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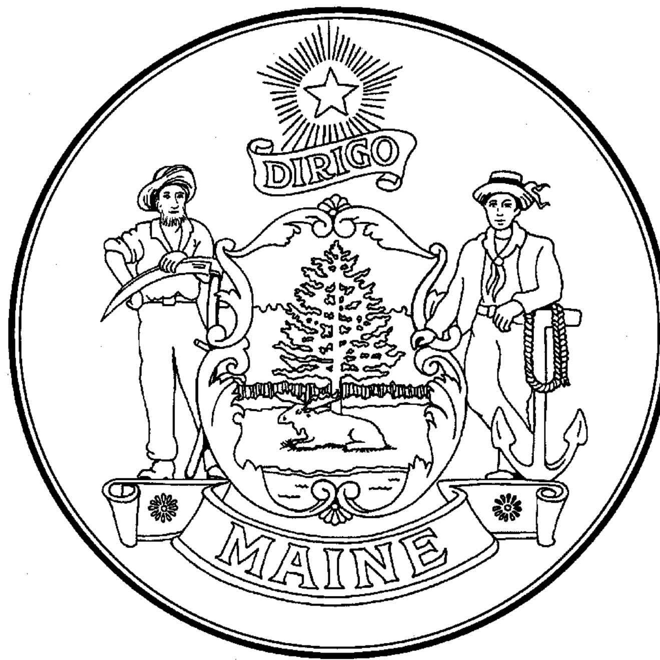

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ON
HEALTH AND HUMAN SERVICES

117th Maine Legislature

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

November 22, 1996

Appendix 2

NOV 28 1996

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

June 27, 1996

RECEIVED
JUN 27 1996
OPLA

The Honorable Joan Pendexter, Senate Chair
The Honorable Michael Fitzpatrick, House Chair
Health and Human Services Committee
State House Station 115
Augusta, ME 04333

Dear Senator Pendexter and Representative Fitzpatrick:

I am writing in response to your letter of June 13, 1996 requesting copies of communication or correspondence between the federal Health Care Finance Administration, the Department of Human Services and the Department of Mental Health, Mental Retardation and Substance Abuse Services pertaining to recent inspections and compliance with federal and state certification standards at the Augusta Mental Health Institute. It is my understanding that the correspondence of May 17, 1996, which I forwarded to your attention on May 23, 1996, is the only correspondence that has been exchanged between the above entities. I will immediately forward to you any further correspondence between the Health Care Finance Administration, the Department of Human Services and the department.

On a different note, and at the request of your committee, I am enclosing a copy of a memo from Larry Ventura, Superintendent of the Bangor Mental Health Institute and Acting Superintendent of the Augusta Mental Health Institute, which responds to the Bangor Mental Health Institute's status regarding the McDowell Report's recommendations concerning the Augusta Mental Health Institute. I am also including a list of Quality Improvement Council members designated by category.

Please feel free to contact me if you have questions.

Sincerely,

Katie Fullam
Assistant to the Commissioner

PRINTED ON RECYCLED PAPER

PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

PROGRESS TOWARDS A COMMUNITY-BASED SYSTEM OF CARE: HIGHLIGHTS:

- **The Department's vision is one in which all Maine's citizens with disabilities have the highest possible quality of life in their local communities. Significant action steps have been taken during the last 18 months toward accomplishing this vision.**

- **We are moving into community based care rather than treating people in institutions, away from their friends, families and communities.**

  - Pineland has been successfully closed, and people with mental retardation now live and are supported by a network of services based in local communities.

  - During the past year, over 70 long-stay patients from AMHI have found homes in the community, with appropriate supportive services.

  - The Bath Children's Home is being replaced with community-based services for high-risk and homeless adolescents.

  - The reinvestment account established by the Legislature , with the flexibility it provides, has initiated a significant shift of resources from hospital to community.

- **We are structuring an integrated, accountable, coordinated, effective and efficient network of services for adults and children in each regional area, so people know where to go in their local community to get help, and providers will be accessible and accountable to citizens locally.**

  - Fiscal resources and staffing have been put in place to implement needed changes over time:

  Regional Directors have been hired in each region, providing a single point of coordination and accountability for mental health, mental retardation, children with special needs, and substance abuse services. Regional offices are located in Bangor, Augusta and Portland.

  A Medical Director for each regional office will be responsible for upgrading the quality of clinical care offered in community mental health programs.

  Mental Health Team Leasders in each regional office are available to solve problems that arise in the local mental health service system.

  New Mental Health and Mental Retardation Program Managers in central office have been hired to be responsible for statewide standards of care.

- Seven local service areas and nine "Quality Improvement Councils" have been established, providing a structure through which Maine citizens can have direct input into planning and monitoring their local mental health system.

- New quality assurance and evaluation systems are being developed to ensure that advances in mental health treatment are implemented and that providers are held accountable for meeting basic standards of care.

- Substance abuse services are being integrated with other services, making it easier to ensure that people with more than one diagnosis receive coordinated care and treatment.

- **For the first time, "core services" are mandated in all localities to meet the needs of people with serious mental illness, whether or not they are covered by the AMHI Consent Decree. Core services include housing, case management, outpatient/medication management, crisis services and rehabilitation.**

Supervised and supported housing arrangements have expanded rapidly.

- In the past 18 months, 24-hour staffed residential units have increased by 23% (from 192 to 237); subsidized apartments by 44% (from 119 to 172); and subsidized housing vouchers by 678% (from 56 to 436).

- Major outreach efforts have been initiated to locate people who are not currently engaged in services and provide them access to safe, decent and affordable housing and other necessary services.

- An $8 million dollar bond has become available to support housing development for mentally disabled individuals.

- New program models are being developed and tested for difficult-to-serve individuals, including people who have experienced chronic homelessness and those who have both mental illness and substance abuse disorders.

Crisis response programs are working with law enforcement personnel to provide a more effective "safety net" in a growing number of Maine communities.

- A 24-hour crisis system for persons with mental retardation has been implemented, with 3 regional programs already in operation, 40 new statewide crisis workers, a 24-hour counseling crisis hotline, and a total of 8 crisis beds in Bangor, Biddeford, Aroostook county, and to be developed in the Tri-County area.

- Outreach and home-based education is now available for people with mental retardation, their family members, agency staff and significant others.

- Proposals have been developed in Cumberland and York Counties for comprehensive crisis services.

- Contract negotiations are underway with community hospitals for further development of community beds for acute inpatient care.

- "Ride-along" programs and other joint efforts between mental health and law enforcement personnel are being implemented in a number of communities, based on successful local priorities.

- DMH/MR/SAS is working with the Department of Corrections to improve mental health services for youth served at the Maine Youth Center while they are at the Center and when they return to their home communities.

<u>A comprehensive approach is being taken to meeting the needs of trauma victims in the mental health system. People who have previously been unable to find help anywhere are beginning to feel hopeful, often for the first time.</u>

- Nearly 80 survivor/consumers and 70 professionals with specialized expertise are presently meeting regularly across the state to identify treatment options, services and resources appropriate for persons in the mental health system with histories of traumatic abuse. Educational and training interventions are being implemented at various sites in preparation for a statewide training initiative beginning in 1997.

<u>Medication Monitoring</u>:

- DMH/MR/SAS is working with DHS to use Medicaid pharmacy data to monitor medication utilization practices as a quality assurance tool.

<u>Case Management</u>:

- Eight Consent Decree Coordinators have been hired and charged with ultimate responsibility for ensuring that services are available for the 3,200 individuals covered by the Consent Decree.

- Twenty new case workers have been added to the community mental retardation system to provide better services by lowering the number of individuals on each worker's caseload.

- Six Assertive Community Treatment Teams have been established to provide multi-disciplinary treatment and interventions for people with serious mental illness who have high levels of functional impairment and who need intensive skill training and support. Three more teams are planned for FY97.

- Sixty Intensive Clinical Case Managers/Outreach Workers will be hired during the fall and winter of FY97. They will receive specialized training and ongoing supervision to enable them to work effectively with people who have serious mental illness and who are traditionally hard to interest in receiving services, such as people who are homeless and those who are involved in the criminal justice system.

Rehabilitation:

- An Office of Consumer Affairs has been developed, and recruitment and hiring efforts are near completion. This office will provide a focus on meaningful work and full participation for people with disabilities.

- Efforts are underway to train and hire people in recovery from serious mental illness and those who are successfully coping with the challenges of their disabilities to serve as "peer counselors" and role models for others.

- DMH/MR/SAS is working with local business leaders and with the Departments of Labor and Economic Development to explore ways of stimulating local economies and simultaneously increasing job opportunities for people with disabilities.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

July 26, 1996

1. **Out of State Placements**

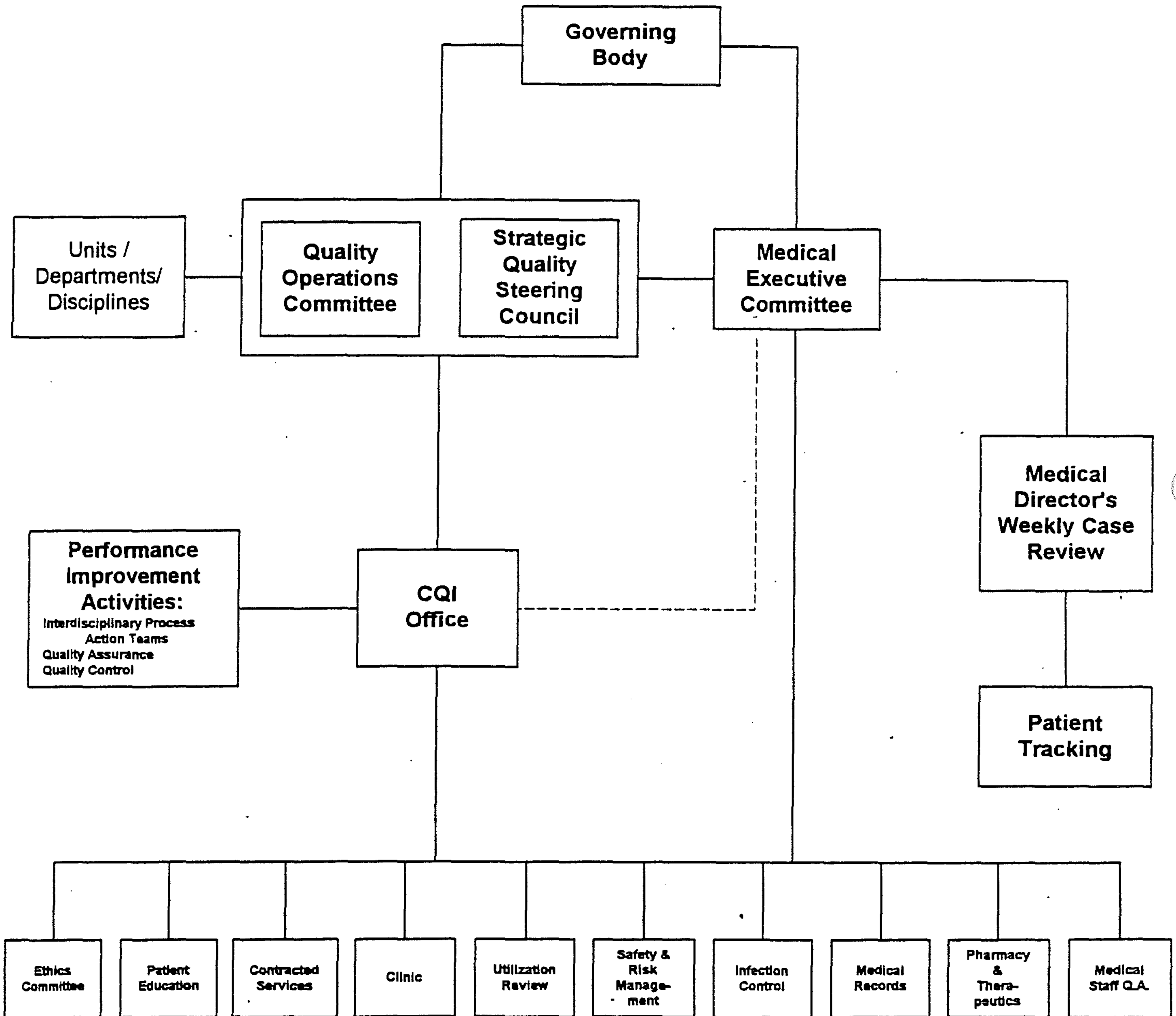
2. **Adult Mental Health Cycle/Procedure**

3. **FY96 Summary of Contacted Services**

4. **Sample Contract - Mid-Coast Mental Health Center - FY96**

5. **Sample Contract (Performance-based) Mid-Coast Mental Health Center FY97**

Augusta Mental Health Institute
Performance Improvement
Information Flow



Revised 7/96

ADDENDUM #2

Continuity of care

The following steps are in place to ensure treatment continuity on units with locum tenens psychiatrists:

1. All new locum tenens physicians meet with the Assistant to the Medical Director for orientation to general hospital policies and procedures. New physicians then meet with Unit Program Service Directors who provide them with introductions to unit staff and procedures. The Unit Program Service Director ensures that each new psychiatrist has an opportunity to meet with the psychiatrist already on the unit early in the orientation procedure.

2. Each patient is assigned to a stable multidisciplinary team including a primary nurse and social worker/team coordinator who manage the case from admission through discharge. When a new locum tenens psychiatrist is assigned to the team, the nurse and social worker are already familiar with the patient's history and treatment plan, and can respond to questions and developing issues.

3. In addition, the medical physician and clinic nurse are available to familiarize the locum tenens psychiatrist with any medical issues.

4. When leaving AMHI, each locum tenens psychiatrist writes a thorough off-service noted intended to provide the new psychiatrist with a summary of important clinical issues, treatment problems to date and anticipated plan. Before leaving, each locum tenens psychiatrist is encouraged to speak with the new psychiatrist by telephone to discuss any particularly critical cases or anticipated problems. In addition, the locum tenens psychiatrist who is leaving meets with the psychiatrist who is staying on the unit to thoroughly discuss clinical issues pertaining to his/her patients.

5. Within the limitations of the new Comp Health contract, all new locum tenens psychiatrists will serve for a minimum of three months at AMHI. According to the attached schedule (Addendum #3), two physicians will be serving for periods of two months. All others are serving for at least three months and several have been at AMHI for more than one rotation. Schedules on each unit are staggered so that each new psychiatrist can meet with a psychiatrist who has already been on the unit for a period of time.

6. Continuing oversight is provided by the Medical Director who reviews all critical cases in weekly Medical Director Review meetings, in addition to being available for case consultation. Additional oversight is provided by the Director of Clinical Operations who runs the Daily Tracking Meeting and who can ensure that critical cases are brought to the attention of the Medical Director, immediately if necessary, or at the weekly Medical Director's Review.

All quality of care issues identified in the weekly Medical Director's review are referred to the Medical Executive Committee for consideration and any necessary action.

Addendum # 1

APPLICATION FOR REAPPOINTMENT

TO AMHI MEDICAL STAFF

The Medical Director has the overall responsibility for the Medical Staff appointment and reappointment.

1. 60 days prior to renewal date an application for renewal of Medical staff privileges will be provided to the applicant by the Medical Directors office.

2. 60 days prior to renewal date the Medical Directors office will begin the <u>verification</u> process.

   A. Written verification from the Maine Board of Registration of Medicine/Board of Osteopathic Medicine, of current licensure.

   B. Query National Practitioner Data Bank report.

   C. Current D.E.A. certificate.

   D. Copy of Maine State License

   E. If appropriate

      Medical School Residency, etc.

   F. Proof of liability insurance face sheet, when required will be provided.

3. Medical Directors office will obtain 2 professional and personal written references on applicant. A written summary will be prepared for telephone reference checks..

4. The Medical Director review application, clinical privileges, QA findings, peer review, treatment results and supervisory review along with verified material.

5. The Medical Director reviews and concurs with clinical privileges requested. If non-concurrance needs to be discussed with applicant.

6. Medical Director reviews completed file then brings his recommendation concerning the application for appointment to Medical Executive Committee for recommendation.

7. Medical Executive Committee recommendation then goes to Governing Body for approval.

APPLICATION FOR APPOINTMENT

TO AMHI MEDICAL STAFF

The Medical Director has the overall responsibility for the Medical Staff appointment and reappointment process.

1. Potential applicant provides a current C.V.
2. Preliminary interview of applicant by Medical Director or a senior physician as designated. This may be done by telephone with approval of Medical Director with MFR.
3. Application kit is given to the applicant with a cover letter that states this process could take 90 days to 120 days to complete with privileges requested.
4. Application is reviewed by the Medical Director's staff to assure that the application is complete. Incomplete applications will be returned to the applicant for completion..
5. Medical Director reviews the completed application - provides guidance whether to continue with process. (Medical Director's questions may need further investigation/evaluation)
6. In addition to a completed application form the applicants file will contain the following documents:
   - A. Written verification from the Maine Board of Registration of Medicine/Board of Osteopathic Medicine, of current licensure
   - B. Query National Practitioner Data Bank report
   - C. Current D.E.A. certificate
   - D. Copy of Maine State License

E. If appropriate

Medical School Residency, etc

F. Proof of liability insurance, face sheet, when required will be provided.

7. Medical Director's office will obtain (2) professional and personal references on applicant. A written summary will be prepared for telephone reference checks.

8. The Medical Director reviews and concurs with clinical privileges requested. If non-concurrence needs to be discussed with applicant.

9. Medical Director reviews completed file and brings his recommendation concerning the application for appointment to Medical Executive Committee for recommendation.

10. Medical Executive Committee recommendation then goes to Governing Body for approval.

July 11, 1996

Dr. Roger Wilson
Augusta Mental Health Institute
Hospital Street, Box 724
Augusta, ME 04332

Dear Dr. Wilson:

Pursuant to our recent conversations I have compiled and enclosed a tentative schedule for long-term (6-month minimum) coverage for Augusta Mental Health Institute through June 1997. I also have a tentative schedule outlined through December 31, 1997, but because of the present political upheaval and the governor's intent of facility closures in summer of 1997, I felt the most immediate need was for the next 12 months.

Again, I reaffirm my position that most of these long-term physicians have provided Augusta Mental Health Institute coverage before and have a truly vested interest in the well-being of the staff and patients there. The past experience of these physicians and their established relationships with staff and patients will be critical to the welfare of the hospital, especially with the impending closure.

CompHealth has appreciated and enjoyed our long-standing relationship and hopes to continue providing quality coverage to you through these times of uncertainty. We also regard you as old friends and do have a personal commitment to our friends at Augusta Mental Health Institute. Our physicians feel the same way.

All of the physicians listed in the attached schedule are very well aware of the situation at Augusta Mental Health Institute and are sensitive to your unique needs at this time. If the worst scenario occurs and the hospital is forced to close, we will be there to assist you until the last patient is transferred.

Three years ago we had a long standing contract with Central State Hospital. They experienced the same situation and were forced to close. I t was painful for the staff and patients. Our physicians worked through low morale and difficult circumstances to care for the patients when all staff was gone.

4021 South 700 East, Ste. 300 ■ Salt Lake City, UT 84107 ■ Telephone 800-453-3030 ■ Facsimile 801-264-6464

AUGUSTA MENTAL HEALTH INSTITUTE
LOCUM TENENS SCHEDULE

Physicians in bold type have provided previous coverage at AMHI.
Underlined physicians are new to AMHI but will return for further coverage.

JOB #1

6/10/96-11/1/96	**Boris Kconikow**	
11/4/96-1/3/97	**Alfred Strauss**	
1/6/97-3/28/97	Eugene Randall	Would return in the fall of '97
3/31/97-6/27/97	**John Steinhilber**	Would also return in '97

JOB #2

4/22/96-8/9/96	**Jason Kirkpatrick**	Will repeat rotation in '97 in 3-month intervals
8/12/96-8/30/96	**John Mogan**	To fill in for Kirkpatrick
9/2/96-11/15/96	**Jason Kirkpatrick**	
11/18/96-2/28/97	Anselm Schurgast	Will return in '97
3/3/97-5/30/97	Joseph Heaney	Will return in fall of '97

JOB #3

7/8/96-8/30/96	**Martin Keeler**	
9/2/96-5/31/97	John Morris	Will need occasional time off to be filled from options below *

JOB #4

6/3/96-7/19/96	Milton Hirschberg	
7/22/96-9/27/96	Abelardo Negrete	
9/30/96-12/20/96	**Jozef Safier**	
12/23/96-1/3/97	* see below	
1/6/97-3/28/97	Louis Noltimier	
3/31/97-6/27/97	**Kent Eller**	

(CONT'D)

CommHealth

JOB #5

Present to 6/27/97	John Arness	Will continue his rotation with 2-week breaks every four months to be filled with Chandra Lal (as it has been in the past)

JOB #6

7/15/96-8/9/96	Candidate replacing Weston, to be named	
8/12/96-10/23/96	David Jendusa	
10/24/96-1/3/97	**Alfred Strauss**	Or possibly David Jendusa returning after a short break
1/5/97-3/28/97	**Keith Chapman**	
3/31/97-6/27/97	Joseph Heaney	Would return in fall for 3 months

JOB #7

7/1/96-9/13/97	Michael Hitz	
9/16/96-1/3/97	Kyle Johnson or Robert Bort	
1/6/97-6/27/97	**Hudson Bates**	Or 1/6-3/28 **Hudson Bates**, and 3/31-6/27 Robert Bort or Kyle Johnson

* Two- to four-week fill-in physicians (these physicians are well established in the AUGUSTA MENTAL HEALTH INSTITUTE system and have provided repeated coverage)

John Mogan
Robert Spitzer
Richard Rawson
Martin Keeler

Alfred Strauss
Michael Sheard
Joan & Gerald Roskin
Elisabeth Small

MEDICAL DIRECTOR ORIENTATION:
(WEEK ONE)

ATTEND HOSPITAL ORIENTATION (SEE ATTACHED) ORIENTATION SCHEDULE WILL BE ADAPTED TO FACILITATE THE FOLLOWING:\\

DAY ONE:

1. 8 AM: MEET MEDICAL DIRECTOR OFFICE STAFF AND GET ACQUAINTED WITH OFFICE OPERATIONS/ SCHEDULING/KEYS ETC.

2. 9-11AM: TOUR OF THE FACILITY- INFORMALLY MEET CLINICAL STAFF ON EACH UNIT.

3. LUNCH WITH MEMBERS OF THE MEDICAL STAFF

4. 1-4 PM MEET WITH ROGER WILSON, ACTING MEDICAL DIRECTOR TO REVIEW MEDICAL STAFF BYLAWS AND DEPARTMENTAL POLICIES.

DAY TWO:

MEET WITH BILL LAJOUSKY AND FOLLOW THE ORIENTATION PLAN FOR ALL PHYSICIANS.

DAY THREE:

CONTINUE WITH HOSPITAL ORIENTATION AND ATTEND MEDICAL STAFF MEETING AT 12 NOON AND CLINICAL CASE CONFERENCE AT 1:30 PM.

DAY FOUR:

SHADOW ROGER WILSON FOR THE DAY.

DAY FIVE:

CONTINUE WITH HOSPITAL ORIENTATION

(WEEKS TWO THROUGH SIX)

COMPLETE HOSPITAL ORIENTATION. BEGIN DEPARTMENTAL ORIENTATION(EXAMPLE ATTACHED, ENTITLED TRAINING SCHEDULE).

CONTINUE TO MEET WITH ROGER WILSON WEEKLY UNTIL ORIENTATION COMPLETED.

TRAINING PLAN

COURSES	DURATION	PRESENTING
Overview of TQM, Values, Vision (AMHI CQI Plan)	1/2 day	Rod Bouffard, Linda Moulton
UR/QA	1/2 day	Linda Moulton
Patient Rights	1/2 day	Lisa Manwaring, Gerry Daly
LSA's and New System Initiatives	1/2 day	Katherine Guilbault, Richard Michaud
Treatment Planning	2 hours	Ann Leblanc
Customer Service / Patient Satisfaction	2 hours	John Greene, Scott Dow, Ann LeBlanc, Irene Begin
Client-Directed Treatment	3 hours	Coni Kalinowski, MD
Consent Decree	2 hours	Carol Trottier
Staffing	2 hours	Katherine Guilbault
Affirmative Action / ADA	2 hours	Katherine Lincoln
Human Resources	2 hours	Nicole Morin Scribner
Support Services	2 hours	Richard Besson
Billing / Reimbursement Issues	1 hour	Brian Forni
Administrator on Call Duties	1 1/2 hours	Katherine Guilbault
Meeting with Community Providers		Rod Bouffard, Katherine Guilbault, Alan Boufford

Updated 7/16/96

ORIENTATION TOPICS FOR NEW PHYSICIANS

1.___ A.M.H.I.'s vision.

2.___ A.M.H.I.'s mission.

3.___ Physician accountability.

4.___ Weekly meetings for physicians.

5.___ Patient's rights.

6.___ Capacity to give informed consent.

7.___ Administrative hearings.

8.___ Psychiatric Assessment.

9.___ Admission Note.

10.___ Treatment planning.

11.___ Clinical Resume.

12.___ 24-Hour Certification.

13.___ Terminology relating to release of patient from AMHI.

14.___ Notification of transfer to community provider (form).

15.___ Definitions of mechanical restraint and protective devices.

16.___ Documentation for SRC, restraint and protective devices.

17.___ Sample SRC order and notes.

18.___ Off-ward levels.

19.___ UR procedure for certification/recertification.

20.___ UR tasks.

21.___ UR extended stay reviews.

22.___ UR codes used at AMHI.

23.___ Dictation system.

24.___ Referring institutions (by county).

25.___ Group homes.

26.___ Key policy.

27.___ Codes: (1) Medical emergency.
(2) Code 99 (medical patient not breathing).
(3) Code 77 (fire)
(4) STAT Help.

28.___ Fire and emergency number: 7-7333.

29.___ Duties of the OD.

30.___ AMHI admission criteria.

31.___ Admission Request-Intake Form.

32.___ E.D. Transfer Data Base/Medical Clearance Form.

33.___ Program service managers.

34.___ O.D. schedule and duties.

35.___ Medical staff documentation guidelines for evaluation and management services.

36.___ Medical Records Dept..

37.___ Admission Office.

38.___ Library.

39.___ Brief review of AMHI's recent history.

40.___ Secure name tag.

ADDENDUM #3

July 11, 1996

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Robert Spitzer
Richard Rawson
Martin Keeler
Alfred Strauss
Michael Sheard
Joan & Gerald Roskin
Elisabeth Small

ADDENDUM #4

While the search for a permanent Medical Director is ongoing, one of the permanent psychiatrists will be appointed to serve as acting Deputy Medical Director. Dr. Wilson will continue to supervise this psychiatrist a minimum of one day per week on site, as well as continue to be available by phone, as needed based on Dr. Wilson's judgment. While the Deputy Medical Director will be expected to have a strong clinical focus, an additional locum tenens psychiatrist will be hired to assume is or her treatment team responsibilities.

ADDENDUM #5

The Medical Staff has been given the responsibility to develop, in coordination with the Quality Director, a system to utilize QA sessions to review data, formulate recommendations and actions in response to QA findings. An annual review of the QA program will be completed at the end of each year. QA will be a standing agenda item for all Medical Executive Committee meetings as of 7/17/96. The QA Director will attend all Medical Executive Committee meetings with the exception of the executive meeting to provide Medical Executive Committee meeting with all QA pertinent information. The Medical Executive Committee minutes will reflect discussion and action.

ADDENDUM #6

Katherine Guilbault, RN, Director of Clinical Operations will provide administrative support and oversight to the infection prevention nurse and infection prevention committee.

Ms. Guilbault met with Mr. Chavarie, Infection Prevention Nurse to review data collection techniques. Formulas for collecting nosocomial data were reviewed. It was determined that the current formula for calculating the incidence rate was not mathematically correct. Utilizing the text, entitled, "The APIC Curriculum for Infection Control Practice, Volume 1", the formula to be utilized was identified as follows:

$$\frac{\text{\# of nosocomial inf ID during the month}}{\text{Total \# of inpatient days}} = \text{Incidence Rate}$$

The selection of this formula has historical merit. This was the formula approved by the Infection Prevention Committee and was utilized prior to 1995.

Mr. Chavarie, Infection Prevention Nurse was directed to go back one year (the Infection Prevention Program is summarized on an annual basis - July '95 through June '96) and revise the data reporting to reflect the corrected formula. At the bottom of the data reports, it reads: "This report was revised July 1996." The formula for calculating the nosocomial rate was revised.

At the next meeting of the Infection Prevention Committee, August 3, 1996. This corrected data report will be presented for discussion. On August 4, 1996 Dr. Davis, Chairperson will present this report to the Medical Executive Committee.

D. LIST ADVANTAGES AND DISADVANTAGES OF EACH OF THESE MEASURES.

1. Mean

   Most statistical tests use the mean because it is more amenable to mathematical manipulation. However, it is the measurement most affected by outliers (unusually high or low values) especially when the number of observations is small. As the sample size gets very large, this is less important.

2. Median

   It is least affected by outliers. Therefore, it is frequently the best measure to use in describing a data set. It is best for ordinal data. It requires ordering all observations in the sample.

3. Mode

   It is most useful for qualitative data, rarely used as a single measure for describing central tendency. With a small number of observations, there may be no mode.

4. These terms are often referred to as numerical summaries, because one or two numbers are used to describe an entire data set.

Objective III: **The learner will have an understanding of the use of rates and ratios in statistical inference**

see ES: IS1

A. RECOGNIZE THE APPROPRIATE USE OF THE TERM: RATE.

A rate measures the probability of occurrence in a population of some particular event such as cases of disease or deaths.

2, 17: CHP 2, *22:* CHP 7

B. GIVE THE BASIC FORMULA USED FOR ALL TYPES OF RATES, DEFINING EACH COMPONENT.

1. $\text{rate} = \frac{\text{numerator}}{\text{denominator}} \times \text{constant} = \frac{x}{y} \times k$

2. x = the *numerator* equals the number of times the event (e.g., infections) has occurred during a specified time interval.

3. y = *denominator* equals a population (e.g., number of patients at risk) from which those experiencing the event were derived during the *same* time interval.

4. k = a whole number (fractions are inconvenient) 100, 1000, 10 000 and 100 000 usually used (selection of k is usually made so that the smallest rate calculated has at least one digit to the left of the decimal point) or is determined by accepted practice, the magnitude of numerator compared to denominator).

NOTE: numerator events are always among the denominator events in a rate.

C. CALCULATE COMMONLY USED RATES.

1. Incidence rate

$$\text{Incidence rate} = \frac{\text{Number of NEW cases of a disease for a specified time period}}{\text{Population at risk for same time period}} \times k$$

2, *12:* CHP 2, *20:* CHP 5, *22:* CHP 7

EXAMPLE: During 1980, a total of 514 patients in Hospital A, developed UTIs. The hospital had 44 659 total discharges for the year. What is the annual incidence of UTIs per 100 000 discharges?

$$\frac{514}{44\,659} \times 100\,000 = 1150.9/100\,000 \text{ discharges}$$

2. Prevalence rate

$$\text{Prevalence rate} = \frac{\text{Number of EXISTING cases of disease from specified interval or point in time}}{\text{Population at risk for same time period}} \times k$$

EXAMPLE: Prevalence on a specified day identifies 16 patients with nosocomial urinary tract infections. On the day of the study, the hospital census is 403. What is the prevalence of urinary tract infections per 1000 patients?

$$\frac{16}{403} \times 1000 = \mathbf{39.7/1000\ patients}$$

There are two approaches to determining the numerator for prevalence surveys. Both approaches are acceptable provided the composition of the rates is clearly defined. In both cases, the denominator would be number of charts reviewed, number of patients examined, etc.

a. Only *active* cases of nosocomial infection are included in the numerator; i.e., all cases from a point in time up to a second point in time are included (e.g., for a 10-day period). This will reduce the prevalence rate and will more nearly reflect incidence.
b. All nosocomial infections up to a certain point in time are included whether they are active or inactive; i.e., all infections on the day(s) of the study are counted. This will produce a higher prevalence rate because it counts *all* cases regardless of state of infection.

3. Attack rate

$$AR = \frac{\text{Number of NEW cases of disease for a specified time period}}{\text{Population at risk for same time period}} \times 100$$

Same as incidence rate, except attack rates are always expressed as cases per 100 population or as a percent.

EXAMPLE: During a 34-month period, there were 158 admissions to the burn—trauma unit of a hospital, with 52 of the patients subsequently experiencing an infection with *Staphylococcus aureus*.

Of the total 158 admissions to the burn—trauma unit, 129 were admitted with burns. The remainder were trauma cases. Of the 52 patients with *S. aureus* infections, 49 had burns.

Of the 129 burn patients, 81 had burns that covered less than 20% of their body; 48 had burns that covered more than 20% of their body.

Of the 49 infections in burn patients, 16 were inpatients with burns that covered less than 20% of their body; 33 were inpatients with burns that covered more than 20% of their body.

Calculate the following rates:

a. overall attack rate

$$\frac{52}{158} \times 100 = \mathbf{32.9\%}$$

b. burn patient attack rate

$$\frac{49}{129} \times 100 = \mathbf{38\%}$$

c. trauma patient attack rate

$$\frac{3}{29} \times 100 = \mathbf{10.3\%}$$

d. attack rate for burn patients with less than 20% burns

$$\frac{16}{81} \times 100 = \mathbf{19.8\%}$$

e. attack rate for burn patients with greater than 20% burns

$$\frac{33}{48} \times 100 = \mathbf{68.8\%}$$

4. Mortality rate:

x = the number of people in a defined population during a specified interval of time who: (a) die from any cause (crude rate) or (b) die from a specified cause (cause-specific rate)
y = same as incidence rate
k = usually an assigned value of 1000 when calculating crude rates: 100 000 is used for cause specific rates.

$$\text{MR} = \frac{x}{y} \times k$$

ADDENDUM #7

Effective immediately, parallel plans will function to address the shortage of a Clinical Dietitian. This is necessary because of the limited response to recruiting over the past year with zero results. It is our goal to have a Clinical Dietitian on duty not later then October 1, 1996. This can be done provided we can recruit, issue a contract or reclassify a position based on the time table indicated below.

Implementation:

Plan #1: Continue to advertise for a full time Dietitian.

A. Continue to advertise weekly until August 16, 1996.

B. Expand Advertising to Boston area or other appropriate publication for two weeks starting not later then July 27, 1996. Current Advertising would continue until August 16, 1996.

C. Allow a grace period of 5 calendar days after the last advertisement for a response
to the ad.

D. If no responses are received by August 16, 1996 all advertising will stop. We will then rely on Plan #2 or #3 for final resolution.

Plan #2: Negotiate a contract with Food Service Organizations and Hospitals capable of providing a Clinical Dietitian.

A. Contact the Bureau of Purchases to determine vendor availability. Due: July 16, 1996.

B. Draft Request for Proposal, job description and any other requirements expected
from a contractor. Due: July 18, 1996.

C. Sent RFP to Contract Review Committee for approval. Due July 22, 1996.

C. Sent a cover letter to each known vendor that can provide services outlined in the
job description. Due: July 26, 1996.

D. Set bid opening date and time with the Bureau of Purchases. Due: July 26, 1996.

E. Open bids not later then August 23, 1996.

F. Award contract to bidder most capable of providing the required service. Due: August 30, 1996.

Plan #3: Reclassify the current vacancy (Clinical Dietitian) to a Food Service Manager.

A. Reclassify the existing Clinical Dietitian to a Food Service Manger position. This would allow the Director of Dietary Services to provide clinical services and oversee the operation of the Dietary Department. Due: October 1, 1996

B. Conduct bench marking with compatible psychiatric hospitals. This will validate the number of Dietitian's required based on our population. Due: August 16, 1996

During the implementation of this plan of correction the Director of Dietary Services in conjunction with the Director of Human Resources will maintain a complete file of actions taken on plan #1, #2 and #3. A weekly up date will be provided to the Superintendent on progress made to implement this plan of correction by the Director of Hospital Services.

For Licensing and Certification Us
POC Accepted ____ Date ____
Not Accepted ____ Date ____
Returned For:
Revision ____ Date ____

DIVISION OF LICENSING AND CERTIFICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Surveyors: Linda Ayer, R.N., Mary Dufort, R.N., Beth Patterson, R.N., Sandy Brown, R.N. Francine Blattner, M.D., Steve Blattner, M.D., Jim Nickerson, HFS

Date Survey Completed: June 6, 1996 and June 21, 1996

Name of Facility: Augusta Mental Health Institute

Address: Arsenal Street, Augusta, ME 04330

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
AMHI June 4-6, 1996 and June 20-21, 1996 State Survey		
Chapter VII.J.2.		
The procedure related to the submission and processing of applications involves the administrator, credentials committee of the Medical Staff or its counterpart, and the governing board, all functioning on a regular basis.		
This regulation was not met as evidenced by the following findings:		
A review of Credentials files and meeting minutes of the Board of Trustees provided docuemtned evidence that four (4) of four (4) physicians due for reappointment in 1995 and 1996 were not reapponted in accordance with the medical staff by-laws (Article 5).	Four physicians have been recommended for reappointment by Medical Executive Committee on 6/4/96 pending National Practitioner Data Bank query. All were approved. Governing Body met on 6/18/96 and approved all four appointments pending National Data Bank findings. National Data Bank query was completed on 7/10/96 with no negative findings. Medical Executive Committee received these results on 7/10/96 and recommended approval for reappointment.	7/10/96
Chapter IX.D.2.		
Reappointments are made periodically, and recorded in the minutes of the governing board. Reappointment policies provide for a periodic appraisal of each member of the staff,		

Signatu   Person Completing Plan of Correction:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
including consideration of his physical and mental capabilities. Recommendations for reappointments are noted either in the credential committee or medical staff meetings' minutes. **This regulation was not met as evidenced by the following findings:**		
• A review of Credentials files and meeting minutes of the Board of Trustees provided documented evidence that four (4) of four (4) physicians due for reappointment in 1995 and 1996 were not reappointed in accordance with the Medical Staff By-Laws. (Article 5) • It was determined through a review of credentials files and meeting minutes of the Medical Executive Committee for nine (9) months prior to survey, and confirmed through interview with the Medical Director, that four (4) of four (4) physicians due for reappraisal and reappointment in 1995 and 1996 did not undergo reappraisal or reappointment as required in the Medical Staff By-laws (Article 5).	A written procedure has been developed for the appointment and reappointment process (see attached). The Medical Director is accountable for assuring compliance with this task. (see addendum #1) Governing Body met on 6/18/96. Privileges for the four physicians were approved pending National Practitioner Data Bank query. The Governing Body will meet monthly to address key issues such as policies and procedures dealing with family notification of critical events, management of patients refusing treatment and discharge planning and to assure compliance with the hospital quality improvement plan.	6/18/96
<u>**Chapter IX.D.3.**</u> Temporary staff privileges (for example, locum tenens) are granted for a limited period if the physician is otherwise properly qualified for such.		

Signature of Person Completing Plan of Correction:

Date:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
This regulation was not met as evidenced by the following findings:		
• It was determined through a review of credentials files for locum tenens physicians that although the medical staff qualifies members, in part, through primary verification of credentials as required in the medical staff by-laws (Article 5.2.1), locum tenens physician credentials files did not contain primary verification of those required credentials.	A procedure has been developed to procure primary verification of Locum Tenens physicians. As of this date a query has been made to verify the licensure of all locum tenens physicians. The National Practitioner Data Bank is being queried and was completed on 7/11/96 with no issues noted. (see attached) Addendum #1	7/10/96 7/11/96
<u>Chapter IX.F.1.</u>		
Regardless of any other categories having privileges in the hospital, there is an active staff, properly organized, which performs all the organizational duties pertaining to the medical staff. These include:		
1. Maintenance of the proper quality of all medical care and treatment in the hospital.		
This regulation was not met as evidenced by the following findings:		
• It was determined through a review of the Medical Staff Executive Committee meeting and QI minutes for nine (9) months prior to survey and confirmed through interviews with the Medical Director, that the medical staff lacks a		

Signature of Person Completing Plan of Correction:

Date:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
mechanism for evaluating all medical care and treatment in the hospital as evidenced, specifically by the following findings:	The quality of care provided by the locum tenens physicians is monitored as part of the hospital QA program with follow up and correction of problems. Continuity of care is ensured as described in the attached addendum. (see addendum #2)	
1. Assessment of medical care and appropriateness is significantly hampered by an inordinate reliance on short term locum tenens physicians whose provision of care has not been amenable to quality monitoring, identification, follow up and correction of problems;	(1) The hospital is actively seeking permanent physicians, i.e. the Liberty Group has reviewed the hosptial's needs. Employment agencies have been contacted along with National Level Mental Health professionals. We will interview in the next 3 weeks for the position of Medical Director. Medical Director continuity will be assured as described in addendum #4	7/09/96 8/15/96
2. Patient care problems or serious incidents identified in 10/95; 1/96; and 4/96 and referenced in the minutes were not correlated with documentation of determination of causes of problems, corrective action, or follow up;	(2) According to the hospital's CQI plan and the attached flow sheet, the Director of QA will track the reporting system and monitor responses from the Medical Executive Committee. If necessary, the Director of QA will report on any failures to follow up to the Governing Body.	7/31/96
3. It was determined from the above, plus a review of data relative to Drug Utilization Evaluation (DUE) for polypharmacy and polypharmacy with Clozaril, that although these DUE are an integral part of the medical staff's quality assurance program, there was no documented cumulation, trending, or interpretation of the DUE data, nor was there documentation of the impact on quality of care of the DUE findings;	(3) The D.U.E. for polypharmacy and polypharmacy with Clozaril quality data will be documented in Medical Executive minutes for discrepencies in data, interpretation and documentation. Polypharmacy and polypharmacy with Clozaril data will be presented in 30 days to Medical Executive Committee for review, evaluation, and appropriate action according to the hospital's CQI plan and the attached CQI flow chart.	7/31/96
4. It was determined from the above, plus a review of nosocomial infection data, that although records of infections are maintained, data collection techniques were inconsistent and interpretations of data by the medical staff to determine potential patient care ramifications, trends, or potential for improvement was not documented and nosocomial rates and thresholds were not definitative;	(4) See addendum #6	7/31/96

Signature of Person Completing Plan of Correction: Date:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
5. Although quality monitoring through indicator screening, revealed performance below threshold on indicators which was documented in the minutes, there was no documented discussion, analysis, or effective remedial action taken by the medical staff to address deficiencies.	(5) As part of the hospital's CQI plan, and the attached CQI flow chart, Medical Executive minutes will document discussion, analysis, or effective remedial action on quality monitoring. This is consistent with Medical Staff bylaws. A copy of Medical Executive minutes will be sent to Governing Body.	7/10/96
<u>Chapter IX.I.1.</u> Requires that "The by-laws of the medical staff are a precise and clear statement of the policies under which the medical staff regulates itself." **This regulation was not met as evidenced by the following findings:**		
1. The medical staff by-laws (Article 7.1) requires that the Medical Executive Committee shall be a committee of the whole of the voting members of the medical staff; however, it was determined that a physician participating as a member of the Medical Executive Committee was not a voting member of the medical staff during the period surveyed;	In accordance with Medical staff bylaws (article 7.1) this physician's status was changed to a non-voting, honorary member.	6/19/96
2. The medical staff by-laws (Articles 7.2 and 8.3) requires that the Medical Executive Committee utilize quality assurance sessions to review QA data, formulate recommendations and actions in response to QA findings, evaluate quality monitoring data regularly, evaluate and take actions in response to problematic situations, and	See addendum #5	7/31/96

Signature of Person Completing Plan of Correction:

Date:

Name of Facility: Augusta Mental Health Institute | Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
annually review the quality assurance program. It was determined that the Medical Executive Committee did not consistently document that it performed these activities in the period surveyed;		
3. Although the medical staff by-laws (Article 8.10) requires that the medical staff identify and analyze the incidence and causes of infection and review results of antimicrobial susceptibility, it was determined that the Medical Executive Committee did not perform these functions in the period surveyed;	The chairman of the Infection Prevention Committee, George Davis, M.D., will report infection prevention data and actions taken to control infection to the Medical Executive Committee according to the hospital's CQI plan. The Medical Executive Committee will analyze the report and make reocmmendations regarding infection prevention. This information is reported quarterly to the QOC and to the Governing Body, as described in the hospital CQI plan.	7/31/96
4. Although the medical staff by-laws (Article 8.8) requires that the medical staff conduct ongoing monitoring and evaluation of drug use and appropriateness and record findings, conclusions, and recommendations on a quarterly basis, it was determined that evaluation of findings, conclusions, and recommendations resulting from analysis and discussion of the findings were not performed;	As data is collected by Quality Assurance, it will be presented to the Medical Executive Committee, where it will be discussed and reviewed for appropriate action.	7/31/96
5. Although the medical staff by-laws (Article 9.6) specifies a procedure for summary suspension, it was determined that two (2) summary suspensions in August, 1995 were not in accordance with the specified procedure.	The Medical Director will assure that the medical staff, the Superintendent, and members of the Governing Body are familiar with the medical staff bylaws. In those areas where physicians are exempt from the usual personnel policies, the Medical Director will attempt to educate those administrators who are unaware of the exemption. Should this fail, the Medical Director will immendiately consult with the Chairman of the Governing Body, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse.	9/11/96
<u>Chapter IX.P</u> Requires that the evaluation of clinical practice be met by: "Monthly meetings of the medical staff...at which the quality of medical work is adequately appraised...action is taken by		

Signature of Person Completing Plan of Correction: | Date:

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
the executive committee, and reports are made to the active staff...Minutes of such meetings give evidence of....A review of the clinical work done by the staff on at least a monthly basis; Minutes of such meetings give evidence that....this includes consideration of selected deaths, unimproved cases, infections, complications, errors in diagnosis, results of treatment...[and include a]...short synopsis of each case discussed...".		
These regulations were not met as evidenced by the following findings:		
• It was determined through a review of Medical Staff Executive Committee meeting minutes for nine (9) months prior to survey, and confirmed through interview with the Medical Director, that although the committee met on at least a monthly basis, clinical quality discussions meeting these requirements were not documented.	The Medical Executive Committee will discuss, review and document quality improvement data, serious injuries, sentinel events, infections, complications, and other clinical issues. Action plans will be developed for each issue as appropriate.	7/01/96
<u>Chapter XI.A.5</u>		
The number of administrative and technical personnel, such as bakers, cooks, dishwashers, dietary assistants, etc. is adequate to perform effectively all defined functions and to cover all hours of departmental operations.		

Signature of Person Completing Plan of Correction:

Date:

DIVISION OF LICENSING AND CERTIFICATION - STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION - Continuation Sheet

Name of Facility: Augusta Mental Health Institute

Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
This regulation is not met as evidenced by:	Effective immediately, parallel plans will function to address the shortage of a clinical dietitian.	
• Through a review of the dietary policy and procedure manual, an interview with the Dietician, review of the Dietary Quality Improvement plan and monitoring reports and record review, provided documented evidence of inadequate staffing to enable the patient nutritional assessment, teaching and participation in treatment planning.	See addendum # 7	10/01/96
<u>Chapter XXI.B.</u> There shall be a hospital-wide written plan describing the organization, scope, objectives and procedures for implementing these activities to include: b. A description of the methods of monitoring, documenting, evaluating and reporting of QA/QI activities for all clinical departments of the hospital, as well as for all support service departments and contracted servioces which impact, in any manner, upon the care and treatment of patients.		
This regulation is not met as evidenced by:		
• A review of the Dietary Quality Improvement plan and monitoring reports and confirmed an interview with the Dietician, provided documented evidence that the trends and data collected through the Dietary Quality	As part of the hospital CQI plan, and the attached CQI flow chart. The Director of Dietary Services reports quarterly to Support Services Quality Steering Council. The Director of Hospital Services then reports these findings to the QOC. Then the QOC will actively discuss, review and document the Dietary Quality Imrpovement data and recommend remedial action if necessary. Issues requiring further administrative action will be referred to	6/27/96

Signature of Person Completing Plan of Correction: Date:

Name of Facility: Augusta Mental Health Institute | Date of Survey: 6/6/96 & 6/21/96

SUMMARY STATEMENT OF DEFICIENCIES	PLAN OF CORRECTION	COMPLETION DATE: month/day/year
Improvement Program were not being utilized in the evaluation process.		

Signature of Person Completing Plan of Correction: Date:

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION, and SUBSTANCE ABUSE SERVICES

AGREEMENT TO PURCHASE COMMUNITY SERVICES

THIS AGREEMENT is made this 1st day of July, 1996, by and between the State of Maine, Department of Mental Health, Mental Retardation, and Substance Abuse Services, hereinafter called "Department", and Mid-Coast Mental Health Center, located at 12 Union Street, Box 526, Rockland, Maine 04841, telephone number (207) 594-2541, hereinafter called "Provider", for the period of July 1, 1996 to June 30, 1997.

The Employer Identification Number of the Provider is 01-0277794.

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and furnished by the Department, the Provider hereby agrees with the Department to furnish all qualified personnel, facilities, materials and services and, in consultation with the Department, perform the services, study or projects described in Rider A. The following Riders are hereby incorporated into this agreement by reference:

Rider A - Specifications of Services to be Provided.
Rider B - Method of Payment and Other Provisions.
Rider C - Certification Regarding Lobbying

IN WITNESS WHEREOF, the Department and Provider, by their duly authorized representatives, have executed this agreement in six originals as of the day and year first above written.

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION, and SUBSTANCE ABUSE SERVICES - Mental Health Services, Region II

By: ______________________________
David Lawlor, Program Services Director, Community Mental Health

Approved as to form
July 22, 1990
Attorney General

and

MID-COAST MENTAL HEALTH CENTER

By: ______________________________
Jeffrey Mitchell, Executive Director

Total Contract Amount: $ 723,430.00

Account Code: (See next page.)

____
State Controller

MFASIS Account Coding, Mid-Coast Mental Health Center, FY'97:

Service Category	*Fnd*	*Agy*	*Org*	*Appr*	*Activity*	*Obj*	*Amount*
Crisis Intervention	010	14a	2142	022	1004	6401	$233,117.00
	015	14a	2142	922	1004	6401	20,254.00
	015	14a	2142	932	1004	6401	3,040.00
Outpatient	010	14a	2142	022	1010	6401	36,304.00
	015	14a	2142	922	1010	6401	3,154.00
	015	14a	2142	932	1010	6401	473.00
Medication Clinic	010	14a	2142	022	1009	6401	29,757.00
	015	14a	2142	922	1009	6401	2,585.00
	015	14a	2142	932	1009	6401	388.00
Com. Residential	010	14a	2142	022	1002	6401	130,640.00
	015	14a	2142	922	1002	6401	11,351.00
	015	14a	2142	932	1002	6401	1,703.00
Geriatric	010	14a	2142	022	1006	6401	29,036.00
	015	14a	2142	922	1006	6401	2,523.00
	015	14a	2142	932	1006	6401	379.00
Community Support	010	14a	2142	022	1003	6401	198,856.00
	015	14a	2142	922	1003	6401	17,278.00
	015	14a	2142	932	1003	6401	2,593.00
						Total:	$723,430.00

RIDER A
Specifications of Work to be Performed

I. CONTRACT SUMMARY

Funds are provided under this Agreement by the Division of Mental Health for the provision of mental health services to persons with mental illness. The sources of funds and compliance requirements for this agreement are as follows:

A. $657,709.00 from the State General Fund. Use of funds shall be in accordance with requirements detailed in the DMH & MR Fiscal Accountability Rules and Exceptions to Federal OMB Circulars (CMR 114-191, Chapter 009); with the Maine Uniform Accounting and Auditing Practices for Community Agencies (CMR 08-114, Chapter 1); and with the terms of this agreement.

B. $ 57,145.00 from the Community Mental Health Services Block Grant (CFDA 93.958). Use of funds shall be in accordance with the Public Health Services Act as amended by Public Law 98-509; with restrictions contained in the appropriate CFDA; with Federal OMB Circulars A-110, A-122, and A-128, with CMR 08-114, Chapter 1, as applicable; and with the terms of this agreement.

C. $ 8,576.00 from the Social Services Block Grant (CFDA 93.667). Use of funds shall be in accordance with Public Law 97-35; with restrictions contained in the appropriate CFDA; with Federal OMB Circulars A-110 and A-122; CMR 08-114, Chapter 1, as applicable; and with the terms of this agreement.

