JOINT STANDING COMMITTEE
ON
HEALTH AND HUMAN SERVICES

117th Maine Legislature

Majority And Minority Reports
On
REVIEW OF
THE MAINE MENTAL HEALTH SYSTEM

November 22, 1996

Members supporting the Majority Report
- Sen. Joan M. Pendexter, Senate Chair
- Sen. John W. Benoit
- Rep. Glenys P. Lovett
- Rep. Jeffery G. Joyner
- Rep. Jean Ginn Marvin
- Rep. Robert J. Winglass
- Rep. Henry L. Joy

Members supporting the Minority Report
- Rep. Michael J. Fitzpatrick, House Chair
- Sen. Rochelle M. Pingree
- Rep. Birger T. Johnson
- Rep. David Etnier
- Rep. J. Elizabeth Mitchell
- Rep. Kyle W. Jones

M E M O R A N D U M

DATE: November 22, 1996

TO: President Jeffrey H. Butland

Speaker Dan A. Gwadosky

FROM: Senator Joan M. Pendexter, Senate Chair

Representative Michael J. Fitzpatrick, House Chair

RE: Review of the Maine Mental Health System by the Joint Standing Committee on Health and Human Services

You authorized the Joint Standing Committee on Health and Human Services to meet after the Second Regular Session to review the Maine mental health system.

We enclose for your study the majority and minority reports of the committee. Copies of the reports and the materials considered by the committee are on file in the State Law Library.

REVIEW OF THE MAINE MENTAL HEALTH SYSTEM

REPORT OF
THE JOINT STANDING COMMITTEE
ON
HEALTH AND HUMAN SERVICES
OCTOBER 1996

Beginning in June 1996, the Joint Standing Committee on Health and Human Services met regularly to review circumstances surrounding several deaths that occurred in the mental health system earlier in the year, and to report its findings and recommendations to the Legislature and the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services. Heading the list of committee concerns were three main issues: the safety and well-being of AMHI patients; supervision of community-based treatment of non-compliant patients; and the public safety in cases of violent mental health patients.

A legislative investigation was determined to be necessary when neither an internal review nor an "independent" review succeeded in determining accountability and responsibility for the events leading up to the death of Wrendy Hayne, a patient at AMHI. Because state and federal laws protect the confidentiality of patient, medical and personnel records, a great deal of time was spent pursuing legal channels to obtain the information critical to a meaningful evaluation of specific incidents, including the death at AMHI and the two murders in Waterville, and to the development of the Committee's resulting conclusions and recommendations.

The committee was granted access by the court to specific confidential records, and was able to make some progress because of the voluntary testimony of Wrendy Hayne's parents and their release of portions of Ms. Hayne's records. In the absence of subpoena powers and a court order to compel testimony, the Committee was unable to require AMHI and Department employees to testify before the Committee. The confidentiality laws surrounding personnel records remained an insurmountable barrier; future investigations should benefit from changes the Committee recommends in this area. The pending criminal prosecution of the accused assailant in the Waterville murders also stopped Committee efforts to hear testimony in that case.

The Committee takes exception to the conclusion by the McDowell Commission that "... none of the recommended changes, alone or together, might have prevented the tragic outcome in this case [Wrendy Hayne's death]." The committee believes it is **more likely than not** that the death could have been prevented, if, at the time of Wrendy Hayne's death, the recommended changes had been in place and the then-existing policies and laws had been complied with.

RECOMMENDATIONS

Despite the many roadblocks created by confidentiality laws, the Committee was able to reach consensus on the following recommendations:

1. Governing body of AMHI. Revise the governing body of AMHI to include members of the community. These members should be nominated by the Governor and subject to the usual process of confirmation by the Legislature. This should be done within the parameters of State and federal accreditation standards. *Legislation is needed to carry out this recommendation.*

2. Patient advocacy. Using the Long Term Care Ombudsman Program as a model, establish an office of patient advocacy that operates independently from the Department. Families and volunteers from the community should be encouraged to participate. Transfer all current advocacy functions within the Department and contracted for by the Department to the new advocacy program. Fund the new advocacy program with the existing DMHMRSAS budget for advocacy services. *Legislation is needed to carry out this recommendation.*

3. Quality assurance; treatment. Make quality assurance the top priority of the state's mental health system and take a pro-active, aggressive approach to treatment.

