at all clear that these things are being provided or that they are "readily accessible" to the residents in the same sense that ordinary individuals have access to their personal possessions. On some units residents may obtain the use of their personal property only with the assistance of direct care staff because all such items are kept under lock and key in a central location. To replace these things in the storage areas one likewise needs a key. Residents are not given keys, nor are they instructed in the use of keys as a routine matter. Access to their personal possessions, therefore, depends upon the assistance of direct care staff who may or may not be available.*

The decree does not contemplate the central locking away of personal possessions from residents in order to prevent theft, loss, and breakage. Section B.5. requires that each resident be afforded adequate individual storage space. This space could be fitted with a lock which the resident could be taught to operate. Breakage and loss could be minimized by proper instruction in the use of personal possessions. In fact, the decree envisions such instructions as a matter of course as is evident in sections C.1.(e),(f), and (h) which describe the role of direct care staff vis-a-vis the rights of residents. Defendants justify their failure to provide ready access to recreational equipment on the ground that it may be lost, broken or stolen. The decree says, "An adequate budget for such equipment and materials shall be maintained so that items which are lost, broken or stolen can be replaced within a reasonable time."

Finding: Telephone service at Pineland does not comply with section B.11. of Appendix A which provides in part, "A phone providing privacy to a resident shall be accessible in each resident building . . ."

Discussion: Phones available to residents are not private. Nearly all phones in residence buildings are located in an office for staff. One resident said she was spanked by unit staff for trying to call a relative. The resident's advocate stated that the relative was becoming annoyed at the resident's frequent calls. The resident would seem to be a candidate for instruction in proper use of a telephone. Spanking her suggests that her calls were not private. All out-going and in-coming off-campus phone calls are routed through a central switchboard which is sometimes unattended. When no one is at the switchboard, Pineland is cut off from the outside world. When, as happens, the phones cease to work at all, intra-campus communication is impossible.

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* Sec. C.1.(e), App. A makes it the responsibility of direct care staff to "protect and uphold each resident's rights to keep and enjoy personal possessions. . ."

Finding: Defendants have not made "[A] concerted effort . . . to provide residents affected by renovation or temporary placement in a residence with accommodations meeting the requirements of [the environmental] section" of the decree.

Discussion: Entire residence units have been relocated from one building to another in order that renovations and improvements be made. These moves have placed some plaintiffs into less home-like, dignified, comfortable and normal living facilities than they previously enjoyed. In some cases these moves have resulted in more, not less, restrictions for residents.* Moves were made for administrative convenience only and in circumvention of the individual planning process. Pineland has made no interim improvement in the living environment for persons who are required to live in a building which Pineland plans to abandon. The children who are still assigned to Pownal Hall know nothing of the guarantee of a home-like environment. Pownal Hall violates virtually every environmental provision of the decree.

Finding: Even after the end of the first decree year, direct care staff continue to perform routine housekeeping chores during the residents' waking hours in violation of section C.2., Appendix A.

Discussion: At the end of the first decree year, at least fourteen unit supervisors reported that direct care staff were doing housekeeping chores when the residents were not sleeping. This report represented almost no change from conditions noted in the compliance reports prepared some six months earlier. In addition to the question of who is to perform housekeeping chores, there is the issue of how well such tasks are done. Unit supervisors report a wide range of housekeeping quality. While some units ordinarily meet commonly acceptable standards of cleanliness, others are in frequent violation of section B.7., which includes the simple directive that, "Every building shall be kept clean . . ."

Finding: Defendants frequently violate the requirement of section F.1., Appendix A, that, "To the extent possible, residents shall be taught to eat in leisurely family style . . ."

Discussion: Meals may be rushed for a variety of reasons. The residents may be scheduled for an off-campus trip or some other recreational event which requires that they be ready at a certain time. Direct care

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* Some residents have been moved out of ICF-designated units, disentitling them to a small federal monthly income. They have thus lost things and activities which Pineland requires residents to purchase but which the decree requires the State to provide.

staff may be short-handed or simply less than conscientious at meal times.

Finding: Defendants do not provide direct care staff with training in proper feeding techniques, as required by section F.1.

Discussion: When direct care staff are hired, they are given a very brief orientation to the institution. They are instructed on the use of the Pineland Program Guide* which does contain information on on feeding techniques. However, this section of the decree is very specific. The skill with which a resident eats his meals is important both to normal life and to his preparation for community living, one of the prime rights guaranteed by the decree. Unit staff have almost exclusive responsibility for improving the residents' eating skills. The decree, therefore, contemplates that unit staff be given special training in teaching people, for the first time, how to eat normally. This training is not being provided to the staff, and the staff, in turn, are not teaching residents acceptable eating skills.

Finding: Pineland fails to comply with section F.9. which states that, "All residents will be provided training at a level appropriate to the resident's functional abilities in the purchase, preparation and eating of food."

Discussion: Very few residents are ever provided training in the purchase of food. Training in the preparation of food is provided rarely, if at all. In buildings which have kitchens the kitchen facilities are usually kept under lock and key. Residents have no ready access to the appliances and culinary equipment which most of us take for granted in our daily lives, and they are not taught how to use a kitchen and its equipment. It is simply easier to deny residents access to potentially hazardous tools than to afford them proper instruction in safe usage.**

Finding: It is the intent of section F, Appendix A, that the residents be furnished meals in the most normal fashion possible. The use of

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* Barely minutes are spent in initial staff orientation on how to use the Pineland Program Guide. As to the Program,"see page 117, et. seg."

** The managers at Pineland wanted to continue this practice of excluding residents from the kitchen when they planned a group home in Freeport. Their assumption that a retarded individual cannot learn to function in a kitchen is contrary to the decree, underestimates the capacity of retarded individuals, would, in this case, have cost considerable money (to enclose a kitchen area with walls), and is now being proven to have been false in fact in the Freeport group home.

Alladin food trays violates this section of the decree.

Discussion: Alladin air-void trays are used in an attempt to keep food warm in transit from the central kitchen to the dining rooms of some residence halls. There is dispute about their efficacy. However, there is no dispute as to the abnormal, institutional quality of using trays instead of plates. Pineland is currently considering alternatives to the Alladin tray method. Meanwhile, a violation of the decree which three times daily touches the lives of many Pineland residents continues.

Finding: Pineland does not comply with section F.10., Appendix A. Non-compliance results from failure to meet several of the various directives of this section:

> Residents shall be provided with clean, adequate and seasonably appropriate clothing which is comparable in style and quality with clothing worn by persons of similar age and sex in the community.

Discussion: This section supposes that such clothing shall be provided for residents, not merely obtained for residents with some small means from their own funds to pay for the clothing. Far too often, the quantity and quality of a resident's clothing depends upon his ability to pay. If a resident has sufficient funds in his Pineland account, direct care staff submit an F-8 form to the Business Office to obtain money to purchase clothes for the resident. If the resident has no funds, staff must take the resident to "The Store" after submitting Form F-13. At "The Store" the resident is fitted with clothing, but there is no variety from which to choose. Clothing is purchased in large lots of one color and style. Purchase lots are often so large that they are not used up in one year, and residents are then fitted with styles from years past. This process also contributes to non-compliance with that portion of section F.10. which requires that each resident be involved in the selection of his clothing. Unit staff frequently complain that the procedures used by the Business Office to get funds from residents' accounts for such purchases result in lengthy and unnecessary delays. In its unit-by-unit compliance reports the Business Office took notice of these complaints. Six months later, the problems have yet to be resolved.

> Each resident shall also be provided with sufficient clothing for rainy weather, snow and extreme cold.

Discussion: Some supervisors still complain that the residents of their units are without rain gear at the beginning of the second decree year. The importance of seasonal and foul-weather clothing in the overall scheme of the decree cannot be too strongly emphasized. Habilitative programs are intended to be provided away from the residence halls where the participants live. Inhospitable weather is sometimes given as a reason for whole groups of residents being unable to attend programs.

Pineland in effect excuses its failure to provide programming on the basis of its failure to provide clothing required to get to a program center. Pineland can ill-afford to allow any such impediment to programming to go unresolved in view of its poor record of compliance to date with the program sections of the decree.

> Every resident will be provided with an adequate supply of undergarments such that he will have clean underclothing of his own.

Discussion: It is not at all clear that this requirement is being met on a regular, routine basis. On a recent visit to Kupelian Hall it was noticed that none of the residents were wearing belts. This phenomenon was also observed by the Residents' Advocate some time earlier and was the subject of a memo by her to the appropriate department. Apparently, no corrective action was deemed necessary. The result, of course, is that the resident's pants frequently slip down, often to the thighs, before unit staff can assist the individual. At the time of the last visit to Kupelian Hall it was apparent that the residents were wearing neither belts nor undershorts. On a recent visit to Doris Anderson Hall the Special Master was told that twenty of twenty-four residents present were not wearing underpants.

> Each resident shall be provided specific habilitative services to teach the proper use and maintenance of clothing.

Discussion: This training is simply not done in any systematic way. In fact, if it is done at all, it is done infrequently. The infrequency of instruction probably results from the fact that such instruction is left entirely to direct care staff, who, pressed for time, find it easier to do something for a resident than to implement a consistent, daily program of teaching the resident to do it independently. The direct care staff are, themselves, not taught how to teach the residents. Again, referring to the example of Kupelian Hall's beltless residents, it is easier for staff simply to pull up a resident's pants whenever they slip down than to painstakingly, incrementally instruct each resident in the proper use of a belt. When a unit is under-staffed, and Kupelian Hall sometimes is, shortcuts become more than convenient for direct care workers; they become necessary. Nevertheless, they deny residents the rights guaranteed them by federal law.

> Unless contraindicated by a resident's PPP, each resident shall be involved in the selection of his clothing and shall have ready access to it.

Discussion: Residents are not often involved in the selection of their clothing. Certainly, personal involvement may be expected to vary depending upon such factors as the resident's developmental level. It is clear, however, that residents do not have ready access to their clothing on all units. As of late August, 1979, at least 94 residents had no access to their own clothing. Even on units where residents have been furnished dressers or other individual storage space, it is not uncommon to find the drawers empty and the clothing stored in a central,

locked location. (Doris Anderson Hall is one example.) Reasons usually given are that if clothing were not locked up or otherwise made inaccessible, it would be stolen, torn or lost. If all residents were being taught the proper use and maintenance of clothing, these reasons would disappear. Residents would have all the clothing they need so theft would diminish. Residents properly instructed in the use and maintenance of clothing would be less likely to lose or destroy it. Aides are not taught how to teach residents the proper use of their clothing; and the Business Office fails to provide sufficient replacements for clothing that is misused. The processes of an institution thus require the lock and key. The lock is a substitute for education.

Finding: Pineland fails to comply with section F.12., Appendix A, which reads, "There shall be sufficient number of qualified personnel to fulfill the objectives of this section."

Discussion: Again, it is fair to emphasize that defendants do not achieve automatic compliance with all decree requirements for staffing merely by meeting the minimum staff-to-resident ratios specified in sections C.5., C.6., and C.7. As Pineland has moved closer to compliance with the minimum direct care staff ratios, it has become apparent that, even where these ratios have been met, there are not sufficient unit staff to provide all the residents of a unit with proper instruction in the preparation of food, the use and maintenance of clothing, normal living skills, and hygiene practices, as well as the benefits contemplated by section C.1., Appendix A. Not only is the number of unit-staff present and on-duty often inadequate, but those present have not been given sufficient orientation and training to deliver these services. Section F.12. recognizes the need for such preparation by its use of the words "qualified personnel." Pineland very seldom provides direct care staff with more than the minimum, decree-mandated orientation including cursory instruction in use of the Pineland Program Guide. In-service training presentations, while often open to direct care staff, do not constitute an adequate substitute because attendance at such seminars requires that direct care staff neglect other duties. Residents are likely to be denied some of the benefits of the decree while direct care staff learn how to provide other benefits.

PROGRAMMING - INTRODUCTION

The problems pertaining to Pineland's environment are essentially problems of cost; all environmental standards can be met, as well sooner as later by simply paying the price. The problems of programming are more than matters of money; they are problems of personnel: what Pineland employees do; how well they do it; how well they are trained; how well they are organized; whether they are supported properly. Many residents who could benefit from sustained, careful training in skills of ordinary daily living are not receiving it. Aides are not now well trained to provide it. Nevertheless, Pineland residents have a right to receive it. Institutional life inhibits careful training.

In the morning direct care staff are hurried. Residents are rushed through breakfast and tasks of daily living are performed for them. Residents are bathed, dressed, and groomed but are not taught how to do these things for themselves. Severely retarded persons do not learn easily or quickly. When a task is simply performed for them, they acquire no skills and are no closer to normalcy and self-dependence.

Pineland has convened interdisciplinary teams which have prepared individual plans for all Pineland residents. Pineland has established some program areas outside residential units and has scheduled some attendance at program centers for most Pineland residents. Daily living skills are sometimes taught in residential buildings. Trips away from Pineland are being increased. But programming at Pineland, which defines Pineland's only sustainable mission, bears little resemblance to the prescriptions of the Court's decree.

The method of addressing a resident's habilitative needs is termed "programming." The term includes any activity specified in a resident's prescriptive program plan that is individually designed and structured to increase the resident's physical, social, emotional or intellectual growth and development. The plan should include a clear explanation of the daily program needs of the resident for the guidance of those responsible for daily care. The recommendations of the prescriptive program plan must be the least restrictive means suited to addressing the resident's needs. Unless a physician certifies in writing that an activity would be medically harmful to the resident, the interdisciplinary team responsible for writing a plan must recommend that at least six hours per weekday of formal, scheduled programming be provided. Recommended programming must be provided within thirty days of the IDT meeting, or, if it is not available within thirty days, Pineland must implement an interim program and submit a plan and time schedule for developing a suitable program or documentation demonstrating that the program is not required by professionally accepted standards of care. IDT recommendations are to be based upon the team's assessment of the resident's actual needs rather than upon what services are currently available at Pineland.

Program coordinators are the interdisciplinary team leaders. They are the key personnel for ensuring that residents are taught and taught well whatever they may be presently capable of learning. Qualified program coordinators have simply not been hired in even the minimum numbers prescribed. Interdisciplinary teams are inescapably bound to such program and other opportunities as Pineland presently offers. Accordingly, they address only in the most limited, hesitant, and fitful fashion the actual needs of Pineland residents.* Interdisciplinary teams frequently recommend fewer than six daily hours of formal program without a medical excuse and without considering methods of providing a minimum program other than simply assigning a person to an existing program center. Interdisciplinary team reports do not set forth individually tailored educational plans; they do not contain clear explanations of a resident's daily program for the guidance of persons responsible for his daily care. They do not contain short-range and long-range objectives with timetables for measuring progress toward their attainment. They do not attempt to match individual needs, which are inadequately assessed, with individualized programs, which are, frankly, unavailable.

The quality of team meetings varies even within the above limiting norms. Important members of the team may not show up at team meetings, or they may come with nothing to report. Sometimes a professional discipline is represented by a person who is unfamiliar with the resident. He may present the report of an absent professional but be unable to answer questions posed by other team members about the resident. Reports are sometimes patently inadequate. Psychologists may present results of tests which they have not personally administered.**

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*There has been firm and continued resistance to the requirement that the PPP address the actual needs of each resident. Recommendations for program have been routinely limited to the range of services currently available. Even when an IDT has recommended unavailable programming, Pineland has never made any attempt to comply with the requirement that it submit to the Master for approval a plan for developing the program. In such a case, the resident is placed in the interim program, or, often on the waiting list for the interim program, and the decree is simply ignored.

**The principal psychometric device used by Pineland psychologists is called the Vineland. It consists of a checklist of various tasks and competencies which are considered to correspond to chronological ages in the development of the normal human. Direct care staff are summoned to the psychologist's office. The psychologist then completes the checklist by questioning the aide as to the resident's ability to perform each task. Sometimes the test is given over the telephone.

Very often suggestions to an IDT for changing residents' behavior are made without any consideration of why the behavior is being exhibited. Thus, there is no way to be sure that the means chosen to correct the behavior is the least restrictive. For example, a resident may be described by a team member as "hyper-active." The team may recommend

(footnote continued on next page)

Pineland residents seldom receive the programming to which they are entitled. Slippage occurs at each point in the progression from assessment of individual need to implementation of program. First, the resident may not even be scheduled to receive the minimum of six hours per weekday of program. The IDT may fail to recommend it. It may be recommended but unavailable because there are no openings. In such a case the resident's name is put on a waiting list. Because IDT's often fail to address actual needs, the resident may be waiting for an inappropriate service; thus, even when the resident is finally admitted to a service, for him it is not "programming." Second, although a resident may be scheduled for a certain number of program hours, the anticipated programming is often not delivered. A litany of reasons is proffered to explain cancellations, nearly all of which are inconsistent with the obligations imposed by the decree. Direct care staff may not bring the resident to his program area; program staff may be absent; the area may be so overcrowded that it amounts to nothing more than a day-care center; the resident may be sent home on account of toileting problems or because he irks program staff.

Finally, the number of program hours which defendants purport to have delivered, already considerably in arrears of decree minimums, is highly inflated. One source of inflation flows from the failure to formulate and provide programming that is individually designed and structured.

Inflation also results from the fact that residents may simply be physically present at the program area and receive little by way of habilitation. For example, in one room of the New Gloucester Learning Cooperative, one of the six major program areas at Pineland, two staff are expected to provide sensory stimulation to sixteen participants.* As the residents begin arriving, staff members provide each of them with some activity and circulate among them. As the number of participants in the room exceeds eight, some residents complete their activities and are left unattended. By the time twelve of the sixteen scheduled residents have arrived, the room resembles a layman's conception of bedlam. Attendance at a program area does not translate into an equal number of program hours.

(cont.) a review of the resident's psychotropic medication. If the resident is merely restless from a lack of exercise, the least restrictive method has not been used. Or a resident may be kept in a locked unit because he is aggressive. Even though he has never been known to be violent in any other setting, the team may fail to investigate the possibility that the resident is aggressive because he is confined and suffering from boredom and frustration.

* Section C.16. of Appendix A provides: "Each . . . program area shall maintain an adequate number of program aides to carry out the recommendations of the PPP for each resident. To this end, paraprofessional staff performing services in programs shall be maintained at a ratio of at least 1 to 5 while programs are in operation.

PROGRAMMING - FINDINGS

Program Overview

Finding: Pineland residents do not receive adequate education and training and opportunities for leisure time activities.

Discussion: The changes most needed at Pineland are in program. More hours of training and recreation must be provided, and the quality of both must be improved. Constructive and enjoyable activity is central to the purpose of the decree: for each resident, a life as normal as possible, "habilitation according to his needs," and progress toward the goal of independent community living. Programming comprehends both formal scheduled program, the weekday activities which take the place of job or school on a regularly scheduled basis and occur outside the residence, and other enjoyable activities such as recreation, social life, and training in "activities of daily living" given by residential unit staff.

Pineland is far from meeting decree requirements for program, and at least until recently has not been planning adequately. See, for example, minutes of the Program Quality Committee for the 20th of June, 1979 (24 days before the deadline for compliance with decree program standards):

> Cheryl Fortier [resident advocate] and John Conrad [business manager] recommend that the committee make recommendations to Executive Management to come up with an overall program planning process in order to facilitate adequate programming. At the present time program planning is stalemated due to lack of direction on the following issues:
>
> 1.) Space for programs
> 2.) Definite location of programs
> 3.) Transportation to and from programs
> 4.) Time frames for moves, renovations, etc.
> 5.) Lack of definite times for beginning and ending programs
> 6.) Program staffing patterns/deficiencies
>
> . . .
>
> It was agreed that the committee would summarize these issues and present them to Executive Management for input.

Considerable planning and discussion are going on now in the field of program objectives and methods. Many members of the Pineland staff want reform in the direction of a "developmental" style of resident training. This means paying closer attention to each resident's indi-

vidual development: more precise assessment of his skills, more detailed and individualized planning of his program, closer monitoring of his achievements, and closer cooperation between the professional disciplines and the direct care staff who have responsibility for him. The Program Quality Committee has identified some practical problems and has worked with a special task force to propose solutions. Reforms have been recently instituted in the planning procedure. The Staff Development Office has arranged for a new type of in-service training program on how to teach ordinary living skills. It involves the use of consultants, training movies, and texts related to a program developed by a psychological consulting firm. It is to be begun in three residential units, and if successful, to be used in the others. The school is being reorganized and will make a greater effort in the direction of prevocational training for severely and profoundly retarded children. Similarly, the sheltered workshop is interested in trying different kinds of work projects and in making its work,and the residents' training, closer to competitive employment. The impetus for all of these changes has come from Pineland staff or from the Bureau Director. These changes, if successful, will bring Pineland closer to the decree goal of maximum habilitation for each resident. The Decree leaves considerable leeway in choice of methods, but it requires effort and measurable results. We can say at present that some needed program planning is being done, at the end of the first year of the decree.*

Formal, regularly scheduled program, i.e., an occupation, should be the center of a resident's life. A few residents have no program at all. An example is Resident R. In the spring of 1978 he was dropped from program because of staff shortage. At that time he was attending New Gloucester Learning Cooperative, for residents of intermediate ability. He is now on the waiting list for Kupelian Hall Open Classroom, for less able people. It is felt that Kupelian is more appropriate because of his short attention span; with training there, he may be able to move back to New Gloucester. He is deaf and should be learning sign language. At present he receives some recreational activity through his unit and is said to receive about eight hours a week of training in daily living skills, but he spends his daily living in his residential unit. There he walks round and round, hour after hour.

Program provides attention, which is very important to most residents; it also encourages mental and physical development and provides various forms of stimulation to people who may not receive or understand the sights, sounds, smells, and touches that help to teach nonretarded people in a way they take for granted. A report on one near-blind, partly-ambulatory, and profoundly retarded girl provides an example of program for a multiply handicapped person. She has been scheduled for over

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* Success cannot be reliably predicted. Changes, reorganizations, shifting people around, abandoning a building and suddenly reopening it are constantly happening at Pineland. Changes must be carried out by employees who may not understand them. Major plans laid with the good intention of solving a major problem can contribute to Pineland's disorder.

five hours each school day this year. (She often physically abuses herself. Self-abuse is common with some residents at Pineland and appears to have many different causes: boredom, mental distress, physical pain or discomfort. To some extent self-abuse for this particular resident is a cyclical matter. Mood swings are also common among Pineland residents.) A report on this resident states: "Goals for S. are independent ambulation to degree can be achieved with severe sight problems, and decreased self-abusiveness . . . She enjoys gross motor activities [exercising arms and legs], rolling in barrels, swinging in the hammock, etc. S. also enjoys walking, cuddling, and playing games. . . During therapy S. has been laughing, playing games, and in a very good mood." This resident has been observed being held by staff with her hands in mitts, her head in a helmet, squirming, crying, trying to slap herself and to bang her head on the floor. Program is not always productive, but when successful, it brings help and pleasure to people who lead very bleak lives.

The decree requires that residents receive six hours each weekday of formal program. It also requires training in skills of daily living and recreation. The general structure envisioned by the decree is this: everyone should have an occupation; everyone should learn as much self-care as possible; everyone should have something pleasant to do after work.

The decree requires, for each resident, "a habilitation program which will maximize his human abilities, enhance his ability to cope with his environment and create a reasonable expectation of progress toward the goal of independent community living." Pineland keeps records of hours spent in program areas. As quantity of program increases, quality must also be improved. We emphasize that quality is as important as quantity, if not more so. Pineland residents are difficult to serve, and there can be no assumption that if they spend the right number of hours in a program area they are productively engaged for that length of time. Individuals in program areas are left unattended. (This results in routine overreporting of scheduled program hours because reported hours reflect only a person's presence in a program center.)

Finding: Pineland residents as a rule do not have prescriptive program plans as defined by the decree.

Discussion: Section D.4. of the decree defines a prescriptive program plan as follows:

> Each program plan shall describe the nature of the resident's specific needs and capabilities, his program goals, with short-range and long-range objectives and timetables for the attainment of these objectives. The prescriptive program plan shall address each resident's residential needs, medical needs, ADL skill learning needs, psychological needs, social needs, recreational needs, and other needs including educational,

> vocational, physical therapy, occupational therapy, and speech therapy, as appropriate. The individual program plan shall include a clear explanation of the daily program needs of the resident for the guidance of those responsible for daily care. The recommendations included in each resident's prescriptive program plan, both as to residential and programming placements, shall in all cases be the least restrictive placements suited to the resident's needs. The recommendations included in each resident's prescriptive program plan, both as to residential and programming placements, shall in all cases be the least restrictive placements suited to the resident's needs. The recommendations of the prescriptive program plan shall be based on the interdisciplinary team's evaluation of the actual needs of the resident rather than on what programs are currently available. In cases where the services needed by a resident are unavailable, the IDT shall so note in the prescriptive program plan and shall recommend an iterim program based on available services which meet, as nearly as possible, the actual needs of the resident. The number of residents in need of a service which is not currently available and the type of program each needs shall be compiled and these figures shall be used to plan for the development of new services and programs.

Plans prepared at Pineland do not conform to this description. As a rule, plans do describe an individual's various characteristics and do identify individual needs but only insofar as Pineland offers some service roughly corresponding to an identified gap. Otherwise, plans do not set forth "specific needs" or "actual needs" and virtually never prescribe short or long-range objectives with any method of measuring progress toward them. Programmatic needs are gross generalizations based upon present services, such as specifying that a resident needs to be added to the waiting list at a particular program center.

Plans do not generally include any explanation of "daily program needs for the guidance of those responsible for daily care." Instead, a plan might say simply that a person needs training in activities of daily living. The assumption seems to be that direct-care aides (whose views are reportedly not usually relied upon by interdisciplinary teams) will know which skills a person most lacks and can acquire and will assume responsibility for teaching them. Direct-care aides, however, are not trained prior to their commencing work on how to become teachers of the retarded. Their instruction in the use of Pineland's Program Guide is simply one part of a one-hour lecture on the IDT process. The Program Guide (which is an elaborate, step-by-step instruction book) is not generally used at Pineland.

Changes are made in a resident's program, his residential setting, his overall treatment and so forth without reference to his individual plan. Massive relocations were prescribed by the Pineland management during the summer of 1979 without consideration of the individual problems which might be thereby caused. Residents who objected to being moved from unlocked to locked units contrary to the decree were told that IDT's would subsequently be convened to ratify and validate the shifts which by then would have been accomplished. Of course, procedures for objecting to individual plans were not then and are virtually never if ever used; procedures for objecting to plans are generally ignored.

In sum, Pineland's plans are not individualized, are not generally prescriptive of individual programs, and are not plans.

Finding: Section D.8. states, "The prescriptive program plan shall provide in the first year following the signing of this decree, for a minimum of five scheduled hours of program activity per weekday for each resident and in the second year following the decree for at least six hours of program activity per weekday for each resident." Pineland's plans do not meet the minimum.

Discussion: Pineland's plans frequently do not provide for the minimum hours of programming. IDT recommendations are informed by the knowledge of what is in fact available. All program areas are already way over subscribed to be able to provide individual programming. The best an excluded individual can hope for is to be placed on a waiting list or that some way be found to increase the time he will be allowed to be present at a program site to reach his minimum entitlement. Under these circumstances, any reason for not adding another demand in an individual's plan which is impossible to meet will naturally be relied on. When plans do prescribe the minimum, the minimum is not scheduled for the same reason: Pineland is presently incapable of providing even the minimum programming required. Pineland has never submitted to the Master any plan for developing missing programs.

Recreation

Recreation may be counted as a part of the six hours per weekday of formal program to which each resident is entitled if, in accordance with the resident's prescriptive program plan, it is individually designed and structured to increase the resident's physical, social, emotional or intellectual growth and development.* The decree also entitles plaintiffs to recreational activity in addition to formal program.**

> H.1. . . . There shall be enough recreational equipment to provide adequate recreational services to all residents. There shall be a special effort to find equipment appropriate for multiply handicapped and profoundly retarded residents. . . . A minimum of five hours of recreational program activity shall be provided to each resident each week.

Finding: It is unclear to what extent Pineland Center has complied with the requirement of adequate recreational equipment.

Discussion: The Recreation Department noted, in a March, 1979 memo, a lack of recreation equipment in some units, especially equipment required by more severely and multiply handicapped residents, but also noted that equipment was being ordered. Unit-by-unit "needs lists" of mid-May noted a continued lack of recreation equipment in the following units: Cottages I & II, Perry Hayden I, Perry Hayden III, and Pownal Hall. If sufficient recreational equipment is available in other units, it is not often evident.

The gym and pool apparently have sufficient equipment to meet present demand. However, both Janet Brown and Mary Crichton of the Recreation Department have cited a lack of recreational equipment at the Leisure Center. The Center has a pool table, ping-pong table, game table, piano, and T.V., all of which appear to be in serviceable, though greatly used, condition. The building itself has a ramp for wheelchair access, but there is a distinct lack of equipment adaptable to the recreational capabilities of nonambulatory residents.

Finding: Pineland is not providing a minimum of five hours per week per resident of recreational program. Noncompliance is substantial.

Discussion: For the week of June 18-22, 1979, a resident population of approximately 400 was furnished a total of 918.25 hours of recreational

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*See definition number 15 and Section H.2., App. A.

**See generally, section H., App. A.

program. The average hours furnished per resident was thus less than half the number required by the decree. During this same week a few residents received more than five hours of recreation. The great majority received less, and nearly one-half received none at all. Figures for September are worse. During the week ending September 28, 1979, Pineland furnished only 737.5 hours of recreation to 389 residents. Hours furnished in June were 46% of decree minimums; in September, only 38%. The average hours of recreation received by each resident dropped from 2.3 to 1.9 hours per week.

H.4. . . .Additional vehicles shall be provided to ensure adequate transportation for residents, regardless of handicap.

Finding: Additional vehicles equipped to transport nonambulatory residents are needed to allow full compliance with items H.4., H.6., and V.2.

Discussion: At the end of March 1979, Pineland recreational opportunities were limited by lack of adequate transportation. This was especially true for the nonambulatory. By the end of July sufficient vehicles had been made available such that, with proper planning and scheduling, the recreational transportation needs of Pineland's ambulatory resident population could be met. No one now cites lack of transportation as a reason for failure to comply with Sections H.6. and V.2. for this group of residents.

For Pineland's 79 wheelchair-bound residents, however, lack of transportation continues to be an obstacle to realization of their right to recreation. Currently, only one wheelchair lift van (carrying four passengers) and one wheelchair lift bus (carrying fourteen passengers) are available for recreational transportation of the nonambulatory. Although some nonambulatory residents can, with assistance in getting in and out of wheelchairs, be conveyed in conventionally equipped vehicles, there is a problem of fitting both passengers and wheelchairs into the same vehicle especially with adaptive chairs which do not fold up for storage in transit. Mrs. Beggs, chairman of the Nursing Department, feels that safety requires that all wheelchair residents travel in lift vans. While there is little disagreement on this point, the vehicles have not been purchased. Janet Brown suggests that two additional lift vans would meet present demand for recreational transportation of the nonambulatory and would provide enough transportation to allow full compliance with the recreational items of the decree. Transportation remains a problem in non-recreational programs. The recent addition of three class II licensed bus drivers to the Pineland staff has alleviated a shortage of drivers which the Recreation Department had earlier cited as an obstacle to compliance with decree requirements for recreation.

H.5. . . . Recreation shall be conducted primarily during evening and weekend hours.

Finding: More evening recreational opportunities should be provided.

Discussion: There are two reasons for the mandate that recreation be conducted primarily during weekends and evenings. First, the principle of normalcy requires that Pineland provide residents with an approximation of the ordinary events and rhythms of daily American life.* Second, recreation which is not part of core program should not conflict with or detract from program. Pineland, not now in compliance with decree requirements for either recreation or program, schedules them in conflict.

Although it sends recreation aides directly to program areas, the Recreation Department provides on-campus recreational opportunities chiefly through three facilities, the leisure center, the gym, and the pool. The leisure center is presently open briefly during the afternoon and again from 5:30 to 8:00 p.m. each day of the week. There should be some assessment of whether the center should remain open longer in the evenings.** The center itself is inadequate as will be discussed later. During the week of July 20-26, 1979, the center logged a total of 307 hours of use by a total of 79 different residents or about one-fifth of the resident population.

During the same time-frame, and for fewer actual hours of operation, the gym logged a total of 610.5 hours of use by 185 residents. During most of the first decree year, the gym was open for general use only for a few evening hours. The rest of the time it was locked, and residents seeking to use it were turned away by Recreation Department staff.*** As late as August 1979 the gym was still often locked. The Recreation Department attributed this state of affairs to a staff vacancy. When this position was filled in late August, open gym hours were established between 8 a.m. and 4 p.m. These hours conflict with regular program hours resulting in substantial under-use of the facility. Under-use of the gymnasium is not, however, a uniform phenomenon among residence halls. From August 24 to September 22 the recreation department kept track of which units visited the gym during "open-gym" hours. Only nine residence halls made use of the gym during that month. That Vosburgh

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*See Sec. A.6., App. A: "Pineland's rhythm of life shall conform with practices prevalent in the community."

**Direct care aides make a concerted effort to put residents to bed early. The earlier the residents are in bed, the easier is the work of the aides.

***The gym was accessible only to residents who were scheduled to use it by the program area which they attended or who happened to be brought there by a direct care aide. If a person who was not so scheduled wanted to use the gym, he could not unless he, a mentally retarded individual, were able to convince an employee of the desirability of allowing him to do so. Pineland residents could be seen sitting on the front steps of the gym while behind them were locked doors, to which they had no keys, and behind the doors was a million dollar, empty gymnasium. Pineland justified its locked door policy on the basis that residents create a mess and can hurt themselves with recreational equipment.

and Doris Anderson Halls were heavily represented belies the possibility that aggressive or more developmentally delayed residents cannot benefit from activities offered by the gym. More likely explanations are the conflict between open gym hours and scheduled programming, shortage of direct-care staff to accompany residents to the gym, and apathy on the part of direct care workers. This conflict can only be expected to increase as Pineland moves closer to compliance in the area of programming by furnishing each resident the requisite number of hours of regular programs during the day. This schedule will decrease the opportunity for complying with recreational standards during residents' working hours.

The recreation department makes vehicles available to the unit staff for off-campus events and activities. During May and June a few of these vehicles sometimes would go unused for a portion of the day. However, at least some, and often many, of these vehicles went unused during the evening hours of every calendar day of May and June.

The concensus is that unit staff shortage is the primary cause of decreased use of vehicles for recreation-related transportation for off-campus activities during the evening hours. Unit staff must attend to residents returning from afternoon programs, and adequate time must be allowed for supper, oral hygiene, toileting, etc. Residents may need assistance bathing as well. Unit staff must perform end-of-the-shift record-keeping and paperwork chores. When some residents do not wish to participate in an evening recreation activity, unit staff coverage must be adequate for each group, those remaining on the unit and those wishing to attend the event. If the unit is fully-staffed and no unusual situations arise, the staff can provide adequate coverage for each group and perform all necessary tasks. If the unit is under-staffed or short-staffed because of absenteeism, residents who want to cannot participate in planned events.

> H.6. . . . Unless contraindicated by the resident's PPP, at least one major and two minor evening and weekend recreational activities shall be available to each resident each week. . .

Finding: While not yet complete, compliance with H.6. has increased dramatically in recent weeks. This gain, while not illusory, is at least partly seasonal.

Discussion: The Recreation Department collects and furnishes excellent data on Pineland's compliance with decree item H.6. Overall compliance with items H.6. and V.2. for all twenty-one residence units is expressed in percentages. From October 1978 through February 1979 overall compliance for these decree items remained below 50%, showing an actual decrease during that time of over 3%. By May 1979 compliance had climbed to 70% and by June stood at 81%. However, nearly one-third of all units remained below 75% of full compliance with these items.

Compliance for July was reported to be at 85% with only four units below 75%. In August these figures worsened somewhat; overall compliance with items H.6. and V.2. was reported at 77%. Seven units (one third) were again below 75%. Nonambulatory ICF units account for most but not all of the substantial noncompliance with these decree items; some of Pineland's most capable residents live in three of the seven units.

The recreation hours reflected in these figures include not only activities provided by the Recreation Department itself, but also activities planned and conducted by direct care staff. Unit staff are encouraged to report recreation activity hours to the Recreation Department for inclusion in the overall compliance figures. Compliance figures for each unit are separately reported by the Recreation Department providing easy comparison between units and, therefore, incentive to conduct and report unit recreation activities.

Although the increase in H.6. and V.2. compliance is due in part to the increased number of vehicles and qualified drivers, the Recreation Department notes a more positive attitude on the part of unit staff toward conducting recreational activities and attributes part of the increase to their attitude.* There is general agreement, however, that the most significant contribution to the recent surge in compliance has been climate. With warmer weather has come an increased availability of off-campus recreational facilities and events, improved road conditions, and increased ease in transporting the nonambulatory. Decreased rates of compliance can be expected during the winter months unless plans are made now.

Finding: The quality of the recreation now being provided to Pineland residents is difficult to assess because clear standards have not been promulgated and unit staff must be taken at their word regarding the actual nature of the activities they conduct and report to the Recreation Department.

Discussion: It is not certain that any of the reported recreation program hours are of less than adequate quality. Program coordinators report improvement in the quality of trips taken for recreation over those of years past, and the Recreation Department is commendably concerned to ensure the quality of recreational activities. The Recreation Department will disallow unit-reported "recreational" activity which it feels does not qualify as worthwhile, bona fide recreation. The Department exercises similar discretion over requests for vehicles, and it may "bump" a scheduled recreational vehicle use for another use which it feels will provide residents with more worthwhile recreation. The honesty of the Recreation Department and its willingness to exercise judgment on matters of quality even when it may have an adverse effect on paper-compliance should be underscored.

* In some units compliance is half-hearted and in name only. At the end of the month a flurry of activity occurs "to get in our V-2's and H-6's."

Finding: Compliance with section V.2. is made more difficult for indigent residents by cumbersome, slow-moving Business Office procedures.

Discussion: When recreation or unit staff wish to afford indigent residents the opportunity to eat, shop, or attend an event in the community, as is required by decree item V.2. at specified frequency, unit staff must request funds from the Business Office. A separate form must be submitted for each resident, and each form requires multiple signatures. This process always takes days and sometimes weeks. The business office requires proof of indigency upon each request for funds regardless of a resident's financial status at the date of the last request on his behalf and regardless of when the last request was made. "Accountability" of institutional employees is the reason for burdensome procedures. The more burdensome the procedures, the less an employee wants to invoke them unless he has to. The economic value of Business Office procedures is unproven. Human needs and federal rights are beside the point to the values of the Business Office.

The amount of money allocable through the Business Office to indigent residents for recreation is insufficient to allow compliance. Residents who are indigent may receive only $3.50 per month for personal spending money, and this amount is to be spent on food only.* While this amount may be marginally sufficient for compliance with V.2.(a) of the decree, it leaves unit staff with no means of satisfying the requirements of items V.2.(b) through (d). Unit staff have indicated that $15 to $20 per month would be sufficient.

Finding: The condition and status of the residents' leisure center is a continuing obstacle to compliance with item H of the decree.

Discussion: Although the decree does not impose upon defendants a duty to maintain a residents' leisure center on the grounds of Pineland, defendants have chosen to do so and the residents have come to very much depend on it and to anticipate its continued operation and accessability. Maintenance of such a facility improves the opportunity for full compliance with item H.1., which requires that each resident be afforded the chance to have a minimum of five hours of recreation weekly.

The center continues to be the only recreational facility at Pineland which is solely devoted to use by residents. Staff make at least some use of all other recreational opportunities available at Pineland. It seems fair to assume, therefore, that the center would be afforded priority of attention with regard to access, sufficiency of equipment, and

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* This figure was recently increased to $8.50 per month and criteria for determining indigency were standardized. Prior to this, unit supervisors were apparently free to decide, independently, whether a resident's account should be invaded to finance compliance with items H and V.2.

physical plant, especially since money spent on these items would directly influence chances for full compliance with sections H.1. and H.6. This has clearly not been the case, and quite the opposite is true. In February of 1979 the Business Office determined that the canteen and the leisure center, located on superadjacent floors of the same building, should be relocated, each to the space then occupied by the other. Each space, the Business Office advised, would be refurbished promptly, allowing for a speedy and simultaneous reopening of both facilities. The canteen, operated for profit by an outside organization, was renovated by state employees and correctional inmates. It reopened a few days after both facilities closed. The center did not reopen. It remained closed for renovations for nearly three months during which time very little renovation was accomplished.

Although the leisure center is finally operating again in its new location, it remains deficient in several respects:

(a) The leisure center is drab and visually unappealing.
(b) Equipment is old and inadequate, especially that needed to provide recreation to the nonambulatory residents.
(c) Accoustical tile has not been installed. Tests conducted by the communication department show noise levels to be at least disturbing and sometimes above the range of safe human tolerance. The department feels that working at the leisure center is a hazard to employees' hearing. Leisure center staff believe that noise levels cause residents to become agressive.
(d) Apart from the main entrance there is only one fire exit. This exit is located at the end of a short maze of corridors and is not plainly marked.

The leisure center now meets the needs of a relatively few, high functioning, independent, ambulatory residents. It has little to offer the nonambulatory or more developmentally disadvantaged residents.

It should also be noted here that when the canteen was reopened at its new location its business hours were sharply reduced. The canteen now closes at 4:00 p.m. and is not open on weekends. Thus, the canteen is open only during regular program hours making it virtually worthless to many residents, especially persons involved in full-day work programs, who are the most likely to have a little money to spend on themselves. Residents and staff are unanimous in their disdain for the new canteen hours. The canteen has been the subject of a petition drive for more hours of operation and of resolutions by the the Residents' Council. The Council has also complained that the operator of the canteen dislikes residents. While the canteen plays no specific role in the scheme of the consent decree, it has the potential to be indirectly helpful to full compliance with the requirements for programming and community interaction. For example, the canteen has been used, albeit unsystematically, by direct care staff to teach residents how to handle money, to make purchases, and in general to conform to societal expectations

of proper behavior in public places. In addition to providing a tool to direct care staff in the area of programming, the canteen has been used by unit and recreation staff to prepare residents for the types of community excursions and activities mandated by decree items H and V.2. Reduced hours of operation will make it more difficult for staff to prepare residents for community recreation.

Finding: Staff shortage hampers full realization of both on-campus and off-campus recreation opportunities.

Discussion: When the pool and gym are opened for general use, the following procedure is used: Recreation Department staff devise a schedule of activities which is made available to the staff of each residential unit. Unit staff then compare the types of activity listed with the needs, wants, and abilities of the residents in their unit. The residents thus matched to a given activity who wish to participate must then get to the gym or pool. If they are not accompanied by sufficient unit staff to assist Department of Recreation personnel, the activity may not be well-supervised, and resident participation may be diminished or rendered impossible. If there is sufficient unit staff to provide coverage for all residents (those wishing to participate and those wishing to remain at the unit), the system works. As in the case of off-campus recreation, if a unit is understaffed or short-staffed due to absenteeism or if crises arise, then no one from that unit may get to participate in the scheduled activity.

A possible solution would be to have the Recreation Department determine the extent to which full compliance with section H of the decree is being hampered by staff shortages. Additional recreation aides could be made available to supervise the residents of units suffering staff shortages which would otherwise prevent residents from taking part in on-campus activities.

ADL Training

Finding: Pineland does not provide the training the residents need in basic self-care. Pineland does not comply with those sections of the decree which impose a duty to teach basic self-care. See sections A.1. and C.1.(f).

Discussion: ADL stands for "Activities of daily living." We use the term to cover training in bathing, grooming, toileting, and the like. Last March the program coordinators reported on ADL needs. Coordinators in 15 units reported a substantial deficiency. In some others there was a need for better documentation of existing programs or for more attention to table manners. Most of the serious shortages of ADL training were in the units for the profoundly retarded.

Defendants' violation of decree requirements for staffing accounts for some of the lack of ADL teaching. In the Perry Hayden units, for the most profoundly retarded and gravely handicapped, the coordinator asked for more staff time and trained and experienced staff. He asked that the staff-resident ratio be brought to the 1:4 level required by the decree for this unit. As of September 1979 this had not been accomplished. The residents of Perry Hayden Hall are all bedridden or wheelchair bound; most are incontinent and require the assistance of staff to accomplish even small tasks. Staff must perform strenuous nursing duties. Until recently, they were also required to perform unit housekeeping chores in violation of the decree. (Staff report an improvement in ADL since the Housekeeping Department assumed cleaning duties at Perry Hayden.) The type of ADL assistance required by the residents of some units is exacting and time consuming. The coordinator at Bliss Hall described the elaborate feeding programs necessary for five children. A staff member must manipulate the child's jaw while he eats; otherwise, these children are in grave danger of developing arthritis of the jaw. For one of these children the program takes an hour; the other four average 45 minutes each.