II. SERVICE GOALS

Goals of service to be provided under this Agreement shall conform to the Department's mission to develop a consumer driven system that is responsive to the wants and needs of the individual consumer. Services will be provided in a manner consistent with the executed *Assurance Statement Regarding Provision of Mental Health Services and Compliance with Relevant Laws and Regulations*, which is incorporated in this agreement and made part of it by reference.

III. SERVICE SPECIFICATIONS

A. CRISIS SERVICES - OUTCOMES

CORE VALUE: To assure that consumers have access to the necessary personal supports and services to maximize their opportunities to remain in their homes and communities during and after crisis events.

Crisis Goal 1) Stabilization of most persons experiencing a psychiatric crisis without psychiatric hospitalization.

Measurement: Rate of crisis contacts stabilized without psychiatric hospitalization.

Indicator: Rate of crisis responses which result in psychiatric hospitalizations.

Performance Indicator: Minimum of 85% of all contacts will be stabilized without psychiatric hospitalization.

Performance Indicator: Minimum of 95% of all persons receiving crisis in-home or crisis residential support services will be stabilized without psychiatric hospitalization.

Performance Indicator: 10% decrease in number of psychiatric hospital admissions from Knox & Waldo Counties compared to state fiscal year 1996.

Crisis Goal 2) Short-term solution-oriented or brief treatment services enable some persons experiencing psychiatric crises to be successfully stabilized without the need for further mental health services.

Measurement: Short-term service cases closed within 30 days of first crisis contact where crisis has been stabilized and no further crisis services are needed at that time.

Indicator: All short-term cases closed in contract period.

Performance Indicator: 80% of all short-term cases will be successfully stabilized within the first 30 days.

Crisis Goal 3) Crisis services will be assertive and will reach out to where the persons experiencing the psychiatric crises are located.

Measurement: Utilization of crisis outreach services.

Indicator A: Number of crisis contacts.

Performance Indicator: 95% of crisis contacts will occur in the location of the consumer's choice.

Indicator B: Number of hours of outreach services provided divided by the total number of hours services provided.

Performance Indicator: 80% of service time available will be related to direct crisis services.

Crisis Goal 4) Crisis response services which are integrated and coordinated with the person's individualized support plan so that all efforts work together to meet the individual's identified needs and preferences.

Measurement: Development and implementation of crisis plans within the ISP process, plan and service agreement.

Indicator A: For individuals known to the mental health system, record review evidencing crisis plan.

Performance Indicator: 75% of ISP's will contain crisis plans except where specifically rejected.

Performance Indicator: All crisis contacts will document timely coordination with the individual's ISP coordinator/community support worker/case manager.

Indicator B: For those persons unknown to the mental health system, availability of ISP, community support and case management services explained, if determined eligible.

Performance Indicator: Documentation that all individuals with serious mental illness contacting the crisis response program were advised of the availability of these services.

Performance Indicator: Referrals made to community support providers following 100% of contacts in which such services are indicated.

B. COMMUNITY SUPPORT SERVICES - OUTCOMES

CORE VALUE: To assure that consumers live as independently and with as much stability as possible, utilizing needed services, with support and assistance in meeting their wants and needs and in engaging in valued and meaningful activities.

Community Support Goal 1) Persons with severe and persistent mental illness are best served in their home communities rather than psychiatric hospitals or units.

Measurement: Community tenure, measured in days residing in the community.

Indicator: Days in a psychiatric hospitalization divided by total days in the period.

Performance Indicator: A 95% rate of community tenure.

Community Support Goal 2) Provide services to as many people as possible, prioritizing services for those most in need.

Measurement: Number of persons served and hours of direct service provided.

Indicator A: All persons provided with community support services during contract period.

Performance Indicator: 250 persons will be served during contract period.

Indicator B: Aggregate hours of services provided to persons eligible for services.

Performance Indicator: 10,000 hours of direct service for the contract year.

Community Support Goal 3) Services meet the wants and needs of the consumers, as identified by the consumers.

Measurement: Consumer satisfaction survey and identified ISP and service plan goals, wants and needs.

Indicator A: Satisfaction with service, as indicated by consumer responses on survey.

Performance Indicator: 85% of respondents will indicate satisfaction.

Indicator B: Achievement of or satisfactory progress, as indicated by consumer, in meeting goals and identified wants and needs.

Performance Indicator: Consumers will have achieved or indicate they are satisfied with progress in meeting 75% of identified goals, wants and needs.

Community Support Goal 4) Consumers will demonstrate improved and/or stable functioning over time.

Measurement: Measurement of functionality selected by agency.

Indicator: Stability or improvement as indicated by total score on tool selected by agency at beginning and end of fiscal year.

Performance Indicator: 70% of consumers will remain stable or show improvement.

C. OUTPATIENT SERVICES

Client Description: The purpose of this program is to provide high quality psychiatric outpatient services to those eligible consumers 18 years of age and older. The emphasis will be on providing service to the priority target population as defined by the Division of Mental Health. The services will be provided from offices in Belfast and Rockland, as well as at the county jails, boarding homes, or other residences so as to remove geographic barriers to treatment.

Psychiatric outpatient services are defined as including professional assessment, counseling, and therapeutic services which promote positive orientation, relief of excess stress, and growth toward more integrated and independent levels of functioning. Services will be delivered through planned interaction involving the use of physiological, psychological, and sociological concepts, techniques, and the processes of evaluation and intervention. Components may include diagnosis and assessment; psychometric evaluation; intervention services by psychological examiners; individual, group, family or couples therapy; and similar professional therapeutic services.

Treatment services offered will be linked through integrating services to basic support and rehabilitation services so the consumer may receive maximum benefit and achieve an adequate quality of life. Isolation and fragmentation of services can frequently interfere with service delivery, making access and linkage vital components of the local support system.

The services of this program will be offered through traditional modalities such as individual, group, family, and couples therapy, but also may include family groups, and network support. Consumers will be assisted in identifying patterns of behavior, and learning which work for them and which do not. Each consumer will be assisted in developing a "relapse prevention" plan to help avoid falling back into non-productive behavior and thoughts.

Outpatient Services Goals and Objectives:

Goal 1: Provide easy access to treatment services.

Objective 1: Provide phone access to service 24 hours daily, seven days weekly.
Objective 2: Offer initial assessment appointments for non-crisis cases within seven days of the request for service.

Objective 3: Offer service in a variety of locations. In addition to Belfast and Rockland Offices, service sites might include boarding homes, jails, rural health clinics or other sites to reduce geographic barriers to service.
Objective 4: Offer appoints for services two evenings weekly.

Goal 2: Provide treatment services to eligible consumers based on their strengths, needs, and desires.

Objective 1: In collaboration with the consumer, complete a biopsychosocial assessment within the first four appointments. When a recent biopsychosocial assessment is available, that will be utilized rather than duplicating the service.
Objective 2: In collaboration with the consumer, develop an individualized plan for treatment services within thirty days of the start of services.

Goal 3: Provide services that are integrated and coordinated.

Objective 1: If eligible consumer does not have Individualized Support Plan and Case Manager, offer referral to the Provider's Community Support Services Program, and document outcome of referral.
Objective 2: Refer to appropriate source for services needed by not provided by this program, and document outcome of referral.
Objective 3: Attend case conferences regarding consumer.

Goal 4: Provide psychotherapeutic services as agreed to by consumer and family and listed in treatment services plan.

Objective 1: Provide documentation of progress in client record.
Objective 2: Review and revise treatment interventions as indicated, but no less than every ninety days.
Objective 3: Provide educational information to help families and other natural supports understand consumers' needs.

Goal 5: Provide 2,756 hours of outpatient service annually.

Objective 1: Maintain requirement for staff to provide direct service hours equal to 60% of time worked.

Goal 6: Provide well trained and supervised staff to deliver services.

Objective 1: Provide five days continuing education leave annually for clinical staff.
Objective 2: Provide regular clinical supervision and consultation for staff.

Goal 7: Maintain Quality Assurance program.

Objective 1: Maintain a schedule of weekly peer review in outpatient services.
Objective 2: Maintain program of continuous client record review to assure all requirements are met.
Objective 3: Write service plan goals and objectives in measurable terms. Utilize percent of service plan goals and objectives achieved as one measure of case outcome.
Objective 4: Have consumer complete "Satisfaction with Services" survey form at termination of services with goal of 85% choosing top two options on 4 point Likert type scale.

D. MEDICATION CLINIC SERVICES - Goals and Objectives

Goal 1: Provide Medication Clinic Services as needed by consumer.

Objective 1: Staff psychiatrist will evaluate consumers for need for medication within two weeks of referral.

Objective 2: If medication is recommended, consumer will be given information on which to base informed consent.

Objective 3: Staff psychiatrist will monitor consumer as needed.

Goal 2: Evaluate consumer for medical problems and for further evaluation and treatment when indicated.

Goal 3: Provide supportive psychotherapy along with medication monitoring if it can be provided within that context when needed.

Goal 4: Provide 2,375 hours of service to adults annually.

E. GERIATRIC MENTAL HEALTH RESOURCE PROGRAM

Consumers to be served: Individuals eligible for Eldercare Mental Health Services are those who are 60 years of age or older living in non-institutional settings in Knox and Waldo Counties, and the towns of Jefferson and Waldoboro in Lincoln County who have serious mental illness and substantial functional impairment. Adults who are over age 60 who are class members in the Bates vs. Davenport class action suit and the resulting consent decree are also eligible. The Provider's Eldercare Mental Health Services Program will serve approximately 56 individuals and their families during the contract period.

The Mission of the Eldercare Mental Health Services Program is to address the major mental health service needs of elderly persons described by the Task Force on Mental Health Services to Elderly Persons (1984), and updated by the Department of Mental Health and Mental Retardation in 1988.

Goal 1: Outreach and casefinding activities are carried out and access to eldercare services is easily accomplished.

Outcomes: To meet this goal, the Eldercare Program will document all requests for services and the outcome of each request; complete an assessment of each person who has requested services, and develop a comprehensive service plan for those who complete the assessment and intake process. Outcomes will be measured by maintaining a log of all requests for service and through case records of persons receiving community support services.

Goal 2: Each person requesting EMHS services, who is found to be eligible, will be offered an individualized support plan and the services to carry it out.

Outcomes: To meet this goal, the Eldercare Program will complete a service plan *with* each client and maintain it in the case record.

Goal 3: All Eldercare program participants will be comprehensively assessed to identify their individual needs.

Outcomes: All assessments will be included in consumer case records and will meet Department regulations.

Goal 4: All Eldercare program participants will have a comprehensive plan of care, based on the needs identified in the assessment, which addresses their needs/goals and plans to achieve them.

Outcomes: All consumers will have a comprehensive service plan, a copy of which will be contained in their case record.

Goal 5: All Eldercare program participants will be eligible to receive the full range of eldercare services available, based on their identified needs and wants, and designed to ensure support necessary to achieve and maintain an adequate and individual-choice-based quality of life. This includes home-based services, 24-hour crisis services and all other agency services available.

Outcomes: All consumers will identify the services they want from the Eldercare Worker and be provided with those services, or linked to them. Case records will document all services provided. In addition, the Provider will document individual progress on six performance measures and maintain this information in each case record.

Goal 6: All dually diagnosed consumers (those with substance abuse difficulties in addition to their mental health needs) will receive service appropriate to address their needs.

Outcomes: The Eldercare worker will be dually certified/registered and case records will document dual diagnosis services. The Provider will maintain dual licensure as a mental health provider and as a substance abuse provider.

F. COMMUNITY RESIDENTIAL SERVICES - OUTCOMES

CORE VALUE: To assure that consumers live as independently as possible, utilizing needed services, in the residence of their choice and are treated with dignity and respect.

Residential Goal 1) Persons with severe and persistent mental illness are best served in their home communities rather than psychiatric hospitals or units.

Measurement: Community tenure, measured in days residing in the community.

Indicator: Days in a psychiatric hospitalization divided by residential bed days utilized.

Performance Indicator: A 90% rate of community tenure.

Residential Goal 2) Provide services to as many individuals as permitted by available capacity.

Measurement: Number of bed days.

Indicator: Aggregate annual number of bed days.

Performance Indicator: 85% occupancy.

Residential Goal 3) Services meet the needs of the residents, as determined by the residents and/or their guardians.

Measurement: Resident satisfaction survey and identified ISP service plan goals/needs.

Indicator A: Satisfaction with service, as indicated by resident responses on survey.

Performance Indicator: 80% of respondents will indicate satisfaction.

Indicator B: Achievement of or satisfactory progress, as indicated by resident, in meeting goals and identified needs.

Performance Indicator: Residents will have achieved or indicate they are satisfied with progress in meeting 67% of identified goals and needs.

Residential Goal 4) Residents will demonstrate improved and/or stable functioning over time.

Measurement: Measurement of functionality selected by agency.

Indicator: Stability or improvement as indicated by total score on tool selected by agency at beginning and end of fiscal year.

Performance Indicator: 67% of residents will remain stable or show improvement.

IV. REPORTING AND FISCAL REQUIREMENTS

The Provider has submitted a budget for the services described herein which is approved by the Department as the budget for services contracted. Provider understands and agrees that the approved budget will be used by the Department on program audit to assess financial requirements and performance under this Agreement. The Provider agrees to be bound by the regulations and principles of the Department with regard to contract administration and contract settlement.

The Provider agrees to submit a quarterly report of financial, staffing, and service data in accordance with the specifications of the Department. Provider understands that such reports are due within thirty (30) days after the end of each quarter, and that subsequent payment installments will not be made until such reports are received and reviewed. Provider further agrees to submit such other data and reports as may be requested.

The Provider further understands and agrees that the Department has set aside $687,320.00 in a Medicaid seed account. This amount may be adjusted to reflect a revised budget based on actual experience with the use of Medicaid seed.

The Provider's staffing of all service programs described herein will be in accordance with its final approved budget submission for the contract period. The Provider will supply all staff training, clinical and administrative supervision, and evaluation necessary and appropriate to the performance of services under this Agreement.

Provider is responsible for maintaining internal records necessary to substantiate financial, staffing, and service data reported to the Department. Provider understands that all records are subject to review, analysis, and/or audit by the Department. The Provider agrees to be bound by applicable regulations and policies of the Department.

V. SUMMARY OF SERVICES PURCHASED

Service Category	*Total Cost*	*DMH Grant*	*DMH Seed*	*Units*
Crisis Intervention	$441,257.00	$256,411.00	$59,291.00	1,330
Outpatient	246,182.00	39,932.00	61,150.00	2,756
Medication Management	319,499.00	32,730.00	79,560.00	2,375
Community Residential	831,371.00	143,694.00	229,334.00	1,862
Geriatric	60,937.00	31,937.00	8,500.00	665
Community Support	966,356.00	218,726.00	249,485.00	9,350
Total:	$2,865,602.00	$723,430.00	$687,320.00	

RIDER B

METHOD OF PAYMENT AND OTHER PROVISIONS

1. **CONTRACT AMOUNT** $723,430.00

2. **INVOICES AND PAYMENTS**

The Department agrees to provide a total of $ 723,430.00 to the Provider in installments on or about the following dates in the following amounts:

Amount	Date	Amount	Date
$120,572.	07/15/96	$180,858.	03/01/97
$180,858.	09/01/96	$ 60,284.	06/01/97
$180,858.	12/01/96	$	

This payment schedule is subject to the Provider's compliance with all items set forth in this contract and subject to the availability of funds. The above payment schedule may be adjusted to deduct for Medicaid seed per Department procedures. Payments shall be made by the Department after receipt of an invoice on the Provider's usual billing forms or business letterhead.

3. **BENEFITS AND DEDUCTIONS**

If the Provider is an individual, the Provider understands and agrees that he/she is an independent contractor for whom no Federal or State Income Tax will be deducted by the Department, and for whom no retirement benefits, survivor benefit insurance, group life insurance, vacation and sick leave, and similar benefits available to State employees will accrue. The Provider further understands that annual information returns, as required by the Internal Revenue Code or State of Maine Income Tax Law, will be filed by the State Controller with the Internal Revenue Service and the State of Maine Bureau of Taxation, copies of which will be furnished to the Provider for his/her Income Tax records.

4. **INDEPENDENT CAPACITY**

The parties hereto agree that the Provider, and any agents and employees of the Provider, in the performance of this agreement, shall act in the capacity of an independent contractor and not as officers or employees or agents of the State.

5. **CONTRACT ADMINISTRATOR**

All progress reports, correspondence and related submissions from the Provider shall be submitted to:

Holly Stover, Mental Health Team Leader
DMHMRSAS Region II
State House Station #141
Augusta, Maine 04333-0141

who is designated as the Contract Administrator on behalf of the Department for this agreement, except where specified otherwise in this agreement.

6. DEPARTMENT'S REPRESENTATIVE

The Contract Administrator shall be the Department's representative during the period of this Agreement. He/she has authority to curtail services if necessary to ensure proper execution. He/she shall certify to the Department when payments under the agreement are due and the amounts to be paid. He/she shall make decisions on all claims of the Provider, subject to the approval of the Commissioner of the Department.

7. PROCEDURE FOR MODIFICATION

By mutual written agreement of the parties, this agreement may be modified at any time, with or without new consideration. Any material modification to the approved budget by the Provider shall not be paid under this agreement without prior written approval from the Contract Administrator.

8. PERIOD OF PERFORMANCE

A. Effective Date: July 1, 1996
B. Termination Date: June 30, 1997

9. SUBCONTRACTS

Unless provided for in this agreement, no arrangement shall be made by the Provider with any other party for furnishing any of the services herein contracted for without the consent, guidance and approval of the Contract Administrator. Any subcontract hereunder entered into subsequent to the execution of this agreement must be annotated "approved" by the Contract Administrator before it is reimbursable hereunder. This provision will not be taken as requiring the approval of contracts of employment between the Provider and its employees assigned for services thereunder.

10. SUBLETTING, ASSIGNMENT OR TRANSFER

The Provider shall not sublet, sell, transfer, assign or otherwise dispose of this agreement or any portion thereof, or of its right, title or interest therein, without written request to and written consent of the Contract Administrator. No subcontracts or transfer of agreement shall in any case release the Provider of its liability under this agreement.

11. EQUAL EMPLOYMENT OPPORTUNITY

During the performance of this agreement, the Provider agrees as follows:

a. The Provider will not discriminate against any employee or applicant for employment relating to this agreement because of race, color, religious creed, sex, national origin, ancestry, age, physical or mental handicap, unless related to a bonafide occupational qualification. The Provider will take affirmative action to ensure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age or national origin.

   Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Provider agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

b. The Provider will, in all solicitations or advertising for employees placed by or on behalf of the Provider relating to this agreement, state that all qualified applicants will receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age, physical or mental handicap.

c. The Provider will send to each labor union or representative of the workers with which it has a collective bargaining agreement, or other contract or understanding, whereby it is furnished with labor for the performance of this agreement a notice to be provided by the contracting agency, advising the said labor union or workers' representative of the Provider's commitment under this section and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Provider will cause the foregoing provisions to be inserted in any subcontract for any work covered by this agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

12. STATE EMPLOYEES NOT TO BENEFIT

The Provider shall not employ on any basis in the performance of this agreement any employee of the State who may participate in his/her official capacity in reaching a decision or recommendation in a governmental proceeding affecting the Provider.

13. WARRANTY

The Provider warrants that it has not employed or contracted with any company or person, other than a bonafide employee working solely for the Provider, to solicit or secure this agreement and that it has not paid, or agreed to pay, any company or person, other than a bonafide employee working solely for the Provider, any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this agreement. For breach or violation of this warranty, the Department shall have the right to annul this agreement without liability or, in its discretion to otherwise recover the full amount of such fee, commission, percentage brokerage fee, gift, or contingent fee.

14. ACCESS TO RECORDS

The Provider shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to this agreement and to make such materials available at its offices at all reasonable times during the period of this agreement and for such subsequent period as specified under Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP) rules. The Provider shall allow inspection of pertinent documents by the Department or any authorized representative of the State of Maine or Federal Government, and copies thereof shall be furnished, if requested.

15. AUDIT

Funds provided under this agreement are subject to the audit requirements contained in the MAAP rules, and may further be subject to audit by authorized representatives of the Federal Government.

16. TERMINATION

The performance of work under the agreement may be terminated by the Department in whole, or, from time to time, in part, whenever for any reason the Contract Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Provider of a Notice of Termination specifying the extent to which performance of the work under the agreement is terminated and the date on which such termination becomes effective.

17. GOVERNMENTAL REQUIREMENTS

The Provider warrants and represents that all governmental ordinances, laws and regulations shall be complied with.

18. INTERPRETATION AND PERFORMANCE

This agreement shall be governed by the laws of the State of Maine as to interpretation and performance.

19. STATE HELD HARMLESS

The Provider agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work, services, materials or supplies in connection with the performance of this agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Provider or in the performance of this agreement and against any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy, arising out of publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished under this agreement or based on any libelous or other unlawful matter contained in such data.

20. APPROVAL

This agreement is subject to the approval of the State Controller before it can be considered as a valid, executable document.

21. LIABILITY

The Provider shall keep in force a liability insurance policy issued by a company fully licensed or designated as an eligible surplus line insurer to do business in this state by the Maine Department of Professional & Financial Regulation, Bureau of Insurance which policy includes the area to be covered by this agreement with adequate liability coverage to protect itself and the Department from injury or damage suits arising from any accident to any person occurring at the facility. Providers insured through a "risk retention group" insurer prior to July 1, 1991 may continue under that arrangement. Prior to or upon execution of this agreement, the Provider shall furnish the Department with written or photocopied verification of the existence of such liability insurance policy.

22. BONDING

The Provider shall obtain and maintain at all times during the contract period a fidelity bond covering the activities of all employees who handle Provider funds in an amount equal to at least 25% of the total amount of this contract.

23. ACKNOWLEDGEMENT

The Provider agrees that any publication, presentation, or display of information regarding this project's activities, services, or funding will include, at minimum, a statement which indicates that the project is funded by the Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services.

24. ENTIRE AGREEMENT

This document contains the entire agreement of the parties, and neither party shall be bound by any statement or representation not contained herein.

RIDER C

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his/her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant or subgrant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant or subgrant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C., 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Date:________________ By:____
(Authorized Signature)

For: Mid-Coast Mental Health Center
(Name of Provider)

Community Mental Health Services Block Grant

Social Services Block Grant

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

AGREEMENT TO PURCHASE COMMUNITY SERVICES

THIS AGREEMENT is made this 1st day of July, 1995, by and between the State of Maine, Department of Mental Health and Mental Retardation, hereinafter called "Department", and Mid-Coast Mental Health Center, located at 12 Union Street, Box 526, Rockland, Maine 04841, telephone number (207) 594-2541, hereinafter called "Provider", for the period of July 1, 1995 to June 30, 1996.

The Employer Identification Number of the Provider is 01-0277794.

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and furnished by the Department, the Provider hereby agrees with the Department to furnish all qualified personnel, facilities, materials and services and, in consultation with the Department, perform the services, study or projects described in Rider A. The following Riders are hereby incorporated into this agreement by reference:

Rider A - Specifications of Services to be Provided.
Rider B - Method of Payment and Other Provisions.
Rider C - Certification Regarding Lobbying

IN WITNESS WHEREOF, the Department and Provider, by their duly authorized representatives, have executed this agreement in six originals as of the day and year first above written.

Richard G Thompson

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
DIVISION OF MENTAL HEALTH

By: Susan Wygal

Susan Wygal, Program Services Director, CMH
(Typed name and Title)

Approved as to form
July 22, 1990
Attorney General

and

MID-COAST MENTAL HEALTH CENTER

By: Julianne Edmondson

Julianne Edmondson, Executive Director
(Typed name and Title)

Total Contract Amount: $ 511,208.00

Account Code:

010 14a 1101 022 1003 6401 96 **$459,773.00**
015 14a 1101 922 1003 6401 96 **$ 42,859.00**
015 14a 1101 932 1003 6401 96 **$ 8,576.00**

ENCUMBERED
AUG 0 4 1995
STATE CONTROLLER

Victor Fleury Deputy

State Controller

Specifications of Work to be Performed

I. CONTRACT SUMMARY

Funds are provided under this Agreement by the Division of Mental Health for the provision of mental health services to persons with mental illness. The sources of funds and compliance requirements for this agreement are as follows:

A. $459,773.00 from the State General Fund. Use of funds shall be in accordance with requirements detailed in the DMH & MR Fiscal Accountability Rules and Exceptions to Federal OMB Circulars (CMR 114-191, Chapter 009); with the Maine Uniform Accounting and Auditing Practices for Community Agencies (CMR 08-114, Chapter 1); and with the terms of this agreement.

B. $ 42,859.00 from the Community Mental Health Services Block Grant (CFDA 93.958). Use of funds shall be in accordance with the Public Health Services Act as amended by Public Law 98-509; with restrictions contained in the appropriate CFDA; with Federal OMB Circulars A-110, A-122, and A-128, with CMR 08-114, Chapter 1, as applicable; and with the terms of this agreement.

C. $8,576.00 from the Social Services Block Grant (CFDA 93.667). Use of funds shall be in accordance with Public Law 97-35; with restrictions contained in the appropriate CFDA; with Federal OMB Circulars A-110 and A-122; CMR 08-114, Chapter 1, as applicable; and with the terms of this agreement.

II. SERVICE GOALS

Goals of service to be provided under this Agreement shall conform to the Department's mission to develop a consumer driven system that is responsive to the wants and needs of the individual consumer. Services will be provided in a manner consistent with the *Assurance Statement Regarding Provision of Mental Health Services and Compliance with Relevant Laws and Regulations*, which the Provider has satisfactorily executed.

III. SERVICE SPECIFICATIONS

A. CRISIS AND EMERGENCY SERVICES

The Department agrees to fund the Provider in the amount of $144,505.00 for the provision of Crisis and Emergency Services. Of this amount, $120,483.00 is a grant and $24,022.00 is in the form of Medicaid seed payments.

Client Description: Crisis and Emergency services will be provided to adults 18 years of age and older, living in Knox, Waldo, and parts of Lincoln Counties. The service will be available to all adults within the catchment area, but the primary emphasis will be on serving those with severe mental illness and substantial functional impairment. The purpose of the program is to provide high quality crisis and emergency services to eligible consumers within the catchment area. Based on crisis activity during the past year, 1,600 crisis contacts requiring 2,400 direct staff hours are anticipated. Approximately 46%, or 1,100 hours, will be face-to-face contacts.

Crisis and Emergency services are defined as immediate, crisis-oriented services provided to a consumer with an acute problem of disturbed thought, behavior, mood or social relationships. Services are oriented toward the amelioration and stabilization of these acute emotional disturbances to ensure the safety of an individual or society. The service may be delivered in a variety of ways, by phone or in person.

Crisis Telephone Services are provided 24 hours daily, seven days weekly. They are often the first point of contact with the mental health system, and include triage services for more intensive evaluation needs. Often, supportive counseling, help in problem solving and information and referral to needed services will meet the needs of the situation.

Emergency Services are defined as including all components of psychiatric assessment, evaluation, screening, intervention and disposition commonly considered appropriate to the provision of emergency mental health care.

Crisis Intervention Services are defined as being provided in an outreach manner by mobile staff in a variety of locations such as homeless shelters, boarding homes, jails, consumer residences, or other community settings. Components of the service include identification and prevention, assessment and screening, intervention, brief counseling services, acute treatment planning, problem resolution, clinical consultation, and short-term follow up to assist consumers in developing coping skills and in becoming more integrated into their community.

Service Objectives

Goal 1: Provide easy access to service.

- Objective 1: Provide 24 hours daily, seven days weekly access to service.
- Objective 2: Provide a toll-free 1-800 number for easy access to services for consumers and families.
- Objective 3: Provide service at multiple locations, with an outreach-oriented focus.
- Objective 4: Provide 2,400 hours of direct service.

Goal 2: Assist consumers in resolving situations that may have precipitated or contributed to the crisis.

- Objective 1: Provide needed crisis intervention services, assuring safety of all involved, and providing a crisis management plan.
- Objective 2: Assist consumer in regaining previous level of functioning through short term follow up and brief treatment.

Goal 3: Provide single point of entry for Mid-Coast Mental Health Center and triage for all requests for service.

- Objective 1: Link consumers with community services and supports, informing consumer of services available and documenting referral in the crisis log.

Goal 4: Maintain adequate numbers of trained staff to provide service.

- Objective 1: Maintain professional direct service staff of 6.03 FTE. Assure that staff have proper certification to perform the services contracted herein.
- Objective 2: Provide direct service staff with supervision by LCSW or other qualified mental health professional.
- Objective 3: Provide five days leave annually for training or continuing education for staff.
- Objective 4: Provide psychiatric consultation by having a psychiatrist on call 24 hours a day, seven days a week, and available within one hour of contact.

Goal 5: Foster collaboration and integration of services with other providers.

- Objective 1: Meet at least semi-annually with other community providers.
- Objective 2: Continue regular meetings with local law enforcement.

Objective 3: Meet with appropriate providers in Knox and Waldo County to explore development of crisis stabilization beds in the area.

Objective 4: The Director of Emergency Services will attend monthly C.L.A.S.S. Committee meetings.

Objective 5: Provide training and consultation to agencies, organizations, families, and schools on subjects of crisis intervention, suicide identification, and prevention.

Objective 6: Monitor emergency and crisis services to providers, families, and clients via an evaluation survey which will be administered to a random selection each month to determine what service was provided, satisfaction with the service, and unmet needs.

B. COMMUNITY SUPPORT SERVICES

The Department agrees to fund the Provider in the amount of $409,079.00 for the provision of Community Support Services. Of this amount, $199,074.00 is a grant, and $210,005.00 is in the form of Medicaid seed payments.

The mission of the Provider's Community Support Program is to provide a network of highly trained, caring, and responsible people, and high quality, state of the art services committed to giving consumers and their families more opportunities to participate in their own health care. The intent in stressing consumer-focused care is to re-evaluate the way services are delivered to improve access, enhance quality, and increase satisfaction.

Eligibility: A person meets eligibility requirements for community support services if he or she is age 18 or older or is an emancipated minor, is a class member, as defined in the Maine Medical Assistance Manual (MMAM) Chapter II, Section 17.01-10, or has a severe and disabling mental illness, as defined in MMAM Chapter II, Section 17.01-9.

Target Population: Provider will assure that emphasis of service in its Community Support Program will be on the priority target groups of the Division of Mental Health Services, listed below in priority order:

1. All persons currently receiving active discharge planning while in state hospitals or who have been discharged in the last six months.
2. All persons with a psychiatric-related diagnosis receiving active discharge planning from other inpatient units or residential treatment centers or who have been discharged in the last six months.
3. Persons with hospitalization or residential treatment care of at least six months duration in the last eighteen months.
4. Persons with two or more periods of hospitalization in the last twelve months.
5. Persons with four or more emergency face-to-face incidents in the last twelve months.
6. Persons currently residing in a living arrangement financially supported by the Division of Mental Health.
7. Persons who are homeless.
8. Persons who are in current crisis.
9. Persons who are likely to deteriorate clinically to a point of needing immediate institutionalization in the absence of prompt community support service intervention.
10. Persons who are currently receiving the medication clozaril or its generic equivalent or will be receiving the medication in the next 30 days.
11. Persons who have a history of hospitalization for mental illness and a level of functional ability such that continued community support services are needed.

The Community Support Program is designed to ensure the availability of the four major service system functions required to comprehensively serve persons with serious mental illness and substantial impairment. The four core service functions are: *Integrating Services, Basic Supports, Treatment Services, and Rehabilitation Services.*

Integrating Services

Integrating Services include Outreach and Casefinding Services, Comprehensive Individualized Assessment and Planning Services, and the Facilitation of Linkages, Coordination, Advocacy, and Monitoring.

Integrating Services' Goals and Objectives:

Goal 1: Outreach and casefinding activities are available on an on-call and regularly scheduled basis at predetermined sites in the community to eligible persons who are in need, or those who are referred by others who feel there is a need for assistance.

Objective 1: The CSS Program will develop a system for documenting contacts with new individuals referred through the Provider's Crisis/Intake Unit, and others, minimally documenting: the presenting reason for contact, the location and time of contact, and the result of the contact.

Objective 2: For those consumers contacted who agree to service, the CSS program will develop a system for documenting: identifying information, an informal assessment of the person's goals and needs, the person's level of commitment to initiate services or supports, and an informal plan for engaging the person further.

Outcome 1: Minimize the number of potentially eligible consumers unserved.

Outcome 2: Minimize the number of consumers and potential consumers unwilling to receive services or supports.

Goal 2: Each person requesting CSS services and/or supports will be offered the Individualized Support Planning process.

Objective 1: The CSS worker will document the outcome of offering the consumer the ISP process through completing the DMHMR form: *Documentation of Presentation.*

Goal 3: Each class member from the catchment area who is currently a long-stay (150 days or more) patient at the Augusta Mental Health Institute (AMHI), and who has been identified as able to be safely discharged will be offered the Individualized Support Planning process.

Objective 1: The CSS worker will initiate the ISP, working with the Augusta Mental Health Institute's (AMHI) treatment team to develop and carry out a discharge and transition plan.

Goal 4: An individualized biopsychosocial assessment will be conducted by an individual chosen or agreed to by the consumer.

Objective 1: The CSS worker will document in the consumer's record the results of the initial assessment.

Outcome 1: An individualized biopsychosocial assessment is completed within 30 days of initiation of service or 30 days from the completion of an ISP.

Outcome 2: The initial assessment is updated annually to ensure that it is current.

Goal 5: Each person requesting services will have access to a comprehensive individualized plan of care which addresses the consumer's needs and aspirations.

Objective 1: The plan of care reflects the results of the assessment.

Outcome 1: A plan of care is developed within 30 days of initiation of service.

Outcome 2: The plan of care is reviewed and revised, a minimum of every 90 days to ensure that it is current.

Outcome 3: The consumer's unmet needs are included in the plan of care.

Basic Supports

Basic Supports are resources and services that ensure successful community living by providing for basic needs such as adequate income, housing, food, and protection of human and civil rights.

Basic Supports Goals and Objectives:

Goal 1: Consumers of Community Support Services have access to case management services to ensure the income supports necessary to achieve and maintain an adequate quality of life.

Objective 1: CSS staff will identify in the ISP and/or comprehensive plan of care those income supports and other sources of entitlement the consumer has agreed to be linked to in order to ensure that physiological and safety needs are being met.

Objective 2: CSS staff will ensure the protection of consumers' basic rights by linking consumers denied access to entitlement to Maine's Advocacy Services and/or other sources of legal aid.

Outcome 1: Funding and entitlements are adequate to provide an "above poverty level" standard of living for all consumers served.

Outcome 2: Consumers will not be unnecessarily dependent upon entitlements.

Goal 2: Consumers have access to needed medical and dental care.

Objective 1: CSS staff will identify consumers' health and dental needs in their biopsychosocial assessment, and include them in the ISP and/or comprehensive plan of care.

Objective 2: The CSS Program will develop a directory of health and dental practitioners for use by staff and consumers who need and request linkages to those services.

Outcome 1: The incidence of untreated medical and dental problems will be reduced.

Outcome 2: Access to medical and dental care for consumers served will be improved.

Goal 3: Consumers have access to decent, safe, affordable housing to match their preferences, goals, and functional levels.

Objective 1: The CSS Program will develop and make available to consumers a resource directory of existing housing alternatives for Knox and Waldo Counties.

Objective 2: CSS workers will assist consumers in identifying housing preferences and goals in the biopsychosocial assessment, and include those housing goals in the consumer's ISP and/or comprehensive plan of care.

Outcome 1: Consumers will not be homeless.
Outcome 2: The number of consumers discharged from residential or inpatient facilities without a home will be minimized.

Goal 4: Consumers will have access to supportive care and supervision.

Objective 1: CSS workers will assist consumers in identifying supportive care and supervision needs in the biopsychosocial assessment, and include them in the ISP and/or plan of care.
Objective 2: CSS staff will coordinate, monitor, and evaluate supportive care and supervision services provided each consumer in order to ensure appropriateness and protection of basic rights.

Outcome 1: Consumers' funds and entitlements are appropriately managed.
Outcome 2: Consumers will manage their own finances if possible.
Outcome 3: Consumers will function in the least restrictive manner possible.
Outcome 4: Consumers will have their civil rights protected.

Treatment Services

Treatment services are services that address the signs and symptoms of mental illness through prevention, symptom control, and crisis intervention.

Treatment Services Goals and Objectives:

Goal 1: Consumers of Community Support Services have 24 hour, 7 day/week access to crisis services, psychiatric and psychological assessment, medication prescription and monitoring, counseling and psychotherapy, and specialized treatment services.

Objective 1: CSS staff will ensure that consumers have their treatment needs identified in their biopsychosocial assessment, and treatment goals identified in their ISP and/or comprehensive plan of care.
Objective 2: The CSS Program will develop a resource directory of psychiatric and other treatment services in Knox and Waldo Counties and make it available to consumers who request, and are in need of, these services.

Outcome 1: Consumers will receive the treatment they want from the system.
Outcome 2: The frequency of crisis episodes experienced by consumers receiving treatment services will be minimized.
Outcome 3: The frequency of relapse or recurrence of symptoms will be minimized.
Outcome 4: The length and frequency of psychiatric hospitalizations will be minimized.

Rehabilitation Services

Rehabilitation services are services and resources that aid in improving or recovering a person's functional capacity, and that promote mastery in daily living, social interaction, and a meaningful work life.

Rehabilitation Services Goals and Objectives:

Goal 1: Consumers will have access to rehabilitation services which are needed and requested.

Objective 1: CSS staff will assist consumers in developing and documenting rehabilitation needs, goals, desired outcomes, and services and supports in their biopsychosocial assessment, and in their ISP or comprehensive plan of care.

Objective 2: CSS staff will develop a resource directory of rehabilitation services available in Knox and Waldo Counties and make it available to consumers requesting these services.

Objective 3: The CSS program will hire consumers to provide role modeling and peer support to enhance recovery processes and encourage empowerment.

Outcome 1: Stated needs and goals for personal, social, educational, and vocational skills development are evidenced in ISP's and plans of care.

Outcome 2: Consumers are linked with necessary rehabilitation services.

Outcome 3: Consumer support groups and peer counseling is available to the Provider's consumers.

Goal 2: Rehabilitation services will be available within the CSS program for consumers requesting these services.

Objective 1: CSS staff will make available daily and community living skills training, interpersonal skills training, psychoeducation, and vocational skills training at a wide range of times, in various locations within Knox and Waldo Counties such as consumers' homes and boarding homes; community environments such as community centers and drop-in centers; and at the Provider's facilities in Rockland and Belfast.

Objective 2: CSS staff will develop and provide to consumers a resource directory of elementary, secondary, GED, continuing education and literacy training, college-level educational opportunities, and tutorial services available within Knox and Waldo Counties, and the state's higher education system.

Objective 3: To make available staff resources and psychoeducational curricula to groups and individuals as needed and requested to address information related to such topics as mental illness, symptom management and control, medication maintenance, and relapse prevention.

Outcome 1: CSS staff have variable schedules to include evening and weekend availability.

Outcome 2: Consumers are able to perform daily and community living skills sufficiently to ensure more independent living.

Outcome 3: Consumers have increased social contacts.

Outcome 4: Consumers state increased satisfaction with social life.

Outcome 5: Consumers have increased awareness of social and recreational options.

Outcome 6: Consumers have increases awareness of how mental illness affects their lives.
Outcome 7: Consumers show evidence of relapse prevention strategies.

Goal 3: To promote and provide access to meaningful work experiences for consumers requesting and needing these opportunities.

Objective 1: To develop and make available to consumers a resource directory of supported and regular employment opportunities in Knox and Waldo Counties.

Objective 2: To develop, within existing resources, work programs at Mid-Coast Mental Health Center facilities at pre-vocational, supported employment, and regular employment levels.

Outcome 1: Consumers are more financially self-supporting.
Outcome 2: Consumers have increased job skills.
Outcome 3: Consumers have increased job satisfaction.
Outcome 4: Consumers have increased awareness of and access to work opportunities.

C. OUTPATIENT SERVICES

Client Description

The Department agrees to fund the Provider in the amount of $97,124.00 for the provision of Outpatient Services. Of this amount, $45,638.00 is a grant and $51,486.00 is in the form of Medicaid seed payments.

The purpose of this program is to provide high quality psychiatric outpatient services to those eligible consumers 18 years of age and older. The emphasis will be on providing service to the priority target population as defined by the Division of Mental Health. The services will be provided from offices in Belfast and Rockland, as well as at the county jails, boarding homes, or other residences so as to remove geographic barriers to treatment. In FY'96, it is anticipated that approximately 350 clients will be served for a total of 2,946 visits of direct service.

Psychiatric outpatient services are defined as including professional assessment, counseling, and therapeutic services which promote positive orientation, relief of excess stress, and growth toward more integrated and independent levels of functioning. Services will be delivered through planned interaction involving the use of physiological, psychological, and sociological concepts, techniques, and the processes of evaluation and intervention. Components may include diagnosis and assessment; psychometric evaluation; intervention services by psychological examiners; individual, group, family or couples therapy; and similar professional therapeutic services.

Treatment services offered will be linked through integrating services to basic support and rehabilitation services so the consumer may receive maximum benefit and achieve an adequate quality of life. Isolation and fragmentation of services can frequently interfere with service delivery, making access and linkage vital components of the local support system.

The services of this program will be offered through traditional modalities such as individual, group, family, and couples therapy, but also may include family groups, and network support. Consumers will be assisted in identifying patterns of behavior, and learning which work for them and which do not. Each consumer will be assisted in developing a "relapse prevention" plan to help avoid falling back into non-productive behavior and thoughts.

Outpatient Services Goals and Objectives:

Goal 1: Provide easy access to treatment services.

Objective 1: Provide phone access to service 24 hours daily, seven days weekly.
Objective 2: Offer initial assessment appointments within two weeks of the request for service.
Objective 3: Offer service in a variety of locations. In addition to Belfast and Rockland Offices, service sites might include boarding homes, jails, rural health clinics or other sites to reduce geographic barriers to service.
Objective 4: Offer appoints for services two evenings weekly.

Goal 2: Provide treatment services to eligible consumers based on their strengths, needs, and desires.

Objective 1: In collaboration with the consumer, complete a biopsychosocial assessment within the first four appointments. When a recent biopsychosocial assessment is available, that will be utilized rather than duplicating the service.
Objective 2: In collaboration with the consumer, develop an individualized plan for treatment services within thirty days of the start of services.
Objective 3: Write service plan goals and objectives in measurable terms. Utilize percent of service plan goals and objectives achieved as one measure of case outcome.
Objective 4: Have consumer complete "Satisfaction with Services" survey form at termination of services.

Goal 3: Provide services that are integrated and coordinated.

Objective 1: If eligible consumer does not have Individualized Support Plan and Case Manager, offer referral to the Provider's Community Support Services Program, and document outcome of referral.
Objective 2: Refer to appropriate source for services needed by not provided by this program, and document outcome of referral.
Objective 3: Attend case conferences regarding consumer.

Goal 4: Provide psychotherapeutic services as agreed to by consumer and family and listed in treatment services plan.

Objective 1: Provide documentation of progress in client record.
Objective 2: Review and revise treatment interventions as indicated, but no less than every ninety days.
Objective 3: Provide educational information to help families and other natural supports understand consumers' needs.

Goal 5: Provide 2,946 hours of outpatient service annually.

Objective 1: Maintain requirement for staff to provide direct service hours equal to 60% of time worked.

Goal 6: Provide well trained and supervised staff to deliver services.

Objective 1: Provide five days continuing education leave annually for clinical staff.
Objective 2: Provide regular clinical supervision and consultation for staff.

Goal 7: Maintain Quality Assurance program.

Objective 1: Maintain a schedule of weekly peer review in outpatient services.
Objective 2: Maintain program of continuous client record review to assure all requirements are met.

D. MEDICATION CLINIC SERVICES

The Department agrees to fund the Provider in the amount of $46,300.00, in the form of Medicaid seed payments, for the provision of Medication Clinic Services.

Medication Clinic services are defined as those services which directly relate to the prescription, administration, and/or monitoring of medications intended for the treatment and management of mental illness. The program is estimated to provide 1,288 hours of medication clinic services in FY'96.

Medication Clinic Services Goals and Objectives:

Goal 1: Provide Medication Clinic Services as needed by consumer.

Objective 1: Staff psychiatrist will evaluate consumers for need for medication within two weeks of referral for medication evaluation.
Objective 2: If medication is recommended, consumer will be given information on which to base informed consent.
Objective 3: Staff psychiatrist will provide monitoring services as needed.

Goal 2: Provide 1,288 hours of medication clinic services annually.

E. GERIATRIC MENTAL HEALTH RESOURCE PROGRAM

The Department agrees to fund the Provider in the amount of $42,568.00 for the Geriatric Mental Health Resource Program. Of this amount, $36,330.00 is a grant, and $6,238.00 is in the form of Medicaid seed payments.

Consumers to be served: Individuals eligible for Eldercare Mental Health Services are those who are 60 years of age or older living in non-institutional settings in Knox and Waldo Counties, and the towns of Jefferson and Waldoboro in Lincoln County who have serious mental illness and substantial functional impairment. Adults who are over age 60 who are class members in the Bates vs. Davenport class action suit and the resulting consent decree are also eligible. The Provider's Eldercare Mental Health Services Program will serve approximately 56 individuals and their families during the contract period.

The Provider's Eldercare Mental Health Services Program is designed to address the major mental health service needs of elderly persons described by the Task Force on Mental Health Services to Elderly Persons (1984), and updated by the Department of Mental Health and Mental Retardation in 1988. The highest priority needs identified are: (1) outreach and casefinding to homebound elderly and mentally ill persons; (2) in-home mental health assessments; (3) in-home mental health treatment including counseling and psychiatric emergency services; (4) case management services; and (5) training and consultation to caregivers and other providers or services to the elderly. These services are consistent with the four major service system functions required to comprehensively serve persons with serious mental illness and substantial functional impairment as defined in Maine's Community Systems Workbook. The four core service functions are: *Integrating Services, Basic Supports, Treatment Services, and Rehabilitation Services.*

Integrating Services

Integrating Services include Outreach and Casefinding Services, Comprehensive Individualized Assessment and Planning Services, and the Facilitation of Linkages, Coordination, Advocacy, and Monitoring.

Integrating Services' Goals and Objectives:

Goal 1: Outreach and casefinding activities are available on an on-call and regularly scheduled basis at predetermined sites in the community to eligible persons who are in need of assistance.

Objective 1: Eldercare Mental Health Services (EMHS) will be available to consult with a CSS worker when accessed to respond to non-emergency requests for outreach services.

Objective 2: EMHS will develop a system for responding to referrals from CSS staff to ensure the timely assessment of the consumer's needs.

Outcome 1: Minimize the number of potentially eligible elderly persons unserved.

Outcome 2: Minimize the number of elderly persons and potential consumers unwilling to receive, unaware of, or unable to access services or supports.

Goal 2: Each person requesting EMHS services and/or supports will be offered the Individualized Support Planning process.

Objective 1: The Eldercare Social Worker will refer identified consumers to the Community Support program within three working days of agreeing to service to develop an ISP.

Goal 3: An individualized biopsychosocial assessment will be conducted by the Eldercare Social Worker or an individual chosen or agreed to by the consumer.

Objective 1: The Eldercare Social Worker will document in the consumer's record the results of the initial assessment.

Outcome 1: An individualized biopsychosocial assessment is completed within 30 days of initiation of service or 30 days from the completion of an ISP.

Outcome 2: The initial assessment is updated annually to ensure that it is current.

Goal 4: Each person requesting Eldercare Mental Health Services will have access to a comprehensive individualized plan of care which addresses the consumer's needs and aspirations.

Objective 1: The plan of care reflects the results of the assessment.

Objective 2: When consumers refuse to develop a biopsychosocial assessment or plan of care, the Eldercare Social Worker will document the reason for refusal.

Outcome 1: A plan of care is developed within 30 days of initiation of service.

Outcome 2: The plan of care is reviewed and revised, a minimum of every 90 days to ensure that it is current.

Outcome 3: The consumer's unmet needs are included in the plan of care.

Basic Supports

Basic Supports are resources and services that ensure successful community living by providing for basic needs such as adequate income, housing, food, and protection of human and civil rights.

Basic Supports Goals and Objectives:

Goal 1: Consumers of Eldercare Mental Health Services will have access to case management services to ensure the income supports necessary to achieve and maintain an adequate quality of life.

Objective 1: To identify in the ISP and/or comprehensive plan of care those income supports and other sources of entitlement the consumer has agreed to be linked to in order to ensure that physiological and safety needs are being met.

Objective 2: The Eldercare Social Worker will refer consenting persons to the Provider's Community Support Services case managers to ensure linkage with necessary community, state and federal financial entitlements and supports.

Objective 3: The Eldercare Social Worker will ensure the protection of consumers' basic rights by linking consumers denied access to entitlement to Maine's Advocacy Services and/or other sources of legal aid.

Outcome 1: Funding and entitlements are adequate to provide an "above poverty level" standard of living for all consumers served.

Outcome 2: Consumers will not be unnecessarily dependent upon entitlements.

Outcome 3: Consumers receive services from community, state, and federal programs for which they are eligible.

Goal 2: Consumers have access to needed medical and dental care.

Objective 1: Consumers' health and dental needs will be identified in their biopsychosocial assessment, and include them in the ISP and/or comprehensive plan of care.

Objective 2: The Eldercare Social Worker will refer consenting consumers to the Provider's Community Support Services case managers to ensure linkage with needed health and dental services.

Outcome 1: The incidence of untreated medical and dental problems will be reduced.

Outcome 2: Access to medical and dental care for consumers served will be improved.

Goal 3: Consumers have access to decent, safe, affordable housing to match their preferences, goals, and functional levels.

Objective 1: The Eldercare Social Worker will assist consumers in identifying housing preferences and goals in the individualized biopsychosocial assessment, and include those housing goals in the consumer's ISP and/or comprehensive plan of care.

Objective 2: The Eldercare Social Worker will refer consenting consumers to the Provider's Community Support Services case managers to ensure linkage with needed housing.

Outcome 1: Consumers will not be homeless.
Outcome 2: The number of consumers discharged from residential or inpatient facilities without a home will be minimized.

Goal 4: Consumers will have access to supportive care and supervision.

Objective 1: The Eldercare Social Worker will assist consumers in identifying supportive care and supervision needs through the biopsychosocial assessment and plan of care.
Objective 2: The Eldercare Social Worker will refer consenting consumers to the Provider's Community Support Services case managers to coordinate, monitor, and evaluate supportive care and supervision services provided to each consumer.

Outcome 1: Consumers' funds and entitlements are appropriately managed.
Outcome 2: Consumers will manage their own finances if possible.
Outcome 3: Consumers will function in the least restrictive manner possible.
Outcome 4: Consumers will have their civil rights protected.

Treatment Services

Treatment services are services that address the signs and symptoms of mental illness through prevention, symptom control, and crisis intervention.

Treatment Services Goals and Objectives:

Goal 1: Consumers of Eldercare Mental Health Services have access to crisis services, psychiatric and psychological assessment, medication prescription and monitoring, counseling and psychotherapy, and specialized treatment services.

Objective 1: The Eldercare Social Worker will ensure that consumers have their treatment needs identified in their biopsychosocial assessment, and treatment goals identified in their ISP and/or comprehensive plan of care.
Objective 2: The Eldercare Social Worker will develop a resource directory of treatment services for use by consumers who request, and are in need of, these services.

Outcome 1: Consumers will receive the treatment they want from the system.
Outcome 2: The frequency of crisis episodes experienced by consumers receiving treatment services will be minimized.
Outcome 3: The frequency of relapse or recurrence of symptoms will be minimized.
Outcome 4: The length and frequency of psychiatric hospitalizations will be minimized.

Rehabilitation Services

Rehabilitation services are services and resources that aid in improving or recovering a person's functional capacity, and that promote mastery in daily living, social interaction, and a meaningful work life.

Rehabilitation Services Goals and Objectives:

Goal 1: Consumers will have access to rehabilitation services which are needed and requested.

Objective 1: The Eldercare Social Worker will assist consumers in identifying, developing and documenting rehabilitation needs, goals, and desired services as part of the assessment process, and as part of their ISP or comprehensive plan of care.

Objective 2: The Eldercare Social Worker will develop a resource directory of rehabilitation services available in Knox and Waldo Counties and make it available to elderly consumers requesting these services.