4. Accountability and responsibility. Accountability and responsibility for patient treatment must be clearly defined within the institution and in the community.

5. Consent decree. Review the status of the AMHI consent decree with the court-appointed master Gerald Rodman. Clarify remaining mandates and the timeline for completing them. Obtain a progress report on the status of implementation to members of the 118th legislative Joint Standing Committee on Health and Human Services.

6. Legislative oversight. Increase legislative oversight through monthly progress reports and quarterly written reports by the DMHMRSAS to the Joint Standing Committee on Health and Human Services. Review all deaths in the public system within 30 days. Review all serious incidents within public system. For purposes of this recommendation, "public system" means all facilities licensed or serviced by the Department of Mental Health, Mental Retardation and Substance Abuse Services. *Legislation is necessary to carry out this recommendation.*

a. The Commissioner should appoint a serious incident team immediately following a serious incident in the community, similar to the procedure in place for serious incidents within the institutions. The team should report to the Health and Human Services Committee within five days of the incident.

b. DMHMRSAS to report to the Committee all results of its site review of Kennebec Valley Mental Health Agency and recommend changes to current system of contracting and accountability between the Department and community-based agencies.

7. Future direction of mental health services. The Governor should make recommendations regarding the future direction of mental health services and care in institutions and in the community in his 1997-99 biennial budget proposal.

8. Other legislation. In addition to the recommendations listed above, the Committee recommends that the 118th Legislature address the following specific issues:

a. Confidentiality issues - remove impediments to access to information for future investigations;
b. Involuntary commitment procedures;
c. Medication policy in institution-based and community-based services;
d. Death reviews procedure.

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Mental health review by the Health and Human Services Committee
collected documents and information July - October 1996

SUBJECT	TYPE OF DOCUMENT	DESCRIPTION	DATE	SOURCE
AMHI	chart	position count at AMHI, 1995-1997	distributed 9/20/96	DMHMRSAS
AMHI	minutes	AMHI Medical Executive Committee minutes, re: staffing	6/26/96	DMHMRSAS
AMHI	by-laws	AMHI governing body by-laws	distributed 10/7/96	DMHMRSAS
AMHI	policy manual	mandatory reporting protocol: patient injuries; patient to patient incidents; patient sexual behavior; staff to patient incidents; allegations of abuse, neglect, exploitation	distributed 10/7/96	DMHMRSAS
AMHI	list	AMHI review team (McDowell task force) interview list	7/10/96	Donald McDowell
AMHI	letter	selection of Dr. William McFarlane, Chief of Psychiatry at MMC to chair AMHI review panel	7/8/96	DMHMRSAS
AMHI	consent decree plans, letters, analysis	communications re: plan for completing class member assessments and review of assessment plan	4/11/96, distributed 7/26/96	Gerald Rodman, Court Master, Katherine Greason, AAG
AMHI	compilation	AMHI psychiatric records, list of documents separate from medical record, incident reporting process, cover letter	7/26/96	DMHMRSAS
AMHI	letter	description of nonpatient chart documents and their availability	9/13/96	DMHMRSAS
AMHI	memo	list of AMHI staff in April, 1996	9/17/96	DMHMRSAS
AMHI	survey	key survey of New England area psychiatric hospitals	distributed 7/12/96	DMHMRSAS
AMHI	policy	policies for staffing dining room with CPR-certified staff; administration of CPR	1/96, distributed 7/12/96	DMHMRSAS
AMHI	contract and forms	contract between Maine Medical Assoc. and AMHI, standard peer review forms	distributed 10/7/96	Gordon Smith, MMA