ADL training is also sacrificed to other conflicting duties required of direct care staff. A staff member at Perry Hayden said that clinics are the biggest bottleneck for direct care staff. "At times it gets tight," said one worker. Another reported that the staff feel pushed. "They are good people," said the nursing supervisor, "but they have too much to do." The afternoon shift is more seriously understaffed than the morning one; on many days, only three staff members are on duty. On Thursdays, but only on Thursdays, five staff members (the decree minimum for this unit) are scheduled for the afternoon shift.

The coordinator for three of the Kupelian Hall units, for profoundly retarded and often very difficult residents, reported a need for varying amounts of additional ADL time, regularly each week: 3 1/2 hours, 7 hours, 12 1/2 hours, depending on the needs of the individual resident. More staff was called for.

The supervisor of coordinators recommended for Kupelian II:

> More professional consultation in training programs. Documentation of what constitutes each program. More open classroom [formal program area] involvement in ADL.
>
> (March 29, 1979)

On August 28, 1979, the coordinator for Kupelian IV was interviewed. She said that this unit did not complain of short-staffing, but she felt there were organizational problems. Kupelian IV staff felt that ADL should be done on a one-to-one basis, but there were always residents to be taken to clinics, or emergencies, and there were not enough staff present in the unit so that one aide could work with one resident and leave the others adequately supervised. The coordinator said there was still a lack of "serious ADL training," intensive work on a regular basis, the same time each day. The coordinator for Perry Hayden also reported scheduling problems.

In other units, an extra hour a day of ADL training was a common request; two hours more were asked in a few cases. A need for consistency was mentioned in several reports and, in two, a need for clearly written programs. One unit was described as providing "inconsistent training as staff have time." More work is needed on table manners in units with capable residents.

In one of the units which is generally running well, staff dish out food, then sit at the side and watch until the residents need something. The residents eat together without observing meals as served to non-retarded people and without being instructed. "Refining eating skills" is a common IDT requirement.

Another problem mentioned in Perry Hayden and Bliss Halls was the need for adaptive toilets and other equipment necessary for providing proper ADL training.

One direct care aide asked if a "check system" could be set up for monitoring ADL. Present systems can be quite time-consuming. Pineland has only recently begun documenting hours of ADL received. The supervisor of the program coordinators wrote:

> Slowly, more in-house programs (including ADL) are being written up, and, therefore, an increase is seen in program hours. Right now this increase is indicative of counting more and more of what is already being done, and not as much actual increased programming. But with this system, there is more initiative on some people's part to see "credit" given for their work, which has increased the programming that the resident is getting.*
>
> (March 3, 1979)

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* We are not using in-house program figures in this report. Such figures include ADL training and may also include other activities. The reporting system is not standardized, and the figures are open to serious doubt.

Both the present supervisor of coordinators and the IDT Task Force saw a need for residential supervisors to help program coordinators in monitoring ADL training. There are various on-going and prospective efforts to improve training of aides in the teaching of ADL skills.

There is at present a Program Guide available. It is considered a model; other institutions have asked for copies. The consultant now working with the IDT Task Force was the author of the Guide. She feels that it should be revised, and the format changed to make it less formidable and more usable. By staff development policy, all Pineland employees are given training in the use of the Guide, but some of them have not been trained or do not remember what it is. Actual use of the Program Guide is rare.

The Program Guide section on toothbrushing gives an idea of the patience and consistency necessary to teach ADL.

1. [Put toothpaste on toothbrush, etc.]
   Teach the resident to put toothbrush to the outside back and brush the upper and lower teeth on one side of his mouth. Then have him repeat this on the other side of his mouth.
   Cue words: 1. "Put the toothbrush to the back of your mouth."
   2. "Now brush your teeth."
   3. "Now do the other side."

2. Give the resident as much assistance as he needs at first, gradually fading out. Teach the resident to clear his mouth if necessary.
   4. "Spit."

3. Next teach the resident to brush the insides of his back teeth, top and bottom. . . .

4. Now, teach the resident to brush the inside of his front teeth, top and bottom.

5.- 8. Outside front top and bottom teeth, rinsing mouth, rinsing brush, putting toothbrush away.

To get through all eight steps could take months or years. If the trainer is in a hurry, the easiest thing to do would be to brush the resident's teeth.

Staff development has proposed a new program, the "Try Another Way" system developed by the Marc Gold consultants. Staff Development will institute the Gold system in three units next year, under the guidance of a consultant, two days a month. The system will train direct care staff to write and implement programs for individual residents. The Program Guide would be used as a reference but would be adapted for individual residents. Staff Development feels that this system could produce substantial progress in one year in the three units and should

then be tried in others. Many staff members are enthusiastic about the Gold system and see it as a real break-through.

An experimental program, tried in three units, does not meet decree requirements; other units must also increase their commitment to ADL.

Formal Programming

Finding: Pineland does not schedule six hours each weekday of formal program activity for each resident.

> A.1. Residents have a right to training and care, suited to their needs, regardless of age, degree of retardation, or handicapping condition.
>
> D.8. The prescriptive program plan [for each resident] shall provide in the first year following the signing of this decree for a minimum of five scheduled hours of program activity per weekday for each resident and in the second year following this decree for at least six hours of program activity per weekday for each resident. Each resident shall receive these scheduled hours of programming . . . in exceptional cases, residents may receive fewer hours of program activity per weekday if a physician certifies in writing that such activity would be medically harmful to the resident.

Discussion: Chart I on page 53 shows program hours, both actual and scheduled, as reported by Pineland. For ease of comparison, scheduled hours are in bold outline for the test weeks in September 1978, March 1979, and September 1979. Chart II on page 54 is based upon the figures seen in Chart I on the row titled "Core Program Total."

From Chart II the following appear: In September 1978 Pineland scheduled 8326 hours of core program for 425 residents in one week. The decree required at least 10,635. Pineland had thus scheduled only 78.4% of the programming required. Furthermore Pineland actually provided only 83% of what it scheduled, or 65% of what was required.

Reading from left to right across the rows of Chart II, one sees that these figures become progressively worse. In March 1978 Pineland scheduled only 75.7% of required hours and furnished only 77.3% of what it did schedule. Hours provided were only 58.5% of those required.

The data for September 1979 shows further decline in compliance with the decree. Only 66.7% of the minimum required core program was scheduled and only 77% of that was actually provided. Hours provided were only 51.4% of the minimum required, 13.6 percentage points less than one year ago.

Another way to measure compliance is in the terms of number of residents scheduled for the minimum hours. Twenty-five hours a week were required last year; thirty, this year, assuming program equally divided among weekdays. In September 158 residents were scheduled to

receive 25 or more hours a week; in March, 138. In September compliance was 37.1%; in March 30.9%. In March Pineland scheduled fewer than 15 hours a week for 166 residents. In March, but not in September, Pineland listed the number of residents "scheduled" for fewer than 25 hours a week of formal program, recreation, and in-house program combined. This figure came to 98, or 24% of the population. (This figure is noteworthy only as evidence that for 24% of the population, nothing much is done. To count as program, recreation must be scheduled and must "consist of organized and structured activity related to the achievement of [prescriptive program plan] goals." Pineland lists all recreation in "scheduled hours"; furthermore, in-house program cannot be counted toward the decree minimum of six hours of scheduled, formal program per weekday.

Non-compliance in this area is very substantial and very serious. During the test week in March, 274 residents, from a population of 416, were scheduled to receive fewer than 25 hours a week of program. In March Pineland failed to comply with decree program requirements for more than 65% of its population.

	7/21/78	8/11/78	Scheduled 9/29/78	9/15/78	10/27/78	12/8/78	1/12/79	2/7/79	Scheduled 3/16/79	3/9/79	4/13/79	5/18/79	6/22/79	7/20/79	8/24/79	Scheduled 9/21/79	9/28/79
Berman School	2,095	1885	1896	1769	1644	1610	1332	1223	1686	1270	1,266	1,566	1372	1,389.25	1,290.67	1,535.00	890.00
Schools off grounds	25	45	200	185	215	140	160	150	175	175	170	250	—	150.00	Vacation 00.00	200.00	190.00
NGLC	1410	1369	1462	1302	1337	1352	1208	1354	1630	1349	1287	1,530	1479	1487.42	1,309.00	1,597.50	1,512.50
ADAC	659	853	1110	976	923	789	693	869	1113	863	300	736	1128	718.50	800.25	957.50	623.75
Vocational	1036	1141	1373	981	1248	1113	953	1043	1246	982	762	1,096	1046	972.75	969.25	1,119.25	923.75
KHOC		994	454	397	370	394	407	395	421	382	408	391	450	422.50	400.00	415.00	379.50
PHDAC			1212	866	362	482	441	284	851	432	689	824	743	888.00	736.00	923.45	654.75
Adults off grounds	325	293	325	306	325	325	286	280	325	306	228	355	300	614.50	575.00	690.00	522.00
Therapy*	453	85	294	132	124	156	159	279	385	295	263	231	227	138.41	15.91	351.75	302.92
Core Program total	6003**	6665	8326	6914	6548	6361	5639	5877	7832	6054	5373	6979	6745	6781.33	6096.08	7789.45	5999.17
Recreation	2333	1602	1145	1172	992	1088	1017	963	752	928	866	728	918	942.25	924.52	731.83	737.50
ADL											4391	4537	4788	4,453.33	4,093.33	5,698.80	4,492.10

*A constant of 205 hours per week has been subtracted from scheduled and actual hours in this category to allow for medical and dental appointments.

**1978 Summer figures are inflated by double reporting.

TEST WEEK IN MONTH OF:	September, 1978	March 1979	September, 1979
Resident Census	425	414	389
Hours per week of program to which each resident is entitled	25	25	30
Minimum Hours Required Per Population	10,625	10,350	11,670
Hours Scheduled	8,326 (78.4%)	7,832 (75.7%)	7,789.45 (66.7%)
Hours Actually Provided	6,914 (65.0%)	6,054 (58.5%)	5,999.17 (51.4%)
Average Hours Per Resident Actually Provided	16.3	14.6	15.4
Percent of Scheduled Hours which were actually delivered	83%	77.3%	77%

At present, two areas schedule more than 25 hours a week of program to some of the residents enrolled. The sheltered workshop schedules 31 hours a week for some residents. The school schedules 27 1/2 hours a week for residents under 21 years old. (Most children attend school. A few children from the unit for the most profoundly retarded are in a different program; a few others attend for less than a full day because of medical reasons. A memo of April 13 stated that eight children were on half day program for the summer because of lack of staff. During the school year 1977-1978, the number of hours spent at school was increased; effort was concentrated on improving behavior, attention span, and socialization. The increase in hours brought dramatic improvement to some children who had been programmed slightly or not at all.) New Gloucester Learning Cooperative schedules 17 1/2 hours per week for morning clients, 13 3/4 per week for afternoon clients. In June Kupelian Hall Open Classroom, for profoundly retarded clients, provided 11-15 hours for most of the residents in its program; Perry Hayden Day Activities Center, for very profoundly retarded and severely handicapped residents, provided 14 or fewer hours for about 2/3 of its clients; more, up into the 20's, for about 1/3. The geriatric program provides mild social and physical activity to 16 residents in their fifties or older. None receives more than 12 1/2 hours a week. There is a waiting list for the program.

Finding: Pineland does not provided adequate education for blind residents.

> Sec. G.6.: Those residents with specialized needs, such as the blind . . . shall receive programs of special education and development specifically designed to meet those needs, and special education staff shall receive specialzed training. . .

Discussion: There is a "blind program" serving 11 residents, staffed by one teacher and providing (in April, 1979) minimal program for four residents (six hours a week or less); 10-16 hours to six residents, 23 hours to one. There are about 41 blind or visually impaired residents at Pineland. Most attend program with sighted residents; they lack specialized attention. Mr. Eastman, the teacher of the blind, would like increased staff so that he could improve quantity and quality of program. This seems essential although, thanks to him, progress has been made even with very limited resources. Here is a report about one resident:

> I have been quite pleased and encouraged with A's responses and performance over the past two weeks. Although I have him only 30 minutes a day, on an individual basis, this has been sufficient time to note a definite improvement in communication skills and general awareness. . . He has consistently responded

> to walks and related experiences such as safety training, noting the weather and temperature, and limited social interaction with people encountered along the way during travel training.
>
> (A at that time received no other formal programming. He presently receives 6 hours a week.)

There is a group of six blind residents with severe behavior problems who are among the most difficult to work with at Pineland. Of this group, Mr. Eastman reports:

> Reference has been made to a select group of special projects involving residents with such severe physical and emotional problems that any sort of conventional programming is usually impossible. . . Here again, they could be programmed on an individual basis at their unit or integrated somewhat into classroom programs and other activity areas if the right kind of additional program staff were available to properly handle the kind of crisis and disruptive problems that would inevitably arise while programming this type of resident.

Finding: In the first Decree year, Pineland has actually decreased the number of scheduled program hours. As to scheduling of formal program, Pineland is seriously out of compliance with section W.1. of the decree.

> W.1. Unless otherwise specified herein, all steps, standards, and procedures contained herein, including those relating to staffing, programming. . . recreation, education, etc., shall be achieved, and thereafter maintained within 12 months of the signing of this decree.

Discussion: Pineland must provide more hours of intensive program right away for residents ready to accept it, and more hours of less stressful activity for those who cannot tolerate a full six hours of the programming currently available. Every attempt should be made to increase the residents' tolerance for program participation.*

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* It cannot be too strongly emphasized that the decree does not recognize a resident's low frustration tolerance or short attention span as excuses for failure of the IDT to recommend that each resident receive six hours of program. Only medical excuses suffice. (See section D.8.) If the resident cannot tolerate a full six hours of any of the presently available programs, that resident should be seen as having an unmet need for programming to which he can attend. The decree recognizes this possibility and specifies a solution of intermittent programming. Sec. G.4. states: "A resident shall be seen several times during the day where the PPP determines that continuous hours of education would be inappropriate for a resident." The IDT report should always recommend six hours of program in the absence of medically verified potential harm. It is up to defendants under the terms of the decree to devise and implement the programming required to meet the needs presented by each resident's IDT report. Quite simply, neither of these steps is being carried out systematically.

The Activities and Training Department provided a list of residents ready for more program of intensive quality as of June 8. At New Gloucester there were 14 residents, some needing 3.5 hours more a day, some 2.75. Total hours needed were 208. At Adult Day Activity Center, 41 residents needed three hours more a day. (These residents are only one step away from the sheltered workshop, the program for the most able residents.) Total hours needed for these 41 residents, plus four others needing lesser increases, comes to about 622 hours. Perry Hayden Day Activity Center, for the most profoundly retarded and seriously physically handicapped, listed 28 residents who could be brought up to a full day of program right away, 11 who could be increased to a full day slowly. This might mean about 504 hours right away, 198 hours more later on. The single-teacher blind and geriatric programs should both be expanded. The geriatric program was started this year and is considered a success as far as it goes. One coordinator said that it would have to grow bigger. "People are just finding out about it."

Finding: Pineland must make a much greater effort to ensure that scheduled hours of formal program are in fact provided.

Discussion: Actual hours are well below scheduled hours. In September 1978 Pineland provided 83% of scheduled hours; in March of 1979, 77.3%; in September of 1979, 77%. (This last figure takes into account the increase in required hours for the second decree year.)

In March the gap between hours scheduled and hours received was caused mainly by staff absence. The problem was particularly acute at the school. In March hours scheduled for the school were 1,686; hours received were 1,270, 75% of hours scheduled. The lost hours represent enough program time for 16 residents. It is important to remember that lost hours are distributed unequally. One boy received 16 hours of program in the test week in December, none in the test week in January, and one in the test week in February. Lack of transportation, as well as program cancellations, contributes to the difference between hours scheduled and hours provided.

In March the school staff spent 1,505 hours in direct program activity; 408 hours in miscellaneous other duties. They spent 197 hours in sick leave and uncompensated time off; 171 hours in vacation and administrative leave. About 402 hours of program were cancelled because of teacher absence. Pineland management is working to reduce sick leave and to find ways to cover vacation time.

Pineland has only recently begun to try analyzing fully the causes of lost program hours, including the various causes of program cancellations and nonappearance of residents. The system is still rough; an item for August reads "21 residents, 1/2 hour each, therapist out/camp." With this system, a reader only knows that a given number of residents missed program for any of several reasons. We found for the month of August that at least 575.75 hours were lost as a result of sickness, home visit, or medical appointments. If this is a standard figure, and 8,000 or so hours are regularly scheduled, then perhaps there is a legitimate excuse for 7.2% of the lost hours. On the other hand, with half-day program, there should be plenty of free time in which to schedule appointments.

Finding: Pineland has not demonstrated compliance with sec. V.5. which requires "sufficient vehicles, including vehicles capable of accommodating handicapped residents" to meet the requirements of section V, integration with the community. Pineland has not shown that it will be able to provide transportation adequate to meet the requirements of sec. D.8., which requires six hours a day of program for all residents, or of secs. D.4. and D.11., which require that each resident receive program suitable to his particular needs.

Discussion: Transportation is needed to bring residents to programs, and to allow program areas to take residents on field trips or to the gym. Transportation was considered a very serious problem last winter, and last winter the majority of Pineland's wheelchair residents attended programs within their residential units. Some residents were inadequately scheduled because of lack of transport; some missed particular types of program; some were scheduled for hours which they did not receive. Transportation is particularly important for wheelchair residents and for others who are timid or unsteady.

In March and April combined, transportation problems accounted for 76 or so of the hours lost between "scheduled" and "actual" hours.* Since April, two new vans have been purchased, and three new drivers have been hired. Even so, the Director of the New Gloucester Learning Cooperative reports that his program had to give up its van for the summer to Pineland's summer camp, Camp Tall Pines. Transportation has been a major problem and will continue to be one. If the overall hours of core program are increased as they should be, and if Pineland complies with sections H (Recreation) and V (Community Exposure) of the decree, then more vans will be needed for wheelchair residents, and new drivers may need to be hired. The Master has yet to see a detailed numerical analysis of future transportation needs, though we have been provided with statistics on current use of vehicles. Wheelchair residents need vans with hydraulic lifts. Pineland has one hydraulically equipped minibus with space for 14 wheelchairs; it has two vans with places for four wheelchairs in each.** There are 79 residents in wheelchairs. In winter, vans are essential, as it is hard to push wheelchairs on slush. (The medical office sees no probelm in wheeling residents on cold, clear days over dry ground.) A goal of the decree is to stop the practice of confining people to residential units. Moving programs out of residential units will make transportation much more difficult next winter than it was last; last winter transportation was a serious problem for many residents.

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* This is an estimate; number of cancellations was shown, but not length of time lost in each cancellation.

** Each van holds four small wheelchairs or two large ones.

All program coordinators saw transport as a major unmet need. A report on Gray Hall by the Communication Department states that wheelchair residents were usually half an hour tardy for program and sometimes absent. Because of lack of transportation people have missed particularly beneficial programs such as swimming and physical therapy. Gray had one long ramp for wheelchairs which terminated at the side of the building in a dirt driveway. There was a drain pipe which concentrated water just at the foot of the ramp. It was often very difficult to get chairs from the end of the ramp to the tar road.

Mr. Eastman, teacher of the blind, states the following:

> With regard to transportation problems, we have at least three blind wheelchair residents who appear ready for quite extensive programming, but lack of mobility and human supportive help makes it impossible to properly schedule or program them. . . During the severe winter months one can triple this number before coming close to the number of blind residents that seldom reach their programs because of the general lack of an adequate transportation system.
>
> (Report, March 26, 1979)

Finding: Pineland does not provide individually developed plans, suitable to meet the needs of each resident, within 30 days of an annual team meeting as required by secs. D.4. and D.11. of Appendix A.

Discussion: The Decree stresses individualized program. One must tour Pineland to understand fully how important this is. Residents differ enormously in their needs and capabilities. Some residents love attention and cuddling; others are terrified of any physical contact. Some must be urged to participate in any activity at all; others want and need strenuous projects to use their energy. Either too little or too much stimulation can lead to violence or self-abuse. The retarded are often physically handicapped, and the most profoundly retarded are the most cruelly handicapped. People who live at Pineland often develop serious behavior problems. Residents must advance by very small steps. A program must be difficult enough to be interesting, easy enough to allow small successes. Residents must be helped in a variety of ways, by people from different disciplines, but should not be subjected to too much pressure. To put together and deliver the package necessary for each resident requires planning techniques and resources that Pineland does not now have.

Planning requires coordination of the range of services involved. At a given moment, a single resident may be receiving direct or indirect help from several different departments and may need several different kinds of follow-up treatment from direct care staff.* Coordination is the responsibility of an "interdisciplinary team" or IDT. The interdisciplinary team meets once a year at least; a smaller group meets quarterly to update the resident's prescriptive program plan. The team is

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* For most Pineland residents, direct care aides provide no follow-up to programming. With a few notable exceptions, direct care aides do not

(footnote continued on next page)

required by the decree to make recommendations based on the resident's actual needs rather than on services that are currently available (D.4.). If service cannot be provided within 30 days of the meeting, then Pineland must submit to the Master, for approval, a plan to implement later the report as written or a statement that a recommended action will not be taken. The statement must be accompanied by documentation showing "that the service or program is not required by professionally accepted standards of habilitation or care." App. A, sec. D.11. The 30 day reports and statements have never been submitted.

The IDT should discuss very specific program needs for each resident, including, for residents over 21, the possibility of adult education. All residents are presumed capable of benefiting from adult education. (Sec. G.1.) Coordinators do not feel that all the unmet needs are being brought up at the IDT meetings. Staff is not in the habit of planning on a basis of the necessary rather than the available; they are reluctant to suggest difficult or expensive programs.*

Professional departments which might be represented on an IDT include Medical and Nursing, Activities and Training, Recreation, Psychology, Social Service, Communication, Physical and Occupational Therapy. These last three departments play an important role in the care of the retarded. Professional staff should offer direct therapy to residents and consultation and training for direct care staff. The communication department is in charge of speech and hearing, and also communication through signing or communication boards; (some residents carry boards covered with small pictures; residents communicate by pointing to the pictures). Physical and Occupational Therapy overlap considerably. The occupational therapist works on splinting, positioning, and "range of motion" exercises for residents with certain congenital physical problems. Residents with muscular "contractures," tightening of arm and leg muscles, may be placed in certain positions or may wear splints for a certain number of hours to straighten their limbs. "Range of motion" maintains or improves ability to use one's joints. Occupational therapy also conducts some feeding programs and "sensory stimulation" which involves systematic exposure of the resident to various experiences;

(cont.)
go to programs with the residents who are in their care. They do not see participation in program activities as an opportunity to learn how to become teachers themselves. On the other hand, they envy program positions because of the favorable day-time hours. Employee representatives are seeking to secure for them the right to transfer from the position of aide to the position of teacher on the basis of seniority without regard to qualifications.

* It also appears that Pineland's program coordinators are not sufficiently familiar with existing community resources to comply with section V.1, which states in part: "Pineland shall utilize existing services and resources in the community to the maximum extent possible." Some program sources, available to Pineland residents, are thus going untapped at the present time.

watching, listening, tasting, smelling, rocking in hammocks, bouncing on air-mattresses. Sensory stimulation is considered an important technique in behavior control. Physical therapy is concerned with motion and muscular development: walking, range of motion, positioning.

At present an IDT Task Force is studying program and IDT procedure at Pineland. They want to "make sure that all residents' programs are coordinated and are part of their daily living routines and that conflicting instructions are minimized." (Interview with Betsey Davenport, Chairman of IDT Task Force)

The quality of program planning is not satisfactory to Pineland staff. They do not feel that there is now enough teamwork between the various members of the IDT's. Mrs. Paine, head of the occupational therapy department, feels that the interdisciplinary team should agree on four or five major goals and coordinate their efforts to reach those goals. She gives the example of a person learning self-feeding with direct care staff, and having his hands weighted, and rubbed with hand cream by the occupational therapy department so that he will become more aware of his hands. Some staff members see a conflict between program area activity and the residents' needs to spend time becoming independent in dressing, etc.; Mrs. Paine says that the various activities can be put together so that different forms of learning reinforce each other. Goals should be planned in small sequential steps so that something is accomplished in 6 months or a year. Goal setting should be the major effort of the IDT meeting. Dr. Monroe of the psychology department says that the IDT needs to set priorities and to devise a program closely adjusted to the resident's skills and his perceptual abilities. Mrs. Paine asks for more communication among IDT members and discussion and agreement upon specific goals. Dr. Monroe would like the direct care staff to receive more training so that they can accurately report the resident's progress and problems.

The decree requires that "each habilitation need of the resident . . . be professionally assessed." The prescriptive program plan is to "describe the nature of the resident's specific needs and capabilities, his program goals, with short-range and long-range objectives and timetables for the attainment of these objectives." These principles are agreed upon but not applied. Various comments have been made about the IDT process as it has existed in the first decree year:

> [Mrs. Paine:] We just go in there and read our reports.
> (Interview with Master's assistant)

> [Program Quality Committee (representatives from Activities and Training, Occupational Therapy, Physical Therapy, Program Coordinators, and Acting Superintendent):] It was agreed by all members [present] that priority assigned to IDT reports [here meaning reports taken to IDT meeting] vary according to each discipline and program area and that lack of time to prepare reports was a major problem, since professional staff often do paperwork at home. The lack of a true interdisciplinary

process and the reluctance of professional staff to question other disciplines or program areas was discussed . . . [Chairmen of occupational therapy and communication departments] will continue to pursue the possibility of overtime pay for professional staff.

(Minutes of meeting, 2/7/79)

[Program Quality Committee:] The IDT should be cancelled if the staff comes unprepared.

(Ibid.)

[A Building Report:] The IDT's at Pownal Hall are more interdisciplinary than most.

[Program coordinators:] Direct care staff are afraid to speak up.

(Interview with Master's assistant)

[Dr. Hoffman, Research Scientist:] These are general comments pertaining to IDT's in all areas so far seen. . . Presence of the resident at the entire IDT meeting. If the resident lacks comprehension altogether, no purpose is served by his presence. If the resident has some comprehension, his presence inhibits the discussion (which may take partial refuge in polysyllables), he understands only part of what is said, he may be depressed or humiliated by what he does understand, and he tends to participate minimally. Suggestion: the regular IDT meeting should be held without the resident (who has some understanding), the resident should be brought in at the end, the content of the meeting summarized for him at his own level and language, and input should be sought actively from him on his own views. [Mrs. Davenport, chairman of the IDT Task Force, feels it is essential that IDT members have the resident with them, whether he can participate or not.]

[Program Quality Committee and IDT Task Force:] [There is a need for] more individualization of professional and direct care programs--Need for quality in goal setting and monitoring.

(PQC minutes, July 12, 1979; Task Force memo, July 18, 1979)

[Executive Management Committee report of February 2 on a particular residential unit:] Since the psychologist . . . has not been able to attend most of the IDT meetings of late, there is a question as to adequate support in this area.

> [Program Study Task Force:] At Work Activities Center, special IDT's are held without advance notice.
>
> (Report, August 10, 1979)
>
> According to the Building Survey reports, IDT's were sometimes held without progress notes from the program areas. (Report, April 25)

We here describe one recent IDT report with the aim of showing roughly what an IDT report is and of pointing out areas where at least one report did and did not meet decree standards. The report was prepared in 1979 following an IDT meeting on March 28, 1979, and concerns a resident with behavioral and other problems. The first page of the report provides name, description, address of "correspondent," guardianship status, certification dates, "level of functioning," medication, some other basic information, a list of team members at the IDT, and a list of reports. The second page describes "present program" by listing recommendations of the last IDT report, along with present status of those recommendations. There follow reports from various professional departments and from the residential unit. The last two pages of the report are devoted to the "service agreement" in which various people agree to provide particular kinds of service to the resident. The prior service agreement had eight clauses, including the following:

> 1. Direct-care staff will continue to work with resident on refining his ADL skills in the areas of eating, dressing and toileting. STATUS: ADL training continuing, staff are trying to teach resident to keep his head up while eating, and he dresses himself well. . . .
>
> 4. Resident will continue to have community excursions weekly. STATUS: Weather and transportation permitting, resident has been having community excursions almost weekly, either with direct-care staff or the Open Classroom. . . .
>
> 7. Resident to be referred to physical therapy for motor planning activities. STATUS: Physical therapy has given the Open Classroom suggestions for motor activities.
>
> 8. Resident to be referred to the Open Classroom teacher for inclusion in more vigorous large muscle activities. STATUS: The Open Classroom teacher is involving resident in vigorous large muscle activities.

Reports of various departments followed. These included Communication, Nursing, Residential Services (represented by two direct-care aides from two shifts), Psychology, Social Work, Recreation, and Activities and Training, represented by an Open Classroom teacher.

The Residential Service and Social Work reports showed the resident to be aggressive, apparently from boredom, and from being asked to participate in activities when he did not feel like it. He was toilet trained but inclined to smear feces. When eating he put his head near his tray and shoveled food in; he stole bread from other residents. Occupational Therapy reported a tremendous increase in tolerance to program and in attention span. He was able to stay in the Open Classroom "cubicles" (area for intensive work) for an hour, while at the beginning of the year he had only been able to stay for 10 minutes. Communication reported notable gains in understanding speech. The Recreation Department reported that this resident went to the gym for 3 1/2 hours on Tuesdays and to the pool for one hour a week. They reported considerable gains in gym activities; he had overcome his fear of the trampoline and had learned to float contentedly in the pool with a life preserver.

The Service Agreement included, among other provisions:

> 2. Direct care staff, under the supervision of [the building supervisor] are to continue to work with [Resident] on refining his ADL skills in the areas of eating and toileting. The program coordinator is to monitor this program by June 30, 1979. . . .
>
> 6. Direct care staff [under supervision] are to involve [Resident] in as much gross motor activity [walks, swims, etc.] as they can, documenting such activity in his chart. Program coordinator to review his chart for these activities by 6/30/79.
>
> 7. In order to lessen [Resident]'s stripping behavior, he should not be redressed immediately upon stripping but should be left unchanged for 10 minutes before dressing.
>
> 8. The team's recommendation is that [Resident] should be transferred to a higher functioning unit, i.e. Doris Anderson I. However, an immediate transfer would deprive [Resident] of Open Classroom programming hours, so such a transfer is not recommended until he is acceptable in the NGHLC program.
>
> 9. A behavior modification program, involving the use of mitts, should be tried to prevent [Resident] from scratching others--trial period to last five days; if successful to be followed up by a written behavior modification program. The trial program follows:
>
> a. The mitts are to be applied with brief, consistent verbal directions.
>
> b. The mitts are to be applied for 10 minutes at a time, immediately after he has scratched somebody.

This IDT report, taken as a whole, gives quite a complete picture of a resident; it would be useful to anyone who read the whole. It does not satisfy the requirement of sec. D.4. that "the individual program plan shall include a clear explanation of the daily program needs of the resident for the guidance of those responsible for daily care." Direct care staff from both morning and afternoon shifts were present at the IDT meeting, which does not always happen, and is to be very much encouraged. The IDT meeting was held on the 28th of March, and monitoring of ADL and gross motor activities was not to take place until June 30 although section D.11. provides: "Pineland shall provide the programming recommended by the resident's prescriptive program plan within 30 days of the preparation of the plan."

More of the material from the reports of individual disciplines should have been incorporated into the service agreement, at least by reference. For example, the resident was making good progress in communication games which could have been carried on in the unit as well if direct care staff could and would refer to the IDT report for guidance.

Something more specific than "community excursions" should have been included. There should have been more specific directions about ADL, including time-frames and short- and long-range goals. According to a veteran direct care aide, the best sources of information on resident care come from professional consultation, from other direct care staff, and from trial and error. He was afraid that a "clear explanation of daily program needs" might become rigid, and inhibit creativity. This is, of course, a danger with legally mandated "explanations." We would stress the fact that the decree asks for an "explanation," not an order. If the explanation becomes outdated, it should be changed. Suggested revision of the IDT process includes a two-step procedure under which direct care and a few professional staff work out detailed systems for ADL and other training. If the new system works well, it should provide more detailed explanations which would help to provide guidance for different shifts and for "floats."* Consistency in the training of the retarded is a prime requirement. Another change in procedure involves sharing of individual disciplines' reports before the IDT meeting.

The content of the IDT report is, of course, academic to the extent, unmeasured but probably substantial, that the report is unread. Last year, in some cases people got along for more than half a year without IDT reports. In August staff in one unit were surprised to find that a report had been missing since May. This fact suggests that much more should be done to make sure the reports play a useful role at Pineland. Content should be improved; management should make sure that they are read and discussed and that each section is comprehended

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* "Floats" is the Pineland term for a pool of direct care workers drawn upon, as needed, to fill staffing gaps created by absenteeism.

by the people who are expected to use it. We have no evidence that IDT reports are actually used.

Given good content and systematic use, the speed of filing of IDT reports is important. During the first decree year they were often late. Section D.11. of Appendix A requires that Pineland provide the IDT-recommended programming "within 30 days of the preparation of the plan." Since the plan is "prepared" at the meeting of the IDT, the meeting marks the start of the 30-day period. Pineland has set itself a 30-day limit for the filing of IDT reports. This limit was met regarding recent reports in three units; five units ran between 30 days and six weeks; nine units took over six weeks; at least two reports were unfiled on August 21 that had been written in May; last winter's record for unfiled IDT's was 267 days. The decree requires (by implication) that the report be filed soon enough to be useful in planning; that is, in time to allow the various service providers to commence implementing their respective program responsibilities within 30 days of the IDT meeting and to be able to check what other service providers are supposed to be doing. Pineland should try to approach more closely the standard set by the fastest units: two or three weeks. There may be two important consequences of late filing of IDT reports: major changes may be held up for want of a signed service agreement and direct care staff would not have "a clear explanation of daily program needs." (Sec. D.4.) There are two bottlenecks in IDT preparation, neither of which is clerical; one is reports from the separate disciplines, and the other is signatures. A recent policy change by the coordinators should greately reduce the signature problem; as for reports from the disciplines, it is Pineland's duty to find time for reports as presently written or to simplify them.

Restraints

Finding: Pineland uses restraints as a substitute for program and as a substitute for staff. Pineland uses restraints without showing that other techniques, including one-to-one training, have been tried and found to have been inefficacious.

> D.7. At the first interdisciplinary team meeting held on behalf of a resident under the terms of this decree, any regressive or self-abusive behavior which has been exhibited by the resident will be noted. The prescriptive program plan shall address in detail the programs and services which must be provided to the resident so that such behavior can be eliminated as quickly as possible. One-to-one training shall be an option considered by the interdisciplinary team.
>
> N.1. The routine use of all forms of restraint shall be eliminated. Physical or chemical restraint shall be employed only when absolutely necessary to prevent a resident from seriously injuring himself or others. Restraint shall never be employed as punishment, for the convenience of staff, or as a substitute for programs. In any event, restraints may only be applied if alternative techniques have been attempted and failed. . . .

Discussion: Very little one-to-one training is done at Pineland. The reason is lack of staff. Because IDT's frequently consider the actual availability of needed services, one-to-one is not often recommended. Coordinators know that one-to-one will not usually be provided even if recommended. They, therefore, seek alternatives, even if inappropriate ones. We are concerned that more could be done to devise ways of dealing with residents who are self-abusive or aggressive, that one-to-one is not seriously considered. The decree forbids restraints if any other method of dealing with problem behaviors can be found. IDT's of difficult residents must show all the alternatives considered, including one-to-one, particularly if restraints are being considered. To the extent that restraints are now used without first providing one-to-one training, restraints are being used for the convenience of staff or as a substitute for staff.

On June 11, 1979, Allita Paine, Chairman of Pineland's Occupational Therapy Department reported:

> I consider inservice training to be a vital role of the O.T. Department at Pineland. We have developed much media which is only partially organized. If greater priority could be given to this activity [by the staff development office], we could put together training programs on . . . techniques to control behavior problems [distractibility, self-abuse].

From this view it appears that the Occupational Therapy Department feels quite sure that it could substantially improve resident behavior by providing programs which would overcome the tendency toward self-abuse.

If this is so, then it means that restraints to control such behavior are now used as a substitute for programming.

Of the seven individuals wearing mitts for over 250 hours in September 1979, only one had more than 25 hours of program. The others were provided only 12.5 to 15 hours a week, or 50 to 60 hours a month, usually less than half the programming to which residents are now entitled.

Restraint time has increased since the decree was signed. The Human Rights Assurance Committee minutes of September 13, 1979, show that hours rose from 1,400 in July of 1978 to 2,800 in August; for April 1979, 4922; for August 1979, 3780.

Pineland reports the use of physical restraints for the month of July 1979 as follows:

Type of Restraint	Hours
Mitts	2465.75
Crib nets or other devices to keep people from falling out of bed	858.75
Masks	535.75
Arm splints	96.25
Program chairs or other major restraints on liberty	46.25
	4002.75

Mitts are used for various purposes: to prevent self-abuse, prevent scratching at scabs, prevent picking up small objects and eating them. Masks and arm splints are also used to prevent people from swallowing dangerous objects. In some cases, the mitts are used to prevent scratching of infections, which could cause fatal blood poisoning. The nursing office says that some of these conditions date from earlier times, when people were less careful to avoid infections; an effort is being made at present to reduce rashes and infections. A few residents account for most of the time in mitts; mitts are sometimes used while a resident sleeps and at all times when he cannot be watched very closely because of lack of staff. At least one resident in mitts is usually able to go without them at programming (12 1/2 hours per week) and on van rides, which he enjoys.

The danger with mitts is that people will lose hand skills. This happened to some extent with resident S. on whom mitts were used to prevent unwanted behavior. At one time she had been playing with toys for two or three minutes; later when mitts were taken off in therapy, she would either put her hands to her eyes or restrain her arm in a hammock netting. When objects were place in her hands, she discarded them. The most recent report states: "S. is doing well in hand-over-hand eating training, though some break-down in consistency is evident. . . . Attempts at weaning her from the protective mitts are being implemented." (July 25, 1979). Between May and July her hours (per month) in mitts were reduced from 545 to 292. In September she was back to 537.5 hours, perhaps because she had to adjust to new staff at this time.

There is only one resident at Pineland for whom use of chair restraint regularly exceeds 8 hours a month. Resident B is a young man with a history of aggressiveness and self-abuse. A time-out, sitting-in-the-corner program was tried, unsuccessfully. A restraint chair program was instituted in December of 1977. The following comments are taken from his IDT reports of August 20, 1978, nine months later.

> [Building report:] He is very moody and if asked to do something when he doesn't want to he gets extremely upset, and it is usually at these times that he is put in the chair. . . . It is believed that B is progressing very well and should be considered as a primary candidate for placement when an appropriate place is found.
>
> [Communication Department:] He eagerly comes to the classroom, outside activities, or walks to the gym, however he is initially resistant to structured activities unless they are familiar. If care is taken to introduce these activities in a gradual manner his cooperation is usually obtained. Prognosis for B is good, as long as care is taken to monitor the progressive structure of his activities not to exceed his tolerance.

On October 13, a special IDT was held. The reason for the IDT was stated as follows:

> The reason for holding this Special IDT was to consider continuing B's time-out program with chair for another 90 days. If the program cannot be followed consistently, it should not be continued.

The following are excerpts from various reports presented at the special IDT:

> [Kupelian Hall Open Classroom:] B's behavior has improved slightly. He appears to enjoy working with blocks. When returning from bus rides he tends to become upset and self-abusive. When this behavior occurs he is put into

> his chair. We've tried to decrease this behavior after bus rides by placing him on the toilet. This works at times.
>
> [Recreation:] B behaves a lot better than when the classroom first began; he will now wait his turn to go in and gives very little trouble leaving. He is getting more involved in the activities in the classroom and the gym. He behaves very well on bus trips and also on walks.
>
> [Communication:] He appears able to tolerate structure and will accept "no" without becoming upset.
>
> [Psychology:] Since 12/14/78 [sic] a chair restraint, time-out behavior management program has been utilized on this resident. The target behaviors are both aggressiveness and self-abuse, although he is also placed in the time-out chair for denudative behavior, since this is almost always a prelude to self-injurious behavior or aggression. . . During the last reported 10 day interval, various difficulties in condition and availability of the chair [were resolved], concomittantly one notices a very sharp reduction in restraint chair use.*

It was decided to continue the program. Data presented included the following:

> First 120 days, 140.75 hrs.; last 120 days, 69.5 hours; reduction 49%. In the 120 days approx. of May, June, and July of 1979 the resident was in restraint for aggressiveness for 66.75 hours.

The 1978 Recreation report shows B to be an enthusiastic program participant. Enthusiasm was his chief difficulty: he would push his way to the front of the line and wanted to stay as long as possible. The Open Classroom report confirms that B liked to be away from Kupelian

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* Sometimes, IDT's accept and implement the team psychologist's recommendations for a method of dealing with unwanted behavior when the psychological report contains no opinion as to the causes of the behavior addressed. In fact, direct-care staff have been observed to be more consistent in offering suggestions on the origins of residents' behavior than any other category of staff. Professionals have been observed to disregard these suggestions and renew their recommendations to the coordinator. Unless the cause of a particular behavior can be identified, there is no assurance that the means chosen to eliminate it are the least restrictive. Psychologists should be especially sensitive to this principle when restraints, physical or chemical, are recommended since the possibility that some type of program could reduce the behavior must be accounted for. Restraints cannot be used as a substitute for program.

Hall and became upset at the prospect of having to return to it. Only at Kupelian Hall, according to the reports, was restraint required. Everywhere else B was reported to be stubborn but amenable if treated with firm consistency. Although B was known to become uncontrollably aggressive only in a restrictive, nonprogram environment, the team's solution was to continue his regimen of restraint. It appears fair to conclude that restraints were in effect recommended as a substitute for program. The Open Classroom noted that B became upset when his program was over for the day. The team prescribed, not more program, but more restraints. One-to-one training was not considered probably because everyone knew it would not be provided. The decree was violated in the case of Resident B in ways both obvious and subtle.

The Psychology Department report seems to focus entirely on "behaviors" as targets which call for an institutional response with disagreeable techniques. It does not seem to consider the total context in which the person does and does not exhibit his behavior. It does not seem to consider the possibility that the behavior is a reaction to something which could be changed.

After more than a year of the chair restraint program, Resident B was transferred to a different living unit, worse in some respects than where he had been living. Despite increased use of the restraint chair, he became even more aggressive. He caused many hundreds of dollars in damage to the buildings and created general havoc. He was sent back to Kupelian Hall.* Two years ago, the IDT report of direct care staff suggested that Resident B "should be considered as a primary candidate for placement." He still lives at Pineland.

Program chair and camisole were used for 46 hours in July. Of these 14.75 were "IDT" hours; the others were emergency. "IDT" restraints are authorized by the residents's IDT team in case the resident does specified undesirable acts. Nine of these IDT hours were used for chair restraint of Resident B. It is not clear from the report submitted whether or to what extent other "IDT" hours were supposed to have value as training for the residents involved.

Restraint has apparently brought improvement in some cases.** An outstanding example is a woman with a tendency to severe self-abuse who was essentially cured of her behavior problem and is now an unusually happy and appealing person, soon if not already moving to a group home "near my mama."

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*Moving a person from one unit to another is a standard method of addressing behavior problems without any special analysis of the problem or more than a guess that some other environment might make a difference. One resident who is aggressive is said to have been moved to nearly every building at Pineland. He is blind.

**That restraints may be efficacious does not justify their use if other alternatives have not been tried. One woman on whom restraints are used becomes aggressive only in her residential unit. She attends the blind program, where she does not have as much to do as she should because of lack of staff; even though she does not have proper program, the quiet atmosphere is good for her.

APPENDIX TO PROGRAMMING:

OBSERVATIONS ON PINELAND'S PROGRAM AREAS

The Court's decree calls for individually planned programs for each Pineland resident. Persons who are closely familiar with a resident are to meet with professionals from a wide variety of disciplines to consider all of a resident's needs and potential abilities and are to decide how best to meet those needs and take advantage of those abilities.* The team decides what a resident can presently learn and how to go about teaching him; it prescribes short-range and long-range objectives and timetables for attaining those objectives. The polestar guiding preparation of a resident's individual and specific program plan is to "maximize his human abilities, enhance his ability to cope with his environment and create a reasonable expectation of progress toward the goal of independent community living." His educational program, like the other activities of his life, are to take place in an environment which is normal and conducive to learning. His teachers -- professionals, paraprofessionals, and direct-care aides -- are to be trained and are to be present in sufficient numbers to carry out each individual program expertly. All other activities, services, and procedures of Pineland revolve around Pineland's central educational mission.

At Pineland formal programming is a place. Certain standard activities occur at the programming area, and the fortunate resident is one who gets to be there for the time of his minimum six-hour entitlement. The activities are not individually planned; they may or may not coincide with a person's needs and abilities or be purposefully related to his personal objectives. The environment may vary from the very good (as at Berman School) to the extremely poor (as at New Gloucester Learning Cooperative). There may or may not be sufficient staff present to provide a semblance of individual training for a small portion of the time while he is present.