Goal 2: Elderly consumers will have daily and community living skills needs, goals, and desired services identified.

Objective 1: The Eldercare Social Worker will identify and document consumers' daily and community living skills needs, goals, and desired services in the assessment, ISP, and service planning process.

Objective 2: The Eldercare Social Worker will assist in linking and referring elderly consumers to programs that provide daily and community living skills training.

Outcome 1: Elderly consumers are able to perform daily and community living skills sufficiently to ensure more independent living.

Outcome 2: Elderly consumers are accessing services in the least restrictive settings.

Outcome 3: Elderly consumers perceive an improvement in their daily and community living skills.

Outcome 4: Elderly consumers have increased social contacts.

Outcome 5: Elderly consumers state increased satisfaction with social life.

Outcome 6: Elderly consumers have increased awareness of social and recreational options.

Goal 3: Educational goals for elderly consumers requesting educational opportunities will be assessed and developed.

Objective 1: A resource directory of elementary, secondary, GED, continuing education, supported education, literacy training, and Elder Hostel program opportunities will be developed and provided to consumers.

Objective 2: The availability of psychoeducational curricula to groups and individuals as needed and requested to address information related to such topics as mental illness, symptom management and control, medication maintenance, and relapse prevention will be ensured.

Outcome 1: Elderly consumers have more control over educational goals.

Outcome 2: Elderly consumers have increased awareness of how mental illness affects their lives.

Outcome 3: Elderly consumers have more control over their symptoms.

Outcome 4: Elderly consumers show evidence of relapse preventions strategies.

Outcome 5: Elderly consumers' needs for crisis services are minimized.

Goal 4: Access to meaningful work and volunteer experiences for consumers requesting and needing these opportunities will be promoted and provided.

Objective 1: A resource directory of supported and regular employment and volunteer opportunities available in Knox and Waldo Counties will be developed and made available to consumers.

Outcome 1: Elderly consumers are more financially self-supporting.
Outcome 2: Elderly consumers have increased job skills.
Outcome 3: Elderly consumers have increased self esteem.
Outcome 4: Elderly consumers have increased awareness of and access to work and volunteer opportunities.

F. COMMUNITY RESIDENTIAL SERVICES

The Department agrees to fund the Provider in the amount of $183,167.00 for the provision of Community Residential Services. Of this amount, $109,683.00 is a grant and $73,484.00 is in the form of Medicaid seed payments.

Overall goals of the Provider's Community Residential Services include:

a. To administer the ongoing bridge subsidy program for 15 low income mental health consumers.
b. To network with landlords for the purpose of educating them to consumers' needs and identifying support services to meet landlords' needs in working with these consumers. This year we will complete a data base of existing affordable rentals and landlords who are aware of support services available to our consumers.
c. To locate available subsidized housing in the area and develop strategies to make this housing more accessible to consumers.
d. To work with local Community Development, Maine State Housing, and local public housing authorities to identify housing for renovation and lease or purchase to provide more inexpensive or subsidized housing stock.
e. To provide property management and administration.
f. To research and access national and regional housing initiatives.

PARTNERS IN COMMUNITY LIVING (P.I.C.L.)

The Partners in Community Living Program provides housing for eight individuals who meet the criteria of the Division of Mental Health's priority population. Priority referrals to the P.I.C.L. housing option are adults who have a serious mental illness who are currently hospitalized at AMHI, and who are citizens of Knox and Waldo Counties, or the towns of Jefferson and Waldoboro in Lincoln County.

The Partners in Community Living Program is a homesharing program for adults who have a serious mental illness. The program provides a normalized, supportive home atmosphere that services as a part of the individual's support system. The focus of the program is to provide intensive one on one supports and personal care services in the homes of Care Providers. These persons have met all the professional and education requirements of Residential Providers as specified by the Division of Mental Health and stated in the Care Provider Agreement. Each resident has his or her own room while being treated as an integral part of the household.

Prospective residents are referred by the staff of AMHI. Referrals are assisted by the Provider's discharge planner at AMHI in identifying and accessing the full range of services and supports that may be needed, including an assigned community support worker. Every effort is made to design supports in a way that is congruent and responsive to each individual's needs.

Partners in Community Living Goals and Objectives:

Goal 1: To develop and maintain a choice of supportive community housing alternatives for the purpose of enhancing the quality of life for adults with mental illness.

Objective 1: To maintain eight (8) P.I.C.L. placements during FY'96.
Objective 2: To attain 85% occupancy of these eight placements with priority population persons during FY'96.

Goal 2: To offer residents of the P.I.C.L. program comprehensive services and supports to assure successful community living and integration.

Objective 1: To provide Personal Care Services by Care Providers according to individualized comprehensive assessments and service planning developed by Community Support Workers.

Outcome 1: Residents receive the Personal Care Services they need and desire.

Objective 2: To provide food services in each Care Provider's home according to a collaborative agreement among the Care Provider, Partner, and Community Support Worker, and according to the Partner's needs, goals, and choices.

Outcome 1: Each Partner's placement has a written agreement for food services.

Objective 3: To provide Treatment and Rehabilitative Services to each Partner by Community Support Workers and others according to individualized comprehensive assessments and service planning developed by Community Support Workers.

Outcome 1: Each resident receives the Treatment and Rehabilitative Services needed and desired.

Objective 4: To offer each Partner the opportunity to participate in the ISP process with a Community Support Worker.

Outcome 1: There is documentation that each resident has been offered an ISP.

LEASED HOUSING PROGRAM

The Provider's Leased Housing Program serves adults with serious mental illness who are homeless or at risk of homelessness, and who want to live in an independent, unstructured residence in Knox County.

Persons placed in one of the Provider's four leased houses enter into a homesharing agreement with others living in the same house. These houses are leased by the Provider from HUD and FmHA. Tenants are required to pay $300/house, which includes taxes, insurance, utilities and maintenance. Although this is not a directly federally funded housing program, the Provider has adopted HUD Section 8 rental guidelines for administering the program.

The Provider's Community Support Workers, and all other program staff, are available to provide ongoing services and supports to tenants of this program when requested. However, tenants are not required to receive services. The requirements for participation in this program are outlined in the tenant's agreement, and parallel those admission guidelines of HUD.

Leased Housing Program Goals and Objectives:

Goal 1: To develop and maintain a choice of supportive community housing alternatives to improve the quality of life for people living with mental illness in Knox County.

Objective 1: To maintain a residence at Thomaston Street in Rockland for two individuals with mental illness who are homeless or at risk of homelessness.

Objective 2: To maintain a residence at Grace Street in Rockland for two individuals who are homeless or at risk of homelessness, and who are mentally ill.

Objective 3: To maintain a residence at Limerock Street in Rockland for two individuals with mental illness who are homeless or at risk of homelessness.

Objective 4: To maintain a residence at Jefferson Street in Rockland for two individuals who are homeless or at risk of homelessness, and who are mentally ill.

Goal 2: To make available services and supports to residents of the Leased Housing program upon request in order to improve their quality of life.

Objective 1: To offer each resident an opportunity to participate in the ISP process.
Objective 2: To make available to each resident a Community Support Worker to assist in linkages to needed and requested services and supports.

IV. REPORTING AND FISCAL REQUIREMENTS

Funding provided under this Agreement is based on the approved budget for FY'95, and assumes continuation of the services outlined therein. The Provider will submit a budget for services to be provided in FY'96 on or before September 1, 1995. Issuance of subsequent payments is contingent upon receipt and approval of that budget. Provider understands and agrees that the approved FY'96 budget will be used by the Department on program audit to assess financial requirements and performance under this Agreement. The Provider agrees to be bound by the regulations and principles of the Division of Mental Health with regard to contract administration and contract settlement.

The Provider agrees to submit a quarterly report of financial, staffing, and service data in accordance with the specifications of the Division of Mental Health. Provider understands that such reports are due within thirty (30) days after the end of each quarter, and that subsequent payment installments will not be made until such reports are received and reviewed. Provider further agrees to submit such other data and reports as may be requested.

The Provider further understands and agrees that, based on the FY'95 budget, the Department has set aside $411,535.00 in a Medicaid seed account. This amount may be adjusted to reflect a revised budget or actual experience with the use of Medicaid seed.

The Provider's staffing of all service programs described herein will be in accordance with its final approved budget submission for the contract period. The Provider will supply all staff training, clinical and administrative supervision, and evaluation necessary and appropriate to the performance of services under this Agreement.

Provider is responsible for maintaining internal records necessary to substantiate financial, staffing, and service data reported to the Department. Provider understands that all records are subject to review, analysis, and/or audit by the Department. The Provider agrees to be bound by applicable regulations and policies of the Department.

V. SUMMARY OF SERVICES PURCHASED

Service Category	DMH Grant	DMH Seed	Units of Service
Emergency	$120,483.	$ 24,022.	N/A
Community Support	$199,074.	$210,005.	9,100
Outpatient	$ 45,638.	$ 51,486.	2,946
Geriatric	$ 36,330.	$ 6,238.	600
Community Residential	$109,683.	$ 73,484.	2,537
Medication Clinic	$ 0.	$ 46,300.	1,288
Total:	$511,208.	$411,535.	

RIDER B

METHOD OF PAYMENT AND OTHER PROVISIONS

1. **CONTRACT AMOUNT** $511,208.00

2. **INVOICES AND PAYMENTS**

The Department agrees to provide a total of $ 511,208.00 to the Provider in installments on or about the following dates in the following amounts:

Amount	Date	Amount	Date
$ 85,201.	07/15/95	$127,802.	03/01/96
$127,802.	09/01/95	$ 42,601.	06/01/96
$127,802.	12/01/95	$	

This payment schedule is subject to the Provider's compliance with all items set forth in this contract and subject to the availability of funds. The above payment schedule may be adjusted to deduct for Medicaid seed per Department procedures. Payments shall be made by the Department after receipt of an invoice on the Provider's usual billing forms or business letterhead.

3. **BENEFITS AND DEDUCTIONS**

If the Provider is an individual, the Provider understands and agrees that he/she is an independent contractor for whom no Federal or State Income Tax will be deducted by the Department, and for whom no retirement benefits, survivor benefit insurance, group life insurance, vacation and sick leave, and similar benefits available to State employees will accrue. The Provider further understands that annual information returns, as required by the Internal Revenue Code or State of Maine Income Tax Law, will be filed by the State Controller with the Internal Revenue Service and the State of Maine Bureau of Taxation, copies of which will be furnished to the Provider for his/her Income Tax records.

4. **INDEPENDENT CAPACITY**

The parties hereto agree that the Provider, and any agents and employees of the Provider, in the performance of this agreement, shall act in the capacity of an independent contractor and not as officers or employees or agents of the State.

5. **CONTRACT ADMINISTRATOR**

All progress reports, correspondence and related submissions from the Provider shall be submitted to:

Betty M. Lamoreau, Management Analyst II
Division of Mental Health
State House Station #165
Augusta, Maine 04333-0165

who is designated as the Contract Administrator on behalf of the Department for this agreement, except where specified otherwise in this agreement.

6. DEPARTMENT'S REPRESENTATIVE

The Contract Administrator shall be the Department's representative during the period of this Agreement. He/she has authority to curtail services if necessary to ensure proper execution. He/she shall certify to the Department when payments under the agreement are due and the amounts to be paid. He/she shall make decisions on all claims of the Provider, subject to the approval of the Commissioner of the Department.

7. PROCEDURE FOR MODIFICATION

By mutual written agreement of the parties, this agreement may be modified at any time, with or without new consideration. Any material modification to the approved budget by the Provider shall not be paid under this agreement without prior written approval from the Contract Administrator.

8. PERIOD OF PERFORMANCE

A. Effective Date: July 1, 1995
B. Termination Date: June 30, 1996

9. SUBCONTRACTS

Unless provided for in this agreement, no arrangement shall be made by the Provider with any other party for furnishing any of the services herein contracted for without the consent, guidance and approval of the Contract Administrator. Any subcontract hereunder entered into subsequent to the execution of this agreement must be annotated "approved" by the Contract Administrator before it is reimbursable hereunder. This provision will not be taken as requiring the approval of contracts of employment between the Provider and its employees assigned for services thereunder.

10. SUBLETTING, ASSIGNMENT OR TRANSFER

The Provider shall not sublet, sell, transfer, assign or otherwise dispose of this agreement or any portion thereof, or of its right, title or interest therein, without written request to and written consent of the Contract Administrator. No subcontracts or transfer of agreement shall in any case release the Provider of its liability under this agreement.

11. EQUAL EMPLOYMENT OPPORTUNITY

During the performance of this agreement, the Provider agrees as follows:

a. The Provider will not discriminate against any employee or applicant for employment relating to this agreement because of race, color, religious creed, sex, national origin, ancestry, age, physical or mental handicap, unless related to a bonafide occupational qualification. The Provider will take affirmative action to ensure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age or national origin.

   Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Provider agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

b. The Provider will, in all solicitations or advertising for employees placed by or on behalf of the Provider relating to this agreement, state that all qualified applicants will receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age, physical or mental handicap.

c. The Provider will send to each labor union or representative of the workers with which it has a collective bargaining agreement, or other contract or understanding, whereby it is furnished with labor for the performance of this agreement a notice to be provided by the contracting agency, advising the said labor union or workers' representative of the Provider's commitment under this section and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Provider will cause the foregoing provisions to be inserted in any subcontract for any work covered by this agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

12. STATE EMPLOYEES NOT TO BENEFIT

The Provider shall not employ on any basis in the performance of this agreement any employee of the State who may participate in his/her official capacity in reaching a decision or recommendation in a governmental proceeding affecting the Provider.

13. WARRANTY

The Provider warrants that it has not employed or contracted with any company or person, other than a bonafide employee working solely for the Provider, to solicit or secure this agreement and that it has not paid, or agreed to pay, any company or person, other than a bonafide employee working solely for the Provider, any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this agreement. For breach or violation of this warranty, the Department shall have the right to annul this agreement without liability or, in its discretion to otherwise recover the full amount of such fee, commission, percentage brokerage fee, gift, or contingent fee.

14. ACCESS TO RECORDS

The Provider shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to this agreement and to make such materials available at its offices at all reasonable times during the period of this agreement and for such subsequent period as specified under Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP) rules. The Provider shall allow inspection of pertinent documents by the Department or any authorized representative of the State of Maine or Federal Government, and copies thereof shall be furnished, if requested.

15. AUDIT

Funds provided under this agreement are subject to the audit requirements contained in the MAAP rules, and may further be subject to audit by authorized representatives of the Federal Government.

16. TERMINATION

The performance of work under the agreement may be terminated by the Department in whole, or, from time to time, in part, whenever for any reason the Contract Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Provider of a Notice of Termination specifying the extent to which performance of the work under the agreement is terminated and the date on which such termination becomes effective.

17. GOVERNMENTAL REQUIREMENTS

The Provider warrants and represents that all governmental ordinances, laws and regulations shall be complied with.

18. INTERPRETATION AND PERFORMANCE

This agreement shall be governed by the laws of the State of Maine as to interpretation and performance.

19. STATE HELD HARMLESS

The Provider agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work, services, materials or supplies in connection with the performance of this agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Provider or in the performance of this agreement and against any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy, arising out of publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished under this agreement or based on any libelous or other unlawful matter contained in such data.

20. APPROVAL

This agreement is subject to the approval of the State Controller before it can be considered as a valid, executable document.

21. LIABILITY

The Provider shall keep in force a liability insurance policy issued by a company fully licensed or designated as an eligible surplus line insurer to do business in this state by the Maine Department of Professional & Financial Regulation, Bureau of Insurance which policy includes the area to be covered by this agreement with adequate liability coverage to protect itself and the Department from injury or damage suits arising from any accident to any person occurring at the facility. Providers insured through a "risk retention group" insurer prior to July 1, 1991 may continue under that arrangement. Prior to or upon execution of this agreement, the Provider shall furnish the Department with written or photocopied verification of the existence of such liability insurance policy.

22. BONDING

The Provider shall obtain and maintain at all times during the contract period a fidelity bond covering the activities of all employees who handle Provider funds in an amount equal to at least 25% of the total amount of this contract.

23. ACKNOWLEDGEMENT

The Provider agrees that any publication, presentation, or display of information regarding this project's activities, services, or funding will include, at minimum, a statement which indicates that the project is funded by the Maine Department of Mental Health and Mental Retardation.

24. ENTIRE AGREEMENT

This document contains the entire agreement of the parties, and neither party shall be bound by any statement or representation not contained herein.

RIDER C

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his/her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the Provider, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant or subgrant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant or subgrant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C., 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Date: 6/22/95 By: Julianne Edmondson
(Authorized Signature)

For: Mid-Coast Mental Health Center
(Name of Provider)

Community Mental Health Services Block Grant
Social Services Block Grant

Department of Mental Health, Mental Retardation and Substance Abuse Services
Mental Health Out of State Placements
July 25, 1996

Florida Institute for Neuro Rehab - 1 client

The court required a different placement for this client from his prior placement at Lakeview. We are supporting him at Florida Institute for one year until he establishes residency in Florida, as his parents now live there. He is currently supported with general funds as there has been problems re-establishing him as Maine medicaid eligible. If he becomes medicaid eligible we hope to retro bill medicaid to his placement date at Florida Institute. Our commitment should terminate 11/29/96.

Current annual cost: $108,000 (non medicaid seed)

Devereux Foundation, Chester, NJ - 1 client

Currently in process of transitioning client to a less expensive setting in Massachusetts.

Current annual cost: $245,052 (non medicaid seed)

Lakeview (Highwatch), Center Ossipee, NH - 1 client

No other appropriate place.

Current annual cost: $75,000 (medicaid seed and non medicaid seed)

Justice Resource Institute, Boston, MA - 2 clients

This facility specializes in treating young adults with mental illness and criminal histories.

Current annual cost: 1 client - $65,000 (medicaid seed)
1 client - $40,000 (medicaid seed) DOE is paying education costs

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Summary by Category of Service as of January 31, 1996

	State	Federal	Total
Division of Mental Health			
Community Residential Services	3,858,898		3,858,898
Community Support Services	2,454,109	618,990	3,073,099
Deaf Services	101,136		101,136
Emergency/Crisis Services	3,486,482	297,489	3,783,971
Geriatric Services	1,298,011		1,298,011
Inpatient Services	75,682		75,682
Medication Clinic Services	743,303	30,000	773,303
Outpatient Services	240,673	72,648	313,321
Peer/Family Support Services	481,109		481,109
Social Clubs	1,130,738		1,130,738
Vocational Services	391,114		391,114
Other	505,429	150,895	656,324
Total Division of Mental Health	14,766,684	1,170,022	15,936,706
Division of Mental Retardation			
Adult Residential	536,364		536,364
Child Residential	2,453		2,453
Committee on Transition	308,234		308,234
Crisis Intervention	300,000		300,000
Day Programming	1,443,806	823,881	2,267,687
Professional Services	238,766		238,766
Recreation/Leisure	96,713		96,713
Residential Treatment	86,646		86,646
Respite	375,258		375,258
Supported Employment	729,769		729,769
Supported Living	511,187		511,187
Transportation	147,120		147,120
Voucher	192,765		192,765
Total Division of Mental Retardation	4,969,081	823,881	5,792,962
Bureau of Children with Special Needs			
Autism Consultant Srvcs.	169,689		169,689
Case Management	584,543	612,585	1,197,128
Clinical Consultation	16,175		16,175
Crisis Intervention/Resolution Srvcs.	1,112,344		1,112,344
Day Treatment Services	67,200	38,361	105,561
Early Childhood Comm. Sppt. Svcs.	457,402	26,913	484,315
Family Mediation Services	105,200		105,200
Family Support Facilitators	70,000		70,000
Homebased Family Services	616,716		616,716
Homeless Services		150,000	150,000
Ident/Assess/Diag/Eval/Screening	139,983		139,983
Individual Placement	73,007		73,007
Infant Mental Health Services	40,970		40,970
Infant/Toddler Group Services	440,590		440,590

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Summary by Category of Service as of January 31, 1996

	State	Federal	Total
Information and Referral	98,733	100,000	198,733
Outpatient MH Clinic Services	158,645	295,087	453,732
Parent/Sibling Self-Help	5,500		5,500
Program Design and Evaluation		12,390	12,390
Residential Services	1,535,506	166,983	1,702,489
Respite Care	771,400		771,400
School Age Comm. Support Srvcs.	19,034		19,034
Sexual Abuse Treatment Services	60,158		60,158
Social and/or Recreational Services	271,000		271,000
Wraparound(Early Intervention & School Age Services)	520,000	2,717,789	3,237,789
Total Bureau of Children with Special Needs	7,333,795	4,120,108	11,453,903
DEPARTMENT TOTAL	27,069,560	6,114,011	33,183,571 *

* Does not include $44,402,647 in Medicaid seed journaled directly to DHS for the benefit of clients served through agencies jointly funded by the Department and the Federal Medicaid Program.

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Alphabetical Listing of Agencies
FY96 Estimated Expenditures as of January 31, 1996

	State	Federal	Total
Acadia Hospital, Inc.	371,101		371,101
Alliance for the Mentally of Maine	427,276		427,276
American Red Cross - Mid Coast Chapter	20,900		20,900
American Red Cross - Pine Tree Chapter	584,500		584,500
Androscoggin Home Health	5,798		5,798
Area IV Mental Health Coalition	195,646		195,646
Aroostook Council On Transition	34,904		34,904
Aroostook Mental Health Center	1,582,517	203,579	1,786,096
Autism Society of ME	4,000		4,000
Bangor Area Coord Council	35,175		35,175
Bath Brunswick Child Care Services	65,900		65,900
Borderview Manor	11,680		11,680
Case Management for Youth		3,884	3,884
Catholic Charities	482,849		482,849
Center for Community Inclusion (FC)	39,408		39,408
Central Aroostook Assn. for Retarded Citizens	118,474	84,104	202,578
Cerebral Palsy Center	116,000		116,000
Certified Interpreting Associates	7,000		7,000
Charlotte White Center	27,342		27,342
Child Health Center	113,104		113,104
Child & Youth Board of Washington Cty.	124,500		124,500
Children's Center	163,000		163,000
Citizen's Interest Group	5,000		5,000
Coastal Economic Dev Corp	11,000		11,000
Coastal Transportation	24,077		24,077
Coastal Workshop	303,792	94,835	398,627
Community Counseling Center	60,158		60,158
Community Health and Counseling Center	1,268,696	430,410	1,699,106
Community Living Association	66,786	49,667	116,453
Community Living Options	76,500		76,500
Community Support Services	112,656		112,656
Crisis and Counseling Center	540,760		540,760
Crotched Mountain Rehab Center	15,400		15,400
Cumberland Cty Parent Awareness	3,000		3,000
Devereux Foundation	203,712		203,712
Downeast Horizons	69,740		69,740
Drug Rehabilitation, Inc.	21,514		21,514
Elmhurst	65,172		65,172
Evergreen Behavorial Services	104,460		104,460
Florida Institute of Neuro-Rehabilitation	64,500		64,500
Forest City Resources	96,427		96,427
Goodwill Industries	504,797	24,236	529,033

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Alphabetical Listing of Agencies
FY96 Estimated Expenditures as of January 31, 1996

	State	Federal	Total
Gorham Health Care	149,102		149,102
Great Bay	33,653		33,653
Greater Rumford Alliance	228,425		228,425
Green Valley	70,445		70,445
Group Home Foundation	9,700	67,894	77,594
Hawthorne House	138,502		138,502
HealthReach Network	198,615		198,615
Helping Hands for Children and Families	30,000		30,000
HFP Management	177,200		177,200
Home Counselors, Inc.	81,700	40,500	122,200
Independence	224,000		224,000
John F. Murphy Homes, Inc.	211,251		211,251
Katahdin Friends	77,792		77,792
Ken-A-Set Association	187,000		187,000
Kennebec Valley Mental Health Center	277,826	84,483	362,309
Kennebec Valley Transition Council	37,340		37,340
Lakeview (Highwatch)	44,000		44,000
Maine Association for Autism	6,000		6,000
Maine Association of Broadcasters	25,000		25,000
Maine Center for the Blind	14,469		14,469
Maine Foster Parents Association	2,500		2,500
Maine Medical Center	79,080		79,080
Maine Parent Federation	51,900		51,900
Maine Resource Development Corporation	66,868		66,868
Maine Special Olympics	25,000		25,000
Maine Vocational Region 9	46,520		46,520
Markland Enterprises	60,792		60,792
Medical Care Development	96,283		96,283
MERT Enterprises	12,102		12,102
Mid-Coast Children's Services	80,000		80,000
Mid-Coast Compeer	2,000		2,000
Mid-Coast Mental Health Center	609,371	153,837	763,208
Mid-Maine Medical Center	7,200		7,200
Mobius, Inc.	6,551	65,270	71,821
Motivational Services	893,324	10,000	903,324
Mt. Saint Joseph	113,937		113,937
Multi Handicapped Center of Central Aroostook	24,730		24,730
Multi Handicapped Center of Penobscot Valley	127,083	77,388	204,471
New Beginnings		36,500	36,500
NFI North, Inc.	235,037		235,037
Northern Maine Medical Center	57,670		57,670
Northern Maine General Hospital	37,795		37,795

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Alphabetical Listing of Agencies
FY96 Estimated Expenditures as of January 31, 1996

	State	Federal	Total
No. Aroostook Association for the Handicapped	4,040		4,040
N.E. Occupational Exchange	4,776		4,776
Opportunity Housing, Inc.	161,368		161,368
Oxford County Assn. for Retarded Citizens	9,294		9,294
Pathways, Inc.	191,192		191,192
Penobscot County Sheriff's Department	6,000	93,500	99,500
Penquis CAP, Inc.	99,200		99,200
Peregrine	55,696		55,696
Personal Services of Aroostook	155,805		155,805
Pine Tree Legal Assistance	26,878		26,878
Pine Tree Society	23,000		23,000
Pineland Parents and Friends	40,670	0	40,670
Port Resources	148,667	0	148,667
Pottle Hill	61,533	65,270	126,803
Project Atrium	318,350	36,500	354,850
RAFTS (47 Wood Street)	12,292		12,292
Regional Education Treatment Center	22,800		22,800
Resources for Developmentally Disabled	660	42,565	43,225
River Resources	97,939	64,055	161,994
Riverside Estates, Inc.	23,450		23,450
Rumford Group Home	204,336		204,336
SAD #20 Fort Fairfield School	32,600		32,600
Sandy River Rehab	43,091	35,425	78,516
Sebasticook Farms	248,335	77,388	325,723
Sedgewood Commons	22,960		22,960
Sentry Enterprises	8,600		8,600
Shalom House	461,135		461,135
Shoreline Community Mental Health Services	594,143	80,431	674,574
Shoreline Mental Health Center	290,023	77,930	367,953
So Penob Reg Prog for Except Children	44,400		44,400
Southern Maine Regional Mental Health Board	4,142,804	280,100	4,422,904
Southern Me. Technical College	10,000		10,000
Spaulding Youth Center	17,580		17,580
Special Children's Friends	77,800		77,800
Spurwink School	548,685		548,685
St. John Valley	72,942	6,975	79,917
Sunrise Opportunities	130,698		130,698
Sweetser Children's Services	628,923		628,923
The Children's Center	47,200		47,200
The Pines	59,716		59,716
Together Place	553,289		553,289
Town of Dexter	34,840		34,840

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Alphabetical Listing of Agencies
FY96 Estimated Expenditures as of January 31, 1996

	State	Federal	Total
Tri-County Mental Health Center	1,455,509	283,096	1,738,605
United Cerebral Palsy of N.E. Maine	89,500		89,500
United Families for Children's Mental Hlth		100,000	100,000
University of Maine	52,995	12,390	65,385
Uplift	14,002		14,002
Waban Projects	368,911		368,911
Washington County Psychotherapy	708,846		708,846
Wings for Children and Families		3,322,890	3,322,890
Woodfords, Inc.	124,993		124,993
Work Opportunities	54,490		54,490
Yesterday's Children	3,700		3,700
York County Community Action Program	36,998		36,998
York County Parent Awareness	40,500		40,500
York County Shelters		36,500	36,500
York Cumberland Association	46,225	68,809	115,034
Youth Alternatives	553,440		553,440
Youth and Family Services	77,018		77,018
YWCA of Portland	100,710		100,710
Individual Providers	597,029	3,600	600,629
Total	27,069,560	6,114,011	33,183,571 *

*Does not include $44,402,647 in Medicaid seed journaled directly to DHS for the benefit of clients served through agencies jointly funded by the Department and the Federal Medicaid Program.

Background information on advocacy structure and funding

1. Public Law 1995, Chapter 560, section K-18 moved the Office of Advocacy of the Office of Advocacy from its own office to the Office of Advocacy and Consumer Affairs within the Department of Mental Health, Mental Retardation and Substance Abuse Services. See 34-B MRSA 1205, sub-§5.) Funding for the Office of Advocacy is provided through the Department. In FY 1995-96 it was $696,277. In FY 1996-97 it will be $702,439 (subject to deappropriation). The position count for both years is 13.5 positions. The statutory duties include investigating claims and grievances of clients of the department, investigating with the Department of Human Services allegations of adult and child abuse in state institutions and advocating on behalf of clients for compliance by the institution, facility or agency licensed or funded by the department with laws, rules and policies relating to the rights and dignity of clients.

2. Maine Advocacy Services used to receive a General Fund appropriation but now does not. It is a private entity.

3. The Department contracts with community agencies to provide advocacy, education and peer and family support services. The particular agency would have to provide information about the proportions of their services within those fields. In 1995-96 the Department provided funding to Mid-Coast Compeer ($2000), Southern Maine Regional Mental Health Board ($103,333), and the Alliance of the Mentally Ill of Maine ($375,776).

4. The Long Term Care Ombudsman Program is a private non-profit organization that provides investigation, education, assistance and advocacy services for residential care, long-term care, home-based care and adult day care. Its duties are set forth in 22 MRSA §5106, sub-§11-C and 5107-A. Funding is provided through the Department of Human Services, Bureau of Elder and Adult Services. Employees are not state employees. The appropriation for FY 1996-97 is $202,558 (subject to deappropriation).

Jane Orbeton, OPLA, 9/25

State of Maine
REQUISITION FOR SPECIAL SERVICES CONTRACT

Date: September 26, 1996

Department: Mental Health and Mental Retardation
Contact: Rod Bouffard, Superintendent
Contractor: Liberty Healthcare Corporation
Telephone: 287-7230
Contractual Services: Professional services - One (1) Medical Director and four (4) staff psychiatrists.
Contract Sum: $2,467,040.00
Appr.:014 14b 2401 202 4099
Appr.:010 14b 5401 102 4099
Term: ending 9/30/98

NOTE: Respond to all questions below applicable to this contract. Additional pages may be attached as necessary.

SUBSTANTIATION OF NEED:

Despite concerted efforts to recruit qualified physicians to fill vacancies at Augusta Mental Health Institute, state line positions remain vacant. The Department has met the need for psychiatric services through Locum Tenens agreements, which provide very little continuity of care and make development of stable doctor/patient relationships difficult at best. Through this contract, the Department gains the benefit of experienced physician recruiters with a proven track record, as well as greater continuity of physicians' services.

IMPACT OF CONTRACT ON CIVIL SERVICE SYSTEMS:

This Agreement reflects the Department's continuing difficulty in recruiting qualified individuals to fill state line positions.

EMPLOYER/EMPLOYEE RELATIONSHIP BETWEEN STATE AND CONTRACTOR:

None.

EFFECT ON STATE AFFIRMATIVE ACTION EFFORTS:

None.

JUSTIFICATION FOR SOLE SOURCE PROCUREMENT (if applicable):

The sole source nature of the contract is justified by the need for immediate access to qualified medical staff and administration with reasonable continuity of care for patients, best assured by a two year contract term. The provider is unwilling to provide these services for any term shorter than two years. The Department reviewed several options to address the need for a more stable, permanent psychiatric staff at AMHI. A summary of that review is attached. The number of potential contractors for these services is very limited. All other providers capable of providing such services in the State of Maine were consulted and advised that they would be unable to bid on a contract of this nature. Liberty Healthcare was deemed the most appropriate to work with due to the combination of their successful experience providing psychiatrc services in several states, and the positive references given by those states to the Department.

MSEA REVIEW: Date Forwarded: ( )Info Request ( )Conference Date Cleared: File No.________

Please forward to: Bureau of Purchases, Room 1119, State Office Building
State House Station No. 9, Augusta, Maine 04333

STATE OF MAINE
CONTRACT FOR SPECIAL SERVICES

PO H996255

E232428586	$1,562,130.00	014	14B	2401		202		4099				
E232428586	904,910.00	014	14B	5401		102		4099				

Termination Date September 30, 1998 Date Received ____________

THIS AGREEMENT, made this 1st day of October, 19 96, is by and between the State of Maine, Dept. of Mental Health, Mental Retardation & Substance Abuse Services hereinafter called "Department," and Liberty Healthcare Corporation hereinafter called "Contractor."

The type of organizition of the Contractor is (complete appropriate statement):

- ☐ 1. An individual doing business as ____________
- ☐ 2. A partnership.
- ☒ 3. A corporation of the State of PA (Pennsylvania)
- ☐ 4. Other ____________

The principal office of the Contractor is located at (street, city, state, zip):
401 City Avenue, Suite 820, Bala Cynwyd, PA 19004

The Employer Identification Number of the Contractor is 23-2428586
IRS or Social Security Number

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and performed by the Department, the Contractor hereby agrees with the Department to furnish all qualified personnel, facilities, materials and services and in consultation with the Department, to perform the services, study or projects described in Rider A. The following riders are hereby incorporated into this contract by reference:

Rider A — Specifications of Work to be Performed
Rider B — Payment and Other Provisions

ENCUMBERED $256,760 OCT 0 1 1996 STATE CONTROLLER

IN WITNESS WHEREOF, the Department and the Contractor, by their representatives duly authorized, have executed this agreement in six (6) originals as of the day and year first above written.
Number

APPROVED AS TO FORM:

Date: ____________ 19__

By: ____________
Attorney General

DEPARTMENT:

Mental Health, Mental Retardation, and Substance Abuse Services
Department Name

By: [signature]
Authorized Signature

Melodie J. Peet, Commissioner
Typed Name and Title

APPROVED, CONTRACT REVIEW COMMITTEE:

Date OCT 01 1996 19__

BY: [signature] RCB
Chairman

CONTRACTOR:

Liberty Healthcare Corporation
Contractor Name

BY: [signature]
Authorized Signature

Herbert T. Caskey, M.D., President
Typed Name and Title

*By Bureau of Accounts and Control

BP54 (863) (Rev. 9/89)

TINTED FIELDS ARE REQUIRED ON MFASIS

CONTRACT FOR SPECIAL SERVICES
RIDER A
SPECIFICATIONS OF WORK TO BE PERFORMED

I. Parties and Statement of Intent

A. Background. The Augusta Mental Health Institute ("Institute") is a state operated acute psychiatric hospital licensed by the Maine Department of Human Services, certified by the Health Care Financing Administration, and accredited by the Joint Commissioner on Accreditation of the Healthcare Organizations. The Institute is managed and operated by the Department, in accordance with the requirements of federal and state law, and the requirements of the Consent Decree in Maine Superior Court Civil Action Docket No. 89-88 and related Court Orders ("Consent Decree"), and the bylaws, rules and policies of the Institute and its medical staff, all as may be amended from time to time.

1. Institute. The Institute provides three types of services: (1) a forensic program that provides evaluation and treatment of adults who are committed by the courts prior to adjudication; (2) acute in-patient psychiatric treatment for adults who have been referred for admission by appropriate community providers; and (3) an out-patient clinic that provides clinical services to adults. The Institute is funded through state and federal funds and third party reimbursements and patient fees. Services are available to residents of Maine regardless of ability to pay, providing each individual meets criteria for admission as set forth in state law and the controlling Consent Decrees.

2. Liberty Healthcare Corporation. Liberty Healthcare Corporation is an eighteen year old management firm. It is totally committed to public sector medical services, providing all or significant parts of medical services to state facilities throughout the country. It provides a broad array of services in psychiatric, emergency medicine, occupational medicine, and ambulatory care. Liberty Health Care Corporation is the largest provider of psychiatric and primary contract medical management services to public psychiatric facilities in the United States.

B. Purpose. The purpose of the contract is to establish the mechanism that enables the State to provide clinical management and psychiatric services for the Institute. The parties intend to enter into a written contract whereby Liberty will provide professional services as hereinafter set forth for the Institute located in Augusta, Maine and, in the event that downsizing or closure occurs, in an alternative community care setting. The parties expressly acknowledge the responsibility of the State to comply with the provisions of the Consent Decree and agree that this contract shall be construed so as to maximize the State's ability to comply with the Consent Decree, and that in no event shall the contract be construed in such a fashion as to hinder or prevent the State's compliance with the Consent Decree,

or to require payment of penalties or damages by the State in the event that the contract must be modified to achieve such compliance. This provision shall not be interpreted to require an increase in services by the Contractor without an appropriate increase in compensation.

II. Scope of Services

A. Duties of Contractor. The Contractor will provide professional services for the Department's Institute located in Augusta, Maine, as follows. It is understood that Contractor's primary responsibility will be the provision of services at the Institute, or other transfer location assigned under the terms of this Agreement.

1. Provision of Services

(a) Physician Services (Psychiatric). Contractor agrees to provide one (1) psychiatrist medical director who is Board Certified and has demonstrated medical administrative experience and four (4) staff psychiatrists who are Board Certified or Board Eligible who will provide their services at the Institute 1,720 hours per year. One psychiatrist shall be on-call by telephone to consult for psychiatric emergencies for the Institute during nights, weekends, and holidays. The Superintendent and Medical Director of Institute shall approve Contractor's selection and/or retention of physicians to be provided pursuant to this Agreement. The Contractor shall provide no fewer than three (3) candidates for consideration for the position of Medical Director. The Superintendent shall approve selection and/or retention of the Medical Director. In the event that the Superintendent requests the removal of a physician, it shall be in writing with a minimum of thirty (30) days notice.

(b) Additional Physician Services. In addition to the positions set forth in 1 (a) above, the Institute currently has two (2) full-time equivalent psychiatric positions. In the event that the current physicians filling these full-time equivalent slots leave these positions and in the event the Department determines that it is necessary that the position be refilled, said positions shall immediately be added to this Agreement. The terms and conditions relating to such positions will be negotiated between the parties at that time, and this Agreement shall be amended in writing to reflect said changes.

(c) Management/Location Services. Contractor agrees to use its best efforts and due diligence to timely locate qualified physicians to fill the positions referred to in this Agreement and to seek to provide continuity of care to Institute patients through a stable group of psychiatrists.

2. Scope of Contractor Services

(a) Treatment Standards. Contractor agrees that at all times during the term of this Agreement, its physician(s) will make available psychiatric treatment to persons who are admitted to the Institute in need of treatment, irrespective of ability to pay. Such treatment shall be consistent with the facilities available and the standard established in the medical community of which the Institute is a part, and shall conform to the ethical and professional standards of the American Medical Association, American Psychiatric Association and the standards of the Joint Commission on Accreditation of Healthcare Organizations, as well as any requirements imposed by the Consent Decree.

(1) Contractor agrees that at all times during the term of the agreement, its physicians will participate in the Institute's utilization review, quality assurance and other required committees.

(2) Contractor agrees that it will comply with all standards as described in this contract, as may be amended from time to time by law, regulation, or court order.

(b) Medical Records. Contractor physician(s) shall maintain adequate and current medical records for persons treated in the Institute in the manner required by the Institute. The medical records shall comply with the standards set forth by the Medical Records Committee of the Institute, and with acceptable standards and practice.

(c) Insurance. Contractor shall furnish a professional liability insurance policy to cover each individual physician with limits of $1,000,000.00 per occurrence with a $3,000,000.00 total policy limit. Department has the right to review any insurance policies procured by the contractor, and to approve any changes in insurance coverage. Such approval will not be unreasonably withheld. Failure to provide proof of insurance acceptable to the Department is grounds for immediate termination of this Agreement by the Department. At the time of termination of this Agreement, Contractor shall provide continuous coverage for services rendered by Contractor and/or its sub-contractors and employees using a professional liability insurance policy subject to the same Departmental review and approval provisions described above, for a period sufficient to meet any Maine statute of limitations applicable to all patients treated.

(d) Independent Contractor Status; Performance Standard. It is mutually understood and agreed that, in the performance of the work, duties and obligations under this Agreement, Contractor is at all times acting and performing as an independent contractor. The standards of medical practice and standards of professional duties of physician(s) shall be consistent with the standard established in the medical community

of which the Institute is a part, and shall conform to the ethical and professional standards of the American Medical Association, American Psychiatric Association and the standards of the Joint Commission on Accreditation of Healthcare Organizations, as well as any requirements imposed by the Consent Decree. All applicable provisions of law and other rules and regulations of any and all governmental authorities relating to licensure and regulation of physician(s) and to the operation of the Institute (including the Consent Decree) shall be fully complied with by all parties hereto; in addition, the parties shall also operate and conduct the Institute in accordance with the standards and recommendations of the Healthcare Financing Administration (HCFA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the bylaws, rules and regulations and policies of the medical staff as may be amended from time to time.

(e) Monthly Visits. Contractor senior management during the initial six month period of operation will visit the Institute monthly to insure proper success and not less than once per calendar quarter for each subsequent twelve (12) month period.

(f) Consulting Services. Institute shall have access to Contractor's pool of consultants for agreed upon telephone and on-site visits in areas including quality improvement, psychology, medical staff structuring, nursing, surveys, and JCAHO.

B. Duties of the Institute

1. Supplies. The Institute shall provide Contractor physician(s) with all expendable and non-expendable equipment, computers, drugs, supplies, furniture, and fixtures which the parties mutually agree are required for the efficient provision of services under this Agreement.

2. Nursing Services. Institute shall provide services of nurses and all other physician and non-physician personnel (including dictation services), excluding the personnel provided by Contractor, which the parties mutually agree are reasonably required for the efficient operation of the Institute.

3. Practice Limitations. During their term of duty at the Institute, all psychiatrists shall limit their practice to treating Institute patients only. Notwithstanding the above, psychiatrists may perform occasional outside practice duties, with the advance written approval from the Superintendent of the Institute, but only if said duties do not, in the sole judgment of the Superintendent, interfere with the psychiatrists' duties at the Institute.

4. Staff Membership. Before an individual psychiatrist shall be permitted to serve hereunder, he must give evidence that he has been licensed in the State of Maine and shall

be required to submit his credentials for the purpose of becoming a member of the Medical Staff of the Institute in accordance with the rules and regulations of the Institute.

5. Temporary Replacements. Should a temporary replacement be required for an individual psychiatrist serving hereunder, it is agreed that any such replacement must be approved in advance by the Institute.

III. **Term**

This Agreement shall be in effect for a twenty-four (24) month term commencing October 1, 1996 and terminating on September 30, 1998. The Agreement may be extended for an additional two year period upon mutual written agreement of the parties no later than March 31, 1998. Notwithstanding this provision, the State may elect to terminate this Agreement at any time, pursuant to the termination provisions of this Agreement.

IV. **Fees**

A. Institute Patients. Fees for services to Institute patients shall be established by the Institute. All fees shall be established and charged, subject to the polices of Institute, in a manner to assure compliance with the policies and schedules for reimbursement by third-party payors.

B. Billing for Fees. Contractor shall not directly bill or receive professional fees from patients or third-party payors for the performance of services under the terms of this Agreement. Institute shall bill for all services provided under the terms of this Agreement. All billing and collection services where applicable shall be provided by the Institute.

C. Compensation to Contractor. The Department shall compensate Contractor in accordance with the provisions of this Paragraph.

1. Management Fee. From October 1, 1996 until September 30, 1997 the Department shall pay Contractor twenty-nine thousand nine hundred and fifty eight dollars and thirty three cents ($29,958.33) per month for its Management Fee for the services rendered by this Agreement, as set forth in Exhibit #1.

2. Physician Compensation and Benefits. From October 1, 1996 until September 30, 1997 in addition to any money paid to Contractor in paragraph IV.C.1 above, the Department will pay Contractor its monthly charges for physician compensation and physician benefits as set forth in Exhibit #1 attached hereto and made part hereof as services are provided. Said monthly charges

shall be 1/12 of any amounts as set forth in Exhibit #1 for each staffed position.

3. Institute Payment. All monthly compensation as set forth in paragraph IV.C.1 and 2 above shall be paid by the Department to Contractor within 30 days of receipt of an itemized invoice for the preceding month's services.

4. Inflation Adjustment. For every twelve (12) month period following the first (12) months of this Agreement, during any term of this Agreement commencing September 30 of each year, the Department shall increase Contractor's compensation and charges as set forth in paragraph IV.C. 1 and 2 above by the annual percentage increase in the Physician component of the Medical Care Index of the United States Consumer Price Index, published in the month of January that immediately precedes said twelve (12) month period by the U.S. Department of Labor, Bureau of Labor Statistics for all urban consumers, the U.S. city average.

5. Contractor Recruitment Efforts. Department acknowledges that recruitment and/or replacement of physicians may take considerable time, during these times when one or more physicians are not present, Contractor shall only charge pursuant to paragraph IV.C.2 for those physicians it is actually providing. Department shall pay Contractor its Management Fee pursuant to paragraph IV.C.1 above regardless of the number of physicians Contractor is providing on a monthly basis.

D. Temporary Medical Director Expenses. In the event Contractor provides a temporary Medical Director, Department shall pay for or provide, at its option, said Medical Director's reasonable travel and lodging costs to include meals, an automobile, and automobile insurance coverage with limits of $300,000.00 in addition to compensation to Contractor as set forth in paragraph IV.C above.

V. **Service of Notices**

Notices to be served on the Department shall be served by certified mail, return receipt requested to: Commissioner Department of Mental Health/Mental Retardation and Substance Abuse Services, State Office Building, (Station #40) Augusta, Maine 04333-0040, and Acting Superintendent, Augusta Mental Health Institute, P.O. Box 724, Augusta, Maine 04332-0724. Notice to be served on Contractor shall be served by certified mail, return receipt requested at 401 City Avenue, Suite 820, Bala Cynwyd, PA 19004 or Contractor's last known address.

VI. **Amendments**

This Agreement constitutes the entire Contract between the parties hereto, pertaining to the subject matter hereof, and supersedes all prior and contemporaneous agreements, understandings, negotiations and discussions, whether written or oral, of the parties, and there are no representations or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth herein. No supplemental modification or waiver of this Agreement shall be binding unless executed in writing by the parties to be bound thereby.

VII. **Non-interference**

The Department and the Institute shall not employ, contract with, engage for hire or otherwise contract for service with any of Contractor's current or former subcontractor or employee physician(s), as defined below, at any time during any term of this Agreement or at any time less than three years after the termination of this Agreement. It is further agreed that the Department and the Institute shall not contract for services provided under this Agreement with any corporation, company, partnership, association, or other business entity in which any of Contractor's current or former subcontractor or employee physicians, as defined below, are an employee, subcontractor, consultant, advisor, partner, shareholder, owner, officer or director, at any time during any term of this Agreement or at any time less than three (3) years after the termination of this Agreement. Contractor's current or former subcontractor or employee physicians shall mean those physicians who have provided services in or for the Institute as employees, subcontractors, or consultants of Contractor, on behalf of Contractor, at any time during any term of this Agreement. Physicians who had a prior employment or direct contract relationship (e.g. not through any third party) with the State of Maine within three years prior to the date of the Agreement shall not be considered Contractor's subcontractor or employee physicians for purposes of rehiring by the State during any period after the term of this Agreement. It is further agreed by the Department and Contractor that the Department shall not enter into any agreement with any individual, partnership, corporation, association or other business entity to provide for the furnishing of psychiatric physician services at the Institute during any term of this Agreement, unless the Agreement has been terminated for nonappropriation under paragraph XI or for just cause under paragraph XII by the State of Maine. However, any of the provisions of this paragraph may be waived or amended by mutual written agreement of both parties. Notwithstanding any provisions of this paragraph, Contractor acknowledges that the Institute may contract with any individuals or entities in order to comply with the Consent Decree or fiscal or program audit requirements, including, but not limited to, death reviews, clinical assessments and facility evaluations.

VIII. Severability

The invalidity or unenforceability of any particular provision or part thereof of this Agreement shall not affect the remainder of said provision or any other provisions, and this contract shall be construed in all respects as if such invalid or unenforceable provision or part thereof had been omitted.

IX. Waiver

The waiver by either party of this Agreement of any breach of any provision of this Agreement by the other party shall not operate or be construed as a waiver of any subsequent breach.

X. Transfer of Contractor Personnel

In the event the State of Maine closes the Institute, or substantially downsizes the population of AMHI, it shall notify Contractor in writing of such closure or downsizing at least one hundred and eighty (180) days prior to such action, or as early as possible in the event of an action mandated by law or court order in a shorter time period. During the period of time after said notice and within one hundred and eighty (180) days of said closure or substantial downsizing, the Department shall make all good faith efforts to transfer all physicians provided by this Agreement to suitable positions either in the community or at another Departmental operated Mental Health facility. Said transfer requests shall be communicated in writing to Contractor. Contractor shall respond in a timely manner to the request and shall not unreasonably deny the request. The aforementioned locations shall not be a distance greater than approximately one hours drive from Institute without Contractor's written approval. However, said time restriction shall not apply to the Bangor Mental Health Institute. In the event said positions remain with the Contractor, this Agreement shall continue as stated for those positions; thus, these physicians shall continue as Contractor physicians under this Agreement. In the event some or all of staffed positions are not transferred by the Department and written notice of closure or downsizing was given during the first twelve months of this Agreement, then Contractor shall receive one hundred percent (100%) of its full compensation as set forth in paragraph IV.C.1 through 4 of this Agreement, including full compensation for staffing and support services as set forth in Exhibit #1 attached until the completion of the Agreement term. However, if the position terminated at the Institute was not actually staffed by Contractor at the time of closure or downsizing, or if Contractor has declined a transfer request under this section by the Institute with respect to that position, the Contractor shall not be entitled to receive compensation for staffing services as outlined in paragraph IV.C.2. In the event some or all of said positions are not transferred by the Department and notice was given after the first twelve months of

this Agreement, then Contractor shall receive fifty percent (50%) of its full compensation as set forth in paragraph IV.C.1 through 4 of this Agreement, including 50% of full compensation for staffing and support services as set forth in Exhibit #1 attached until the completion of the Agreement term, but only if the position terminated at the Institute was actually staffed by Contractor at the time of closure or downsizing and if Contractor has not declined a transfer request under this section.

XI. **Non-appropriation**

Notwithstanding any other provision of this Agreement, if the State does not receive sufficient funds to fund the contract and other obligations of the State, or legal authority to expend those funds from the Maine State Legislature or Maine courts, then the State is not obligated to make payment under this contract. The State also is not obligated to make payment if any required state or local matching money is not available at the time the bill is presented for payment. When an action is necessary in order to avoid deficit spending, the State may terminate the contract effective upon receipt of written notice to Liberty. Nothing set forth herein shall relieve the State of its obligation to make payment to Liberty for work actually performed under the contract prior to the date of notice of termination consistent with Rider B, Paragraph 16.

XII. **Termination for Just Cause**

The Contractor acknowledges that the Department may terminate this contract for just cause, including a material breach of this Agreement or a failure of Contractor to substantially perform its obligations under this Agreement. The Department shall provide at least 30 days notice to Contractor of the Department's intent to terminate for just cause.

XIII. **Termination Consequences**

In the event of termination for nonappropriation under paragraph XI or for just cause under paragraph XII, Contractor acknowledges that the State will have no continuing legal or financial obligations to Contractor after that date, including payment of compensation for staffing and support services as outlined in paragraph IV.C.1 through 4. Contractor further acknowledges that in the event of termination for nonappropration under paragraph XI or for just cause under paragraph XII, the non-interference provisions of paragraph VII shall apply, allowing the the State to hire qualified replacement personnel or contractors to replace the services that are the subject of this Agreement as provided for by paragraph VII.

XIV. **Governing law**

This Agreement shall be governed in all respects by the laws, statutes, and regulations of the United States of America and of the State of Maine. Any legal proceeding against the State regarding this Agreement shall be brought in State of Maine administrative or judicial forums.

XV. **Attorney's fees**

In the event of any litigation, appeal, or other legal action to enforce any provision of this Agreement, the Contractor and the State agree to pay their own expenses of such action including attorney's fees and costs at all stages of litigation, unless otherwise set by the court or hearing officer.