SUBJECT	TYPE OF DOCUMENT	DESCRIPTION	DATE	SOURCE
AMHI - licensing	report	letter from federal HHS on AMHI deficiencies as found by DHS along with plan for correction, with transmittal memo	memo: 5/31/96 DMHMRSAS ltr: 5/23/96 USHHS letter: 5/2/96	DMHMRSAS
AMHI - licensing	letter	letter from HHS committee requesting info from DMHMRSAS	4/25/96	committee
AMHI - licensing	letter	letter from HHS committee requesting info from DHS	6/13/96	committee
AMHI - licensing	letters	DHS letter to AMHI re: conditional license because of noncompliance, with cover letter	DHS letter: 6/27/96 cover letter: 7/1/96	DHS DMHMRSAS
AMHI - licensing	letter and plan	letter from Acting Superintendent Bouffard, listing of deficiencies (by JCAHO, McDowell report, HCFS, DHS) and the DMHMRSAS's response or action taken	7/9/96	DMHMRSAS
AMHI - changes	memos	Written reprimands of Kathleen Whitzell and Diane Gilbert	6/25/96, distributed 7/19/96	DMHMRSAS
AMHI - changes	memo	changes taking place at AMHI, key policy	6/21/96	DMHMRSAS
AMHI - changes	memos	directive from Lowell, Gowler and Guilbault to physicians and program service managers: patient levels, sexual behavior policy, safety concerns, advanced directives	5/8/96, distributed 7/12/96	DMHMRSAS
AMHI - changes	memo	response to McDowell Report recommendations, as pertaining to BMHI	6/20/96	N. Lawrence Ventura, Supt., BMHI
AMHI - changes	press release	DMHMRSAS response to recommendations of McDowell task force	6/12/96	DMHMRSAS
AMHI - disciplinary actions	letter	letter re: access to disciplinary action records	7/26/96	Sen. Beverly Miner Bustin

SUBJECT	TYPE OF DOCUMENT	DESCRIPTION	DATE	SOURCE
AMHI - disciplinary actions	letter	reply to request for AMHI disciplinary records	8/1/96	DMHMRSAS
AMHI - disciplinary actions	letter	MSEA position on access to disciplinary action records	8/1/96	MSEA
Behavioral Health Network	letter	discussion of contract, role of Dr. Clark	7/17/96	DMHMRSAS
Behavioral Health Network	letters	letters from Attorney Begel re: contract	7/11 and 7/15/96	DMHMRSAS
Behavioral Health Network	letters, memos and contract	review of BHN contract and position of Dr. Clark by the Office of the Attorney General	7/24/96	Office of the Attorney General
Behavioral Health Network	compilation, brochure, descriptive materials	cover letter, details of BHN organization and activities, assessment form, info about the network, its purpose, service locations, member providers, services,	8/1/96	Grete Chandler, BHN
Behavioral Health Network	memo, executive order, rules	proposal for class member assessments, procedures and rules for contracts, grants and appeal of contracts, grants	distributed 8/2/96	BHN
Behavioral Health Network	letter	request that BHN seek a refund from Dr. Clark	8/19/96	DMHMRSAS
Behavioral Health Network	articles of incorporation	articles of incorporation of BHN as nonprofit corporation	distributed 9/13/96	BHN
Behavioral Health Network	chart	AMHI consent decree class member assessment statistics by region	9/6/96	DMHMRSAS
Behavioral Health Network	chart	AMHI consent decree class member assessment statistics by region	9/13/96	DMHMRSAS
DMHMRSAS	list	list of advisory groups or councils to DMHMRSAS	distributed 10/7/96	DMHMRSAS
DMHMRSAS	memo	background information on advocacy structure and funding	9/25/96	committee
DMHMRSAS	budget categories	summary by category of service and listing of agencies, as of 1/1/96	distributed 10/7/96	DMHMRSAS
DMHMRSAS	lists	DMHMRSAS agencies, funding and short descriptions	distributed 10/7/96	DMHMRSAS
DMHMRSAS	contract	contract with Liberty Healthcare	distributed 10/7/96	DMHMRSAS
DMHMRSAS	booklet	Rights of Recipients of Mental Health Services	distributed 7/96	DMHMRSAS