The differences between the programmatic prescriptions of the Court's decree (which the State participated in formulating and promised to carry out) and programming at Pineland are not just incongruities. There is little relationship between the two. Pineland does not provide anything close to what the State, by its consenting to the Court's decree, has promised. Nevertheless, however great the distance between the promised and the provided, it is Pineland's effort toward programming which is its one redeeming feature.

Not until the close of the first decree year, when the Director of the Bureau of Mental Retardation assigned himself to the acting superintendency, did Pineland realize that education lies at the heart of the Court's decree and thus at the heart of Pineland Center. It remains to be seen how well the lesson has been learned. Efforts toward programming must have the highest priority. If anyone can narrow the enormous distance between program as promised and program as it exists it must be the program coordinators. But one thing is clear. That distance renders intolerable those obstacles even to Pineland's present efforts toward programming. Those obstacles principally emanate from the Pineland Business Office; that small portion of direct-care aides who, encouraged by their bargaining representatives, disparage education and the capacity of

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*The decree establishes a procedure for a resident or persons acting on his behalf to object to a prescriptive program plan and to appeal adverse decisions to a level as high as the Director of the Bureau of Mental Retardation.

Pineland residents to benefit by it; personnel procedures which prevent hiring the persons best qualified to be teachers; and the indifference of some psychologists and perhaps other persons. What follows are observations on Pineland's program areas as they exist.

Overview of Program Areas

Program staff have been praised for their good relationships with residents. (Report of Program Quality Task Force). Program staff have been observed by assistants to the Master. They are generally patient and enthusiastic; response of the residents is often impressive. On the other hand, there are some difficult problems common to various program areas. One is insufficient coordination between the various disciplines represented in each area, between the various areas and the residential units, and between the areas themselves. Others are budgeting and equipment, insufficient and sometimes unsatisfactory use of direct-care staff at program area, need for more precise goals and methods, and lack of space in which to operate.

The Program Quality Committee reported: "The small budgets alotted to the open classroom and other program areas was discussed. Further discussion and monitoring of this problem will be on an ongoing basis for the Program Quality Committee." (Minutes, June 20, 1979; see also memo of IDT Task Force, July 18, 1979.)

Budgeting is presently being done on the assumption that program hours will not be greatly increased. If the budgets are low now, they will be patently inadequate if more program is provided. Getting equipment is also a problem recognized by the IDT Task Force. Program areas now wait many months for any equipment which is to be fabricated by Pineland's maintenance department. New Gloucester Learning Cooperative, for example, has been waiting over a year for some program equipment to be built. This, in itself, constitutes a violation of Sec. Q.5., App. A. which requires "prompt elimination of existing maintenance backlogs."*

The Program Quality Task Force found that staff in various program areas felt isolated from the total workings of Pineland. The Program Quality Committee has noted "the lack of a true interdisciplinary team in some areas particularly Berman School." It was felt that special services providers (Physical Therapy, Occupational Therapy, and Communication Department) were not being considered as part of the habilitation team. (Program Quality Committee minutes, 1/31/79.) Direct care aides do not believe that they are considered as part of the habilitation team either. Pineland Staff see a need for greater coordination between departments, and discussion of philosophy. Minutes of the program quality committee, April 25, 1979, state:

> The need for a consistent philosophical model to be adopted by all program areas was discussed. Functionality and appropriateness of program activities was also stressed. It was agreed that professional and paraprofessional discipline staff were not always being utilized to best advantage for goal-oriented training in program areas.

*This state of affairs is further illustrated by the memoranda which follow Page 9 of this report. Note the dates of each, the seriousness of the problem, and the relative ease with which it could have been corrected.

A winter report from the communication department stated that not all areas were carrying over signing with non-verbal residents. (Building report, Doris Sidwell Hall, Jan. 1, 1979.)

A key issue at Pineland is how best to use direct-care staff in the training of residents. This is important both in ADL and other training in the residential units and in formal program at program areas. Program areas depend on direct-care staff for help. Five of the six major programs report varying degrees of dissatisfaction with this arrangement, not in theory, but as it works in actual practice. Irregular attendance is one problem. Short staffing contributes; so does lack of motivation. The use of "float teams" who are assigned to short-staffed units on a shift-by-shift basis provides a partial solution to low attendance. This is less than satisfactory, however, since"floating" direct-care staff may not be familiar with the particular residents with whom they will be expected to work. Direct-care staff are more effective program assistants when they are thoroughly familiar with the residents and their individualized plans of habilitation. Furthermore, direct-care staff who regularly care for a given resident should learn at program areas how to build the resident's skills when he is at home, but they now do not.

When direct-care staff fail, for whatever reason, to attend programs with the residents from their units, the adverse impact on program effectiveness is likely to be substantial. Professional and paraprofessional staff must then ignore program activities, many of which should be conducted in very low ratio settings, in order to attend such peripheral problems as toileting, behavior, and time-out.* Shortage of direct-care staff may contribute to the rate at which residents are returned to their units from program areas for various behavior problems in violation of section D.9. of Appendix A. Direct-care staff are most needed in programs for the most profoundly retarded. Clients in these programs must be taught skills that babies pick up by themselves: "eye tracking" moving objects, localizing sound, grasping objects. Much of the training has to be on a one-to-one basis. With insufficient staff each client spends considerable time doing the sorts of things he would do without programs: staring into space, wandering aimlessly, rocking back and forth, pulling threads out of his shirt. In some cases, direct-care aides or "foster grandmothers" (part-time helpers hired under a federal grant) have been extremely helpful. In other cases aides have appeared at program areas but not done much. Program areas need to improve training and organization of direct-care staff. "There is as much or as little as you want to do," explained one direct-care aide. Sometimes aides develop a specialty, and the other aides are left with toileting and a temptation to take extended coffee breaks The Program Quality Committee reported:

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*Aides refuse to go to program areas because they are expected to handle those disagreeable problems. Aides believe that program staff treat them disdainfully by expecting them to handle those problems. Aides do not see why they should be expected to go to program areas to handle the most disagreeable problems in order to make life easier for program staff whose working hours are more normal and thus more favorable than their own. Union representatives of direct care aides promote suspicion of persons who are qualified to be teachers referring to them as "people with pieces of paper [i.e. college degrees]."

> Most direct-care staff have difficulty with their role as trainers in the program area...It was identified that what was needed to be done was to (1) decide on the job role of the direct-care staff, (2) design/implement a formalized training system, and (3) design a competency measurement for direct-care staff.
>
> (Minutes, July 25, 1979)

The IDT Task Force is studying the following problems identified by the Program Quality Committee:

(1) Need for design of "minimal competencies" for direct-care staff [certain specific skills which must be mastered] before going off probation. [Direct-care staff have a probationary period, which may be extended, before they are permanently hired. Pineland seldom fires a staff member who has passed the probationary period.*] The Program Quality Committee would draw up specific tasks which would have to be mastered by probationary direct-care staff.

(2) Facilitation of communication/cultivation of relationship between program areas and residential services. Possible use of WAC/DAH II relationship as a model. [Memo, IDT Task Force, July 18, 1979.]

Minutes of the Program Quality Committee of June 27, 1979 state:

> Discussion centered around training of direct care staff. Cheryl Fortier [the advocate] suggested giving feeding programs top priority. The need for more practical orientation for new direct-care staff receive training in positioning, feeding, sensory stimulation, a few basic signs, etc. before they begin to work on the units. Passing of some sort of measurement criteria in these areas could be held as a contingency for removal of the 6 month probationary period.

Adult education is clearly mandated by the decree, but Pineland does not provide it. The Activities and Training Department feels that education is most needed for the residents at the sheltered workshop but would be beneficial to other adults in less advanced programs. One resident at age 35 is learning his numbers; another, who is scheduled for only two hours at the workshop, can add four figures. Under the decree, all residents are presumed capable of benefiting from education. "Education," to the Activities and Training Department, means fairly intensive work on "cognitive" skills, understanding letters, numbers, traffic rules, coin values.

Housekeeping has been inadequate at program areas; Pineland has a plan to have program areas cleaned by an outside company. This service began in September.

Waiting lists: At least 60 places need to be found in present programs for residents not programmed at all or programmed inappropriately.

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*State procedures make it almost impossible to fire someone for anything short of criminal conduct. Even discharging an employee who has abused a resident is a struggle.

The problem of program hours has already been discussed. We will, in this section, consider the many residents who either receive no formal program at all or who have been positively recommended, or recommended for an evaluation, for a different program than they now receive. As it happens, the residents receiving a nearly full schedule of hours are either at the school or at the Work Activities Center and are not on waiting lists. The people on the lists are receiving program which is acknowledged to be deficient both in quantity and quality.

As of July 4, 40 residents were on waiting lists for Adult Day Activities and Work Activities Center. There were three unprogrammed residents who should be admitted to Kupelian Hall. Kupelian Hall was hoping to get two residents into New Gloucester Learning Cooperative.

There are nine prople on the waiting list for the geriatric program as of September 21. Perhaps 6 people would be on a waiting list for a blind program if the program had any hope of taking them in. (There are about 41 blind or partially sighted residents. Eleven or twelve are in the blind program and eight placed at school. Sixteen need special instruction at Perry Hayden.) In all, perhaps 60 residents are either totally unprogrammed or in need of a change of program area. This figure includes neither the 16 needing a special program for the blind at Perry Hayden nor the much greater number needing adult education.

Blind Program: Lack of suitable program for the blind is an obstacle to community placement for some and to any kind of a rewarding life for others. Of Pineland's approximately 41 blind or visually impaired residents, six "should be considered feasible candidates for a community day care training program and eventually more comprehensive community placements." (Report of Mr. Eastman, Teacher of the Blind, March 26, 1979) These residents are in the program for the blind but none are scheduled for the minimum number of hours per week mandated by the decree.

> The program needs more staff, and minor renovation, which would allow for a formal classroom area on one end of the program area, a central bathroom in the middle, and living skills and household activity area on the other end. Such a facility would lay some foundation for participation in a group home, day program, or workshop program at the community level. Six other residents should be integrated into the classroom for the blind, for limited social academic training. In order for these six individuals to experience classroom integration and attend other programs and therapies, or even approach their possible potential we get back to the matter of more program staff under this instructor's direct guidance and supervision.

Six blind residents, as reported under "program hours," presently receive almost no programming. Another eight are placed at Berman School.

There is also a group of about 16 residents at Perry Hayden who are blind or visually impaired. Mr. Eastman states:

Most of these residents are currently being programmed at Perry Hayden Hall to varying degrees, and more individual attention and quality services are probably being provided than these particular individuals have ever experienced previously. However, program staff has stressed the special care and complex problems of working with this unique group and expressed the need for one additional full-time person to work exclusively with blind people involved in that particular program.

Work Activities Center: At the Work Activities Center residents work on contracts for Pineland customers and are paid at piece rates. They put partitions into boxes, sort IBM cards, tear rags, fringe kilts, box toothbrushes and soap, and do some other jobs. Partition work is the most frequent; some residents greatly prefer it.

Some people who sit and doze in their residence may be quite chipper at the work center. The social atmosphere is pleasant, and the residents are delighted to earn money. They understand the difference between earning and being given something. They are proud of their accomplishment. Staff have been commended for good relationships with residents and for the use of signing. Nevertheless, the work experience needs to be upgraded and supplemented. The basic activity is determined by the needs of Pineland customers. The program is not designed to build skill upon skill indefinitely, and at least one resident has been there for ten years.* After a time the program, though beneficial, cannot be considered "educational" except in the sense that any sociable activity is educational. At present the program is not in fact a stepping stone to independent employment. This state of affairs is questionable under Section R.2., App. A, which states "Residents may be required to perform vocational training tasks...subject to a presumption that an assignment of longer than four months to any specific task is not a training task...".

Residents are paid according to the amount of work they do in comparison to non-handicapped workers; in the week ending March 1, none earned more than $25 for 31 hours of work. A thorough study should be made of different projects and methods. A staff member working on school reorganization reports that some workshops in other states are very successful. Some sheltered workshops train severely and profoundly retarded people to work as well as or better than non-retarded people. For example, a deaf, blind, profoundly retarded person has been taught to assemble a 19-piece bicycle brake.

The work experience is apparently much more beneficial to some residents than to others. Payment records provide some indication of response to the work program; some residents, including some among the more intelligent, work 30 hours for under ten dollars. One resident earned $2.06 for 26.5 hours. On the other hand, one resident who earned $8.18 for 30 hours work said that he liked the work and liked the chance to earn money. Workshop policy is to require people to come but not to pressure them to work. This policy should be reconsidered.

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*The Acting Superintendent visited the workshop this summer unannounced. No work was available. Residents spent their day making and unmaking partitions.

The Program Quality Task Force found the following deficiencies: lack of a smooth flow of available work, lack of clarity as to contract procurement responsibility, and a need for recreational and social experiences when work is not available. A proposal had been submitted for use of the gym; it was turned down. Staff feel they are not part of the total picture at Pineland. They do not know why they keep statistics. (Report of Program Study Task Force, August 10, 1979)

Sheltered workshop staff and the Activities and Training Department would like to offer more learning experiences. At present 28 workshop clients receive on a regular basis one or one and a half hours a week of "experiences of daily living" (similar to adult education) and some miscellaneous training at the workshop, but much more is needed. Adult education was stopped at Pineland because the institution was bound by state law to educate all children, and there were not enough teachers to go around. The class action suit has also been blamed for the lack of teachers for adults. In fact, the decree clearly mandates adult education:

> The educational philosophy shall be that all residents are presumed to be capable of benefitting from education. Education services shall be provided to adult residents upon recommendation of the resident's prescriptive program plan. (G.1)

Subjects which might be taught include recognition of one's name and of letters and numbers, simple arithmetic in some cases, coin identification and coin combinations, basic nutrition, language. Clients would be taught to read signs and might be taught a little general reading. Some of these subjects are dealt with at the workshop, but residents could benefit from more intensive training in small groups with a teacher to every two or three residents. The Director of Activities and Training feels that workshop clients are those most in need of "adult education," but that similar training would be beneficial to other adults in less advanced programs. The head of the sheltered workshop program would like to stress "awareness of money"; this seems essential as residents are very proud of their paychecks and show them to everyone they see.

Adult Day Activities Center: The Adult Day Activities Center prepares people for the sheltered workshops. The Center has been praised by the Program Quality Task Force for "excellent interaction with residents and good organization of overall program." The task force recommended more communication with other program areas and questioned whether the program as it was should be changed to fit in better with other program areas. The ADL area should be expanded. There should be in-service training in communication and physical therapy. There should be more use of direct-care staff to get residents ready for the work Activities Center.

New Gloucester Learning Cooperative

The program quality task force praised New Gloucester for good interaction between staff and residents. The physical plant was criticised. It is a large, old, unrenovated residence hall. It is noisy and dirty. Housekeeping is a constant problem. Its bathrooms do not conform to

applicable sections of the decree. Heat in the basement where classes are conducted cannot be turned off. Equipment is needed, has been ordered and reordered and is still needed.*

"The quality of the environment is poor, with walls needing painting, floors needing to be replaced, and the whole place and its materials/ equipment needing to be cleaned. The building [should] be renovated if it is to be used for programming for another year."

(Mrs. Paine, Executive Management Survey)

Staff recommended more interaction with direct-care workers. Mr. King, Director of New Gloucester, reports:

> Direct-care staff are not assigned to New Gloucester Learning Cooperative on a consistent basis. The ratio varies from day to day. We receive anywhere from one Mental Health Worker I from a unit to three. Whenever possible this staff is assigned to the same area in order that they become as proficient and helpful as possible. Moreover, it is hoped that they will identify with that discipline and the program staff.

Mr. King said,

> I don't think we have a good system. I don't know what the answer is. Afternoon is the greater problem. First shift aides come for an hour or an hour and a half; this breaks the day. Furthermore, they are tired when they come. Some of the aides are very good.
>
> (Conversation with Bill King. Director of New Gloucester Program, Sept. 21)

The Executive Management Committee report praised one unit's direct-care staff for their work at New Gloucester:

> [Vosburgh staff do a nice job at New Gloucester], showing a real sensitivity to their residents' developmental needs and behavioral problems.

As to program quality, an Executive Management Committee report said:

> NGLC needs to develop more specific goals, more intensive programs, and more comprehensive reporting on individual residents. With recent staff additions and program changes, these issues are being addressed.

Physical therapy needs are not met:

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*The Business office has a rule that it will not replace any item unless the used item is presented as evidence of the need for replacement. New Gloucester had this summer about two dozen brand new hand-held vibrators to use for sensory stimulation, but the Business Office refused to supply any batteries because no old batteries could be presented.

> Twenty-five per cent of our people need physical therapy - we had one aide, but Perry Hayden needed her more. [No physical therapy is now being provided.]
>
> (Conversation with Bill King, Sept. 21)

As a result of New Gloucester's overcrowded, noisy, dirty, short-handed conditions, its staff is increasingly demoralized. They feel that they receive little by way of support or recognition from Pineland management. Whether or not these latter feelings are justified, they are genuine. It is a common observation among direct-care and program area staff that management does not maintain sufficient contact with "front line workers" to appreciate their daily problems.

Perry Hayden Hall Day Activities Center

The program at Perry Hayden was just begun last fall and has not had a director until recently. (See the section on Staffing for a discussion of this problem.) On February 15, Mrs. Paine reported:

> The program has had a very difficult beginning with little self indentity or representation

The most encouraging feature of the Perry Hayden program is the professional and paraprofessional staff; they are enthusiastic and eager to serve the residents assigned to them, people with such severe handicaps that until recent years they were put in the "back wards" and merely kept alive. At the Day Activity Center one resident was observed lying on a mat and, with the direction of an aide, stacking rings with his good hand; he was thoroughly enjoying himself. Another resident was walking between railings with an aide urging him on. All aides present were working hard. On the other hand, some residents were lying on mats doing nothing. This program needs intensive staffing.

The acting director of the Perry Hayden program wrote in August 1979:

> No field trips have been taken since I have taken over as acting Director due to lack of documentation of previous trips and lack of support and aides to help from the units. Most trips before that time were van rides for the purpose of sensory stimulation which is the primary goal of the program.
>
> We have experienced little support and attendance in our program area. [Direct-care staff] attended the Day Activity Center sporadically and mostly at their convenience. Usually they would only attend for an hour or so and then return to their unit. Some are very helpful. Most, however, don't understand the usefulness of the program and therefore didn't assist very much. This I think was due to the fact that the program aides didn't have any direct supervisor besides myself. We were without an OTR (Registered Occupational Therapist) for five months which made it very difficult on the OT aides. However, the program is beginning to come together to becoming an excellent program area. We now have a new OTR and a Director will soon be hired.

Mrs. Paine's February report said that several necessary items of equipment ordered in August had not arrived by February. The coordinator for the Perry Hayden units reports less use of the swimming pool in August than nine months previously. This is very unfortunate, for the Perry Hayden people, even more than other residents, need every pleasure they can get; furthermore, they benefit greatly from the physical experience of being in the water, relatively free from the burden of gravity in the pool. They have an opportunity to move which is important for their development.

The Perry Hayden Day Activities Center needs soundproofing materials and staff resources; it also needs an environment where residents can be separated into smaller groups. Transportation is a problem. Staffing is a problem. Housekeeping is a problem, with as much as 27 hours weekly of professional program staff time given to cleaning.

Kupelian Hall Open Classroom

There are five staff members to 17 or 18 residents. Usually one, sometimes three, direct care aides come to the program. The program needs more.

A report on Kupelian Hall Open Classroom, written in August, states:

> Attendance of direct-care staff irregular because of shortage of staff. At least two from Sebago, one from Vosburgh with three boys. They assist with group and individual sensory stimulation, walks, field trips, and at the gym, toileting, and ADL skills.

A memorandum from the director of the open classroom stated that rapport with direct-care staff was a problem, although the present acting director feels there has been improvement. A memorandum of June 18 said that the Open Classroom would expand its case load to include at least seven more residents; the program needed more staff. The program is ready to move off its unit and should do so as soon as possible.*

Berman School

The school was surveyed by the Program Quality Task Force, and found in need of extensive reorganization. Reorganization may occur and include exploration of different program sources, a reorientation toward more prevocational training, more supervision of teachers, staff meetings, an effort to eliminate cancellations of programs, an effort to improve the use of direct care staff and foster grandparents, and better use of teacher time. On the plus side, the Task Force found that the faculty were dedicated and genuinely interested in the residents, that the facility was "extremely adequate," and that there was enough equipment. Court personnel have found the school generally pleasant, and have observed some good use of direct-care staff and foster grandparents. The grandparents take their title literally; they provide the warmth and attention that goes with it.

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*The program moved recently to the basement of a residential unit, Vosburgh Hall.

Despite the findings of the Task Force, there is probably a need for increased supplies and extra space. The staff member in charge of program development says that different equipment and more space will be needed for prevocational training. Even before the question of change in program arose, a teacher had submitted a memorandum strongly requesting more classroom materials. The teacher had submitted to the acting principal a list of necessary materials costing $741. He was granted $70 (from the Library Fund, which is "around" $250 per quarter.) According to the teacher:

> [This budget] of $250/quarterly supplies paper, paste, crayons, staples, scotch tape, pencils, folders, duplicator paper, etc.; I would guess that a portion of this money is spent on office supplies and not directly for the students' benefit. This obviously leaves an extremely small amount of money for each student per year; quite possibly and most probably well under $10. The town of Cumberland spends $45 per year per student....It is obvious that students with special needs require a significant increase in allocated budget to provide adequate programming materials.

It should be added that the Pineland School, unlike the Cumberland schools, lasts all year long; also, that much of its equipment is obviously designed for very small children. To the extent it is feasible to replace present equipment with more age-appropriate things, this would be in line with good practice. The acting principal mentioned the need of replacing toys that are lost or broken. Sec. G.2. and G.8. mandate that:

> Educational services at Pineland shall be, equivalent to the special education services provided in the community in accordance with Maine Law in terms of:
>
> (c) Nature, content, and quality of programs;
> (d) Curriculum guides, equipment...
>
> All necessary classroom materials and equipment shall be on hand and reordered as necessary. Teachers shall have a major voice in deciding what is needed. All necessary diagnostic equipment shall be ordered immediately.

The acting principal wanted to have a bus assigned to the school.

Participation of direct-care aides in school program has increased, but has not become consistent. School staff feel that consistency of attendance is absolutely necessary to make the aides' help as useful as it should be. It is universally felt that direct-care staff at school need training. The acting principal reported:

> Staff should provide explanation of why procedures are important, goals of program, techniques used in school, education and discipline, and our educational philosophy. Staff would also assist and demonstrate activities as needed. Most training would be on the job. An in-service on philosophy and theory also should be conducted....With

> direct-care staff working cooperatively in the program areas we could encourage carry-over (further training in the residential unit) in behavior management techniques, (and the following kinds of skills: fine motor, visual motor, socialization, conceptual, communication, ADL)...The worker needs to internalize the need for carry-over, before we would have effective carry-over between school and the buildings.

One of the most appealing features of the school is the music program. All children seem to enjoy it; for some it is a very special treat. Direct-care staff and foster grandparents often assist. A Special Master's assistant observed the program and found that some grandparents were trying to help with counting games; others did not seem to have much to do. What direct-care workers or grandparents do in music program needs to be looked at; perhaps they could be very useful, or perhaps a good deal of their time might be better used elsewhere.

The Program Quality Task Force reported that children generally use the swimming pool one hour a week; some children who don't like the pool lose an hour of program. The principal reports difficulty in persuading direct-care aides to get into the pool.

Coordination between disciplines has been a problem. The Program Quality Committee reported:

> [At Berman] there had been situations where goals set by different staff members were either not developmentally appropriate, functional, or mutually complementary. [Minutes, Feb. 28]

A more recent report from Mrs. Paine states:

> Problems at Berman School alluded to in past reports for the Executive Management Committee regarding lack of inclusion of disciplinary (i.e., professional) staff in planning school programs for the residents have eased in a few situations. Also, Mary Bamford, OTR, now meets with Pat Knowles, Acting Principal, occasionally for communication purposes. The program quality committee will be following up on this matter. [Report, June 11, 1979]

RECOMMENDATIONS BASED UPON CONVERSATIONS AND OBSERVATIONS
OF THE BERMAN SCHOOL & STAFF 8/6-8/7

SUBMITTED BY: JACQUELINE GIASSON M.Ed., COORDINATOR OF PROGRAMS
EDEN INSTITUTE
PRINCETON, N.J.

1. Structure of a "Head Teacher" be set up immediately and fulfill the following recommendations:

   1. Regularily scheduled staff meeting times be arranged to cover the following: behaviors, programatic issues, scheduling & scheduling problems, sharing of general information, staffing of individual children, field trip information, new educational issues or coverage of current research.

      (BASED UPON: needs expressed by staff members, observations of common frustrations of teachers (expressed and witnessed), expressions of "lack of knowing what the other teachers are doing," separation of staff ("Pownal vs Bliss teachers"), needs for general staff-continuity, recognition of acting principal that "there is a need for more meetings," in addition to Inservice Training Meetings.)

      1A. Emphasis on staff abilities and assets be stressed.

   2. Direct supervision of classroom time (monthly basis per teacher and additional on a need basis and for general observation of day-to-day flow) *Possibly include in-house evaluation.

      (BASED UPON: No existing evaluation of program by the individual writing the bulk of programs through direct observation exist to date; Pat - "I'm in and out of the room but haven't gotten involved in the "Nitty-Gritty" aspects of the teachers and children in the classroom," need for adaptation of individual programs on an individual child basis, expression of frustration by teachers in dealing with, the implementation of educational programs or behaviors.

      2A. Each childs individual program be evaluated by direct observation.

   3. Utilization of existing materials more extensively.

      (BASED UPON: Observation of approximately 20-30% of materials that exist being used by teachers on a daily basis, expression by the teachers that the materials needed are either (1) more pictures to hang on the walls, expressed by two teachers and (2) materials that the children could do, without teaching necessary, expressed by three (the remaining felt they had sufficient materials), use of a variety of materials may eliminate some of the behavioral problem that presently exists).

4. Structure of class time be analyzed.

(BASED UPON: Amount of actual program time taking place appears to be anywhere from 4-5 hours, the residents appear to have no difficulty with the length of program time as it exist, many children observed to be sitting idly and in some instances asleep, utilization of recess or break time appears random and possibly could be better structured around in-school program times, teachers or teacher-aides often observed idle while during classroom time, implementation of programs involve approximately ½-1 hour time spent individually with each child.

4A. Suggestions to teachers include increased group activities or where more than one child interacts with teacher.

5. Eliminate the "Cancellation of children" from programming concept,

(unless 2 or more certified teachers are out).

(BASED UPON: (1) Extremely poor utilization of Grandparent and Mental Health Workers as additional and supportive staff, (2) Non-use of acting principal as an additional certified teacher-substitute, (3) As the program exist, it appears that it would not be detrimental to other residents if the extra residents were absorbed by the other classrooms, (4) the necessary back-up system should be considered part of programming responsibilities to be assumed by the coordinator or principal, (5) it was expressed that "usually a two day notice is provided to the principal when a teacher is generally out (sufficient time to seek out support if needed).

6. Resource be made -- materials be made available and circulated to staff (relevant program ideas be discussed on a need basis).
(BASED UPON: expressions by staff members that new ideas be introduced to aid them in their teaching or behavioral management, observations of lack of confidence by staff members in their choice of management techniques, lack of resource available within the building).

7. Use of additional resource materials be utilized when programming for each child and further adaptations be made when necessary.
(BASED UPON: observation and confirmation that one program source is presently the guide being followed (it is four years old), additional resources may provide ideas for programming for the more severely handicapped).

8. Grandparent-involvement be analyzed, and procedures be outlined to best utilize their involvement.
(BASED UPON: Poor or lack of appropriate use of the grandparent as an additional staff, inconsistent preparation of the classroom time while the grandparent is present, Grandparents' excessive removal of children from programs to take walks (some appropriate, many not).

9. Mental Health Workers - Procedures be developed to utilize MHW's as additional staff, with specific guidelines and task assignments.
(BASED UPON: Observation of lack of use of MHW's as aides, those MHW's observed not assigned to specific classrooms and inconsistent assignements given to them).

10. Re-evaluate placement of individuals according to "Classroom Placement" (Possible re-work according to compatability of working together on programs).
(BASE UPON: Expression by teachers, "that it is impossible to implement programs and work simultaneously with two or more children," similarity of programs across classrooms).

11. Addtional responsibilities be assumed by teachers as follows:

1. Teachers assume more initiative in the development of each individual program to be approved by the principal.
(BASED UPON: Observation of lack of initiative in making adaptations or introducing new programs other than what is provided).

2. Daily record keeping of activities that take place in addition to the programmed material and/or scheduling of how and when the programs will be implemented over the course of the day.
(BASED UPON: The existence of too much idle time and seemingly a lack of available possibilities to fill that ime).

3. Better utilization of preparation time to include the above.
(BASED UPON: Paper work not a concern for 6/6 teachers spoken to and 4/6 reported that there is usually plenty of time "left-over", this time observed to be primarily inactive time for teachers).

III. Points to work from:

1. Staff (teaching) generally hardworking, dedicated, interested, and caring in their respective jobs.

2.. Staff members seemingly responsive to suggestions and recommendations made.

3. Extremely adequate facilities available.

4. Sufficient materials (childrens') and resources available (i.e. recreational facilities).

5. Sufficient staff available to be able to run the school very effectively.

6. Isolated aspects of programming and teaching are very appropriate and carried through effectively.

STAFFING - INTRODUCTION

Pineland does not often have, present and on duty, qualified staff sufficient to deliver the services contemplated by the decree. Minimum staff to resident ratios specified by Appendix A are not consistently maintained. Staff shortage is the result of several related situations.

First, defendants have not received and filled enough personnel positions. Even if all staff, now hired, were to be present and on duty from day to day, there would not be enough paraprofessional aides to satisfy decree ratios. Recent statistics show that, on many "units," there are not enough direct care workers scheduled to meet minimum ratios. None of the major program areas has enough paraprofessional aides to comply with the decree. These shortages contribute to non-compliance in delivery of required program, recreation, ADL training, and professional services. Lack of adequate supervision of residents contributes to the rate of accidental injuries and to the use of more restrictive means of behavior control, i.e. chemical and physical restraint, reduced freedom of movement, denial of access to belongings and recreational equipment.

Second, a significant fraction of the staff members hired and scheduled to work on any of the three daily shifts fails, for a variety of reasons, to be present and on duty. Vacation-time, sick-time, and unauthorized absences all contribute to the discrepancy between positions filled and persons working. Direct care staff may be present on the Pineland campus but may have duties which conflict with providing care and habilitation to residents. Staff Development may require that direct care workers attend the orientation and training sessions specified by Appendix A. Residential Services simultaneously needs their presence on the "units" to maintain the ratios prescribed by other sections of the decree. No means of resolving these kinds of inherent tensions, while achieving full compliance, have been implemented. The net result is that, on a given day, over 40% of all residential "units" do not have enough direct care workers present to satisfy minimum ratios or to provide the range of services required of direct care staff by Appendix A.

Defendants also fail to supply required services because a number of the staff hired and on duty are not adequately trained. Pineland has not closed the gap between minimum training requirements of the decree and the current qualifications of staff. No attempt has been made to ensure that, prior to promotion, direct care staff have logged fifty hours of appropriate training.* Furthermore, Pineland's annual employee turnover rate exceeds 40%. This casts some doubt upon the efficacy of that training which is being provided.

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* Section E.4.(e), Appendix A.

Pineland's staff development efforts have suffered, as well, from forces beyond the defendants' control. Although Pineland is enjoined to "actively recruit qualified staff"* and to design its personnel policies "to maximize use of individual employees' skills and to enhance effective programming for residents,"** the direct care workers' union takes a contrary view. The union has insisted that promotions be made in accord with employee seniority alone. In its negotiations and dealings with Pineland the union applies the same criteria it uses to assess the personnel policies of all other State-run agencies and institutions. That union has, as yet, seen no reason to cooperate with the decree.

Procedures used by the State Department of Personnel in the hiring, promotion, demotion, and firing of staff also contribute to defendants' present staffing situation.*** Pineland has suffered long delays in filling positions. Intransigent or incompetent employees are seldom demoted and very rarely fired because of the lengthy and cumbersome procedures imposed upon defendants by State personnel policies and the union contract. Neither of these entities is legally competent to frustrate the implementation of federal law, yet each constitutes a roadblock to Pineland's compliance.

It must be noted that morale and the attitude of employees toward their work also contribute to the failure to provide staff-delivered services to the plaintiffs. Staff may work very hard only to find their accomplishments undercut. Educational gains, slowly and painstakingly achieved, may be rapidly lost when a resident is inadvisedly moved, is cancelled from a program, or fails to receive consistent follow-up care. Staff may work very hard, performing above and beyond their job descriptions, only to find that they are, after all, no closer to compliance with Appendix A standards because of circumstances they are powerless to change. The resulting low morale swells the ranks of employees whose concern for resident care slips progressively, who simply put in their time and collect their pay.

Finally, it is not at all clear that the ultimate problems besetting Pineland can be effectively addressed by a mere infusion of staff. It cannot be said that a 20% increase in staff would yield a 20% increase in habilitation for Pineland residents.

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* Section E.1., Appendix A.

** Section E.101, Appendix A.

*** At appropriate intervals, and collected at the end of this section of the report, there appear, as exhibits, memoranda which illustrate some of these difficulties.

STAFFING - FINDINGS

Most of the important benefits of the decree, such as those requiring habilitative and educational programs, can be provided only through the daily labors of the defendants and their agents. Mere renovation of buildings and acquisition of equipment cannot suffice. Pineland must retain adequate staff in all its departments, not only to meet the absolute minimum staff-to-resident ratios determined by the decree, but also to ensure the actual delivery of all decree benefits.

Finding: Pineland does not have enough staff present and on duty to safeguard the physical well-being of its residents.

Applicable sections of Appendix A:

> Q.1. All necessary steps shall be taken to correct health and safety hazards . . .
>
> Q.2. [In preparing emergency procedures] [s]pecial attention shall be paid to the needs of physically handicapped residents.

Conclusion: Substantial non-compliance poses a threat of death or serious bodily harm to residents.

Discussion:

(1) Pineland is geographically isolated from population centers. The critical time for response to a residential fire, according to the Pineland Fire Department, is five minutes from the time of outbreak. Pineland must, therefore, rely upon its own resources to prevent injury or loss of life from fire. The Pineland Fire Department is a mixture of volunteers and fully qualified, professional fire fighters. It is so severely understaffed that effective response to a fire in a residence hall would be virtually impossible. Loss of life among the nonambulatory residents would be a distinct possibility.

Except for the evening weekend shifts when two trained fire fighters are on duty, there is only one fireman available at Pineland. If his duties require him to leave the firehouse for any reason, the problem is further exacerbated since time for response to a fire must then include the time necessary for him to return to the station.

The roofs of some residence halls are beyond the reach of equipment now on hand. Emergency equipment is otherwise adequate. However, this equipment, while available, may prove worthless in an actual fire emergency because of a shortage of personnel trained in its use. Large ladders require three men for handling, and a pumper truck requires a crew of five.

Firefighters entering a burning building with Scott air packs should always work in pairs. Their lives depend upon the expertise of the truck crew keeping them supplied with water. Trained volunteers may or may not be available to assist the fireman. A night-time fire, when residents would be most likely to be on the unit, would be the most dangerous. It is precisely during these hours that the fewest volunteers are available.

It must be noted here, that, in some instances, unit staffing patterns constitute deliberate violations of sections Q.1. and Q.2. as well as section C.5.(b) which require, as an absolute minimum, a staff-to-resident ratio of one to twelve during sleeping hours. In recent interviews with unit supervisors it was discovered that Pineland very often fails even to schedule sufficient direct care workers to meet this ratio. This conclusion is inescapable despite the use of "float teams" as a method of alleviating specific unit staff shortages for the evening shifts. Even where "floats" are used, a more careful inspection of personnel records often reveals that, in fact, the same float was scheduled to work on more than one unit or that, while the float did work the night shift of a particular unit, he was there only for an hour or so. Although it should not be concluded that staff coverage statistics are being reported in a deliberately misleading way, there is no escape from the conclusion that defendants have intentionally violated the above-mentioned decree sections with the result that the lives of many residents are daily endangered. One example of this course of conduct is scheduling of direct care staff for Perry Hayden Hall. This building comprises three residence units, each having individuals who are among the most multiply handicapped and physically dependent beneficiaries of this decree. Each unit has about twenty residents. Many have severe medical problems such as frequent, violent seizure activity. Some require medication soon after a seizure; if left unassisted they may aspirate and die. The evening shift direct care staff must attend constantly not only to the most basic needs of these residents, but to a substantial amount of other work as well. Unit staff are obviously the front line of defense in an emergency situation jeopardizing the residents of that unit. In a fire emergency, unit staff would have to remove physically each resident of Perry Hayden. If this took one minute per resident, it would require at least four staff to remove all the residents of any unit of Perry Hayden within the five minutes' time cited by the Fire Department as a maximum time-frame for avoiding death or serious injury.

In spite of this, all three shift supervisors interviewed at Perry Hayden reported that there is rarely more than one aide per unit scheduled to work the evening shift in that building. If the direct care staff of other units are to act as "volunteers" in the event of a fire, it is clear that they will be leaving their respective units understaffed in many instances if they must leave to assist the one regularly scheduled fireman. In fact, if there were a fire on any unit of Perry Hayden, the lone aides on the other two units would be forced to choose between leaving the residents of their units totally unattended and watching helplessly as a disaster unfolded on the involved unit.

Even on units where sufficient staff are scheduled to provide the 1:12 coverage required by section C.5.(b) on the 11:00 p.m. to 7:00 a.m. shift, such coverage is often not achieved in fact, and defendants are well aware of this. Pineland's Department of Personnel recently reported that on this shift, on Thursday, August 16, 1979 only about two-thirds of all residence units were staffed according to minimum decree ratios. On Friday, August 17, this shift was less than minimally staffed on fully one-half of all units.

(2) Accidental injuries and injuries inflicted by other residents are sometimes attributable to staff shortages. At least this explanation is sometimes given by unit staff in their reports of such incidents.

This explanation receives some support from the conclusions of Bert Schmickel, an independent consultant, who evaluated Pineland's staffing situation and reported in January of 1979 that sixty additional staff would be needed to ensure "minimum coverage." Such coverage is defined as that ". . . which assures only safety of life and limb to the resident." It seems clear that staff shortage is still well within the realm of reasonable explanations for accidental injuries to residents at the present time even though the positions recommended by Mr. Schmickel have been acquired and filled since his report was filed. As will be seen in the following pages, positions filled do not nearly equate with persons actually working.

Nursing personnel have considered the incidence and cause of serious accidents on a unit-by-unit basis. For units on which accidental injuries were a problem, the near universal conclusion was that an increase in unit staff could decrease the frequency of such harm. "Accidents," as used here, include cases of resident-to-resident abuse.

There follows, for illustration a series of memoranda concerning the effects of understaffing upon the residents of Pownal Hall and Doris Anderson Hall I. The former span the time-frame 12-28-78 to 5-21-79 indicating that, even after being formally apprised of a dangerous situation, defendants allowed it to continue for at least five months. Recent data show that, even now, the situation continues virtually unabated. During the two weeks of October 1 to October 14, 1979, Pownal Hall was staffed below minimum decree standards on 31 out of 42 shifts or 74% of the time.*

The situation described by the Doris Anderson I memos is also roughly the same today. The conditions they cited in November of 1978 were not effectively addressed by Pineland's managers until June or July of 1979,

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* See Table 3, page 108.

OFFICE OF ADVOCACY

STATE OF MAINE

DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

GEORGE A. ZITNAY
COMMISSIONER

SUSAN YOUNG
CHIEF ADVOCATE

RM. 411 STATE OFFICE BLDG.
AUGUSTA, MAINE 04333
TEL. 289-3161

INVESTIGATORY REPORT

OF ALLEGED VIOLATION OF THE RIGHTS OF

A MENTALLY RETARDED PERSON

Client: Pownal Hall I residents (26-29)

Place of Residence: Pownal Hall

Date of Alleged Violation: Dec. 28 - present (1/18/79)

Description of Alleged Violation: Understaffed unit. Residents unsafe. [Name] bitten by other resident, [Name] was making progress in diminishing self abuse, outbursts increased dramatically since Pownal I. crowded by move - he is recommended for private room. The report on [redacted] comes to me from Art Bannister, teacher. Last Sunday there were ~~Investigation Results:~~ daytime ratios of 1 staff to 13 residents for some periods of time. Only Ora Littlefield and Bob Malcolm were on. Marilyn Finch, shift supervisior, went in to help part of the shift.

Recommended Action: Increase numbers of mental health workers available to residential services for assignment to Pownal Hall.

1/19/79
Date

[redacted]
Advocate

cc: Administrator of Facility
Commissioner of MH&C
Chief Advocate
Bureau Director

from "pownal file"

PINELAND CENTER

Inter-Departmental Communication

TO: Charlene Kinnelly, Acting Superintendent DATE: April 19, 1979

FROM: Joseph Witt, Acting Resident Advocate Jwitt

SUBJECT: Pownal Hall

The current situation at Pownal Hall is one that requires attention and action, as you are most likely aware. There are two interrelated issues which have been brought to my attention by a number of sources: the unwiedly heterogeneous mix of residents and inadequate numbers of staff.

When one group of residents moved from Pownal Hall to the cottages the group which remained at Pownal Hall was combined on one floor of the building. The result is a group which varies widely in age, aggressiveness, behavior, etc. I urge speeding the process of relocating, rennovating, and whatever else is involved in providing an adequate setting for Pownal Hall residents.

Concurrently, the situation is complicated by what appear to me to be inadequate numbers of staff. In my opinion the building is understaffed for 24 residents when all staff scheduled are present. A supervisor and three aides is insufficient at the times when all residents are the responsibility of the building staff, ie: when residents are not in school. Further, there are indications that even this number of staff is occasionally if not frequently shortened by staff not reporting to work.

The most recent events calling this to my attention were the most recent Consumer Advisory Board Meeting and [redacted]'s IDT. Mrs. [redacted] reported at C.A.B. that the morning of the meeting she found the building short staffed with many residents, including her son, not properly groomed by a reasonable hour. She was told the ratio at the time was one to nine. At [redacted]'s IDT staff expressed doubts as to their ability to consistently carry out parts of the program [redacted] needs due to short staff.

I know there are plans for filling at least some staffing gaps. I wanted to be sure you are aware of this perception of the Pownal Hall problem and to ask what will be done to insure the quality of life for those in this current situation.

JW:pbt
cc - Cheryl Fortier
C. M. Macgowan
Joseph Ferri

P.S. CHARLENE,
THERE'S AN ERROR ON MY PART THIS IS BEING SENT TO YOU ONE MONTH LATER THAN IT WAS WRITTEN I BELIEVE THE COMMENTS TO BE STILL RELEVENT. AS YOU KNOW, THOUGH, THE RESIDENT ADVOCATE HAS (ex) MAY OR MAY NOT [illegible]

F-5

OFFICE OF ADVOCACY

STATE OF MAINE

DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

GEORGE A. ZITNAY
COMMISSIONER

SUSAN YOUNG
CHIEF ADVOCATE

RM. 411 STATE OFFICE BLDG.
AUGUSTA, MAINE 04333
TEL. 289-3161

REPORT OF

ALLEGED VIOLATION OF RIGHTS OF

A MENTALLY RETARDED PERSON

Pursuant to 34 MRSA c. 186-A, the following report is submitted to the Attorney General's Office.

Mentally Retarded Person: Pownal Hall I residents (24)

Place of Residence: Pineland Center

Date of Alleged Violation: 5/21/79

Description of Alleged Violation: (include all pertinent names, dates, places, etc.)

Follow up on Report filed 1/19/79

Understaffing. 1/6 ratio in bldg.

Problem ameliorated somewhat but continues. Mrs [redacted] (C.A.B.) also registered same complaint at last meeting on 5/8/79.

See attached memo.

An investigation is being conducted by the Office of Advocacy. A summary report will be submitted to the Commissioner and, if applicable, to the Chief Administrative Officer of the residence of the mentally retarded person.

5/21/79
Date

[redacted]
Advocate

Copies to Chief Advocate and Attorney General's Office
Superintendent - Court Master
Bureau Director
Commissioner

[EXACT COPY]

PINELAND CENTER

Inter-Departmental Communication

To.: J. Ferri
GHP
Date: 11/2/78

FROM: G. Parsons MHW III Supervisor DAH I

SUBJECT: Coats

In trying to meet requirements of the decree it is difficult to comply with each standard and still meet others.

While working with a ratio of 1 aide to ten residents time, especially while getting resednts to programing is in short supply

Although working with this high aide to residnt ratio emphasis has been placed on tooth brushing and shaving skills The period of time between 6:00 AM and 8:05 AM is very rushed to get necessary shaving accomplished even though staff is required to make beds, put away soiled linen and clean bathrooms also during this time period

Due to time priorities, unfortunally each resident did not recieve his own coat.

Also at this time I would like to bring you up to date on the situation concerning the unlocked rooms.