XVI. **Subcontractors**

It is understood that the Contractor may employ subcontractor physicians in the provision of services under this Agreement.

XVII. **Nonassignability**

Contractor shall not assign its rights or obligations under this Agreement to any other individual or entity without the prior written approval of the State of Maine. The State's approval shall be based wholly upon the sole discretion of the State, in light of the personal services nature of this Agreement.

EXHIBIT # 1

September 27, 1996

AUGUSTA MENTAL HEALTH INSTITUTE

LIBERTY HEALTHCARE BUDGET OF CHARGES

STAFFING

PHYSICIAN COMPENSATION:

Medical Director	$170,000
Staff Psychiatrist	$145,000
Staff Psychiatrist	$145,000
Staff Psychiatrist	$145,000
Staff Psychiatrist	$145,000
On-call Services	$93,520
Sub Total	**$843,520**

PHYSICIAN BENEFITS

Malpractice Insurance	$15,500
Continuing Medical Education	$15,000
Sub Total	$30,500

CONSULTATIVE SUPPORT SERVICES

As deemed required by Liberty to a maximum of the number of days set forth below:

Psychiatric Oversite	24 Days Annually	$21,600	
Medical Oversite	12 Days Annually	$10,800	
Quality Improvement Consultation	24 Days Annually	$12,000	
Nursing Staffing Consultation	12 Days Annually	$6,000	
Clinical Staffing Consultation	12 Days Annually	$6,000	
Administrative Consultation	24 Days Annually	$18,000	
Treatment Planning Consultation	12 Days Annually	$10,800	

Note: Some of these consultations and services may be delivered off-site or via written communication. Days of consultation include some travel time.

Travel and other Support Related Services		$9,000	
Sub Total			**$94,200** *

GENERAL AND ADMINISTRATIVE

Includes corporate staff & costs, recruiting costs, recruiting and corporate travel, moving expenses, etc.	23.00%	$222,691 *
PROFIT		**$42,609** *

* These items totaling $359,500 annually constitute the management fee referred to in Agreement Paragraph IV.C.1, and are paid monthly in the amount of $29,958.33.

TOTAL CHARGES FOR PSYCHIATRIC MANAGEMENT AND PHYSICIAN SERVICES: **$1,233,520**

Note: All charges set forth above may contain an element of profit.

RIDER B
PAYMENT AND OTHER PROVISIONS

1. CONTRACT PRICE. $2,467,040.00. Per monthly invoices.

	FY'97	FY'98	FY'99	Total
014 14B 2401 202 4099	$ 585,799.00	$ 781,065.00	$ 195,266.00	$1,562,130.00
010 14B 5401 102 4099	$ 339,341.00	$ 452,455.00	$ 113,114.00	$ 904,910.00
	$ 925,140.00	$1,233,520.00	$ 308,380.00	$2,467,040.00

2. INVOICES AND PAYMENTS. Payment shall be made by the Department within 15 days after receipt of an approved itemized invoice submitted by the Contractor upon his usual billing forms or business letterhead.

3. BENEFITS AND DEDUCTIONS. If the Contractor is an individual, the Contractor understands and agrees that he is an Independent Contractor for whom no Federal or State Income Tax will be deducted by the Department, and for whom no retirement benefits, survivor benefit insurance, group life insurance, vacation and sick leave, and similar benefits available to State employees will accrue. The Contractor further understands that annual information returns as required by the Internal Revenue Code or State of Maine Income Tax Law will be filed by the State Controller with the Internal Revenue Service and the State of Maine Bureau of Taxation, copies of which will be furnished to the Contractor for his Income Tax records.

4. INDEPENDENT CAPACITY. The parties hereto agree that the Contractor, and any agents and employees of the Contractor, in the performance of this agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

5. CONTRACT ADMINISTRATOR. All invoices, progress reports, correspondence and related submissions from the Contractor shall be directed to:

Name: Rodney E. Bouffard

Title: Acting Superintentent - Augusta Mental Health Institute.

Address: P.O. Box 724, Augusta, ME 04333

who is designated as the Contract Administrator on behalf of the Department for this contract.

6. DEPARTMENT'S REPRESENTATIVE. The Contract Administrator shall be the Department's representative during the period of this agreement. He has authority to stop the work if necessary to insure its proper execution. He shall certify to the Department when payments under the contract are due and the amounts to be paid. He shall make decisions on all claims of the Contractor, subject to the approval of the Head of the Department.

7. CHANGES IN THE WORK. The Department may order changes in the work, the contract sum being adjusted accordingly. All such orders and adjustments shall be in writing. Claims by the Contractor for extra cost must be made in writing and signed by the Contract Administrator before executing the work involved.

8. PERIOD OF PERFORMANCE. The Contractor shall (check one as applicable):

a. Work when called by the Department

10. SUBLETTING, ASSIGNMENT OR TRANSFER. The Contractor shall not sublet, sell, transfer, assign, or otherwise dispose of this agreement or any portion thereof, or of his right, title or interest therein, without written request to and written consent of the Contract Administrator, except to a bank. No subcontracts or transfer of agreement shall in any case release the Contractor of his liability under this agreement.

11. EQUAL EMPLOYMENT OPPORTUNITY. During the performance of this contract, the Contractor agrees as follows:

    a. The contractor will not discriminate against any employee or applicant for employment relating to this agreement because of race, color, religious creed, sex, national origin, ancestry, age or physical handicap, unless related to a bona fide occupational qualification. The Contractor will take affirmative action to insure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age or national origin. Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Contractor agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

    b. The Contractor will, in all solicitations or advertising for employees placed by or on behalf of the Contractor relating to this agreement, state that all qualified applicants will receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age or physical handicap.

    c. The Contractor will send to each labor union or representative of the workers with which he has a collective or bargaining agreement, or other contract or understanding, whereby he is furnished with labor for the performance of this contract, a notice, to be provided by the contracting department or agency, advising the said labor union or workers' representative of the Contractor's commitment under this section and shall post copies of the notice in conspicuous places available to employees and to applicants for employment.

    d. The Contractor will cause the foregoing provisions to be inserted in any subcontracts for any work covered by this agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials. The Contractor, or any subcontractor holding a contract directly under the Contractor, shall, to the maximum feasible, list all suitable employment openings with the Maine Employment Security Commission. This provision shall not apply to employment openings which the Contractor, or any subcontractor holding a contract under the Contractor, proposes to fill from within its own organization. Listing of such openings with the Employment Service Division of the Maine Employment Security Commission shall involve only the normal obligations which attach to such listings.

12. EMPLOYMENT AND PERSONNEL. The Contractor shall not engage on a full-time, part-time or other basis during the period of this agreement, any professional or technical personnel who are or have been at any time during the period of this agreement in the employ of any State Department or Agency, except regularly retired employees, without the written consent of the public employer of such person. Further, the Contractor shall not engage on this project on a full-time, part-time or other basis during the period of this agreement any retired employee of the Department who has not been retired for at least one year, without the written consent of the Contract Review Committee.

13. STATE EMPLOYEES NOT TO BENEFIT. No individual employed by the State at the time this contract is executed or any time thereafter shall be admitted to any share or part of this contract or to any benefit that may arise therefrom directly or indirectly due to his employment by or financial interest in the Contractor or any affiliate of the Contractor. This provision shall not be construed to extend to this contract if made with a corporation for its general benefit.

14. WARRANTY. The Contractor warrants that it has not employed or written any company or person, other than a bonafide employee working solely for the Contractor to solicit or secure this agreement, and that it has not paid, or agreed to pay any company or person, other than a bonafide employee working solely for the Contractor any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this agreement. For breach or violation of this warranty, the Department shall have the right to annul this agreement without liability or, in its descretion, to deduct from the contract price or consideration, or otherwise recover the full amount of such fee, commission, percentage, brokerage fee, gifts, or contingent fee.

15. ACCESS TO RECORDS. The Contractor shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to cost incurred under this agreement and to make such materials available to their offices at all reasonable times during the period of this agreement and for three years from the date of the expiration of this agreement, for inspection by the Department or any authorized representative of the State of Maine and copies thereof shall be furnished, if requested.

16. TERMINATION. The performance of work under the contract may be terminated by the Department in whole, or, from time to time, in part whenever for any reason the Contract Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Contractor of a Notice of Termination specifying the extent to which performance of the work under the contract is terminated and the date on which such termination becomes effective. The contract shall be equitably adjusted to compensate for such termination and the contract modified accordingly. In any event, this contract shall terminate on September 30, 1998.

17. GOVERNMENTAL REQUIREMENTS. The Contractor warrants and represents that all governmental ordinances, laws and regulations shall be complied with.

18. INTERPRETATION AND PERFORMANCE. This agreement shall be governed by the laws of the State of Maine as to interpretation and performance.

19. OWNERSHIP. All notebooks, plans, working papers, or other work produced in the performance of this contract are the property of the Department and upon request shall be turned over to the Department.

20. STATE HELD HARMLESS. The Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work, services, materials or supplies in connection with the performance of this contract, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this contract and against any liability, including costs and expenses for violation of proprietary rights, copyrights, or rights of privacy, arising out of publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this contract or based on any libelous or other unlawful matter contained in such data.

21. APPROVAL. This contract us subject to the approval of the Maine Attorney General's Office, the Contract Review Committee and the State Controller before it can be considered as a valid, executable document.

22. ENTIRE AGREEMENT. This contract contains the entire agreement of the parties, and neither party shall be bound by any statement or representation not contained herein.

DISTRIBUTED 10/7/96

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION

Alphabetical Listing of Agencies

FY96 Estimated Expenditures as of January 31, 1996

	State	Federal	Total
Acadia Hospital, Inc.	371,101		371,101
Alliance for the Mentally of Maine	427,276		427,276
American Red Cross - Mid Coast Chapter	20,900		20,900
American Red Cross - Pine Tree Chapter	584,500		584,500
Androscoggin Home Health	5,798		5,798
Area IV Mental Health Coalition	195,646		195,646
Aroostook Council On Transition	34,904		34,904
Aroostook Mental Health Center	1,582,517	203,579	1,786,096
Autism Society of ME	4,000		4,000
Bangor Area Coord Council	35,175		35,175
Bath Brunswick Child Care Services	65,900		65,900
Borderview Manor	11,680		11,680
Case Management for Youth		3,884	3,884
Catholic Charities	482,849		482,849
Center for Community Inclusion (FC)	39,408		39,408
Central Aroostook Assn. for Retarded Citizens	118,474	84,104	202,578
Cerebral Palsy Center	116,000		116,000
Certified Interpreting Associates	7,000		7,000
Charlotte White Center	27,342		27,342
Child Health Center	113,104		113,104
Child & Youth Board of Washington Cty.	124,500		124,500
Children's Center	163,000		163,000
Citizen's Interest Group	5,000		5,000
Coastal Economic Dev Corp	11,000		11,000
Coastal Transportation	24,077		24,077
Coastal Workshop	303,792	94,835	398,627
Community Counseling Center	60,158		60,158
Community Health and Counseling Center	1,268,696	430,410	1,699,106
Community Living Association	66,786	49,667	116,453
Community Living Options	76,500		76,500
Community Support Services	112,656		112,656
Crisis and Counseling Center	540,760		540,760
Crotched Mountain Rehab Center	15,400		15,400
Cumberland Cty Parent Awareness	3,000		3,000
Devereux Foundation	203,712		203,712
Downeast Horizons	69,740		69,740
Drug Rehabilitation, Inc.	21,514		21,514
Elmhurst	65,172		65,172
Evergreen Behavorial Services	104,460		104,460
Florida Institute of Neuro-Rehabilitation	64,500		64,500
Forest City Resources	96,427		96,427
Goodwill Industries	504,797	24,236	529,033

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Alphabetical Listing of Agencies
FY96 Estimated Expenditures as of January 31, 1996

	State	Federal	Total
Gorham Health Care	149,102		149,102
Great Bay	33,653		33,653
Greater Rumford Alliance	228,425		228,425
Green Valley	70,445		70,445
Group Home Foundation	9,700	67,894	77,594
Hawthorne House	138,502		138,502
HealthReach Network	198,615		198,615
Helping Hands for Children and Families	30,000		30,000
HFP Management	177,200		177,200
Home Counselors, Inc.	81,700	40,500	122,200
Independence	224,000		224,000
John F. Murphy Homes, Inc.	211,251		211,251
Katahdin Friends	77,792		77,792
Ken-A-Set Association	187,000		187,000
Kennebec Valley Mental Health Center	277,826	84,483	362,309
Kennebec Valley Transition Council	37,340		37,340
Lakeview (Highwatch)	44,000		44,000
Maine Association for Autism	6,000		6,000
Maine Association of Broadcasters	25,000		25,000
Maine Center for the Blind	14,469		14,469
Maine Foster Parents Association	2,500		2,500
Maine Medical Center	79,080		79,080
Maine Parent Federation	51,900		51,900
Maine Resource Development Corporation	66,868		66,868
Maine Special Olympics	25,000		25,000
Maine Vocational Region 9	46,520		46,520
Markland Enterprises	60,792		60,792
Medical Care Development	96,283		96,283
MERT Enterprises	12,102		12,102
Mid-Coast Children's Services	80,000		80,000
Mid-Coast Compeer	2,000		2,000
Mid-Coast Mental Health Center	609,371	153,837	763,208
Mid-Maine Medical Center	7,200		7,200
Mobius, Inc.	6,551	65,270	71,821
Motivational Services	893,324	10,000	903,324
Mt. Saint Joseph	113,937		113,937
Multi Handicapped Center of Central Aroostook	24,730		24,730
Multi Handicapped Center of Penobscot Valley	127,083	77,388	204,471
New Beginnings		36,500	36,500
NFI North, Inc.	235,037		235,037
Northern Maine Medical Center	57,670		57,670
Northern Maine General Hospital	37,795		37,795

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Alphabetical Listing of Agencies
FY96 Estimated Expenditures as of January 31, 1996

	State	Federal	Total
No. Aroostook Association for the Handicapped	4,040		4,040
N.E. Occupational Exchange	4,776		4,776
Opportunity Housing, Inc.	161,368		161,368
Oxford County Assn. for Retarded Citizens	9,294		9,294
Pathways, Inc.	191,192		191,192
Penobscot County Sheriff's Department	6,000	93,500	99,500
Penquis CAP, Inc.	99,200		99,200
Peregrine	55,696		55,696
Personal Services of Aroostook	155,805		155,805
Pine Tree Legal Assistance	26,878		26,878
Pine Tree Society	23,000		23,000
Pineland Parents and Friends	40,670	0	40,670
Port Resources	148,667	0	148,667
Pottle Hill	61,533	65,270	126,803
Project Atrium	318,350	36,500	354,850
RAFTS (47 Wood Street)	12,292		12,292
Regional Education Treatment Center	22,800		22,800
Resources for Developmentally Disabled	660	42,565	43,225
River Resources	97,939	64,055	161,994
Riverside Estates, Inc.	23,450		23,450
Rumford Group Home	204,336		204,336
SAD #20 Fort Fairfield School	32,600		32,600
Sandy River Rehab	43,091	35,425	78,516
Sebasticook Farms	248,335	77,388	325,723
Sedgewood Commons	22,960		22,960
Sentry Enterprises	8,600		8,600
Shalom House	461,135		461,135
Shoreline Community Mental Health Services	594,143	80,431	674,574
Shoreline Mental Health Center	290,023	77,930	367,953
So Penob Reg Prog for Except Children	44,400		44,400
Southern Maine Regional Mental Health Board	4,142,804	280,100	4,422,904
Southern Me. Technical College	10,000		10,000
Spaulding Youth Center	17,580		17,580
Special Children's Friends	77,800		77,800
Spurwink School	548,685		548,685
St. John Valley	72,942	6,975	79,917
Sunrise Opportunities	130,698		130,698
Sweetser Children's Services	628,923		628,923
The Children's Center	47,200		47,200
The Pines	59,716		59,716
Together Place	553,289		553,289
Town of Dexter	34,840		34,840

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Alphabetical Listing of Agencies
FY96 Estimated Expenditures as of January 31, 1996

	State	Federal	Total
Tri-County Mental Health Center	1,455,509	283,096	1,738,605
United Cerebral Palsy of N.E. Maine	89,500		89,500
United Families for Children's Mental Hlth		100,000	100,000
University of Maine	52,995	12,390	65,385
Uplift	14,002		14,002
Waban Projects	368,911		368,911
Washington County Psychotherapy	708,846		708,846
Wings for Children and Families		3,322,890	3,322,890
Woodfords, Inc.	124,993		124,993
Work Opportunities	54,490		54,490
Yesterday's Children	3,700		3,700
York County Community Action Program	36,998		36,998
York County Parent Awareness	40,500		40,500
York County Shelters		36,500	36,500
York Cumberland Association	46,225	68,809	115,034
Youth Alternatives	553,440		553,440
Youth and Family Services	77,018		77,018
YWCA of Portland	100,710		100,710
ıdividual Providers	597,029	3,600	600,629
Total	27,069,560	6,114,011	33,183,571 *

*Does not include $44,402,647 in Medicaid seed journaled directly to DHS for the benefit of clients served through agencies jointly funded by the Department and the Federal Medicaid Program.

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION
Division of Mental Health
Summary by Category of Service

	State	Federal	Total
Community Residential Services	3,858,898		3,858,898
Community Support Services	2,454,109	618,990	3,073,099
Deaf Services	101,136		101,136
Emergency/Crisis Services	3,486,482	297,489	3,783,971
Geriatric Services	1,298,011		1,298,011
Inpatient Services	75,682		75,682
Medication Clinic Services	743,303	30,000	773,303
Outpatient Services	240,673	72,648	313,321
Peer/Family Support Services	481,109		481,109
Social Clubs	1,130,738		1,130,738
Vocational Services	391,114		391,114
Other	505,429	150,895	656,324
Totals	14,766,684	1,170,022	15,936,706 *

* This amount does not include $8,036,974 in Medicaid seed journaled directly to DHS for the benefit of clients served through agencies jointly funded by the Division of Mental Health and the Federal Medicaid Program.

Division of Mental Health
Peer/Family Support Services

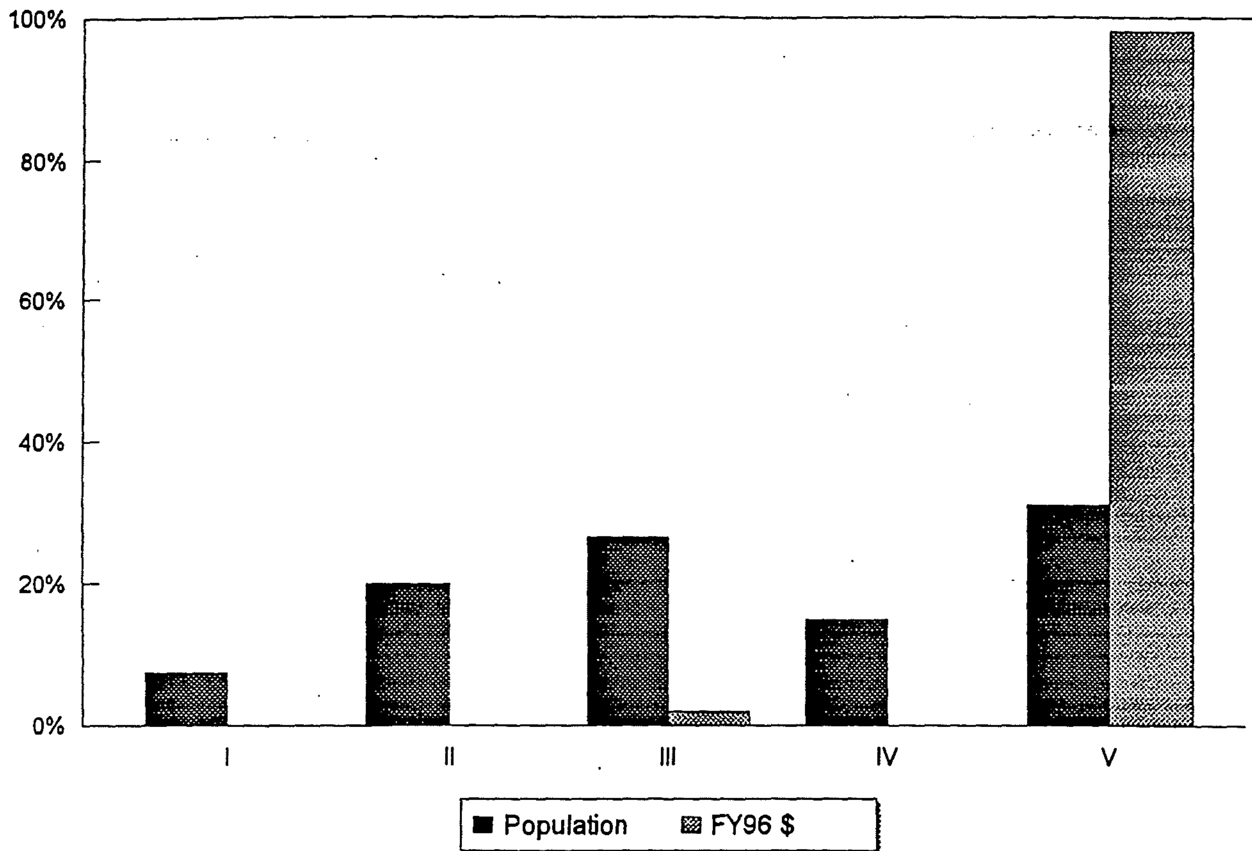
	State	Federal	Total
*Alliance of the Mentally Ill of Maine	375,776		375,776
*Mid-Coast Compeer	2,000		2,000
*Southern Maine Regional Mental Health Board	103,333		103,333
Total Peer/Family Support Services	481,109	0	481,109

Family/Peer Support services include support, education, and advocacy for families of persons with mental illness as well as consumer support and self-advocacy.

Division of Mental Health
Social Clubs

	State	Federal	Total
Area IV Mental Health Coalition	111,500		111,500
Aroostook Mental Health Center	30,600		30,600
Community Living Options	76,500		76,500
Greater Rumford Alliance	23,425		23,425
Motivational Services	252,317		252,317
Southern Maine Regional Mental Health Board	590,563		590,563
Together Place	45,833		45,833
Total Social Clubs	1,130,738	0	1,130,738

Social clubs are community-based-drop-in centers for people who are current or past recipients of mental health services and who have been labeled as having a mental illness. Club members are integrally involved in the operation of and decision-making process regarding the functioning of all aspects of the social club. Members and staff work together to provide varied social, recreational and educational opportunities.



Region	I	II	III	IV	V
Population	88,520	240,040	320,990	179,380	375,870
FY96 $	$0	$0	$2,000	$0	$103,333

In addition to the regional funding shown above, the Division spends $375,776 for state-wide peer and family support services.

Peer/Family Support Services

The Division of Mental Health provides funding to the Alliance for the Mentally Ill of Maine and local affiliates for support, education and advocacy for families of persons with mental illness. Also DMH provides assistance to consumer support and self-advocacy organizations and individuals, including the Portland Coalition for the Psychiatrically Labeled.

DISTRIBUTED 10/1/96

OFFICE OF ADVOCACY (MH&MR)

RICHARD A ESTABROOK, ESQ., CHIEF ADVOCATE

Central Office: STATE OFFICE BLDG, AUGUSTA, ME 04333
Mail Address: 60 STATE HOUSE STATION, AUGUSTA, ME 04333
Established: 1975 *Telephone:* (207) 287-2205
Reference: Policy Area: 03 ; *Umbrella:* 14 *Unit:* 207 ; *Citation:* T0034B M.R.S.A., *Sect.* 000001205
Average Count–All Positions: 14.00 *Legislative Count:* 14.00

PURPOSE:

The Office of Advocacy is established within the Department of Mental Health and Mental Retardation to investigate the claims and grievances of clients of the Department. The Office also advocates for compliance with all laws, administrative rules and regulations, and institutional and other policies relating to the rights and dignity of these clients, and acts as a monitor of restrictive and intrusive treatments. In addition, the Office of Advocacy is designated investigatory agent of the Department under the mandate of the Adult Protective Services Act (22 M.R.S.A., Sect. 3470 et seq.).

ORGANIZATION:

Presently, Pineland has 1.5 advocate positions, AMHI has two and BMHI has one. In addition, there are seven community advocate positions for persons with mental retardation who reside in the community. One community advocate also serves persons at the Levinson Center. There is also one advocate serving clients of the Bureau of Children with Special Needs. One chief advocate supervises all of the advocates.

The community advocates and the advocates at Pineland: (1) investigate allegations of abuse exploitation and neglect pertaining to persons with mental retardation; (2) approve and monitor the utilization of aversive behavior modification plans both at Pineland and in the community; (3) represent clients at inter-disciplinary team meetings at which programs for treatment, services, goals and habilitation are planned, developed and recorded; (4) seek ways to implement and enforce the rights of persons with mental retardation under the Community Consent Decree, state and federal law; and (5) review policies and actions of the Bureau's regional offices and at Pineland and suggest ways to deliver high quality care to persons with mental retardation.

The three advocates based in the state's two major mental health institutions (1) investigate allegations of abuse, exploitation and neglect; (2) assist in the investigation, prosecution and resolution of patient grievances; (3) attend treatment team meetings to aid in having the patient's treatment desires met; and (4) review and suggest policies and practices which encourage humane care. In addition, the advocates at AMHI advocate for compliance with the provisions of the AMHI Consent Decree. The Office of Advocacy administers a contract under which civil legal services may be provided to clients and patients of the Department.

PROGRAM:

The Office of Advocacy has provided assistance or information to upwards of 2,000 people with mental health difficulties and/or mental retardation through investigations of alleged abuse, review of aversive programming, representation of clients at Interdisciplinary Team meetings and Pupil Evaluation Team meetings. The Office has been actively involved in the implementation of the AMHI Consent Decree and regulations assuring mentally ill patients' rights and actively enforces those rights. The Office is also actively involved in the enforcement of the Community Consent Decree, which is a modernized version of the old Pineland Consent Decree. A major goal of the Office is to be able to provide to the Department suggestions which will not only impact upon individual client's lives, but will also aid the Department and clients in general, through helpful systematic changes.

PUBLICATIONS:

(1) Pineland Center Clients' Rights Handbook-free from Advocate, Pineland Center, Box C, Pownal, ME 04069. (2) Patients' Rights at Augusta Mental Health Institute-free from Advocate, AMHI, P.O. Box 74, Augusta, ME 04330. (3) Patients Rights at Bangor Mental Health Institute (in French/English)-free from Patient Advocate, BMHI, P.O. Box 926, Bangor, ME 04401. (4) Rights of Recipients of Mental Health Services-free from the Chief Advocate, SHS 60, Augusta, ME 04333, or any of the advocates in the mental health institutions. (5) Copies of the

Consent Decree and the Pineland Consent Decree, free, from Chief Advocate, SHS 60, Augusta, ME 04333. The Office of Advocacy and each individual advocate working for the Office maintains a substantial library of information regarding clients' rights. These materials are available for on-site use and in many cases are available for loan to individuals involved in service provision for clients of the Department.

FINANCES, FISCAL YEAR 1995: The following financial display was generated from this unit's accounts as recorded in the files of the Bureau of the Budget's MFASIS System

OFFICE OF ADVOCACY (MH&MR)	TOTAL FOR ALL FUNDS	GENERAL FUND	SPECIAL REVENUE FUNDS	HIGHWAY FUND	FEDERAL FUNDS	MISC. FUNDS
EXPENDITURES						
SALARIES & WAGES	456,694	456,694				
HEALTH BENEFITS	58,969	58,969				
RETIREMENTS	77,688	77,688				
OTHER FRINGE BENEFITS	5,765	5,765				
OTHER CONTRACT SERVICES STATE	50	50				
OTHER CONTRACT SERVICES	56,377	56,377				
COMMODITIES	31	31				
GRANTS, SUBSIDIES, PENSIONS	43	43				
TOTAL EXPENDITURES	655,617	655,617				

AROOSTOOK RESIDENTIAL CENTER

TERRY L. SANDUSKY, M.S., DIRECTOR

Central Office: 21 LOMBARD ST, PRESQUE ISLE, ME 04769
Mail Address: PO BOX 1285, PRESQUE ISLE, ME 04769-1285
Established: 1972 *Telephone:* (207) 764-2010
Reference: Policy Area: 03 ; *Umbrella:* 14 *Unit:* 199 ; *Citation:* T0034B *M.R.S.A., Sect.* 000005403
Average Count--All Positions: 21.00 *Legislative Count:* 21.00

PURPOSE:

The primary purpose of the Center is provide residential services and behavioral training aimed at increasing functional independence to help the adult client learn to live in the mainstream of society.

Specific objectives include the provision of the following:

(A) Respite care to families who are in need of either temporary or emergency placement of their family member with mental retardation or autism in the Center's two(2) available respite care beds; (B) Transitional programming for Pineland Center residents; (C) Transitional programming for all residents from more restrictive residential environments to less restrictive residential placements; (D) Independent living training to help individuals live in their own apartments; and (E) Basic teaching activities in such areas as daily living skills, basic household cleanliness, personal hygiene, individual and group social and recreational skills and overall community socialization.

ORGANIZATION:

The Aroostook Residential Center began operation in October 1972. Pre-admission evaluations are conducted by the regional office of the Division of Mental Retardation with final screening conducted by the facility's Admissions Committee. Decisions to admit are based on specific program recommendations developed through a multi-disciplinary approach. All admissions require certification of eligibility for intermediate care facility for mentally retarded services after twenty-one (21) days.

Following admission, the resident is assigned a specific staff member who is responsible for the implementation of the the resident's individual program plan. Quarterly monitoring and staff reviews are conducted to assess program effectiveness. Modification of the resident's program is made as the need arises and implemented by Center staff.

DEPARTMENT OF MENTAL HEALTH & MENTAL RETARDATION 5/22/96

APPROVED FUNDING FOR FY 96 & 97 SOURCE CH. 368, 395, 502, 560, 665, 685 & 691

ACCOUNT NAME	ACCOUNT #	POS	P.S	A.O	CAP	96 TOTAL	POS	P.S	A.O	CAP	97 TOTAL
GENERAL FUND											
Administration	01014A0164 01	84.5	4,447,391	777,136	116,200	5,340,727	95.5	4,964,824	1,018,884	55,000	6,038,708
OSA	01014G0679 01					0	21.0	1,044,182	5,037,432	3,595	6,085,209
OSA-DEEP	01014G0700 01					0	7.0	220,524	774,344		994,868
OSA-Medicaid	01014G0844 01					0			150,000		150,000
Mental Health	01014A0121 02	27.0	953,345	17,815,958		18,769,303	92.5	2,748,627	19,842,140		22,590,767
BCSN	01014A0136 07	53.5	2,538,877	8,959,206		11,498,083	53.5	2,525,194	9,729,261		12,254,455
D.S. AMHI Match	01014B0733 10		7,321,575	2,504,517	41,795	9,867,887		6,568,288	2,003,287	21,164	8,592,739
MR Medicaid	01014A0705 12			36,659,886		36,659,886			38,491,665		38,491,665
C.D. Reinvestment	01014A0819 13			4,818,286		4,818,286			8,681,436		8,681,436
MH Medicaid	01014A0732 14			8,478,748		8,478,748			16,162,726		16,162,726
D.S. BMHI Match	01014C0734 15		7,378,454	1,946,020	44,849	9,369,323		7,110,949	1,942,167	12,605	9,065,721
BCSN Medicaid	01014A0731 17			2,930,205		2,930,205			3,987,168		3,987,168
Advocacy	01014A0632 42	13.5	663,104	33,173		696,277	13.5	673,624	28,815		702,439
BCH	01014A0157 45	18.0	660,459	106,201		766,660	0.0	109,533			109,533
AMHI	01014B0105 50	4.0	134,779	19,906		154,685	4.0	139,325	20,400		159,725
BMHI	01014C0120 55	0.0	801,697	393,663	10,295	1,205,655	0.0	71,565	208,630	3,753	283,948
DMR	01014A0122 60	175.5	6,949,007	7,770,459	0	14,719,466	191.5	8,302,302	9,682,058		17,984,360
Pineland Center	01014D0166 64	134.5	7,983,501	1,458,214	30,800	9,472,515	9.0	708,632	173,492	3,300	885,424
ARC	01014F0118 66	21.0	789,606	259,155	6,000	1,054,761	21.0	822,457	270,513	5,700	1,098,670
ELC	01014E0119 68	48.0	1,881,094	275,636		2,156,730	48.0	1,951,185	277,221		2,228,406
Freeport Towne Sq.	01014D0814 69	24.0	1,005,108	87,293	3,500	1,095,901	24.0	1,035,533	88,480		1,124,013
TOTAL GENERAL FUND		603.5	43,507,997	95,293,662	253,439	139,055,098	580.5	38,996,744	118,570,119	105,117	157,671,980
FEDERAL FUNDS											
ACCOUNT NAME	ACCOUNT #	POS	P.S	A.O	CAP	96 TOTAL	POS	P.S	A.O	CAP	97 TOTAL
OSA	01314G0679 01					0	0.5	22,379	1,126,203		1,148,582
OSA-DrugFree School	01314G0679 02					0	5.0	232,754	2,751,485		2,984,239
MH-Community	01314A0121 40	2.0	109,512	1,428,026	2,500	1,540,038	2.0	109,933	2,040,315		2,150,248
BCSN	01314A0136 47	9.0	456,598	4,970,756		5,427,354	4.0	242,650	5,028,439		5,271,089
BMHI	01314C0120 57	0.5	9,340	1,660		11,000	0.5	9,586	1,274		10,860
MR-Community	01314A0122 61	4.0	210,751	209,724		420,475	4.0	207,138	213,337		420,475
TOTAL FEDERAL		15.5	786,201	6,610,166	2,500	7,398,867	16.0	824,440	11,161,053	0	11,985,493
OTHER SPECIAL REVENUE											
ACCOUNT NAME	ACCOUNT #	POS	P.S	A.O	CAP	96 TOTAL	POS	P.S	A.O	CAP	97 TOTAL
OSA	01414G0679 01					0	4.0	178,470	376,206		554,676
AMHI DISPRO	01414B0105 20	477.5	13,922,040	4,331,804	76,268	18,330,112	342.5	12,075,561	3,667,152	38,336	15,781,049
BMHI DISPRO	01414C0120 25	462.5	14,028,992	3,426,519	79,201	17,534,712	439.0	13,084,951	3,340,977	21,742	16,447,670
Administration	01414A0164 32					0			188,400		188,400
MH-Community	01414A0121 48			56,195		56,195			3,677,395		3,677,395
BMHI	01414C0120 58	1.0	28,004	46,213		74,217	1.0	28,946	53,031		81,977
DMR	01414A0122 62			35,750		35,750			37,375		37,375
BCSN	01414A0136 67					0			500		500
Freeport Towne Sq.	01414D0814 77			96,085		96,085			97,094		97,094
TOTAL OTHER SPECIAL REVENUE		941.0	27,979,036	7,992,566	155,469	36,127,071	786.5	25,367,928	11,438,130	60,078	36,866,136
BLOCK GRANTS											
ACCOUNT NAME	ACCOUNT #	POS	P.S	A.O	CAP	96 TOTAL	POS	P.S	A.O	CAP	97 TOTAL
OSA	01514G0679 01					0	8.0	353,688	4,442,787	2,000	4,798,475
MH-CMHS	01514A0121 92			697,148		697,148			697,148		697,148
MH-Social Services	01514A0121 93			273,895		273,895			273,895		273,895
MR- Social Services	01514A0122 96			924,149		924,149			924,149		924,149
BCSN-CMHS	01514A0136 97			612,437		612,437			603,503		603,503
TOTAL BLOCK GRANTS		0.0	0	2,507,629	0	2,507,629	8.0	353,688	6,941,482	2,000	7,297,170
TOTAL ALL SOURCES		1560.0	72,273,234	112,404,023	411,408	185,088,665	1391.0	65,542,800	148,110,784	167,195	213,820,779

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AUGUSTA MENTAL HEALTH INSTITUTE	Currently No Openings	
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FAMILY Perry, Laura 43 Academy Street Hartland, ME 04943 TEL: 938-3736 Diane Farnum 69 Main Avenue Mexico, ME 04253 TEL: 369-0542	Schaeffer, Gloria 126 Western Avenue Box 245 Augusta, ME 04330 TEL: 626-3105	Sirois, Cindy ~~RFD 1A~~ Rt 5, Box 1330 Rt.5 Gardiner, ME ~~04072~~ TEL: 622-5767
CONSUMER Ginny Cost 46 Oak Street Waterville, ME 04901 TEL:873-4262	Desrosiers, Gerard PO Box 724 Augusta, ME 04330 TEL: 287-7296	Deb Demski RR1, Box 2386 Hebron, ME 04238 TEL: 966-1258

Consumer's Cont'd Saucier, Brian Augusta Mental Health Insittute PO Box 724 Augusta, ME 04333 TEL: 287-7200		
COMMUNITY-AT-LARGE Bruno, Joseph Gould Health Systems PO Box 508 Augusta, ME 04330 TEL: 622-7153 Lopes, George Ten Riverside Ridge Windham, ME 04062 TEL: 892-3632	Kingman, Bob c/o JBI 175 Running Hill Road So. Portland, ME 04106 TEL: 761-2254	McKelvy, Mary Jean Mid Maine Medical Center 30 Chase Street Waterville, ME 04901 TEL: 872-4157
SUPPORT Mike McClellan DMHMRSAS !65 State House Station Augusta, ME 04333 TEL: 287-4227 FAX: 287-4268 Holly Stover DMHMRSAS Region II 141 State House Station Augusta, ME 04333 TEL: 287-8118 FAX: 287-8007	Rod Bouffard, Act. Supt. Augusta Mental Health Institute PO Box 724 Augusta, ME 04333 TEL: 287-72 FAX:	Kenneth Dym, Program Mgr. MH Services, DMHMRSAS 40 State House Station Augusta, ME 04333 TEL: 287-4271 FAX: 287-4268

BANGOR MENTAL HEALTH INSTITUTE	Currently Open: 1 Family 1 Community	
PROVIDER		
Hoguet, Jo Dolly PO Box 738 Searsport, ME 04974 TEL: 667-7640	Quimby, Ph.D., Lucy 277 State Street, Suite 2A Bangor, ME 04401 TEL:	St. Germaine, Sandra 319 West Broadway Bangor, ME 04401 TEL: 973-6199
Williams, Priscilla 98 Cumberland Street Bangor, ME 04401 TEL:		
FAMILY		
Fortier, Patricia PO Box 44 Guilford , ME 04443 TEL:	Parent, Juliet Rt. 1, Box 475 Orrington ,ME TEL:	Coombs, Mary Ann 8 Moosehead Blvd. Bangor, ME 04401 TEL: 947-9833
CONSUMER		
Allen, Christine PO Box 778 Millinocket, ME 04462 TEL:	Bard, Mike 1st Street, Apt. 108 Bangor, ME 04401 TEL:	Pelletier, Lynn Ellsworth, ME 04605 TEL: 667-2557

Family Co. Vallie, Virgil c/o Mary Adair Kilkenney MH Center 8 Union Street Ellsworth, ME 04605 TEL: 469-0730		
COMMUNITY-AT-LARGE Croce, Bob HC76 Box 580 Greenville, ME 04441 TEL: 843-5456	Grover, Nancy 47 Kennebec Road Hampden, ME 04444 TEL:	Shahaway, Mary Lo Rt. 1, Box 690 Sangerville, ME 04479 TEL: 876-2242
SUPPORT Mike McClellan DMHMRSAS 165 State House Station Augusta, ME 04333 TEL: 287-7441 FAX: Kenneth Dym DMHMRSAS 40 State House Station Augusta, ME 04333 TEL: 287-4271 FAX: 287-4268	 Patrick O'Brien DMHMRSAS Region III 106 Hogan Road Bangor, ME 04401 TEl: 941-4360 FAX: 941-4389 Larry Ventura Bangor Mental Health Institute PO Box 926 Bangor, ME 04401 TEL: FAX: 941-	

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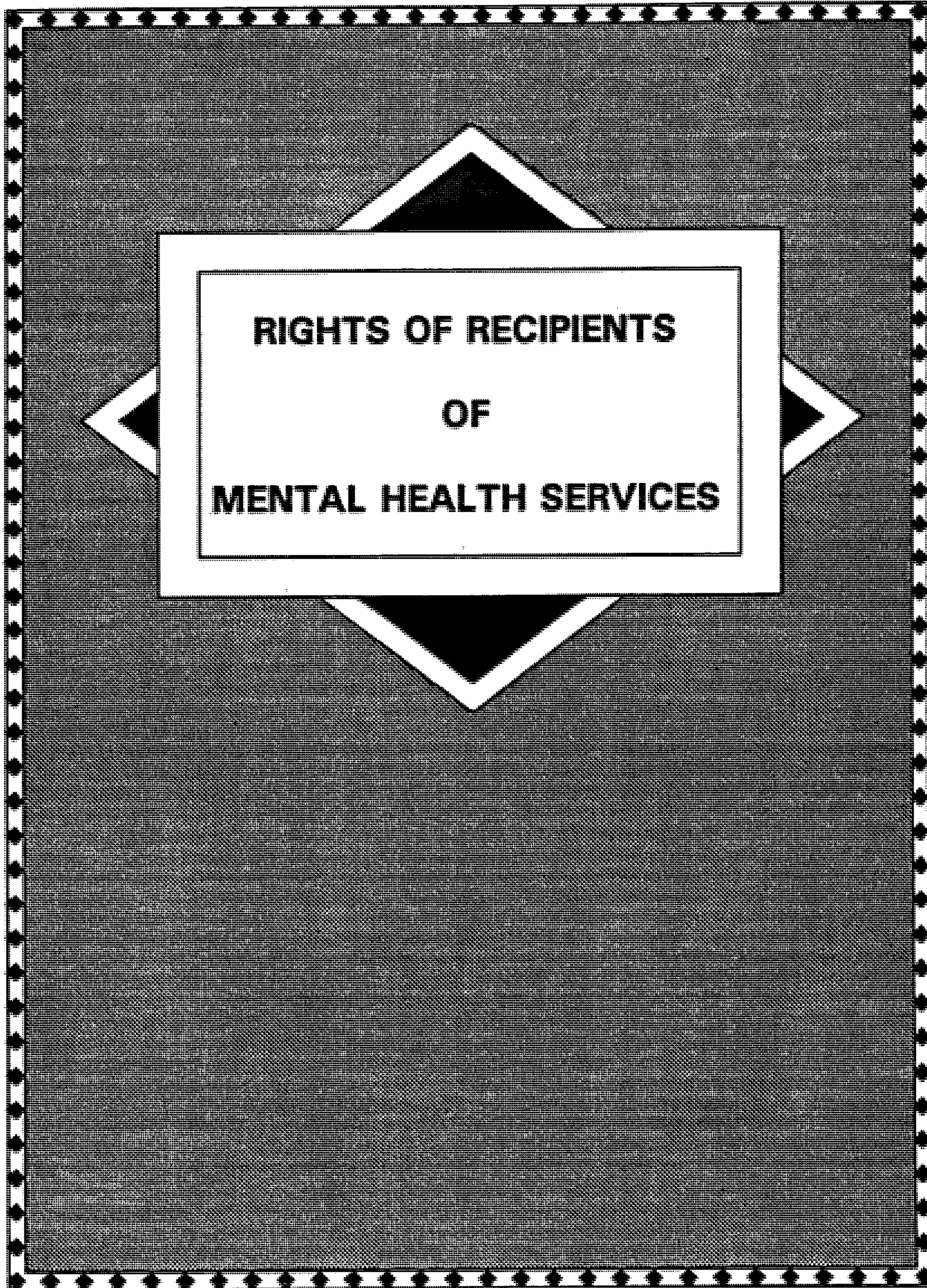
LIST OF ADVISORY GROUPS OR COUNCILS TO DMHMRSAS

Mental Health Advisory Board
Quality Improvement Council
Joint Advisory Committee on Select Services for Elder Persons
Maine Advisory Committee
Consumer Advisory Board
Several Mental Retardation Advisory Committees
Consumer Advisory Council
Children's Advisory Committee



DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Non-Discrimination Notice

The Department of Mental Health and Mental Retardation (DMHMR) does not discriminate on the basis of disability, race, color, creed, gender, age, or national origin, in admission to, access to, or operations of its programs, services, or activities, or its hiring or employment practices.

This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and in accordance with the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973, as amended, the Age Discrimination Act of 1975 and the Maine Human Rights Act.

Questions, concerns, complaints, or requests for additional information regarding the ADA may be forwarded to DMHMR's ADA Compliance Coordinator/Affirmative Action Officer, State House Station #40, Augusta, Maine 04333, 207-287-4289 (v), 207-287-2000 (TTY).

Individuals who need auxiliary aids for effective communication in programs and services of DMHMR are invited to make their needs and preferences known to the ADA Compliance Coordinator/Affirmative Action Officer.

This notice is available in alternate formats by contacting the ADA Compliance Coordinator/Affirmative Action Officer.

11/94

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

PART A

RULES OF GENERAL APPLICABILITY

MAINE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
DIVISION OF MENTAL HEALTH
AUGUSTA, MAINE

BASIS STATEMENT

These rules were initially promulgated on October 1, 1984, pursuant to 34-B M.R.S.A. § 3003, that directed the Division of Mental Health to promulgate rules pursuant to the Maine Administrative Procedure Act for the enhancement and protection of the rights of clients receiving services from the Department of Mental Health and Mental Retardation, state and non-state mental health institutions or units, or from any program or facility administered or licensed by the Department. These rules were subsequently amended on October 1, 1986, October 1, 1989 and January 1, 1995.

On August 2, 1990, the Kennebec County Superior Court approved the terms of a Consent Decree in the case of Paul Bates, et al. v. Sue Davenport, et al., Docket No. CV-89-88. The Consent Decree incorporated the contents of a Settlement Agreement, the terms of which require the defendants to draft revisions to the "Rights of Recipients of Mental Health Services" as needed to incorporate the provisions governing grievances and complaints and to make these rules consistent with the terms of the Settlement Agreement.

INTRODUCTION

The 110th Maine Legislature enacted into law, 34 M.R.S.A. section 2004, now 34-B M.R.S.A. section 3003, entitled "An Act Authorizing and Directing the Bureau of Mental Health to Enhance and Protect the Rights of Recipients of Mental Health Services," that directed the Bureau to promulgate rules, under the Administrative Procedures Act, in a number of areas of patient/client rights.

The intent of the Legislature was to provide a process whereby the Division of Mental Health, as the lead administrative agency for institutional and community mental health services, would develop comprehensive rules in this complex area, taking into account clinical, social and administrative factors while promoting and safeguarding the rights of people receiving mental health services.

These rules apply to all agencies licensed by the Department of Mental Health and Mental Retardation and all public or private inpatient psychiatric institutes and units, including the state operated mental health institutes.

These rules were developed by a task force made up of consumers, providers, regulators, professionals, family members, advocates and others, with the input of citizens throughout the State.

These rules were initially promulgated on October 1, 1984, were amended October 1, 1986, October 1, 1989 and January 1, 1995.

Questions regarding the applicability or interpretation of these rules should be directed to the Director, Division of Licensing, Department of Mental Health and Mental Retardation, State House Station 40, State Office Building, Augusta, Maine 04333, Area Code (207) 287-4200 or 287-2000 (TTY).

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

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PART A. RULES OF GENERAL APPLICABILITY

I. STATEMENT OF INTENT

The purpose of these rules is to articulate the rights of recipients of mental health services so that these rights may be enhanced and protected. Mental health service recipients should suffer no loss of basic human or civil rights. Because of the exceptional circumstances under which such patients are treated, however, the exercise of some rights may require special safeguards. These rules, therefore, are intended to keep recipients' rights paramount, to assure that individual rights will be both recognized and protected during the course of service delivery, and to ensure treatment consistent with ethical and professional standards. Procedural mechanisms that exist to ensure enforcement of these rules include the licensing authority of the Department of Mental Health and Mental Retardation pursuant to 34-B M.R.S.A. § 1203-A, the grievance and complaint procedures set forth in these rules, and the Department's contracting authority.

Part A, Rules of General Applicability that apply to all recipients, regardless of the treatment setting, should be read in conjunction with either Part B (for inpatient or residential settings) or Part C (for outpatient settings).

II. DEFINITIONS

A. Advocacy Program means the Office of Advocacy of the Department and the rights protection and advocacy agencies or other governmental agencies authorized by law to investigate grievances and protect rights.

B. Complaint means an allegation by a person or agency charged with investigating violations of client rights or with delivering or monitoring mental health services of violation of basic rights of a recipient, including those enumerated in these rules and the Settlement Agreement in Bates, et al. v. Davenport, et al. or any other applicable law or regulation.

C. Conjoint Family Treatment Services means services jointly provided to more than one member of a family, in which all members in question are recipients.

D. Department means Department of Mental Health and Mental Retardation.

E. Division means the Division of Mental Health.

F. Grievance means an allegation by a recipient of violation of basic rights, including those enumerated in these rules and the Settlement Agreement in Bates v. Davenport or any other applicable law or regulation.

G. Individualized Support Plan (henceforth referred to as "ISP") means an approach to support

planning that focuses on the development of a life plan that expresses, in the recipient's own words, his or her wants, needs and goals, as well as an action plan for meeting these goals.

H. Mental Health Facility, Agency, or Program means any facility that provides in-patient psychiatric services and any agency or facility providing in-patient, residential or outpatient mental health services that is licensed by, funded by or has a contract with either the Department of Mental Health and Mental Retardation or the Department of Human Services.

I. Mental Health Institute means state-operated inpatient facilities.

J. Non-State Mental Health Institution means a public institution, a private institution or a mental health center, that is administered by an entity other than the State and that is equipped to provide in-patient care and treatment for people with mental illness.

K. Person with long-term mental illness means a person who suffers from certain mental or emotional disorders that erode or limit the capacities of daily life. For purposes of this definition, mental and emotional disorders include organic brain syndrome, schizophrenia, recurrent depressive and manic depressive disorders, paranoid and other psychoses, plus other disorders that may become chronic. For purposes of this definition, capacities of daily life include personal hygiene and self care, self direction, interpersonal relationships, social transactions, learning, recreation and economic self-sufficiency. While persons with long-term mental illness may be at risk of institutionalization, there is no requirement that these persons are or have been residents of institutions providing mental health services.

L. Program Area means any discrete part of a facility or agency, including any building, residential program, ward, unit or program site.

M. Recipient means any person over age 18 receiving mental health treatment from any mental health facility, agency or program.

N. Representative means any person who has been designated in writing by a recipient, or by his or her guardian to act to aid the recipient in upholding his or her rights under these rules. Such person shall not be a patient of an inpatient facility nor a staff person currently serving the recipient.

O. Rights Protection and Advocacy Agency means the protection and advocacy program established by 42 U.S.C. §§ 10801 et seq. and described in 5 M.R.S.A. §§ 19501 et seq.

P. Treatment means any activity meant to prevent, ameliorate, prevent deterioration of, or cure a recipient's mental health problem or mental illness and includes behavioral, psychological, medical, social, psychosocial and rehabilitative methods that meet usual and customary standards in the field of mental health treatment.

Q. Treatment Team means those persons, including the recipient, who plan, carry out and

review treatment.

III. BASIC RIGHTS

A. Recipients have the same human, civil and legal rights accorded all citizens, including the right to live in a community of their choice without constraints upon their independence, except those constraints to which all citizens are subject. Recipients have the right to a humane psychological and physical environment within the facility or program. Recipients have the right to be treated with courtesy and dignity. Recipients are at all times entitled to respect for their individuality and to recognition that their personalities, abilities, needs, and aspirations are not determinable on the basis of a psychiatric diagnosis. Recipients have the right to have their privacy assured and protected to the greatest extent possible in light of their treatment needs. Recipients shall not be incapacitated nor denied any right, benefit, privilege, franchise, license, authority or capacity of whatever nature that they would otherwise have, simply due to their status as recipients of mental health services.

B. There shall be no limitation on the freedom of religious belief.

C. Discrimination in the provision of services due to race, creed, sex, age, national origin, political belief, or handicapping condition shall be prohibited.

D. All basic rights shall remain intact unless specifically limited through legal proceedings, as in the case of guardianship or in an emergency or when necessary to protect the rights or safety of the recipient or others, only as outlined in specific sections of these rules.