SUBJECT	TYPE OF DOCUMENT	DESCRIPTION	DATE	SOURCE
DMHMRSAS	vision statement and plans	progress towards a community-based system of care	distributed 7/19/96	DMHMRSAS
DMHMRSAS	memo	description of organization, duties and budget of Office of Advocacy	distributed 10/7/96	DMHMRSAS
DMHMRSAS	summary	information on out of state placements, contracts with agencies	distributed 7/25/96	DMHMRSAS
DMHMRSAS	list	listing of membership of Quality Improvement Councils	distributed 10/7/96	DMHMRSAS
DMHMRSAS	list	members of AMHI and BMHI Quality Improvement Councils	distributed 10/7/96	DMHMRSAS
Health and Human Services Committee work	memo	statement of mission and goals	adopted 7/12/96	committee
Health and Human Services Committee work	letter	letter from Attorney General Ketterer to Governor King re: employee testimony before the committee	9/19/96	Andrew Ketterer, Attorney General
Health and Human Services Committee work	article	mental health records confidentiality article	5/96	committee
Health and Human Services Committee work	letter	letter from Governor King re: committee work	9/20/96	Governor Angus King
Health and Human Services Committee work	list	options for governing boards of state psychiatric institutes	distributed 10/7/96	Dr. Steven Katz
Health and Human Services Committee	list	outline for discharged medical records	distributed 10/7/96	Dr. Steven Katz
KVMHC	critical incident review	process and results of review, plans	6/10/96	DMHMRSAS
KVMHC	letter	denial of access to confidential records; special events information	6/20/96	Stephen O'Donnell, Esq.
KVMHC	testimony	testimony of John Shaw, Exec. Director, KVMHC	7/26/96	John Shaw, KVMHC
KVMHC	letter and materials	Clozaril case statistics; policies and procedures concerning Clozaril use and monitoring; job description of Clozaril case manager; Clozaril monitoring	8/1/96	John Shaw, KVMHC

SUBJECT	TYPE OF DOCUMENT	DESCRIPTION	DATE	SOURCE
KVMHC	letter, memos	information re: Clozaril, protocols for monitoring medication	8/1/96	John Shaw, KVMHC
KVMHC	plan	plan for site visit of KVMHC by DMHMRSAS	distributed 8/23/96	DMHMRSAS
KVMHC	draft, report	report of site visit	distributed 11/15/96	DMHMRSAS
KVMHC	letter and attachments	KVMHC confidentiality agreement; coordinated services form; emergency alert procedures; Clozaril testing procedure clarification; Clozaril statistics;	8/8/96	KVMHC
Maine Task Force on Mental Health	list	members of task force	distributed 7/12/96	Governor King
Maine Task Force on Mental Health	Executive order	Executive order creating the Maine Task Force on Mental Health	5/20/96	Governor King
Maine Task Force on Mental Health	report	report of the Maine Task Force on Mental Health	10/22/96	DMHMRSAS
Wrendy Hayne	letter and draft court order	draft order to release McDowell report, report of McDowell task force to Commissioner Peet regarding the death of Wrendy Hayne	distributed 6/6/96	DMHMRSAS, Office of the Attorney General
Wrendy Hayne	waiver form	waiver signed by Janice Burns	8/16/96	committee
Wrendy Hayne	cover letter, two reviews	memo re: reviews of death of Wrendy Hayne	reviews dated 5/1/96, 6/22/96; memo dated 8/30/96	DMHMRSAS
Wrendy Hayne	letter	letter from Lawrence Bloom, Esq., re: patient records	9/5/96	L. Bloom, Esq.
Wrendy Hayne	letter	letter from Lawrence Bloom, Esq., re: patient records	9/13/96	L. Bloom, Esq.
Wrendy Hayne	letter	notice of claim of suit against the State and employees	9/27/96	E. Mehnert, Esq., and L. Bloom, Esq.
Wrendy Hayne	letter, petition, orders	cover letter, petition to authorize release of confidential records, order, supplemental order	8/15/96, 8/30/96, 9/19/96	Office of the Attorney General

SUBJECT	TYPE OF DOCUMENT	DESCRIPTION	DATE	SOURCE
Wrendy Hayne	letter	letter re: release for public review of medical records	9/20/96	L. Bloom, Esq.
Wrendy Hayne	poem	poem	undated	Janice Burns
Wrendy Hayne	letter	description of requested nonpatient records and why they are not available	9/20/96	Office of the Attorney General

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MAINE STATE LEGISLATURE
Augusta, Maine 04333

REPORT AND RECOMMENDATIONS OF THE DEMOCRATIC MEMBERS TO THE JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

Review of Department of Mental Health and Retardation
September 20, 1996

Background

Since the beginning of 1996, there have been a series of tragedies and events that have created questions about the management of Maine's mental health system. In June, the Committee met to discuss their role in providing accountability and oversight over the Department of Mental Health and Retardation (DMHMR). On July 12, 1996, the Committee adopted it's Mission and Goals (attached) and began a process that involved weekly meetings and hearings into the operations of the Department and it's response to recent tragic events. Although the work of the Committee was scheduled to end September 1, 1996, the Committee has met three times in September. Now the Committee on Health and Human Services has completed it's mission and goals and makes the following findings and recommendations.