As documentation has shown the destruction of clothing has necessitated that clothing can no longer can be be put in the rooms

In turn this has had a very damaging effect on the resident that were able to choose clothing and dress themselves. In general the entire program of residnts dressing themselves has been effected.

Taking into consideration the pros and cons of each issue, the rooms being open and the deterioration of the dressing program, I am locking the bedroom doors so that clothing can be kept in the bedroom.

Perhaps with proper staff ratios the unit would be able to comply with both standards.

cc. J. Ferri
R. Gregory
C. Fortier

PINELAND CENTER

Inter-Department Communication

TO: [illegible] DATE: 11/2/76

FROM: [illegible] DAVE

SUBJECT: [illegible]

In trying to meet the requirements of the law it is difficult to comply with such standard and attainment areas.

While working with a ratio of 1 aide to ten residents time, especially while getting residents to programs is in short supply.

Although working with this high aide to resident ratio emphasis has been placed on tooth brushing and shaving skills. The period of time between 6:00 AM and 7:00 AM is being stacked to get necessary daily activities completed even though staff is required to make beds, put away soiled linen and clean bathrooms also. This time period

Due to time priorities, until recently each resident did not receive his own coat.

Also at this time I would like to bring you up to date on the situation concerning the contract issue.

PINELAND CENTER

Inter-Departmental Communication

TO: _____ DATE: _____

FROM: _____

SUBJECT: _____

As documentation has shown the destruction of clothing has necessitated that clothing can no longer be kept in the rooms

In turn this has had a negative effect on the resident that are able to have clothing and their values. In general the entire program of resident training has been effected.

Taking into consideration the pros and cons of each issue, the board is in favor of the deterioration of the dressing program. I am locking the entire closet so that clothing can be kept in the bedroom.

Cottages with proper staffing ratio the unit would be able to comply with both standards.

cc: J. Ferri
P Gruening
C Fordien

Pineland Center

Inter-Departmental Memorandum Date Nov. 15, 1978

To Al Wrenn *Dept.*

From John C. Milazzo *Dept.*

Subject Justification for 3 Project Positions for DAH 1

I am requesting 3 project MHW I positions for Doris Anderson Hall I. My justification for this request is as follows:

Doris Anderson Hall I is a unit which houses 29 male and female residents. Most of these residents are very active and excitable, and a number are aggressive. Therefore, the present staff to resident ratio of 8 to 1 during waking hours is not appropriate or safe.

In addition to the difficult nature of a number of the residents, the physical structure of DAH I, with its long corridors and semi-private rooms, in line with Consent Decree requirements, causes difficulty relative to properly supervising the large number of residents. There have been a large number of accident reports recently involving this unit, and a significant number of accidents with unknown causes. This indicates that the residents are not being properly supervised and I do not believe the staff are negligent. DAH I lost two CETA positions recently, and the amount of clothes being destroyed by a number of residents has almost doubled, again indicating a problem with shortage of staff.

The residents of DAH I have a number of programming needs, and are very active in programming. If they were not, the number of assigned staff might be sufficient to sustain life with minimal hazards. But being active and very involved in programs, both at Pineland and in the community, has served to increase staff demands drastically, and in some cases, increased the potential for accidents proportionately.

At this point, I consider DAH I a priority area for assistance, hence this request. At the present time, no other area at Pineland has the potential for entropy that DAH I has. If you have any questions, please contact me. Thank you.

JCM:dw

OFFICE OF ADVOCACY

STATE OF MAINE

DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

GEORGE A. ZITNAY
COMMISSIONER

SUSAN YOUNG
CHIEF ADVOCATE

RM. 411 STATE OFFICE BLDG.
AUGUSTA, MAINE 04333
TEL. 289-3161

INVESTIGATORY REPORT

OF ALLEGED VIOLATION OF THE RIGHTS OF

A MENTALLY RETARDED PERSON

Client: 27 residents

Place of Residence: DAH I

Date of Alleged Violation: ongoing at present 1/18/79

Description of Alleged Violation: Understaffed unit. Minimum 4. Active, aggressive residents. Male and female. Atmosphere on unit chaotic and frightening. Many extra staff requests have come from within Pineland. Special 3 project positions recently denied by John Conrad. (See Rights Violation Report on [redacted] 12/20/78.) Now waiting for approval of ~~Investigation Results~~ hiring 50 MHW I in vacant positions. Supervisor of DAH I informed me that staff are working 5-6 extra shifts/week to cover needed overtime. Staff work more than they want to in order to help out with poor situation. Supervisor says staff reach their frustration point and may abuse residents because they reach their limit. Nurse on unit ~~[illegible]~~ very concerned about many recent accidents - lacerations found on residents - with unknown causes. Nurse coneeeds staff are frustrated -- was crying herself out of frustration -- but does not think

1/19/79
Date

Advocate

cc: Administrator of Facility
Commissioner of MH&C
Chief Advocate
Bureau Director
Asst Attorney Gen'l

staff abuse residents. Recently a staff member was being strangled by a resident and it took 2 other staff to get him off and marks were left on woman's neck. My observation of the staff is that they work well with residents but much of their time is spent averting crisfs with little time left for other work. Also, supervisor does not seem to provide good role model or organization.

Recommend: To residential services - new supervison. To Bureau Director: Moving as fast as possible to get new staff approved.

Cheryl Tobin
Advocate

[redacted]

according to the Residents' Advocate. Even now, this unit is understaffed as much as 43% of the time.*

It is hard to assess the extent to which short staffing is being used either as an excuse or as a bona fide explanation of why accidents happen at Pineland. The Resident Advocate's office will keep track of such reports from now on and determine whether the unit or program area was, in fact, short-staffed at the time of the accident. In at least one case, unit staff blamed lack of personnel for an accident which occurred at a time when five persons, including the supervisor, were signed in to work on the unit. This particular unit houses about twenty residents who, under the decree, require a staff/resident ratio of one to four at that time of the day. Without further investigation it cannot be determined whether staff shortage merely constituted a convenient excuse for the accident or whether the minimum decree ratios, even when met, as they apparently were at the time of this accident, are sometimes inadequate to "correct health and safety hazards" as required by sec. Q.1.

Section C.5. of Appendix A determines the minimum ratios permissible for direct care staff:

> C.5. Pineland shall employ and maintain sufficient living unit staff to ensure that the following numbers are present and on duty:
>
> (a) During the hours of the day and evening when residents are awake:
>
> (1) One direct care worker for every four residents in buildings primarily for residents who are children, nonambulatory, multiply handicapped or have behavior problems (e.g., persons residing on Kupelian Hall at the time the decree is signed).
>
> (2) One direct care worker (or psychological aide) for every resident receiving an intensive behavior

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*Id. The first DAH I memo is noteworthy in two more respects. First, the supervisor notes that he will begin locking residents out of their rooms in order to facilitate storage of clothing in individual dressers. At last inspection, ten months later, not only were the residents of DAH I still being locked out of their rooms, but all clothing, toys, and possessions were concurrently stored in a locked, central location.

Second, this is the memo which prompted Pineland managers to circulate memoranda to all staff in repeated attempts to block the flow of such information to the Special Master. Instead of heeding the supervisor's advice and devoting their energies toward correcting conditions which threatened the safety of residents and the efficacy of their habilitation, Pineland's management worked hard at keeping such information secret. Although they were unsuccessful in this attempt, meanwhile, nothing was done to protect the beneficiaries of the decree.

> modification program.
> (3) One direct care worker for every six residents for all residents and buildings not covered above.
> (b) During sleeping hours, one direct care worker for every 12 residents; but in no event less than one staff person on each floor of each building. . .

In addition, section C.7. states:

> C.7. In no living unit except as provided in 5(b) above shall the staff to resident ratio actually within the unit ever be lower than one to eight.

It is difficult to determine the extent to which this last section of the decree is being contravened because violations result not only from inadequate scheduling of staff and from absenteeism among those scheduled to work, but also from the fact that direct care personnel are often called upon to leave their units for various reasons over the course of the day. Often, not all the residents of a given unit will participate in some off-unit activity. For example, some may go to the gym, leisure center, program area or to therapy and others remain in their living areas. Staff for that unit must then be split among these groups to provide adequate coverage for each. The problem is most likely to arise when an individual resident must be accompanied by a staff member. Since the need for supervision often depends upon the capability of the resident, and since residents are housed according to developmental level, the problem is obviously more acute for some units than for others.

One would assume that the favored solution would be to bring the service to the resident in a situation where the one to eight ratio would be violated by bringing the resident to the service. However, this is not always the case. For example, units having severely handicapped residents, many of whom suffer chronic medical conditions, complain that Pineland's Medical Department no longer makes house calls as a routine matter. Use of the clinic as a central medical resource is more efficient, allows better medical practice, and is more normal than having the doctors make rounds. However, direct care staff must often leave their units to accompany residents to the clinic. The very units which most need a high staff to resident ratio are the most likely to have to violate section C.7. The Medical Department reports that it has recommended one additional employee be hired to assist the on-campus van driver in situations where use of direct care staff to transport residents to the clinic would result in a violation of section C.7. for other residents of the same unit. This recommendation has not been implemented, nor have other solutions been provided.

In the spring of 1979 Pineland conducted a multidisciplinary, unit-by-unit review of compliance with a variety of decree items. This review showed that only a few residence units were in compliance with section C.5. In January of 1979 Bert Schmickel had estimated the shortage of unit staff to be about 60 positions. On February 20 Pineland's Department of Residential Services estimated the need for unit staff at 71 positions, assuming a resident population of 400.

By the third week of August 1979, Pineland had authorized a total of 331 positions for direct care staff, Mental Health Workers I, II and III. 305 of these positions were filled, reflecting a vacancy rate of about 8%. During that week, the number of direct care staff needed to fulfill the ratios specified by section C.5. of Appendix A was 235. John Milazzo of Pineland's Residential Services and independent consultant Bert Schmickel recommend hiring 1.2 times this figure to determine the size of the empolyee pool necessary to provide actual coverage, allowing for scheduled vacations and sick leave. 235 X 1.2 = 282. Therefore, one would suppose that, with a pool of 305 filled positions to draw upon, Pineland could staff its units at least to meet decree ratios. In fact, for the two-week period August 13 to August 26, 1979, these ratios were frequently not met.* By October 19, Pineland had 345 direct care positions of which 314 were filled.

More precise figures are available for the two-week period, October 1 to October 14, 1979. Table 1 shows that, including floats, sufficient staff are assigned to each shift to allow for scheduling proper coverage of each unit. Table 2, however, shows that, frequently, this was not done. Table 2 shows the number of times, from a possible maximum of 14, that each shift was scheduled to be out of compliance with the decree.**

Table 2 should be compared with Table 3, following. Table 3 shows the number of times each unit was actually staffed in violation of Appendix A during the same two-week period. From this it is apparent that large numbers of direct care staff scheduled to work fail to report.***

Some means must be agreed upon for ensuring that the requisite number of direct care staff are, in fact, present and on duty. Once workers are employed, attendance must be monitored to make sure that the increased staffing actually provides the specified levels of coverage. Units may be amply staffed on paper while dangerously understaffed in practice. An example is Kupelian Hall, in theory the most heavily staffed at Pineland. In these units live profoundly retarded adults, many of whom present severe behavior problems. By the terms of the decree, defendants are to maintain an actual ratio of one staff member to every four residents.****

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* Statistics show that on a given day, the number of understaffed units often exceeded 40%.

** Note especially the night shift figures for Perry Hayden Halls I, II, and III which are populated by profoundly retarded, multiply handicapped and helpless people.

*** Again, note the figures for Perry Hayden Hall.

**** It should again be noted that Pineland does not achieve automatic compliance with the decree requirements for staffing merely by meeting the minimum ratios for various categories of staff to residents. Meeting these ratios is necessary to full compliance but need not be sufficient in every case. If there are not enough direct care staff on a given unit to prevent accidental injuries or resident-to-resident abuse or to furnish adequate support to program area staff for the residents of that unit, then there is non-compliance with applicable decree items regardless of whether the direct care-to resident ratio for that unit is being met.

TABLE 1

BUILDING	# RESIDENTS	RATIO STATUS* (A or B)	ASSIGNED am-pm-night
KH I	20	A	8-7-1
KH III	15	A	8-7-3
PHH I	20	A	8-7-1 1/2
PHH II	20	A	8-5-1
PHH III	19	A	8-7-2
BH I	20	A	8-7-1
BH	24	A	9-9-3
CH I	23	B	7-6-1
CH II	20	B	7-5-2
DAH I	24	A	7-9-2
DAH II	24	A	7-6-1
STAPLES	23	B	7-5-2
VH I	24	A	8-7-2
VH II	21	A	8-8-2
PH	23	A	7-9-2
GH	17	B	6-6-2
DSH	17	B	7-6-2
GAR	6	B	3-3-1
COT I	6	A	4-3-1
COT II	6	A	3-3-2
SEBAGO	15	A	8-7-2
FLOATS			4-5-7

* A = 1:4, 1:4, 1:12
  B = 1:6, 1:6, 1:12

TABLE 2

Scheduled coverage - October 1 - 14, 1979 Times Below Ratio

BUILDING	AM	PM	NIGHT
KH I	1	3	6
KH III	0	0	0
SEBAGO	0	0	10
PHH I	4	0	9
PHH II	4	8	9
PHH III	1	9	9
CH I	1	0	4
CH II	1	1	9
DAH I	7	10	0
DAH II	13	14	13
SH	1	0	13
VH I	11	11	8
VH II	11	11	14
PH	10	2	6
BH	2	7	0
BH I	4	9	4
GH	0	0	13
DSH	0	0	12
GAR	0	0	0
COT I	2	0	0
COT II	0	0	0

TABLE 3

Number of times below ratio, October 1 - 14, 1979

BUILDING	AM	(%)	PM	(%)	11-7	(%)
KH I	5	35.5	5	35.5	12	85.2
KH III	1	7.1	0	----	2	14.2
PHH I	4	28.4	7	49.7	11	78.1
PHH III	4	28.4	13	92.3	10	71
PHH II	6	42.6	12	85.2	14	100
BH I	5	35.5	10	71	10	71
BH	6	42.6	9	63.9	1	7.1
CH I	3	21.3	2	14.2	6	42.6
CH II	4	28.4	9	63.9	14	100
DAH I	8	56.8	10	71	0	----
DAH II	14	100	14	100	10	71
SH	3	21.3	2	14.2	13	92.3
VH I	13	92.3	13	92.3	7	49.7
VH II	13	92.3	13	92.3	12	85.2
PH	14	100	7	49.7	10	71
GH	0	----	0	----	14	100
DSH	0	----	0	----	14	100
GAR	0	----	0	----	0	----
COT I	0	----	1	7.1	0	----
COT III	2	14.2	0	----	0	----
SEBAGO	1	7.1	0	----	13	92.3

Nevertheless, a program coordinator reported in February:

> This morning when I came in at 7:25 a.m., the following staff were present at Kupelian Hall:
> K.H.I (for 16 residents): Assistant supervisor and two aides.
> K.H.II (for 21 residents): Two female aides. (this also constitutes a violation of C.7. which requires an absolute maximum ratio of 1 to 8 during waking hours.
> K.H.III (for 18 residents): Assistant supervisor and two aides.
> K.H.IV (for 19 residents): Supervisor and three aides.

The coordinator concluded her report with the observation:

> SOMETHING HAS GOT TO BE DONE ABOUT COVERAGE AT KUPELIAN HALL!!!

Not only are section C.5. ratios for direct care staff frequently not met as observed, supra, but defendants often fail to ensure that living unit supervisors are present and on duty as required by section C.9. of Appendix A.

Of 19 residence units visited by the Special Master's Office in late August, 1979, six units, or nearly one-third, had no supervisor present on the morning shift. One unit had not had a regularly scheduled supervisor for this shift in two months. Unit staff at the Mental Health Worker I level reported that they refused to fill the leadership void because this would impose an added burden of responsibility with no corresponding increase in pay. Therefore, when a unit supervisor is absent, there is usually no one in charge. That someone in the administrative hierarchy may be available by telephone to assume the responsibility for certain actions and to give advice does not satisfy section C.9.

Various reasons were cited for the absences of supervisors. Some could have been eliminated by simple planning. For example, at Bliss Hall the supervisor was on vacation and the assistant supervisor was on a regularly scheduled "off-day" or "0 day." Such absences could be addressed by a "float" system.

Finding: Staffing continues to be one of the problems behind Pineland's substantial, continuing non-compliance with decree requirements for habilitative programs, although it is not the only cause of those deficiencies.

Applicable sections of Appendix A:

> A.1. Residents have a right to habilitation, including . . . education [and] training suited to their needs . . .
>
> D.8. Each resident shall receive five scheduled hours of program activity per weekday in the first year following the signing of this decree, and six hours in the second.
>
> C.16. Each professional department or major program area shall maintain an adequate number of program aides to carry out the recommendations of the [Prescriptive Program Plan] for each resident. To this end, paraprofessional staff performing services in programs shall be maintained at a ratio of at least 1 to 5 while programs are in operation. Paraprofessional staff shall receive training appropriate to their assignments. Professional supervision shall be provided to all paraprofessional personnel.
>
> [Education] G.3. There shall be no more than ten residents to a class. Each class of more than five students shall be staffed by a paraprofessional as well as a teacher.

Discussion: As noted in the section of this report dealing with programming, Pineland fails to schedule much of the program time required by the decree for each resident. Not all of the program hours which are actually scheduled are finally delivered. Shortage of program staff and shortage of direct care staff who aid these professionals and paraprofessionals in carrying out program activities have been cited as reasons for both of these phenomena. A recent assessment by the Department of Personnel shows that none of the six major program areas has enough paraprofessional aides to meet minimum requirements of section C.16. Not only have defendants failed to hire sufficient paraprofessionals to staff what is, at present, a grossly deficient program regimen, but the ratios are even worse in actual practice because of absenteeism. Non-compliance is substantial and continuing. However, Pineland's Program Director, Mary Crichton, reports that the overriding problems with delivery of decree-mandated program hours are lack of coordination and communication between programs and between program areas and residence units and, more importantly, lack of physical space in which to conduct program activities. Pineland is currently conducting an analysis of programming. Once this is done and the other obstacles to full programming are addressed, the need for additional program area/direct care staff to enable Pineland to comply with the programming sections of the decree will be more easily quantified.

Nevertheless it is apparent that, although staff shortages at program areas may not be the only problem, such understaffing is contributing to non-compliance in the field of programming. The effectiveness of any program depends upon each of three categories of staff.

(1) Professional staff. The decree does not specify the number of professionals needed in program areas other than the school* It is nevertheless clear that each program area must have sufficient professional staff to allow for compliance with all relevant decree items including those listed above for this finding. For example, when there are not sufficient professionals to design and supervise enough programs to supply the IDT program recommendations of all Pineland residents, there is no compliance with sections C.16., D.8., and A.1. regardless of the absolute number of professionals hired.

The occupational therapy department is chronically understaffed. Pineland has alloted enough positions to fulfill the decree requirements, but it is extremely difficult to recruit therapists. Furthermore, therapists are not always used to the best advantage. The therapist at New Gloucester is a class instructor all morning, and during some afternoons when there is a coverage problem. In addition she does the usual work of a therapist, screening residents, consulting, training, and supervising aides, and fabricating and repairing splints. The department considers her workload excessive and frustrating.

In March, the director of the occupational therapy department found coverage at school inadequate to meet "the legal mandate that all children needing O.T. services shall receive them within their total school program." (Report, Cottages, Executive Management Committee)

There are some adults in the vocational training program that the O.T. Department used to work with, and would be interested in working with again. There is no waiting list for therapy, as there is no plan to provide it. The therapy was formerly provided by aides, rather than registered therapists. At present, Pineland is not in compliance with section D.1., which requires that "each habilitation need of a resident be professionally assessed and appropriate remedial recommendations be made."

Last winter there was a backlog in annual evaluations. (Gray Hall, Paine, EMC, 1/19/79)

(2) Paraprofessionals are program aides who have received specialized training from professionals in such areas as physical or occupational therapy. Section C.16. of Appendix A requires that, while programs are in operation, paraprofessionals be participating in a ratio of 1 to 5. If the total Pineland resident population were receiving the minimum number of program hours required by the decree, at least 60 of

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* Nevertheless, sec. C.12., App. A requires an overall ratio of professionals to residents of 1 to 3. As of August 17, 1979, Pineland had only 120 professionals and a census of at least 390, for an overall ratio of 1 to 3.25. It is doubtful whether all 120 professionals should be counted, however, since some are not included in the exhaustive list of disciplines comprehended by C.12.

these program aides would be necessary. This assumes a resident population of about 400 receiving six program hours per day. With the attendant preparation and paperwork considerably less than a full eight-hour shift could be devoted to actual program activity. Pineland's major program areas now employ the equivalent of only 42.35 paraprofessionals (full and part time).

Although at current program enrollment levels the shortage of professional and paraprofessional staff does not appear to be critical in all of the six major program areas, this fact must be placed in context. Many Pineland residents either receive no program hours or fewer than the required six hours per day. Therefore, if Pineland is ever to comply with section D.8. of Appendix A, it will have to hire more program staff in order to comply with sections C.16.and G.3. since the demand on programs will have to be increased dramatically.

(3) Unit staff. All six of the major program areas depend to some extent for their efficacy upon the participation of direct care staff who accompany residents to the program areas and assist program staff. The program problems created by lack of direct care staff are also considered in the section of this report dealing with programming.

The relationship between professional and direct care staff is complicated and needs to be improved. Professional staff have not generally used the authority they have to monitor or discipline direct care staff. Coffee breaks and absenteeism have been a problem at the program areas. In theory, direct care staff should continuously treat residents consistently with professionals' program goals. However, while on the unit, direct care staff have a great deal of de facto independence. One coordinator said, "They can subvert anything they don't agree with."

On the other hand, management generally feels that direct care staff need to be made more aware of the importance of their role. The chairman of the IDT Task Force sees this as an important problem. Sensitivity training sessions were held, and were helpful to the staff involved; not everyone was involved. One staff member reported that professional IDT members do not always meet with direct care staff every month as they are required to do by the decree; when they do not meet, "This widens the gap" between direct care and professionals. IDT meetings are generally scheduled at the convenience of professional staff. "The professionals should bend a little."

The Open Classroom program associated with Kupelian Hall provides a good example of problems at Pineland's program areas. It has a staff of one half-time and four full-time employees including the acting director. It has an enrollment of thirty-five and a waiting list of three. One of the residents on the waiting list has been without habilitative program of any kind since early spring of 1978. The program does not operate for all thirty-five residents at one time. None of the residents receives a full day of programming. In this manner the

Open Classroom maintains a working ratio of 1:3. (During program activities the staff/resident ratio may be 1:3.) The overall ratio for the program is only about 1:7, and the ratio of paraprofessionals to residents is only 1:6.8 at best; often it is only 1:8.5 -- a clear violation of section C.16. of Appendix A. This figure becomes even worse when total resident enrollment is compared to paraprofessional staff, yielding a ratio of only 1:10.625, twice the 1:5 figure contemplated by section C.3.(b) as a minimum. Attendance of direct care staff is not a problem for this program since it operates in the residence hall where the participants live and the staff work. Direct care and program staff have a good working relationship and productively share in the responsibilities. Direct care staff are variously reported to be indifferent to or actively involved in programming.

The critical problem for this program is lack of suitable space in which to operate. When an area which can accommodate the entire Open Classroom program is found and renovated, the staff should be increased to around twelve. Section C.16. will require eight paraprofessionals for the Open Classroom as the ratio of 1 to 5 will be applied to an enrollment of at least thirty-eight. But achieving this staffing level before suitable space is ready would not have the effect of increasing enrollment in the program or of affording present participants more hours of habilitative services.

Finding: The IDT process is one of the central features of the decree. The effectiveness of the IDT in the scheme of developmental habilitation efforts is being severely undercut by staff shortage. Non-compliance is substantial.

> C.10. Sufficient [Prescriptive Program Plan] Coordinators at the Mental Health Worker V level shall be employed such that the PPP of every resident will be appropriately prepared, coordinated, implemented and carefully monitored. The ratio of PPP coordinators to residents shall be at least 1 to 35. PPP coordinators shall not conduct, on a routine or ongoing basis, residential programs.

Discussion: A ratio of 1 to 35 would require a minimum of 12 PPP coordinators for the present resident population which exceeds 385. As of March 28, 1979, Pineland had managed to retain only 6. As of August 17, 1979, Pineland had 7 Mental Health Worker V positions for PPP coordinators. Six of these positions were filled. Most of Pineland's PPP coordinators continue to carry more than one-third again the case-load contemplated by the decree as a maximum. About 84 residents are served by PPP coordinators at the Mental Health Worker II level. This has the effect of removing some of the case-load burden from the 6 MHW V-level staff but does not have the effect of bringing Pineland any closer to compliance with decree item C.10.

The fact that Pineland has failed to hire more than one-half of the IDT coordinators required by the decree constitutes more than a merely numerically remarkable deficiency; it cuts to the quick of the decree. As described in the section of this report discussing programs, the IDT report is crucial to the decree's vision of Pineland as an evaluative, prescriptive, educational and habilitative resource. It is the IDT which makes the assessments upon which all future services to the resident will be based. It is the source of wisdom regarding the programmatic needs of each resident and constitutes the point of reference to which all service providers return for guidance.

Nevertheless, during the first decree year it was not at all uncommon for the time-lag between the team meeting and the filing of the final IDT report to run weeks and months, leaving the original observations and assessments upon which programmatic recommendations were based subject to a host of variables during that passage of time. Although the decree does not specify a maximum length of time which is permissible for preparation of the IDT report,* it seems clear that any delay sufficient to hamper the intended purpose of the IDT is contrary to the decree. The average delay has now been cut considerably, and new procedures are being tested by Program Coordinators to reduce it even further. The Coordinators continue to cite their unwieldly case-loads as the primary cause of delay in getting IDT reports out, however.

Finding: Pineland now meets or exceeds the ratios of professional staff for ten of the twelve disciplines listed in sections C.12. and C.15. of the decree. The fact that compliance is not total does not appear to be the result of any lack of effort by defendants to recruit.

Discussion: Decree ratios for professional staff are not met in the disciplines of Physical Therapy and Nursing. These particular deficiencies simply mirror a nation-wide situation. People trained in these two areas are in short supply. Although Pineland now offers competitive salaries, it has the disadvantages of geographic isolation

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* Section D.11. of Appendix A states that, "Pineland shall provide the programming recommended by the resident's prescriptive program plan within 30 days of the preparation of the plan." Program coordinators have routinely considered the plan "prepared" at the IDT meeting itself, not when the plan is finally drafted and filed. Under this construction, the 30 day period starts to run on the day of the IDT meeting. It has the advantage of maximizing decree benefits in the area of program. Coordinators now try to have the IDT report drafted and signed well within the 30-day limit so that all service providers can refer to it as they begin to implement IDT recommendations according to section D.11.

from population (housing) centers and less than glamorous working conditions. Defendants have not offered prospective employees premiums to offset these disadvantages.

Finding: Pineland does not comply with section C.14. of Appendix A.

Discussion: This section of the decree delcares that, "A minimum of 40 percent of social service professionals shall have a Master of Social Work degree from an accredited school." In the first decree year Pineland maintained a roster of 11 social service professionals, 3 of whom held Master's degrees. To meet the 40 percent figure 5 of these 11 should have held Master's degrees. On March 29, 1979, Pineland's Personnel Officer noted this non-compliance and recommended it be rectified as vacancies occurred. During the same decree year two professionals at the Bachelor's degree level left the Department of Social Services. The Department again filled these positions with staff at the Bachelor's degree level. At least one of these social service professionals was hired after the Personnel Officer's recommendation to rectify non-compliance through attrition. As of August 17, 1979, only 3 of 11 social services professionals held a Master's degree, and no progress had been made during the first decree year towards compliance with section C.14 of Appendix A.

Finding: Procedures imposed by the State Department of Personnel put an unnecessary burden on Pineland's recruitment efforts.

Discussion: By way of example, the Open Classroom program needs an occupational therapist. This position is "competitive" by Maine Personnel Board regulations. To hire staff under the competitive system is an elaborate process. The state administers tests to potential workers and keeps a list of those who pass. When requested to do so by a state agency, it sends a "register" of six names. The agency then hires one of the persons named on the register or requests a new register if none of the initial candidates is suitable for the position. When candidates are in short supply, the actual practice differs from this procedure. Pineland hunts for therapists by itself. Advertisements may be sent all over New England, to Florida, California, and several other states. If a licensed therapist comes to Pineland to apply for a job, the applicant's name and qualifications are sent to Augusta where the Department of Personnel determines that the applicant is, in fact, licensed. The applicant is then given the appropriate test. As there are never enough unemployed therapists to overload a 6-name register, the therapist's name is always returned to Pineland. The time lost is at best an unnecessary nuisance; there is the risk that by the time the register returns, the original applicant will be happily employed elsewhere.

Nursing is a "non-competitive" discipline under the state personnel system. Pineland's Personnel Officer has requested that the various categories of therapist also be made non-competitive. As in nursing, only licensed practitioners would be qualified and competence would be guaranteed.

The state's system for classification of employees has led to delays in hiring necessary staff at Pineland. For example, during the first decree year the Day Activities Center, one of only six program areas at Pineland,was without a leader. When an institution wishes to hire a program leader, it must apply to the State Personnel Board. It does so by forwarding a job description. The Personnel Board then takes that description and determines the title and salary range which the position will carry. Pineland's request for the Day Activities program leader included an exact duplicate of the duties and necessary qualifications of another program leader who had been hired shortly before and who was determined by the Personnel Board to be a Mental Health Worker VI. One month after its request was filed, Pineland was granted a Mental Health Worker III position for the Day Activities leader. Four months after its request was filed, Pineland's appeal from this decision was heard. It was decided that the position should indeed carry the same salary range as Mental Health Worker VI, although the Personnel Board refused to use that appellation and invented instead the title, Mental Retardation Program Supervisor. From the time its initial request was filed until Pineland was able to hire its program leader, six months had elapsed, and a crucially important habilitative program had been foundering for want of leadership.

One final link in the chain of compliance with staffing specifications is that Defendants must take proper steps to ensure that staff are properly trained in accordance with the requirements of section E of Appendix A.

Finding: Some direct care staff have not yet received the training contemplated by section E as necessary for minimal competency in delivering decree benefits to the plaintiffs.

Discussion: Section E.4.(a) of Appendix A requires defendants to submit to the Office of the Special Master a plan to improve Pineland's orientation and in-service training programs. Such a plan was received by the Special Master. Overall, the plan is good, and in general it has been adhered to in actual practice. There are, however, certain notable deficiencies which remain in Pineland's efforts to comply with the personnel training paragraphs of section E. Two key portions of this section of Appendix A are E.4.(b) and (c):

Cheryl Fortier, Resident Advocate May 9, 1979

Dennis R. Corson, Personnel Officer

O. T. Positions

This memo is in response to your inquiry concerning the inadequate salaries for recruitment of Occupational Therapists and other positions that regularly go unfilled for lack of interested job applicants. Alita is absolutely correct in that our salary is about equal to that of a regular school system with a six-hour day. She is also correct that the new contract will add approximately $1,500 to this base pay if and whenever the legislature acts. However, you have to understand that Pineland Center is not the only state institution or agency employing Occupational Therapists. Regardless of the situations, an Occupational Therapist is an Occupational Therapist whether that person works at Pineland Center, Augusta Mental Health Institute, or the Department of Education and Cultural Services. The State Department of Personnel attempts to administer the present merit system with the most basic concept of equal pay for equal work. If Occupational Therapists are doing the same type and level of work, Pineland Center would not be justified in paying its Occupational Therapists at a higher rate.

The other alternative would be to raise the salary of all Occupational Therapists. There are several problems in this. For instance, Pineland Center would at this time have adequate monies to pay for such a range increase. However, Bangor Mental Health Institute or the Department of Education or the Department of Human Services, etc., may not have the money to pay for these upward range changes. The facts of governmental bureaucracy are that if one agency cannot afford this transaction, the entire transaction is scuttled for everyone.

Other positions that regularly go unfilled for lack of applicants are Physical Therapists when vacancies arise; presently nurses are extremely hard to recruit. These occupations (O.T., P.T., and nurses) are extremely competitive classifications in that there does not appear to be a sufficient number of applicants to fill the needed slots in any health care setting, not only in Maine but in New England. Statistics will show that all hospitals in New England are experiencing a tremendous difficulty in filling the above-mentioned positions.

I hope that this has answered your questions. If not, please contact me for further discussion.

DRC:mar

cc: D. Gregory
A. Raine

August 23, 1978

Robert J. Stolt, Commissioner — Personnel

Dennis R. Corson, Dept. Personnel Officer — Pineland Center

Classifications--Noncompetitive Hiring Procedure

Per our conversation of August 21, 1978, I am formally requesting that the classifications listed below be placed in the noncompetitive designation. The rationale for this is that in order for a person to be qualified for these classifications, licensure of one form or another is mandatory. For example, at this point in time nursing classifications are noncompetitive because we cannot hire a nurse unless she is certified by the Maine State Board of Nursing. In almost every case, your department does not have a valid register, and Pineland Center has to recruit these people individually and then send all of the necessary paperwork to your department which in turn sends Pineland Center a register. Hopefully, by placing these classifications in a noncompetitive designation, this time delay will be eliminated.

Occupational Therapist I and II; Chief Occupational Therapist
Physical Therapist I and II; Chief Physical Therapist
Speech Pathologist I and II; Chief Speech Pathologist
Pharmacist
Recreation Therapist
Psychologist I, II, III, IV

DRC/mar

Personnel Hiring

September 13, 1978

Robert J. Stolt, Commissioner — Personnel

Dennis R. Corson, Dept. Personnel Officer — Pineland Center

Memo of August 23, 1978

I submitted a memo to you on August 23, 1978, requesting approval for certain classifications to be made noncompetitive as well as a draft statement for prospective provisional appointees to sign. It is now September 13 and neither Pineland Center nor the Department of Mental Health and Corrections has received any correspondence from your department concerning these requests.

I can understand the delay in that several of your important positions either are or have been vacant for a period of time. However, I am also under constraints as dictated by Appendix A.

If further information is needed or desired concerning these requests, I will be more than happy to furnish it.

DRC/mar

STATE OF MAINE

Inter-Departmental Memorandum Date January 10, 1972

To Kevin W. Concannon, Director Dept. Bureau of Mental Retardation

From Paul N. Tabor, Director Dept. Northern Resource Center

Subject Personnel recruitment

As you know, I have been actively involved in recruiting for a number of professional vacancies over the past few months. While I have not encountered any active interference from the Department of Personnel, I am becoming increasingly frustrated by their considering physical, occupational, and speech therapy positions as competitive, requiring establishment of a register. All of these professionals are licensed by their respective state or national boards. It is unnecessarily redundant for Personnel to verify their credentials beyond the fact of licensure. Nurses, physicians, and teachers, who are similarly licensed, are not considered competitive.

It is especially frustrating when these professionals are scarce, as they are now, and much time is devoted to extensive recruitment, to locate an interested individual and then have to wait for the Personnel Department to review, certify, and make up a register.

I understand that Dennis Corson addressed this matter to Commissioner Stolt some time ago. I would like to add my support to a Departmental effort to eliminate this small but aggravating hurdle in the hiring process.

PNT/vp

cc: Frank Mack, Mental Health & Corrections
✓Dennis Corson, Pineland

STATE OF MAINE

Inter-Departmental Memorandum

Date January 16, 1979

To Robert J. Stolt, Commissioner — Dept. Personnel

From Paul N. Tabor, Director — Dept. Northern Resource Center

Subject Competitive registers for licensed professionals

Since August 1, 1978 I have been Director of the Bureau of Mental Retardation's Northern Resource Center. One of my major tasks has been recruiting the professional staff mandated in the Pineland Consent Decree (Appendix B, Section D, paragraph 1), specifically an Occupational Therapist II, Physical Therapist II, Speech Therapist II and Psychologist II.

I have found it very frustrating that these classifications are treated as competitive, and applicants must be certified for registers. Right now all of these professionals are in short supply. I have seen only one name for an Occupational Therapist, two names for a Psychologist, and one name for a Physical Therapist, and all of these people were happily employed elsewhere. Because of this extreme scarcity of registers, I have invested a considerable part of my time and a significant part of our budget in advertising and recruiting. This investment has brought some response from qualified people, but it poses a problem when I inform them they must apply for certification to a register, which may take several weeks. Professional people looking for a new job expect to be treated as professionals and accepted on the strength of their license or professional certification. Some classifications in the state system which require licensure, such as physicians and nurses, can be employed directly as long as their application and credentials satisfy the class specifications. In the interests of consistency and professional consideration I suggest that licensed professionals be excluded from the competitive registers.

I understand that this issue has been raised before, without resolution. It may not have a high priority among the other concerns throughout the Personnel system with which you are faced daily, but it has been a stumbling block and an aggravation to me fairly consistently over the past several months as well as occasionally during previous years. I appreciate your consideration and look forward to receiving your reply.

PNT/vp

> E.4.(b) Orientation training for all new employees shall consist at a minimum of the following: Within two weeks of being hired, each new employee shall receive 90% of a 20-hour orientation. At least the following areas shall be addressed: introduction to mental retardation, principles of normalization and developmental growth, human and legal rights, fire protection, safety, growth-oriented programming, behavior shaping, function of each professional department, and role of staff in implementing the philosophy of care and training of residents at Pineland. In addition, all new resident care and programming staff shall receive within two months at least the following training: eight hours of practical training in resident programming including the interdisciplinary team process, twelve hours of practical training in behavior influencing techniques and the utilization of the Program Guide, two hours of practical training in proper oral hygiene for residents, and two hours of training in the requirements of this decree.
>
> E.4.(c) All current employees will have the equivalent of orientation training within six months of the signing of this decree and the additional 24 hours of training within one year.

The requirement that 90% of a 20-hour orientation be furnished within two weeks of hiring is frequently and routinely violated. Orientation is now offered once in each four week period on grounds that the decree-mandated time frame is inefficient.* Furthermore, new employees sometimes miss orientation when first scheduled.

Most new employees do, eventually, receive the orientation and training contemplated by section E.4.(b). However, since Pineland relies upon its own professional staff, all of whom have many other duties, classes scheduled for the orientation package are sometimes cancelled. No systematic attempt is made to re-schedule classes cancelled because the instructor was absent. Usually, in such a case, the employee simply fails to receive that portion of his orientation.

Failure to implement methodically the requirements of section E.4.(c) constitutes the most serious example of defendants' non-compliance with staff development features of the decree. Employees on board prior to July 14, 1978 receive only a four-hour "re-orientation." Beyond this, no

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* An important consequence of this particular non-compliance is that it jeopardizes compliance with sec. E.6., App. A: "A staff member shall not do any resident programming without assistance from a qualified staff person until such staff member has completed 90% of the training required in paragraph[s] [4(b) and 4(d)] of this section."

attempt is made to ensure that such employees get the equivalent of section E.4.(b) orientation or the 24 hours of training required for direct care and program staff. Defendants could have complied with E.4.(c) by providing E.4.(b) training to pre-decree workers as a matter of routine or by selectively filling in the gaps in their training records to avoid duplication of training previously provided. Defendants have done neither. The annual turn-over rate for Mental Health Worker I's (direct care staff) slightly exceeds 40%. It therefore seems logical to conclude that over 50% of Pineland's direct care staff were affected by this lack of training at the end of the first decree year, amounting to substantial non-compliance. Since direct care staff have perhaps the most significant impact upon the beneficiaries of the decree, they should, in fact, have been the focus of any "re-orientation" effort. Instead, they received the standard four-hour program given to all pre-decree employees.

Plans are currently underway in Pineland's office of Staff Development to provide direct care staff with training in new techniques of teaching self-care skills to the profoundly retarded. Such training exceeds the minimums required by section E. However, this training is not a substitute for the entire regimen of "re-orientation" required by section E.4.(c). Furthermore, this training will not be completed for many months. It cannot be cited as a source of compliance with section E.4.(c).

Finding: Pineland substantially complies with the in-service training requirements of sections E.4.(d) and (e).

Discussion: Clearly, the orientation and training schedule established by section E.4. is a minimum. Pineland must ensure that each employee receives sufficient training to enable him to provide residents with each benefit he is expected to implement under other applicable sections of the decree. Initially, Pineland set out to canvass the direct care staff of each unit to determine their need for additional training. This program was abandoned and attention was redirected to the above-mentioned training system for teaching self-care, or ADL, skills to residents. Although the latter system should go far towards providing unit staff with the skills necessary to performance of their responsibilities, as determined by section C.1. of Appendix A, Pineland should undertake a comprehensive evaluation of the strengths and weaknesses of direct care staff, modifying additional training programs accordingly. Unit workers sometimes report that they have educational "blind spots" which decrease their effectiveness in dealing with residents. One direct care worker made repeated requests for training in how best to deal with low-functioning, aggressive residents on his unit. He was told to use his best judgment. The worker finally requested a transfer to another unit because he did not feel that he possessed the skills necessary to care for residents with such special needs. Such a response to a plea for training violates at least the final provision of section C.3.: "Professional staff shall respond to requests by living unit personnel for consultation."

It is very difficult to determine the extent to which this type of thing goes on at Pineland. Professional staff have expressed a wish that direct care could be taught more theory; in addition, they need

very specific guidance with regard to their particular residents. Left to themselves, they develop their own habits and prejudices and their own idea of what is possible and desirable for their residents. Program coordinators have asked that direct care staff have more training in occupational and physical therapy, communication, and psychology. They need suggestions and guidance for interacting with residents and for providing "constructive and pleasurable activities." The nurses have asked for more medical training, especially for units for the multiply handicapped. (See "Direct Care and Residents' Rights.") A monitoring mechanism should be established to log each request for in-service training and the action, if any, taken by staff development personnel.

Training efforts which have pleased coordinators and professional staff are the interdisciplinary training program at the cottages and the communication department program at Doris Sidwell, the residential unit for signing residents. Mrs. Paine feels that the Doris Sidwell experience should be a model; staff learned to sign, accepted it as part of their job, and are proud of their ability. Similar effort should go into other forms of training; she sees ADL as a prime need at present.

Although not tailored to the self-perceived training needs of direct care staff, Pineland now offers a wide variety of in-service education programs for employees in conformity with section E.4.(d) and (e). It must be noted, however, that Pineland makes no attempt to comply with the final directive of section E.4.(e): "Fifty hours of appropriate training shall be a prime requisite for advancement for nonprofessional resident care staff." Promotion of a Mental Health Worker I to the level of paraprofessional (e.g., occupational therapy aide) is done without regard for whether he has logged fifty hours of appropriate training. Defendants have not complied with this specific requirement by virtue of their compliance with the remaining portions of sections E.4.(d) and (e). Such training must also precede promotion, not merely follow after the fact. A college program leading to the Associate Degree in Liberal Arts with heavy emphasis on developmental disabilities will soon be operating at Pineland. This expanding array of training opportunities should result in a more highly qualified and confident team of habilitative employees. The coming year should see telling gains in staff training which may yield significant benefits for Pineland residents.

STATE OF MAINE

Inter-Departmental Memorandum

Date October 6, 1978

To Frank J. Mack, Jr., Chief Personnel Officer Dept. Mental Health and Corrections

From Dennis R. Corson, Dept. Personnel Officer Dept. Pineland Center

Subject CUSTODIAL WORKER I UPGRADINGS

I have just received a copy of Commissioner Stolt's memorandum to you with the returned FJA-1 and Form 5's attached. I would like for you to know the following facts that may not have been clear in Commissioner Stolt's memo. Namely, these facts are:

1) When first contacted by Everett Johnson in the FJA Room to supply supporting material, I complied. I hand-delivered to Mr. Johnson copies of my original request and organizational charts that I had sent to the Bureau of Budget for their organizational review. He called shortly thereafter and asked for further information. I again complied by bringing all material and correspondence between the Budget Office and Pineland Center concerning the proposed upgradings. I might also add that I really didn't have to do this because copies of all correspondence to and from the Budget Office were sent to the Department of Personnel.

2) The request for an FJA-1 and Form 5 for each individual position to be upgraded is a change from past practice. For example, the approximately 25 positions that Pineland Center upgraded to Mental Health Worker II's were done in the fashion of one FJA-1 and 25 Form 5's. Also, the 24 summer positions were established in the same manner, i.e., one FJA-1 and 24 Form 5's. This practice has been in effect for the past two years. I might also point out that the Form 5 does in fact provide the exact position number of each position being upgraded. The FJA-1 not only gives the incumbent's name and immediate supervisor but also each individual task that that person will be performing. My able assistant also points out that page 3 of the FJA document delineates any and all supervisory tasks.

It would seem that this is a frivolous attempt to delay any action on these positions. You are well aware of the Class Action Decree standards for custodial workers. Pineland Center feels that these upgradings are instrumental in recruiting people to do these much-needed tasks. I will supply an organizational chart as requested by Commissioner Stolt. However, as you and I are both aware, that organizational chart will be valid for that one moment in time. Any transfer, substitute appointment, leave of absence, resignation, dismissal, etc., will make that organizational chart instantly out of date. The custodial work force is at this time being hired on a float basis in that because of our tremendous turnover in these areas, a person cannot be assigned to only one area for eternity. We must have the flexibility to assign the present workers to the areas that need the most attention.