E. Services delivered to recipients shall be based on their identified individual needs and shall be delivered according to flexible models that accommodate changes in recipients' needs and the variations in the intensity of their needs. To the extent possible, recipients will not be required to move from one setting to another in order to receive the services appropriate to their changed needs.

F. Recipients have the right to refuse all or some of the services offered, subject to the exceptions noted below. A person's refusal of a particular mode or course of treatment shall not *per se* be grounds for refusing a recipient's access to other services that the recipient accepts. Only the following services may be imposed against a recipient's wishes:

1. Involuntary hospitalization pursuant to 34-B M.R.S.A. §§ 3863 *et seq.*;

2. Forensic services pursuant to 15 M.R.S.A. § 101-B in a residential or hospital setting;

3. Services permitted under applicable law in the case of a person under guardianship, upon the guardian's informed consent and within the limits of the guardian's authority;

4. Emergency treatment in a residential or hospital setting during a psychiatric emergency, pursuant to procedures set out in these rules; or

5. Treatment in a residential or hospital setting pursuant to the administrative hearing provisions of these rules for individuals who lack capacity to consent to services.

G. Recipients have the right to exercise their rights pursuant to these rules without reprisal, including reprisal in the form of denial of or termination of services.

H. Recipients with long term mental illnesses have the following additional rights, to the extent that state and community resources are available:

1. The right to a service system that employs culturally normative and valued methods and settings;

2. The right to coordination of the disparate components of the community service system;

3. The right to individualized developmental programming that recognizes that each recipient with long-term mental illness is capable of growth or slowing of deterioration;

4. The right to a comprehensive array of services to meet the recipient's needs; and

5. The right to the maintenance of natural support systems, such as family and friends of recipients with long-term mental illnesses, individual, formal and informal networks of mutual and self-help.

IV. LEAST RESTRICTIVE APPROPRIATE SETTING

A. Recipients have the right to be treated in the least restrictive appropriate setting to meet their needs.

B. Any restrictions or limitations in an inpatient setting shall be determined and imposed pursuant to the Right to Individualized Treatment and the Right to Informed Consent to Treatment.

C. No recipient shall be held in treatment against his or her will by policy, procedure or practice, except by order of court or by emergency hospitalization procedures.

D. Agencies or facilities proposing persons for commitment shall first fully consider less restrictive appropriate settings and treatment modalities pursuant to 34-B M.R.S.A. § 3864(5).

E. Involuntary hospitalization provisions shall not be utilized only as a means to accomplish admission, to obtain transportation, or for administrative reasons.

V. NOTIFICATION OF RIGHTS

A. Recipients have the right to be notified of all rights accorded them as recipients of services, by Maine statute, these rules, the Bates v. Davenport Settlement Agreement, if applicable, and associated policies.

B. At the time of admission or intake, or as soon afterwards as is reasonably feasible, each recipient shall be informed, to the extent possible, of his or her rights under these rules in terms that he or she understands.

1. Such information shall be given by an employee of the facility or program in a manner designed to be comprehensible to the individual recipient.

2. In cases where the recipient does not understand English or is deaf, the notification of rights shall be conducted by an interpreter.

3. If the recipient's condition at admission or intake precludes understanding of his or her rights, additional attempts to provide information about rights shall occur and be documented.

4. Documentation of the results of the discussion about rights shall be noted in the recipient's permanent treatment record.

5. Recipients shall be advised of their right to name a designated representative or representatives to assist them to receive notices of meetings and to participate at meetings. Recipients shall additionally be given information regarding available advocacy and peer advocacy programs.

6. Recipients shall be further advised of their rights pursuant to these rules and the Settlement Agreement in Bates v. Davenport, as applicable.

C. At the time of admission or intake, each recipient shall be given a summary of these recipient rights written in plain language. In instances in which the recipient is deaf, the summary of these recipient rights will be communicated in American Sign Language.

1. Copies of the summary shall be given to:

a. The recipient's guardian, if any; or

b. In the case of any recipient without a guardian, up to three individuals, if designated by the recipient.

2. Those persons, including the recipient, given copies of summaries shall be noted in the medical record.

3. Copies of the summaries shall be conspicuously posted in all agencies, facilities, and program areas.

4. The summaries shall contain instructions for viewing these rules, the Settlement Agreement in Bates v. Davenport, and associated policies developed to implement these two documents.

5. The summaries shall be made available in foreign languages or American Sign Language, if necessary.

D. At the time of the notification required above, recipients shall be notified that they, their guardians acting on their behalf, or their designated representatives may bring grievances claiming that the practices, procedures or policies of the Department, a non-State mental health institution, or any agency licensed by, funded by or under contract with the Department to provide mental health services, violate the terms of these rules, the terms of the Bates v. Davenport Settlement Agreement, or any other applicable law or regulation. They shall additionally be notified of the process whereby grievances may be filed and of their right to be assisted throughout the grievance procedure by a representative of their choice. In the written notice required by section V(C) above, recipients shall additionally be notified of the advocacy services available through the Department's Office of Advocacy, the rights protection and advocacy agency, peer advocates, and the Ombudsman Program established pursuant to 22 M.R.S.A. § 5112(2).

E. Each program area shall have complete copies of these recipient rights rules, the Settlement Agreement in Bates v. Davenport, and associated agency policies. Each recipient shall be offered a copy of these rules. Additional copies of these documents shall be available from the Department of Mental Health and Mental Retardation, Station 40, State Office Building, Augusta, Maine 04333.

F. The Office of Advocacy shall have copies of all statutes referenced in these rules. These statutes shall be available for review during regular working hours at the Office of Advocacy, Station 60, State Office Building, Augusta, Maine 04333.

VI. ASSISTANCE IN THE PROTECTION OF RIGHTS

A. Recipients have the right to assistance in the protection of their rights.

B. Recipient Representative. Each agency, facility or program shall inform all recipients of their right to name a representative, including a peer representative, to aid them in the protection of their rights. Aid may include one or more of the following activities: assistance in the formulation and processing of a grievance; participation in the informal or formal development and revision of an ISP, individualized service or treatment plan or hospital treatment and discharge plan; or any other type of representative assistance activity referenced in these rules. The provision of aid by a designated representative shall be governed by this section and by other relevant sections of these rules.

1. Designation in writing. If the recipient or his or her guardian desires a representative for the recipient, the person desiring a representative for the recipient shall designate, in writing, a person to aid the recipient in upholding his or her rights.

2. Time for designation. The recipient or his or her guardian may designate a representative at any time.

3. Change in representative. Provision shall be made for change of representative should the recipient so desire, or if the recipient is placed under guardianship, should the guardian so desire.

4. Representative's physical access. The representative shall have reasonable access to all living and program areas and to staff involved in the treatment of the recipient in order to assist the recipient in the protection of his or her rights.

5. Confidentiality. The representative may obtain access to confidential information as defined under 34-B M.R.S.A. § 1207 concerning the recipient by obtaining the appropriate party's written informed consent to disclosure under Section IX of these rules.

6. Communication. A recipient shall have access, at any reasonable time, to a telephone to contact his or her representative.

7. Involvement in ISP and Service or Treatment and Discharge Planning.

a. The recipient representative shall be given 10 days written notice of ISP meetings unless the recipient directs that the representative not be invited. The recipient's involvement may include, without limitation, participation in service or treatment planning meetings, or discharge planning meetings. When the meeting is being convened to address an emergency, notice reasonable for the circumstances shall be given.

b. The representative shall be notified when the recipient is determined to lack clinical capacity pursuant to Section V, Part B (Inpatient and Residential Settings) or Section IV, Part C (Outpatient Settings) of these rules.

c. The representative shall receive, upon the recipient's authorization, a copy of prescribed medication, dosage levels, schedules and side-effects and a copy of the aftercare plan upon the discharge of the recipient.

C. Advocacy Programs. Each recipient shall be informed of advocacy programs available in the state. Recipients have the right to request assistance from the advocacy programs at any time. Advocacy services are available through:

1. The Office of Advocacy of the Department, which is mandated by State law to

investigate the claims and grievances of recipients of mental health services provided by the Department or facilities or agencies administered, funded or licensed by the Department and to monitor the compliance of any facility or agency administered by the Department with all laws, rules, and policies relating to the rights and dignity of service recipients.

2. Other agencies including the rights protection and advocacy agency, and the Ombudsman program established pursuant to 22 M.R.S.A. § 5112(2).

D. Recipients may, at their request, be represented by a private advocate. In such cases the recipient shall bear the cost, if any, of such representation.

E. A report of complaints and grievances appealed to the Superintendent of AMHI and BMHI, the Director of the Division of Mental Health, and the Commissioner shall be compiled semi-annually and submitted to the Office of Advocacy, the Chief Administrative Officer of the agency or facility, the Office of the Master established pursuant to the terms of the Settlement Agreement in Bates v. Davenport, and plaintiffs' counsel in that action.

VII. RIGHT TO DUE PROCESS WITH REGARD TO GRIEVANCES

A. Recipients have the right to due process with regard to grievances.

B. Notwithstanding any other civil or criminal recourse that the person bringing the grievance may have, the facility, agency, and/or Department shall afford every reasonable opportunity for informal resolution of concerns or formal resolution of grievances.

C. Recipients or other persons may bring grievances regarding possible violations of basic rights, including any rights enumerated in these rules and the Settlement Agreement in Bates v. Davenport or any other applicable law or regulation; any questionable or inappropriate treatment or method of treatment; or any policy or procedure or action, or lack thereof, of the mental health agency or facility.

D. Persons who may bring grievances include, but are not limited to:

1. The recipient;

2. The recipient's guardian;

3. The recipient's attorney, designated representative or representative of the Office of Advocacy or the rights protection or advocacy agency;

4. Other persons specifically aggrieved.

E. A grievant shall in no way be subject to disciplinary action, reprisal, including reprisal in

the form of denial or termination of services, or loss of privileges or service as a result of filing a grievance.

F. Notice

1. Notices summarizing a recipient's right to due process in regard to grievances, including the process by which grievances may be filed, as well as copies of forms to be used for that purpose, shall be available within each program area.

2. An employee of the mental health facility, agency or program shall inform each recipient of this right and the right to be assisted throughout the grievance procedure by a representative of his or her choice, in a manner designed to be comprehensible to the individual recipient. In instances in which the recipient does not understand English or is deaf, this information shall be delivered by an interpreter.

G. Formal Grievances

1. A grievance may be undertaken by a recipient, or a guardian acting on his or her behalf, making a formal written claim that provisions of these rules, the Settlement Agreement in Bates v. Davenport or any other applicable law or regulation have been violated by any facility, agency or program.

Grievances regarding the actions of specific employees shall be handled in accordance with personnel rules and contract provisions. No disciplinary action may be taken nor facts found with regard to any alleged employee misconduct except in accordance with applicable personnel rules and labor contract provisions.

2. Formal grievances may be appealed through three sequential levels:

a. The supervisor of the program or unit or the agency employee designated to hear grievances as applicable;

b. For grievances arising in inpatient facilities, the Administrator of the facility; for grievances arising in the community, the Director of the Division of Mental Health; and

c. The Commissioner of the Department.

3. Additional levels of grievance resolution may be added by agency or facility policy, but in no case shall such additional levels add to the overall time allotted for grievance resolution.

4. At each level of the formal grievance procedure the recipient or other grievant shall have rights to the following:

a. Assistance by a representative of the recipient's own choice;

b. Representation by the Office of Advocacy or the rights protection and advocacy agency of the Maine mental health system;

c. Review of any information obtained in the processing of the grievance, except that which would violate the confidentiality of another person;

d. Presentation of evidence or witnesses pertinent to the grievance;

e. Receipt of complete findings and recommendation except those that would violate the confidentiality of another person.

5. An electronic or written record shall be made of all proceedings associated with formal grievances. An electronic recording shall be made of any hearing held pursuant to this section.

6. In all grievances the burden of proof shall be on the agency, facility or program to show compliance, or remedial action to comply with the policies and procedures established to assure the rights of recipients under these rules.

7. Findings shall include:

a. A finding of facts, consistent with the terms of the Maine Administrative Procedure Act;

b. A determination regarding the facility, agency, program or employee adherence, or failure to adhere, to specific policies or procedures designed to assure the rights of recipients under these rules; and,

c. Any specific remedial steps necessary to assure compliance with such policies and procedures.

8. Upon appeal, all pertinent information gathered regarding a formal grievance shall be forwarded, by the person to whom the grievance was addressed, to the next responsible official.

9. Steps of Formal Grievances:

a. Level One

i. Formal grievances shall be filed first with the supervisor of the service delivery unit in which the grievance arises.

ii. Copies of the grievances shall be forwarded by the supervisor to the administrative head of the mental health facility or agency and, upon the request of the grievant, to the Office of Advocacy. In the case of state operated facilities, all formal grievances shall be immediately forwarded to the Office of Advocacy.

iii. A formal written response shall be made within five days, excluding weekends and holidays.

iv. If the agency staff needs a longer period to investigate the circumstances of the grievance, a five day extension may be made and the grievant so notified.

v. If the grievant is unsatisfied with the findings at the first level, he or she may appeal the decision to the Chief Administrative Officer of the mental health facility or, for grievances arising in the community, the Director of the Division of Mental Health.

vi. Such an appeal must be made within ten days, excluding weekends and holidays.

vii. Copies of such an appeal shall be forwarded to the Office of Advocacy by the Chief Administrative Officer of the facility or the Director of the Division of Mental Health.

b. Level Two

i. The Chief Administrative Officer or the Director of the Division of Mental Health, as applicable, or designee shall respond to a Level Two grievance within five days, excluding weekends and holidays, of day of receipt of the appeal.

ii. If the Chief Administrative Officer or designee needs a longer period to investigate the circumstances of the grievance, a five day extension may be made with the permission of the parties to such a grievance.

iii. The Chief Administrative Officer or the Director of the Division of Mental Health, as applicable, or designee may, at his or her discretion, hold a hearing before an impartial hearing officer, who shall be an individual free of bias, personal or financial interest, with all parties involved.

iv. If the grievant is dissatisfied with the finding at Level Two, he or she may appeal the decision to Level Three to the Commissioner,

Department of Mental Health and Mental Retardation, Station 40, Augusta, Maine 04333. Appeals must be made within ten days, excluding weekends and holidays.

c. Level Three

i. The Commissioner or designee shall make a formal written reply within five days, excluding weekends and holidays.

ii. If no hearing was held at Level Two a hearing shall be held at Level Three.

iii. A five day continuance may occur if a hearing is to be held or if the parties to such a grievance concur.

iv. The Commissioner's or designee's finding shall constitute the final action by the Department regarding a grievance.

10. The decision at each level of the grievance procedure shall be final and binding unless the grievant appeals within the indicated time frames.

H. The Commissioner's decision shall constitute final agency action, and the grievant may appeal the decision to Superior Court pursuant to the Maine Administrative Procedure Act, 5 MRSA s 11001 et seq.

I. Under no circumstances shall the remedies requested in a grievance be denied nor shall the processing of a grievance be refused because of the availability of the complaint procedure.

J. Exceptions

1. Grievances regarding abuse, mistreatment, or exploitation.

a. Any allegation of abuse, mistreatment, or exploitation shall be immediately reported to the Office of Advocacy and to the Chief Administrative Officer of the mental health facility or agency. Any disciplinary actions or findings of fact in these instances shall be consistent with personnel rules and labor agreements.

b. Investigation of any such allegation shall be conducted pursuant to statutory and regulatory standards including those relating to the Child and Family Services and Child Protection Act (22 M.R.S.A. Chapter 1071 s 4001 et seq.) and the Adult Protective Act (22 M.R.S.A. Chapter 958-A) and facility policy approved by the Department.

2. Urgent Grievances.

a. Any grievance that the grievant considers urgent shall be forwarded by staff within one working day to the Chief Administrative Officer of the facility or for grievances arising in the community, to the Director of the Division of Mental Health, or designee, at Level Two, and the Office of Advocacy so notified.

Such grievances must be reviewed by the Chief Administrative Officer, the Director or designee, who shall either arrange to hear the grievance within three working days or immediately refer the grievance to Level 1 for response.

b. All grievances concerning the development, substantive terms, or implementation of ISP's or hospital treatment and discharge plans shall be considered urgent grievances.

3. Grievances Without Apparent Merit

a. A grievance may be found to be without apparent merit, upon Level Two review, upon the concurrence of the Chief Administrative Office or the Director of the Division of Mental Health, as applicable, and, when the grievance relates to a state mental health institute, the representative of the Office of Advocacy.

b. Any decision that a grievance is without merit and the justification for that decision shall be forwarded to the grievant in writing, and shall include notice of other avenues of redress.

c. Grievances without apparent merit may not be appealed administratively beyond Level Two. This dismissal constitutes final agency action for purposes of judicial review.

VIII. COMPLAINTS

A. A written complaint may be filed by any person or agency that is charged with investigating violations of client rights or with delivering or monitoring mental health services. The complaint procedure may be used when:

1. The person or agency knows or has reason to believe that the practices, procedures (including the development, substantive terms or implementation of ISP's or hospital treatment and discharge plans) or policies of the Department or of any agency licensed, funded or contracted by the Department to provide services elsewhere described in these rules, violate these rules, the terms of the Settlement Agreement in Bates v. Davenport or any other applicable law or regulation; and

2. The information was obtained during the general course of the person's or agency's performance of their responsibilities.

B. Complaints that include allegations of employee misconduct shall be processed, but no disciplinary action may be taken nor facts found with regard to the alleged misconduct except in accordance with applicable personnel rules and labor contract provisions.

C. Complaints arising in an in-patient setting shall be addressed to the chief administrative officer of the in-patient facility, who shall forthwith refer them to the supervisor of the service delivery unit in which the complaint arose.

D. Complaints arising in the community shall be addressed to the agency employee designated to receive complaints.

E. A formal written response shall be made within five days of receipt by the persons listed in (C) and (D) above, excluding weekends and holidays. Upon appeal, all pertinent information gathered regarding a complaint shall be forwarded by the person to whom the complaint was addressed to the next responsible official.

F. Decisions about complaints described in (C) above shall be appealable within five working days to the Chief Administrative Officer of the facility, who shall respond within five working days. If the person assigned to investigate a complaint needs a longer period to investigate the circumstances of the complaint, a five-day extension may be made and the complainant so notified.

G. Decisions about complaints described in (D) above shall be appealable within five working days to the Director of the Division of Mental Health, who shall respond within five working days.

H. Decisions resulting from appeals described in (F) and (G) above shall be appealable within five working days to the Commissioner, who shall respond within five working days. If the person assigned to investigate a complaint needs a longer period to investigate the circumstances of the complaint, a five-day extension may be made and the complainant so notified.

I. Investigations shall be conducted at each level of the complaint and shall include, as needed, interviews, site visits, or other data collection activities. At the conclusion of each investigation, a written summary of the results of the investigation and a statement of the remedial action to be taken, if any, shall be provided to the complainant, subject to the limitations of 5 M.R.S.A. § 7070(2)(E).

IX. CONFIDENTIALITY AND ACCESS TO RECORDS

A. Recipients have the right to confidentiality and to access to their record.

B. All information regarding mental health care and treatment shall be confidential except as otherwise provided below.

C. A recipient or guardian shall be notified, upon admission or intake to any mental health facility or program of:

1. What records will be kept, including any duplicate records;

2. How the recipient may see those records;

3. The use to which the records will be put;

4. What will happen to the record after the recipient leaves the facility or program;

5. How to add information to records;

6. How to obtain copies of material in records; and

7. The limits of confidentiality, as provided in J. below.

D. The recipient or legal guardian shall be informed when the possibility exists that the costs of the recipient's care, treatment, education or support will be borne by a third party. That information shall indicate that clinical information may be used to substantiate charges. The recipient or guardian may indicate that he or she will bear such costs privately rather than allow the release of information.

E. The recipient or guardian shall have the right to written and informed consent prior to release of any information to any agency or individual, whether or not such agency or individual is directly involved in the recipient's treatment or supervision thereof, except as provided in J below. Informed consent shall include:

1. Identification of the specific information to be disclosed;

2. Notice of the right to review mental health records upon request at any reasonable time including prior to the authorized release of such records;

3. The name of persons or agencies to whom disclosure is to be made;

4. The purpose to which the information is to be put;

5. The length of time within that the information is to be disclosed not to exceed one year; and

6. Notice of the right to revoke consent to release at any time.

F. Recipients have the right to require written informed consent for release of case record material that discloses the recipient's identity to students when they temporarily become a part of

treatment team, except when the student is involved in a professional program that has a formal relationship with the facility or agency.

G. All personnel of agencies or programs, including students or trainees, shall be trained regarding confidentiality and shall be held to confidentiality statutes, rules and policies.

H. Duplication:

1. If the facility or agency duplicates a portion of, or the entire care record of a recipient pursuant to any exception contained in J(1)(a) through (e) below a recipient or his or her guardian shall be notified, if possible, as to the purpose of such duplication.

2. Copies of original records shall be noted as such.

I. Separate personalized records shall be maintained when group treatment methods are employed except that individualized recordkeeping for service or treatment shall not be required in instances in which conjoint family treatment services are provided, under the following conditions:

1. Informed consent must be obtained to the conjoint treatment recordkeeping, pursuant to B.III., and such consent shall be documented by using a Department-approved form. This form shall be made a permanent part of the treatment record.

2. If any family member previously received treatment other than conjoint family treatment services at the facility, agency or program, or received conjoint family treatment services as a member of a different family group at the facility, agency or program, an extracted individualized discharge summary shall be placed in that family member's individualized record.

3. If any family member refuses to have treatment records blended, separate records must be maintained for that family member.

4. If any family member requests the release of his or her records subsequent to the termination of conjoint family treatment services, the facility, agency or program shall respond to this request by providing an extracted individualized discharge summary. The facility, agency or program shall not release information concerning an individual family member without that family member's written consent.

5. Nothing in these regulations shall preclude individualized recordkeeping by any program, facility or agency. Intake data, evaluations or assessments collected or performed for the purposes of determining eligibility for conjoint family treatment services are not treatment records for the purposes of this exception.

6. This exception shall be reviewed no later than December 31, 1995 to assess the

impact and effect of these rules. The review shall include representatives of the Bureau of Children with Special Needs, the Division of Mental Health, the Division of Licensing, the Office of Consumer Affairs, the Office of Advocacy and other interested parties as designated by the Commissioner of the Department of Mental Health and Mental Retardation.

J. Exceptions:

1. Information may be released without written informed consent, as provided by Maine statute (34-B M.R.S.A., section 1207, sub-section 1) in the following circumstances:

a. Disclosure may occur as necessary to carry out the statutory functions of the department or statutory hospitalization provisions. This shall include obtaining the services of an interpreter in cases in which the recipient does not speak English or is deaf.

b. Disclosure may be made as necessary to allow investigation by the rights protection and advocacy agency, the Office of Advocacy, or, in the following circumstances, the Department of Human Services.

i. Disclosure may be made to the Department of Human Services to cooperate in a child protective investigation or other child protective activity pursuant to an interdepartmental agreement promulgated as a rule by the Department of Mental Health and Mental Retardation.

ii. Disclosure may be made to the Adult Protective Services of the Department of Human Services in instances in which Adult Protective Services is acting as public guardian or conservator for the recipient.

c. Disclosure may be ordered by a court of record subject to any limitations contained within the Maine Rules of Evidence.

d. An oral or written statement relating to the physical condition or mental status of a recipient may be disclosed to the recipient's spouse or next of kin upon proper inquiry:

i. Outpatient setting. Before responding to a request for information the recipient or the recipient's guardian shall be asked whether release of confidential information is acceptable. If the recipient or his or her guardian authorizes disclosure, the information shall be disclosed in accordance with that authorization. In the instance where a recipient lacks capacity to authorize release of such information, repeated attempts shall be made to determine capacity to make such a decision and, if capacity exists,

to obtain a decision. Efforts to determine capacity and the rationale for termination of such efforts shall be documented.

ii. Inpatient setting. The physical presence, and physical and mental condition of a recipient shall be immediately disclosed to a recipient's spouse or next of kin upon proper inquiry.

e. Disclosure may be allowed of biographical or medical information concerning the recipient to commercial or governmental insurers of any other corporation, association or agency from which the Department or licensee of the Department may receive reimbursement for the care, treatment, education, training or support of the recipient. Such disclosure may be made only after determination by the Chief Administrative Officer of the facility or designee that the information to be disclosed is necessary and appropriate.

f. Disclosure of information, including recorded or transcribed diagnostic or therapeutic interviews concerning any recipient may be allowed in connection with any educational or training program established between a public hospital and any college, university, hospital, psychiatric counseling clinic or school of nursing, provided that in the disclosure or use of any such information as part of a course of instruction or training the recipient's identity shall remain undisclosed. Such disclosure shall be conducted according to uniform standards consistent with deidentification.

g. Disclosure may be made to persons involved in statistical compilation or research conducted in compliance with these rules pursuant to Section XV. In the case of such disclosure records shall not be removed from the facility and reports shall preserve the anonymity of the recipient. Data that do not identify the recipient, or coded data, may be removed from the facility, provided the key to such code shall remain at the facility.

2. Information regarding the status and medical care of a recipient may be released by a professional, upon inquiry by law enforcement officials or treatment personnel, if an emergency situation exists regarding the recipient's health or safety.

3. Confidentiality may be violated if there is clear and substantial reason to believe that there is imminent danger of serious physical harm inflicted by the recipient on him or herself or upon another. Information regarding such danger or harm shall be immediately given to supervisory personnel or clinical mental health professionals who, if they concur in the assessment of imminent danger, shall notify civil authorities and any specific person threatened by direct harm.

4. A licensed mental health professional providing care and treatment to an adult recipient may provide to certain family members or other persons, in accordance with

rules promulgated pursuant to 34-B M.R.S.A., section 1207, sub-section 5, information regardińg diagnosis, admission to or discharge from a treatment facility, the name of any medication prescribed, side effects of that medication, the likely consequences of failure of the recipient to take the prescribed medication, treatment plans and goals, and behavioral strategies.

K. Recipient Access to Records

1. The recipient or the recipient's guardian has the right to review the recipient's record at any reasonable time upon request, including prior to its authorized release. Such records shall be made available within three working days of such request.

2. Review of the care record shall occur under the supervision of a designee of the Chief Administrative Officer of the facility or program.

3. In cases where there exists a reasonable concern of possible harmful effect to the recipient if the review of the record occurs, the Clinical Director or designee shall supervise the review.

a. In cases where access of the guardian to the recipient's record would create documented imminent danger to the physical or mental well being of the recipient, the professional may refuse to disclose a portion of or the entire record to the recipient or guardian.

b. Written documentation shall be placed in the recipient's record in the event that access to the record or any portion of it is denied based on the above and the reasons for denial.

4. In cases where a recipient is unable to review the record at the program site, a certified copy of the record shall be forwarded to a professional, designated by the recipient, in the recipient's area, who shall supervise review of the record.

5. In cases where the record is at the program site, a certified copy of the record shall be forwarded to a professional, designated by the recipient, in the recipient's area, who shall supervise review of the record.

6. In cases where the recipient, after review of his or her record, requests copies of the record, or parts of the record, such copies shall be made available to the recipient at the actual cost of reproduction.

7. A recipient may add written material to his or her record in order to clarify information that he or she feels is false, inaccurate or incomplete.

8. Material that was obtained from another individual or facility through assurance of

confidentiality shall not be available to the recipient in reviewing his or her record. A summary description of that material shall be provided to the recipient, and the recipient shall be informed regarding the process of gaining access to that material and shall be offered aid in securing appropriate release of information.

X. FAIR COMPENSATION FOR WORK

A. Recipients have the right to be paid a fair wage for work done.

1. Each individual or agency subject to the provisions of these regulations shall pay at least the minimum wage to each recipient who performs work regardless of level of performance, regardless of whether the work is considered therapeutic, and regardless of whether the recipient replaces or would replace a non-recipient worker.

2. Agencies shall compensate any recipient performing any work that is similar or identical to that performed by a non-recipient employee at the rate at which the non-recipient employee is compensated.

B. For purposes of this section, the following definitions shall apply:

1. Work shall mean any work having consequential economic benefit to the mental health agency, including but not limited to sheltered workshop employment programs, or any activity involved in the care, maintenance, and operation of the mental health agency.

2. Work shall not mean those tasks performed by each recipient for his or her own basic care or hygiene or upkeep of personal living space.

3. Federal law shall mean the Fair Labor Standards Act that sets national labor standards.

4. Minimum wage shall mean that hourly rate of pay established by the United States Congress or by the State of Maine, whichever is higher, as the legal minimum.

C. Agencies shall not directly or indirectly compel a recipient to perform any work, or punish any recipient for declining to perform work. Agencies shall not make any privilege or agency service conditional upon a recipient's agreement to perform work or withdraw a recipient's privileges or services because of that recipient's failure to perform work.

D. Agencies shall not discriminate in the hiring of agency staff. Any recipient is eligible to apply for and occupy, if qualified, any job classification.

E. Exceptions:

1. Agencies and service providers subjected to these regulations may pay a

sub-minimum wage to a recipient who performs work after proper certification has been made by the United States Department of Labor under Handicapped Worker provisions contained in federal law.

2. Payment for work shall not be required when a recipient is a participant in an independent living program that requires a fair division of labor among all participants, including community-based psychosocial clubs and transitional living facilities, or in community-based transitional employment programs.

XI. PROTECTION DURING EXPERIMENTATION AND RESEARCH

A. Recipients have the right to refuse to participate in experimentation and research without loss of services.

B. All participation in experimentation and research shall be voluntary with full written informed consent, except as provided in these rules.

C. A recipient's refusal to participate in a research project or an experimental activity shall not be cause for denying the provision of indicated services to that recipient.

D. Definitions

1. Experimentation and research

a. Experimentation and research means the use of any medical, behavioral, or environmental intervention involving practices not commonly accepted by the discipline involved.

b. Experimental drug use means:

i. the use of any Food and Drug Administration non-approved drug.

2. Informed consent means the agreement obtained from a subject, or from his or her authorized representative, to participate in an activity. Informed consent requires that subjects understand the purpose, benefits and risks of research in which they are asked to participate and are given the opportunity to consent to, reject, or withdraw from participation without penalty.

3. Minimal risk means that the risk of harm anticipated in the proposed research or experimentation is not greater, considering probability and magnitude, than that ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tasks.

4. Board means the Research and Experimentation Review Board.

E. Research and Experimentation Review Board Membership

1. A Research and Experimentation Review Board, selected by the administrative head of the particular facility or agency, shall have at least five members with varying backgrounds, in order to promote complete and adequate review of research and experimental activities proposed for consideration.

2. The Board shall be sufficiently qualified, through the experience and expertise of its members and the diversity of the members' backgrounds, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects.

3. In addition to possessing the professional competence necessary to review such activities, the Board shall be able to ascertain the acceptability of proposed research or experimentation in terms of institutional commitments, regulations, applicable law, and standards of professional conduct and practice.

4. The Board shall consist of interdisciplinary members of both sexes including at least one member whose primary concerns are in non-scientific areas, such as law, ethics or theology, at least one member who is not otherwise affiliated with the institution or agency proposing the research or experimentation and at least one member who is a peer of the research subject.

5. No Board member may participate in the Board's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the Board.

6. At the Board's discretion, individuals with competence in special areas may be invited to assist in the review of complex issues that require expertise beyond or in addition to that available on the Board. These individuals may not vote.

F. General Procedures

1. All experimentation and research shall commence only after review and approval by the Research and Experimentation Review Board.

2. The Research and Experimentation Review Board shall have the authority to approve, require modifications in, or disapprove, any proposed research or experimentation activities.

3. The Office of Advocacy shall be informed of any proposed experimentation or research involving more than minimal risk.

4. The Board shall maintain adequate documentation of its activities.

5. The Board shall provide written notification of its approval or disapproval of the proposed research or experimentation activity, or of any modifications required to secure research and experimentation review board approval of any activity in question.

6. If the Board decides to disapprove a research or experimentation activity, it shall include, in its written notification, a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.

7. Investigators and others directly involved in the research or experimentation shall, both in obtaining the consent and in conducting research, adhere to the ethical and research standards of their respective professions concerning the conduct of research or experimentation and to the regulations for research involving human subjects required by the U.S. Department of Health and Human Services in effect at the time of the adoption of these rules.

8. Researchers must report substantial changes or unanticipated problems immediately to the Chairperson of the Board.

9. The Board shall conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once a year, and shall have authority to observe or have a third party observe the consent process and research.

10. The Board shall have the authority to suspend or terminate approval of research that is not being conducted in accordance with the Board's requirements, these rules, or that has been associated with unexpected harm to subjects. Any suspension or termination of approval shall include a statement of the reasons for the Board's action and shall be reported promptly to the investigator, appropriate institutional officials, and the secretary of the Department of Health and Human Services as required by federal regulations.

11. Upon completion of the research and/or experimentation procedures the principal investigator shall attempt to remove any confusion, stress, physical discomfort, or other harmful consequences that may have been inadvertently produced as a result of the research or experimentation procedures.

G. Criteria for Board Approval of Research and Experimentation. In order to approve research covered by these regulations the Board shall determine that all of the following requirements are satisfied:

1. Risks to subjects are minimized by using procedures that are consistent with sound research or experimentation design and that do not unnecessarily expose subjects to risk, by confidentiality protocols consistent with other record keeping and, wherever appropriate, by using procedures already being performed on the subject for diagnostic or treatment purposes.

2. Risks to subjects are reasonable in relationship to anticipated benefits to subjects. In evaluating risks and benefits, the Board shall consider only those risks and benefits that may result from the research and experimentation, as distinguished from the risks and benefits of therapy these subjects would receive in not participating in the research, or possible long-range benefits of applying knowledge gained in the research.

3. Selection of subjects is equitable, taking into account the purposes of the research and the setting in which the research will be conducted.

4. Informed consent is sought and appropriately documented in accordance with these rules.

5. The research or experimentation plan makes adequate provisions for monitoring the data collected or the activities allowed to ensure the safety and confidentiality of the subjects.

6. There are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

7. Where some or all of the subjects are likely to be vulnerable to coercion or undue influence, appropriate additional safeguards have been included in the project to protect the rights and welfare of these subjects.

H. Special Procedures; Exceptions to Informed Consent

1. Research involving the Need for Non-disclosure

a. If the research or experimentation methodology requires that the purpose, nature, expected outcome and/or implications of the research not be disclosed to the participants before it begins, the researcher shall clearly and vigorously justify to the Research and Experimentation Review Board the need for non-disclosure.

b. The Board may approve research or experimentation procedures that do not include, or that alter, some or all of the elements of informed consent set forth in these rules, or waive the requirements to obtain informed consent provided the Board finds and documents that:

i. the research involves no more than minimal risks to the subjects;

ii. the waiver or alteration will not adversely affect the rights and welfare of the subjects;

iii. the research or experimentation could not practicably be carried out without the waiver or alteration; and

iv. whenever appropriate, the subjects will be provided with full disclosure or additional pertinent information after the research or experimentation project is completed.

2. Research Involving Archival Review, Statistical Compilation or Record Review.

a. Research that is limited to archival review, statistical compilation or record review may be carried out pursuant to Title 34-B, MRSA, section 1207(2). Such research may be carried out without informed consent provided that:

i. the research is reviewed and approved by a Research and Experimentation Review Board;

ii. all data involved in said research shall not be identifiable as to individual recipients of services;

iii. the research plan shall be submitted to, and approved by, the head of the mental health facility or his or her designee.

3. Research Involving Persons Unable to Give Informed Consent, and Involuntary Recipients.

a. No experimentation or research involving more than minimal risks shall be conducted with persons unable to give informed consent, or involuntary patients unless:

i. the experimentation or research poses a clearly expected benefit to the individual recipient involved; and

ii. the experimentation or research has been reviewed and approved by the Research and Experimentation Review Board.

b. In the case of recipients adjudicated incapacitated, consent must be obtained from the recipient's legal guardian, and such consent must be reviewed by the Office of Advocacy and the rights protection and advocacy agency.

4. Utilization of Approved Food and Drug Administration Drugs for unlabeled uses.

a. Any use of drugs approved by the Food and Drug Administration, when applied in an unlabeled manner, shall receive prior approval from the Clinical Director or his or her designee.

I. Applicability

1. Questions regarding the applicability of this section to specific recipients or activities shall be referred in writing to the Chairperson of the Research & Experimentation Board who shall determine applicability.

2. Where disagreement continues to exist, questions may be presented through the Grievance Procedure, Section VI.

3. In issues regarding professional standards, referral of the question may be made to the appropriate national professional standards committee whose decision shall be final and binding.

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

PART B

RIGHTS IN INPATIENT AND RESIDENTIAL SETTINGS

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
DIVISION OF MENTAL HEALTH
AUGUSTA, MAINE

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STATEMENT OF INTENT:

These rules [Part B] are applicable to all inpatient psychiatric units and hospitals and to all residential facilities providing mental health treatment to recipients. Individualized support planning for recipients in residential settings shall be governed by Section C.III, Individualized Support Planning Process.

Part B should be read in conjunction with Part A, Rules of General Applicability.

II. PRIVACY AND HUMANE TREATMENT ENVIRONMENT

A. Recipients have the right to a humane psychological and physical environment within the treatment facility.

B. Each recipient has the right to be treated with courtesy and with full respect for his or her individuality and dignity, and to recognition that his or her personality, needs and aspirations are not determinable on the basis of a psychiatric diagnosis.

C. Recipients have the right to have their privacy assured and protected and to preserve the basic rhythm of their lives to the greatest extent possible in light of their treatment needs.

D. The treatment facility shall be designed to afford recipients comfort and safety, shall promote dignity and independence and shall be designed to make a positive contribution to the efficient attainment of treatment goals.

E. Each inpatient or residential facility shall provide at least:

1. nutritious food in adequate quantities;

2. access to or provision of adequate professional medical care;

3. a level of sanitation, ventilation and light that meets health standards;

4. a reasonable amount of space per person in sleeping areas;

5. a reasonable opportunity for physical exercise and recreation, including access to outdoor activities;

6. an area for private conversation with other recipients and family and friends; if all designated areas are in use, staff shall make other reasonable arrangements to assure the recipient's and visitor's comfort and privacy;

7. an area for private telephone conversations;

8. areas that assure privacy for personal hygiene, counseling and physical examinations;

9. a secure and accessible storage area of adequate size to accommodate the recipient's personal belongings;

10. opportunities for appropriate involvement in community activities, subject to the requirements of Section III, Individualized Treatment and Discharge Plan in Inpatient Settings;

11. common areas with space and equipment sufficient to permit patients comfortably to socialize, relax, or engage in leisure time activity. To reduce the chance that recipients engaged in activities will intrude upon others not similarly engaged, such areas shall be equipped so that intrinsically incompatible activities are not performed in the same areas; and

12. schedule of available therapeutic, rehabilitative and recreational activities to each recipient. The schedule shall be updated monthly or more frequently as necessary.

F. Recipients have the right to be free from abuse, exploitation, or neglect.

1. Recipients shall not be subjected to humiliation or verbal abuse.

2. Recipients shall not be subjected to physical abuse, and corporal punishment is expressly prohibited.

3. Recipients shall not be subjected to exploitation or neglect.

4. Any allegation of abuse, exploitation or neglect shall be immediately reported to the Chief Administrator of the facility or agency, to the Office of Advocacy and, in the case of an adult recipient who does not have mental retardation, to the Department of Human Services pursuant to the Adult Protective Act (22 M.R.S.A. Chapter 958-A).

G. Simple, understandable written rules setting the limits of recipients' behavior required for the protection of the group and individuals shall be established and made known to the recipients.

H. Personal Property

1. Except as provided below, recipients have the right to retain and use personal property.

2. The use of personal property may be limited or items held in safekeeping only when the number or use of such items infringes upon the rights of other recipients, or poses a safety risk.

3. Each recipient shall have the right to manage his or her own personal financial affairs. A recipient's funds and access to funds shall not be limited unless:

a. the restrictions are a part of a plan of treatment pursuant to informed consent to treatment;

b. a conservator, guardian or representative payee has been appointed;

c. court ordered restrictions exist;

d. the restriction is to safeguard a recipient's assets during the initiation and pendency of any protective proceedings.

4. Any limitations on personal property or financial affairs shall be documented by a physician and receipts for all money or material held in safekeeping shall be given to the recipient or his or her guardian.

5. The facility or agency shall bear responsibility for any money or material held in safekeeping.

I. Every recipient has the right to be free from unnecessary searches of the person, of personal space or of common areas. A search shall only be conducted when staff have a reasonable belief that misappropriated articles are present or that certain items that would endanger the health or safety of a particular recipient or other recipients are present. Every search and the reasons therefor shall be documented.

III. INDIVIDUALIZED TREATMENT AND DISCHARGE PLAN IN INPATIENT SETTINGS

A. Recipients admitted to a State psychiatric facility or community psychiatric facility or unit have the right to treatment according to a written individualized treatment and discharge plan that shall be incorporated into the recipient's ISP as a discrete sub-part.

B. Treatment and discharge plans shall be based upon consideration of the recipient's housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs as well as his or her potential need for crisis intervention and resolution services following discharge. Assessments shall be conducted by hospital personnel with appropriate credentials. These assessments shall be updated as frequently as changed circumstances may require, but no less frequently than the standards of the individual professional discipline dictate in order to assure that the information is current and reliable. The treatment and discharge plan shall include a description of the manner of delivery of each service to be provided. The manner of delivery shall be one that maximizes the recipient's strengths, independence and integration into the community. The names of the service providers and their performance expectations will be included in the plan.

C. The plan shall be developed by an inter-disciplinary team that includes the recipient and hospital staff representing the disciplines of social work, psychiatry, psychology, and nursing, except that in community hospitals and units, psychology will be represented when clinically indicated. Other hospital personnel, and other individuals from the community with whom the recipient has authorized the exchange of information and who are needed to assure that the recipient's needs are adequately assessed and that appropriate recommendations are made, shall be included on the team. One of the hospital staff team members shall be designated as a recipient's team coordinator.

D. The team coordinator or designee shall notify the recipient of all treatment and discharge planning meetings and invite and actively encourage the recipient to attend. If a recipient does not attend the meeting, the team coordinator or designee shall relay the recipient's views on issues to other members of the team. A recipient's guardian, if any, shall also be notified of all treatment and discharge planning meetings and shall be invited to attend. The recipient may invite other persons to his or her treatment and discharge planning meeting, and the team coordinator or designee shall encourage him or her to do so. Notices required by this paragraph shall be given by the team coordinator or designee at least two days in advance of the meeting date, with the following exception: When a meeting is being convened to address an emergency, or is called to formulate a preliminary or initial treatment and discharge plan, notice reasonable for the circumstances shall be required.

E. All recipients shall have a preliminary treatment and discharge plan developed within three working days of admission and a treatment and discharge plan within seven days thereafter. This plan shall be reviewed and revised as frequently as necessary, but in no case less frequently than within 30 days of development, every 60 days thereafter for the first year, and every 90 days thereafter.

F. Complete histories shall be obtained from the recipient, community service providers, and to the extent possible, from other individuals in the community as authorized by the recipient or guardian. Upon learning that a recipient has had a prior psychiatric hospitalization, the team coordinator or designee shall request the recipient's consent to the release of the records of that hospitalization to the inpatient facility where the recipient is currently hospitalized. If consent is given, the team coordinator shall, within two working days, send for copies of the records. These records shall be reviewed upon arrival and, to the extent of their relevance, shall be considered in the review of the recipient's treatment and discharge plan.

G. In addition to the foregoing requirements, the treatment and discharge plan shall be based upon a comprehensive assessment of the recipient, and shall meet the following standards:

1. Goals that must be met in order for the recipient to meet discharge criteria shall be clearly noted.

2. At each review, the team shall assess whether the recipient may be safely discharged.

3. The treatment and discharge plan shall include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals.

4. A description of short-term and long-range treatment goals, with a projection of when such goals will be obtained;

5. A statement of the rationale or reason for utilizing a particular form of treatment will be included;

6. A specification of treatment responsibility, including both staff and recipient responsibility and involvement to attain treatment goals will be noted;

7. Criteria for discharge or release to a less restrictive treatment setting will be included; and

8. Documentation of current discharge planning will be included.

H. Limitations

1. Such a plan must describe any limitation of rights or liberties. Such a limitation shall be based upon professional judgment and may include a determination that the recipient is a danger to him or herself or to others absent such limitation. Any limitation shall meet criteria outlined for the limitation in other sections of these rules.

2. When any limitation is included, the treatment and discharge plan shall address the specific limitation, and the restriction shall be subject to periodic review. When possible, the limitation shall be time specific.

3. Whenever possible specific treatment shall be developed to address the basis of the limitation.

4. Documentation regarding the limitation shall include documentation as per H.1. through 3. above and shall include specific criteria for removal of the limitation.

I. A copy of the treatment and discharge plan shall be offered to each recipient, to a guardian, if any, and to a recipient's representative if confidentiality has been waived pursuant to Section A.IX.

J. All facilities or agencies shall maintain specific written guidelines describing their practices concerning development of treatment and discharge plans.

K. Discharge or termination

1. Each recipient has the right to be informed of and referred to appropriate resources upon discharge or termination from a facility or program.

2. Each recipient has the right to a treatment and discharge plan and to assisted referral to existing resources in such areas as transportation, housing, residential support services, crisis intervention and resolution services, vocational opportunities and training, family support, recreational/social/avocational opportunities, financial assistance, and treatment options. Recommendations made in treatment and discharge plans shall not require the facility or department to provide recommended goods or service.

3. Upon a recipient's discharge from an inpatient facility, the facility shall provide each recipient with a written list of his or her prescribed medication, dosage levels, schedules, and side-effects. A copy of the medication list and the aftercare plan shall be sent to the recipient's guardian and to the recipient's representative upon the recipient's request.

4. Notification

a. The recipient's representative, with the permission of the recipient, and the recipient's guardian, shall be notified of and, if the representative, or guardian is available, involved in any treatment and discharge planning. Involvement may include, but need not be limited to, participation in any discharge planning meeting. Invited persons who cannot attend shall be notified that they may submit information in writing for consideration at the meeting.

b. The recipient's guardian shall be given prior notification of the recipient's discharge from an inpatient facility, if possible. Upon the recipient's request, his or her representative shall be notified, if possible. At least twenty-four hour notice shall be given in planned discharges, if possible. In the case of other discharges, the notice shall be given as quickly as possible. Good faith efforts shall be made to notify guardians or representatives, and such efforts shall be documented.

c. A family member designated by the recipient shall, if possible, receive notification of the recipient's discharge from inpatient facilities, pursuant to subsection 4(b) above. The recipient shall be informed prior to the notification.

L. Exceptions

1. A recipient may choose not to be involved in developing his or her treatment and discharge plan and may refuse treatment and discharge planning or services. All such cases shall be documented in the recipient's permanent treatment record.

2. A guardian shall be actively involved in the treatment and discharge planning, to the maximum extent possible. A public guardian has an affirmative duty to be fully and

actively involved in treatment discussions and discharge planning.

IV. INDIVIDUALIZED TREATMENT OR SERVICE PLAN IN RESIDENTIAL SETTINGS

A. Recipients have the right to an individualized treatment or service plan. For recipients who have an ISP, the ISP process will provide the foundation of the development of the treatment or service plan.

B. Treatment or service plans shall, in instances in which the recipient has an ISP, be based upon the life plan, needs, targets and action plans developed in the ISP process. Treatment or service plans shall be based upon an individualized assessment of the recipient's housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs as well as their potential need for crisis intervention and resolution services. Each facility or agency shall fully consider the least restrictive appropriate treatment and related services taking into account factors that are supportive of each recipient's exercise of his or her basic rights, consistent with each individual's strengths, needs and treatment requirements, pursuant to this section and sections III and IV of these rules. Such considerations shall include accommodation of particular needs involving communication and physical accessibility to all treatment programs.

C. The recipient or guardian, shall be fully and actively involved in the development or revision of the treatment or service plan. Upon the request of the recipient, the recipient's representative or family members designated by the recipient shall be included in the development or revision of the treatment or service plan. Each agency program or facility shall give 10 days' notice of any treatment or service planning meetings, to the recipient's guardian, and designated representatives. If the meeting is being convened to address an emergency, notice reasonable for the circumstances shall be required. Invited persons shall be notified that, if they are unable to attend a treatment or service planning meeting, they may submit information in writing for consideration at the meeting.

D. Treatment or service plans shall be developed within 20 days of initiation of service and shall thereafter be reviewed and revised no less frequently than every 90 days. Plans may be reviewed more frequently as necessary to address substantial changes in a recipient's life, such as hospitalization.

E. Treatment or service plans shall be developed by a team consisting of the recipient and others among whom the recipient has authorized the exchange of information and who are needed to ensure that the recipient's needs are adequately assessed and that appropriate recommendations are made, based upon a comprehensive assessment of the recipient. The plan shall contain but need not be limited to:

1. A statement of the recipient's specific strengths and needs. The treatment or service plan should include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those

afforded non-disabled individuals.

2. A description of services to assist the recipient in meeting identified needs. Goals shall be written for each service. Short-range objectives shall be stated such that their achievement leads to the attainment of overall goals. Objectives shall be stated in terms that allow objective measurement of progress and that the recipient, to the maximum extent possible, both understands and adopts.

3. A description of services based on the actual needs as expressed or approved by the recipient rather than on what services are currently available. If at the time of the meeting, team members know on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet service needs" on the treatment or service plan and develop an interim plan based upon available services that meet, as nearly as possible, the actual needs of the recipient.

4. A description of the manner of delivery of each service to be provided. The manner of delivery shall be one that maximizes the recipient's strengths, independence and integration into the community.

5. A statement of the rationale or reason for utilizing the described treatment or services to meet such goals;

6. A specification of treatment or service responsibility, including both staff and recipient responsibility and involvement to attain treatment or service goals; and

7. Documentation of current discharge planning.

F. Within one week of the meeting, the recipient shall be offered a written copy of the treatment or service plan. The recipient shall also be notified, by means he or she shall most likely understand, of the process to pursue, up to and including the right to file a grievance if he or she disagrees with any aspect of the plan or the assessments upon which the plan is based, or is later dissatisfied with the plan's implementation.

G. Limitations

1. Such a plan must describe any limitation of rights or liberties. Such a limitation shall be based upon professional judgment and may include a determination that the recipient is a danger to him or herself or to others absent such limitation. Any limitation shall meet criteria outlined for the limitation in other sections of these rules.

2. When any limitation occurs, the treatment plan shall address the specific limitation, and the restriction shall be subject to periodic review. When possible, the limitation shall be time specific.

3. Whenever possible specific treatment shall be developed to address the basis of the limitation.

4. Documentation regarding the limitation shall include documentation as per G.1., 2. and 3. above and shall include specific criteria for removal of the limitation.

H. A copy of the treatment or service plan shall also be offered to the recipient's guardian, if any, and to recipient's representative, if confidentiality has been waived.

I. All agencies shall maintain specific written guidelines describing their practices concerning development of treatment or service plans.

J. Recipients who have had a community support worker assigned to them have the right to a variety of appropriate services from the community support worker, including the following, when pertinent to meeting a recipient's need for services:

1. assistance in locating services;

2. continuing monitoring of the services provided;

3. notification of ISP meetings and coordination of the ISP;

4. participation in the recipient's hospital discharge planning meeting; and

5. assistance in the exploration of lesser restrictive alternatives to hospitalization.

K. Discharge

1. Each recipient has the right to be referred to appropriate resources prior to discharge from a program.

2. Each recipient has the right to a comprehensive discharge plan and to assisted referral to existing resources in such areas such as transportation, housing, financial assistance, and mental health treatment. Recommendations made in discharge plans shall not require the agency or department to provide recommended goods or service.

3. Notification

a. The recipient's representative, upon request of the recipient, and the recipient's guardian, shall be notified of and, if the representative, or guardian is available, involved in any discharge planning. Involvement may include, but not be limited to, participation in a discharge planning meeting.

L. Exceptions

1. No treatment or service plan is required for recipients who solely received informal social support and recreation in drop-in mental health programs or social clubs.

2. A recipient may choose not to be involved in developing his or her treatment or service plan and may refuse planning.

3. A legally responsible guardian shall be actively involved in treatment or service planning, to the maximum extent possible. A public guardian has an affirmative duty to be fully and actively involved in treatment or service planning.