Findings

System Problems

- The current mental health delivery system is in trouble and the Department's response has been slow and inadequate.

- Years of neglect, downsizing, funding cuts, and the lack of a comprehensive vision of an effective mental health delivery system are responsible for the chaotic system that now exists. The turnover in Commissioners has played a clear role in the lack of vision and leadership. These problems are long standing and can not be placed on one person.

- The mental health delivery system has been characterized by a lack of communication, coordination and cooperation among mental health service providers. There was very little monitoring of clients of mental health services who live in the community. As a result, the risk of tragedies and accidents was great.

- Inadequate departmental auditing and monitoring of services provided by community mental health service providers has resulted in an inability to measure and determine the adequacy, effectiveness, and timeliness of mental health services. This has jeopardized quality of care and access to care.

- There isn't a reliable central hot line which Maine citizens can use to report serious problems, emergencies, or threats to the public which involve mental health clients. There is no central telephone number that mental health clients or their families can use to obtain immediate help.

AMHI Problems

- AMHI lacks leadership from it's top administrators. There is a culture or environment at AMHI that differs substantially from the environment of Bangor Mental Health Institute (BMHI) and hospitals in general. It is clear that at AMHI, the structure necessary to run a high quality health care facility was lacking.

- The culture at AMHI is characterized by a sense of employee powerlessness, low morale, fear of criticizing institutional policies and procedures, a top-down approach to operations, and instability with respect to treatment and services.

- The staffing problems, especially with the wide spread practice of using *locum tenens, (*temporary doctors) interfered with the collaboration of treatment teams and seriously jeopardized the continuity of care.

- There was an overall lack of accountability and inadequate supervision.

- There was a lack of security.

- Standard operating policies and procedures at AMHI were disregarded on occasion.

- Record keeping was sloppy and inaccurate.

- For some families of patients at AMHI, particularly those who are assertive and actively involved in the treatment of their family members, AMHI officials and supervisors were described as not communicative and not helpful.

Improvements to the Mental Health System Made by the 117th Legislature

Recognizing the tragic flaws in Maine's mental health system, the 117th Legislature in its Second Session reorganized the system and added new services that will build on existing emergency and outreach programs. These changes were the result of the DMHMR's AMHI Consent Decree Plan to Justice Nancy Mills, as well as LD 1704 and LD 1764.

LD 1704, which was passed by the Health and Human Services Committee by a unanimous vote, significantly reorganizes the Department into seven geographic dispersed regional entities. Each region will have a citizen council (Quality Improvement Council) that will participate with DMHMR in planning case management, medication management, treatment, in-home supports and rehabilitation programs and dedication management.

These reforms will also ensure that outcome based assessments on all service providers will be used as the basis for funding decisions. It also ensures that moneys saved by downsizing or reorganization within the Department will be reinvested to fund service for persons with mental illness.

The Legislature **added $8.2 million in new funding** generated by the supplemental budget coupled with the reinvestment of savings which will create "bridge" funding to:

- Create an integrated crisis service system statewide which will include, at a minimum, a crisis phone line, 24 hour mobile outreach, crisis stabilization, residential and respite capability, 24 hour walk-in site and triage capacity, 24 hour psychiatric back-up, in-home service, and wrap-around capacity and access to acute hospitalization including involuntary capacity. Phone services, mobile services, triage and psychiatric services will be located in a single organization or agency.

- Develop additional emergency involuntary hospital beds

- Maintain positions at AMHI and BMHI through January 1997 to ensure a smooth transition to the new programs

- Add case worker to staff intensive case management programs and Assertive Treatment Teams (ACT) for individuals who may require daily support for purposes such as medication management.

Immediate Action Required

The Committee has gone as far as it can with available information. The Committee has received all reports, documentation, and papers requested from the Department. Further information is covered by confidentiality laws, and won't be made available to the Committee.

State and federal confidentiality laws protect all recipients of medical services with strict confidentiality provisions. These laws protect all recipients of mental health services as well. With the exception of the Burns family, there are no other patients or guardians who are willing to publicly disclose their personal medical records. To go further will jeopardize the state's case in prosecuting Harold Pulsifer and may jeopardize the state's ability to prosecute any other potential defendants in these cases.