If you need or would be interested in further information concerning this dilemma, please contact me.

DRC/mar

cc: Commissioner Zitnay
K. Concannon
David Gregory
J. J. O'Toole
C. Kinnelly

STATE OF MAINE

Inter-Departmental Memorandum Date March 28, 1979

To Frank J. Mack, Jr., Chief Personnel Officer Dept. Mental Health and Corrections

From Dennis R. Corson, Dept. Personnel Officer Dept. Pineland Center

Subject 30 POSITIONS

As you are well aware, the negotiated settlement with the Budget Office concerning the use of 30 Mental Health Worker I positions to be utilized in lieu of the hard-to-recruit positions came to fruition in your office on March 9, 1979. Much to my chagrin, many disturbing incidents have occurred since that meeting. The 30 positions that we settled on is now 12. The 30 positions that became 12 have also been changed to type 07 (project) after you so graciously hand carried the Form 5's to Pineland Center so that the type could be changed to 01. Also, the negotiated 039-99 identifier has been changed to 039-00 with no change in activity. These "subtle" changes will make it impossible to track these positions. As I remember, this tracking/controlling device was paramount to the Budget Office emissary. The change to project presents a severe problem in that how can we recruit someone to work on a project basis when we have vacancies that are permanent, full time?

To reiterate, I find the above changes to be quite distressing in that what appeared to be negotiations in good faith and negotiations for a solution to a common problem have manifested itself to be another round won for the bureaucracy in the championship bout for the Consent Decree.

DRC/mar

cc: Charlene Kinnelly
Kevin Concannon

PINELAND CENTER

Inter-Departmental Communication

TO: Tom Meiser DATE: July 6, 1979

FROM: Dennis Corson

SUBJECT: Register

The attached copy of Form 15 for Reproduction Equipment Supervisor (our language printer), will show that it started its arduous trek through the Personnel wilderness on May 31, 1979. A hasty background summary will reveal the Dept. of Personnel did not have a valid register, therefore, my request was forwarded to the Functional Job Analysis room. The request for a printer plummeted deeply into the chasm and abyss of the FJA room on June 4, 1979.

To this date, no advertisement and therefore no list of eligibles is forthcoming. It would appear that either;

1.) the request has been lost
2.) it is receiving the usual "special" attention that Pineland requests receive
3.) these time frames are typical of actions requested of the Dept. of Personnel.

In any of the possibilities listed, it would seem Pineland Center has done without the services of a printer long enough. I would propose that you investigate the possibilities of making this classification non-competitive so that we may hire directly and avoid the continued poor service provided by the Dept. of Personnel.

DRC/kfg

cc: F. Mack
D. Gregory
K. Grzelkowski
J. Conrad

STATE OF MAINE

Interdepartmental Memorandum Date July 17, 1979

To [illegible] Dept. Personnel

From Dennis R. [illegible], Supt. Pineland Dept. Pineland Center

Subject REPRODUCTION EQUIPMENT SUPERVISOR

On May 31, 1979, Pineland Center forwarded a Form 15 to your department requesting a list of eligibles for the classification of Reproduction Equipment Supervisor. I was informed by a member of your staff that there were no names, and the appropriate paperwork was sent to the FJA room for opening the class and advertising. The FJA room received this request June 4, 1979.

The attached memorandum dated July 6, 1979, and sent to Tom Meiser expressed my concern of the seemingly unending delay for advertising of Reproduction Equipment Supervisor. Mr. Meiser's sleuth work revealed that the request had been buried in an employee's basket. Tom was informed that the necessary work would be done expeditiously. I was quite upset when I perused this past weekend's edition of the Portland Sunday Telegram and saw no announcement or advertisement.

I am further distressed by the fact that the position of Reproduction Equipment Supervisor was established on May 21, 1979. It would seem that the next logical step after establishing a new position would be to call for a list of eligibles. It would further seem logical that when a new position of other than the ordinary variety is established, a cursory glance at the appropriate register might be in order. With the inherent delays built into the system, the classification could be and probably should be opened, announced, and advertised while the system is busily meandering upon its set course of running us.

In short, I am formally protesting the totally unacceptable amount of time that Pineland Center has been waiting for a Reproduction Equipment Supervisor register.

DRC/mar

Attachment

cc: F. J. Mack, Jr.
K. W. Concannon
D. Gregory

STATE OF MAINE

Inter-Departmental Memorandum

Date September 13, 1979

To Jadine R. O'Brien, Commissioner — Dept. Personnel

From Dennis R. Corson, Dept. Personnel Officer — Dept. Pineland Center

Subject Reproduction Equipment Supervisor

This memo is to follow-up my past correspondence to you dated July 17 and your acknowledgement and answer dated July 27, 1979. As you may remember, in my memo I expressed deep concern for the seemingly unending delay in the announcement, advertisement, recruitment, and referral of qualified applicants to the classification of Reproduction Equipment Supervisor here at Pineland Center. Your memo expressed your belief that "test construction and announcement procedures have been followed as rapidly as possible." While that phrase may well be true, the only avenue that I may follow is the receipt of a Form 17.

I have monitored the advertising, recruiting, acceptance, and revenue process of those who have applied; and I still find it most distressful that here it is September 13, 1979, and I still do not have a register. It is even more distressing when after I submitted a Form 15 on May 31, the class was not opened for recruitment until August 11 and closed August 25 and that only two people applied for that position. Three weeks later I still do not have a register to choose from.

I must again quote the last paragraph of my July 17, 1979, memo when I said, "I am formally protesting the totally unacceptable amount of time that Pineland Center has been waiting for a Reproduction Equipment Supervisor register."

DRC:mar

cc: F. J. Mack, Jr.
K. W. Concannon
D. Gregory

STATE OF MAINE

Inter-Departmental Memorandum Date. August 29, 1979

To Robert W. Maxwell, Merit System Adm. Dept. Personnel Department

From Betsy J. Davenport, Program Consultant Dept. Pineland Center
Roger Deshaies, Program Coordinator Supv.

Subject Mental Health Worker V Exam

In response to your memo of 8/27/79 to Mr. Corson, it would appear necessary to clarify the facts in this matter. We did indeed spend a considerable amount of time with a Mr. Allen Shervis working on the development of this exam. It should be noted that there were numerous points of disagreement regarding the inclusion of items. The questions regarding knowledge of cretinism come to mind immediately. We specificly requested that such questions be deleted. In discussions with applicants, we have been told that there are indeed questions involving cretinism.

It should further be noted that although we were asked to review questions and we did in fact relay to Mr. Shervis our selections, we were never shown the final draft nor were we given any indication that our choices would appear in total on the exam. We were told that our input was merely a step in the process.

In terms of providing you with specific evidence, the problem is this. In the inimitable style of the State Personnel Department, you have placed us in a catch 22 situation. You will not allow us to see the test without specific evidence, we cannot give specific evidence unless we see the test.

Since we did "participate in the selection and review of questions", it would seem only fair that we be allowed to see the final product.

BJD:pbt
cc - Dennis Corson
Jadine O'Brien
Frank Mack

APPENDIX TO STAFFING:

OBSERVATIONS ON DIRECT CARE

Direct care is very good in some ways, inadequate in others. Everyday physical care of residents is generally good, but could be improved. For the most part, residents are treated kindly. Direct-care aides do not yet function as guides and teachers of the retarded.

> C.1. The primary responsibility of the living unit staff shall be the proper care, habilitation, and development of each resident. In addition, living unit personnel shall insure that the rights of residents set out in this decree are respected. In particular they shall:
>
> a. Develop and maintain a warm, home-like environment conducive to the habilitation of each resident and consistent with the habilitation of each resident and consistent with the normalization principle.
>
> e. Protect and uphold each resident's rights to keep and enjoy personal possession and money.
>
> g. Manage behavior problems in a consistent, humane manner calculated to maximize resident safety and to facilitate the learning of more adaptive behavior.
>
> i. Respect and promote each resident's right to privacy including physical modesty, the right to be alone at times . . .

A first impression at Pineland, and a valid one, is that a large proportion of the direct-care staff have a genuine interest in, and fondness for the residents. Usually, you see staff speaking gently to the residents, and residents showing affection for staff. A Special Master's Assistant has observed a few instances in which individual residents became violent. Staff were impressively kind and patient. On the other hand, not all staff members are as patient as they should be. Problems of staff shortage and lack of training and organization can result in bad situations. Low morale among some staff, and in some instances irresponsibility, have caused problems.

Various events of last Christmas season show strength and weakness of Pineland Staff. On the good side, there is the report on the Christmas party at Kupelian Hall, a residence for the profoundly retarded. Staff had given extra time, and had made decorations, arranged music and tableaux, baked cookies, and provided a very nice Christmas party for the residents and their families. Staff offered to put on a bake sale to raise money for presents.*

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*The money was raised by the volunteer office, as a matter of Pineland policy.

Two very distressing incidents also occurred at Christmas time. One resident was left on the toilet for three or four hours and missed the Christmas party at the gym. The morning shift worker didn't tell the afternoon shift worker about the resident; apparently there was no system of double checking to make sure everyone was accounted for. In another unit, all the morning shift, and all but one of the afternoon shift, called in sick on Christmas Day. A near-fatal accident occurred which might have been related to short staffing. A child left on the toilet slipped under a restraining cord and nearly strangled. The physical system of tying him was obviously faulty; furthermore, he may have been left there for 45 minutes to an hour while the direct care worker was otherwise occupied. The advocate's report states:

> [Residents are supposed to be left on the toilet only 20-30 minutes.] The 20-30 minute limit on toilet time is not now strictly enforced because of other duties which apparently interfere. This limit can probably realistically be enforced if it is considered a priority.
>
> [On March 20 a nurse wrote:] Some toilet training programs on these residents are not carried through per IDT. Those residents that are hoppered are sometimes left longer than the 20-30 minutes specified.

Questions of number of staff, morale, supervision, organization and training are closely related. There are bad situations caused by lack of staff, and by absenteeism among staff actually hired and scheduled to work. There are other situations in which staff, even if otherwise conscientious, probably use shorthandedness for an excuse. A nurse reports of one unit:

> Basically the staff is conscientious. At times when linen supplies are consistently low or when a particular resident consistently becomes unmanageable, and when people feel leadership lacks interest, morale gets a bit low. . . . A frequent excuse not to utilize the gym etc., is lack of staff.

Another report states:

> [Afternoon staff in a particular unit] often refuse to transport residents back from [the program area] on the basis of being short but are then found [by program staff] to be all in the office or coffee room, as they were also during my visit (4:15PM) with residents apparently left alone behind the locked door.

In one case, a school administrator called a given unit to find out why no staff had accompanied residents to school; she was told it was none of her business.

The decree requires that professional staff have input into the evaluations of direct care staff.* Allita Paine, Director of Occupational Therapy, reports that professional staff speak to supervisors if they feel that direct care staff do not adequately follow up on professional recommendations. She felt that supervisors were not always program-oriented and that a more formal procedure might be useful.

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* See, section C.3. Appendix A

Pineland must make a concerted effort at training direct-care staff, in order to achieve proper care and habilitation. In general, the nurses found that direct-care aides were in fact adequately trained in dealing with medical situations. In some units, aide staff are considered superior in this respect. The type of expertise needed is described in the nurse's comment on Kupelian Hall II:

> Kupelian Hall II is fortunate to have several direct care staff who have successfully completed the basic nursing course. Other staff members have years of experience in their field and are consequently very adept at dealing with daily situations. The aide staff of this unit are totally capable of dealing with emergency situation, and I place a great deal of confidence in their judgement. Seizures are handled very well by the majority of the staff. They are well trained in dealing with abrasions, lacerations, nose bleeds, bruises, etc.; and, foremost, they know when nursing intervention is necessary. The majority of the staff do well in describing signs and symptoms of medical problems to the doctors and nurses.

A count of 16 residential units showed that the nurses found 6 adequate, 7 excellent, and 3 definitely in need of improvement. (This is a rough estimate as between adequate and excellent; the nurses used various adjectives. The 3 less than adequate ratings were clearcut). Of the three units needing improvement, two were units for the multiply handicapped. One had 16 direct-care personnel, 10 of whom had received Pineland's course in Basic Nursing. As to one unit, the nurse's report said:

> Lack of experience results in denying residents proper care...It is important to know and apply all aspects of basic nursing to care for these residents, including seizure care, taking of vital signs, proper positioning to alleviate further contractures and deformities, diet, bowel training programs, and many more.

Positioning is essential in that unit. The residents are children. Because of recent medical advances, proper care can save them from some of the deformities now suffered by adult residents at Pineland. Positioning must be carefully monitored. Pineland staff report finding children in need of positioning lying in contracted positions while a nearby aide watches television. Aides caught this way are not even embarrassed.

Another residence for the multiply handicapped is Perry Hayden Hall. As noted elsewhere in the staffing section of this report, Perry Hayden Hall is often deliberately understaffed. Sometimes, a single direct-care worker is left to care for all the residents on a Perry Hayden unit. In interviews, supervisors of all three units stated that direct-care staff are expected to administer non-injectable medications, and routinely do so. These workers usually have insufficient training to be considered qualified to administer medication.* At least one aide assigned to Perry Hayden refused to give medication, demanding that this be done by someone with nursing training. According to supervisors, the lone aide assigned to a Perry Hayden unit is sometimes a member of the "float" team. The "float" may never have worked in Perry Hayden Hall before; he is left, unsupervised, to follow unfamiliar procedures in the care of unfamiliar residents who depend upon that worker for their every need.

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*Sec, O. II., App. A: "Only appropriately trained persons shall be allowed to administer drugs."

The nurse's comment on Perry Hayden is:

> For this unit--on all shifts--should hire experienced certified nurses aides instead of on-the-job training in this unit with basic nursing scheduled well after they have been here. Example: On 2/12 PM shift only one certified aide, 4 others, fairly new employees, with no knowledge of seizures, aspiration, value of frequent turning, importance of extra fluids, proper washing at diaper change, etc.

In this unit all residents are profoundly retarded; all are incontinent and confined to beds and wheelchairs. Although the nursing office reported no bed sores, a nursing supervisor reported an unnecessarily high incidence of body rash. The units for the profoundly retarded sometimes smell of stale diapers.

Section M.4. of Appendix A provides:

> There shall be regular training sessions for direct care staff on the identification and reporting of medical problems, with particular emphasis on seizure control, aspiration, prevention of bed sores, and other common health problems of Pineland residents.

Regular training sessions, plus adequate staffing, should make it possible for new employees to be trained soon enough so there would not be four workers at Perry Hayden with no knowledge of aspiration. The Nursing Department has instituted a new course which provides certified nurse's training for direct-care staff. The Nursing Department would like all direct-care workers to qualify as nurses' aides.

There have been many requests for inservice training, both from the Executive Management committee and the program coordinators. It is recognized that staff now doing a good job will do better with increased technical knowledge:

> Day care staff of Vosburgh I [are] to be complimented on the good work they have been doing both at VHI and N.G.L.C. Evening staff to be complimented on recent improvements they have made. Inservice training should be made available to them on how to interact with their residents, on how to provide specific ADL training, and on how to do appropriate recreational and sensory stimulation activities in the evening.

Encouraging comments come from Doris Sidwell Hall, the unit for residents who communicate through signing. This unit was set up by and received intensive effort from the communication and occupational therapy departments. The comments show that progress can be made in a short period of time, but that it is difficult to ensure consistency:

> Ability of direct-care staff to interact with residents has improved greatly just since last summer. During a one-hour visit by this therapist last summer, staff were observed not to interact with the residents in the building even though three were inappropriately self-stimulating, in one case leading to self-abuse. This week's

> visits revealed staff who were interested in using their special communication skills to interact with the residents; they also asked about the possibility of inservice training on how to better develop residents' sensory-motor skills and improve behavior. [Mrs. Paine O.T.]

> Carry-over of signing ranges from very consistent to non-existent depending upon the person conducting each specific activity. Overall, it is fair to say that during major training activities (mealtime, dressing, bathing, and other ADL tasks, as well as evening leisuretime activities), signing is carried over with good consistency. [Mrs. Kalloch, Head of Communication Dept.]

Both unit staff and program coordinators would like to see more training in "behavior modification", techniques of changing specific behaviors.

Berman School could be helpful in teaching direct-care aides techniques of psychological management. A Special Master's Assistant observed a boy sitting before a triple mirror, pointing to eyes, nose, mouth, etc., being complimented by the teacher, and obviously very pleased with himself. The same boy would hardly sit still last year. Teachers feel the secret of handling retarded children is consistency. This has to be learned..."Screaming and hollering is built into adults, and it doesn't work", said one teacher. "Consistency does. I've tried it, and I know." The general disorder of Pineland is not conducive toward consistency.

Other useless instincts are built into adults. One aide was seen trying to punish a child for slapping herself. The aide slapped her.

Program coordinators from various units mention the need for more training in the technical skills of occupational therapy, communication, and physical therapy. They also mention the need for training in interaction and socialization--simply providing the stimulation of human contact in a way that is appropriate. The coordinator for the Perry Hayden units (those housing the most profoundly retarded and physically handicapped) asks for training in ADL teaching, in programming, and in socialization. Until this year, these residents have had no programming. It is imperative that staff be helped to find ways to engage their attention and to help them live a fuller life than was considered possible before.

There must be better organization and more support for direct-care staff. The quality of aide/resident interaction in the living units is a matter of supreme importance, but very difficult to monitor or evaluate. Training direct-care aides, changing their role, seeing that they "internalize the need for program carry-over", none of these tasks is sure of accomplishment. One encouraging theme runs through Pineland reports: when the aides understand the need for a given procedure, they do a good job. Aides are generally champions of their residents; they are proud of the residents' skills.

A unit program would answer questions like these:

Which residents need positioning and range of motion, and when do these occur; how many residents need extra chances for guided walking, and when do they have this training; what training is given in communication, and when; what games are

the residents able to play, and when do they have the opportunity to play them;* what sensory stimulation activities are practiced in the unit. Excessive regimentation would be wrong, but it would be helpful to know the type of activity appropriate for each unit and the time of day when it is most likely to occur.

Some change needs to be made in the Residential Services Department so that there will be more time available for support and monitoring. Some unit supervisors have said that they would like more in-unit contact with Residential Services; in the past, administrative energy has tended to go into matters like days off (an important problem) without enough time devoted to questions of management and morale. We cited earlier a nurse's comment: "basically the staff is conscientious but morale gets a little low when it seems that leadership lacks interest. Basically leadership is conscientious, but it needs organizing."

Another change which would be good for morale is better supplies for residential units. The supervisor of coordinators calls the shortage of supplies for in-unit activities "critical." The units must have physical equipment to do carryovers (activities which are consistent with the curricula of the resident's formal program and which augment or build upon skills acquired in daily program).

There is a difference, not merely quantitative, between economising and penny-pinching. Direct-care staff and program coordinators should have the feeling that available resources are being apportioned fairly and systematically, rather than according to moment by moment shifts in the financial picture and the workload of the business office. Pineland's business managers have traditionally been both overworked and defensive about requests for money. Part of the class action suit should be establishment of priorities which everyone can understand and many people agree with. Equipment for on-unit activities should be a high priority. Here are two examples:

First, there is the story of the sheets and pillowcases ordered by Perry Hayden Hall. They were needed for wheelchair residents who liked to sit outdoors during warm weather and needed coverings for vinyl wheelchairs; without the coverings they risked skin trouble caused by perspiration during the hot months. On April 25 the problem was reported to the Program Quality Committee. A member agreed to check. On May 16 the committee reported no word from the business office; on May 30, still no word; on June 20 the Program Quality Committee received word that sheets and cases had been received.

Second, the Decree requires that residents receive training in the preparation of food. One unit (since dispersed) had an active cooking program which the residents enjoyed. The coordinator for another unit reported that she was unable to get saucepans and food for a cooking program. Another coordinator reported that he was able to get saucepans but no food.

There have been some encouraging developments. On a spring evening spot check, staff were found taking residents for walks or for trips into the community. Unit staff are concerned about "bringing up our percentages" of compliance with standards H. and V. of the Decree, requiring recreation and

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*Sec. H.7., App. A provides: "Developmentally appropriate reading materials, coloring books, film strips, special toys, games and records shall be available to residents in places which are comfortable and conducive to resident use." This accurately describes few, if any, of Pineland's residence units.

integration with the community. Much more discussion and monitoring is needed before these standards can be declared satisfied as to quality of the residents' experience; in general, coordinators and communication department staff feel that the quality of the trips is improving. Some instances have been reported in which staff showed considerable imagination and effort. One blind and very difficult resident was taken to a farm where he patted the animals and feasted on fresh tomatoes. He also went, with two aides, to climb Bradbury Mountain.

COMMUNITY PLACEMENT - INTRODUCTION

The Court's decree requires Pineland to assume the role of an educational, habilitative organization devoted to preparing its residents for a more normal, less restrictive style of life. An important goal for each resident is the goal of independent community living. Each of them enjoys a present and personal right to leave Pineland.* Every Pineland resident could experience as good or better quality of life outside Pineland Center.

A prime barrier to community placement is that many of Pineland's residents are now thoroughly "institutionalized" by the abnormal conditions under which they have so long lived. For years, the residents of Pineland have been segregated and exposed to a style of life which bears no resemblance to the styles of life they might be expected to encounter outside the institution. They have not learned how to live other than as "residents" of Pineland. They have not been exposed to family-style living, dignity, comfort, or sanitation. They have not learned proper deportment in public places. They have not been educated. Thus, their confinement becomes the rationale for keeping them confined to Pineland.

Placements have suffered lengthy delays pending some necessary approval by agencies other than the Department of Mental Health and Corrections. The Department of Human Services, the Office of the State Fire Marshall, and the Department of Education are unfamiliar with the special characteristics and needs of the retarded. This unfamiliarity is the natural consequence of confining retarded individuals to Pineland. Because they are unfamiliar with the condition of Maine's retarded citizens and with the Consent Decree itself, these agencies make no special allowance for either. They apply their rules and regulations with mechanical uniformity. Pineland must direct energies toward educating state agencies whose cooperation is needed for the development of homes for its residents. Pineland cannot wait passively, as it does now, for the disinterested to cooperate.

Once others have overcome external obstacles to placement opportunities and have prepared a community residence to receive residents, Pineland does perform well as a coordinator and facilitator of placements. Even so, Pineland has created its own unnecessary obstacles to placement. For example, the length and intensity of the relationship between residents and direct care staff sometimes result in the formation of friendships. Staff are then reluctant to have the resident leave. Ironically, the very residents capable of forming such attachments are often the best candidates for community living. They tend to be the least handicapped and cause the fewest problems for staff.

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* Section A.1. of Appendix B states that defendants are to reduce the Pineland census to 400 by July 1, 1979. This was done. The census must be further reduced to 350 by July 14, 1980. This too will probably be done.

Pineland also hinders the placement process because it uses inappropriate criteria to evaluate the suitability of placement openings. It is the policy of Pineland's Department of Social Services not to place any resident at a greater geographic distance from his concerned family than he enjoys at Pineland. Residents' IDT's routinely accede to this position although it is without foundation in the decree. Pineland refused to place a resident over the opposition of his parent or guardian. It ignores the detailed proceudre set out in section A.8., Appendix B, whereby residents or their correspondents may appeal a placement proposal. That section specifies the criteria to be used in determining whether a placement is proper: If the challenged placement will offer the resident "a better opportunity for personal development and a more suitable living environment and will result in placement in the least restrictive alternative appropriate for the resident," then the placement should be effected.

Pineland is extremely cautious and conservative in its assessment of placement openings. Its Department of Social Services takes pride in its conservatism. It points to the relatively low number of placements made during the first decree year as evidence that it is doing a good job screening placements. Staff travel great distances to meet the operators of community residences and to conduct inspections of the homes. Placements have been delayed because of subjective determinations that a potential home is not suitable, despite prior approval of the home by Bureau of Mental Retardation regional workers. Even so, Pineland has been unable to document a single instance in which regional workers had conducted a faulty evaluation and recommended a home which was, in fact, substandard. Worst of all, Pineland does not consider the relative merit between a proposed placement and Pineland itself.

Pineland can no longer play the part of a self-contained institution insulated from the rest of society. The decree assigns Pineland the status of an integral part of a state-wide service system for the retarded. Pineland and the Bureau's regional offices can no longer operate as separate entities in the placement process. Pineland should take an active role in the development of alternative residential facilities, such as small group homes and intermediate care facilities for the mentally retarded, and habilitative programs which residents will need after leaving the institution. Pineland's institutional instinct for self-preservation, manifest by inflated statistics on programming and a reluctance to take an agressive role in developing good placement opportunities, will ultimately be self-defeating. The future of Pineland rests on its ability to discover a new indispensable foundation besides custodial care.

COMMUNITY PLACEMENT - FINDINGS

The unifying decree principles of normalcy and the least restrictive alternative require that Pineland take appropriate action to secure community placements for all its residents. These principles mandate successive approximations of ordinary residential living conditions, if this cannot be accomplished in one move, through a process of preparing the resident by training, habilitation, and education. (See, Report of the Special Master to the U.S. District Court, March 19, 1979, III.A., p.5).

Specific sections of the decree add form and substance to this general directive. Section A.1. of Appendix A makes it the right of each resident to have provided such habilitation as will "create a reasonable expectation of progress toward the goal of independent community living."

Section A.3. of Appendix A provides that ". . . Pineland shall make every attempt to move residents from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residences; (5) segregated to integrated community living; (6) dependent to independent living.

Section D.1. and section D.4., Appendix A, specify and describe the format of an individual Prescriptive Program Plan to be prepared for each resident at Pineland. The decree clearly contemplates that the ultimate goal of independent community living be given initial and continuing attention by Pineland staff. To this end, section D.5., Appendix A, states:

> Each resident's prescriptive program plan shall include an analysis of the community placement best suited for that resident and a projected date for the resident's progress to a community setting. There shall be at least an annual review of each resident's progress toward community placement.

Finding: Pineland has no systematic approach to preparing residents for community living.

Discussion: Programming at Pineland bears no necessary correlation to the goal of community placement. Pineland does not assess a person's behavior patterns or incapacities which might make adjustment to community placement difficult and then address those needs to smooth the path to release. Programming is haphazard on this score; and, in fact, the day-to-day life at Pineland reinforces uniquely institutional behavior which will predictably complicate a person's transition to noninstitutional life. Pineland personnel are well aware of Pineland's failure to promote readiness for placement. Placement evaluations,

on the other hand, will cite those behavior patterns and incapacities as a reason for not recommending placement. Accordingly, a person who is involuntarily confined to Pineland develops habits as a result of his being institutionalized which form obstacles to placement; the institution not only fails to address those habits but also reinforces them; and institution-inspired behavior becomes the reason why a person cannot leave the institution.*

Pineland has made little effort to move persons from more restrictive to less restrictive facilities within the institution. The only persons who have obtained the benefit of such directed movement are those living just off Pineland proper in the cottages. Other, and more substantial relocations within Pineland resemble a shell game with people more than a planned sequence of movement. Persons have been moved from open units to locked units for no reason pertaining to themselves as individuals. They have been forced to move from better to worse; and they have protested, but to no avail. Some residents have complained to the Master that they feel like they were put in jail as a result of moves made solely for institutional convenience. On the other hand, almost invariably when a person has been allowed to make a bona fide move from a more restrictive to a less restrictive setting, aides report that his attitude and behavior improves as a result.

In the summer of 1978 the Master observed how Pineland controlled a resident who threw a temper tantrum: Five sturdy males wrestled him to the ground and held him until he knew that persistence was useless. The Master observed the same person throw a tantrum in his new community residence: There a petite female teacher firmly told him to go to his room until he could change his attitude, and he complied without delay.

Finding: Pineland fails to take adequate steps to assist Pineland residents in realizing their right to leave the institution.

Discussion: Pineland's attitude toward its role in placement is essentially this: Pineland has the duty to "identify" candidates for placement. Otherwise, the components of placement are the obligations of others.

The persons who know more about the personalities of Pineland residents are Pineland employees. They know better than anyone what a person

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* Pineland staff have indicated that a placement would be blocked, for example, if a prospective home were located on a busy thoroughfare and the candidate for placement had been known to wander in Pineland's quiet streets.

needs and what he is capable of doing and learning. When it comes to placement, Pineland makes no effort to meet those needs and take advantage of the capabilities. Instead, Pineland waits. Pineland waits for regional offices of the Bureau of Mental Retardation to "develop" a new group home or residence. Pineland waits until the Department of Human Services inspects a home even though all persons concede that the home is a good place to live. Pineland waits until a school district, which has had no connection with the candidate for placement in the past, convenes a pupil evaluation team meeting.* Pineland waits until furniture has arrived even if Pineland has unused furniture which could be sold, given, or lent to the new home. Pineland has even delayed placements because it did not approve of a home which had already been approved by all other concerned parties. Pineland has refused to make placements over the objection of a parent in complete contravention of the proper procedures for objection to placement. Pineland fails to assist residents in overcoming outside obstacles to their placement away from Pineland.

Pineland fails to provide complete information concerning persons who are placed into community residences. In some cases, three or four sheets containing the most cursory information of most recent physical examinations is sent to the regional staff and home operators. It has required community social workers to come personally from all over the state to Pineland Center in order to obtain substantive information from a person's Pineland record.

Pineland has not discovered that it has nearly 400 already identifiable candidates for community placement.

Finding: Pineland has made minimum placements required.

Discussion: During the first decree year, July 1, 1978, to July 10, 1979, 42 of Pineland's residents were placed into the community. Nine of these placements failed for a variety of reasons. Only six of the nine residents placed were returned to Pineland, and of that number two were returned solely because the home closed. The remaining unsuccessfully placed residents were moved from one community home to another. It does not appear that poor matching of residents to homes could be the cause of more than a few, if any, of the unsuccessful placements.

Finding: Pineland fails to take adequate steps to ensure the continued success of community placements.

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* Such a meeting is supposed to facilitate providing special education to handicapped children in the least restrictive environment possible. In fact, because it is a triggering mechanism for financing education, it functions for Pineland residents as an obstacle to placement.

Discussion: Once a Pineland resident has been placed into the community, the involvement of Pineland staff essentially ceases. BMR regional staff must then assume responsibility for service delivery. However, this does not mean that Pineland's duties end inasmuch as Pineland remains the chief source of information about the former resident and Pineland employees are familiar to him.

If a placement shows signs of breaking down and a specific request for intervention is made, the Pineland Department of Social Services may assemble a "mini-IDT" comprising the Pineland staff most knowledgeable about that former resident. Former direct care staff may be able to address the problems presented and suggest to the current home operators ways of dealing with specific behaviors. While this approach is eminently sensible, this service is not "advertised" to BMR regional offices as a possible crisis intervention resource. It remains largely discretionary. It is used only upon a specific request for assistance, but it seems logical to conclude that such requests are not likely to be made unless it is generally known that the service is, in fact, available. The Department of Social Services has agreed to formally apprise the regional offices of this service. The focus will be to prevent placement crises rather than upon crisis intervention.

Prior to any actual move into the community by a resident, Pineland holds a placement IDT in order to make current assessments and recommendations for that resident in a number of respects relevant to community living. These IDT reports and other data supplied by Pineland to the regional office are important to the regional staff who, as noted above, become entirely responsible for coordinating the delivery of services to that resident. Regional case management personnel have complained that the information supplied them by Pineland is often inadequate. In addition, placement IDT reports often do not arrive until some weeks after the resident has been placed in that region. Pineland staff acknowledge that requests for additional information have been received from regional offices of BMR because of the untimeliness and insufficiency of information voluntarily supplied. Typically, Pineland fails to supply copies of all the following evaluations: occupational therapy, physical therapy, speech & heaving, vision, education, and programming history. Also missing are psycho-social histories in narrative form, certification of mental retardation, and permission for service forms.

While Pineland supplies some professional reports, some family data, and a check list of self-help skills and abilities, this information is insufficient to give a useful picture of how this individual's time was spent at Pineland, or how capable that person is outside of a few narrow areas.

Regional office staff must now expend inordinate, unnecessary effort to obtain this information (or to actually secure professional evaluations in cases where they were simply not done at Pineland). For example, in some cases the examining Pineland physician has simply checked off "Hearing: o.k." or "Vision: o.k." on the data sheets furnished to the regional office without making it clear whether the physician means to indicate merely that the organs of audition and vision are free from organic disease or that the full evaluations required by sections D.2.(a) and D.9.(a) of Appendix B have been performed. The regional worker must then take the newly-placed resident to an M.D. in the community for a recommendation for a hearing or vision examination in order to make such an exam Medicaid reimbursable. No reason appears why such evaluations could not be performed routinely at Pineland prior to placement.

Regional staff believe that the flow of information accompanying Pineland residents upon placement should closely approximate that furnished when a BMR client is transferred between regions. This would include essentially all information available which is relevant and non-cumulative. The Department of Social Services has agreed to resolve this difficulty. They will inquire of regional staff what information is routinely needed following placement and move to meet those needs with a standard packet of information.

Regional staff find Pineland placement IDT reports to be of poor quality. Regional staff would like to see more attention to detail and more comprehensive coverage in these reports. Pineland staff counter that this detail is to be found in prior Pineland IDT reports for that resident and that the purpose of the placement IDT should not be to recapitulate this body of existing information. It would seem beneficial, however, to summarize this pre-existing data in a placement IDT and to make specific references to prior IDT assessments and recommendations. This is not being done routinely. Placement IDT reports typically give a very sketchy picture of what substantive programs the resident has participated in and benefited from, of what sort of person he really is.

Pineland staff have been recently instructed to maintain coverage of community-placed residents for a period of 90 days after placement in cases where the Pineland staff have been involved with the resident's family. This service will be limited to placement problems vis-a-vis the resident's family. The extent to which this will aid in "bridging the gap" between Pineland and the community remains to be seen. It is also obvious that Pineland staff will be of rather limited effectiveness in this regard unless they are prepared to travel long distances across the state to be of service. Probably the great bulk of assistance contemplated by this directive will be delivered by telephone. However, coupled with the "mini-IDT" crisis prevention service discussed above, this community out-reach effort by Pineland may prove to have significant value in pursuing the continued success of community placements. This also remains to be seen.

Finding: Pineland uses restrictive criteria in evaluating the suitability of openings for community placement.

Discussion: As previously noted, Pineland engages in virtually no residential resource development. When community homes are developed or when openings occur in existing homes, BMR regional staff notify Pineland. If home operators contact Pineland directly, seeking to have residents placed in their homes, they are referred to the proper BMR regional office. Therefore, all homes have presumably been fully evaluated by BMR regional staff in accordance with sections A.2.(1) and (b) of Appendix B and a determination made that the home could serve the needs of at least some category of Pineland residents. The function of Pineland staff then becomes that of matching what the home can provide to the needs of a particular resident. Pineland is reluctant to facilitate a placement unless near-perfection can be assured. Pineland does not consider the relative merits of the proposed community residence versus Pineland itself.

In making placements the Pineland Department of Social Services puts great emphasis on geographic location of the home vis-a-vis the family of the resident. Section A.2.(c) of Appendix B provides that given two openings, one near the resident's former home and one some distance away, this consideration has merit. Pineland now furnishes each BMR region with a list of residents whom Pineland feels are properly placeable in that region alone. This practice is potentially detrimental to the placement process since every resident should be considered for every placement opening primarily according to the criteria stated in the decree. Such a system of reporting candidates for placement may also be distorting the actual incidence of particular residential needs among the Pineland population, thus hampering resource development efforts. While information on absolute housing needs (e.g., number of residents needing pediatric ICF placement) is made available to regional resource developers upon request, it should be furnished periodically as a matter of course.

Pineland staff also engage in placement evaluation by inquiring into other features of a prospective home, although this is clearly not their function under the decree, and even though these considerations are the responsibility of regional BMR staff. Pineland apparently remains skeptical of the ability of regional staff and other state inspection and licensing agencies to make proper evaluations of homes or finds these entities to be less than conscientious in performing these tasks. However, the Department of Social Services has not furnished any concrete examples of such deficiencies.

Finding: Pineland's documentation of its process of making placement decisions is inadequate.

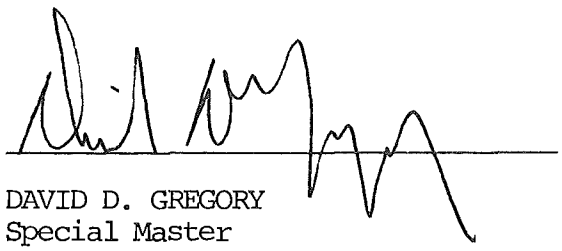
Discussion: Section A.8. of Appendix B defines the process of appeal from placement decisions. It presupposes the availability of sufficient evidence to reach a conclusion regarding the propriety of any such decision. Pineland does not maintain adequate placement files to allow compliance with section A.8.

When an opening for a resident is located or developed by regional staff, the Department of Social Services solicits names of residents from Pineland social workers. It is strictly up to the social workers to match the IDT-identified needs and goals of each resident nominated to the ability of the home to meet those needs and goals. No further consideration of IDT recommendations is entertained in the placement process. Once nominations have been received, a Department of Social Services committee selects a resident from the names submitted. No minutes or other formal memoranda of these meetings are kept making it very hard to document the selection criteria actually used.

CONCLUSION

The foregoing report constitutes the first annual report of the Special Master. It is submitted to the Court for its consideration in partial fulfillment of the obligations owed to the Court by the Special Master.

Respectfully submitted,



DAVID D. GREGORY
Special Master

Dated: November 14, 1979
Portland, Maine

ARTHUR R. DINGLEY
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P I N E L A N D C O N S E N T D E C R E E

FINDINGS AND RECOMMENDATIONS

OF THE SPECIAL MASTER

MEDICAID: ICF-MR

December 24, 1979

MARTTI WUORI, et al.,

Plaintiffs

v.

GEORGE A. ZITNAY, et al.,

Defendants

Civil no. 75-80-SD

FINDINGS AND RECOMMENDATIONS

OF THE SPECIAL MASTER

MEDICAID: ICF-MR

I. EXPLANATION OF RECOMMENDATIONS

A. Objective of Recommendations.

The purpose of these recommendations is to shift state administration of one part of a federal program from the Department of Human Services to the Bureau of Mental Retardation, a division of the Department of Mental Health and Corrections. The program involved is that aspect of medicaid pertaining to intermediate care facilities for the mentally retarded. This transfer of authority is necessary, first, to enable the State to establish a soundly financed, adequately staffed, and well-supported system of authentic community homes and programs for persons who are mentally retarded; second, to facilitate the State's qualifying for substantial federal financial assistance to meet its obligations under the order of this Court; and, third, to ensure that a federal program, which is consistent in both its purposes and terms with the Court's decree, is not administered at cross-purposes to the decree.

Establishing a system of intermediate care facilities for the mentally retarded could have major fiscal implications for the State. Approximately seventy per cent of the cost of providing authentic community homes, occupational or educational programs outside the home, and various support services for persons who are retarded could be financed with federal funds if the homes were designated under federal law as ICF-MR. The State must provide such homes, programs, and services in any event pursuant to the order of the Court. By treating decree expenditures as the State's matching share for medicaid reimbursement, the State can effectively triple its resources for financing community homes, programs, and services without increasing expenditure of state funds. Thus the medicaid ICF-MR program could make available to the State substantial federal aid to assist the State in meeting its obligations under the Pineland consent decree.

Of equal importance is the manner in which the State takes advantage of this opportunity under medicaid to establish an ICF-MR system. It is essential that the system be established by persons who are closely familiar with the affirmative capabilities of retarded citizens and their educational as well as other needs. Federal regulatory standards applicable to the ICF-MR program have sufficient latitude to allow for a variety of interpretations and applications. Unless the program is administered by persons familiar with the actual needs of retarded citizens, the ICF-MR program can defeat its own purpose and become an obstacle to compliance with the order of the Court. Numerous particular restrictions and requirements can be imposed by the State which are inconsistent with the Court's decree, which impede fulfillment of the purposes of the decree, especially its purpose to promote normal living, and which build in unnecessary, wasteful costs.

Federal law contemplates a state's primary medicaid agency's contracting out certain portions of its responsibilities. This course is particularly appropriate where, as here, a discrete component of the federal program applies only to persons who are mentally retarded and a separate state agency has the greater expertise in evaluating and meeting their actual needs. The recommendations set forth herein would compel such a delegation of administrative responsibility.

B. Authority to Make Recommendations.

This Court's order of July 21, 1978, entitled "Appointment of a Master," establishes the Master's authority to make formal recommendations concerning implementation of the Court's decree. Recommendations must be based upon a determination of noncompliance with the decree accompanied by findings of fact indicating the evidence on which the findings are based; recommendations must be consistent with the decree and susceptible of implementation within the framework of the decree. The Master's recommendations are binding upon the parties unless a party requests a hearing before the Master. Promptly following the conclusion of a hearing, the Master is required to render a decision, which is final unless reviewed by the Court on the record before the Master. Pertinent provisions of the order of July 21, 1978, are set forth as an appendix to these recommendations.

C. Noncompliance with the Decree.

The basis of the Master's recommendations is the State's failure to comply with the Court's decree. The decree guarantees to members of the plaintiff-class a right to an individually planned program of habilitation, including medical treatment, education, training, and care,* and a right to live and learn in the least restrictive environment necessary to achieve the purposes of habilitation,** including especially a right to placement out of Pineland Center into an authentic community home.*** Most residents of Pineland live in a more restrictive setting than is necessary for their habilitation, and they are not provided with individually planned habilitation programs conforming to decree requirements.**** Plaintiffs have been certified by the District Court of the State of Maine to remain at Pineland Center, not because it provides an environment suited to their needs, but rather because the State has failed to provide any better alternative.***** Many plaintiffs who were formerly confined to Pineland live in boarding homes, nursing homes, and state institutions which are not programmatically oriented and violate major decree requirements. Many plaintiffs do not have suitable programs of habilitation and lack necessary supportive services, notably transportation between home and work.

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*Wuori v. Zitnay, Civil no. 75-80-SD, Order of July 14, 1978, Appendix A §§ A.1 (residents' rights), D (programming), F.1 (eating ability), F.10 (dressing ability), F.11 (grooming and hygiene), G (education), L (speech and communication), Appendix B §§ B (programming), F.1 (community residences), G.1 (programs).

** Id., Appendix A §§ A.3 (residents' rights), B (environment), Appendix B §§ A (community placement), F.1(b)-(c) (community residences), G.1 (community programs).

*** Id., Appendix A §§ A.3-4 (least restrictive environment), D.5 (individual plans to address community placement), Appendix B §§ A (community placement), C (development of community placements). See Report of the Special Master to the United States District Court, March 19, 1979, at 5-8,12, 13.

**** See generally Report of the Special Master to the United States District Court, Nov. 14, 1979, part II.

***** For the state-court procedure and standards for certifying persons to be confined to Pineland, see M.R.S.A. tit. 34, § 2659-A (1979-1980 Supp.).

The State's failure to comply with the order of the Court constitutes an emergency. The State is requiring plaintiffs to live under conditions violating the Court's decree because the State is failing to provide an adequate array of community services. The State's failure results in a daily denial of plaintiffs' rights and requires the swiftest possible corrective action.

In order to implement the Court's decree, both at Pineland and in the community, it is necessary for the State to establish a soundly financed, well-staffed, sensibly regulated system of true community homes and programs and to provide necessary support services. Such a system is a practical prerequisite to the realization by many members of the plaintiff-class of the rights guaranteed by the Court's decree. The State's obligation to establish such a system derives from the consent decree. It is not optional. The State has a duty to make such expenditures as may be necessary to comply with this Court's mandate.

D. The Medicaid Option.

The ICF-MR program can provide the State with substantial federal financial assistance in meeting the State's decree obligations. If the State cannot excuse its failure to implement the Court's decree on the ground of a shortage of state funds, it most assuredly cannot excuse its failure to take maximum advantage of available federal funding to be expended in maximum cooperation with the order of the Court. Medicaid funding through the ICF-MR program could be used to finance approximately seventy per cent of the cost of new community-based group homes, programs, and support services.*

The reason that federal money is available to assist the State in implementing the Court's decree is that the congressional purposes embodied in the federal program are essentially identical to the purposes of the decree. The two federal laws -- the Court's decree and the ICF-MR component of medicaid -- are not only harmonious in purpose but also substantially similar in their mechanisms and terms. Consistently with the Court's decree, a community residence designated as an ICF-MR "must provide training and habilitation services to all residents, regardless of age, degree of retardation, or accompanying disabilities or handicaps." 42 C.F.R § 442.463. "The living unit staff must make care and development of the residents their primary responsibility. This includes training each resident in the activities of daily living and in the development of self-help and social skills." 42 C.F.R. § 442.433. Residents are to be encouraged to be independent. See 42 C.F.R. § 442.442 (clothing), 442.443 (health, hygiene, and grooming), 442.472 (eating), 442.436 (personal possessions). Planned activities and recreation

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* Statutory authority for ICF-MR is found in 42 U.S.C. § 1396d(d) (1974). Accompanying federal regulatory standards are set forth in 42 C.F.R. §§ 442.400 et seq.

must be provided. 42 C.F.R. §§ 442.435, 442.491. Various professional services must be available according to client needs. 42 C.F.R. §§ 442.474 (medical services), 442.482 (pharmacy services), 442.486 (physical and occupational therapy), 442.489 (psychology), 442.494 (social services). The mechanism for providing active treatment for ICF-MR residents, like the decree's prescriptive program plan, is an individual written plan of care which

> sets forth measurable goals or objectives stated in terms of desirable behavior and that prescribes an integrated program of activities, experiences or therapies necessary for the individual to reach the goals or objectives. The overall purpose of the plan is to help the individual function at the greatest physical, intellectual, social, or vocational level he can presently or potentially achieve.