V. INFORMED CONSENT TO TREATMENT

A. Right to informed consent. Recipients have the right to informed consent for all treatment.

B. Statement of purpose. This rule has the following purposes:

1. To promote respect for individual autonomy and recipient participation in decision-making;

2. To ensure that, whenever possible, the informed consent of a recipient is obtained prior to treatment;

3. To avoid, whenever possible, forcible imposition of any treatment;

4. To provide reasonable standards and procedural mechanisms for determining when to treat a recipient absent his or her informed consent, consistent with applicable law; and

5. To ensure that the recipient is fully protected against the unwarranted exercise of the state's parens patriae power.

C. Treatment of recipients. All recipients with unimpaired capacity have the right to consent to or to refuse treatment, absent an emergency. Treatment may be provided to a recipient only when:

1. Informed consent for the treatment has been obtained from the recipient; or

2. The recipient has been judged by a court of competent jurisdiction to lack capacity to give informed consent to the particular treatment, and the informed consent of the recipient's guardian has been obtained; or

3. The recipient has been found to lack clinical capacity to give informed consent to the particular treatment pursuant to subsections D and E of this rule and:

a. in the case of an inpatient recipient willing to comply with treatment,

approval of the treatment is being processed in a timely fashion or has been obtained in accordance with subsection E(2) of this rule; or

b. in the case of a recipient willing to comply with treatment in a residential facility or program, the provisions of E(3) have been followed; or

c. in the case of an involuntary inpatient recipient unwilling to consent to treatment, treatment may be provided in accordance with the procedures and standards provided in subsection F of this section; or

4. An emergency exists, as defined in subsection H of this rule, and the emergency procedures required by sub-section H are observed.

D. Informed consent to treatment. Informed consent to treatment is obtained only where the recipient possesses capacity to make a reasoned decision regarding the treatment, the recipient or the recipient's guardian is provided with adequate information concerning the treatment, and the recipient or guardian makes a voluntary choice in favor of the treatment. Informed consent must be documented in each case in accordance with this section.

1. Capacity. Capacity means sufficient understanding to comprehend the information outlined in section (D)(2) and to make a responsible decision concerning a particular treatment. Recipients are legally presumed to possess capacity to give informed consent to treatment unless the recipient has been judged by a court of competent jurisdiction to lack capacity generally, or to lack capacity to give informed consent to a particular treatment.

2. Adequate information. The licensed, certified or other qualified mental health professional recommending a particular treatment shall provide to the recipient, or guardian, all information relevant to the formulation of a reasoned decision concerning such treatment.

The recipient shall have the right to have a person of his or her choice present during the presentation of this information, provided that the nominee can be available within 48 hours, or within such other reasonable period as may be agreed upon; and the recipient, or guardian, shall be informed of this right. The information may be provided orally, in sign language or in writing, shall be communicated in terms designed to be comprehensible to a lay person, and shall include, without limitation:

a. An assessment of the recipient's condition and needs, including the specific signs, symptoms or behaviors that any proposed medication is intended to relieve;

b. The nature of the proposed treatment, and a statement of the reasons why the professional believes it to be indicated in the recipient's case;

c. The expected benefits of the treatment, and the known risks that it entails, including precautions, contraindications, and potential adverse effects of any proposed medication;

d. The anticipated duration of the treatment;

e. A statement of reasonable alternatives to the proposed treatment, if any;

f. Information as to where the recipient may obtain answers to further questions concerning the treatment; and

g. A clear statement that the recipient has the right to give or withhold consent to the proposed treatment.

3. Voluntary choice. Consent to treatment must be given willingly in all cases, and may not be obtained through coercion or deception. Special care shall be taken to assure that consent is voluntary where the recipient's status as an involuntary inpatient militates against truly voluntary consent.

A recipient or guardian's initial refusal of treatment shall not preclude renewed attempts to obtain the recipient's willing consent; and a recipient's initial willing consent shall not preclude the recipient from validly withdrawing such consent at any time before or during treatment.

4. Documentation. The informed consent of a recipient or his or her guardian to a particular treatment shall be documented to show:

a. From whom consent is obtained, whether recipient or guardian;

b. If consent is given by the recipient, a signed statement that the recipient possesses capacity to give informed consent;

c. That adequate information, including at a minimum all the elements listed in section D(2) of this rule, was provided;

d. The signature of the recipient or, where applicable, the signature of a guardian, indicating consent. In residential programs, a signature is necessary for psychotropic medication treatment only.

e. Exceptions to Written Consent

In cases of unanticipated treatment needs, the informed consent of a guardian may be obtained by telephone, but that oral consent shall be confirmed in writing in accordance with this section as soon as practicable.

E. Recipients with clinical incapacity.

1. Administrative finding. Where a licensed, certified or other qualified mental health professional recommending a particular treatment determines that, in his or her opinion, a recipient not having a guardian lacks clinical capacity to give informed consent to the treatment under subsection D, he or she shall, by means of a written statement to that effect, refer the recipient to a physician or licensed clinical psychologist not directly responsible for the recipient's treatment for an examination in regard to capacity. The physician or clinical psychologist to whom the recipient is referred shall conduct the examination, and shall make a documented finding that the recipient either possesses or lacks clinical capacity to give informed consent to the particular treatment.

a. Finding of capacity. Where the recipient is found to possess capacity to consent to treatment by the physician or licensed clinical psychologist, he shall be referred back to the licensed, certified or other qualified mental health professional recommending the treatment for the processing of his or her informed consent to or refusal of such treatment.

b. Finding of clinical incapacity. Where the recipient is found to lack clinical capacity to consent to treatment by the physician or licensed clinical psychologist, he shall be referred back to the licensed, certified or other qualified mental health professional recommending the treatment for a documented determination as to whether the recipient, notwithstanding lack of clinical capacity, is willing to comply with or refuses the proposed treatment.

Such determination must be based upon the provision to the recipient of adequate information as required by subsection D(2) of this rule.

If an inpatient recipient is willing to comply with treatment, the procedure outlined in subsection E(2) shall be followed. If a recipient in a residential program is willing to comply with treatment, the procedure outlined in subsection E(3) shall be followed. If any recipient refuses treatment, the procedure outlined in subsection E(4) and, in the case of inpatient recipients, if applicable, subsection (F) shall be followed.

c. Notice. Where the recipient is found to lack clinical capacity pursuant to this section, the licensed, certified or other qualified mental health professional recommending the treatment shall notify the following persons of such finding:

i. the Office of Advocacy and the rights protection and advocacy agency of the Maine mental health system;

ii. the recipient's next of kin, if the recipient does not object;

iii. the recipient's designated representative, if the recipient has waived his or her confidentiality with respect to such representative; and

iv. the head of the mental health facility.

Such notice shall include a copy of the documented administrative finding, and shall state that the recipient has been found to lack clinical capacity to give informed consent to a particular treatment; that notwithstanding such finding, the recipient may refuse treatment; and that in the case of involuntary, inpatient recipients, treatment shall not be administered unless authorized by a hearing officer following an administrative hearing held in accordance with subsection F of this rule.

2. Inpatient recipients with clinical incapacity, compliant. This subsection shall apply where it is determined pursuant to subsection E(1)(b) above that an inpatient recipient with clinical incapacity is willing to comply with the proposed treatment. In such case:

a. Treatment may be authorized by the licensed, certified or other qualified mental health professional for a period not to exceed 72 hours. Treatment may continue beyond such period only if approval of the head of the mental health facility is obtained prior to treatment in accordance with subsection E(2)(c) below. The professional shall document:

i. the nature of the proposed treatment, including expected benefits, known risks and any alternatives and a statement of the reasons why he believes the treatment to be a necessary part of the recipient's treatment plan;

ii. that the recipient lacks clinical capacity pursuant to the provisions of section E(1) above; and

iii. that the recipient is willing to comply with the proposed treatment.

Such documentation shall be immediately forwarded to the Clinical Director of a mental health institute or his or her equivalent in any other mental health facility and to the resident advocate in a state mental health institute.

b. Within 48 hours of any authorization to treat under section E(2)(a) above, the Clinical Director or his or her equivalent shall review the documentation required by that section and shall make a written report to the head of the mental health facility as to whether or not, in his or her opinion

i. the recommendation of the proposed treatment is based on an adequately substantiated exercise of professional judgment;

ii. the proposed treatment is the least intrusive appropriate treatment available under the circumstances; and shall include a brief statement of the reasons for his or her opinion. A copy of such report shall be immediately forwarded to the resident advocate in a state mental health institute.

c. If the Clinical Director or his or her equivalent reports an affirmative opinion as to both elements set forth in section E(2)(b)(i) and (ii) above, the head of the mental health facility may, following due consideration of the circumstances of the particular case, approve treatment on behalf of the recipient. Such approval shall authorize administration of the proposed treatment to the recipient for a period not to exceed sixty days. The recipient shall be monitored throughout such period for any change in regard to capacity, and at the latest upon expiration of such period, the recipient shall be re-examined in accordance with section E(1) above.

d. If the Clinical Director or his or her equivalent reports a negative opinion as to either element set forth in sections E(2)(b)(i) and (ii) above, the head of the mental health facility shall not approve treatment, and treatment shall not be continued beyond the 72 hour period authorized in accordance with section E(2)(a) above until informed consent for treatment can be obtained from a legal decision-maker.

3. Recipients in residential settings with clinical incapacity, compliant. This subsection shall apply where it is determined pursuant to subsection (E)(l)(b) that an recipient in a residential setting with clinical incapacity is willing to comply with the proposed treatment. In such case treatment may be provided only if:

a. Protective proceedings are initiated in accordance with law; and

b. A licensed, certified or other qualified mental health professional follows the procedures outlined in subsection (D) and, where applicable, subsection (E) on at least an annual basis.

4. Recipients with clinical incapacity, refusing. This subsection shall apply where it is determined pursuant to subsection E(1)(b) above that a recipient with clinical incapacity is refusing the proposed treatment.

a. Alternative treatment meeting. The licensed, certified or other qualified mental health professional recommending the treatment and a representative of the treatment team shall meet with the recipient to explore the reasons for the recipient's refusal and to discuss any appropriate alternatives to the proposed treatment that may be available and that may include behavioral, psychological, medical, social, psychosocial or rehabilitative treatment methods.

The purpose of the meeting shall be to elaborate in an informal setting an

alternative treatment that is both professionally justified and acceptable to the recipient. If agreement can be reached as to an alternative treatment, review by the Clinical Director or equivalent and approval by the head of the mental health facility, if appropriate, of such treatment shall be processed in accordance with subsection E(2) or E(3) above.

b. Voluntary or outpatient recipient, no agreement. Where no agreement can be reached as to an alternative treatment, and the recipient is a voluntary recipient at an inpatient facility or a recipient at an outpatient facility, the licensed, certified or other qualified mental health professional recommending the proposed treatment shall report in writing to the head of the facility concerning the outcome of the meeting held pursuant to subsection E(4)(a) above.

The head of the inpatient or residential facility or designee may discharge a voluntary recipient from the facility. Any such discharge shall be made in accordance with the section III, subsection J and section IV, subsection K of this part.

c. Involuntary recipient, no agreement; request for hearing. Where no agreement can be reached as to an alternative treatment in the case of a recipient who is an involuntary recipient at an inpatient facility and the licensed, certified or other qualified mental health professional recommending the proposed treatment continues to believe, in the exercise of his or her professional judgment, that the proposed treatment would be in the recipient's best interest, either the professional or the recipient may request that an administrative hearing be held for the purpose of deciding whether or not treatment may be administered, in accordance with subsection F of this rule. Such request shall be directed to the head of the mental health facility.

F. Administrative hearing.

1. When afforded. An administrative hearing for the purpose of deciding whether or not a proposed treatment may be administered shall be afforded in all cases where each of the following conditions is met:

a. Where an involuntary recipient at an inpatient facility lacks clinical capacity pursuant to subsection E(1) of this rule; and

b. Where it has been determined that the recipient is refusing a proposed treatment pursuant to subsection E(1)(b) of this rule; and

c. Where no agreement as to an alternative treatment has been reached following a meeting held pursuant to subsection E(4)(a) of this rule; and

d. Where the licensed, certified or other qualified mental health professional fecommending the proposed treatment continues to believe, in the exercise of his or her professional judgment, that the proposed treatment would be in the recipient's best interest pursuant to subsection E(4)(c) of this rule; and

e. Where the licensed, certified or other qualified mental health professional recommending the proposed treatment or the recipient requests an administrative hearing pursuant to subsection E(4)(c) of this rule.

2. Time frame. An administrative hearing shall be held as soon as possible but in no event later than 10 working days from the date of the request. On motion by any party, the hearing may be continued for cause for a period not to exceed 10 additional working days.

3. Notice. Upon receipt of a request for an administrative hearing pursuant to subsection E(4)(c) of this rule, the head of a mental health facility or his or her designee shall provide adequate and timely notice of such request and of the date set for hearing at least 5 working days prior to the date set for hearing to:

a. the recipient;

b. the recipient's attorney, if any;

c. one person designated by the recipient; and

d. the Clinical Director of a mental health institute or his or her equivalent in any other mental health facility.

4. Parties. The mental health facility and the recipient shall be parties to the administrative hearing, and shall have the right to call and cross-examine witnesses and introduce relevant evidence.

5. Right to counsel. The recipient shall have the right to be represented by counsel at the administrative hearing. Upon receipt of a request for hearing pursuant to subsection E(4)(c) of this rule, the head of the mental health facility or designee shall inform the recipient of his or her right to counsel, and ascertain whether the recipient is already represented by counsel, or specifically desires to employ his or her own counsel. If the recipient is not already represented, does not specifically desire to employ his or her own counsel, and does not explicitly refuse representation by appointed counsel, the head of the mental health facility or designee shall appoint counsel to represent the recipient. The Bureau shall maintain a list of attorneys from which such appointed counsel shall be selected. In cases where the recipient is not represented by counsel and refuses representation by appointed counsel, the head of the mental health facility or designee shall request that a representative of the rights protection and advocacy agency of the Maine

mental health system contact the recipient in an effort to arrange to represent the recipient. If the recipient refuses such representation, the representative of the rights protection and advocacy agency shall nevertheless attend the hearing as an observer.

6. Medical Records. The recipient shall have access, upon request, to his or her medical records to prepare for the hearing within one working day of his or her request.

7. Hearing officer. An independent hearing officer shall preside at the administrative hearing.

8. Informal setting; mediation.

a. The hearing shall be conducted in an informal setting and atmosphere.

b. The hearing officer shall open the hearing by exploring with the parties the reasons why they were unable to agree to an alternative treatment pursuant to subsection E(3)(a) of this rule and shall attempt to mediate a solution. Where no mediated solution is reached, the hearing officer shall proceed with the hearing in accordance with subsections F(9) - (11) below.

9. Burden on facility. The hearing officer shall authorize treatment of the recipient over his or her objection and absent his or her informed consent only if the recipient fails to make the affirmative showing under subsection 10 below and the facility is able to make a clear and convincing showing on each of the following four factors:

a. That the recipient lacks capacity to make a decision in regard to the particular treatment as outlined in subsection D of these rules. For purposes of this showing, the administrative finding of clinical incapacity made pursuant to subsection E(1) of this rule is not conclusive; and the recipient's refusal of treatment is not evidence of incapacity; AND

b. That the proposed treatment is based on an adequately substantiated exercise of professional judgment; AND

c. That the benefits of the proposed treatment outweigh the risks and possible side-effects; AND

d. That the proposed treatment is the least intrusive appropriate treatment available under the circumstances.

10. Affirmative showing by recipient. The hearing officer shall not authorize treatment of the recipient over his or her objection and absent his or her informed consent if the recipient affirmatively shows that, if he possessed capacity, he would have refused the proposed treatment on religious grounds or on the basis of other previously expressed

personal convictions or beliefs.

11. Decision

a. Ruling

i. Denial of treatment

Where the facility fails to carry its burden as required by subsection F(9) above in any respect, or where the recipient makes the affirmative showing pursuant to subsection F(10), the hearing officer shall rule that the proposed treatment shall not be administered to the recipient.

ii. Approval of treatment

Where the facility carries its burden in all respects, and the recipient fails to make the affirmative showing pursuant to subsection F(10), the hearing officer shall rule that the proposed treatment shall be administered to the recipient in the exercise of the state's parens patriae power.

b. The hearing officer may announce his or her decision at the conclusion of the hearing and shall, in any event, issue a written decision detailing his or her conclusions and reasoning within 3 working days of the hearing.

c. If the hearing officer decides that treatment may be administered, treatment may begin one full working day after the decision is announced, unless stayed by order of court. The hearing officer's decision shall be effective for a period not to exceed sixty days from the date on which treatment is begun. The recipient shall be monitored throughout such period for any change in regard to capacity, and, at the latest, upon expiration of such period, the recipient shall be re-examined in accordance with subsection E(1) of this rule.

d. The hearing officer's decision shall constitute final agency action and may be appealed to Superior Court pursuant to the Maine Administrative Procedure Act, 5 M.R.S.A. s 11001 et seq. If the issue of incapacity of the recipient is raised on appeal, the Superior Court may conduct a hearing de novo on such issue.

e. An electronic recording of the hearing shall be made, and an accurate transcription thereof shall constitute the administrative record for purposes of an appeal.

f. The hearing shall be confidential and no report of the proceedings may be released to the public or press, except by permission of the recipient, his or her counsel and with the approval of the presiding hearing officer.

G. Notice; protective proceedings. In all cases where an administrative finding of clinical incapacity is made, the head of the mental health facility shall be notified immediately. If treatment is authorized for a 60-day period pursuant to subsection E(2)(c) or subsection F(11) of this rule, the head of the mental health facility or designee shall, within such 60-day period, notify the family, public guardian or other appropriate party of the potential need for protective proceedings. No renewal of treatment pursuant to subsections E(2)(c) or F(11) shall be authorized unless and until the notice required by this subsection has been given and documented.

H. Emergency treatment

1. Definition. An emergency is defined as a situation where, as a result of a recipient's behavior due to mental illness, there exists a risk of imminent bodily injury to the recipient or to others.

2. Declaration of emergency. A licensed physician [or physician extender] may declare an emergency when he reasonably believes an emergency exists as defined in subsection G(1) above, and when

a. A recognized form of treatment is required immediately to ensure the physical safety of the recipient or of others; and

b. No-one legally entitled to consent on the recipient's behalf is available; and

c. A reasonable person concerned for the physical safety of the recipient or of others would consent under the circumstances.

3. At no time may a physician or physician extender declare an emergency merely because the recipient refuses treatment.

4. Documentation. When an emergency is declared, documentation of the emergency shall be immediately entered into the recipient's permanent treatment record and, if declared by a physician extender, endorsed within 24 hours by the physician. Such documentation by the physician or physician extender shall include the following:

a. A description of the behaviors that he has observed, and that created the emergency;

b. The period, not to exceed 72 hours, during which the medication may be administered;

c. The expected benefits of the order; and

d. The specific behaviors or physical responses that staff should monitor and record, and the means they should use.

5. Emergency treatment. Following a declaration of emergency pursuant to subsection H(2) above, a licensed physician or a person acting under his or her direction may administer a recognized form of treatment over the recipient's objection and absent his or her informed consent. Treatment imposed following a declaration of emergency may continue for a period not to exceed 72 consecutive hours.

6. Notice and review. The administrative head of the facility and the Clinical Director or his or her equivalent shall be notified, as soon as possible, of any emergency. Any renewal of emergency treatment requires review by and the written authorization of the Clinical Director of a mental health institute or his or her equivalent in any other mental health facility. Additionally, an order for continued medication may be entered only upon compliance with the foregoing provisions of this sub-section and, if the recipient lacks capacity, only upon consent of the guardian or initiation of administrative hearing proceedings described in sub-section (F) above.

I. Electroconvulsive Therapy (ECT). ECT treatment shall not be administered to a recipient except as provided in these rules. The authorized treating professional seeking to administer ECT treatment shall:

1. Obtain written informed consent for such procedure according to the procedures outlined in Section IV of this part from:

a. the recipient, or

b. from a court of competent jurisdiction, in the case of a clinically incapacitated recipient, or

c. from a guardian or other legal decisionmaker for an incapacitated recipient who has a guardian;

2. ECT treatment shall not be authorized pursuant to Section IV(E)-(H) of this part.

J. Psychosurgery. Psychosurgery shall only be performed on an adult recipient upon order of a court of competent jurisdiction.

K. Documentation. All documentation required by this rule shall be made a part of the recipient's clinical chart.

VI. BASIC RIGHTS

A. Recipients have the right to freedom of association and communication.

B. Recipient's Right to Visitors

1. Each facility shall establish the most liberal visiting policies that are administratively feasible.

a. Each facility shall establish regular daily visiting hours. Such hours shall be prominently posted in the facility. Visitation during these hours shall not require prior notification or request by either the recipient or the visitor except when such visits would conflict with regularly scheduled therapeutic activities of which the recipient has been notified.

b. Recipients have the right to refuse or terminate visitation from specific visitors or all visitors.

2. Suitable areas shall be provided by the facility for privacy during visitation.

3. The facility shall provide unrestricted visitation by a recipient's attorney, clergy, professional service provider or advocate of the rights protection or advocacy services of the Maine mental health system, accompanied by a sign language interpreter, if needed, at any reasonable time.

4. Exceptions

a. When a physician or licensed clinical psychologist treating a recipient determines, in consultation with the treatment team, that denial of access to a particular visitor or visitors, except those visitors listed in subsection 3 above, is necessary for treatment, or for security purposes in the case of forensic recipients, such professional may, for a specific limited and reasonable period of time, deny such access.

i. A written order denying such visitation including the reasons for the denial, shall be entered into the recipient's permanent treatment record.

ii. Any limitation of this right shall be explained to the recipient and to the specifically restricted visitor, and when appropriate to the recipient's family or any other regular visitors. Those same people shall be immediately notified, if possible, when the restrictions on visitation have been lifted.

iii. Any limitation on visitation may be appealed by the recipient or by the specifically restricted visitor, if aggrieved, through the grievance mechanism as outlined in Section V.

C. Recipient's Right to Communicate by Mail

1. No facility shall censor, delay or restrict incoming or outgoing letters or packages.

Incoming letters and packages shall be delivered sealed and unopened to the recipient, and outgoing letters and packages shall be mailed in like manner.

2. Writing materials and postage funds adequate to mail at least one letter per day shall be provided to inpatient recipients who are unable to procure such items.

3. Exceptions

a. If staff of a facility reasonable believes that mail contains contraband, such mail may, upon the written order of a physician or Chief Administrative Officer, be subjected to physical examination in the recipient's presence if appropriate.

b. Any illegal items found during such an examination may be confiscated by the facility.

c. Any other contraband shall be held in safekeeping, and returned to the recipient upon discharge, except that no medication shall be released without the authorization of a physician.

d. Any exception to the right to communicate by mail under subsection (a) above must be explained to the recipient. The justification for any such exception, and an itemized list of any materials confiscated must be documented in the recipient's permanent treatment record.

e. Additional procedures may be developed to assure security in the cases of forensic recipients.

D. Recipient's Right to Communicate by Telephone.

1. Each inpatient and residential treatment facility shall provide all recipients reasonable access to telephones for placing and receiving confidential calls, including access to telecommunication devices for the deaf, when necessary.

2. Each inpatient and residential treatment facility shall assure, at any reasonable time, a recipient's access to a telephone for contact with a particular designated family member, clergy, professional service provider, or personally designated representative. Reasonable time means from the hours of 7:00 a.m. - 10:00 p.m., daily. Telephone access to an advocate of the rights protection and advocacy service or to an attorney shall be assured at all times.

3. Each inpatient facility shall provide use of telephones at no charge, or telephone usage funds in reasonable amounts, to recipients who would otherwise be unable to communicate with family or friends by telephone.

4. Exceptions

a. Upon the recommendation of a physician or licensed psychologist, the chief administrator of the facility may restrict a recipient's right to communicate by telephone when the facility is notified, by a person receiving calls, that the person is being harassed and wishes the calls to be curtailed or halted. Telephone restrictions shall apply only to those persons so notifying the facility.

b. Upon the recommendation of a physician or licensed psychologist, the chief administrator of the facility may restrict or monitor a recipient's right to communicate by telephone, if it is determined that the recipient has made obscene or threatening phone calls, or for other security reason in the case of forensic recipients.

c. If a physician or licensed psychologist determines, in consultation with the treatment team, that restrictions on asking or receiving telephone calls, except to those listed in 2 above, is necessary for treatment purposes, the physician or licensed clinical, psychologist may restrict the recipient's right to communicate for a specific limited and reasonable period of time, not to exceed one week without reauthorization.

i. Any such restrictions shall become incorporated in the recipient's treatment plan, and be a focus of treatment, pursuant to Section IX(F).

ii. An explanation of any such restrictions shall be given to the recipient's regular callers as designated by the recipient. The recipient's designated regular callers, so requesting, shall be immediately notified, if possible, when the restrictions on communication by telephone are lifted.

iii. Any limitation on telephone calling may be appealed by the recipient or specifically restricted caller, if aggrieved, through the grievance mechanism as outlined in Section V.

E. Recipients are entitled to receive individualized treatment, to have access to activities necessary to the achievement of their individualized treatment goals, to exercise daily, to recreate outdoors, and to exercise their religion.

F. At no time shall the entitlements or basic human rights set forth in this Section be treated as privileges that the recipient must earn by meeting certain standards of behavior.

VII. FREEDOM FROM UNNECESSARY SECLUSION AND RESTRAINT

A. Seclusion

1. Seclusion means the placement of a recipient alone in an isolation room from which exit is denied.

2. Seclusion may be employed only in the following instances:

a. when absolutely necessary to protect the recipient from causing physical harm to self or others; and

b. to prevent further serious disruption that significantly interferes with other recipients' treatment. Behaviors causing serious disruption that interferes with others' treatment may include uncontrollable screaming, public masturbation, indecent exposure and uncontrolled intrusiveness on other recipients. Use of seclusion may be appropriate in these circumstances if the behaviors cannot be controlled through lesser restrictive means than seclusion and if the behaviors will likely be controlled with the use of seclusion. Seclusion may not be used solely to address the comfort, convenience or anxiety of staff; to address factors related to ward or unit dynamics; to control a recipient's mild obnoxiousness, rudeness, obstinacy, use of profanity or other unpleasantness; nor as discipline for resolved behaviors.

Seclusion under these circumstances shall be employed in the following manner:

i. if the recipient is examined in person by a physician or physician extender prior to the implementation of seclusion; or

ii. by a registered nurse in telephone consultation with a physician or physician extender.

3. Seclusion may be used only if less restrictive measures are inappropriate or have proven to be ineffective.

4. The decision to place a recipient in seclusion shall be made by a physician or physician extender and shall be entered as a medical order in the recipient's records.

5. All recipients must be examined before being placed in seclusion in accordance with the following:

a. If the physician or physician extender is not immediately available to examine the recipient, the recipient may be placed in seclusion following an examination by a registered nurse if the registered nurse finds that the recipient poses a risk of imminent harm to self others or following an examination by the nurse and with telephone consultation from the physician or physician extender in order to prevent further serious disruption that significantly interferes with other recipients' treatment. Any recipient placed in seclusion under these circumstances

shall be kept under constant observation while awaiting an examination by a physician or physician extender.

b. The examination by the registered nurse shall be conducted in accordance with a protocol approved by the chief of psychiatry or medicine and by the Director of Nursing. The protocol must include the following:

i. A list of indicators for organic causes of changed behaviors.

ii. Elements for assessment including but not limited to: known medical disorders;

a. the recipient's medications including PRN administrations;

b. mental status, with observation of behavior, speech, affect and suicidal/homicidal ideation;

c. brief neurological examination: pupil size and reactivity, gait, limb movement and strength;

d. vital signs; and

e. cognition using a standard tool.

iii. Provision for completion as soon as is clinically sound, those elements of assessment that require the recipient's cooperation and that the nurse may not be able to perform immediately due to the recipient's condition.

c. A physician or physician extender shall personally evaluate the recipient within 30 minutes after the recipient has been placed in seclusion. If the evaluation does not take place within 30 minutes, the reasons for the delay shall be documented in the recipient's record. This provision applies to all recipients, including those placed in seclusion during the night. Any recipient placed in seclusion shall be kept under constant observation while awaiting an examination by a physician or physician extender. The physician examination must be conducted as follows:

i. At Augusta Mental Health Institute the physician or physician extender examination shall be conducted in person in all instances.

ii. At all other facilities, the physician examination may be conducted via telephone consultation with the registered nurse and shall include consideration of the results of the nurse's formal assessment. The physician

may order seclusion on the basis of this consultation and shall enter any additional orders for further assessments or treatment as appropriate. Thereafter a physician or physical extender shall examine the recipient in person:

a. within 1 hour when the registered nurse requests that a physician evaluate the recipient in person;

b. within 1 hour when the information is suggestive of organic causes that could lead to harm to the recipient;

c. within 1 hour if the recipient has not had a physical examination during the current hospital stay; and

d. within 12 hours in all other instances.

6. Documentation of the physician or physician extender's examination and, if applicable, the registered nurse's assessment must be entered in the recipient's file.

7. Staff who place recipients in seclusion shall have documented training in the proper techniques, in less restrictive alternatives to seclusion and in the detection of organic causes of behavioral disturbances.

8. As soon as possible, staff should make reasonable efforts to notify the recipient's parent, guardian or designated representative, if any, that the recipient has been placed in seclusion, and the reasons therefor.

9. Each order for initiation or extension of seclusion shall state the time of entry of the order. It shall state the number of hours the recipient may be secluded, not to exceed ten and the conditions under which the recipient may be sooner released.

10. No PRN orders for seclusion may be written and no treatment plan may include its use as a treatment approach.

11. The need for a recipient's continuation in seclusion shall be re-evaluated every 2 hours by a nurse. The nurse shall examine the recipient in person. This examination may be conducted outside the seclusion room. The nurse shall note the clinical reasons for selection of the examination site. The nurse shall assess the recipient to determine whether he or she continues to pose a danger to self or others, or continues to cause serious disruption of other recipients' treatment (in cases in which an examining physician or physician extender has ordered seclusion for this reason). If the nurse finds danger and that the recipient continues to require seclusion, seclusion may be continued if the physician's or physician extender's order has not yet lapsed. Should the recipient not need continued seclusion, the nurse shall release the recipient even if the time frame of the

original order has not yet elapsed.

12. A special progress record/check sheet shall be maintained for each use of seclusion and shall include the following documentation:

a. The indication for use of seclusion, i.e. whether a danger to self, others, or serious disruption of other recipients' treatment;

b. A description of the behaviors that constitute the recipient's danger to self, others, or serious disruption of other recipients' treatment;

c. A description of less restrictive alternatives used or considered, and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration.

13. All orders for the extension of seclusion shall include documentation as for an original order. If the recipient is examined outside of the seclusion room, progress notes shall additionally state where the recipient was examined and the clinical reasons for selecting the site.

14. Every recipient placed in seclusion shall be released, unless clinically contraindicated, at least every two hours to eat, drink, bathe, toilet and to meet any special medical orders.

15. Recipients placed in seclusion shall be given maximum observation and in no instance shall they be visually monitored less often than every 15 minutes.

16. A description of the recipient's behavior as observed shall be noted on the progress record/check sheet every 15 minutes.

17. The total amount of time that a recipient spends in seclusion may not exceed 24 hours unless:

a. The recipient is reassessed in accordance with the protocol described at 5(b) above;

b. The recipient is examined, at Augusta Mental Health Institute, by the director of psychiatry or clinical services and, in other hospitals, by a chief of psychiatry or medicine or his or her physician designee. In cases where the chief or director is also the treating physician, he or she shall appoint another physician to conduct the required examination;

c. The order extending seclusion beyond a total of 24 hours is entered by the director of psychiatry or clinical services or by the chief of psychiatry or medicine

following the examination of the recipient and consultation with the other examiners; and

d. The recipient's guardian or designated representative, if any, and if available, has been notified.

18. Records required by the above provisions shall be a part of the recipient's permanent record. At the mental health institutes, copies shall be forwarded to the medical director, the clinical services director and the recipient advocate. At all other facilities, copies shall be forwarded to the chief of psychiatry or medical services. For a period of one year following adoption of these regulations, these facilities shall submit summaries or copies of reports of each use of seclusion to the Division of Licensing of the Department of Mental Health and Mental Retardation. Said reports to DMHMR shall be submitted on a quarterly basis, shall not contain information identifying the recipient by name but shall be reported in a manner to permit the reader to discern whether individual recipients have been secluded on repeat occasions.

19. Seclusion may be ordered on the basis of a recipient's self-report, provided the physician extender otherwise verified that the recipient meets the criteria of paragraph 2 above and provided the decision is otherwise clinically appropriate.

B. Restraint

1. Restraint is the immobilization of a recipient's arms, legs or entire body through the use of an apparatus that is not a protective device as described in sub-section VI.C below.

2. Restraint may be employed only when absolutely necessary to protect the recipient from serious physical injury to self or others and shall impose the least possible restriction consistent with its purpose.

3. Restraint may be used only after less restrictive measures have proven to be inappropriate or ineffective. The extent to which less restrictive measures ar attempted at the time of the incident will be governed by the degree of risk of physical harm to the recipient or others.

4. The decision to place a recipient in restraint shall be made by a physician or a physician extender and shall be entered as a medical order in the recipient's records.

5. All recipients must be examined before being placed in restraint in accordance with the following:

a. If the physician or physician extender is not immediately available to examine the recipient, the recipient may be placed in restraint following

examination by a registered nurse if the nurse finds that the recipient poses a risk of imminent harm to self or others.

b. The examination by the registered nurse shall be conducted in accordance with a protocol approved by the chief of psychiatry or medicine and by the Director of Nursing. The protocol must include the following:

i. A list of indicators for organic causes of changed behaviors.

ii. Elements for assessment, including but not limited to: known medical disorders;

a. the recipient's medications including PRN medications;

b. mental status, with observation of behavior, speech, affect and suicidal/homicidal ideation;

c. brief neurological examination: pupil size and reactivity, gait, limb movement and strength;

d. vital signs; and

e. cognition using a standard tool.

iii. Provision for completion as soon as is clinically sound, those elements of assessment that require the recipient's cooperation and that the registered nurse may not be able to perform immediately due to the recipient's condition.

c. A physician or physician extender must thereafter examine the recipient within 30 minutes of the recipient's having been placed in restraint. If the evaluation does not take place within 30 minutes, the reasons for the delay shall be documented in the recipient's record. This provision applies to all recipients, including those placed in restraint during the night. The physician examination must be conducted as follows:

i. At Augusta Mental Health Institute the physician or physician extender examination shall be conducted in person in all instances.

ii. At all other facilities, the physician examination may be conducted via telephone consultation with the registered nurse and shall include consideration of the results of the registered nurse's formal assessment. The physician may order seclusion on the basis of this consultation and shall enter any additional orders for further assessments or treatment as

appropriate. Thereafter a physician shall examine the recipient in person:

a. within 1 hour when the registered nurse requests that a physician evaluate the recipient in person;

b. within 1 hour when the information is suggestive of organic causes that could lead to harm to the recipient;

c. within 1 hour if the recipient has not had a physical examination curing the current hospital stay; and

d. within six hours in all other instances.

6. Documentation of the physician or physician extender's examination and, if applicable, the registered nurse's assessment must be entered in the recipient's file.

7. Staff who place recipients in restraint shall have documented training in the proper techniques, in less restrictive alternatives to restraint and in the detection of organic causes of behavioral disturbances.

8. As soon as possible, staff should make reasonable efforts to notify the recipient's guardian, or designated representative, if any, that the recipient has been placed in restraint and the reasons therefor.

9. Each order for initiation or extension of restraint shall state the time of entry of the order. It shall state the number of hours the recipient may be restrained, not to exceed six, and the conditions under which the recipient may be sooner released.

10. No PRN orders for restraint may be written and no treatment plan may include its use as a treatment approach.

11. The need for a recipient's continuation in restraint shall be re-evaluated every two hours by a nurse. The nurse shall examine the recipient in person. This examination may be conducted with the recipient free of restraints. The nurse shall note the clinical reasons for selecting whether the recipient is examined in or free of restraints. The nurse shall assess the recipient to determine whether he or she continues to pose a danger of imminent injury to self or others. If the nurse finds such danger and that the recipient continues to require restraint, restraint use may be continued if the physician's or physician extender's order has not yet lapsed. Should the recipient not need continued restraint, the nurse shall release the recipient even if the time frame of the original order has not yet elapsed.

12. A special progress/check sheet record shall be maintained for each use of restraint and shall include the following documentation:

a. The indication for use of restraint.

b. A description of the behaviors that constitute the recipient's danger to self or others.

c. A description of less restrictive alternatives used or considered, and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration.

13. In all facilities, the recipient shall be examined in person by a physician or physician extender before any order for restraint is extended. All orders for the extension of restraint shall include documentation as for an original order, but shall additionally state whether the recipient was examined in or free or restraints and the clinical reasons therefor.

14. Every recipient placed in restraint shall be frequently monitored and released as necessary to eat, drink, bathe, toilet, and to meet any special medical orders. Recipients in restraint shall have each extremity examined and the restraint loosened, sequentially, no less frequently than every 15 minutes. In instances in which blanket wraps are utilized for restraint, the recipient will be released and examined no less frequently than every hour.

15. Recipients in restraint shall be kept under constant observation.

16. A description of the recipient's behavior as observed shall be noted on the progress record/check sheet every 15 minutes.

17. The total amount of time that a recipient spends in restraint may not exceed 24 hours unless:

a. The recipient is reassessed in accordance with the protocol described at 5(b) above.

b. The recipient is examined, at Augusta Mental Health Institute, by the director of psychiatry or clinical services and in other hospitals, by a chief of psychiatry or medicine or his or her physician designee. In cases where the chief or director is also the treating physician, he or she shall appoint another physician to conduct the required examination.

c. The order extending restraint beyond a total of 24 hours is entered by the director of psychiatry or clinical services or by the chief of psychiatry or medicine following his or her examination of the recipient and consultation with the other examiners.

d. The recipient's guardian or designated representative, if any, has been fiotified.

18. Records required by the above provisions shall be made a part of the recipient's permanent record. At the mental health institutes, copies shall be forwarded to the medical director, the clinical services director and the recipient advocate. At all other facilities, copies shall be forwarded to the chief of psychiatry or medical services. For a period of one year following adoption of these regulations, these facilities shall submit summaries or copies of reports of each use of restraint to the Division of Licensing of the Department of Mental Health and Mental Retardation. Said reports to DMHMR shall be submitted on a quarterly basis, shall not contain information identifying the recipient by name but shall be reported in a manner to permit the reader to discern whether individual patients have been restrained on repeat occasions.

19. If a recipient communicates via sign language, consideration will be given to restraining the recipient in such a manner as to permit the use of hands for communication purposes.

C. Protective Devices.

1. Protective devices that are used for medical reasons to ensure a recipient's safety and comfort, to provide recipient's stability during medical procedures, facilitate medical (non-psychiatric) treatment or safeguard health in the treatment of a health-related problem are exempt from the operation of the foregoing procedures governing the use of restraints. The following procedures for use of protective devices may never be used, however, as a substitute for those governing restraint or seclusion.

Examples of some protective devices are: bed-padding or bolsters to maintain a recipient's body alignment; devices for the immobilization of fractures; devices to permit the safe administration of intravenous solutions or to prevent their removal; protective equipment, such as mitts, to prevent the aggravation of the medical condition through scratching, rubbing or digging; helmets to protect the head from falls due to unsteadiness, seizures or self-injurious behavior; seat belts or vest restraints to prevent ambulation when it is medically contra-indicated or to permit a recipient, who for medical reasons could not do so unassisted, to remain in a seated position.

The use of protective devices shall be subject to the following:

a. The decision to use a protective device shall be made by a physician who has examined the recipient prior to its use. The decision shall be entered as a medical order in the recipient's record.

b. When ordering use of a protective device, the physician shall select a device that interferes with the recipient's free movement and ability to interact with his

or her environment to the least degree necessary to achieve the medical purpose for which the device is ordered.

c. Staff who use protective devices shall have the documented training in their application.

d. The need for the use of a protective device shall be re-evaluated bi-weekly by a physician who examines the recipient. Orders for devices that immobilize recipients shall be re-evaluated daily. If the physician determines that continued use of the protective device is clinically indicated, further use may be ordered. The order for extension of use shall be entered as a medical order in the recipient's record.

e. Protective devices that hamper a recipient's free movement, such as mitts or vest restraints, shall be removed every two hours, so that the recipient may be permitted free movement, unless the physician's order indicates that removal would interfere with the recipient's health care. The physician shall indicate in his or her order the level of staff supervision and assistance necessary during the recipient's periods of free movement. Where protective devices have been routinely used, the recipient's treatment plan will address ways of reducing or eliminating their use.

f. A special progress record/checksheet shall be maintained for each use of protective devices that hamper a recipient's free movement. These checksheets shall be used to document the recipient's relief from the device every two hours and shall include a description of the recipient's condition as observed during the period of free movement.

g. Every recipient to whom a protective device has been applied shall be frequently monitored and assisted as necessary to meet personal needs and to participate in treatment and activities.

RIGHTS OF RECIPIENTS OF MENTAL HEALTH SERVICES

PART C

RIGHTS IN OUTPATIENT SETTINGS

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
DIVISION OF MENTAL HEALTH
AUGUSTA, MAINE

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I. STATEMENT OF INTENT

These rules [Part C] are applicable to all outpatient agencies or programs that are licensed or funded by the Department of Mental Health & Mental Retardation to provide mental health services to recipients. Part C should be read in conjunction with Part A, Rules of General Applicability.

II. INDIVIDUALIZED SUPPORT PLANNING PROCESS

A. The individualized support planning (ISP) process will result in the development of a life plan based upon the wants and needs of the recipient.

B. All recipients with severe and prolonged mental illness have the right to an ISP presentation and, if they so choose, an ISP.

C. For those recipients who accept the ISP process, the following stages will occur:

1. A life plan will be developed with the recipient, based upon the recipient's vision of his or her future and will include consideration of all areas that the recipient deems relevant. The time frame of the life plan will be defined by the recipient.

2. A list of needs will be developed with the recipient, including those things that need to occur for the recipient to move toward his or her vision of the future. This list should include those needs that appear as unlikely to be met at the time the list is developed.

3. The recipient will select the areas that he or she wishes to target for immediate activity, in order to move toward his or her life plan.

4. Action plans will be developed in instances in which recipients and providers agree to work toward the achievement of a goal. The action plan will be consistent with the recipient's life plan, priority needs and targets. The action plan will contain the following:

   a. Measurable outcomes;

   b. Criteria for success;

   c. Time frames; and

   d. Assignment of responsibilities.

D. All unmet needs identified in the ISP process will be reported to the Division of Mental Health.

E. ISP's will be reviewed with the recipient no less frequently than every 90 days and revised as needed.

III. INDIVIDUALIZED TREATMENT OR SERVICE PLAN

A. Recipients have the right to an individualized treatment or service plan. For recipients who have an ISP, the ISP process will provide the foundation of the development of the treatment or service plan.

B. Treatment or service plans shall, in instances in which the recipient has an ISP, be based upon the life plan, needs, targets and action plans developed in the ISP process. Treatment or service plans shall be based upon an individualized assessment of the recipient's housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs as well as their potential need for crisis intervention and resolution services. Each facility or agency shall fully consider the least restrictive appropriate treatment and related services taking into account factors that are supportive of each recipient's exercise of his or her basic rights, consistent with each individual's strengths, needs and treatment requirements, pursuant to this section and sections IV and V of these rules. Such considerations shall include accommodation of particular needs involving communication and physical accessibility to all treatment programs.

C. The recipient or guardian, shall be fully and actively involved in the development or revision of the treatment or service plan. Upon the request of the recipient, the recipient's representative or family members designated by the recipient shall be included in the development or revision of the treatment or service plan. Each agency program or facility shall give 10 days' notice of any treatment or service planning meetings, to the recipient's guardian, and designated representatives. If the meeting is being convened to address an emergency, notice reasonable for the circumstances shall be required. Invited persons shall be notified that, if they are unable to attend a treatment or service planning meeting, they may submit information in writing for consideration at the meeting.

D. Treatment or service plans shall be developed within 30 days of initiation of service and shall thereafter be reviewed and revised no less frequently than every 90 days. Plans may be reviewed more frequently as necessary to address substantial changes in a recipient's life, such as hospitalization.

E. Treatment or service plans shall be developed by a team consisting of the recipient and others among whom the recipient has authorized the exchange of information and who are needed to ensure that the recipient's needs are adequately assessed and that appropriate recommendations are made, based upon a comprehensive assessment of the recipient. The plan shall contain but need not be limited to:

1. A statement of the recipient's specific strengths and needs. The treatment or service plan should include a description of any physical handicap and any accommodations necessary to provide the same or equal services and benefits as those afforded non-disabled individuals.

2. A description of services to assist the recipient in meeting identified needs. Goals shall be written for each service. Short-range objectives shall be stated such that their achievement leads to the attainment of overall goals. Objectives shall be stated in terms that allow objective measurement of progress and that the recipient, to the maximum extent possible, both understands and adopts.

3. A description of services based on the actual needs as expressed or approved by the recipient rather than on what services are currently available. If at the time of the meeting, team members know on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet service needs" on the treatment or service plan and develop an interim plan based upon available services that meet, as nearly as possible, the actual needs of the recipient.

4. A description of the manner of delivery of each service to be provided. The manner of delivery shall be one that maximizes the recipient's strengths, independence and integration into the community.

5. A statement of the rationale or reason for utilizing the described treatment or services to meet such goals;

6. A specification of treatment or service responsibility, including both staff and recipient responsibility and involvement to attain treatment or service goals; and

7. Documentation of current discharge planning.

F. Within one week of the meeting, the recipient shall be offered a written copy of the treatment or service plan. The recipient shall also be notified, by means he or she shall most likely understand, of the process to pursue, up to and including the right to file a grievance, if he or she disagrees with any aspect of the plan or the assessments upon which the plan is based, or is later dissatisfied with the plan's implementation.

G. Limitations

1. Such a plan must describe any limitation of rights or liberties. Such a limitation shall be based upon professional judgment and may include a determination that the recipient is a danger to self or to others absent such limitation. Any limitation shall meet criteria outlined for the limitation in other sections of these rules.

2. When any limitation occurs, the treatment plan shall address the specific limitation, and the restriction shall be subject to periodic review. When possible, the limitation shall be time specific.

3. Whenever possible specific treatment shall be developed to address the basis of the limitation.

4. Documentation regarding the limitation shall include documentation as per G.1., 2. and 3. above and shall include specific criteria for removal of the limitation.

H. A copy of the treatment or service plan shall also be offered to the recipient's guardian, if any, and to recipient's representative, if confidentiality has been waived.

I. All agencies shall maintain specific written guidelines describing their practices concerning development of treatment or service plans.

J. Recipients who have had a community support worker assigned to them have the right to a variety of appropriate services from the community support worker, including the following, when pertinent to meeting a recipient's need for services:

1. assistance in locating services;

2. continuing monitoring of the services provided;

3. notification of ISP meetings and coordination of the ISP;

4. participation in the recipient's hospital discharge planning meeting; and

5. assistance in the exploration of lesser restrictive alternatives to hospitalization.

K. Termination

1. Each recipient has the right to be informed of and referred to appropriate resources upon termination from a program.

2. Each recipient terminated from the outpatient agency after ten days or longer term of treatment has the right to a comprehensive termination plan, and to assisted referral to existing resources in such areas such as transportation, housing, financial assistance, and mental health treatment. Recommendations made in termination plans shall not require the agency or department to provide recommended goods or service.

3. Notification

a. The recipient's representative, upon request of the recipient, and the recipient's guardian, shall be notified of and, if the representative or guardian is available, involved in any termination planning. Involvement may include, but not be limited to, participation in a termination planning meeting.

K. Exceptions

1. No treatment or service plan is required for recipients who solely received informal

social support and recreation in drop-in mental health programs or social clubs.

2. A recipient may choose not to be involved in developing his or her treatment or service plan and may refuse planning.

3. A legally responsible guardian shall be actively involved in treatment or service planning, to the maximum extent possible. A public guardian has an affirmative duty to be fully and actively involved in treatment or service planning.

IV. INFORMED CONSENT TO TREATMENT AND/OR SERVICES

A. Recipients have the right to informed consent for all treatment and/or services.

B. Statement of purpose. This rule has the following purposes:

1. To promote respect for the individual autonomy and recipient participation in decision-making;

2. To ensure that the informed consent of a recipient is obtained prior to treatment and/or services;

3. To avoid the forcible imposition of any treatment and/or services;

4. To provide reasonable standards and procedural mechanisms for determining when to treat and/or serve a recipient absent his or her informed consent, consistent with applicable law; and

5. To ensure that the recipient is fully protected against the unwarranted exercise of the state's parens patriae power.

C. Treatment and/or service of recipients. All recipients with unimpaired capacity have the right to consent to or to refuse treatment and/or services, absent an emergency. Treatment may be provided to a recipient only when:

1. Informed consent for such treatment and/or services has been obtained from the recipient; or

2. The recipient has been judged by a court of competent jurisdiction to lack capacity to give informed consent to the particular treatment and/or services, and the informed consent of the recipient's guardian has been obtained; or

3. The recipient has been found to lack clinical capacity to give informed consent to the particular treatment and/or services pursuant to subsections D and E of this rule, the recipient is willing to comply with treatment and/or services and the provisions of E(2)

have been followed.

D. Informed consent to treatment and/or services. Informed consent to treatment and/or services is obtained only where the recipient or his or her guardian possesses capacity to make a reasoned decision regarding the treatment and/or services and the recipient or his or her guardian is provided with adequate information concerning the treatment and/or services; and the recipient or guardian makes a voluntary choice in favor of the treatment and/or services. Informed consent must be documented in each case in accordance with this section.

1. Capacity. Capacity means sufficient understanding to comprehend the information outlined in section (D)(2) and to make a responsible decision concerning a particular treatment and/or service. Recipients are legally presumed to possess capacity to give informed consent to treatment and/or services unless the recipient has been judged by a court to competent jurisdiction to lack capacity generally, or to lack capacity to give informed consent to a particular treatment and/or service.

2. Adequate information. The licensed, certified or other qualified mental health professional recommending a particular treatment and/or service shall provide to the recipient, or guardian, all information relevant to the formulation of a reasoned decision concerning such treatment and/or service. The recipient, or his or her guardian, shall have the right to have a person of his or her choice present during the presentation of this information, provided that the nominee can be available within time frames established for the service in question in the Licensing Standards, or within such other reasonable period as may be agreed upon; and the recipient, or guardian, shall be informed of this right. The information may be provided orally or in writing, shall be communicated in terms designed to be comprehensible to a lay person, and shall include, without limitation:

a. An assessment of the recipient's condition and needs, including the specific signs, symptoms or behaviors that any medication is intended to relieve;

b. The nature of the proposed treatment and/or service, and a statement of the reasons why the professional believes it to be indicated in the recipient's case;

c. The expected benefits of the treatment and/or service and the known risks that it entails, including precautions, contraindications, and potential adverse effects of any medication;

d. The anticipated duration of the treatment and/or service;

e. A statement of reasonable alternatives to the proposed treatment and/or service, if any;

f. Information as to where the recipient may obtain answers to further questions concerning the treatment and/or service; and

g. A clear statement that the recipient has the right to give or withhold consent to the proposed treatment and/or service.

3. Voluntary choice. Consent to treatment and/or services must be given willingly in all cases, and may not be obtained through coercion or deception.

A recipient or guardian's initial refusal of treatment and/or services shall not preclude renewed attempts to obtain the recipient's willing consent; and a recipient or guardian's initial willing consent shall not preclude the recipient from validly withdrawing such consent at any time before or during treatment and/or service.

4. Documentation. The informed consent of a recipient or guardian to a particular treatment and/or service shall be documented to show:

a. From whom consent is obtained, whether recipient, or guardian;

b. That adequate information, including at a minimum all the elements listed in section D(2) of this rule, was provided;

c. The signature of the recipient or, where applicable, the signature of a guardian, indicating consent, in the case of psychotropic medications only.

d. Exceptions. In cases of unanticipated treatment and/or service needs, the informed consent of a guardian may be obtained by telephone; but such oral consent shall be confirmed in writing in accordance with this section as soon as practicable.

E. Recipients with clinical incapacity.

1. Administrative finding. Where a licensed, certified or other qualified mental health professional recommending a particular treatment and/or service determines that, in his opinion, a recipient not having a guardian lacks clinical capacity to give informed consent to the treatment and/or service under subsection D of these rules, he or she shall, by means of a written statement to that effect, refer the recipient to a physician or licensed clinical psychologist not directly responsible for the recipient's treatment for an examination in regard to capacity.