Further meetings and publicity will jeopardize the State's ability to successfully prosecute defendants in the cases coming to trial.

It is time to end this investigation and concentrate on improving the system for the future.

Recommendations:

Committee Democrats make the following recommendations.

1. The Department must report to the Committee on it's continuing efforts to implement all recommendations of the McDowell Commission's Report, as well as comply with all conditions and time-lines from state and federal reviews of AMHI (JAICO, HCFA, DHS).

The Commissioner must:

- Make a final decision on the role and mission of AMHI and ensure and demonstrate that adequate community services are in place before further downsizing or closure occurs.
- Take immediate action to see that AMHI is in compliance with all current policies, such as proper notification to all legal guardians of any action taken in regards to patients.
- Dismiss all senior clinical management staff who were in charge at the time of the Haynes' death.
- Make Quality Assurance the top priority of the state's mental health system and take a proactive, aggressive approach to treatment issues.
- Ensure that communication and collaboration between units at AMHI is occurring and ongoing.
- Ensure that effective staff development and training takes place.
- Develop and implement policies, procedures and practices of working collaboratively with the families of patients at all state institutions and for all state funded services.
- Ensure that all criminal laws are enforced at state institutions and that there is communication and cooperation with local police and law enforcement.
- Creation of a Serious Incident Team (SIT) to take immediate action when a serious incident or death takes place. The SIT will conduct an audit of all agencies involved in the incident and connect with police, family members, and the community. The SIT Team will report to the Health and Human Services Committee within five days of the incident.

2. DMHMR will present to the Committee all results of the Department's Site Review of Kennebec Valley Mental Health Agency and make any recommendations for changes to the current system of contracting and accountability between the Department and community based agencies.

- The Department will comply with all state efforts to move towards performance based budgeting as soon as possible.
- Community based agencies will agree to cooperate with the Serious Incident Team in all investigations..

3. DMHMR must complete it's Systems Review of mental health services in the Waterville area and make recommendations for improving on the cooperation and collaboration among and between community based services for the mentally ill.

The Department must establish a well publicized, reliable, state-wide hot-line for citizens and mental health clients and their families to use in emergency situations and to obtain help.

4. DMHMR must present a progress report to the Health and Human Services Committee by November 22, 1996 on the implementation of the Department's Reorganization of services including but not limited to:

- New 24 hour Crisis Services
- Community collaboration among mental health service agencies and other effected community services i.e.) police, hospitals , homeless shelters, municipal offices, county jails, etc.
- Quality Improvement Councils
- Provider Service Networks
- Negotiations and written agreements with community hospitals on voluntary and involuntary committal.

5. Suggestions for the 118th Legislative Session

- Review of the state's Confidentiality laws.
- Review of Patient's Rights Laws and Committal Laws including the option of "Community Committal"
- Review of oversight responsibilities of Committees of Jurisdiction
- Determine adequate funding source for outpatient mental health services for uninsured and work with Maine Judicial system to avoid sentencing of uninsured people to (outpatient) services that are not available to them.
- Recommend that the Corrections Committee and the Health and Human Services Committee work together to develop a plan for collaboration between the Department of Corrections and DMHMR

MISSION AND GOALS OF JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES IN REVIEW OF MENTAL HEALTH DEPARTMENT:

1. Provide a review of the five recent deaths (Haynes, Cunningham, Pulsifer, Bechard, and Lee cases) to determine the circumstances of those tragedies, define what led up to them, and to relate the findings to an analysis of the mental health delivery system.

2. Determine what policies were in place, but not followed, and what policies are needed to establish accountability and safety.

3. Review what has been done to address problems previously identified.

4. Review and recommend the need for disciplinary action if appropriate.
   - get advise from Attorneys in office Employee Relations.

5. Review laws around confidentiality issues and ascertain changes to better protect the public if necessary.

6. Ensure positive changes for future directions including review of contracts between the Department and mental health service providers, and accountability for services rendered to those in care of the Dept.

7. Review any relevant legislation for consideration by the 118th Legislature including but not limited to, issues surrounding violence of some mental health clients toward the public, public safety, treatment for noncompliant patients, and commitment laws.

8. Finish date of September 1, 1996.

Approved 7/12/96