42 C.F.R. § 435.1009. Federal ICF-MR regulations and the consent decree are written in pari materia.

For a Maine ICF-MR system to work properly and consistently rather than at odds with the consent decree, it is essential that the program be administered by those persons who are most familiar with the capacities and actual needs of retarded citizens. Otherwise, the ICF-MR program, so far from being facilitative of the purposes of the Court's decree, can become a barrier to the State's compliance with the Court's mandate as well as being wasteful of state, federal, and private money. These results would occur, for example, if the State were to adopt state ICF-MR standards which were at variance with the consent decree or if state or federal regulations were construed to impose useless requirements based on a standard other than clients' actual needs.

The agency currently designated to administer the federal medicaid program in this State is the Department of Human Services. That Department has no special expertise in mental retardation. It has applied to group homes for the mentally retarded state regulations which are contrary to both the terms and objectives of the Court's decree. On the one hand, the Department has imposed artificial limits on allowable staff and other necessities without regard to client needs, and, on the other hand, it has imposed state regulations requiring expenditures for unnecessary physical renovations.*

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* In an exchange of correspondence, dated respectively June 27, 28, and 22, 1979, among the Special Master, Commissioner George A. Zitnay of the Department of Mental Health and Corrections, and Commissioner Michael R. Petit of the Department of Human Services a request was made and acknowledged for the Department of Human Services to bring

(footnote continued on next page)

In the course of the Department's certification of Pineland Center as an ICF-MR, it has imposed upon Pineland federal regulations that were vacated in 1977.* It has required physical and other alterations designed to make Pineland Center more, not less, institutional in character. The programmatic and fiscal dangers inherent in the potential misuse of the ICF-MR program counsel persuasively toward delegating administrative authority to persons who know the plaintiffs best.

(cont.)
the State's system of community homes, programs, and services within the ICF-MR program. On September 13, 1979, the Department stated that it would defer complying with the request until April 1, 1980, while it formulated new state ICF-MR regulations. By letter dated October 7, 1979, the Special Master indicated that he would accept the judgment to defer inclusion of the State's community system within medicaid pending adoption of new state regulations but that no delay in adopting those regulations was warranted. (Federal law does not require the State to adopt separate ICF-MR regulations. Any community home designated as an ICF-MR would be bound by both the federal ICF-MR regulations and the Court's decree. There is no apparent need for an additional layer of regulations.) Despite a request for a response at the Department's earliest convenience, no substantive response has been received.

* Citations to federal law in the plan of corrections imposed upon Pineland by the Department of Human Services refer to 45 C.F.R. § 249.13 (superseded volume dated Oct. 1, 1976). Those regulations were vacated in September 1977. See 42 Federal Register 52827 (Sept. 30, 1977). The correct regulations, hand-delivered to the Commissioner of the Department of Human Services by the Special Master on June 19, 1979, are found in 42 C.F.R. § 442.400 et seq.

II. FINDINGS OF FACT AND RECOMMENDATIONS

A. Determination of Noncompliance.

The defendants are not in compliance with the Court's decree. This determination is based on the following findings of fact.

B. Findings of Fact.

1. Residents of Pineland Center are not being provided with their minimum entitlement to individually planned programs of habilitation and are not being allowed to live and learn in the least restrictive conditions necessary to achieve the purposes of habilitation.

> [This finding is based on Pineland Center's official programming statistics, an examination of Pineland's interdisciplinary team reports, personal observation of programs and residences at Pineland Center, and interviews with Pineland residents.]

2. Residents of Pineland Center are being confined to Pineland because the State has failed to provide suitable community residences, suitable programs in the community, and adequate support services.

> [This finding is based on records of Pineland Center's department of social services, interdisciplinary team reports, interviews with social services personnel and community resource developers, and the records of the Maine District Court pertaining to certification of Pineland residents.]

3. Plaintiffs who are no longer confined to Pineland Center are living in places which substantially fail to conform to the purposes and terms of the Court's decree.

> [This finding is based on personal observation of community residences and interviews with community service workers, advocates, and former Pineland residents.]

4. Plaintiffs who live in community homes are not being provided with programs suited to their needs or support services adequate to meet actual client needs.

[This finding is based on interviews with community service workers, advocates, and former Pineland residents.]

The foregoing findings of fact apply in each case to a substantial number of members of the plaintiff class. The Special Master believes that all of the foregoing findings can be established at an evidentiary hearing exclusively through the official records of agencies of this State and the testimony of employees of the State of Maine.

C. Recommendations.

1. The Director of the Bureau of Mental Retardation of the Department of Mental Health and Corrections shall assume full responsibility for administration of that part of the medicaid program known under the designation of ICF-MR. Such responsibility shall include adopting state ICF-MR regulations based upon the Court's decree, inspecting, licensing, and certifying residences as ICF-MR, approving programs, services, staffing patterns, and allowable rates of cost, and all other ICF-MR administrative responsibilities except ministerial disbursement of funds. The Director shall notify the Attorney General of the assumption of this responsibility and shall request the Attorney General to inform the United States Department of Health, Education and Welfare in an appropriate manner. The Director shall so notify the Commissioner of the Department of Human Services and shall request the Commissioner to take such steps as may be necessary or desirable to effectuate the transfer to the Director of such responsibility.

2. The Attorney General shall certify to the United States Department of Health, Education and Welfare that the Director of the Bureau of Mental Retardation has assumed full responsibility for administration of that part of the medicaid program known under the designation of ICF-MR.*

---

* This recommendation would require only amending the State's official certificate notifying the U.S. Department of Health, Education and Welfare of the State's division of authority for administering the medicaid program. See State Plan Under Title XIX of the Social Security Act Medical Assistance Program, attachment 1.1-A, variously dated Sept. 3, 1976, May 10, 1974, Oct. 1, 1975, signed by Andre Janelle, Assistant Attorney General.

3. The Commissioner of the Department of Human Services shall transfer to the Director of the Bureau of Mental Retardation full responsibility for administration of that part of the medicaid program known under the designation of ICF-MR. Such responsibility transferred shall include adopting state ICF-MR regulations based upon the Court's decree, inspecting, licensing, and certifying residences as ICF-MR, approving programs, services, staffing patterns, and allowable rates of cost, and all other ICF-MR administrative responsibilities except ministerial disbursement of funds.

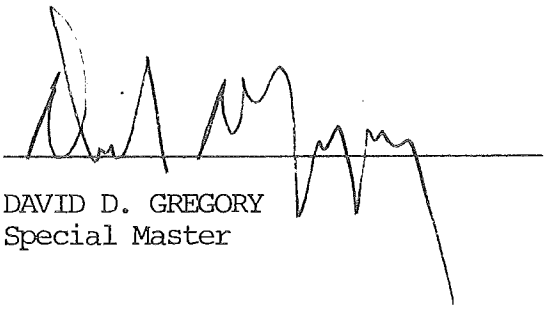
4. The foregoing recommendations shall be done on or before the sixteenth business day following the filing with the Court of these findings of fact and recommendations unless, within fifteen business days, any party hereto files an objection with the Master and requests an evidentiary hearing.

5. In the event that recommendation number 3 is not promptly carried out, the Special Master recommends that Michael R. Petit, Commissioner of the Department of Human Services, be added in his official capacity as a named defendant under this Court's decree of July 14, 1978, for the purpose of requiring him to take such steps as may be necessary to effectuate the Court's decree including the recommendations contained herein.

III. CONCLUSION

The foregoing findings of fact and recommendations are submitted to the Court for the reasons explained herein pursuant to paragraph 6j(2) of the order of July 21, 1978, "Appointment of a Master."

Respectfully submitted,



DAVID D. GREGORY
Special Master

Dated: December 24, 1979
Portland, Maine

Professor David D. Gregory
University of Maine School of Law
246 Deering Avenue
Portland, Maine 04102

APPENDIX

PROVISIONS OF THE ORDER APPOINTING A MASTER

Following are paragraphs 6j(1)-(5) of the order of July 21, 1978, "Appointment of a Master":

> (1) The Master shall have the authority to make recommendations with regard to implementation of the decree if: (a) he determines defendants are not in compliance with the decree; (b) this determination is accompanied by written findings of fact which indicate the source of the evidence upon which each finding is based; and (c) the recommendations are consistent with and can be implemented within the framework of the decree. Such recommendations shall include, where necessary, timetables for implementation of steps or measures necessary to bring defendants into compliance.
>
> (2) Copies of each recommendation accompanied by the findings of fact required by (1) of this paragraph shall be filed with the Court and served upon counsel for the parties. All parties shall be bound by the recommendation unless within 15 business days any party files an objection with the Master and requests a hearing. A copy of any such request shall be filed with the Court and served upon counsel for all parties. Objections may be made on the basis that (a) the findings of fact relied upon by the Master are erroneous, (b) the Master's determination of noncompliance is erroneous, or (c) the Master's recommendations are beyond the provisions of or inconsistent with the decree.
>
> (3) The hearing on the objection shall be held before the Master at the earliest convenient time. Each party shall have the right to present evidence of a documentary and testamentary nature, and to cross-examine adverse witnesses. The Master shall make a record of all proceedings and render a written decision within 10 business days and provide the parties and the Court with a copy of the decision.

(4) The parties may agree prior to the hearing to be bound by the Master's written decision.

(5) If an agreement to be bound by the Master's decision has not been reached, any party may apply to the Court, with notice to all parties and the Master, for review of the Master's decision. An application for review must be filed within 15 business days after the Master's written decision is rendered. Upon receipt of the notice of application for review, the Master shall certify the record of hearing to the Court. Review shall be on the record unless the Court determines that a hearing is necessary. The Court may adopt the Master's decision or may modify it or may reject it in whole or in part or may remand it with instructions.

CERTIFICATE OF SERVICE

I hereby certify that the foregoing Findings of Fact and Recommendations of the Special Master were served upon counsel of record by depositing this day in the United States mail, postage prepaid, one copy addressed to each of the following persons:

Honorable Richard S. Cohen
Attorney General
State House
Augusta, Maine 04333

William H. Laubenstein, III
Assistant Attorney General
State Office Building
Augusta, Maine 04330

Neville Woodruff
193 Middle Street
Portland, Maine 04101

Jane Bloom Yohalem
Robert Plotkin
Mental Health Law Project
1220 Nineteenth Street, N.W., Suite 300
Washington, D.C. 20036

Date December 24, 1979

ARTHUR DINGLEY
Assistant to the Special Master

MARTTI WUORI, et al.,

Plaintiffs

v.

GEORGE A. ZITNAY, et al.,

Defendants

Civil No. 75-80-SD

REPORT OF THE SPECIAL MASTER

TO THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MAINE

COMMUNITY STANDARDS: APPENDIX B OF THE COURT'S DECREE

April 22, 1980

TABLE OF CONTENTS

MARTTI WUORI, et al.,

Plaintiffs

v.

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Defendants

Civil No. 75-80-SD

REPORT OF THE SPECIAL MASTER

TO THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MAINE

COMMUNITY STANDARDS: APPENDIX B OF THE COURT'S DECREE

This action concerns the rights of mentally retarded citizens of the State of Maine. The Court entered its decree on July 14, 1978, with the consent of the State. The Court retained continuing jurisdiction for a two-year period and appointed a Special Master to oversee the State's conduct affecting the decree.

The State's failure to comply with the Court's decree remains substantial. Achievements have been made in establishing small, normal homes for retarded citizens in Maine's communities and in helping retarded citizens to lead productive lives. The State could have made much greater achievements if all State agencies bound by the decree had given their active, informed cooperation. The administrative complexity of carrying out the decree in the absence of just such cooperation has prolonged the time needed for compliance without bringing any countervailing benefit to the State and has demonstrably increased the cost to the State.

I. INTRODUCTION

A. THE DECREE

The Court's decree is divided into two parts: "Appendix A: Pineland Center Standards" and "Appendix B: Community Standards." On November 14, 1979, this office filed a comprehensive report to the Court on Pineland Center. The present report focuses on appendix B, community standards. The two halves of the decree are intimately related; success or failure on one side affects the other. In terms of the State's actions and the likelihood of their success, the center of gravity of the Court's decree is the community: Maine's cities and towns where retarded persons have the right to live and work comparably to other citizens. By consenting to entry of the decree, the State has assumed the legal duty to provide normal homes, educational and occupational opportunities, and supportive services to persons presently as well as formerly confined to a custodial institution. The State's failure to provide the kind of homes, programs, and services required by appendix B has an immediate impact on the lives of persons who have already been discharged from the institution; but that failure may even more profoundly affect persons still confined to the State's custodial institution. Scores of individuals have been designated by Pineland Center staff and the Maine District Court as being ready to leave Pineland and join the community from which they have been excluded; others are also ready. They remain in custodial confinement solely because of the State's failure to provide the homes, programs, and services they need. The State's violation of federal law is not an abstraction to persons whose fundamental human rights are being daily denied.

In essence, the decree guarantees to members of the plaintiff-class three rights: (1) the right to a normal home, (2) the right to education and a productive occupation, and (3) the right to supportive services. Every member of the plaintiff-class has the right to "be provided with the least restrictive and most normal living conditions" appropriate for him and "a right to a habilitation program which will maximize his human abilities, enhance his ability to cope with his environment and create a reasonable expectation of progress toward the goal of independent living."

The State is obligated to provide community homes offering "a better opportunity for personal development and a more suitable living environment which will result in placement in the least restrictive alternative appropriate for that resident." A community home must be "a normal home," a "typical private home," "comparable to . . . private homes," "of normal residential design." Their occupants must be assured "privacy, dignity, comfort, sanitation and a home-like environment." Home sites must"be chosen in residential settings normal for the community in which they are located and with ample opportunity for interaction with the community." Community homes must

be educationally oriented. They are not to be small custodial institutions. Like other homes, they are places for learning and development, for acquiring independence and the skills requisite to independence. "[E]ach client shall receive training in his residential setting in everyday living skills, including, as appropriate: (1) care of individual living area; (2) management, preparation and service of well-balanced meals; (3) selection, purchase and appropriate use of clothing; (4) development of grooming and hygiene skills; (5) preventive health and dental care; (6) use of telephone; (7) safety skills; and (8) use and management of money."

Just as other citizens ordinarily attend school or work outside their homes, so must retarded persons be given opportunities to learn and work outside of their homes. Individually planned programs are to prescribe program activities based upon individual needs and capabilities and are to be designed to foster growth and independence. Program sites "shall be chosen in or close to a population center. Programs shall be located in areas appropriate to the training purposes of the program. For example, workshop programs should be developed in business areas." Community homes and programs "shall be integrated into the community."

For a retarded person, particularly one who has been confined to a custodial institution, coping with normalcy may not be easy. A variety of supportive services must be at readiness for him. Daily transportation is one necessary support-service. Crisis intervention and respite care must be available. Community homes and programs must have sufficient well-trained staff. Family-support services, including homemaker services, are needed for retarded persons living with their families. They need regular medical and dental care and may need special services in psychology, speech and hearing, occupational therapy, physical therapy, and social work.

The mechanism set forth in the decree for providing the plaintiffs with the benefits to which they are entitled is an "interdisciplinary team" which prepares and periodically reviews for each individual a "prescriptive program plan." Plans prepared by interdisciplinary teams are the means of identifying individual needs and provide the basis for locating or developing resources to meet those needs.

B. SOURCES

This report is essentially an examination of the results of the interdisciplinary-team process in the community over the first year and a half of the decree. We have examined 455 prescriptive program plans prepared by interdisciplinary teams for compliance with the decree's requirements on timing, composition of interdisciplinary teams and attendance at team meetings, providing specific guidance to teachers and others, periodic reviews of individual plans,

interim plans when services are unavailable, and recommendations on residential placement and day-programs. The results of our findings have been corroborated by interviewing responsible personnel of the Bureau of Mental Retardation, including program coordinators, case workers, supervisors, and regional administrators. Information on homes and programs was derived from prescriptive program plans, interviews with case work supervisors, information reported by the State pursuant to this decree, personal inspections of homes and programs, interviews with staff workers, and reports prepared by the State. We have visited homes and programs in all six regions of the Bureau of Mental Retardation and examined records and interviewed employees in each regional office. All of the information upon which this report is based comes from the State.

C. SUMMARY OF FINDINGS

The community side of the Court's decree is a study in contrasts, and the contrast can be stark. Every region of the Bureau of Mental Retardation has a few excellent, model group homes in which persons who were formerly confined to an institution are living increasingly normal lives. Every Bureau region has a few model day-programs which are teaching retarded individuals to become productive. Those few homes and programs prove that the decree can be done. On the other hand, many plaintiffs are living in institutional-type boarding homes and nursing homes, some without any program, others with inadequate educational and occupational opportunities. Across the State there is a decided lack of support services including transportation, family-services, crisis intervention, and occupational and physical therapy.

° Sixty percent of the members of the plaintiff-class who have been discharged from the institution live in homes which substantially fail to conform to the Court's decree.

° Fifteen percent of the class-members have no program activity at all, and many others have program opportunities unsuited to their needs and skills.

° Sixty percent of residential recommendations contained in prescriptive program plans fail to comply with the requirements of the decree.

° Forty percent of the program recommendations contained in prescriptive program plans fail to comply with the requirements of the decree.

° The State does not now know the extent of unmet needs as to residence, program, or support services.

° The State has wholly failed to provide crisis-intervention services and substantially failed to provide respite care, both of which can be crucial to assisting recently institutionalized persons to adjust to normal living.

° Advocacy services are inadequate.

° Just under one-half of all annual interdisciplinary-team meetings are late.

° Quarterly reviews of prescriptive program plans are not being made.

° Clear guidance on program goals and how to assist in attaining those goals is not being given to persons responsible for daily care.

As serious as these findings are, the community system is not in utter disarray. The regional offices of the Bureau of Mental Retardation are operating at high levels. The interdisciplinary-team process is established, and its problems are beginning to be worked out. A statewide survey of unmet needs is being conducted, and results should be available next summer. A uniform set of standards for various types of day programs has been agreed upon to eliminate purposeless conflicts among state agencies. Steps are being taken, as a result of the Special Master's recommendations of December 24, 1979, to establish a statewide system of intermediate care facilities for the mentally retarded. (While such a system could provide substantial federal assistance in fulfilling the objectives of the Court's decree, the quality of the State's product is still substantially in doubt.) The Attorney General has filed suit to prevent the city of Brewer, Maine, from zoning out mentally retarded citizens who are working toward independence.

The fact remains that the State is a considerable distance from complying with the order of the Court to which the State gave its consent. The State is not providing the kinds of homes, programs, and services to retarded persons living in Maine communities which the State, by its consent, has guaranteed to them, and, most seriously, the State is not prepared to provide the homes, programs, and services needed by persons who continue to be involuntarily confined to Pineland Center.

II. INTERDISCIPLINARY TEAMS

A. INTRODUCTION

The Court's decree establishes a planning process by which nearly all of the substantive benefits of the decree are to be secured for the plaintiffs individually. An "interdisciplinary team" must meet at least annually to prepare a "prescriptive program plan" for every individual member of the plaintiff-class. (This individual planning process corresponds to similar mechanisms required by such federally financed programs as special education for the handicapped, vocational rehabilitation, and intermediate care facilities for the mentally retarded.) Interdisciplinary teams' preparing and monitoring individual program plans are central to the State's discharging its decree obligations. The State does not itself necessarily provide the services required by the decree. The State does not generally, for example, establish and operate homes and programs for persons who are retarded. Those responsibilities are carried out by others in contract with the State. Interdisciplinary-team evaluations are the only means by which the State knows whether the rights guaranteed by the decree are in fact being enjoyed by any individual member of the plaintiff-class. Interdisciplinary-team functions are the responsibility of the Bureau of Mental Retardation, a division of the Department of Mental Health and Corrections.

1. Bureau of Mental Retardation.* The Bureau of Mental Retardation maintains six regional offices, each directed by a regional administrator who reports to the Bureau's central office in Augusta. Each regional administrator supervises a mid-management group including, in most regions, a prescriptive program plan coordinator (responsible for convening and chairing interdisciplinary-team meetings at least annually for each Bureau client), a resource developer (responsible for developing new homes, programs, and services to fill client needs identified by interdisciplinary teams), and a case-work supervisor (responsible for the region's client-services coordinators and child-development workers, who perform day-to-day case-management and social-work functions). Regional offices must assess individual needs, develop resources according to needs still unmet, and monitor services provided in contract with the Bureau.

As will be seen, none of these responsibilities is being adequately discharged. Prescriptive program plans do not uniformly meet the requirements of the Court's decree either as to content or timing. Services promised are not consistently monitored to determine whether they are being provided. Absent this function, the State has absolutely no idea what benefits are or are not being provided to the plaintiffs during the months between interdisciplinary-team meetings. The results of

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* See Appendix B, §§ C.1, C.2(a), C.5, C.7, D.1(d), D.10.

resource development have fallen far short of providing the homes and programs needed by the plaintiff-class.

Certain direct, professional services are provided by the Bureau of Mental Retardation through two resource centers established pursuant to the decree.* The resource centers are now staffed beyond minimum decree requirements; but the demand for professional services is large and growing, and the resource centers are nearly overwhelmed. Their services are by and large limited to evaluations and consultations. Resource center staff devise programs to be carried out by operators of homes and day-activity centers but are rarely able to monitor implementation. They are almost never able to provide the type of on-going therapy they recommend. Accordingly, the State is not complying with the decree requirement that "[a]dditional professional services shall be obtained as necessary to provide the habilitation, programming and therapy specified in each client's prescriptive program plan. [Appendix B, § D.1(c).]"

2. Methods of Assessing Compliance. To obtain an objective measure of the State's compliance with the Court's decree, the office of the Special Master requested a copy of the most recent annual prescriptive program plan for each member of the plaintiff-class now living outside Pineland Center. The State was able to provide 455 plans within two months of the request. This number, while not complete, provides a sufficient basis for quantifying certain features of the plans and yields some general conclusions about the process of individual planning during the term of the decree. Information obtained by analysis of prescriptive program plans was supplemented by interviews with State employees and examination of documents obtained from their files.**

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* See Appendix B, §§ D.1, D.3. Additionally, defendants have provided grant-in-aid money to a private non-profit organization which operates a third resource center in Augusta. The bulk of its financing comes through Titles XIX and XX of the Social Security Act. Title XX funding for this operation was recently reduced, and its future appears uncertain. This resource center provides childrens' services, occupational therapy and psychology services either through staff positions or by contract with local professionals.

** During the past year the Bureau of Mental Retardation undertook its own evaluation of prescriptive program planning. Defendants' information was not based on a critical analysis of individual plans but was derived from a number of sources including parents, Bureau staff, and operators of day programs. Defendants discovered an untoward complexity in forms, procedural deficiencies, and problems in developing and monitoring habilitation plans. Using this information, the Bureau has revised its "PPP Procedures Manual." Findings presented in this report corroborate the State's conclusion that there are deficiencies in the Bureau's planning system. The Master concludes, however, that the problems are more extensive, more numerous, and more profound in their implications than those revealed by the defendants' evaluation.

B. TIMING

> Each client shall have by February 1, 1979, an individual plan of care, development and services referred to hereafter as a "prescriptive program plan." By September 1, 1978 half of the clients in the community shall have prescriptive program plans. [Appendix B, § B.1.]

The State substantially complied with this requirement as the following table shows:

PERCENT OF INITIAL PRESCRIPTIVE PROGRAM PLANS PREPARED

BMR Region	By Sept. 1, 1978	By Feb. 1, 1979	LATE
I	35.14	18.92	45.94
II	61.7	31.9	6.38
III	41.05	52.63	6.32
IV	54.09	42.62	3.28
V	33.33	57.69	8.97
VI	44.11	50.	5.88
STATEWIDE	46.12	43.86	10.03

The statewide figure of 10.03% of plans developed late may be inflated. It was determined to some extent by examining subsequent plans which may have occasionally failed to reflect the development of an earlier plan.

> The prescriptive program plan shall be prepared and re-evaluated at least annually by an inter-disciplinary team . . . . [Appendix B, § B.1.]

The following table shows that just over half of the annual reevaluations are being accomplished on time:

PERCENT OF ANNUAL PLAN-REEVALUATIONS PREPARED

ANNUAL PPP LAG	BMR REGION I	II	III	IV	V	VI	STATEWIDE
On time	63.16	51.11	31.46	47.69	95.35	19.6	56.70
Late by 1 month or less	2.6	24.44	7.87	26.98	1.16	7.84	13.40
1-2 months late	0	5.55	26.97	14.28	1.16	3.92	10.57
2-3 months late	5.2	4.44	3.37	6.15	2.33	0	3.87
3-4 months late	5.2	6.66	12.36	1.5	0	1.96	5.41
4-5 months late	0	4.44	3.37	1.5	0	3.92	2.58
Over 5 months late	23.68	3.33	14.61	0	0	5.88	7.22
Cannot be determined	0	0	0	0	0	56.86	

It thus appears that only 56.7% of prescriptive program plans are prepared within one year of the last previous plan. (This figure has been over-calculated somewhat by including, in this category, plans which were scheduled to be developed in 1980. If the pattern here illustrated continues, one could expect that only about half of these scheduled plans will in fact be prepared on time. Conversely, the percentages of late plans are conservative.) Nearly one-third have been prepared over one month late. Nearly one-fifth have been more than two months late.

A variety of circumstances contribute to this situation. Interdisciplinary teams are difficult to convene in the community. Many participants are not employees of the State and cannot always arrange their work schedules so that each may meet at an appointed time. The program plan coordinator may be new to the system. Turnover of coordinators has been considerable since the decree was signed, and State personnel policies make it cumbersome to fill vacant positions quickly. Region I was without a program plan coordinator for over six months in 1979. Training for new coordinators is inconsistent and wholly insufficient when provided. The region IV coordinator reports that she was not provided any training before assuming responsibility and has had very little training since.* Finally, coordinators' case-loads are astronomical. At Pineland Center the ratio of coordinators to residents now approaches 1:35. In the community case-loads of twice and three times that figure are usual.** And this estimate considers only members of the class. Including non-plaintiff clients, a coordinator may well be expected to cover in excess of three hundred cases.

Not only are there considerable delays in scheduling interdisciplinary team meetings for the purpose of preparing individual plans of care, but also some regions are experiencing long delays in getting the plans written once the team has adjourned. Accurately quantifying such delay is impossible from the information at hand, but some general observations are possible. The speediest regional systems now produce typewritten plans between two and three weeks after the team convenes. In some regions delays of several months are usual.

The consequences of delay are serious. Prescriptive program plans are the means of identifying pressing human needs. Those needs are not being timely met. Timely completion of individual plans must be assured in order to comply with decree requirements for implementing and monitoring team recommendations.

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* Appendix B, §I.3 provides, "There shall be full staff orientation and training programs. . . . Training programs shall be mandatory for all regional office . . . employees." Section I.3 describes in detail the duration, content, and documentation of staff training. Defendants have failed to implement this requirement in any consistent and meaningful way.

** In contrast to Appendix A, Appendix B does not establish a minimum ratio of prescriptive program plan coordinators to clients. Appendix B, § D.1(d) simply states, "One PPP Coordinator shall be employed in each of the Bureau's six Regional Offices." This has been done. In fact one regional office now has two coordinators. Nevertheless, prescriptive program plans continue to be developed late, and, as will be seen, the overall quality of individual plans falls far short of decree requirements. Coordinators are, of necessity, engaged in a mass-production operation. Defendants have not implemented any solution to this obvious problem.

C. COMPOSITION OF INTERDISCIPLINARY TEAMS

> [A]n interdisciplinary team . . . shall include the resident home operator, foster parent or other person responsible for the daily care of the client, the person responsible for the client's programming activities outside the residence, the client's community social worker and other appropriate professionals. The makeup of the interdisciplinary team shall be sufficiently broad such that each habilitation need of the client can be professionally assessed and appropriate remedial recommendations can be made. The client shall be asked to attend the interdisciplinary team meeting and shall be consulted in the development of his prescriptive program plan. Each client's correspondent and the client's advocate, unless a competent client objects, shall be asked to attend the team meeting. [Appendix B, § B.1.]

Although the office of the Special Master has not statistically analyzed the 455 plans for adequacy of interdisciplinary team composition, our review allows us to say that team composition does not uniformly reflect decree requirements. This conclusion is illustrated in the following pages by a sample prescriptive program plan. The plan was prepared without the client or her representatives. No explanation for the client's absence appears in the narrative summary. Professional assessments were not solicited in preparation for the team meeting. A psychological "statement" and occupational therapy report were referred to, although apparently in a second-hand fashion. We are not told when these reports were prepared or substantially what they recommend. The psychological statement appears to conclude that the client's program is incapable of meeting her needs. We are not told what programmatic needs the client has or how they may otherwise be met. The team could have recommended further professional assessment to establish optimal day-program goals, listed this program as an unmet need, and established an interim plan which conformed to decree standards. (Ideally, this would have been accomplished by seeking proper assessment and professional recommendations prior to the meeting.) Instead, the members of the team, none of whom purported to know how to meet the client's program needs, voted to cancel her program. The team apparently expects the home operator to carry out the program plan, without professional assistance, after trained program staff have failed.

BUREAU OF MENTAL RETARDATION

INDIVIDUAL PROGRAM PLAN

III
Region

Case#

NAME Last First middle Birthdate 12-22-19 IDT Date 1-23-79

ADDRESS & TELEPHONE Hall-Dale Manor
385 Main Avenue
Farmingdale, Maine
622-7082

REFERRAL DATE

RECALL DATE 10-79

PREVIOUS IPP DATE 10-78

INTERDISCIPLINARY TEAM PARTICIPANTS

TITLE	NAME	DISCIPLINE/AGENCY
CHAIRPERSON	Barbara McEntee	BMR, Region III
COMMUNITY SOCIAL WORKER	Stephen Zeldow	BMR, Region III
CLIENT		
PARENT/GUARDIAN		
CLIENT ADVOCATE		
CC:	Ida Gibbons	BH Operator
	Dave Wilson	GDAC
CC:	Rick Berg	GDAC

BMR IPP (2)

ASSESSMENT SOURCES

NAME OF ASSESSOR	PROFESSIONAL TITLE	TYPE OF ASSESSMENT	EVALUATION DATE	DATE FILE
~~Barbara McEntee~~	~~IPP Coordinator~~	IPP	10-78	

COMMENTS:

DEPARTMENT OF MENTAL HEALTH & CORRECTIONS

411 State Office Building *Augusta, Maine 04333*

Bureau of Mental Retardation
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(Office location – Hallowell)

NARRATIVE SUMMARY

is a 59 year old woman who currently resides at Hall-Dale Manor in Farmingdale; she attends the Gardiner Developmental Activity Center for programming. In October 1978, her IDT met to consider her needs and to develop a program plan accordingly. At that time, medication review/reduction, DAC placement on a trial basis, and continued boarding home care were recommended for her. Today's IDT was called together to discuss 's progress/problems related to her DAC placement.

Rick Berg and Dave Wilson from the GDAC reported that 's typical day at the Center begins with her arrival at 8:30; she sits at a table where activities take place and may sort beads, the only task she'll perform. Her lack of participation in planned activities is one of the problems that exists due to her presence there; in general, her behavior is disruptive to other program participants. will break crayons, try to eat buttons and thread, throw food, and refuse to participate in any of the planned activities. The clients see her doing things that they know are not right and then they become upset. Drinking a lot of coffee and eating her entire lunch before 10:00, both undesirable behaviors are the only things she consistantly does do. The GDAC has conferred with Dorin Zohner, psychologist, who wrote a statement that was one of three persons attending that program whose activity needs are such that they can be better met in a residential center than in a DAC. The DAC felt that they could meet 's needs if 1:1 staffing was available to her; however, it is not. The boarding home representative, Ida Gibbons, reported concerning her observation of since she has begun attending the GDAC. Initially, she thought was enjoying the GDAC, but then one day she began to tear at her clothes when it was time to go to the DAC. Her behavior change is attributed to her demanding schedule (DAC five- days per week, six hours per day).

's CSC, Steve Zeldow, reported his impressions of 's needs based on his observation of her over the past months. Before she began attending the DAC, Steve found to be happy, in general, even though she really wasn't "doing" much; now she appears frustrated. He feels that her behavior indicates that she was happier with her previous level of activity than she is with her current programming. He recommended that the DAC placement be dropped; that she be allowed to return to the routine she was happy with. The workshop and boarding home were also in agreement with this recommendation. will discontinue attending the Gardiner Developmental Activity Center as of the day following the IDT.

In lieu of programming at the DAC, the OT report that the DAC had prepared to identify 's needs will be provided to the boarding home so that low-key one-to-one instruction can be implemented in recommended areas.

The IDT was split as to how much programming should be implemented. The DAC thought an OT should be provided to work with on a 1:1 basis. Her CSC did not recommend lengthy programming for ., nor programming that was objectionable to her; rather, he supported programming only to the extent that it would not jeopardize her boarding home placement, which is the first one that has been completely successful for .. In the boarding home, participates in housekeeping activities on an irregular basis. Skills she can perform include making her own bed, vacuuming, moving chairs, clearing the table of dishes, and getting her own coffee. She will participate in some activity programming if she knows that a reinforcer will follow.

Concerning 's medication review, this has been attempted and resulting in her ripping a chair and tearing her clothes. Dr. Mathews asked that she be returned to her original medication regime; she is stable now.

The IDT should reconvene in October 1979 to review 's program plan for an update on her progress/needs.

Barbara McEntee

Barbara McEntee
IPP Coordinator

BM:ke

[redacted]

Poorly constituted interdisciplinary-team meetings have been the subject of criticism from the Office of Advocacy of the Department of Mental Health and Corrections. While no statistical analysis has been attempted by the advocate, the Master is in full agreement with the advocate's observation that this initial stage of the interdisciplinary-team process must be carefully attended to if the resultant plans of care are to comply with the decree. A generous amount of flexibility is built into decree requirements for interdisciplinary-team composition. The provision set forth above requires only the presence of "appropriate professionals." The habilitation needs of the individual client determine the overall membership of the team, not vice versa. It would seem sufficient that the members physically present be allowed to make final recommendations based upon recent and thorough professional assessments, submitted in full prior to the team meeting, if those professionals are unable personally to attend the meeting. The observations of both the Master and the advocate have attempted to account for this flexibility and to limit the discussion to instances in which such discretion plays no part.

SOUTHERN MAINE RESOURCE CENTER

INTER-DEPARTMENTAL COMMUNICATION

TO: Regional Administrators - BMR-Reg.4,5,6 DATE December 7, 1979

FROM: Joe Witt, Advocate - Southern Resource Center

SUBJECT: Provision of Service via the I.D.T. process

I will attempt in this memo to make some systematic observations of the I.D.T. process as carried out in the community in regions 4, 5, and 6. I will concentrate on observations of weaknesses in the system and areas where the system appears to be out of compliance with applicable law. My purpose in this particular memo is to alert you to these observations and to ask you to institute changes in the direction of correcting the weaknesses. In the fairly near future this memo or parts of it will probably be incorporated into reports that will be directed outside the Department in accordance with the reporting function of the office of advocacy. Whether for internal or more general consumption, I have a great desire for any reporting I do to be accurate. Accordingly, I would appreciate any written comments or feedback you care to make regarding the accuracy of remarks made here.

The I.D.T./P.P.P. process is the cornerstone and primary component of services provided by the Bureau (see 34 MRSA, 229, 2651). The process of assessing needs and making a plan to meet those needs is basic to the Bureau's responsibility especially in light of the limited direct service provided except at its institutions.

The first point to be made is that all clients receiving services from the Bureau are to have a P.P.P. (see 34 MRSA 229, 2654, paragraph 4 B and 2656 paragraphs 4 and 5). This does not always happen. Even the recent draft form of the revision of the Bureau's I.P.P. manual presented for review by our office in October of 1979 referred to "elligibility" for the I.D.T. process and the I.P.P. "option." (see further comments addressed to Rod McCormick in a memo dated November 6, 1979.)

The next most basic point to be made is regarding the composition of the Interdisciplinary Team, and it is in this area that I perceive the basic problem with the system. Many many teams are not sufficiently interdisciplinary to carry out the functions of the team and some are not interdisciplinary at all and therefore are no different from the older system of planning by the social worker. 34 MRSA 229 requires that each team include at least one professional defined as a person licensed to practice medicine or psychology. This requirement is rarely met even when one counts involvement at I.D.T.'s of persons who appear well qualified but whose licenses as psychological examiners are pending test results or other formalities. In addition to the inclusion of a "professional" under state law, both state law and the Consent Decree require that the team be established in accordance with professional standards. The Consent Decree (appendix B section B) goes on to state that the composition of the team shall be "sufficiently broad such that each habilitation need of the client can be professionally assessed and appropriate remedial recommendations can be made." The composition of the I.D.T. frequently is lacking in such a base. I have attended I.D.T.'s where the product was not a P.P.P. but a list of evaluations needed by the client. I have attended one IDT composed of the client, his wife, two Bureau C.S.C.'s the coordinator, and the advocate. At that I.D.T. medical needs, vocational training needs, and mental health needs were discussed. It is my observation that the typical

SOUTHERN MAINE RESOURCE CENTER

INTER-DEPARTMENTAL COMMUNICATION

TO: Regional Administrators - BMR-Reg. 4,5,6 DATE December 7, 1979

FROM: Joe Witt, Advocate - Southern Resource Center

SUBJECT: Provision of Service via the I.D.T. process (continued) .....Page Two

I.D.T. is not legally or professionally constituted and that the quality of the product of the I.D.T. is thus adversely affected.

There is a part of the product required by both state law and the Decree which may not be quite so related to the composition of the team as some. I refer to the requirement to create a plan or make recommendations based only on client need and without regard to service availability. This is done but inconsistently. It is a great temtation to deal with what is possible in the "real world," but this does the client a disservice in the long run.

The final major area of concern is the timely provision of services recommended. I have made no "scientific" study of the degree to which time lines are followed, but I have been to I.D.T.'s where recommendations from the preceding year had not been carried out and were then repeated. The sense of the situation that I get is that adherence to time lines is inconsistent.

Let me emphasize that this report is not meant to be comprehensive or to be a criticism of any individuals. Rather it is meant as a statement of what I see as the major problems with the system. No attempt has been made here to point out the valuable aspects of the system or the valuable contributions of individuals in the system. Let me simply state that both exist and that I am here critizing parts of the system, important as they are, rather than the entire system.

JW/et
cc: C.M. Macgowan
Cheryl Fortier
Jim Barnes
Ron Welch
I.P.P.C.'s,regions 4, 5, 6

The following table shows the frequency with which clients and client advocates are present at IDT meetings, expressed as percentages of 455 prescriptive program plans:

CLIENT AND ADVOCATE ATTENDANCE

	BMR REGION						
	I	II	III	IV	V	VI	STATEWIDE
Client present	82.5	90.09	67.96	85.94	93.55	92.59	84.84
Client absent with reason	0	5.94	5.83	10.94	4.3	1.85	5.27
Client absent without reason	15	3.96	26.21	3.13	2.15	5.56	9.67
Advocate present	12.5	12.87	13.59	9.38	23.66	24.07	16.04

It appears that clients attended 84.84% of the interdisciplinary team meetings convened by defendants. Compliance with this aspect of the decree has been excellent. Some of the clients who were absent without a stated reason were both profoundly retarded and multiply handicapped. Their attendance would have been physically difficult for them and of doubtful value either to the client or other team members. In such cases, failure to note a reason for the client's absence was likely an oversight.

By agreement between the Bureau of Mental Retardation and the Office of Advocacy, advocates are routinely notified of forthcoming interdisciplinary-team meetings. The case worker or program coordinator indicates on the form whether the advocate should attend. In the usual course, advocates attend team meetings only as requested or, occasionally, when it appears to the advocate from some problematic feature of the particular case that advocacy is strongly indicated. The lack of advocacy services is attributable to the failure of defendants to comply with the decree requirement that "[D]efendants shall ensure that an advocacy system adequate to meet clients' needs is in place. [Appendix B, § J.5.]" During the entire term of the decree, defendants have retained only two community advocates, supplemented by the efforts of the Chief Advocate (who has concurrent responsibility for mental health programs and correctional facilities) and private advocacy organizations.

Advocates play a crucial role in improving the lives of mentally retarded citizens. An advocate can speak for individuals on questions of their legal entitlements, such as eligibility for special education or vocational rehabilitation or entitlement to rights under the decree. As advocates are independent representatives of client interests and preferences, they must clash with the bureaucracy, occasionally including the Bureau of Mental Retardation. The advocates have been responsible for insisting upon change in conformity to this Court's decree.

The Office of Advocacy and the Consumer Advisory Board are the only independent on-going agencies with responsibilities affecting compliance with the decree. The Consumer Advisory Board, a logical successor to the Master's office, has failed thus far to assume an active enforcement role. The Board's reports have been sparse and anemic. Strengthening the Office of Advocacy and the Consumer Advisory Board is important to enabling the Court to withdraw from continuing supervision of the decree.

III. PRESCRIPTIVE PROGRAM PLANS

> Each program plan shall describe the nature of the client's specific needs and capabilities, his program goals, with short-range and long-range objectives and timetables for the attainment of these objectives. The prescriptive program plan shall address each client's residential needs, medical needs, ADL skill learning needs, psychological needs, social needs, recreational needs, transportation needs, and other needs including educational, vocational, physical therapy, occupational therapy, and speech therapy, as appropriate. The prescriptive program plan shall include a clear explanation of the daily program needs of the client for the guidance of those responsible for daily care. The recommendations included in each client's prescriptive program plan, both as to residential and programming placements, shall in all cases be the least restrictive placements suited to the client's needs. The recommendations of the prescriptive program plan shall be based on the interdisciplinary team's evaluation of the actual needs of the client rather than on what programs are currently available in the community. In cases where the services needed by a client are unavailable, the IDT shall so note in the prescriptive program plan and shall recommend an interim program based on available services which meet, as nearly as possible, the actual needs of the client. The number of clients in need of a service which is not currently available and the type of program or residential placement each needs shall be compiled and these figures shall be used to plan for the development of new programs and residential placements.
>
> [Appendix B, § B.4]

The decree requires that each individual's prescriptive program plan address a range of client needs. This report will examine the manner in which interdisciplinary teams have dealt with recommendations for program and residence. Some more general observations may be made on the basis of a review of 455 plans.

A. PROCEDURAL DEFICIENCIES

1. Actual Needs versus Available Service.

> The interdisciplinary team shall monitor the quality of medical and dental care the client receives. . . . [Appendix B, § D.2(d).]

During the term of the decree, interdisciplinary teams have usually taken care to attend to each client's medical needs. The exception is a widespread failure to insist upon, and in many cases to consider, an annual withdrawal of psychotropic medication. The decree is specific on the point.* Other needs, such as "ADL" (i.e., such activities of daily living as eating, dressing, and grooming) and social and recreational needs are often addressed but with less consistency than medical needs. The need for psychological services is usually addressed by the team. Psychological evaluations and reviews are regularly recommended and obtained. A review of a sample of psychological reports and recommendations for members of the class indicates that they appear to be thorough. The same may be said of reports regarding occupational therapy, physical therapy, medicine, and audiology.

It is clear, however, that there is a lack of many of the services which these professional evaluations recommend. In reviewing individual plans it is common to encounter recommendations for continuous professional involvement which cannot be implemented because habilitation professionals are in short supply. Defendants are now engaged in a statewide survey of unmet client needs. Although not yet completed, this survey may be expected to reflect substantial deficits in at least the following services: recreation, transportation, psychology, ADL training, occupational therapy, physical therapy, speech therapy, vocational services, crisis intervention, respite care, and education. All of these services are required by the decree.**

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* Appendix B, section D.2(f) states that "the interdisciplinary team shall ensure that repeated administration of an antipsychotic or antianxiety medication . . . does not cumulatively exceed one year without the attending physician effecting a carefully monitored withdrawal of the medication. This periodic drug withdrawal shall be used to determine the need for continuing medication and the prescribed dosage . . . Medication may be resumed only if there is a clear documentation of benefit derived from its use. Such a drug withdrawal program shall be repeated on an annual basis."