The physician or clinical psychologist to whom the recipient is referred shall conduct the examination, and shall make a documented finding that the recipient either possesses or lacks clinical capacity to give informed consent to the particular treatment and/or service.

a. Finding of capacity. Where the recipient is found to possess capacity to consent to treatment and/or service by the physician or licensed clinical psychologist, he shall be referred back to the licensed, certified or other qualified

mental health professional recommending the treatment for the processing of his or her informed consent to or refusal of such treatment and/or service.

b. Finding of clinical incapacity. Where the recipient is found to lack clinical capacity to consent to treatment and/or service by the physician or licensed clinical psychologist, he shall be referred back to the licensed, certified or other qualified mental health professional recommending the treatment for a documented determination as to whether the recipient, notwithstanding lack of clinical capacity, is willing to comply with or refuses the proposed treatment and/or service.

Such determination must be based upon the provision to the recipient of adequate information as required by subsection D(2) of this rule.

If recipient is willing to comply with treatment and/or services, the procedure outlined in subsection E(2) shall be followed. If any recipient refuses treatment and/or services, the procedure outlined in subsection E(3) shall be followed.

Nothing shall preclude the agency from pursuing guardianship in appropriate cases at any time after a determination of clinical incapacity.

c. Notice. Where the recipient is found to lack clinical capacity pursuant to this section, the licensed, certified or other qualified mental health professional recommending the treatment and/or service shall notify the following persons of such finding:

i. the rights protection and advocacy agency of the Maine mental health system;

ii. the recipient's next of kin, if the recipient does not object;

iii. the recipient's designated representative, if the recipient has waived his or her confidentiality with respect to such representative;

iv. the head of the mental health facility.

Such notice shall include a copy of the documented administrative finding, and shall state that the recipient has been found to lack clinical capacity to give informed consent to a particular treatment and/or service and that notwithstanding such finding, the recipient may refuse treatment and/or service, absent court adjudication of incapacitation.

2. Outpatient recipients with clinical incapacity, compliant. This subsection shall apply where it is determined pursuant to subsection (E)(l)(b) that an outpatient recipient with clinical incapacity is willing to comply with the proposed treatment and/or service.

In such case treatment and/or service may be provided only if:

a. Protective proceedings are initiated in accordance with law;

b. A licensed, certified or other qualified mental health professional follows the procedures outlined in subsection (D) and, where applicable, subsection (E) on at least an annual basis.

3. Recipients with clinical incapacity, refusing. This subsection shall apply where it is determined pursuant to subsection E(1)(b) above that a recipient with clinical incapacity is refusing the proposed treatment and/or service.

a. Alternative treatment meeting. The licensed, certified or other qualified mental health professional recommending the treatment and/or service and a representative of the treatment team shall meet with the recipient to explore the reasons for the recipient's refusal and to discuss any appropriate alternatives to the proposed treatment and/or service that may be available and that may include behavioral, psychological, medical, social, psychosocial or rehabilitative methods. The purpose of the meeting shall be to elaborate in an informal setting an alternative treatment and/or service that is both professionally justified and acceptable to the recipient. If agreement can be reached as to an alternative treatment and/or service, review by the Clinical Director or equivalent and approval by the head of the mental health facility, if appropriate, of such treatment shall be processed in accordance with subsection E(2) above.

b. No agreement. Where no agreement can be reached as to an alternative treatment and/or service, the licensed, certified or other qualified mental health professional recommending the proposed treatment and/or service shall report in writing to the head of the program concerning the outcome of the meeting.

The head of the program may conclude that the recipient's termination from services is the only available option.

F. Electroconvulsive Therapy (ECT). ECT treatment shall not be administered to a recipient except as provided in these rules. The authorized treating professional seeking to administer ECT treatment shall:

1. Obtain written informed consent for such procedure according to the procedures outlined in Part C, Section IV.D.1., 2., 3., and 4.a.-d. of these rules from

a. the recipient, or

b. from a court of competent jurisdiction, in the case of a clinically incapacitated recipient, or

c. from a guardian or other legal decisionmaker, in the case of a minor recipient or an incapacitated recipient;

2. ECT treatment shall not be authorized pursuant to Section III.E.-H. of this part.

G. Documentation. All documentation required by this rule shall be made a part of the recipient's clinical chart.

H. Seclusion and restraint are under no circumstances to be utilized in outpatient settings.

DISTRIBUTED 10/7/96

LIST OF ADVISORY GROUPS OR COUNCILS TO DMHMRSAS

Mental Health Advisory Board
Quality Improvement Council
Joint Advisory Committee on Select Services for Elder Persons
Maine Advisory Committee
Consumer Advisory Board
Several Mental Retardation Advisory Committees
Consumer Advisory Council
Children's Advisory Committee

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Vallie, Virgil
c/o Mary Adair
Kilkenney Mental Health Center
8 Union Street
Ellsworth, ME 04605

Pelletier, Lynn
PO Box 926
Bangor, ME 04401

****

COMMUNITY-AT-LARGE

Croce, Bob
Box 451
East Holden, ME 04429

Grover, Nancy
47 Kennebec Road
Hampden, ME 04444

Shahaway, Mary Lo
Rt. 1, Box 690
Sangerville, ME 04479

Number of BMHI QIC Members

7/12 Hun... Walker

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. } OK.

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

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

4. Review and recommend the need for disciplinary action if appropriate. } ok

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

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. } ok

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. } ok.

8. Finish date of September 1, 1996.

ANDREW KETTERER
ATTORNEY GENERAL

Telephone: (207) 626-8800
FAX: (207) 287-3145

STATE OF MAINE
DEPARTMENT OF THE ATTORNEY GENERAL
6 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0006

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FAX: (207) 941-3075

59 PREBLE STREET
PORTLAND, MAINE 04101-3014
TEL: (207) 822-0260
FAX: (207) 822-0259

September 19, 1996

The Honorable Angus King
Office of the Governor
One State House Station
Augusta, Maine 04333

Dear Governor King:

You have asked for our advice concerning appropriate procedures to be followed in the event that the Joint Standing Committee on Health and Human Services asks officials and employees of the Augusta Mental Health Institute and the Department of Mental Health, Mental Retardation and Substance Abuse Services to appear before the Committee to answer questions related to the events leading up to the death of Wrendy Hayne. It now appears likely that a multi-million dollar lawsuit will be filed seeking damages for the death of Ms. Hayne. Various provisions of the Maine Tort Claims Act, 14 M.R.S.A. §§ 8101 et seq., dictate the manner in which such a suit can proceed.

Because claims against the State itself (including AMHI and the Department) and claims against state officers or employees in their official capacity are barred by the doctrine of sovereign immunity, plaintiffs' primary recourse will be to assert claims for damages against individual state officials and employees in their personal capacities. While there are various limitations on the amount of any damages that might be awarded against state employees personally on state law claims, the potential liability of state officers and employees on federal civil rights claims is not subject to any statutory limitation. Moreover, the State is not obligated to indemnify an employee in whole or in part for any judgment that may be entered. 14 M.R.S.A. § 8112. In addition, even if the State wanted to indemnify a state officer or employee, it is our understanding that there are no funds available to indemnify state officers or employees in the event that a judgment were entered which exceeded $300,000.

We do not mean to suggest any view about the merits of any claims that might be brought. We have not individually evaluated the potential claims that might be asserted against any state officer or employee in their personal capacity, and

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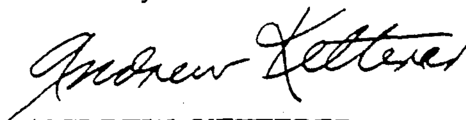
our preliminary view is that the state officers and employees who are potential defendants have strong defenses. However, where a state employee is faced with multi–million dollar claims of liability in a high profile case, such claims cannot be taken lightly, particularly where the employee's personal assets are at risk in the event that plaintiffs prevail.

In any such lawsuit, as to both state and federal law claims, employees of the State are entitled to be represented either by attorneys from this office or by private counsel paid for by the State. 14 M.R.S.A. § 8112. We do not believe, however, that this office could represent a state officer or employee in their personal capacity with respect to a legislative inquiry.

Under these circumstances, we believe that any state official or employee who is asked to answer questions concerning the facts that may be at issue in a suit arising from the death of Ms. Hayne should be advised of his/her right to legal counsel and the State's obligation to pay for private counsel to protect their interests. Those officials and employees should be advised to consider whether to seek the advice of private counsel before answering any questions posed by the Committee in light of the possibility that responding to questions in a public forum could affect or compromise the employee's ability to mount a successful defense of any civil action that may be filed.

I trust this information is responsive to your inquiry.

Sincerely,



ANDREW KETTERER
Attorney General

cc: Jeffrey Butland, Senate President
Dan Gwadosky, Speaker of the House
Joan Pendexter, Senate Chair
Michael Fitzpatrick, House Chair

STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

ANGUS S. KING, JR.
GOVERNOR

September 20, 1996

Senator Joan Pendexter,Chair
Representative Michael Fitzpatrick, Chair
Members of the Health and Human Services Committee
Joint Standing Committee on Health and Human Services
State House - Room 436
Augusta, Me. 04333

Dear Sen. Pendexter, Representative Fitzpatrick and Committee Members:

Throughout the summer, Commissioner Peet and her staff have appeared almost weekly before the Joint Standing Committee on Health and Human Services in order to review policy and management concerns about the mental health system in Maine raised by the Committee following the tragic murders allegedly committed by Mark Bechard and Harold Pulsifer. Commissioner Peet and her staff have engaged openly in policy dialogue and provided all documents that the law allows them to provide, totaling thousands of pages. They have sought the guidance of the Attorney General's Office, and even the courts, in order to assure that their voluntary disclosure of sensitive patient-related information has been as extensive as the law allows. They have worked very hard to listen to the concerns voiced by the Committee and to engage in a constructive dialogue about our ongoing efforts to improve the delivery of mental health services in Maine, both within institutions and in the community.

The assumption throughout this process was that the Committee would conclude its work no later than September 1 and provide recommendations to the Department on needed changes in delivery of mental health services. The Committee has continued on beyond September 1. Last Friday, some members of the Committee indicated that they would like to extend these hearings past October 1 and now want to interview state employees about the facts involved in the murders. Clearly, this would take the hearings from the realm of policy discussions to a new phase of a fact-finding, quasi-judicial process, including cross-examination of employees about factual matters which are likely to become the subject of a lawsuit against the State and individual employees.

Yesterday afternoon, the Attorney General advised that any state employee subjected to this type of questioning must be provided with individual counsel at state expense. Furthermore, during the past week, the Burns family has indicated its intent to bring suit with regard to this matter. In light of this development and the advice of the Attorney General, it is clear that the Committee must now confront the responsibility to provide individual state employees with counsel and establish clear procedural guidelines for the conduct of such an investigation.

PHONE: (207) 287-3531(Voice) PRINTED ON RECYCLED PAPER FAX: (207) 287-1034
(207) 287-6548 (TTY)

The Attorney General has warned the Committee in the past about the legal ramifications of this type of factual investigation. Among these concerns are pre-trial publicity that may adversely affect the State's prosecution of Harold Pulsifer for the murder of Wrendy Hayne and, to a lesser extent, the prosecution of Mark Bechard's judge-tried case. Additionally, there is the risk that the proposed new course for the Committee will almost certainly impair the ability of both the State of Maine and of individual state employees to defend themselves against the likely suit by the Burns family by forcing employees to answer questions when the Committee and the employees are laboring under the limitations of partial facts and without expert guidance, both medical and legal.

Finally, there is a serious question about the authority of the Committee to undertake this type of investigation without specific legislative authorizing action under Title 3, sections 421 through 474 setting for the powers and procedures of Legislative Investigating Committees. The full Legislature reviewed the request of Senator Pendexter for full legislative investigation and subpoena powers for the Committee in connection with these matters and refused the request by defeating S.P. 777, "Joint Order Granting the Joint Standing Committee on Health and Human Services the Authority to Act as an Investigating Committee" just two weeks ago. If the Committee abides by the sentiment of the full Legislature, they would not embark upon a course as an investigating committee without authorization. It is my understanding that the Committee lacks the appropriation to support the expense entailed in such an investigation, given the need to provide individual counsel to all witnesses.

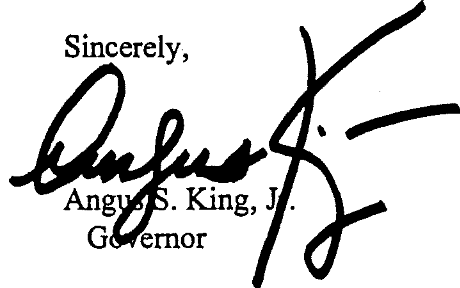
Members of the Department, AMHI staff, and Commissioner Peet have cooperated fully in the Committee's work thus far, subject only to the limits imposed by Maine's confidentiality statutes. Based upon the Attorney General's advice, it now appears prudent to pause in these proceedings to assess their future course to assure the development of all relevant facts while protecting the rights of those involved. This Administration has nothing to hide in connection with this matter; as you remember, I requested an independent investigation of the Pulsifer matter within days of its occurrence, and the Department has implemented many of the recommendations arising from that investigation. The leadership of AMHI has been replaced, changes in clinical staff are being made and numerous policies have been modified.

If it is the Committee's intent to conduct further investigations, some specific authority for such action should be established, the full legal ramifications should be assessed, and then the procedures and policies necessary to guide such a process be clearly defined. This is especially true in light of the counsel of the Attorney General and the Legislature's explicit refusal to grant such powers (by rejecting S.P. 777) within the past two weeks.

Commissioner Peet has detailed her vision for the creation of a stable and inclusive mental health system in Maine. We have convened a Mental Health Task Force to further build on this vision and provide additional insights, and they are scheduled to provide their report to me in two weeks. If the Committee remains true to its original intent, it will provide the Commissioner with its substantive recommendations about needed upgrades to the mental health system as well.

I urge the Committee to make its policy recommendations as soon as possible and stand ready, as always, to work with the Committee to improve Maine's mental health system.

Sincerely,



Angus S. King, Jr.
Governor

cc: Jeffrey Butland, Senate President
Dan Gwadosky, Speaker of the House

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OUTLINE FOR DISCHARGED MEDICAL RECORDS

DOCUMENT	MANDATORY	OPTIONAL
105 Discharge Summary	X	
107 Multidisciplinary Discharge Summary	X	
110 Initial Assessment I	X	
110 A Initial Assessment II	X	
Blue Paper		X
205 Psychiatric Evaluation	X	
215 History and Physical Examination	X	
220 Psychological Testing		X
225 B (3N Only) Multidisciplinary Assessment	X (for 3N)	
227 Abnormal Involuntary Movement Scale		X
228 PPD Testing		X
230 Dietary Assessment		X
231 A-D Initial Rehab Screenings	X	
260 Psychosocial Assessment	X	
265 Psychiatric Update		X
301 A-C Treatment Plans/Reviews (Child/Adolescent)	X	
301.1 Treatment Plans (Adults)	X	
400 A Physician Admission Orders	X	
400 D Physician Admission Orders (Detox)		X
400 Physician Order Sheets	X	
500 Consultations		X
600 Progress Notes	X	
600 A Nursing Daily Flow Sheets	X	
601.1 Rehab Weekly Notes	X	
610 Medical Transfer Note		X
800 Lab/EKG/EEG/ECG/MRI		X
805 HIV Consent for testing		X
1000 A Med Sheets	X	
1000 B Med Sheets	X	
1005 Visual Obs Sheets		X
1005 A Seclusion and Restraint		X
1005 B Seclusion and Restraint		X
1102 Consent to Smoke		X
1105 A AMA Discharge		X
1106 Consent to Treat	X	
1107 Consent to Medicate	X	
1108 Consent to Photo	X	
1112 Managed Care	X	
1114 Utilization Review		X
1115 Release of Information	X	
1116 Verbal Communication Consent		X
1117 Confidentiality Statement		X
1140 TTV Forms		X
1160 Visitor's List	X	
Miscellaneous		X
Patient Valuables Envelope	X	

Mandatory documents need to be in the medical record. Optional documents may or may not be in the medical record depending on the circumstances of the admission.

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*Sub-committees of the Board can assume functions and report to the Board as a whole

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MENTAL HEALTH RECORDS: THE PROTECTIVE VEIL OF CONFIDENTIALITY

By Elliott L. Epstein, Esquire and Susan E. Oram, Esquire

The law zealously guards mental health records from the prying eyes of outsiders by cloaking them in a veil of confidentiality. This cloak of confidentiality is considered vital to the effectiveness of mental health treatment. Mental illness still carries a public stigma, and the afflicted cannot be expected to either seek treatment from, or disclose their darkest secrets to, a psychotherapist without the assurance that they will be shielded from the risk of public humiliation, opprobrium and discrimination.

Yet the information disclosed by a patient in treatment can, at times, be relevant, useful, and even life-saving to others. Under what circumstances can this information be disclosed to those who would benefit from it? What can attorneys do to effectuate disclosure? At the same time, the impressions, observations and opinions of the treating mental health practitioner can, if made available without safeguard to the patient, be harmful to the patient's health and detrimental to the treatment process. Under what circumstances can this information be withheld by the practitioner from his own patient, from the patient's parent or guardian or from litigants who seek to discover it? This article offers Maine mental health providers, and the attorneys advising them, guidance on these issues based upon an analysis of state and federal statutes and regulations regarding confidentiality.

A. THE STATUTORY REQUIREMENTS OF CONFIDENTIALITY

The primary Maine statute which mandates confidentiality, 34-B M.R.S.A. § 1207, provides that "(a)ll orders of commitment, medical and administrative records, applications and reports, and facts contained in them, pertaining to any client *shall be kept confidential and may not be disclosed to any person, . . .*" (emphasis added). The provision applies not only to the Department of Mental Health and Mental Retardation and to state mental hospitals, but to any agency "licensed or funded to provide services falling under the jurisdiction" of the Department.[1] While sweeping in scope, the non-disclosure mandate of section 1207 is narrowed by a series of enumerated exceptions, which are discussed below. Unlawful disclosure of mental health records may not only subject the provider to potential loss of licensure[2] but can result in the imposition of criminal penalties of up to 364 days in prison and a $2,000 fine upon an individual, and as much as a $10,000 fine upon an organization.[3]

Elliott L. Epstein, Esquire

Elliott L. Epstein is a partner in the firm of Isaacson & Raymond in Lewiston. Mr. Epstein received his Bachelors Degree from Georgetown University in 1969 and graduated cum laude *from the University of Maine School of Law in 1978. He has a varied trial practice, which includes personal injury, malpractice, divorce, commercial, real estate and criminal litigation. He also serves on the Advisory committee on Civil Rules and the* Maine Bar Journal *Editorial Committee.*

A federal statute, 42 U.S.C. § 290EE-3, and regulations promulgated under it,[4] also make confidential any records relating to drug abuse or prevention programs that are conducted, regulated, or "directly or indirectly assisted" by the federal government. A similar statute, 42 U.S.C. § 290 DD-3, mandates confidentiality for records relating to federally-assisted alcohol abuse treatment programs. The definition of a "program" under the federal regulations is very broad, including anyone who provides "alcohol or drug abuse diagnosis, treatment or referral for treatment."[5] Since alcohol or drug abuse, and often both in tandem, form a conspicuous part of the pathology of other forms of mental illness, and since most drug and alcohol treatment and rehabilitation programs receive some direct or indirect form of federal assistance (as, for instance, from grants funneled through state governments), the reach of these federal statutes is broad. A practitioner or agency providing substance abuse treatment or referral in conjunction with mental health treatment for other conditions will need to treat the entire patient record as a substance abuse record, unless the substance abuse portion has been segregated from the rest of the record. The federal statutes contain exceptions, discussed below, permitting disclosure under specified circumstances, but the exceptions are fewer and more restrictive than under Maine law. Criminal sanctions are imposed for improper disclosure of federally-protected substance abuse treatment records, with a fine being assessed of $500 fine for the first violation and $5,000 for subsequent violations.[6]

B. THE STATUTORY EXCEPTIONS TO CONFIDENTIALITY

1. Informed Consent and Statutorily Authorized Disclosures

Under Maine law, Section 1207 of Title 34-B permits release of mental health records and information, when an adult patient, his guardian, if any, or his parent or legal guardian, if he is a minor, provides informed, written consent to such disclosure.[7] Disclosure is also permitted to enable a provider to carry out certain statutory mandates, such as the reporting of abuse or neglect of a mentally ill person to a public advocate[8] or the involuntary commitment of a patient to a mental hospital.[9] It is also allowed for insurance billing purposes[10] and for hospital training programs (provided any information identifying the patient is expunged).[11] Furthermore, limited information about the patient's physical and mental status may be given to his spouse or next-of-kin,[12] and more extensive information about his diagnosis, medication and treatment plan may be furnished to a family member or other person with whom the patient lives, upon the caretaker's written request, if, without disclosure "there would be significant deterioration in the client's daily functioning and if the disclosure is in the best interest of the client."[13] For instance, if the patient requires assistance and supervision in taking psychotropic medication, a responsible person residing with the patient could be apprised of the prescription, the dosage, the side-effects, and the consequences of failure to take the medication. Although the patient must be given advance written notice of the disclosure and an opportunity to consent, the provider or responsible person may still appeal to the Commissioner of the Department of Mental Health and Mental Retardation to obtain permission for release of the information if the patient refuses.[14]

In the absence of informed, written consent, or of a statutory exception to the rule of confidentiality, mental health records can only be disclosed under court order, subject to Maine Rule of Evidence 503.[15] A subpoena, which may be issued and signed by a clerk of court or by a licensed attorney, is not a "court order".[16] Therefore, any subpoena directing a mental health provider to appear and testify about, or to produce for copying and inspection, its patient's mental health records should not be obeyed, until a judge has ordered compliance. The target of the subpoena can bring the matter to the court's attention through a motion to quash.[17] Once the matter is before the court, the judge must determine, both for the purposes of disclosure and admissibility, whether the information sought is "relevant to an issue of the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, or of any party claiming through or under the patient."[18]

At the threshold, the court should be asked to examine the records *in camera* before issuing its ruling in order to avoid the unnecessary disclosure of sensitive information.[19] In a criminal case, the defendant will often subpoena the victim's mental health record, hoping that it will contain some exculpatory material or, at least, some ammunition for impeachment of the victim. However, in such a situation, the patient is not a party to the case and has not, either directly or indirectly, presented any claim or defense, so the admissibility of his mental health record is questionable. If, for example, the defendant is a controlling, manipulative parent or step parent who has been accused of physically or sexually abusing his child, preliminary disclosure to the defendant can be potentially damaging to the victim, regardless of the court's ultimate ruling on admissibility, because it may be exploited by the defendant to torment or intimidate the child.

The court must perform a similar analysis when ruling on a request for a disclosure order of substance abuse treatment records pursuant to federal regulations. The review must be in chambers or in some other forum which insures confidentiality,

See p. 164

Susan E. Oram is with the Lewiston firm of Isaacson, Raymond & Bonneau. Ms. Oram graduated cum laude *from Colby College and she received her J.D. from the Vermont Law School. She is admitted to practice in Connecticut, Maine and Virginia.*

Susan E. Oram, Esquire

CONFIDENTIALITY *from p. 163*

and the court must balance the need for information against the potential for injury to the patient, psychotherapist-patient relationship and the treatment service.[20] The patient and the person in possession of the records must have an opportunity to respond in writing and an opportunity to attend the hearing on the request for records.[21] Unless and until the court issues an order compelling disclosure, the provider cannot even disclose or confirm the identity of the patient as someone who has received substance abuse treatment from the provider and should refer to the patient in pleadings and at hearing as "John Doe" or by a similar anonymous moniker.[22]

C. THE *TARASOFF* EXCEPTION TO CONFIDENTIALITY

There probably exists a common-law exception to the rule of confidentiality for threats made by a patient against a third party, when the mental health provider believes that the patient poses an imminent threat of serious physical harm to a third person. Indeed, a tort action would likely lie against the provider, if the target of the threat was killed or seriously injured by the patient, and the provider had failed to warn the target or the authorities. The seminal case on this issue was *Tarasoff v. Regents of the University of California*, decided in 1976,[23] in which the defendant murdered his victim two months after confiding his intention to do so to his therapist. The Supreme Court of California held that "the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others" and that the "protective privilege ends where the public peril begins."[24] Although the issue has not been directly addressed by Maine's courts, the Law Court assumed, without discussion, in *Hewett v. Kennebec Valley Mental Health Center*,[25] that the plaintiff had a cause of action against a mental health provider for failure to warn (although it held that her claim was barred by the statute of limitations). Moreover, a rule of the Department of Mental Health and Mental Retardation, albeit without apparent underlying statutory authority, states that "(c)onfidentiality may be violated if there is clear and substantial reason to believe that there is imminent danger of serious physical harm inflicted by the (patient) . . . upon another."[26]

D. STANDARDS AND PROCEDURES FOR RELEASE OF RECORDS BASED UPON, INFORMED CONSENT BY AN ADULT PATIENT

Under both the Maine statute[27] and federal statutes,[28] an adult patient, provided he is competent, can give informed, written consent to the release of his records to himself or a third party. If he is incompetent, he should have a court-appointed guardian or a person with a power of attorney who can provide that consent. If he is competent, but mentally ill, the situation is cloudier. The constraints which mental illness impose upon the comprehension of a competent adult and his ability to furnish informed consent necessitate a careful exercise of judgment by the treatment provider. The statutes and regulations provide little guidance as to the level of understanding that will suffice to constitute informed consent by a mental health patient. They do, however, discuss at length the procedural precautions to be taken before records are released to the patient himself or to a third party.

Under Maine law, any health practitioner may deny a patient access to his own records, if the practitioner "believes that release of the records is *detrimental to the health of the patient*. . . ."[29] In that event, the treatment records must be made available to the patient's authorized representative, to his guardian, or to a person designated by a durable medical power of attorney.[30]

The disclosure process for mental health records is more guarded than that for ordinary health care records, which are routinely photocopied and sent directly to the patient. Upon admission to a facility or program, a mental health patient must be advised as to how he can see and obtain copies of his record.[31] The record must be reviewed under the supervision of the chief administrative officer (or his designee) of the facility or program.[32] Where there is a "reasonable concern of possible harmful effect to the recipient," the clinical director (or his designee) must supervise the review,[33] presumably to answer questions, clear up misunderstandings and monitor the patient's reactions. When the client is unable to review his record at the mental health facility, the record can be certified and sent to a mental health professional of the patient's choice, who will supervise the review.[34] The review must take place within three (3) working days after a request for review is made.[35]

When the records are to be released to an agency or individual not involved in the patient's treatment or supervision, the patient is entitled to be advised of the nature of the information to be released, his own right to review the record, the identity of the party to whom disclosure will be made, the purpose to which the information will be put, the length of time during which disclosure will continue, and his right to revoke his consent at any time.[36]

Substance abuse treatment records released to either the patient, or to a third party with the patient's consent, must, by federal regulation, bear a warning which informs the recipient of the confidential nature of the disclosure.[37] The regulations provide a special consent form which must be used, and a standard release for medical

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records will not suffice. (A copy of the appropriate release form follows this article as an addendum).[38] Even after release, the records cannot be used to investigate a crime or prosecute a criminal matter against the patient, unless a court has ordered that the records can be used for that purpose.[39] Unlike Maine law, the federal regulations do not give the provider any discretion to withhold records from the patient himself if he requests them, and there is no requirement that the patient review the records in a supervised setting.

E. STANDARDS AND PROCEDURES FOR RELEASE OF RECORDS BASED UPON, INFORMED CONSENT BY A MINOR PATIENT

If the patient is a minor, his mental health records can be released to a parent (or a guardian or custodian).[40] While the parent will usually be entitled to obtain the child's records, the right to do so is not automatic or universal and is constricted by several statutes and regulations. Under various circumstances, the provider is either permitted or mandated to withhold the mental health records from a parent.

1. Drug and Alcohol Abuse Treatment Under Federal Law

Under federal law, when a minor is treated for drug or alcohol abuse, his records are withheld from his parents, unless he consents to their disclosure or the program director determines that he lacks capacity to make a rational decision about disclosure and that the information is relevant to reducing a substantial threat to his life or health.[41]

2. Mental Health, Drug and Alcohol Abuse Treatment Requested by a Minor Under Maine Law

Under Maine law, any minor has the right to request his own mental health treatment or treatment for substance abuse.[42] The statute does not limit or restrict the age at which a minor can request mental health or substance abuse treatment without his parent's consent.[43] A minor seeking such services is considered financially responsible for their cost.[44] Therefore, the provider should not inform a parent that the minor has sought abuse treatment in order to obtain insurance coverage for the treatment without the child's permission. A minor who is treated, at his own request, for abuse of alcohol or drugs, or for emotional or psychological problems, has a right to confidentiality, even as against his own parents, unless the practitioner feels that failure to inform the parent or guardian would jeopardize the health of the minor or seriously limit the practioner's ability to treat him.[45]

3. Emancipated Minors

A minor 16 or older may obtain an order of emancipation from a District Court, if a judge determines that he is self-supporting, sufficiently mature to assume responsibility for his own care, and it is in his best interest to do so.[46] If a minor is emancipated, he has the same right of confidentiality as an adult, even as against his own parents. Thus, his mental health records cannot be released to his parents without his informed, written consent.

4. Children of Divorced or Separated Parents

It is not uncommon for children to receive mental health counseling or psychotherapy during a family crisis such as a

See p. 166

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CONFIDENTIALITY *from p. 165*

divorce. In the course of the treatment, a child may reveal to his therapist information that is relevant to the divorce action, particularly with respect to the issues of primary residence and visitation. The therapist may be reluctant to release the information to one or both of the parents for fear that use of the information will be detrimental to the child and to the therapeutic relationship. Can the therapist ever properly refuse to release the records?

While divorce decrees are generally required to contain a provision making all health-care records available to both the custodial and non-custodial parent, the divorce court may deny access to either parent if "that access is found not to be in the best interest of the child or that access is found to be sought for the purpose of causing detriment to the other parent."[47] Where a minor patient is the child of divorced or divorcing parents, the provider should request a copy of the divorce decree or any order pending divorce to ascertain whether either parent has been denied the right of access to minor patient's records.

In addition, when the minor has been born out of wedlock, there may be an order allocating parental rights in either a paternity proceeding[48] or in a proceeding by the Department of Human Services to obtain support from a non-custodial parent.[49] Since the primary focus of the proceedings brought by the Department of Human Services is to establish a child support obligation, the parents may be unaware of the parental rights provisions of the order. Therefore, the provider should obtain a copy of the order before making a decision to release records.

5. Disclosures Which Constitute an "Imminent Danger" to the Minor Patient

Finally, a rule of the Department of Mental Health and Mental Retardation states that a provider may refuse to disclose a minor patient's mental health record to "legally responsible parents, guardians or custodians," where access of such persons to the record would create "documented danger to the physical or mental well being" of the patient.[50] It is unclear whether this regulation addresses the likelihood of "danger" arising from the untrustworthiness of the parent, guardian or custodian as opposed to the potential harm resulting from the ultimate disclosure of information to the patient himself. In any event, the rule offers some justification for a provider to refuse access to an abusive, exploitative or inept parent whose possession of the information might harm, rather than help, the minor patient.

F. PENALTIES FOR WRONGFUL REFUSAL TO RELEASE RECORDS

The provider is at risk for wrongful withholding of records from adult or minor patients, or from third parties whom they designate, although the risk is not as serious as for wrongful disclosure. A civil penalty of up to $25 may be assessed for wrongful refusal to release records, and an additional penalty of $100 a day may be levied for each day the records are wrongfully withheld.[51]

G. CONCLUSION

Mental health providers need to exercise considerable care in releasing patient records. Wrongful disclosure can subject the provider to criminal sanctions and license suspension, and can be damaging to the patient's health and to the therapeutic relationship. Wrongful withholding of records, after a proper request has been made for their release, can also result in the imposition of civil penalties. Maine and, to a lesser extent, federal, statutes and regulations vest discretion in providers to determine when disclosure is appropriate. That discretion must be used wisely to insure that the patient's mental health needs are weighed against the rights and needs of others, especially the right of the public to be protected from peril, and the need of the patient's parents, guardian or others charged with his care to have access to information that will assist them in keeping him safe and healthy.

ADDENDUM

(b) Sample consent form. The following form complies with paragraph (a) of this section, but other elements may be added.

1. I (name of patient) } Request
   } Authorize:

2. (name or general designation of program which is to make the disclosure)

___

3. To disclose: (kind and amount of information to be disclosed)

___

4. To: (name or title of the person or organization to which disclosure is to be made)

___

5. For (purpose of the disclosure)

___

6. Date (on which this consent is signed)

___

7. Signature of patient

___

8. Signature of parent or quardian (where required)

___

9. Signature of person authorized to sign in lieu of the patient (where required)

___

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition)

(c) Expired, deficient, or false consent. A disclosure may not be made on the basis of a consent which:

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99 Franklin Street, Ste. 304

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(1) Has expired:

(2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;

(3) Is known to have been revoked; or

(4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

(Approved by the Office of Management and Budget under control number 0930-0099)

Notice to accompany disclosure. Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

---

[1]34- M.R.S.A. §§1207-A, 3601.

[2]34-B M.R.S.A. §§1207, 1203-A(1)(C).

[3]34-B M.R.S.A. §1207(4); 17-A M.R.S.A. §§1252(2)(D), 1301(3)(E).

[4]42 C.F.R. Part 2.

[5]42 C.F.R. §2.11(b).

[6]42 U.S.C. §290EE-3(f), 42 C.F.R. §2.1(f).

[7]34-B M.R.S.A. §1207(1).

[8]34-B M.R.S.A. §1207(1)(B); 5 M.R.S.A. §§1950 (1)(B), (C); Section IX(J)(1)(b), *Rights of Recipients of Mental Health Services*, Maine Department of Mental Health Mental Retardation (January 1, 1995)(hereafter referred to as "*Rights of Recipients*".) Copies of the Regulations can be obtained fromthe Department of Mental Health.

[9]34-B M.R.S.A. §1207(1)(B); 34-B M.R.S.A. §3861 *et seq.*; Section IX(1)(e), *Rights of Recipients.*

[10]34-B M.R.S.A. §1207(1)(E); Section IX(1)(f), *Rights of Recipients.*

[11]34-B M.R.S.A. §1207(1)(F).

[12]34-B M.R.S.A. §1207(1)(D); Section VIII(J)(1)(d), *Rights of Recipients.*

[13]34-B M.R.S.A. §1207(5); Section B(4), *Rules Governing the Disclosure of Information Pertaining to Mentally Disable Clients (effective August 15, 1995).* Such information is limited to "diagnosis, admission to or discharge from a treatment facility, the name of any medication prescribed, side effects of that medication, the likely consequences of failure of the client to take the prescribed medication, treatment plans and goals and behavioral management strategies."

[14]34-B M.R.S.A. §1207(5)(B); Section C, *Rules Governing the Disclosure of Information Pertaining to Mentally Disabled Clients.*

[15]34-B M.R.S.A. §1207(1)(C).

[16]M.R.Civ.P. 45(a)(3).

[17]M.R.Civ.P. 45(c)(3)(A)(iii).

[18]M.R.Evid. 503.

[19]Wright and Miller, *Federal Practice and Procedure*, §2458 & n.8 (1995).

[20]42 C.F.R. §2.64.

[21]42 C.F.R. §2.64.

[22]42 C.F.R. §2.13.

[23]*Tarasoff v. Regents of the University of California*, 551 P.2d 334, 83 A.L.R.3d 1166 (1976).

[24]*Tarasoff*, 551 P.2d at 347.

[25]*Hewett v. Kennebec Valley Mental Health*, 557 A.2d 622, 624 (Me. 1989).

[26]Section IX(J)(3), *Rights of Recipients*, and Section IX(J)(3), *Rights of Recipients of Mental Health Services Who Are Children in Need of Treatment* (November 1, 1995)(hereafter referred to as "*Rights of Child Recipients*").

[27]34-B M.R.S.A. §1207(1)(A).

[28]42 U.S.C §290EE-3(b), 42 U.S.C. §290DD-3(b).

[29]22 M.R.S.A. §1711-B(2).

[30]22 M.R.S. A. §§1711-B(3)(B), (C).

[31]Section IX(C), *Rights of Recipients.*

[32]Section IX(K)(2), *Rights of Recipients.*

[33]Section IX(K)(3), *Rights of Recipients.*

[34]Sections IX(K)(4), (5), *Rights of Recipients.*

[35]Section IX(K)(1), *Rights of Recipients.*

[36]Section IX(E), *Rights of Recipients*; Section B(2), (3), *Rules Governing the Disclosure of Information Pertaining to Mentally Disabled Clients.*

[37]42 C.F.R. §2.32.

[38]42 C.F.R. §2.31.

[39]42 U.S.C. §290EE-3(c), 42 U.S.C. §290DD-3(C).

[40]34-B M.R.S.A. §1207(1)(A).

[41]42 C.F.R. §2.14.

[42]19 M.R.S.A. §902.

[43]19 M.R.S.A. §902.

[44]19 M.R.S.A. §905.

[45]19 M.R.S.A. §§902, 905.

[46]15 M.R.S.A. §3506-A(4).

[47]19 M.R.S.A. §752(6)(B).

[48]19 M.R.S.A. §214.

[49]19 M.R.S.A. §281.

[50]Sections VII(K)(3)(a), (b), *Rights of Child Recipients.*

[51]22 M.R.S.A. §1711-B(8).

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ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

June 10, 1996

The Honorable Joan Pendexter
Chair, Health and Human Services Committee
State House Station
Augusta, ME 04333

Dear Senator Pendexter:

As per your request, please find a copy of the Department's Critical Incident Review of the case involving Mark Bechard attached. Please feel free to contact me if you have questions. Otherwise, we look forward to seeing you on the 21st.

Sincerely,

Katie Fullam
Assistant to the Commissioner

PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
CRITICAL INCIDENT REVIEW

Events Leading to Review

On January 27, 1996, Mark Bechard, a resident of Waterville, Maine and a recipient of mental health services form Kennebec Valley Mental Health Center, forcibly entered a convent in Waterville, where he allegedly severely beat four elderly nuns, killing two of the victims.

Purpose

The purpose of this review is to ascertain whether a relationship existed between this event and the adequacy of clinical services, to determine whether there was evidence of any clinical deficiency, and to identify areas for clinical and systemic improvement.

Process

Kennebec Valley Mental Health Center conducted an internal review of the clinical services received by Mark Bechard prior to the incident in Waterville. This review consisted of a clinical review of outpatient and hospital records, and a special event meeting involving KVMHC community support, case management, and emergency staff. Additional information was obtained from crisis staff from the Department of Mental Health Crisis Stabilization Unit. Records from private therapists that Mr. Bechard had seen over the course of years were unavailable for review. The clinical review was completed on February 8, 1996.

The results of the KVMHC review were shared with the Director of Community Clinical Services of the Department of Mental Health and Mental Retardation, who discussed its content with Karen Mosher, Ph.D., Clinical Director for Adult Services at KVMHC. The recommendations is this report reflect a synthesis of this information and information drawn from ongoing departmental studies of community services.

It is understood that much of the information contained in the review of clinical services is confidential and cannot be addressed in this document.

Results of Clinical Review

The clinical review process by KVMHC showed no evidence of failure to meet current standards of practice. A major weakness of the system of care was the emergency services phone relay to Mid-Maine Medical Center, which deactivated during a power outage and did not redeploy when power was restored, making it impossible to contact KVMHC during the night of January 27, 1996. The KVMHC report also identified several clinical areas which, while not deficient by current standards of care, could be improved. These included expansion of coverage by community support services, improved organization of crisis and emergency services, and intensification of intra-agency communication between service providers.

Dr. Mosher concluded that there was no evidence of negligence on the part of KVMHC and that the tragedy could not have been predicted or clinically prevented. Plans are in place to resolve the problems with the phone system, and KVMHC procedures have been amended to enhance intra-agency communications. Dr. Mosher has requested consultation with the Department of Mental Health and Mental Retardation to address the expansion of community support services, and to re-evaluate policy and procedure regarding supported housing.

The departmental evaluator found that the KVMHC review was thorough and candid, and concurred with the conclusions and recommendations in Dr. Mosher's report.

Departmental Review

The conclusions of the clinical review clearly point to several areas of weakness in the current system of mental health services. These areas had largely been previously identified by DMH&MR, and targeted for reorganization as part of the Local Service Network plan.

Improvements indicated by the systemic review include:

1. Reorganization of regional crisis services to include a single 24-hour crisis line, 24-hour mobile crisis response, a wider range of crisis residential alternatives able to serve people having more acute difficulties, and improved collaboration with police and rescue services.

2. Evaluation and expansion of case management services to include intensive case management options for individuals having special needs.

3. Expansion of regional community support and case management services to provide evening and weekend coverage.

4. Evaluation and expansion of rehabilitation services to include supported housing, employment, and supported education.

Departmental Plan

In the absence of evidence of negligence, one can only speculate as to whether alternative services or improved communications could have in any way altered the tragic events of January 27. We can, however, identify ways in which we can improve the supports available to people with psychiatric disorders, attempt to mitigate the risk of harm to or by these citizens, and improve systemic responsiveness when a crisis presents. It is hoped that the present tragedy may signal the urgent need for prompt collaboration to move toward more comprehensive community services.

Systemic issues are being addressed as follows:

1. It is of utmost importance that the public receive the message that the violent episode that occurred in Waterville is not attributable to or characteristic of people having psychiatric diagnoses. Due to deeply ingrained misconceptions linking mental illness to violence, events such as the one in Waterville invariably elicit public fear and outcry against people having psychiatric disorders. DMHMR has an ethical obligation to provide public education, and to resist reactionary demands for the institution of coercive treatment and segregation of people having psychiatric disorders.

2. DMHMR staff will be meeting with Dr. Mosher at KVMHC on March 6 to document that the clinical concerns outlined above have been addressed, and to plan further consultation regarding community support services, crisis response, and supported housing.

3. Providers of crisis and emergency services in the Kennbec-Somerset region are convening to establish a comprehensive, integrated crisis response system. The current plan includes 24-hour crisis line capacity, 24-hour mobile crisis response, crisis residential services with the capacity of intensive staffing and wrap-around services, peer warm lines, and crisis homes. This system will have the capacity to serve adults and children having mental illness, mental retardation, and substance abuse concerns. This plan requires a collaboration between all area providers of crisis services, and will include a complete evaluation of licensure, policy, procedure, and certification requirements that impact crisis services.

   DMHMR plans further collaboration with the police department and the Department of Public Safety to improve coordination of crisis response, and to explore options to establish improved protocols for response to mental health crisis within the 911 system.

4. Currently, a comprehensive study of case management service throughout the state of Maine is in process at DMHMR in collaboration with the University of New England. Preliminary results of that study indicate a need for reorganization and expansion of services in order to provide the needed continuity of care. DMHMR staff will be meeting with area providers to examine organization strategies sand funding needs to see that evening and weekend case management and community support services become available.

   DMHMR is also exploring options for establishing intensive case management services by redeploying state employees to intensive continuous treatment teams. These teams would provide specialized services to people with complex needs such as multiple disabilities, assault or criminal histories, or trauma/abuse survivors. Low client-to-staff rations, extended hours of service, and availability of specialized treatment modalities would ensure high intensity and rapid response of service.

5. The evaluation of rehabilitation service in the Kennebec-Somerset region is complicate by the large number of different providers involved in employment, housing, and educational services. DMHMR staff will be providing consultation to KVMHC as requested regarding the policies and procedures in their supported housing programs. Outreach to other providers is in progress.

6. The Department will establish clear protocols for crisis/disaster reporting, response, and review, including guidelines for the involvement of community agencies and emergency services.

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June 20, 1996

Jane Orbeton, Esq.
Maine State Legislature
Office of Policy & Legal Analysis
State House Station 13
Augusta, ME 04333-0013

RE: Release of Kennebec Valley Mental Health Center Records

Dear Jane:

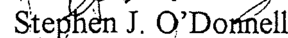
As I discussed with you on the telephone, I have reviewed the reports made by the Kennebec Valley Mental Health Center in response to the incident that occurred in Waterville involving the murder of two nuns. I understand from you that the Health & Human Services Committee is requesting access to these documents.

I am unaware of any statutory or contractual authority that would compel production of any records of the Kennebec Valley Mental Health Center. The Kennebec Valley Mental Health Center is willing to cooperate with the Committee to the greatest possible extent; however; we have determined that most of the records are confidential under 34-B M.R.S.A.§ 1207 which provides *that "all orders of commitment, medical and administrative records, applications and reports, and facts contained in them, pertaining to any client should be kept confidential and may not be disclosed by any person".* None of the exceptions in the confidentiality statute authorize the release to the Committee.

The Kennebec Valley Mental Health Center also has an interest in and a right to keep confidential actions and records relating to peer and policy reviews. After reviewing the records and conferring with staff, I have determined that the enclosed two pages of records relating to the telephone system are neither confidential under 34-B M.R.S.A.§ 1207, nor are they peer or policy review materials.

Notwithstanding our position that the other records cannot be released, the Kennebec Valley Mental Health Center is more than willing to discuss with the Committee its views on how the delivery of community services for people with mental illness can be improved. To that end, either John Shaw, the Director, or other staff are available and willing to participate at Committee hearings with the understanding that no confidential information regarding the patient will be provided.

Sincerely yours,



Stephen J. O'Donnell

SJO/jmb

CC: Christopher Leighton, A.A.G.
John Shaw

KENNEBEC VALLEY MENTAL HEALTH CENTER
SPECIAL EVENTS INFORMATION
ON COMMUNICATIONS FAILURE
JANUARY 27th and 28th, 1996

1. KVMHC's telephone system transferred over to KVMHC's answering service located at Mid-Maine Medical Center at 4:30 p.m. Friday, January 26, 1996.

2. KVMHC's last call transferred to the answering service was at 11:16 p.m. on January 26, 1996.

3. Albert (Buster) McLellen of Crisis Stabilization contacted Paul Theriault - KVMHC's Director of Emergency Services at approximately 9:00 a.m. on - Sunday, January 28, 1996 informing Paul that KVMHC's emergency calls were not being answered by the answering service.

4. Paul Theriault contacted John Shaw, Executive Director and informed him of the problem and was told to contact Lorna Bradstreet, Director of Operations and have the problem fixed immediately.

5. Paul called Lorna at approximately 9:15 a.m. on Sunday, January 28, 1996 and reported the problem.

6. Lorna responded to the emergency and the phones were operational by 10:00 a.m. on Sunday, January 28, 1996.

Kennebec Valley Mental Health Center's after hours telephone calls are automatically forwarded to the answering service located at the Seton Unit of Mid-Maine Medical Center through a call divertor located in the basement of KVMHC. This is activated by engaging a switch located at the reception desk in the main lobby of KVMHC. This switch was engaged properly and calls were forwarded until there was a power outage. When there is a power outage greater than a flicker the call divertor, which is electrical, will shutdown and fail to forward KVMHC's calls directly to the answering service. This shutdown did occur sometime after 11:16 p.m. on Friday, January 26, 1996. The system as it currently is setup does not have the capability to rectify itself and correction needs to be done manually.

Central Maine Power Company has been contacted to try to establish a time when the power went may of out in the location of the office and they have no way of tracking this information. CMP was also asked when calls began coming into their office and was told that the calls began coming in early Saturday morning and continued all day and night. CMP is unable to determine exactly when the power went out that caused this failure in KVMHC's telephone equipment.

KVMHC's telephone communications company (Northstar Communications) has been contacted to rectify the problem of losing the capability of forwarding calls to the answering service in the event there is a power outage.

KVMHC is looking into further options regarding the current telephone system to insure that all calls are responded to in a timely fashion regardless if emergent or not.

KVMHC will be working with the answering service to insure that this problem does not occur in the future. We have established check in procedures with the answering service to assist in this matter.

KVMHC is moving aggressively regarding the above matters and will have implementation of insuring this problem does not occur again. In the interim, the Director of Operations has established check in times with the answering service every half hour when the answering service is responsible for taking KVMHC's telephone calls.

ADDENDUM

KVMHC has not received any complaints regarding the capacity to respond to calls forwarded to the answering service in the past.

KVMHC's answering service, in the past, has contacted the emergency services staff and/or the Director of Operations to report that they hadn't received any calls for a period of time and they were concerned that the phone lines may not be connecting. This procedure did not happen on Saturday, January 27th or Sunday, January 28th. This is not a written procedure for handling power outages but an understood procedure that the answering service took upon themselves to implement. The answering service is more than willing and capable at implementing any procedures that KVMHC puts into place to insure that this problem does not happen again.

sp.wps

Testimony to
The Honorable Members of the Joint Standing Committee on Health and Human Services
By John D. Shaw, Jr. L.C.S.W., Executive Director
Kennebec Valley Mental Health Center
July 26, 1996

My name is John Shaw. I am pleased to come before you today to assist in the evaluation and assessment of the mental health system in Maine. I hope I may bring an interesting perspective in that I have worked for almost thirty years in the human services field. My experience includes work in psychiatric hospitals, non profit agencies, youth corrections, in state government as Director of Licensing for Maine's DMH and for profit corporations. At this time, I serve as Executive Director of Kennebec Valley Mental Health Center. I have also been a consumer of state funded mental health services in this state and have family members who have struggled with mental illness. I am licensed independently in the State of Maine as a Licensed Clinical Social Worker.

Objectivity is hard when a spectacular event, that reinforces societal stereotypes of mentally ill people has taken place. You deserve credit for fighting the urge to respond impulsively and taking the time to look objectively at your task. Using data is an important process in an objective systems review. It may be helpful to have some data on the population served. This may give you a sense of the number of people your decisions will touch. It is estimated that about 1% of the population throughout the world suffers from schizophrenia. In Maine that would be about 12,000 people. Another 1/2% to 1% suffer from manic depressive illness (6,000 people), other biologically based mental illnesses effect another 1% to 2% of the population (12,000 people). serious depression is the largest psychiatric diagnosis in the United States affecting 10% to 15% of the population during their lifetime. suicide is the second largest killer of teenagers behind drunk driving, the divorce rate in America is 50%. It is estimated that serious substance abuse effects up to 10% of the population during their lifetime, over 90% of people in jail for violent crime were abused as children. By rough calculations, your decisions will affect 30,000 people who need or are using mental health services at any one time. Of note, the Consent Decree has about 3,010 class members, almost 40% do not have a diagnosed biologically based, major mental illness.

We live in a society which values independence and self-determination. We have struggled to accept the need for mental health services as part of the human condition. In Maine, the legislature needed to pass law requiring insurance companies to cover mental health services. More legislation had to be passed to ensure there is the same level of insurance coverage for mental illnesses as there is for other biologically based illnesses. Twenty-five years ago, a vice presidential candidate had to drop out of a national race because he had been a recipient of mental health services. More recently, a presidential candidate suffered a drop in his approval rating when he admitted receiving counseling after he lost his brother in an automobile accident. Regulation and law regarding confidentiality and client rights has been a natural outcome of this societal condition, in an attempt to protect those who seek mental health services from discrimination as a result of this kind of stigma.

As you evaluate our current system it is important to understand the philosophical forces which have influenced its design up to this point. As government funding tightened in the 1970's, institutions started to be seen as abusive places which unnecessarily removed people's rights to freedom and self-determination as a result of their mental illness. As states moved to de-institutionalize there was national concern that people with mental illness would be discriminated against. For years doctors had been prescribing treatments including overly long and restrictive hospitalizations, shock treatments and medications with limited positive effects and damaging side-effects for people struggling with the challenge of mental illness. More generally, there was a pervasive sense that a mentally ill person inherently had bad judgment as a result of their illness and, therefore, could not and should not be allowed to make decisions the rest of the so called "normal" people could make.

The client rights movement gathered force throughout the country in the late 1970's and sought to provide some balance so the rights of recipients of mental health services were not trampled on by well meaning service providers and others. These rights were published in Maine in 1984, and became a central core to the state operated licensing process for contracted mental health providers. Since that time, along with financial auditing, they have remained a central part of the Department of Mental Health's oversight mechanism for providers. Rights violations were also used as the core of the class action suit which resulted in the Consent Decree which has driven the development of our mental health system for the past seven years.