** E.g. Appendix B, §§ B.4, D.1, D.6 (transportation), D.8 (psychology), D.9 (speech and hearing), D.3 (crisis intervention), D.4 (respite care), D.5 (education).

STATE OF MAINE

Inter-Departmental Memorandum Date December 5, 1979

To William A. Twarog, Regional Administrator Dept. Bureau of Mental Retardation

From Carroll Macdowell, Chief Advocate Dept. Mental Health and Corrections

Subject IDT's at the Pinkham Home on October 23rd

I had the opportunity to attend five IDT's on class members presently living at the Pinkham Home. I have some observations and concerns garnered during those IDT's which I believe should be shared with you.

First, I recognize that staff changes have taken place the past year and that much of the confusion around recommendations developed last year during IDT's may be a result of staff changes. I also recognize that you were not here when many of last year's IDT's were completed. It is my hope that, with your input, mechanisms can be developed to assure that, regardless of staff changes, client needs and programs can be addressed adequately.

Many of the clients whose IDT I attended had as recommendations during last year's IDT that evaluations be done in specific areas: OT, PT, psychological, etc. My concern with this is that having an IDT before having adequate information on which to formulate program plans does not make a great deal of sense. I am also concerned that many of the evaluations that were recommended last year during the IDT were not completed or were not forthcoming until very recently (some were forwarded at this IDT). This may, in part, be due to the lack of service availability within the system but after an IDT makes a recommendation, regardless of service availability, an attempt should be made to live up to that recommendation. If that means contracting with private service providers instead of waiting for the resource center to do those evaluations, this should be done. The monitoring responsibilities for IDT recommendations do rest with regional office staff. Many of the recommendations in this year's IDT were to again have evaluations done on clients. It is my feeling that very little was accomplished in the way of creating an individual habilitation or program plan for the five clients that were IDT'd on October 23rd. Continuations of programs that were not reviewed to assure the existence of meaningful and measurable behavioral objectives does not suffice in my mind as an IDT.

All the clients at the Pinkham Home are now on pureed or semi-pureed diets. Although there was discussion of this in the IDT, firm demands such as a medical review indicating the need for pureed diets were not made. Likewise, it was accepted that , a twelve-year-old girl, should have a full mouth extraction due to the Dylanton hyperplasure and tooth decay she is experiencing. The extraction may be justified; if it is, there is a necessity to examine the circumstances leading to this necessity (i.e., was medication monitored adequately - were all steps taken to avoid hyperplasure - was there an adequate dental hygiene program to avoid the widespread decay mentioned in the IDT, etc.

Another concern, and I think one that should be carefully monitored, regards Bureau staff's attitude toward the Consent Decree. I recognize that this is not a concern unique to your region, but since it was so apparent during the five IDT's I witnessed, I believe I should express my concern directly to you. There is a two-bedroom room and a three-bedroom room at the Pinkham Home, and there are five class members living in the Pinkham Home. All class members are presently housed in four-bed rooms. I raised the issue of compliance with the Consent Decree requirement that all class members be housed in bedrooms of three or less people and was informed by Bureau staff, namely Ellen Deschaine and Ms. Bustin, that that was not an issue which they felt was worthy of consideration. Mrs. Pinkham did indicate that it was

possible to place class members in smaller rooms if that was required but she would prefer not to. I can understand the underlaying reasons for wishing to avoid the downgrading of one client's services in order to upgrade another client's services simply on the basis of class membership and I agree that that is an unforturnate state of affairs. But the inference presented by the Bureau's desire not to deal with that issue was that the Consent Decree can be easily dismissed if people choose not to deal with it - an inference which I believe might have been of some importance to the two Department of Human Services' employees who were sitting on the IDT. This attitude also fails to acknowledge the legitimate truth that smaller, more private and personalized rooms are, in fact, the ultimate goal of the Bureau. I do not feel it is of service to clients or to service providers to be less than honest with them as to the future direction of client care. To lead Mrs. Pinkham to believe that it is acceptable to have living situations which lack privacy and which do not comply with the federal mandate is not productive for client or service providers. The demand that class members be placed in smaller, more personalized rooms would have been clear indication of the Bureau's attitude towards the importance of privacy and individualization. It also would have set the stage for future demands that other non-class members should have the issue of privacy and individualization addressed. I believe the importance of honestly indicating the future expectations of the Bureau of Mental Retardation to service providers is of the utmost importance and cannot be overstated. I also believe that to ignore sections of the Consent Decree which prove to be inconvenient, no matter how superficially insignificant they may seem, is a grave mistake.

I would appreciate hearing from you regarding any inaccuracies which may be contained in this memo and any plans you may have for dealing with the issues I have raised in this memo. If there is any way that I may be of assistance in clarifying the issues I have raised in this memo or assisting you in planning to deal with those issues, please feel free to contact me.

CMM/dbs

cc: Ronald Welch
Joseph Witt

P.S. I have held this memo pending receipt of copies of information from your office. I have not received the information requested, but, could not hold memo any longer.

STATE OF MAINE

Inter-Departmental Memorandum

Date January 28, 1980

To David N. Stockford — Dept. Div. of Spec. Education - ECS

From Carroll M. Macgowan, Chief Advocate CMM. — Dept. Mental Health and Corrections

Subject Pinkham Home

On January 15th, I had the opportunity to visit the Pinkham ICF in Strong, Maine. The intent of my visit was to clarify a number of alleged problems and conflicting statements regarding the education of school-age clients residing at Pinkham's Home. In speaking to Nellie Pinkham and her staff I discovered a number of substantial contradictions of information I had received from both the Division of Special Education, the Regional office of the Bureau of Mental Retardation and the central office of the Bureau of Mental Retardation. Although I had been informed by both the Region IV Bureau of Mental Retardation office and David Stockford of the Division of Special Education that IEP's had been completed on the clients of the Pinkham Home and that the educational plan included therein was being carried out as part of the ICF habilitation for those clients I discovered while at the Pinkham Home that neither Nellie Pinkham nor her staff were aware of any IEP's which had been completed for the 1979/80 school year.

Mrs. Pinkham and her staff also indicated that the development of the individual education plan was being done by a review of those services being provided by the ICF. The thought that an individual education plan could be developed by indicating that the services being provided are the needed services, seems to be in direct conflict with the evaluation and planning process intended by the PET system.

Also the whole issue of the proper educational setting for the clients of the Pinkham Home should be evaluated and decided through the PET process. Speaking with Mrs. Pinkham it was clear that she was firmly against allowing the clients of her ICF facility to attend an outside program and I believe her input should be heard and considered in the appropriate forum. Unfortunately, such other factors as medical opinion, the needs of the client, the attitudes and beliefs of other mental retardation professionals, and other service providers, are not being given equal weight to that of Mrs. Pinkham and the proper mechanism for determining educational placement and service provision is not being utilized. Also, in contradiction with reports I have received from educators and BMR staff, Mrs. Pinkham indicated her desire for the assistance of either teachers, teacher aides or specialized service providers to assist in the development and implementation of specialized services to her clients. Mrs. Pinkham did mention objections to specific individuals but did indicate her recognition of the need for assistance in meeting the needs of her clients.

Those services which are being provided to the clients of the Pinkham Home, which I presume to be deemed the alternative to educational services, are not being provided with the guidance or supervision of a qualified educator and (though Mrs. Pinkham indicated that educational plans would be developed within the coming month) I am concerned that over half the school year has already passed without an adequately planned and monitored educational program for those clients of school age in the Pinkham Home.

I believe the educational planning process and system of service developed by the State of Maine is an excellent model and, if utilized properly, can provide those services needed by individuals living in the state. I am afraid that in this instance the special education planning process and service delivery process is not being adequately used.

Mrs. Pinkham indicated a desire to meet with the diverse parties involved in this issue, in the hopes of clarifying the communication issues and in coming up with a specific plan for dealing with the whole question of education for the clients at the Pinham Home.

I believe Mrs. Pinkham's desire is a rational and reasonable one and would recommend that her request for a meeting of all persons involved in the education and care of clients at the Pinkham Home be planned and convened as soon as possible. It is entirely possible that Mrs. Pinkham did not have a full understanding of the activities going on in an effort to provide educational services to the Pinkham Home. If her statements were inaccurate, I would appreciate any information you could provide regarding the actual state of affairs regarding education of Pinkham Home clients. Thank you for your attention to this matter.

CMM/dbs

cc: Joe Witt
Dean Crocker
William Twarog
Ron Welch
David Gregory

STATE OF MAINE

Inter-Departmental Memorandum

Date November 30, 1979

To Ron Welch — Dept. Bureau of Mental Retardation

From C.M. Macgowan, Chief Advocate — Dept. Mental Health & Corrections

Subject Educational Services for Clients at the Pinkham Home

As I mentioned during our discussion of Wednesday, October 24th, I had the opportunity on Tuesday, October 23rd, to visit the Pinkham Home in Strong, Maine. While at the Pinkham Home I participated in IDT's on the five class members living at Pinkham's ICF. Two issues raised by my visit to the Pinkham Home are, I believe, of preeminent importance. The two issues which I feel must be carefully scrutinized regarding the Pinkham clients are:

1. a free and appropriate public education for school-aged children, and

2. the adequacy and expense of programming in the Pinkham Home.

I believe on the May 7th meeting of the Maine Committee, there was some discussion regarding future educational planning for Pinkham clients. At that time it was my understanding from Steve Lord (QMRP) of the Pinkham Home that the in-house educational program which had been developed for Pinkham clients was going to be evaluated to determine if those clients should be receiving more normal, less restrictive outside programming. The bottom line of the Maine Committee meeting was basically that adequate educational programs must be supplied to all school-aged clients at the Pinkham Home. It was the feeling of the Maine Committee that, if appropriate, outside educational programming should occur. And for those clients for whom outside educational programming was not appropriate (for medical or other documented and legitimate reasons), that internal educational programming should continue.

Much to my amazement and dismay, I found while visiting the Pinkham Home that no outside programming has become available and that the internal programming which was going on under the supervision of the local school district at the Pinkham Home has not been discontinued. All "educational programming" is now being done by aides in the Pinkham Home. Those clients who were determined last year to be in need of outside educational programs, are not going to outside programs; those clients for whom it was determined that outside educational programming was inappropriate, and internal programming should continue, are now having ICF required treatment considered as their educational programming. As to programming generally, clients are not receiving four hours of active programming a day as required by the Consent Decree and that situation was not addressed by the IDT. When I raised the question of education and adequate programming for the clients at Pinkham Home, I was informed that I did not understand the situation and that BMR, Education and Human Services were working it out in Augusta. Someone working it out in Augusta is not acceptable. There are educational needs evident in school aged clients at the Pinkham Home and they are not being met. Some of the school aged children at Pinkham Home do not have many years left during which they can appropriately demand educational services;

continued...

one client had only one year left during which she could demand and expect that educational services would be supplied as required by law. This means that that client has, at a minimum, lost two months of educational services which that client could rightfully expect. It is my belief that that client has a right not only to begin receiving education services along with all other school aged clients at the Pinkham Home, but that all clients who have lost educational services due to the fumbling planning process which is taking place to deal with the educational needs of these clients, should be repaid in kind with educational services beyond the expiration date of their legitimate expectation for a free and appropriate public education.

It is my hope that this is the stance the Bureau has taken regarding services for school aged clients; I have not heard that stance voiced by anyone from the Bureau. In fact, when I requested that the IDT make a statement as to the appropriateness of outside programming for clients at the Pinkham Home from a purely medical standpoint (based on medical reports which had been received), I was informed that this could not be done as there was no agreement by the members of the IDT. This was not an issue on which members had to agree; simply a statement of the professional opinion of qualified medical personnel. I then requested that on the basis of the medical opinion, appropriately constituted PET's be requested to deal with the programmatic and other needs of those clients. Regional Bureau staff indicated that the problem had been referred to a higher level, yet in speaking to you, you indicated that it was not something with which you are actively involved. Apparently, during the transfer of this problem from the region to the Central Office, the responsibility for demanding that clients receive continuing services during the process of ironing out difficulties and determining the appropriate setting for those services was lost. I am concerned that adequate programming at the Nellie Pinkham Home does not exist. I would appreciate your immediate attention to this memo and would be particularly interested in those areas where my perceptions of the problem may be wrong.

CMM/dlr
cc: Joe Witt

At this point in the team's deliberation, a serious breach of decree-required procedure can occur. The decree states that "[t]he recommendations of the prescriptive program plan shall be based on the interdisciplinary team's evaluation of the actual needs of the client rather than on what programs are currently available. [Appendix B, § B.4.]" The first type of error would be a failure by the interdisciplinary team to list a service need. This error would result from the reasoning that, since no resource exists to meet such a need, there would be no point in bringing it up. Error of this sort, while difficult to detect, does not appear to be common. Important client needs do not appear to be ignored. A second form of procedural error is evident. Once the team has acknowledged the existence of a client-service need not easily met by existing resources, there is a tendency merely to recite that fact without adopting a recommendation that the service be provided. Recommendations are often based upon the team's assessment of what programs and services are currently available. This error is illustrated by the narrative summary portion of the plan reproduced earlier at page 14. There, the team recognized a need for one-to-one training and went on to note only that such training is currently unavailable. The actual recommendation was that the day programming required by the decree be discontinued.*

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* Team members were not simply unaware of what the decree required. An earlier prescriptive program plan written by some of the same team members contains the following notation:

> Steve Zeldow reported that psychiatric and psychological recommendations have been [made] for group counseling and strict behavioral controls to help deal with her temper. The IDT, with [Client's] consent, recommended that she receive group counseling under the direction of a qualified person who has been trained in therapeutic/counseling techniques/skills. The WDAC does not have a program or personnel to meet this need and the KVMHC cannot meet it either; furthermore, no one present at the IDT was aware of any such service currently existing; therefore, this need will be listed in [Client's] IPP as an unmet need and will be referred to the Resource Developer.

2. Interim Programs.

> In cases where the services needed by a client are unavailable, the IDT shall so note in the prescriptive plan and shall recommend an interim program based on available services which meet as nearly as possible, the actual needs of the client. The number of clients in need of a service which is not currently available and the type of program or residential placement each needs shall be used to plan for the development of new programs and residential placements. [Appendix B, § B.4.]

Failure to comply with this procedural step is a frequent error. It is well-illustrated by the plan cited in the previous footnote. The team properly identified a service need, noted that the service was unavailable, and made the unmet need known to the resource developer. Nowhere does the team specify what services will be offered during the interim.

In the following pages are presented portions of a prescriptive program plan which illustrate many of the structural and procedural deficiencies so far discussed.* First, as to composition, the team is in no measure "interdisciplinary." Neither do team members present rely, though making crucial recommendations, upon any professional assessments obtained prior to the team meeting. The client and his representatives are absent without explanation. The obvious need displayed by the client for behavioral psychological intervention is not formally noted and, hence, never even rises to the level of an unmet need. Increased staff at the program center to deal with the client's anxiety is not discussed as a possibility. The team recommends removal from day program in violation of Appendix B, sections B.7 and 8. Interim programs are neither recommended nor discussed.

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* Examples of very good and very bad prescriptive plans can be found in the files of most regional offices. Plans reproduced in this report are not intended as illustrations of the overall quality of plans developed in a particular region. Regional variations do appear from the tables presented in this section of this Report.

BUREAU OF MENTAL RETARDATION

INDIVIDUAL PROGRAM PLAN

III
Region

Case#

NAME _____ Birthdate 2-17-14 IDT Date 1-15-79
Last first middle

ADDRESS & TELEPHONE Clements Boarding Home
R.F.D. #1
E. Winthrop, Me. 04343
395-8512

REFERRAL DATE _____

RECALL DATE 10-79

PREVIOUS IPP DATE 10-24-78

INTERDISCIPLINARY TEAM PARTICIPANTS

TITLE	NAME	DISCIPLINE/AGENCY
CHAIRPERSON	Barbara McEntee, I.P.P.C.	Mental Retardation Ser.
COMMUNITY SOCIAL WORKER	Stephen Zeldow, CSC	BMR
CLIENT		
PARENT/GUARDIAN		
CLIENT ADVOCATE		
Work Activity Manager	CC Marilyn Swift	KVCRCC
Supervisor	Ted Blake	"
Boarding Home	CC Ilene Wing	Boarding Home Staff

January 15, 1979

NARRATIVE SUMMARY

NAME:

D.O.B. 2-17-14

The I.D.T. met at Clements Boarding Home in Winthrop, Maine on January 15, 1979 to discuss 's I.P.P. as established at his October 1978 I.D.T. meeting. His needs as identified at that time included:

1. Developmental Activities Center placement;
2. Opthalmological Evaluation;
3. Boarding Home Care;
4. Speech/language/hearing screening.

Lee Ellis is in the process of arranging for 's speech/hearing evaluation and Sue Ward needs to arrange for 's opthalmological evaluation. 's boarding home continues to meet his need for a quiet, country home; however, problems have arisen at 's program placement at KVCRC which necessitated recalling the I.D.T. to discuss his current status/needs.

was originally referred to the Gardiner Developmental Activity Center for A.D.L. training, music therapy and exercise programming. enjoys "bus rides" and the I.D.T. felt that the Developmental Activity Center would be appropriate up to 5 days per week, but recommended it be on a trial basis as he may be unable to physically tolerate that amount of involvement.

Steve reported that when the bus would come from the Developmental Activity Center, didn't like going (she would have to push him towards the door) and he acted as if he were afraid of the bus (he usually asks to go on a "bus ride"). Steve reported that when he would come home from the Developmental Activity Center, he would glare at staff. Eventually, began coughing; the doctor who examined him could find no medical cause for it and felt that it was a nervous cough. Since stopped going to the Developmental Activity Center, his cough has disappeared. Developmental Activity staff then reported their observations of at the Gardiner Developmental Activity Center. Ted characterized as appearing afraid. He would not perform even simple activities. His eyes had a frightened look flickering back and forth) and the nervous cough appeared. would keep saying "bus ride, bus ride." Although is not known to say anything but "bus ride", Ted said that near the end of the time attended the Developmental Activity Center, he spoke using about 12 different words in an attempt to communicate the fact that he wanted to go home, and wanted his coat. The one day when was able to relax was a day when Ted took him outside for a walk.

Marilyn Swift, Work Activites Manager at KVCRC said that they were unable to implement any of the developmental programming designed for as he seemed so overwhelmed that they spent all of their time trying to adjust him to the center.

(over)

Steve Zeldow, 's Client Services Coordinator, stated his opinion on programming for as he has observed him over the past two or three months. (at age 65) is happy in the boarding home which meets the standards Pineland Center set for a home for him and he is not happy going to the Developmental Activity Center as evidenced by his nervous cough. Steve feels that going to the center has had a negative effect in , causing him to be uncomfortable, nervous, and insecure; therefore, he (along with the rest of the I.D.T.) recommended that return to the boarding home and continue to entertain himself as he did before going to the center.

The I.D.T. recommends modification of 's original I.D.T. on October 24, 1978 to exclude the Developmental Activity Center programming as it has been rejected by and therefore it does not appear to be in his best interest to continue to push him to attend. In 's docile boarding home life style he is more neraly normalized as a 65 year old man than he would be in attending a Developmental Activity Center.

The I.D.T. should reconvene in October, 1979 to consider all aspects of . 's I.P.P. in depth.

Barbara McEntee,
I.P.P. Coordinator

BM/dh

Even when interim plans are recommended, few of them comply with the decree:

> In cases where programming outside the residential setting is unavailable and moving the client would be inappropriate, the interdisciplinary team shall develop an interim plan . . . . This interim plan shall include an alternative plan for integration into the community which shall require frequent participation in social functions, shopping trips, athletic events, meals out or other similar activities in the community. Activities of this sort shall take place at least twice weekly. [Appendix B, § B.7(e).]

On January 22, 1979, an interdisciplinary team in region IV made the following recommendation:

> New federal mandates require that [Client] be involved in a day program outside the home for at least four hours every weekday. . . . There is an activity center in Auburn, but it does not accommodate wheelchairs. As a temporary alternative to an outside day program, federal mandates call for integration into the community through at least two trips weekly into the community for activities. . . . While Clover Manor has its own van and [Client] does get out several times a year, she is unable to get out twice weekly. This will be listed as an unmet need.

Earlier, a region IV team made this recommendation for a different client:

> In regard to day program, Jane will visit the local school program to see if it would meet her need for socialization, language stimulation and increased awareness of herself and her surroundings. If not, Jane will attempt to find someone to work with [Client] or she will alert the Bureau of Mental Retardation Resource Developer to the need for an activity center. Jane felt that the nearby activity . . . is above [Client's] level of functioning. In the meantime, Donna will assure that [Client] participates in community activities such as shopping, etc. at least twice weekly.

In juxtaposition, such recommendations make it difficult to escape the conclusion that defendants are well aware of the decree's procedural requirements but are treating them as discretionary.

> If the recommended services are not available in the community within [45 days]:
> (a) the client shall be placed in the interim program recommended by the client's prescriptive program plan, and
> (b) the Bureau shall submit to the master for his approval either a plan including a time schedule for the development of an appropriate program or a statement that the program will not be developed with accompanying documentation demonstrating that the service or program is not required by professionally accepted standards of habilitation or care. [Appendix B, § B.9.]

Defendants have never complied with sub-paragraph (b).* Defendants claim that the process of formulating prescriptive program plans is not refined enough at this point to allow them routinely to seek the Master's approval of interim plans. In January 1980 the Bureau agreed to provide the Master with brief reports, twice monthly, on its efforts to address the process of meeting individual clients' unmet needs through resource development efforts. This has not been done either.

The Bureau is now implementing a statewide survey of unmet client needs. As yet, information is not fully gathered. Results of this first survey will be subject to two sources of innacuracy. First, regional office staff must become acquainted with the system. Essentially, the Bureau plans a practice run. Revisions in the reporting system are not expected to achieve smooth operation before next summer.** Second, unmet needs are to be gleaned from completed prescriptive program plans, some of which, as just demonstrated, fail to note needs as unmet and form recommendations accordingly. These two factors may be expected to render conservative, the total figures for various categories of unmet needs.

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* The sole exception is an interim plan submitted by Region II. The plan was for individuals placed out of Pineland into a new group home in Eddington.

** Appendix B, section C.14 states, "Defendants shall develop a data system of client needs. . . . An annual report shall be prepared . . ."; thus, the results of the first unmet needs survey will be about one year late.

3. Habilitation Plans.

Each program plan shall describe the nature of the client's specific needs and capabilities, his program goals, with short-range and long-range objectives and timetables for the attainment of these objectives. The prescriptive program plan shall include a clear explanation of the daily program needs of the client for the guidance of those responsible for daily care.

Each prescriptive program plan shall be carried out pursuant to a written service agreement. Each service agreement shall include at least the following information:

(a) It shall specify the respective responsibilities of the client, the family, correspondent or legal guardian of the client, the regional office, the facility, and each public and private agency which intends to provide services to the client. It shall include a specific description of the client's daily activities with an explanation of how they will contribute to the achievement of the client's program goals.

[Appendix B, §§ B.4, 5(a)]

The final procedural step in the interdisciplinary-team process concerns monitoring actual delivery of services recommended by the team. Here is how it should work: Annually, the defendants should convene an interdisciplinary team to prepare a plan of care for each client for the coming year. The plan, a cluster of specific recommendations for meeting identified needs, should "include a clear explanation of the daily program needs of the client for the guidance of those responsible for daily care. [Appendix B, § B.4]." Those team members who have agreed to seek or provide each recommended service should enter into a written service agreement. This agreement should include "a specific description of the client's daily activities with an explanation of how they will contribute to the achievement of the client's program goals. [Appendix B, § B.5(a).]" Supervision of the client's progress and responsibility for ensuring actual delivery of each service falls to each client's community service worker.* Finally, the decree requires that the community service worker and others review the prescriptive program plan at least quarterly in order to ensure service delivery and to make any minor modifications in the plan. Problems should be identified and addressed as part of each quarterly review.

But the current system does not work this way. For the most part, preparation is good. Needs are listed separately and appropriate individuals are assigned to implement and monitor the delivery of each needed service. Implementation dates and target completion dates are faithfully assigned. The problem is the development of concrete instructions on how to carry out each habilitative service, instructions to be followed by the designated provider who may have no special expertise in teaching persons who are retarded. To meet the requirements of providing "a clear explanation of the daily program needs of the client for the guidance of those responsible for daily care," the team decides in each case whether such step-by-step instructions should be drawn up. If so, the team designates a person or organization to develop a "habilitation plan." A habilitation plan is indicated for each and every service task which constitutes a "developmental activity."** A developmental activity is broken down into separate tasks to be learned in sequential steps, each to be mastered in turn. Any learning task lending itself to this approach should require a habilitation plan to be followed by the teacher. This method would also allow monitoring the client's progress toward acquiring each particular skill. Thus, a habilitation plan would be indicated for carrying out a recommendation which assigned a team member the duty of "increasing socialization skills," or "ADL skills." Scheduling an eye examination would not require a habilitation plan.

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* "Community Service Worker" is the decree's title for "social worker." The Bureau uses the designation, "client services coordinator."

** Not all program coordinators, when surveyed, were able to articulate the criteria by which habilitation plans were assigned in their region. Statewide training in habilitation plan development was provided to Bureau staff in September, 1979, but not all coordinators now employed received such training. Regional office staff report that these sessions were poorly attended by staffs of community homes and programs.

Our review of 455 prescriptive program plans revealed that 58.46% of individual plans assigned the development of at least one habilitation plan. Some assigned as many as ten. Using the criteria set forth above, it was found that 29.23% should have required the preparation of at least one habilitation plan but failed to do so.

HABILITATION PLANS

By percent	BMR REGION I	II	III	IV	V	VI	STATEWIDE
Prescriptive program plans assigning at least one habilitative plan	87.5	74.25	57.28	48.44	56.99	25.5	58.46
Prescriptive Program Plans which should have assigned at least one habilitative plan but failed to do so	25	16.83	36.89	51.56	11.83	47.05	29.23

The Master's office requested copies of each habilitation plan assigned as part of each prescriptive program plan it reviewed. Documentation that each habilitation plan had been implemented by the appropriate service providers was also requested. Only the data for region I is complete.* Only 50.7% of all habilitation plans assigned were actually written. Documentation that habilitation plans were implemented existed for only 19.7% of all plans assigned. Habilitation plans and documentation are now being received from other regions but not at a rapid rate. The reason is simply that defendants do not have copies of habilitation plans in their files.

During the entire term of the decree, there has been little, if any, accountability to anyone for the services each team member agrees

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* Region I was uniquely well-situated for complying with this informational request as it provides services to relatively few class members many of whom are served by one facility. Many of the habilitation plans received from region I were written in January 1980, after the Master requested copies of all such plans.

to provide. Signed service agreements are never enforced as binding contracts. Signatories are left to fulfill or to ignore their duties with absolute impunity. At one annual interdisciplinary-team meeting it was routinely noted that Bangor Regional Rehabilitation Center had failed to implement any of the services embodied in five signed service agreements covering a one-year period. Not a voice of protest was noted. There is nothing unusual about this particular case.

4. Quarterly Reviews.

> The prescriptive program plan shall be reviewed by the client's community service worker and by those responsible for the daily care of the client at least quarterly. At the quarterly review, minor modifications in the plan may be made, and progress as well as problem areas shall be noted. The quarterly review team may reconvene the entire interdisciplinary team if they find that reevaluation of the client is necessary. [Appendix B, § B.3]

Finally defendants must devise a method of reviewing quarterly their clients' progress toward prescriptive program plan goals. Quarterly reviews have been carried out irregularly or not at all. A common pattern over the term of the decree has been for interdisciplinary teams to assign service tasks and simply hope that the tasks are carried out sometime over the coming year in a fashion that approximates team recommendations. Very often defendants do not learn how well or to what extent team recommendations have been implemented until the prescriptive program plan is reviewed one year or more later.

The following is an excerpt from the narrative summary of a prescriptive program plan prepared in region V on October 1, 1979:

> As was the recommendation of last year's program plan, an alternative placement was explored and secured in August of this year. It was felt by the previous team that a Nursing Home environment was not the most appropriate placement for [Client]. [Client's] new residence is a six bed group home. . . . This home operates under the philosophy of normalization and appears very conducive to developmental training. . . . Mr. Libby was present at the last IDT and took responsibility for insuring that transportation be worked out in order to allow for [Client] to attend [day program] for at least four hours of programming daily, this has been resolved and is no longer an issue. . . . Communication between program and home was also a problem last year, however [the problem] does not exist with the present situation. . . Positive changes are obvious, not only at home, but also at the program.

> [Client's] communication is much more appropriate in that she now initiates conversation and is able to express feelings more. [Client] stated at the meeting that she now enjoys where she is living. Many of the needs that existed at [nursing home] have seem to be resolved simply by [Client's] moving to a home which offers more appropriate peer grouping and some developmental training.

This excerpt illustrates the real impact which decree compliance may have on people's lives. It is here intended to show the remarkable speed with which decree compliance can accomplish significant habilitative goals. It underscores the need to monitor carefully recommended services in order to insure their provision with all possible dispatch. There is no apparent excuse for the frequent practice of allowing clients to languish for months while interdisciplinary-team members fail to furnish the services and programs they have expressly promised in written contracts to provide.

B. PROGRAM RECOMMENDATIONS

The Special Master has undertaken a statistical analysis of the manner in which interdisciplinary teams have made recommendations which address the programmatic needs of the plaintiff class. Four hundred and twenty-five prescriptive program plans were reviewed and and analyzed for these characteristics.

> Each client's prescriptive program plan shall provide for a minimum of four scheduled hours of program activity per week day, and each client shall receive this programming. This program activity shall be designed to contribute to the achievement of objectives established for each client in his prescriptive program plan. [Appendix B, § B.7(b).]
>
> Each client shall receive the programming required by subparagraph (b) outside the client's residential setting [with exceptions for clients living in four named ICF-MR facilities.] [Appendix B, § B.7(d).]
>
> In cases where programming outside the residential setting is unavailable and moving the client would be inappropriate, the interdisciplinary team shall develop an interim plan pursuant to paragraph 4 of this section. This interim plan . . . shall require frequent participation in social functions . . . in the community. Activities of this sort shall take place at least twice weekly. [Appendix B, § B.7(e).]
>
> A client may receive programming in the residence and/or receive fewer than four hours of program activity per week if:
> (a) a physician certifies in writing that four hours of activity outside the residential setting would be medically harmful to the client. Any such decision shall be reviewed quarterly . . .
> (b) a client who is competent for the purpose of making this decision shall be permitted to choose to engage in fewer hours of programming a day or to engage in programming in his residence. The client shall be asked to reaffirm this decision quarterly. [Appendix B, § B.8.]

Recommendations for program were reviewed from a total of 425 prescriptive program plans. Team recommendations were sorted into six categories:

1. The team recommended four hours of program per week day outside the residential setting and this program was secured for the client.
2. The team recommended such program but noted that it was currently unavailable. An interim plan was established. (Figures reported below for this category of recommendation are inflated. Included are interim plans which, while not complying with section B.7(e) above, demonstrate a real attempt by the team to see that some purposeful activities are provided while needed day program is being developed or pursued.)
3. The team recommended such program and merely noted it as an unmet need. No interim plan was recommended, or the interim plan was wholly deficient.
4. Medical harm was documented pursuant to B.8(a).*
5. Program was not recommended by decree standards.
6. Program was not addressed.

The following table presents the findings expressed as percentages of prescriptive program plans falling into each of the six categories:

PROGRAM RECOMMENDATIONS

Type of Program Recommendation:	BMR REGION I	II	III	IV	V	VI	STATEWIDE
#1	13.5	51.65	18.75	46.77	52.27	47.05	39.76
#2	5.4	28.57	17.71	29.03	2.27	11.76	16.70
#3	0	2.20	14.59	16.13	15.9	23.52	12.24
#4	0	1.1	3.13	0	1.14	0	1.18
#5	78.3	16.48	40.63	22.58	26.14	17.64	30.35
#6	2.7	0	2.08	0	1.14	0	.94

* We have seen no evidence that decisions based on medical harm are being reviewed quarterly.

Categories 1,2, and 4 may be combined. All recommendations which fall into these categories represent substantial compliance with the procedural requirements for program recommendations. Thus the next table presents the total percentage of prescriptive program plans reviewed which made recommendations for program in a manner consistent with Appendix B.

BMR REGION	PERCENT OF PROGRAM RECOMMENDATIONS WHICH COMPLY WITH APP. B
I	18.92*
II	81.32
III	39.58
IV	75.80
V	55.68
VI	58.82
STATEWIDE	57.64

It must be emphasized that these figures do not precisely correspond to the percentages of Bureau clients in each region who now actually receive the amount of program required by Appendix B. These figures represent the degree to which defendants are complying with interdisciplinary-team procedures for recommending such program.

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* This region was without a program coordinator for more than half of 1979. During this period the regional administrator allowed Houlton Residential Center, which houses about half of the region's class members, to conduct its own interdisciplinary-team meetings. It appears that during the first year and a half of this decree the regional administrator was of the opinion that Houlton Residential Center was not required to provide four hours per weekday of program to its residents whether in or out of the residential setting. Whether the regional administrator misread the Court's decree or believed that his region in Aroostook County was shielded by time and distance from review is not clear. Many of the Region I plans were reviewed and signed en masse by the regional administrator in December 1979 following the request that they be provided to the Master's office.

C. RESIDENTIAL RECOMMENDATIONS

We have conducted a similar analysis of 425 prescriptive program plans to determine compliance with the procedural requirements for recommending a residential setting for each client.

> [E]ach client's community interdisciplinary team shall deterimine whether movement to any other living arrangement is necessary to meet the client's needs. If so, the team shall make a placement recommendation. Placement decisions shall be based on a determination that the placement will offer the individual a better opportunity for personal development and a more suitable living environment, and will result in placement in the least restrictive alternative appropriate for the client. [Appendix B, § A.3(a).]
>
> Defendants shall not place clients in and shall remove clients from those facilities that fail substantially to meet the environment, care and programming standards included in this decree . . . [Appendix B, § C.10.]
>
> For any client who resides in a facility of over fifteen beds [with certain exceptions], the interdisciplinary team shall give special scrutiny to the continued appropriateness of the client's residential placement and shall note their findings and the reasons therefor in the prescriptive program plan. The Regional Administrator shall review these findings. [Appendix B, § C.11.]
>
> Clients shall be prepared to move from: (1) living and programming segregated from community to living and programming integrated with the community; (2) more structured living to less structured living; (3) larger living units to smaller living units; (4) group residences to individual residences; (5) dependent living to independent living, as appropriate for the individual client. [Appendix B, § F.1(c).]
>
> Each client has a right to a habilitation program which will maximize his human abilities, enhance his ability to cope with his environment and create a reasonable expectation of progress toward the goal of independent community living. [Appendix B, § F.1(a).]

Interdisciplinary-team recommendations for residential placement were sorted into four categories:

1. The team found that the client's current residence complied with the decree. (Inclusion in this category was not made to depend on mere phrasing of the recommendation, as, for example, use of such words as "least restrictive." If a recommendation to continue the current placement were preceded by sufficient consideration of the factors stated in the above-cited provisions of the decree, the plan was rated in category 1.)
2. The team noted that client's current home failed to comply with the decree and recommended an alternative home or proposed some concrete solution to the problem of noncompliance.
3. The team noted only that the current home failed to comply.
4. The team otherwise failed to address the issue of residential setting according to decree standards.

The findings are presented in the following table, again as percentages of 425 individual plans.

RESIDENTIAL RECOMMENDATIONS

Type of Residential Placement Recommendation	BMR REGION						STATEWIDE
	I	II	III	IV	V	VI	
#1	24.3	4.4	53.13	11.29	21.59	35.29	25.41
#2	10.8	16.48	6.25	12.90	13.64	21.56	13.18
#3	0	2.2	1.04	6.45	0	0	1.65
#4	64.8	76.92	37.5	69.35	63.64	43.13	50.59

Data for categories 1 and 2 may be combined in order to determine the total percentage of team recommendations which complied with the applicable procedural requirements of the decree. Those figures, in percentage, are as follows:

BMR REGION	RESIDENTIAL RECOMMENDATIONS WHICH COMPLY WITH THE DECREE
I	35.14
II	20.88
III	59.38
IV	24.19
V	35.23
VI	56.86
STATEWIDE	38.59

These figures are not the percentages of class members living in homes which comply with the decree. What they show is that over sixty percent of all prescriptive program plans fail to make recommendations for residential placement in accordance with decree standards. This is the most pervasive type of error seen so far. The ramifications of this error are potentially very serious not only because of the impact on quantifying unmet needs for establishing priorities for resource development, but more importantly because of the negative effects on members of the class.*

The sources of this error appear to be many. Sometimes it appears that team members are not even aware of what the decree requires. In some cases they are well aware of what it requires but treat decree provisions as "guidelines" or recommendations" instead of law. In other cases placement recommendations are framed only in

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*See, for example, the excerpt from a Region V plan of October 1, 1979, pages 39-40.

terms of what resources are actually available instead of according to actual client need. Individual plans sometimes preface the recommendation to continue current residence with a brief statement that the home is "appropriate" or "meets the client's needs." The former is wholly inadequate to meet the requirements of the decree. The latter fails to consider, first, whether the home complies with the substantive standards of the decree* and, second, whether the home offers maximum opportunity for growth and development and whether the client's needs could as well be met in a less restrictive residential setting.

D. ILLUSTRATIVE PLANS

On the following pages are reproduced some examples of prescriptive program plans developed for members of the plaintiff class during the term of the decree. They are included to illustrate the manner in which defendants have made some recommendations for program and residential placement.

The first is excerpted from a prescriptive program plan developed on November 9, 1979, in Region II. It is apparent that the "team" is not interdisciplinary. The meeting is nearly three months late. From the narrative summary it appears that some professional assessments were obtained. None of these assessments provides a basis for recommending program outside the residence according to individual need. This client has been without day program outside the residence for fifteen months because of her mother's objection to placement. The mother is not legal guardian and, therefore, lacks the legal competence for waiving the benefits secured by the decree to a member of the class.** The recommendations that the client attend the "NEWP program" appear to be based only upon a perceived need to have the client go somewhere outside the residence for four hours a day. An interim program is described but is not fully consistent with the decree, which requires that the interim plan specify community activities take place at least twice weekly.

The recommendation for residential placement, which appears on the second page of the narrative summary, is preceded by discussion indicating that the home is offering the client some opportunity for growth and development. There is no discussion of whether this home provides such opportunity in the most normal and least restrictive setting in which this client can function. Given the characteristics of the home, it appears doubtful that the question could be answered in the affirmative for any member of the plaintiff class.

Next is presented at page 52 a portion of the narrative summary from an individual plan prepared on January 1, 1979, in region IV. Relying upon professional assessment and recommendation, the team recommends and notes an unmet need for four hours per weekday of outside program more or less tailored to individual need. The team

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* See pages 63-65.

** Over three months after this team meeting, the client was still without program outside the residential setting.

notes the need for an interim plan in keeping with decree requirements but then, for reasons which are not entirely clear, notes an interim plan as an unmet need. This should have been the first basis for recommending new residential placement. Instead, the team goes on to note that the home fails to meet decree standards in several other respects and ends up recommending continuation of the placement, a complete non sequitur.

These two prescriptive plans should be compared to two others, recently developed in region VI. The first team meeting was conducted on January 9, 1980. The cover sheet and narrative summary are reproduced beginning at p. 53. This meeting was held approximately seven months late. While the team is not "interdisciplinary," the team carefully frames its recommendations in conformity to the assessments and suggestions of professionals in psychology and physical therapy. The team's recommendations for program and residence proceed directly from its analysis of actual client needs. The plan gives careful attention to decree requirements. Sources of noncompliance are isolated and slated for corrective action.

The second individual plan was prepared on January 21, 1980, also in region VI. This plan illustrates well the procedures required by appendix B for framing recommendations for program and residential placement. It can be seen from the "INDIVIDUAL PROGRAM PLAN AND SERVICE AGREEMENT" at page 61 that the interim plan is specified with careful attention to appendix B, section B.7(e).

BUREAU OF MENTAL RETARDATION

INDIVIDUAL PROGRAM PLAN

2 (Region) 222035 (Case #)

NAME (Last, First, Middle) BIRTHDATE 1-3-50 IDT DATE 11-9-79

ADDRESS & TELEPHONE Ward's Home
R.F.D. #1, Box 177
Hampden Highlands, ME 04445
Tel: 234-2741

REFERRAL DATE 7-1-77

RECALL DATE 11-9-80

PREVIOUS IPP DATE 8-16-78

INTERDISCIPLINARY TEAM PARTICIPANTS

TITLE	NAME	DISCIPLINE/AGENCY
CHAIRPERSON	Gerry Anne Kearns	IPPC/BMR
CLIENT SERVICES COORDINATOR	Pamela Colson	BMR
CLIENT	(PRESENT)	
PARENT/GUARDIAN		
CLIENT ADVOCATE		
ACTIVITY COORDINATOR	Edna Taber	Ward's Home

BMR IPP (3) Client Case #222035

NARRATIVE SUMMARY (Includes):

1. Summary - presenting problems
   client's current status
   significant medical/other factors
2. Major areas of discussion/priorities with rationales
3. Program direction
4. Client group's involvement in process/reaction to
5. Required resources not available
6. Dissenting opinions
7. If recall date is prior to annual review, state why (recall considerations)

An interdisciplinary team meeting was held November 9, 1979 at Ward's Home for . Those listed on the face sheet had opportunity for input into the development of an individual program plan.

1. is a twenty-nine (29) year-old woman who resides at Ward's Home. She is independent in ADL skills with the exception of needing assistance in bathing and shampooing. She has no behavior problems and gets along well with other residents of the home.

2. The initial individual program plan was reviewed and updated, with the following determinations:

SA #1: Enrollment at MHCPV - gain independence and maturity. An application was filled out for MHCPV, was not submitted due to her mother's concern regarding her attendance at a program. It was determined that the CSC would contact Mrs. about program attendance. The team agreed that 's skills were high enough for her to attend the new program (NEWP) being developed. Pam will make out an application to this program. will have an opportunity to visit NEWP.

SA 2 & 3: Shampoo training - client will shampoo her own hair, and bath scheduling - client will schedule her own bath. Completed. has been working on this at Ward's with Edna and is now independent in these two areas.

SA #4: Alphabet training - client will recognize letters of the alphabet. Ongoing need. has just started working on this. She knows and recognizes her name and can print it, on request, most of the time. Edna will continue to work on this with her.

SA #6: Ongoing medical and dental evaluations - good physical and dental health. This will continue. Judy Jewell will assume responsibility for making arrangements. had her yearly physical Sept. 19, 1979 with Dr. Harold Cross of the Promis Clinic. has lost 7-1/2 lbs. since her last physical. No medical problems were noted. Dental evaluations are through the Pineland Outpatient Clinic, John Rice, Dentist. Pam will assist Judy with making the arrangements.

SA #7: Limited guardianship, medical consent and financial management - legal protection. It was agreed by the team that guardianship was needed. Pam has written to Mrs. about this and she would like to review guardianship. It appears that a relative may be willing to assume this role, if not, public guardianship will be obtained. This will be limited to financial management and medical decisions.

SA #7: (Cont.) Pam noted that there was a need for a handbook for parents and people who are interested in becoming a guardian. She will discuss this with Dan Field, R.A., BMR, Region II.

Other areas of need were discussed and have been added to the new plan. They are listed below.

A visual exam was administered by Dr. Everett Sawyer. No recommendations were made. Dr. Cross will be asked to do a visual screening during physicals and if problems are noted another appointment will be made with Dr. Sawyer. Judy to assume responsibility. takes no medication.

A hearing evaluation was administered by the EMMC's Speech and Hearing Clinic on May of 79, Nancy Kenniston, evaluator. A mild contuctive hearing loss was noted but no recommendations were made.

A speech screening has been completed on Oct. 11, 1979 by Tom Backiel, Speech Therapist of the Northern Resource Center. As soon as this is completed, a modified IDT will be called by Pam, to address recommendations.

An occupational therapy evaluation has been done by Beth Smith, O.T. from EMMC. Edna will continue to carry out her recommendations for perceptual exercises. Edna said that has membership in YWCA and attends programs in macrame and swimming. This will continue year round.

At Ward's, is involved in approximately 8 hours of programming daily. Six hours is individual attention. She has been active in Special Olympics, and won a gold medal in soccer. She attends both summer and winter Olympics as well as the state games. Edna will continue to provide programs in the following areas: Safety and community awareness, home management, shopping, clothing selection, money skills/knowledge, and pre-vocational training.

is very active at Ward's and takes an active part in these classes: Music, rhythm band, nature group, camping/hiking, craft, history, art, camera, exercise classes, diet and nutrition classes. She is involved in the self-awareness class. Pam requested a copy of the checklist from Edna.

The appropriate residential setting for was discussed. expressed that she would like to move to with her mother, but her mother is unable to have her, due to her age. She visits there on holidays. It was agrred by the team that Ward's was the most appropriate living situation for her at this time.

3. Program direction is for to continue to reside at Wards and be involved in their program, until a response is received from the NEWP application, (if accepted, she will attend) and to follow the individual program plan designed at this meeting.

4. attended the meeting, answered questions when asked, but had little input into the development of the plan.

5. Daily program outside of home.

6. None

7. The yearly recall meeting will be Nov. 9, 1980. A modified IDT will be held to address recommendations of the psychological evaluation. The appeal process and the process used to call a modified IDT was explained.

Gerry Anne Kearns

Gerry Anne Kearns
IPP Coordinator

NARRATIVE SUMMARY (Includes):

1. Summary - presenting problems and client's current status.
2. Significant medical/other factors
3. Major areas of discussion/priorities with rationales
4. Program direction
5. Client group's involvement in process/reaction to
6. Required resources not available
7. Dissenting opinions (Note: Unless specified otherwise, there were no final dissenting opinions.)
8. If recall date is prior to annual review, state why.

has been living at the High Street Nursing Home in Auburn for about three years. In September Conrad Wurtz evaluated 's psychological functioning. He found that she is functioning in the profound level of mental retardation. Her social functioning is higher than her intellectual functioning. Her primary strength is her ability to understand what is said to her. She is also described as being friendly with a good sense of humor. She especially enjoys her close relationship with Ina Brainerd, Director. Connie supported 's desires and recommended that she be involved in a training program outside of the home. has not been involved in any outside programming on a regular basis. It was agreed that should be involved in an activity program outside the home at least four hours every weekday. Although there is an activity center in Auburn, it does not accomodate people in wheelchairs. We are left with the only option of informing the local Resource Developer of the Bureau of Mental Retardation of the need for such a program which could provide transportation and a program to teach more about money, use of the telephone, very simple cooking and other areas relevant to . For now we will need to rely on the activity program of games, etc. being provided at the nursing home twice a week. Another temporary alternative to a complete day program would be bi-weekly trips for community activities such as shopping, concerts, sports events etc. Unfortunately, that is not available to and will be considered to be an unmet need.

In the past has enjoyed dances sponsored by the Auburn Activity Center. But at some point Ina stopped getting the notices. It was decided that 's new social worker, Joseph Wallace, will contact the activity center to see about getting Ina's name back on the mailing list. Those dances are held about every three months, but not all of them take place in this immediate area. We decided that needs more frequent dances and other leisure activities with peers. Once again, such a program does not exist presently. The Resource Developer has already been informed that at least eight other people in this area need an evening social program.

In spite of the fact that is living in a large home with people who are mostly much older than her, it was felt that she should remain there. She has a very positive attitude towards the home and it is meeting her needs. We did feel, however, that she could benefit from a friendship with a person her age who could come to visit once a month to put together puzzles, listen to records, have a snack and so forth. We were aware of a particular person who might be ideal. Her social worker will try to make arrangements.

is receiving Physical Therapy five times weekly from Pete Couture. At first he did a lot of stretching exercises. Then he did stimulation of muscles. When he first tried a walker, she just stood. She has made significant progress and is now able to take twenty-five to thirty steps. She can transfer herself with only one person standing by. Self-ambulation is a potential long term goal. Pete will continue to provide therapy for increased ambulation through gait training, correcting posture and reducing contraction. He had two suggestions which we discussed. Her suggested a smaller wheelchair specially made for her with knobs. She would be able to move her own wheelchair much better if it was smaller and had knobs. The reason she doesn't already have that wheelchair is because of money. It was agreed that Joseph will attempt to arrange for the funding of the chair ($350 - $400). Pete Couture could write out a description of the chair and Dr. Mazzo would prescribe it. A smaller chair would also mean that she could go more places in the community.

"PRIVILEGED AND CONFIDENTIAL
NOT TO BE USED AGAINST
CLIENT'S INTEREST"

BUREAU OF MENTAL RETARDATION

INDIVIDUAL PROGRAM PLAN

VI
Region

Case #

NAME _____ Birthdate 2/28/26 IDT Date 1/9/80
Last first middle

ADDRESS & TELEPHONE Hilltop Home
Warren, Maine 04864

REFERRAL DATE _____

RECALL DATE _____

PREVIOUS IPP DATE _____

INTERDISCIPLINARY TEAM PARTICIPANTS

TITLE	NAME	DISCIPLINE/AGENCY
CHAIRPERSON	Susan K. Lanning	IPPC/BMR VI
COMMUNITY SOCIAL WORKER	Heather Field	CSC/BMR VI
CLIENT	(PRESENT)	
PARENT/GUARDIAN		
CLIENT ADVOCATE		
	✓Rod McCormick	CSCS/BMR VI
STAFF MEMBER	Janet Rhodes	Coastal Workshop

BMR IPP (3)

NARRATIVE SUMMARY (Includes):

1. Summary - presenting problems
   client's current status
   significant medical/other factors
2. Major areas of discussion/priorities with rationales
3. Program direction
4. Client group's involvement in process/reaction to
5. Required resources not available
6. Dissenting opinions
7. If recall date is prior to annual review, state why (recall considerations)

1. Presenting Problem

is a Class Member currently residing at Hilltop Home in Warren, Maine and attending the Coastal Workshop in Camden. 's recall date was for May 18, 1979, but due to the resignation of 's CSC and the vacancy of that position until early December, his annual review was not scheduled until today.

2. Major Areas of Discussion

began the discussion himself when he arrived at the meeting stating that he hoped he did not have to move from Hilltop because he liked living there. Rod told that as a Team, we needed to set up a plan to obtain the services needed. went on to say that he was all right there at Hilltop and if he left he wouldn't know where to find a job. Rod told that there were problems with 's living situation at Hilltop. The home is not ramped or barrier-free to afford the mobility and accessibility he should have in his living situation. The home does not provide a trained staff that can train and give therapy to in the areas defined in Psychologist Susan Vayda's report. A recommendation from that report calls for the location of a residential program based on a physical therapist's recommendations. The home in which lives at Hilltop,houses 33 people which is out of compliance with the Consent Decree. Rod suggested that a service agreement be negotiated with Hilltop to move to a smaller home at Hilltop and that in-home services with the development of a hab plan be addressed at a modified IDT. The home would have to be ramped and assistance through Southern Maine Resource Center would be sought. Rod told that the recommendation was being made for him to move to a home more conducive to 's need for physical therapy and training to become more independent in daily living skills. became very angry about this recommendation and Rod told him that he could appeal this. Janet reminded the Team about the difficult transportation problem the workshop was experiencing when it came to finding a suitable home for . Heather told that she would make every effort to find him a home that would enable him to stay at Coastal Workshop, since it was apparent that it was a very important part of his life.

There was some discussion of 's need for development of his ADL skills. It has become noticeable to workshop staff that needs to bathe much more often than he apparently does. An implement for scrubbing his back would aid in 's independence. Time seems to be a factor at Hilltop as far as getting ready for workshop in the mornings. only shaves himself "once in awhile"

because he is always being told to "hurry up" by Hilltop staff who invariably will shave to save time. 's razor is broken and he is in need of a new one that would be for his use only and not other residents. said he would be willing to shave in the evening before going to bed which would also aid in the development of his independence. Bathing and general ADL skills will require the development of a hab plan with Hilltop staff.

does not require medication. His last physical exam was 4/79 with Dr. McCue. His last dental checkup was by Dr. Rice during 1/79.
It was noted that 's wheelchair is in need of minor adjustments. The orthopedic shoes which were fitted specially this past Spring hurt 's feed and he does not wear them. Heather will look into this matter and see that 's shoes are fitted properly so that he can wear them instead of the rubber boots he is currently wearing. 's clothing is also in great need of mending and cleaning and what clothing he does have does not fit him properly. Heather will contact Mr. , 's guardian, to inform him of this need for clothing and to request funds for the necessary purchases.

There was a discussion concerning the program at Coastal Workshop and 's work there. The workshop is primarily concerned with providing a place for clients to come everyday and with securing sub-contracts to keep them busy. Within this workshop structure each individual's specific goals toward improving their basic living/working skills are not perceived by staff as objectives to be worked on in their program. Goals of some clients possibly moving on to work in the community are not seen as realistic.

For it was noted throughout the meeting and from information in his psychological review that he has a need to be less dependent on others. He should be encouraged to do all that he can for himself to strengthen the muscles he is still able to use. The workshop staff agree to encourage to use his walker as often as is feasible and to encourage other clients to allow to be more independent.

Short term goals for include referrals for wheelchair improvements to be made, the home he lives in to be ramped and his shoes and clothing fitted and purchased. Long term goals for will be focused in the direction of an appropriate living environment for his needs and continued support for maximum independence with emphasis on social/recreational activities.

3. Client Involvement

was an active Team member who wholeheartedly disagreed with the Team's recommendation that he move to a safer and more suitable home that would better meet his needs. expressed his thoughts about his friends and how important the workshop is to him.

4. Dissenting Opinions

There are basic differences of opinion between BMR and Coastal Workshop as to what the realistic goals of retarded citizens can be and how those goals can be attained.

5. Program Direction

will remain at Hilltop until a barrier-free home is located which would provide with therapy and support for maximum independence. Until this new home is located, BMR will negotiate service agreements with Hilltop Home, concerning ramps and in-home programming.

6. Required Resources not Available

A small 6 bed or less home which is barrier-free with trained staff to carry out physical therapy recommendations and to train to be more independent in his basic daily living skills as outlined in psychologist's report.

7. Recall Date

Modified IDT to be held in 30 days.

Recommendations

1. All recommendations on psychological review to be carried out.

2. Modified IDT to be held with Hilltop Home to address immediate needs of 's living situation. Service agreements to be negotiated and a hab plan developed for ADL skills within the home.

Susan K. Lanning

Susan K. Lanning, IPPC
Bureau of Mental Retardation
Region VI - Thomaston

BUREAU OF MENTAL RETARDATION

"PRIVILEGED AND CONFIDENTIAL NOT TO BE USED AGAINST CLIENT'S INTEREST"

INDIVIDUAL PROGRAM PLAN

VI
Region

Case #

NAME _____ Birthdate _____ IDT Date 1/21/80
Last first middle

ADDRESS & TELEPHONE Merry Manor
Seven Elms
Washington, Maine 04574

REFERRAL DATE _____

RECALL DATE 1/21/81

PREVIOUS IPP DATE _____

INTERDISCIPLINARY TEAM PARTICIPANTS

TITLE	NAME	DISCIPLINE/AGENCY
CHAIRPERSON	Susan K. Lanning	IPPC/BMR
COMMUNITY SOCIAL WORKER	Tim Garneau	CSC/BMR
CLIENT		
PARENT/GUARDIAN		
CLIENT ADVOCATE	Joseph Witt	SRC
	Joe Curll	CPC/SRC
Psychologist	Dr. Conrad Wurtz	
Home Operator	Moe Potvin	
	Rod McCormick	BMR
Home staff person	Darlene Emery	
Home staff person	Doris Wescott	

BMR IPP (3)

NARRATIVE SUMMARY (Includes):

1. Summary - presenting problems
   client's current status
   significant medical/other factors
2. Major areas of discussion/priorities with rationales
3. Program direction
4. Client group's involvement in process/reaction to
5. Required resources not available
6. Dissenting opinions
7. If recall date is prior to annual review, state why (recall considerations)

1. Presenting Problem:

is a member of the Pineland Class Action Suit who resides at Merry Manor at Seven Elms in Washington. had attended the Mobius program for about 6 months until transportation became difficult for the home to provide. This IDT is being held as an annual IDT and to address program needs.

2. Major Areas of Discussion:

After Team members were introduced, discussion began concerning the previous IDT recommendations (1/15/79). Since there were no service agreements obtained at that meeting the Assets and Needs list was used as a reference. Recommendations concerning Program Direction were for attendance of the Mobius Activity Center and for ADL skills to be encouraged by home staff. Since that time an in-home program assessment has been done by Joe Curll, C.P.C The areas identified as needs for are as follows: washing her hair independently, learning to make her bed, learning to dial a telephone, telling time, using a calander, sharing common space with others, identify denominations of paper currency, scheduling of when to take her bath, and a vocational program. ' skills in hairwashing have come a long way in the past month or two. She is also able to make her bed and is able to do her laundry. She is independent in ADL skills, enjoys cooking can choose quality items when shopping, is friendly and cooperative, can follow multiple step instructions and is motivated to learn.

The issue of guardianship has not yet been clarified and Team members endeavored to do this. Contact will be made with ' mother but it was thought a determination should be made as to whether or not guardianship is necessary. Dr. Conrad Wurtz stated that when experiences any anxiety it almost causes her to not be in reality. Doris said that there are times when reaches points of hysteria. As to whether or not would be able to make clear judgements about medical or financial decisions, Dr. Wurtz felt this would be impossible. The Team therefore recommends Limited Guardianship which Tim will discuss with Mrs. .

Medications were discussed as Tim was concerned with the fact that the amount of ' medication has been doubled in the past year. Dr. Wurtz asked what the condition was that brought on this doubling of the amount

of Mellaril prescribed. According to Doris, was constantly hollering at, kicking and hitting others in the home. Apparently, even though medication has been increased, there has not been a significant change in this behavior. Joe Witt suggested that Dr. Waterman be notified of this and Tim recommended a medication review. Dr. Wurtz asked staff members about the kind of pattern they see in . Darlene said that will act out if she doesn't get her own way and if she can't be first all the time. She copies the bad behavior of others and seems to act out for attention it gets her. It has been occurring more often and has been asking for more medication because she "is nervous". Joe Curll commented that is very responsive to any input and that maybe she needs to be learning more things than she now does. He felt she has a lot of ability and learns very quickly. Tim suggested that more areas be picked out of the home assessment to give more to work on. Joe said that at the present time there are not enough staff members at Merry Manor to give all the involvement she needs. Apparently displayed this negative behavior while attending Mobius also. Dr. Wurtz stated that testing showed to be functioning in the Moderate range of retardation and that has excellent verbal abilities. She is highly variable in her responses. Darlene commented that has trouble in doing things over that she hasn't done correctly the first time. At this point Dr. Wurtz asked if she understood what the problem was we were discussing. said she did, that she is ashamed of herself when she hurts others. She said she was not a low grade but a bright girl who was not sick.[*] Dr. Wurtz stated that there would be some value in therapeautic counseling for . Also, a behavior modification program would help structure in the home environment. He felt that expects herself to react in the manner she does and that she resolves the anxiety without solving the problem. Counseling and relaxing training are recommended by the Team.

As far as a program is concerned Dr. Wurtz felt that it should be a highly structured sheltered workshop with limited competitiveness and fine motor activities (which are difficult for her) and utilizing ' high verbal ability. Dr. Wurtz felt that a smaller number of people in ' living environment would be preferable as too many peoply make her more anxious and causes her to lose control. A foster home with older people would be ideal. will be shown other homes to help make her aware of what might be available to her at some future date.

An Interim Plan will be developed involving community services which will help develop her social skills and utilize her positive assets. Activities within the home program should involve in higher functioning activities.

' last physical exam was on 10/26/79 with Dr. Waterman. She takes Mellaril 100 mg. Q.I.D. Her last dental exam was on June 5, 1979 with Dr. Fowler when she had one tooth extracted.

3. Program Direction:

will remain at Seven Elms until a suitable foster home becomes available that also has access to a highly structured program that will

[*In the past Pineland Center staff (and so retarded persons themselves) designated Pineland residents as "high grades" and "low grades," terms of compliment and insult. Senior Pineland staff may still on occasion be heard to use these terms.]

meet her needs. An interim plan will be developed and more areas from the in-home program assessment will be utilized.

4. Client Involvement:

was noticeably more involved at this IDT than last years. She seemed to follow the conversation and was more relevant in her answers to questions. Her interaction with Dr. Wurtz indicated to the Team that counseling would be of great benefit to her.

5. Required Resources Not Available:

Highly structured sheltered workshop/limited competition/ limited use of fine motor skills/utilizing her high verbal skills. Foster home with older people.

6. Dissenting Opinion:

None

7. Recall:

1/21/80

Susan K. Lanning

Susan K. Lanning, I.P.P.C.
Bureau of Mental Retardation
Region VI - Thomaston

SKL/hmr

REVIEW DATES

5/21/80 10/21/80

Client's Name _____

Date Jan 21, 1980

INDIVIDUAL PROGRAM PLAN AND SERVICE AGREEMENT

	Service Need	Service Objective	Provider Responsible	Date of Initiation	Monitoring Responsibility	Hab. Plan Req.	Comments
7.	Interim Plan	To develop and implement a plan which will address high level of verbal skills within shopping trips, social functions, Nursing Home visits, meals in restaurants etc, twice a week.	Doris Wescott Darlene Emery	1/21/80	Tim Garneau	✓	
8	Hearing Eval.	To make a referral to Lou Lelletier for hearing eval.	Tim Garneau	1/21/80			
9	Contact w/ mother	To contact Mrs. concerning Limited Guardianship	" "	" "			
10	Visits to Other Homes						

DEPARTMENT OF MENTAL HEALTH & CORRECTIONS

Bureau of Mental Retardation
189 Main Street
Thomaston, Maine 04861
TEL: 207-354-8766

March 6, 1980

Mr. Moe Potvin, Director
Seven Elms Boarding Home
Washington, Maine 04574

Subject: Interim Programs

Dear Moe,

Having recently completed the Individual Program Plans for the classmembers at Merry/Twin Maples Boarding Homes, the focus of social services must now become the implementation and monitoring of the program plans developed. One of the first benchmarks of this phrase of service is the development of good interim plans. As I am sure you are aware, the purpose of the interim plan is to provide a realistic alternative to the Consent Decree requirement for training outside of the home, until such time as outside training can be provided.

The interim plans can address a wide range of social, recreational, deversional activities. These activities, however, should focus on the programming needs of the individuals who will receive these services. I feel that these services should occur on a regular, reoccurring, and scheduled basis.

Your agency is responsible for the development and implementation of the interim plans. BMR is responsible for sending a copy of the interim plans to the Court Master. I, therefore, ask for your assistance in providing this office, as soon as possible, with copies of the individual's interim plans with schedules and time frames for their implementation.

Sincerely,

Rod McCormick
Regional Supervisor
BMR - Region VI - Thomaston

RM/dd

cc: Tim Garneau
Joe Curll
Peter Stowell
Art Dingley

IV. COMMUNITY HOMES

A. DECREE STANDARDS

> Each client shall be provided with the least restrictive and most normal conditions appropriate for that client. . . . [Appendix B, § F.1(b).]
>
> Placement decisions shall be based on a determination that the placement will offer the individual a better opportunity for personal development and a more suitable living environment, and will result in a placement in the least restrictive alternative appropriate for that client. [Appendix B, § A.3(a); see § A.2(a).]
>
> Community residences ["shall be integrated into the community"] - - Sites shall be chosen in residential settings normal for the community in which they are located and with ample opportunity for interaction with the community. Preferably placements shall have easy access to shopping facilities and be within a reasonable commuting distance from programs attended by clients during the day. [Appendix B,§ C.12.]

The rules of the decree applicable to community homes reflect the decree's unifying principles of education and normalcy. For purposes of assessing the quality of homes where class members are now living, we have divided relevant decree provisions into "environmental standards" and "program standards." Environmental standards contemplate residential settings which are the antithesis of institutions, whether large or small.

> (a) Defendants shall ensure that community living facilities afford clients privacy, dignity, comfort, sanitation and a home-like environment. This shall include but is not limited to:
>
> (1) individual bed, dresser and storage place;
>
> (2) attractive, comfortable and spacious living and sleeping areas;
>
> (3) privacy in bathroom areas;
>
> (4) normal temperatures and adequate ventilation, comparable to that found in private homes.
>
> (b) Each facility must provide for all the functions characteristic of a normal home, including a kitchen, living room, dining area, bedrooms and bathrooms of normal residential design.
>
> (c) The dining area shall be of sufficient size to permit staff and clients to eat meals together.
>
> (d) Hallways and circulation space must be comparable to that found in typical private homes and apartments.
>
> (e) The facility's activities, routines and rhythms shall conform with practices prevalent in the community and the client's age.
>
> [Appendix B, § F.2.]

As important as the foregoing provisions are, meeting environmental standards alone will not suffice for compliance with the Court's decree. Even a small home which is normal in size and appearance must do more than provide custodial care. The home is a context for learning as well as living.

> Each client has a right to a habilitation program which will maximize his human abilities, enhance his ability to cope with his environment and create a reasonable expectation of progress toward the goal of independent community living. [Appendix B, § F.1(a).]
>
> Clients shall be taught skills that help them learn how to manipulate their environment and how to make choices necessary for daily living. [Appendix B, § F.1(b).]
>
> Clients shall be prepared to move from: (1) living and programming segregated from community to living and programming integrated with the community; (2) more structured living to less structured living; (3) larger living units to smaller living units; (4) group residences to individual residences; (5) dependent living to independent living, as appropriate for the individual client. [Appendix B, § F.1(c).]
>
> In addition to the four hours of programming [outside the home], each client shall receive training in his residential setting in everyday living skills, including, as appropriate:
> (1) care of individual living area
> (2) management, preparation and service of well-balanced meals;
> (3) selection, purchase and appropriate use of clothing;
> (4) development of grooming and hygiene skills;
> (5) preventive health and dental care;
> (6) use of telephone;
> (7) safety skills; and
> (8) use and management of money.
> Such training shall be monitored by the appropriate regional office staff. [Appendix B, § b.7.]
>
> The client's need for training or assistance in tooth brushing and oral hygiene shall be considered by the interdisciplinary team. Any necessary training or assistance shall be provided under the supervision of the registered nurse at each resource center. [Appendix B, § D.2(i).]

> There shall be at least three meals a day provided at normal times, and in a manner as close to normal family-style dining as possible. Clients shall be taught to eat in leisurely family style and to choose their own quantities and items according to individual tastes and preferences. [Appendix B, § F.3(a).]

Finally, the decree is specific on the State's duty to ensure that these benefits are realized by the plaintiffs:

> Defendants shall not place clients in and shall remove clients from those facilities that fail substantially to meet the environment, care and programming standards included in this decree. . . . [Appendix B, § C.10.]

B. FINDINGS

To obtain an initial assessment of the community homes in which the plaintiffs now reside, the Master's office sought the benefit of the judgment of social workers in each regional office of the Bureau of Mental Retardation. Social workers supplied information on the residences of all class members. As a means of verifying the social workers' assessments, each regional case-work supervisor was interviewed and asked to provide an independent evaluation. Criteria for evaluations were the above provisions of the Court's decree.

We found that community residences could be classified in the following categories:

1. Homes provided by members of the client's natural family.
2. Homes which comply with both environmental and programmatic standards of the decree.
3. Homes which fail to comply in one or both respects but which may be improved over time.
4. Homes which show no present promise of compliance.
5. Homes which were not classifiable; information was unobtainable.

The number of clients who live in homes of each category was computed. The data derived is presented in the following table, expressed as percentages of 574 class members for whom defendants were able to account.

ASSESSMENT OF COMMUNITY HOMES

Category	BMR Region I	II	III	IV	V	VI	STATEWIDE
#1	9.30	7.62	1.42	12.22	12.50	10.45	8.36
#2	16.28	30.48	30.50	33.33	34.38	35.82	31.36
#3	4.66	18.10	29.01	26.67	21.88	22.39	22.47
#4	67.44	43.81	39.01	25.56	29.69	31.34	36.93
#5	2.33	0	0	2.22	1.56	0	.87

Categories 2,3, and 4 are, by far, the most significant. Combining categories 3 and 4 yields the percentage of community class members who currently live in homes which fail substantially to comply with the decree.

PERCENTAGE OF CLASS MEMBERS LIVING IN HOMES WHICH VIOLATE THE DECREE

BMR REGION I	II	III	IV	V	VI	STATEWIDE
72.09	61.90	68.09	52.22	51.26	53.73	59.41

C. ILLUSTRATIONS

The following contrasting illustrations are derived from personal observations by the Special Master and his assistant. Home A is a group home located in Region V. It serves eight retarded adults including five members of the plaintiff class. This home exemplifies the residential services described by the decree. Although few in number, homes of equal or superior quality are to be found in every region of the Bureau.

Home A is physically indistinguishable from other homes in its residential neighborhood. Most community services, such as stores, banks, and bus service, are close at hand. Home A is clean and orderly, yet active and "lived-in." The kitchen, living room, dining room, bathrooms, and bedrooms are just like any other homes. Furnishings are comfortable and home-like. Clients are included in decision-making. Rules of conduct are determined jointly by staff and clients. Recently, the home occupants nominated one of their number to serve on the board of directors of the non-profit corporation which operates the home. Household duties are shared; responsibility is appropriately assigned.

The staff at Home A are attuned to providing instruction and encouragement. Clients are consistently taught skills necessary for increased self-dependency and are prepared to live in a less restrictive environment. Community contact is encouraged. Clients learn to cope not only with the narrow environment of the home but with the urban setting as well. They learn to make use of services available to the general public. Two clients at the home are now ready to live, with supervision, in their own apartments.

Home B is a boarding home located in Region II. Fifty-four people live there including 23 members of the plaintiff class. This home violates most environmental and programmatic requirements of Appendix B. Variations of this type of residence are also to be found in other regions of the Bureau of Mental Retardation.

Located on a country road some distance from community services, Home B is distinguishable from other rural homes. It is very large and is marked by a big sign facing the road. Home B is clean, orderly and cheerful but not home-like in design. Bedrooms are arranged in dormitory fashion. The dining area is huge. Most clients, while not at outside programs, are to be found in one large day-room. Hallways and circulation space are not comparable to what is found in typical private homes and apartments. These conditions are not necessary to meet any special needs of the persons who live there.

Home B does not systemmatically prepare clients to live in less restrictive homes by imparting skills which increase self-dependency. During a recent visit to the home we received a complaint from one member of the class that she was not allowed to prepare meals. Staff would not allow her in the kitchen because she "spilled things on the floor." Some activities are provided. Nevertheless, the majority of home occupants are to be found seated in the "day room" staring into space or amusing themselves simply in a diversionary way for lack of anything purposeful to do.. Staff at the home reported that activities were provided according to habilitation plans, but they could find no habilitation plans. Staff reported that program progress was monitored and documented by keeping attendance records at various classes offered by the home. Most of the attendance record cards were blank.

Clients living in Home B have reported to the Office of Advocacy that they are not allowed to smoke, to go outside, or to go to their bedrooms. Clients have spontaneously approached advocates with requests to move from Home B. They say they would like to live in group homes. One member of the plaintiff-class reports that she would rather go back to Pineland Center than return to Home B.

Bureau staff in Region II state that Home B is a valuable link in the chain of community residential services because it provides a "bridge" between institutions, such as Pineland and Bangor Mental Health Institute, and more normal residences such as Home A. Home B is necessary, they say, in order to prepare clients gradually for increased self-sufficiency. But not one person has been placed directly from Pineland into Home B during the term of the decree, and only one class member had been placed into Home B from a mental health institution. In addition, there are now several homes, three of them located in the same region, which successfully serve clients, many with severe mental retardation and psychiatric disorders, who were placed directly from institutions. These homes are comparable to Home A.

The Bureau of Mental Retardation provides few direct services other than professional services available through its resource centers. With the exception of the Freeport Towne Square home and program, the State does not provide on-going residential and program services. All other homes and programs are either proprietary or operated by private, nonprofit corporations and associations, none of which is under the Bureau's complete control. If homes and programs are not inclined to provide services in accordance with decree requirements, the Bureau is left with seeking their cooperation by friendly persuasion and limited financial coercion. Many homes, particularly the largest and the worst when measured against the Court's decree, also have mentally ill and elderly clients who live there along with persons who are mentally retarded. The larger the number of Bureau clients the home or program serves, the less is the Bureau inclined to precipitate a confrontation with the service provider over decree issues. From the Bureau's point of view, having a large number of clients in a bad home is better than having no home at all. Service agreements have not been enforced in such situations even though they bear all the attributes of binding contracts. Their susceptibility to specific performance has not been tested.

D. CRISIS INTERVENTION AND RESPITE CARE

> The defendants shall provide crisis intervention services in emergency situations which threaten a client's program or residential placement. Resource center staff with skills in crisis intervention and behavior programming shall provide intensive intervention at the community placement. Only if intervention at the community placement fails or if the crisis intervention team, after seeing the client, determines that immediate movement is necessary shall the client be moved to a respite care facility or other appropriate treatment facility. Any time crisis intervention services are required, an interdisciplinary team meeting shall be convened as soon as possible thereafter to review the client's prescriptive program plan, and in no event more than 10 days after the event requiring the crisis intervention. [Appendix B, § D.3.]
>
> Respite care or temporary residential assistance shall be available to clients by December 1, 1978. When respite care is reasonably needed, it shall be provided in community facilities. Pineland may be used for respite care purposes of a specialized nature only. [Appendix B, § D.4(a); see Appendix B, §§ D.4(b)-(c), A.4(b).]

The resource centers operated by the Bureau of Mental Retardation have entirely failed to provide crisis-intervention services. This failure

has resulted in total noncompliance with the other requirements of this decree provision. Statewide figures of the practical consequences of the failure to provide crisis intervention have not been compiled by the State. The Northern Maine Resource Center has furnished statistics for region II, the Bangor area. In the calendar year 1979, 25 residential placements were lost in region II because of behavior problems exhibited by clients.* Some of these individuals were re-institutionalized at Pineland Center and Levinson Center. Another 25 residential placements were in jeopardy as of January 1, 1980. By the end of 1980 region II will be responsible for 85 to 103 clients (not all of whom are members of the plaintiff-class) who exhibit serious behavior problems.

Nowhere in the State have defendants kept track of the number of program placements lost to members of the plaintiff-class because of similar behavior. In reviewing prescriptive program plans we found examples of what happens when a client behaves in ways that programs are not able or inclined to confront. Crisis intervention is not provided. An exemplary result may be seen in the prescriptive program plan reproduced at page fourteen of this report. Not only was the intensive intervention required by section D.3 unavailable, but also the Bureau failed to provide any type of alternative support to the day-activity center. The client lost the day program to which he was by law entitled. Occasionally one sees interdisciplinary-team recommendations for increased staffing of homes and programs in order to shore up failing placements. Even if such recommendations were carried out, as they rarely are, such actions do not alone fulfill the decree's mandate for "intensive intervention" by "staff with skills in crisis intervention and behavior programming."

The lack of respite care similarly causes community placements to be lost. A retarded person (or even his parents in the case of persons living at home) needs an occasional respite. The State has not compiled specific data on the need for respite care, but we know that the lack of respite-care services is a statewide problem.

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* Such behavior can include self-inflicted injury, aggression, bizarre or delusional behavior, toileting problems, sexual advances, ingesting inedible objects, or socially unacceptable activity. Defendants commonly refer to some forms of this conduct, which is associated with persons' having been confined to custodial institutions, as "institutional behaviors." Such conduct is not a characteristic of persons who are mentally retarded in general. When removed from institutions and provided with intensive therapy in normal, active environments, the relatively few retarded persons who exhibit such behavior can be taught to behave normally. Absent intensive intervention, the easy "solution" is to re-institutionalize the individual, returning him to the context in which his undesirable behavior was acquired and allowed to flourish.

E. DEVELOPMENT OF NEW HOMES

In the report to the court dated November 14, 1979, we presented data showing that the Bureau had developed 125 residential placements during the first decree year. While that total exceeded the 100 minimum placements required by appendix B, section C.8(a), it did not satisfy the requirement of appendix B, section J.1 that plaintiffs be provided with normal homes within one year of the signing of the decree. It means simply that the minimum resource-development quota was exceeded. There is no similar minimum standard for the second decree year. Appendix B, section C.8(b) requires the development of new homes "as the needs of the class demand." "The type and number of placements developed shall be dictated by the needs of the class and the provisions of [the] decree. . . ."

The following table shows the total amount of residential development so far accomplished by defendants:

CLASS MEMBER RESIDENTIAL PLACEMENTS DEVELOPED

July 1978 to February 1980

Region	I	II	III	IV	V	VI	Total State
Group homes	16	16	19	0	25	0	76
Boarding homes	0	7	10	0	0	20	37
Foster homes	4	23	7	5	3	1	43
Nursing homes	0	8	3	3	0	0	4
Apartments	0	0	1	3	0	0	4
TOTALS	20	54	40	11	28	21	174

Based on resource development now in progress, defendants predict that an additional 87 homes will be available to members of the class by July 1980, as follows:

ADDITIONAL RESIDENTIAL PLACEMENTS PROJECTED

February 1980 to July 1980

Region	I	II	III	IV	V	VI	STATEWIDE
Group homes	3	7	12	4	16	6	48
Boarding homes	0	3	0	0	0	0	3
Foster homes	0	1	5	0	0	0	6
Nursing homes	0	0	2	0	0	0	2
Apartments	0	0	1	2	0	0	3
Intermediate Care Facilities (ICF)	0	10	15	0	0	0	25
TOTALS	3	21	35	6	16	6	87

At the present time over 200 members of the plaintiff class live in community homes which show no present promise of complying with the Court's decree. New homes must be developed for these individuals. Additionally, the present census of Pineland Center is 382. Pineland must reduce its population to 350 by July of 1980. This will require the development of 32 community residential placements. Even if defendants successfully complete development of all projected homes by July of 1980, there will remain a deficit of 157 community placements. This figure exceeds the number of community homes developed in the first decree year by 32. It exceeds by 21 the number of homes which will probably be developed during the second decree year. Development of homes is not accelerating rapidly. At the present rate defendants will not have sufficient homes for plaintiffs before the fall of 1981. This figure assumes no reduction of the Pineland census below 350, an untenable prospect for the remaining residents of the institution, many of whom have been recommended for community placement. Simultaneously, defendants will

have to improve the homes of 129 members of the plaintiff-class to bring these homes into compliance. Meeting this goal will certainly require developing new homes because some of the existing homes must be reduced in size. These circumstances set the date for expected compliance with appendix B of the decree well into the future.*

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* Among the primary obstacles to group-home development in this State are the licensing regulations and principles of reimbursement of the Department of Human Services. The Department of Human Services, not the Department of Mental Health and Corrections, has licensing and financing authority over group homes and other publicly supported residences in Maine. Licensing regulations are based on a model of geriatric nursing care or medically sound custodial care in contrast to the decree's programmatic and educational orientation. Human Services' licensing regulations conduce toward promoting mini-institutions.

The Department of Human Services' "principles of reimbursement" govern financing of group homes. Those principles are designed to cover the expenses of providing custodial, not habilitative, care. Even though an expenditure may be unquestionably necessary to meet the requirements of the Court's decree and is reimbursable as defined by the Department of Human Services, it will not be reimbursed if it exceeds a ceiling imposed by the Department quite regardless of actual client needs. Home operators who are concerned with fostering their clients' independence and complying with the decree must resort to such devices as deficit spending financed with their personal funds, invading line-item budgets, and seeking hard-to-obtain credit at costly rates. Salaries for group-home staff are set at minimum wage minus the cost of room and board if provided. On one hand, Human Services' licensing regulations require that staff be present at night; on the other hand, Human Services' principles of reimbursement forbid payment to a home for a ratable share of expenses "attributable" to the presence of house parents. The home is forced to bill its own staff for a proportional share of operating expenses which the staff must pay from their minimum wage. No overtime payments are made although staff may be required by the needs of their clients to be on duty many extra hours per week. These problems are of particular consequence because the Bureau of Mental Retardation has chosen to make nonproprietary, private organizations the chief means for carrying out the Bureau's responsibility of creating an adequate system of community homes.

V. DAY PROGRAMS OUTSIDE THE RESIDENCE

A. DECREE STANDARDS

An essential feature of the court's decree, program activity, is defined as follows:

> [A]ny activity specified in the client's prescriptive program plan that is individually designed and structured to increase the client's physical, social, emotional or intellectual growth and development. [Appendix B, definition 19.]

Each client should receive this activity for a minimum of four hours per weekday. Program activity is to take place outside the client's residence, with exceptions for those residing in four specified ICF homes on July 14, 1978. When outside program is unavailable, defendants are to implement an interim plan which must include community activities, such as social functions, shopping trips, athletic events and meals out, at least twice weekly. There are but two permissible exceptions to these rules. First, a competent client may refuse to receive program; second, a physician may certify in writing that such program would result in medical harm to the client. (See Appendix B, §§ B.7, B.8.)

Compliance with the decree's requirements for program may be evaluated by looking first to the amount of activity provided by defendants. Not all clients receive four hours per weekday of program outside their homes. Not all clients who reside in the four named ICF homes are receiving the four hours of "in-home" program per weekday to which they are entitled. There must be subtracted from this number those to whom a recognized exception is applicable. Some competent clients refuse program or a part of the minimum amount to which they are entitled. A few would suffer medical harm.*

One must consider whether the activity received is, in reality, "activity prescribed in the client's prescriptive program plan." For, if it is not, it is not "program" as defined by the decree. Finally, it must be determined whether activity recommended by an interdisciplinary team "is individually designed and structured" and whether the recommendations of the prescriptive program plan are "based on the interdisciplinary team's evaluation of the actual needs of the client rather than on what programs are currently available in the community." (See Appendix B, § B.4.)

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* Five prescriptive program plans, 1.18% of 425 plans reviewed, made note of such medical harm.

B. FINDINGS

We were not able to obtain accurate figures for the number of clients who are now without minimum program entitlements in time to include the figures in this report. We did determine that statewide 76 members of the class are entirely without program. This number represents approximately 15% of plaintiffs now released from Pineland Center who have not waived their entitlement to program.* This number does not represent the full extent of noncompliance. Not included are persons entitled to receive out-of-home program but who now receive program at their residence and persons attending outside program part-time. Also not included are those class members entitled only to in-home program who currently receive less than four hours per weekday. (Defendants are now conducting a statewide survey of unmet client needs. Accurate figures on the number of class members who do not receive minimally required program will probably not be available before next summer.)

The number of clients who now take part in activity other than that which was recommended by their prescriptive program plans has not been computed. This computation would require a thorough examination of each client's most recent prescriptive program plan and a comparison of that plan with each client's daily program schedule. The comparison was not possible because defendants have not conducted quarterly reviews of program plans. Defendants are not in possession of the great majority of the habilitation plans which interdisciplinary teams have indicated should be prepared and followed. In short, defendants are unable to state the frequency with which interdisciplinary team recommendations for individually designed activity are being carried out.

For illustration, suppose an organization operates a day program in the basement of a municipal building. Staff from the program attend an interdisciplinary team meeting and agree, by signed service agreements, to provide a client instruction in handling money. A habilitation plan is indicated for the task. Day program staff are to write the plan and implement it by a certain date. Target dates for achieving goals are established by the team. The client then attends the day program for five hours per weekday. If no habilitation plans are written, for one reason or another, no one is the wiser. No review is conducted by the Bureau case-worker until many months have passed. Staff at the client's group home may be puzzled; they had agreed at the meeting to increase the client's community contact by taking him shopping. He attends the program each day but still can't count money. The result is that defendants report the client as receiving decree-required program. He is not, even though he attends a day program for five hours each weekday.

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* Who may decline services is an issue which remains open. Approximately 66 plaintiffs are listed by defendants as having declined decree benefits. Included in this number are persons whose parents or guardians have refused to allow provision of services by defendants, including, in some cases, parents of adult class members not under guardianship.

Bureau employees uniformly report that variations of this scenario are fairly routine. There exists no means of quantifying it. When defendants begin to require timely development of habilitative plans and to implement the quarterly review system of monitoring service delivery, this information will be available. (See Appendix B, §§ B.3, E.1, E.2.)

Finally, not all interdisciplinary-team recommendations for program are framed in terms of actual client needs. In such cases, program availability, not client needs, becomes the basis for the team's recommendations. The result is that the client's daily activity, regardless of the amount, cannot be considered "program activity" under the decree. Defendants nevertheless report such activity as "program."

An example of this phenomenon is what happens to clients attending Bangor Regional Rehabilitation Center (known as BRRC, pronounced "brick"). Clients who first attend BRRC are usually deemed appropriate for "work activities" training. Often, this training is recommended by an interdisciplinary team. Work-activities training teaches good work habits such as how to arrive promptly, how to attend to a task, how to manipulate objects purposefully, and so forth. Upon completing this program, a client may be evaluated by vocational-rehabilitation personnel and found appropriate for "work-adjustment" training, which is then recommended by the client's interdisciplinary team. Upon completion of this program, the client may be re-evaluated and found ready for "sheltered-shop" employment. This type of employment is commonly unavailable in the Bangor area. According to Dan Fields, Regional Administrator for the Bureau of Mental Retardation, what may happen next is that the client may be returned to the work-activities training component of BRRC. The client has no need for this training; it has already been successfully completed. But work-activities training becomes the client's "program" because it is the only out-of-home activity available to the client for more than four hours per weekday. Defendants then report that this client is receiving decree-required program.

While Bureau employees admit that these situations occur, getting a reliable numerical figure on the extent of this form of noncompliance is very difficult. In reviewing prescriptive program plans, the Office of the Special Master classified program recommendations which failed to consider actual client needs under category five.* Although this category includes plans which failed to recommend enough program of the proper type, it can be seen that, during the term of the decree, thirty percent of all prescriptive program plans failed to recommend program by decree standards by making these types of error. Over forty percent failed in some respect properly to recommend program. Although it is not possible to determine precisely the amount of activity provided to clients for whom such plans were developed and then reported as "program," it is clear that much of this activity must be discounted in order to determine compliance.

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* See p. 42.

While noting extensive noncompliance with decree requirements for program we also point out that a few excellent programs for the retarded are now operating in every region of the Bureau. These programs provide individualized activities in accordance with properly identified needs. Short- and long-range goals are established for each client, and progress is objectively measured. Such programs do not merely provide diversionary activities but systemmatically prepare their students to participate in more challenging programs. Self-dependency skills are increased. The promise of the decree is being realized by those members of the class fortunate enough to attend such programs. The problem is their small number.

Appendix B requires that defendants monitor the quality of programs made available to the plaintiff class:

> Employees of the defendants or a consultant retained by defendants shall . . . assess the extent to which recommended services are being provided, and evaluate the adequacy of services and programs. Records of such evaluations shall be forwarded to the Director. [Appendix B, § E.2.]

Paragraph J. 1 of the decree contemplates the completion of this evaluation no later than July 14, 1979, but the State has not done it. Defendants are unable to document the quality or quantity of recommended program received by plaintiffs. Defendants plan to have a system of program evaluation in place by this summer. This survey, in combination with the statewide survey of unmet client needs and a more stringent application of the interdisciplinary team procedure of framing program recommendations in terms of actual needs, may begin to yield the true picture of what remains to be accomplished. Only then will defendants be in a position to begin closing the distance between unmet program needs of the plaintiff class and substantial compliance with the order of the Court.

C. DEVELOPMENT OF NEW PROGRAMS

In Part II of the Report to the Court of November 14, 1979, we indicated that 156 new day-program openings had been developed for class members between July 1978 and July 1979. The following table shows the number of day-program "slots" developed for members of the class during the second decree year:

NEW DAY PROGRAM SLOTS DEVELOPED FOR CLASS MEMBERS
July 1, 1979 to March 1, 1980

REGION	I	II	III	IV	V	VI	TOTAL STATE
New program openings	17	16	3	11	8	19	74

This table shows the total amount of program development so far completed by defendants since the decree was entered:

NEW DAY PROGRAM SLOTS DEVELOPED FOR CLASS MEMBERS
July 1, 1978 to March 1, 1980

REGION	I	II	III	IV	V	VI	TOTAL STATE
New program openings	37	49	49	19	30	46	230

Based upon resource development now in progress, defendants predict that an additional 106 program openings will have been created for plaintiffs by July of 1980 as follows:

DAY PROGRAM SLOTS - PROJECTED DEVELOPMENT
March 1, 1980 to July 1, 1980

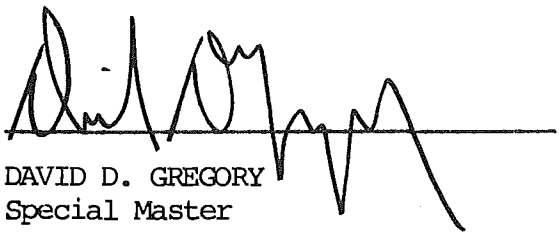
REGION	I	II	III	IV	V	VI	TOTAL STATE
New program openings projected development	17	32	28	4	20	5	106

VI. CONCLUSION

This report is submitted to the Court pursuant to the Court's order of July 21, 1978, "Appointment of a Master."

The Court should be aware that George A. Zitnay is now Superintendent of Pineland Center. Kevin W. Concannon has succeeded him as Commissioner of the Department of Mental Health and Corrections. Ronald S. Welch has been appointed Director of the Bureau of Mental Retardation. Martti Wuori has been placed out of Pineland Center and is now living at the Freeport Towne Square group home; he refuses to go back to Pineland even for a visit.

Respectfully submitted,



DAVID D. GREGORY
Special Master

Dated: April 22, 1980
Portland, Maine

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