This has resulted in a community based system in which all services are voluntary. Unless a person is determined by a physician to be a danger to self or others, there can be no mandate for any person residing outside an institution to receive any service if they are not willing to. That is the same for people with mental illness as it is for you and me. The Rights documents goes so far as to require client signature indicating they have been informed of the risks and benefits of service before the service is delivered to ensure that people are not unduly coerced. This is law and our policies reflect law.

Now, with the occurrence of a number of high profile murders, the pendulum may be swinging back towards a primary concern for public safety. The difficult challenge will be to prevent a return to the convenient structures and prejudices of the past.

A classic Maine guiding principle is "If it ain't broke don't fix it." I have agreed with this philosophy, but have struggled with how we define what's "broke." This is where the need to be objective in the heat of the moment is particularly challenging. There is no question that many things in the mental health system can be improved. Before we redesign, however, we should objectively evaluate the current system to determine if adequate safeguards are in place.

Let us first ask the question if there has been data, not singular spectacular incidents, that would give rise to concern, has there been an increase in violent crime that can be tied to management of people with mental illness in the community? Of the twenty-five to thirty murders committed in the State of Maine each year, how many are being committed by people receiving services as part of a community based mental health system? What is the incidence of violent crime with this population nationally? Without data, there can be no assurance that significant change is needed.

That is not to say, however, that systems cannot be improved. Let us look at what is being done currently to safe guard the community and the many thousands of people using community based mental health services. I will start by outlining for you what is available in our catchment area. I will also try to state what the strength and weaknesses of each system may be from my point of view.

The bottom line is hospital services. In our area they are supplied by AMHI, Kennebec Valley Medical Center and Mid-Maine Medical Center. Without this safety net, community based services are impossible, as there is no safety net to catch those who are dangerous to themselves or others. These services are very restrictive and expensive, however, and there is constant pressure to use less restrictive, less costly services. Concern comes when there is not enough capacity to meet need. Negotiations between private hospitals and DMH to create community hospital based involuntary beds which would allow AMHI to downsize are underway. The private hospitals coordinate activities with themselves and the community through the Ken/Som Mental Health Council. This Council is comprised of consumers, family members, providers, state personnel and other stakeholders. Its primary mission is to assure service coordination as well as create and improved services.

Next in the continuum is the crisis/emergency service system. This system is open twenty-four hours a day, 365 days a year. In our area, three organizations have responsibility for different aspects of its implementation. The agencies are: Crisis and Counseling which provides mobile services for adults and children and a crisis residence for adults in Somerset County; the state run Crisis Program which also provides mobile services and a crisis residence for adults in Kennebec County; and finally, Kennebec Valley Mental Health Center which provides emergency evaluations in hospital emergency rooms. All systems can make determinations as to whether clients pose a risk to themselves or others. Hospitalization, however, can only take place through a doctor's order. These systems coordinate through the Ken/Som Council and have a "systems alert" for those clients who are felt to be a potential risk. The strength of this system is a variety of services available to respond, so if one system cannot respond another can. There is also a menu of services so that different needs can be met in different ways. These systems share a common clinical supervisor. The weakness of the system is the lack of a hot line, the lack of a single point of entry, the need to actively work on coordination issues on an ongoing basis. At times, issues of capacity are of concern when it is particularly busy or when there is lack of available hospital beds. In Augusta, there has been a long-standing positive relationship with the Augusta Police Department. Similar relationships have more recently been established with Waterville Police Department, the Kennebec and Somerset County Sheriff Departments.

Medication Clinic services are also key to a community based system. The central location for these services is Kennebec Valley Mental Health Center which serves over 900 clients in Augusta and Waterville. There is also a substantial private practice and primary care component here too because there are far more than 900 people who want and need psychiatric medications. Psychiatrists are at a premium in our area so we use a number of psychiatrists that also work in the hospitals. Recently we have employed a nurse practitioner with over twenty-five years experience at AMHI. She is independently licensed to prescribe medications. DMH funds a discounted medication program to assist clients who struggle to pay for expensive medications. Recipients of medication clinic services who have a severe and prolonged mental illness are seen by an agency community support worker prior to seeing the nurse or psychiatrist so medication reaction, compliance and general issues of well-being are addressed. If medication compliance is an issue, it is then thoroughly discussed and communication is made to the client's full-time community support worker, if they have one, with proper information release, for follow up. Lastly, we run a Clozaril case management program for those who have this drug prescribed. The Clozaril program is not designed to track medication compliance. Clozaril is a new drug which could have life threatening effects if white blood cell counts are not monitored. This program was specifically set up to ensure regular blood testing for Clozaril recipients. The blood test cannot tell whether someone is taking Clozaril, only if there is a problem with their white blood count which could have a life threatening effect.

The strength of this system is that it is efficient and well managed. Because most state supported clients use this system, coordination is less of an issue, however, it has many weaknesses. Maine has no medical school, so psychiatrists are very expensive and difficult to recruit. Medication compliance is a major issue, because most medications have negative short and long-term side effects and, at times, limited effectiveness. At any one time we estimate that 10% to 15% of our community support clients are struggling with compliance. Some experience psychosis and have violent thoughts. The overwhelming majority of these folks have been adequately dealt with through Community Support Services, Emergency Services, hospital and criminal justice systems.

A majority of chronically mentally ill people have Community Support Services from one of four agencies in our area; Kennebec Valley Mental Health Center, HealthReach, Catholic Charities Maine and Motivational Services. These services are delivered in people's homes, boarding homes, the community and, if necessary, in agency offices. Services include case management, skills training, counseling, activities of daily living and general support. Frequency of service is flexible according to need. These services are coordinated through the Ken/Som Council. There is a single point of entry, the1-800 number to gain access through a coordinated intake system. There are weekly Monday and Thursday meetings of supervisors, and crisis and emergency services, supported by a licensing approved information release, to discuss potentially troublesome cases. Community Support Services do an excellent job of case management and counseling for those who do not require intensive services. They are limited, however, in addressing the service needs of those who require intensive supervision and structure. Underlying all of these systems is the voluntary nature of all services.

For those people with specific mental illness diagnosis, who are difficult to engage, HealthReach has developed an Assertive Community Treatment or ACT team. This team's job it is to assertively pursue treatment resistant clients and provide case management, medication and counseling services to them even if they are refusing service. This is technology that could go along way towards intervening with difficult, potentially dangerous clients. Drawbacks are that they still operate under a voluntary structure and the diagnostic categories they serve are limited.

There are three general types of housing services in our area. First, are structured group homes which provide 24 hour staffing and structured milieus. These are voluntary programs designed for those clients with higher supervision needs. Because they are voluntary, however, not all clients who may ideally benefit from such a setting do so. These services are primarily offered in our area by Motivational Services with the recent addition of Kennebec Valley Mental Health Center. Second, are boarding homes which provide 24 hour supervision, but are not designed specifically for people with mental illness. They provide a limited structured milieu. Many clients in boarding homes receive community support and other services from mental health agencies voluntarily. The third type of housing program is designed to specifically address housing, not service need. These programs supply housing units and rental assistance to people with mental illness. Because these programs have a civil rights underpinning designed to reduce discrimination in housing for people suffering from metal illness, there is no, and cannot be, any service requirement attached to them. Kennebec Valley Mental Health Center is the sole supplier of these apartment units in the area. Motivational Services and Kennebec Valley Mental Health Center offer housing and rental assistance programs and are coordinated through the Ken/Som Council.

There are also a variety of day and vocational support services supplied by Motivational Services, the hospitals, VocRehab and Kennebec Valley Mental Health Center to assist clients in greater levels of community integration than just living outside the hospital. Day programs are designed for those who can benefit from structured activities, activities of daily living and occupational therapy types of services. At the other end of the spectrum are employment services for those who could benefit from supported employment situations. Because the emphasis has been on downsizing hospitals, the active development community integration strategies which can make living in the community meaningful for consumers, has yet to receive the state's full attention. Kennebec Valley Mental Health Center has recently embarked on bringing a Fountain House style vocational clubhouse program to Maine using revenues from fund raising to support the effort.

Outpatient mental health and substance abuse services are offered by Kennebec Valley Mental Health Center, the two hospitals, Catholic Charities Maine, HealthReach and Crisis and Counseling. Demand is high for these services with most agencies maintaining waiting lists. Many clients seeking this service require financial assistance.

I hope this overview has been helpful. I am aware that it is a complex system that takes more than just a brief description to understand. I will be happy to take questions at this time to help clarify some of what I have discussed. Once again, I want to thank you for your time and interest in improving the mental health system.

Protocols for Monitoring the

Utilization of Psychotropic Medication

Clozapine Monitoring

Background

Clozapine use in Maine, as elsewhere, remains tightly monitored by the drug manufacturer, Sandoz, in accord with FDA standards. These standards were established due to the high incidence of lethal side effects to the medication, the most common of which is suppression of white blood cell count.

Sandoz Protocol

In order to begin a trial of clozapine:

1. The person must be fully informed of the risks, potential benefits, and alternative treatments, and the person or guardian must consent to the medication trial.
2. The person must receive, at a minimum, screening laboratory studies consisting of a complete blood count, and must have a white blood cell count (WBC) of 3500 or greater. The blood sample must be obtained no more than 7 days prior to beginning clozapine. Baseline liver function tests and EKG are recommended, especially in individuals having related medical conditions.
3. The person must be registered by the treatment provider with the Clozaril National Registry, which is operated by Sandoz, and must receive a rechallenge number. Without a rechallenge number, no pharmacy can fill a prescription for clozapine.
4. Sandoz requires documentation of compliance with the FDA standard via specific forms (A through D), with signed copies shared between the prescriber, the pharmacist, and Sandoz.

Due to the high incidence of side effects, clozapine is begun at a low dose and advanced gradually. The Sandoz standard titration begins with 25mg and increases the dose by 25mg daily as tolerated. The usual therapeutic range is 400-800mg daily in divided doses, though this varies considerably from individual to individual.

Once clozapine is begun, the person taking it must have a WBC drawn weekly for as long as s/he remains on the drug. The WBC must be above 3500 in order for the person to receive his/her prescription. The pharmacy will only dispense a one-week supply of clozapine, though it is common to provide people with an extra several days' supply in case they are delayed in getting their blood tests for some unavoidable reason.

In practice, clinics have been authorized by Sandoz to dispense the week's clozapine supply at the time the person presents for his/her blood test. The results of the blood test are checked within 24 hours, and reported to the pharmacy by the prescriber. If the WBC has fallen below 3500, the person is also immediately notified. As long as the WBC remains between 3000 and 3500, the person can remain on the drug but WBC must be checked twice weekly. If the WBC has fallen below 3000, clozapine is discontinued immediately and the WBC is followed closely. Whenever clozapine has been discontinued, it is recommended that the person continue to have weekly WBC checks for one month.

AMHI Protocol

The AMHI protocol for clozapine administration is appended. It appears to conform to the FDA standard although there are some minor differences in titration schedules.

Medicaid Pharmacy Claims Utilization Review Process

Protocol Development

DMHMRSAS has requested permission from the Department of Human Services (DHS) to access Medicaid claims history information regarding the use of psychotropic agents. Once approval is obtained, the Department will be able to access the comprehensive database currently in use for utilization review at DHS. It is anticipated that DMHMRSAS will be able to request specific reports from the DHS database by September 1, 1996, and to receive data by October 1.

DHS strongly advises that DMHMRSAS structure the utilization review (UR) process similarly to the one at DHS. The DHS UR process is conducted in order to inform and educate prescribers. Providers have responded cooperatively to the UR process, which has prompted only a few letters of complaint since the institution of OBRA '90.

Proposed Uses for the Psychotropic Medication UR Process

1. Identification of prescribers of psychotropic medications. This will inform the Department's efforts to design and implement training, consultation, and support for primary care physicians and nurse practitioners who are prescribing for people having psychiatric disabilities. This need is particularly pressing in rural areas having few psychiatrists, and in the treatment of the geriatric population.
2. Tracking the number of individuals taking clozapine, risperidone, and other high-cost medication regimens. This will inform projections of needs and costs for regional planning and consent decree compliance. This could also be used as a vehicle to inform physicians of less costly drug regimens that are likely to be equally effective.
3. Identification of individuals taking medications having potentially harmful drug interactions.

4. Identification of poly-pharmacy, including multiple medications within a single class and same or multiple medications from different prescribers.
5. Correlation of medication class with appropriate diagnosis (e.g., identification of individuals taking neuroleptics who do not have a diagnosis that suggests the presence of psychosis).
6. Identification of individuals taking excessive doses of medications.
7. Identification of regional or facility-specific prescribing patterns (e.g., nursing facilities using haloperidol for sedation).
8. Identification of individuals who have been maintained on a given dosage of a medication for a lengthy period of time.

Clinical Follow-up

When UR reports reveal patterns suggesting irregularities in prescribing practices, the prescriber will be contacted regarding the data, and will be provided with information and suggestions for alternatives, and further consultation will be offered. DHS uses a committee of pharmacists and physicians to intervene in more challenging cases involving clinical practice issues.

It will also be possible to use these data to target high risk individuals in order to monitor whether they have filled their prescriptions. Norms will be developed to identify patterns of erratic use, which will then trigger outreach efforts to determine whether an individual is deteriorating clinically. However, in clinical practice, this is not an adequate means to ascertain patterns of medication use, as people can fill a prescription but not follow through with taking the medication, "double up" on doses or otherwise take the medication irregularly. Also, the fact that a person is taking medication as prescribed does not insure that s/he is doing well clinically, as most people do have periodic exacerbations of their difficulties even while taking medications. Clinical follow-up, in most cases, will reveal if a person is having difficulties, and will include ongoing assessment of medication use. Thus UR surveillance cannot substitute for good clinical follow-up, and good clinical follow-up obviates the need for UR surveillance; neither can fully address the dilemmas posed when an individual simply does not want mental health services and medications. Utilization review will therefore be closely linked with outreach case management efforts for high-risk individuals, and with specialized clinical approaches designed to engage people who are choosing not to enter treatment.

APPENDICES

A. AMHI Clozapine Protocol

B. Review of Clozapine Side Effects

b. Each individual unit will collect and evaluate medication err/incident reports and forward action of correction in writing to the Medication Instructor, who is responsible for monitoring medication error/incident reports hospital wide.

c. The Medication Instructor will coordinate this QA process and keep appropriate records. The Medication Instructor sends a report to the Patient Care Committee, coordinators of Quality Assurance and Nurse Manager.

d. The Mediation error/incident report will be reviewed monthly at the Patient Care committee meeting by the Medication Instructor.

e. The Chairperson of the Patient Care Committee will forward any recommendations for procedure or policy intervention to the Executive Committee of the Medical Staff for action.

CLOZARIL

a. The physician who wishes to prescribe CLOZARIL can call the CLOZARIL National Registry (1-800-448-5938) to obtain a Rechallenge Clearance Authorization Number (RCAN) for that patient. The Patient Safety Assurance (form C) will be completed and the top copy of the threpart form will be forwarded to Sandoz. The physician retains one copy and a third copy will be sent to the Pharmacy with the order to start CLOZARIL in that patient. (The physician may prefer to mail form C to the CLOZARIL National Registry rather than telephoning for the information. Sandoz will return form C with the RCAN.

b. Within seven days prior to receiving CLOZARIL, a blood sample must be obtained for a baseline CBC and differential count. IF the WBC count is /3500/mm^2, a RCAN is obtained and there are no other medical contraindications; CLOZARIL therapy may begin. (Medical contraindications include myeloproliferative disorders or simultaneous use with other agents having a wellnown potential to suppress bone marrow functions.)

c. When the initial CLOZARIL order is to be filled by the pharmacy, a copy of form C and WBC count report form must accompany the order before the drug can be dispensed. (WBC count reporting form is also known as form D when used for a single patient; form E when used for multiple patients.)

d. The physician may follow the dosage titration recommended by Sandoz or choose another titration schedule. CLOZARIL should be increased in increments of 100 mg or less to avoid adverse effects.

e. Subsequent weekly fillings will depend upon pharmacy's receipt of an order written for that dispensing and a form D or E, with an acceptable WBC value (obtained within seven days). If the WBC count is not performed the drug will not be dispensed. If the blood is not drawn within eight days since the last draw, the drug will be removed from the ward.

f. The pharmacy obtains a copy of each of the lab results on the same day as the blood is analyzed. The information is entered into the pharmacy computer, showing up to seven consecutive weeks of WBC counts for each patient so that downward WBC trends can be identified. Also on file in the computer is a current list of CLOZARIL patients, those discharged on CLOZARIL and those in whom CLOZARIL was discontinued.

g. The pharmacy is to be notifiedimmediately of any changes in dosage. Borrowing of CLOZARIL from one patient for use in another patient is not allowed. If changes occur during hours when the pharmacy is closed, prescription vials with a minimum number of tablets of each strength are readily available in the pharmacy.

h. Responsibility for monitoring of the WBC counts rests with the attending physician, to watch for abnormalities or downward trends of WBC which could indicate a pending agranulocytosis. The WBC counts will also be monitored by pharmacy. Should a downward trend be identified, the pharmacist will contact the attending physician (or the covering physician/physician extender). The Clinical Director will also be notified.

i. Actions to be taken with decreasing WBC/Granulocyte are available via protocol.

j. When a CLOZARIL order is discontinued for any reason, the WBC count will be monitored weekly for four consecutive weeks following the discontinuance of CLOZARIL.

k. All CLOZARIL orders will be dispensed on the same day eachweek. Dosage changes occurring on other days will be filled immediately.

l. Following completion of CLOZARIL dispensing, weekly reports will be sent to the following:

(1) Clinical Director: Current CLOZARIL patient list, a list of WBC count for all CLOZARIL patients, including recently discontinued patients;
(2) Director of Hospital Services: Current CLOZARIL patient list; and
(3) Quality Assurance Director: Current patient list, WBC counts and this week's dose of CLOZARIL for each patient.

If a patient is admitted to AMHI on CLOZARIL and brings along a supply of the drug, that supply may be used until it can be obtained from the AMHI pharmacy. The medication may be administered if processed through the AMHI Pharmacy to confirm proper med and dosage. The Clinical Director and the pharmacy must be notified on the next business day so as to process the appropriate paperwork with Sandoz. If the newly admitted patient has been on CLOZARIL but did not bring along a supply, the Clinical Director must be notified before any medication can be removed from the pharmacy. Once the start up on CLOZARIL is approved by the Clinical Director, a pharmacist must then be notified prior to receiving the drug.

FOOD AND DRUG INTERACTIONS

Each discipline carries specific responsibilities regarding food and drug interactions. To assure an optimum level of therapeutic care it is essential that our approach be interdisciplinary as follows:

Dietician:
Completes initial screening and performs ongoing assessment
Makes food/dietary modifications based on assessment

Pharmacist:
Reviews all physician orders for potential food/drug interactions
Put labels on medication bottles with special instructions to alert licensed staff/med techs.
Notifies dietician in the event of a med order that will have significant food/drug interactions

Nursing:
Coordinates information from dietician and pharmacist to assure that appropriate medications and diet are received

SANDOZ PHARMACEUTICALS CORPORATION
59 ROUTE 10, EAST HANOVER, NEW JERSEY 07936-1080

SANDOZ

Appendix B

TEL. 201 503 7500
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July 16, 1996

Constance Kalinowski, M.D.
State of Maine
Department of Mental Health
State House Station #40
Augusta, ME 04330

Dear Dr. Kalinowski:

This letter is in follow up to your telephone conversation of 07/16/96 with one of our professional associates, at which time you requested information regarding the use of Clozaril® (clozapine) and the occurrence of agranulocytosis.

The adult bone marrow contains the precursors of all mature hematologic cells found in the peripheral blood. Mature cells are believed to originate from a single cell type, the pluripotent stem cell, which give rise to two kinds of multipotent stem cells. Beyond the multipotent level, development is directed by humoral stimulatory factors, such as interleukins and colony stimulating factors, and the stem cell is then committed to develop into erythroid, granulocyte-monocyte, lymphocyte or megakaryocyte lines.

The total number of peripheral leukocytes (white blood count) is maintained between 4,000 and 10,000 cells/mm^3 by the complex system of pluripotent and committed stem cells in the bone marrow. In the event of infection, this number will increase substantially through the release of cells from endothelial surfaces, bone marrow reserves and enhanced rate of proliferation.

Leukopenia is defined as a decrease in the white blood count (WBC) to less than 3,500 cells/mm^3. It can be drug-induced or caused by a number of other factors such as severe infection, myelodysplastic syndromes, or congestive splenomegaly. A differential cell count will determine the levels of specific leukocytes from which a diagnosis such as neutropenia or agranulocytosis is possible.

The term agranulocytosis implies a complete absence of granulocytes (neutrophils, basophils and eosinophils), but is generally used to indicate an absolute neutrophil count (ANC) -bands plus granulocytes- below 500 cells/mm3. Agranulocytosis can result from a decreased production of

granulocytes, a destruction of the circulating cells, or a combination of both. Depending upon the stage of development at which cell destruction occurs, the clinical picture of drug-induced agranulocytosis is quite different.

Agranulocytosis has been estimated to occur in approximately 0.1% of patients receiving conventional neuroleptics, (i.e., about one patient per thousand). Pre-marketing experience with Clozaril has shown the risk of agranulocytosis to be between 1-2%, while post-marketing experience (since February 1990) has observed the risk to be 0.6% (0.9% in females and 0.4% in males). The early European experience with Clozaril was marred by a number of fatalities in Finland which occurred due to an unobserved drop in white blood cells often while Clozaril treatment was continued. Recognition of this effect and implementation of procedures to monitor the white blood count has proven effective in limiting fatal outcomes of this reaction.

Although the exact mechanism of Clozaril-induced agranulocytosis is unknown, there does not appear to be a cross-reactivity to other agents (Bauer et al 1994). Extensive studies are under way to identify the underlying mechanism and predict which patients are at a greater risk of developing Clozaril-induced agranulocytosis. Some investigators are analyzing the role of Clozaril metabolites in bone marrow supression while others are examining immunogenetic markers to identify a possible susceptibility gene for Clozaril-mediated agranulocytosis.

Most, but not all, cases of Clozaril-induced agranulocytosis have occurred between six and eighteen weeks of therapy. Statistical studies have shown that the mean number of days in the development of agranulocytosis from the initiation of Clozaril therapy was 79 days, with the minimum time being 29 days and the maximum being 335 days. Our studies also observed differences in time to agranulocytosis between males and females on Clozaril therapy. The mean number of days for males was 98, whereas in females this was observed to be 65 days. These observations were derived from a total of 63,682 patients (September 1993) exposed to Clozaril in the United States. Nevertheless, patients should be considered at risk throughout treatment as the development of agranulocytosis does not appear to be related to daily or cumulative dose. Cumulative dosage does not appear relevant since, as previously mentioned, most cases have occurred relatively early in the treatment period.

From our patients exposed to Clozaril therapy, we have observed that 24% of patients had a drop in WBC from the baseline, 1.8% developed a WBC below 3500/mm3, 1.7% had a WBC between 2000-3000/mm3 or granulocytes between 1000-1500/mm3, 0.6% had a WBC below 2000/mm3 or granulocytes

between 500-1000/mm3, and 0.6% had granulocytes below 500/mm3. Since the introduction of Clozaril to the U.S. market, there have been 728 reported cases of leukopenia, 464 cases of agranulocytosis and 13 deaths due to neutropenic infections secondary to Clozaril-induced agranulocytosis.

There is no pattern to the development of agranulocytosis in the cases studied thus far. Most patients experience a gradual decline in WBC over a period of weeks, ultimately resulting in agranulocytosis. While in others the loss of granulocytes may be rapid, reaching the level of agranulocytosis in only days. In either case, timely intervention is the key to both complete hematologic recovery and avoidance of mortality.

Because of the substantial risk of agranulocytosis in association with Clozaril use, which may persist over an extended period of time, patients must have a blood sample drawn for a WBC count before initiation of treatment with Clozaril, and must have subsequent WBC counts done at least weekly for the duration of therapy, as well as for 4 weeks thereafter. The distribution of Clozaril is contingent upon performance of the required blood tests.

Treatment should not be initiated if the WBC count is less than 3500/mm3, or if the patient has a history of a myeloproliferative disorder, or previous Clozaril-induced agranulocytosis or granulocytopenia. Patients should be advised to report immediately the appearance of lethargy, weakness, fever, sore throat or any other signs of infection. If, after the initiation of treatment, the total WBC count has dropped below 3500/mm3 or it has dropped by a substantial amount from baseline, even if the count is above 3500/mm3, or if immature forms are present, a repeat WBC count and a differential count should be done. If subsequent WBC counts and the differential count reveal a total WBC count between 3000 and 3500/mm3 and a granulocyte count above 1500/mm3, twice weekly WBC counts and differential counts should be performed.

If the total WBC count falls below 3000/mm3 or the granulocyte count below 1500/mm3, Clozaril therapy should be interrupted and patients should be carefully monitored for flu-like symptoms or other symptoms suggestive of infection. Clozaril therapy may be resumed if no symptoms of infection develop, and if the total WBC count returns to levels above 3000/mm3 and the granulocyte count returns to levels above 1500/mm3. However, in this event, twice-weekly WBC counts and differential counts should continue until total WBC counts return to levels above 3500/mm3.

If the total WBC count falls below 2000/mm3 or the granulocyte count falls below 1000/mm3, bone marrow aspiration should be considered to ascertain granulopoietic status. Protective isolation with close observation may be indicated if granulopoiesis is determined to be deficient. Should evidence of infection develop, the patient should have appropriate cultures performed and an appropriate antibiotic regimen instituted.

Patients whose total WBC counts fall below 2000/mm3, or granulocyte counts below 1000/mm3 during Clozaril therapy should not be re-challenged with Clozaril. Patients discontinued from Clozaril therapy due to significant WBC suppression have been found to develop agranulocytosis upon re-challenge, often with a shorter latency on re-exposure. To reduce the chances of re-challenge occurring in patients who have experienced significant bone marrow suppression during Clozaril therapy, a single, national master file will be maintained confidentially.

Granulocyte-colony stimulating factor (G-CSF) has been successfully used in the management of neutropenic fever from chemotherapy exposure. This has spurred an interest in the possible use of G-CSF in drug-induced agranulocytosis. Some recent studies have suggested that G-CSF can shorten the duration of Clozaril-induced agranulocytosis if given at the onset of neutropenia. This is of special importance because Clozaril-induced agranulocytosis causes prolonged bone marrow supression, often lasting 12-20 days. The use of G-CSF will also lessen medical costs by accelerating marrow recovery and shortening acute hospital stay.

With the obvious advantage of weekly WBC monitoring and the serious consequences of undetected agranulocytosis, Sandoz has felt an ethical responsibility to ensure 100% enrollment of all Clozaril treated patients in a blood monitoring system. As you may know, at the time of its introduction, the distribution of Clozaril had been restricted to a national home health care company who satisfied the Clozaril package insert requirements of weekly white blood cell counts and dispensing. The labeling for Clozaril has now been revised to allow other "systems" for patient treatment in a more traditional manner. In addition, although we initially insisted that the blood sample be obtained through venipuncture, we now view finger stick as a viable alternative for the monitoring of the patient's white blood count. By mutual agreement, physicians and pharmacists will form "systems" for white blood cell monitoring that will satisfy the package insert requirements for distributing Clozaril. Providers may contract with outside companies, such as Caremark, Inc. or they may develop their own systems to ensure that the once-a-week white blood cell counts are performed, that patients receive no more than a one-week's

supply of drug at each dispensing and that patients discontinued from the drug receive a minimum of four weeks of follow-up blood tests. Patients will be enrolled in a national registry to ensure that those withdrawn from the drug do not receive it again. If you should have any questions regarding this new use of other "systems" for patient treatment, please call 1-800-448-5938.

Clozaril is an atypical antipsychotic agent which has demonstrated superior efficacy in treatment-resistant and treatment-intolerant schizophrenic patients. In clinical trials Clozaril was found to be significantly more effective than neuroleptic drugs in controlling both positive and negative symptoms of schizophrenia. Due to its unique pharmacologic profile, Clozaril appears to have a more specific mechanism of action than traditional neuroleptics. This specificity has resulted in a virtual absence of extrapyramidal side effects, no confirmed reports of tardive dyskinesia, and no significant prolactin elevation. Clozaril has been approved for use only in the management of severely ill schizophrenic patients who fail to respond adequately to standard antipsychotic drug treatment.

Patient response to Clozaril is highly individualized. In a few cases, improvement has been rapid and dramatic. Most patients, however, experience more modest progress. Medical studies have shown that 30% of patients improved after six weeks of Clozaril therapy. After six months of treatment, symptoms improved in more than 60% of patients. The benefits of Clozaril therapy must, however, be weighed against certain risks. Clozaril therapy is associated with a 1% to 2% incidence of agranulocytosis, a potentially dangerous blood disorder, which, if caught early, is reversible. Mandatory weekly white blood cell (WBC) counts and weekly drug dispensing has provided an efficient means of detecting agranulocytosis.

We hope the information provided proves helpful. Thank you for your interest in Clozaril.

Sincerely,

Michael B. Krassner, M.D.
Senior Associate Director
Medical Services

MBK:pm:140858
Enclosures

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Definitions of Leukopenia, Granulocytopenia and Agranulocytosis and Suggested Clinical Management

PROBLEM PHASE	WBC COUNTS (cu mm)	CLINICAL FINDINGS	TREATMENT PLAN
Mild Leukopenia	WBC 3,000 - 3,500 Granulocytes* 1,500 or higher	Patient may or may not show clinical symptoms, such as: lethargy, fever, sore throat, or weakness	1. Monitor patient closely. 2. Institute twice-weekly WBC tests with differentials, if deemed appropriate by attending physician. 3. Clozaril therapy may continue
Moderate Leukopenia ——— Granulocytopenia	WBC 2,000 - 3,000 ——— Granulocytes 1,000 - 1,500	Patient may or may not show clinical symptoms, such as: lethargy, fever, sore throat, or weakness	1. Discontinue Clozaril at once. 2. Institute WBC tests with differentials every day. 3. Increase surveillance, consider hospitalization 4. Clozaril therapy may be reinstituted after normalization of WBC**.
Severe Leukopenia ——— Severe Granulocytopenia	WBC below 2,000 ——— Granulocytes 500 - 1,000	Patient may or may not show clinical symptoms, such as: lethargy, fever, sore throat, or weakness	1. Discontinue Clozaril at once. 2. Place patient in protective isolation in a medical unit with modern facilities. 3. Monitor patient daily until WBC and differential counts return to normal (about 2 weeks on average) 4. Clozaril must <u>not</u> be restarted.
Agranulocytosis	Granulocytes below 500	No symptoms of infection OR Definite evidence of infection, such as: fever, sore throat, lethargy, weakness, malaise, skin ulceration, etc.	1. Consider a bone marrow biopsy to determine if progenitor cells are present. 2. Consult with hematologist or other specialist to determine appropriate treatment regimen including antibiotics. 3. As always, avoid the use of concomitant medications with bone marrow suppressing potential. 4. Clozaril must <u>not</u> be restarted.

* Granulocytes = Bands & Polymorphonuclear leukocytes

** WBC count considered normal when it reaches 3,000/cu mm with normal differential

Kennebec Valley Mental Health Center

149 North Street ~ Waterville, Maine 04901-4900 ~ (207) 873-2136

JOHN D. SHAW, Jr. L.C.S.W
Executive Director

August 1, 1996

The Honorable Joan M. Pendexter
The Honorable Michael J. Fitzpatrick
Honorable Members of the Joint Standing Committee on Health and Human Services

Thank you for the opportunity to address the Committee last week. Given the constraints we are operating under, I hope I was helpful in assisting your understanding of the community based mental health system in greater detail.

I am enclosing the materials you requested at that time, including the job description for the Clozaril Case Manager and interpretive guidelines relating to the issues in question. I have also included our copy of the Medicaid regulations which, along with the job description, provide most of the written guidelines for the program's operation.

It is my understanding, you also have questions regarding whether our agency requires Clozaril recipients to have a Community Support Worker. Karen K. Mosher Ph.D., our Clinical Director for Adult Services, has responded in a memo to that issue with detail about our procedure and client statistics relating to that issue. Also included is a clarification, as a result of last week's discussion, on the procedures used to ensure client receipt of medications. Our sense is that a more aggressive pursuit of clients coerces them and infringes on their rights.

I plan to attend your meeting this Friday at 9:30 a.m. Providing public information is an important part my responsibilities at the Mental Health Center. I respectfully request that we make an effort to be conscious of the time needed to both prepare for and testify before the committee.

Sincerely,

John D. Shaw

John D. Shaw, Jr., L.C.S.W
Executive Director

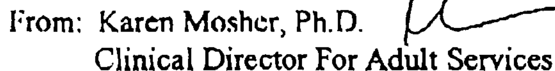
JDS:jpr

KENNEBEC VALLEY MENTAL HEALTH CENTER

MEMORANDUM

To: John D. Shaw, Jr., L.C.S.W.
Executive Director

From: Karen Mosher, Ph.D.
Clinical Director For Adult Services



Regarding: Clozaril Case Coordination Statistics

Date: July 30, 1996

Per your request, as of this date:

Seventy one (71) clients receive Clozaril Case Coordination through Kennebec Valley Mental Health Center.

Of these seventy one (71) clients, sixteen (16) do not have a Community Support Worker.

Of these sixteen (16), nine (9) have not provided us with another contact person, either.

The Clozaril Case Coordinator has been working regularly with these nine (9) clients as well as with their prescribers to have them name a contact person or accept a Community Support Worker. In the event that one of these individuals misses their blood work or needs assistance following up, a Community Support Worker from Kennebec Valley Mental Health Center is assigned to contact or find the client and offer assistance on an as needed basis. We have not, however, made having a Community Support Worker or another contact person a requirement for obtaining the medication or the case coordination.

KENNEBEC VALLEY MENTAL HEALTH CENTER

PROCEDURAL: **INTERPRETATION** UPDATE CLARIFICATION

SYSTEM: Clinical
PROGRAM: Community Support
AREA: Clozaril Case Coordination
SPECIFIC: Insuring that weekly blood samples are drawn
EFFECTIVE DATE: April 30, 1994

The Clozaril Case Coordinator (CCC) maintains a record of all clients receiving Clozaril case management.

This record includes the client's name, address, and phone number.

The record also includes the name of the client's Community Support Worker (CSW), the responsible community support agency or another chosen contact person who can assist the client in getting their blood sample drawn if there is a problem.

In the event that a client does not get their blood work done as scheduled, the CCC contacts the client to find out what happened.

If there is a problem with the client obtaining the blood work, the CCC problem solves with the client. The CCC calls the CSW or contact person if the client needs additional assistance in getting the bloodwork done.

KENNEBEC VALLEY MENTAL HEALTH CENTER

PROCEDURAL: **INTERPRETATION** UPDATE CLARIFICATION

SYSTEM: Clinical
PROGRAM: Community Support
AREA: Clozaril Case Coordination
SPECIFIC: Ensuring that the consumer receives weekly medication from a pharmacy (with prescription).
EFFECTIVE DATE: July 29, 1996

This procedure is intended to insure that consumers are able to get their medication from the pharmacy, that all of the necessary procedures have been completed, and the medications are made available to the consumer. It is not specifically intended to check up on whether or not clients are picking up their medication. However, the CCC does get that information when calling the pharmacy the next week. When the CCC calls with a weeks blood levels the pharmacy tells the CCC if someone did not pick up their medication the prior week. In that circumstance, the CCC follows up with the client, CSW or contact person to ascertain what has happened and to try to get the client back on their medication. The prescribing psychiatrist is also informed and makes a decision as to how the medication is restarted if the person has been off it for a period of time.

Policy No: 2474

POSITION TITLE

Clorazil Case Coordinator

General Description:

Monitor and coordinate services specific to consumers who are receiving the medication Clorazil.

Responsible to:

Regional Director where Clorazil Case Coordination is occurring.

Specific Duties:

1. Ensuring that weekly blood samples are drawn.

2. Ensuring that the consumer attends appointments with prescribing physician.

3. Ensuring that the consumer receives weekly medication from a pharmacy (with prescription) and for maintaining detailed individual consumer records as required by KVMHC clinical records procedures and Medicaid Regulations.

4. Coordinating the receipt of the results of the white blood cell counts with the consumer's physician and pharmacy and communicating any noticeable change in patient status or behavior that may be observed either during visual or telephone contact with the consumer.

5. Verification of the consumer's Medicaid eligibility on a monthly basis.

6. Notification to the pharmacy if or when a physician discontinues prescribing Clorazil for consumer.

7. Making arrangements for the receipt of Clorazil if the consumer is transferred, on vacation or traveling.

8. Provide consumer and family education about Clorazil, the monitoring process and possible side-effects.

9. Developing consumer support groups for those consumers who are receiving Clorazil.

Requirements:

1. Possesses an Associates Degree in Human Services or experiential or academic equivalent.

2. Is eligible as an "Other Qualified Mental Health Staff" as defined by the Bureau of Mental Health Standards.

3. Where applicable to a discipline, hold licensure certification or registration to be eligible for such.

4. Have training or experience in the health care field to the extent of understanding laboratory reporting procedures and pharmacy procedures and an awareness of relevant situations and roles within a pharmacological monitoring and coordination system.

Karen - for Clozaril file

John R. McKernan, Jr.
Governor

Jane Sheehan
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

September 10, 1993

TO: Interested Parties

FROM: Elizabeth McCullum, Director, Bureau of Medical Services

SUBJECT: Final Rule: Chapters II & III, Section 16, Clozaril Monitoring Services

Attached is the final rule, Chapters II & III, Section 16, Clozaril Monitoring Services in the Maine Medical Assistance Manual.

The final rule describes covered services, eligibility criteria and procedures, approved staff, clinical records, utilization review, reimbursement and billing instructions. A hearing was held on August 11, 1993 and comments were accepted until August 23, 1993.

If you have any questions regarding this policy, please call your Provider Relations Specialist.

EMc/dms

Attachment

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16.01 DEFINITIONS

16.01-1. Clozaril and it's generic equivalent are medications used in the treatment of mental illness.

16.01-2. Monitoring is the systematic process used to assure the safety of an individual receiving the medication Clozaril or its generic equivalent.

16.01-3. Side Effects are secondary, usually undesirable, effects experienced by an individual receiving the medication Clozaril or its generic equivalent.

16.02 ELIGIBILITY FOR SERVICES

An individual may be found eligible to receive services as set forth in this policy if he or she meets the following general Medicaid Eligibility Requirements and the specific Medicaid Eligibility Requirements.

A. General Medicaid Eligibility Requirements

1. Categorically Needy Medicaid recipients, whose eligibility is shown on the Medical Eligibility Card as MM, or

2. Medically Needy recipients, whose eligibility is shown on the Medicaid card as MI.

It is the responsibility of the provider to verify an individual's eligibility for Medical Assistance prior to furnishing services by requesting the individual to present his or her Medical Eligibility Card on each occasion that services are provided.

B. Specific Medicaid Eligibility Requirements

The individual is currently recieving the medication Clozaril or its generic equivalent or will be receiving the medication within 30 days.

16.03 ELIGIBILITY PROCEDURE

Eligibility for Clozaril monitoring services will be determined by the monitoring provider. The procedure for determining eligibility for Clozaril monitoring is as follows:

A. Individuals who may be eligible for Clozaril monitoring may be referred by any source, such as a physician, nurse, other health or mental health provider, parent, guardian or public and private community agency.

16.03 ELIGIBILITY PROCEDURE (Con't)

B. The monitoring provider will verify Medicaid eligibility as stated in 16.02 (A and B).

C. If the individual is not currently receiving Medical Assistance, the provider will refer the individual to a regional office of the Bureau of Income Maintenance to determine financial eligibility for Medicaid.

16.04 COVERED SERVICES

Clozaril monitoring services are covered services when provided by staff meeting the criteria stated in 16.05-1.

A provider must provide the services discribed in 16.04 (A and B) and may provide or facilitate access to (C).

A. Case coordination which includes:

1. ensuring that weekly blood samples are drawn;

2. ensuring that the consumer attends all appointments with the prescribing physician;

3. ensuring that the consumer receives weekly medication from a pharmacy (with prescription);

(NOTE:) MEDICATION MAY BE MAILED TO THE CONSUMER

4. maintaining detailed individual consumer records as described in 16.05-2 Clinical Records;

5. coordinating the receipt of the results of the white blood cell counts with the consumer's physician and pharmacy and communicate any noticeable changes in patient status or behavior that may be observed during either visual or phone contact with the patient;

6. verification of the consumer's Medicaid eligibility monthly;

7. notification to the pharmacy if or when a physician discontinues prescribing Clozaril for a consumer;

8. making arrangements for the receipt of Clozaril if the consumer is transferred, on vacation or traveling.

B. Consumer and family education about Clozaril, the monitoring process and possible side effects.

C. Consumer support groups

16.05 POLICIES AND PROCEDURES

16.05-1 Professional and Other Qualified Staff

Clozaril monitoring may be provided by the following approved staff:

Staff who are providing Clozaril monitoring services for Maine residents from a location outside of the State of Maine must be licensed by profession in accordance with State Law in the State in which they are located.

Copies of all professional licenses or certificates held by the staff providing monitoring services shall be on file with the Division of Medical Claims Review.

A. Physician - A physician must have a current and valid physician's license from the Maine Board of Registration of Medicine, or the Maine Board of Osteopathic Medicine.

B. Physician Assistant - A physician assistant must have completed an appropriate training program that has been approved by the Board of Registration in either Medicine or Osteopathy and passed any competency examination required by this board. Before being permitted to practice, such person must obtain a certificate of qualification from the Maine board and, at least bi-annually, a certificate of registration.

C. Pharmacist - A pharmacist must be currently and validly licensed as a registered pharmacist through the Board of Commissioners of the Profession of Pharmacy.

D. Psychologist - A psychologist must be licensed as a psychologist by the Maine State Board of Examiners of Psychology in accordance with 32 M.R.S.A., Chapter 56.

E. Nurse Practitioner - A nurse practitioner, nurse midwife, or specialized nurse practitioner must be a graduate of both an accredited nursing program and either a certified nurse practitioner program with specialization in an appropriate field or nurse midwife program and must hold a current Maine license.

F. Registered Nurse - A registered nurse must be currently and validly licensed as a registered professional nurse by the Maine State Board of Nursing.

G. Social Worker - A social worker must hold a Master's degree from an accredited school of Social Work and be licensed by the Maine State Board of Social Work Licensure in accordance with 32 M.R.S.A., Chapter 83, Section 7001, as documented by written evidence from such Board, or be qualified and

16.05 Professional and Other Qualified Staff (Con't)

H. Licensed Clinical Professional Counselor - A licensed clinical professional counselor must be licensed as such by the Maine State Board of Counseling Professionals Licensure in accordance with 32 M.R.S.A., Chapter 119, as documented by written evidence from that Board.

I. Other Qualified Mental Health Staff - Other qualified mental health staff are staff members of the Bureau of Mental Health or a mental health clinic or contracting agency who have appropriate education, training and experience in mental health disciplines or behavioral sciences as defined by the Bureau of Mental Health and who are approved by the Bureau of Mental Health as documented by a letter on file with the Bureau of Medical Services.

16.05-2 Clinical Records

There shall be a specific record for each consumer which shall include but need not be limited to:

A. The consumer's name, address, birthdate, and Medicaid ID number;

B. the name of the physician;

C. the individualized Clozaril monitoring plan;

D. any communication to or from the physician;

E. record of the white blood cell counts;

F. documentation of any medical incidents or adverse side effects.

16.05-3 Quality Assurance

The protocol for Clozaril monitoring required by Sandoz will be strictly adhered to by providers of Clozaril monitoring services.

The quality assurance function for Clozaril monitoring services will be the responsibility of each entity in keeping with their internal review policies. The Bureau of Medical Services Division of Surveillance and Utilization Review will also monitor quality assurance.

16.05-4 Surveillance and Utilization Review

A. The Division of Surveillance and Utilization Review monitors the medical services provided and determines the appropriateness and necessity of the services.

16.05-4 Surveillance and Utilization Review (Con't)

B. The Department and its professional advisors regard the maintenance of adequate treatment and service records as essential in substantiating the delivery of quality care. In addition, providers should be aware that treatment and service records are key documents used for post-payment reviews. In the absence of proper and complete records, no payment will be made and payments previously made may be recovered in accordance with Chapter I of the Maine Medical Assistance Manual.

C. Upon request, the provider must furnish to the Department of Human Services, without additional charge, the records, or copies thereof, corresponding to and substantiating services billed by the provider.

D. The Department expects that records and other pertinent information will be transferred, upon request and with the parent, legal guardian or custodian's signed release of information, to other clinicians involved in the patient's care.

16.06 REIMBURSEMENT

Reimbursement will be made for Clozaril Monitoring Services and will be the lower of: the providers' usual and customary fee; or the amount listed in Chapter III, Allowances for Clozaril Monitoring Services.

In accordance with Chapter I of the Maine Medical Assistance Manual, it is the responsibility of the provider to seek payment from other third party payors prior to billing the Medical Assistance Program for a rendered service.

16.7 BILLING INSTRUCTIONS

Billing must be accomplished in accordance with the Department's "Billing Instructions for the HCFA 1500 Claim Form."

Kennebec Valley Mental Health Center

149 North Street – Waterville, Maine 04901-4900 – (207) 873-2136

JOHN D. SHAW, Jr. L.C.S.W.
Executive Director

August 8, 1996

The Honorable Joan M. Pendexter
The Honorable Michael J. Fitzpatrick
Honorable Members of the Joint Standing Committee on Health and Human Services

Please find enclosed the information you requested, in writing, from Kennebec Valley Mental Health Center at the Joint Standing Committee on Health and Human Services, last Friday, August 2, 1996.

If you require any further information, please do not hesitate to contact me.

Sincerely,

John Shaw

John D. Shaw, Jr., L.C.S.W.
Executive Director

JDS:jpr

enclosure

COORDINATIVE SERVICES MEETING

Confidentiality Agreement

As a member of the Coordinative Services Meeting I will be reviewing and/or obtaining information related to individuals with persistent and often severe emotional handicaps. This information is confidential and is protected by Federal and/or State statute. I understand that information obtained through the Coordinative Services Meeting is to be used only to facilitate the delivery of services to the individual client.

If it should be brought to the attention of this committee that I have inappropriately used information, the appropriateness of my continued participation on the committee will be reviewed.

DATE: ____________________

MEMBERS PRESENT:

1. ______________________	12. ______________________
2. ______________________	13. ______________________
3. ______________________	14. ______________________
4. ______________________	15. ______________________
5. ______________________	16. ______________________
6. ______________________	17. ______________________
7. ______________________	18. ______________________
8. ______________________	19. ______________________
9. ______________________	20. ______________________
10. ______________________	21. ______________________
11. ______________________	22. ______________________

Form # 700

COORDINATED SERVICES MEETING

DATE__________ AGENCY____________________ PRESENTOR____________________

***CLIENT NAME____

ISSUE/AT RISK BEHAVIOR_______________________________________

____

RESPONSE NEEDED Y__ N__ /BY WHOM_____________________________

____

***CLIENT NAME____

ISSUE/AT RISK BEHAVIOR_______________________________________

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RESPONSE NEEDED Y__ N__ /BY WHOM_____________________________

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***CLIENT NAME____

ISSUE/AT RISK BEHAVIOR_______________________________________

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RESPONSE NEEDED Y__ N__ /BY WHOM_____________________________

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KENNEBEC VALLEY MENTAL HEALTH CENTER
EMERGENCY ALERT PROCEDURES

The Kennebec Valley Mental Health Center has two systems meetings per week, Mondays @ 9 a.m. in Augusta and Thursdays @ 1 p.m. in Waterville, where managers of area mental health agencies (HRN, MDCO, C & C, KVMC, CC/ME, KCCSP, AMHI & KVMHC) give alerts and receive alerts on consumers who are in crisis. See enclosed forms. The risk factors are discussed and where a response is needed the person who needs to respond is notified by the appropriate manager.

The KVMHC emergency staff & KCCSP crisis intervention staff are present at these meetings and take the responsibility to pass along the necessary information to their respective staff members.

If a crisis or an alert arises between meetings, the community support workers alert the KVMHC emergency worker and KCCSP, if appropriate, and the emergency workers pass the alerts on through their respective staffs. The KVMHC emergency staff & KCCSP staff alert each other as well as other agencies alerting specific workers on changes in consumer's mental health status.

KENNEBEC VALLEY MENTAL HEALTH CENTER

PROCEDURAL: INTERPRETATION UPDATE **CLARIFICATION**

SYSTEM: Clinical
PROGRAM: Community Support
AREA: Clozaril Case Coordination
SPECIFIC: Insuring that weekly blood samples are drawn
EFFECTIVE DATE: May 16, 1994

Ensuring that weekly blood samples are drawn. Depending upon the pharmacy that a client selects, the CCC sets each client up with a day of the week on which to have their blood drawn and a day for them to pick up their medication. The CCC gets all of the lab work for clients using a specific pharmacy by noon of the specified day. The CCC highlights any client who doesn't have their lab work and first checks with the lab to see if its available. The CCC then calls the pharmacy, gives them the levels, and tells them who is missing. If the CCC doesn't have the lab work by the next morning, they start calling the client, the CSW or the contact person in order to get them taken care of. If necessary, someone goes out to check with the client. The CCC also lets the pharmacy know to tell the client to get in touch with them if they show up expecting to get their medication.

KENNEBEC VALLEY MENTAL HEALTH CENTER

CLOZARIL STATISTICS

Within a period of 54 weeks, July 1995 through July 1996 a review of our records shows that of the approximately 3500 White Blood Count lab results that the agency monitored, for between 58 and 73 individuals in any given week, there were:

Twenty five (25) incidents where lab work and medication were 1 day late
Five (5) incidents where lab work and medication were 2 days late
Two (2) incidents where lab work and medication were 3 days late
Three (3) incidents where lab work was delayed one week, but the individuals said they had enough medication

One (1) individual who had 2 week long skips and 1 ten day skip. This individual refused the lab work and was not dispensed medication.
One (1) individual who had 10 week long skips, once for a five week period. This was an individual who was moving in and out of the area and who could not be located for long periods of time.

8/23 Dist by Ken

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

SITE VISIT
KENNEBEC VALLEY MENTAL HEALTH CENTER

The Department of Mental Health, Mental Retardation and Substance Abuse Services will undertake a site review of the Kennebec Valley Mental Health Center. Sites reviews of this type are consistent with the Department's mandate, i.e. to monitor the practices of licensed and contractual agencies and fit well within the usual and customary practices of state departments of mental health. The review will focus on broad clinical and programmatic issues. It is specifically **not** a re-opening of any past case or situation **nor** a clinical incident review of any present case or situation.

Among the issues to be reviewed are:

- **The treatment planning process**: how are treatment plans developed, reviewed, updated, amended; how do treatment plans follow diagnosis, level of functioning, clinical assessment, does it address issues of risk management; are there clear goals and objectives.
- **The intake process**: how are cases assigned, what information should be gathered in the intake, how are intakes reviewed.
- **Record keeping**: Does the record reflect the client's progress, is it up to date, it is complete and comprehensive.
- **Treatment**: Does it follow the treatment plan, is it coordinated among the various care givers, is it consistent over time.
- **Crisis management**: What procedures are followed if someone is in crisis, who is responsible, what services are offered to the client.
- **Policies and Procedure**: Are there clear policies and procedures for such clinical issues as: risk management; medication prescribing, administration, and monitoring; coordination of treatment; assignment of cases; treatment planning; record keeping; clinical incidents.
- **Clinical incident review process:** What are the policies and procedures for clinical incident review; what should a review contain; how should it be written; what records and reviews are kept.
- **Coordination of treatment**: How does the agency coordinate treatment if the client receives services from another agency, from a private practitioner.
- **Trauma**: How is this being dealt with in the intake process, the treatment planning process, the actual treatment; what level of training do clinicians have regarding the assessment, evaluation, and treatment of trauma.
- **Medication**: What are the policies and procedures for the prescribing,

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administering and monitoring of psychotropic medications.

- **Medical coordination**: How are consumers' medical treatment coordinated with psychiatric and psycho-social care.

The review will be conducted by Department staff and will consist of at least two people: an experienced, professional clinician and a psychiatrist. The reviewers will want access to:

- **Clinical records**
- **Policies and Procedures**
- **Incident reports**
- **Key clinical personnel**
- **Board members**
- **Consumers**
- **Other information as appropriate**

Prior to the review, the Department staff will discuss with KVMHC administration who will be interviewed. All policies and procedures should be made available and clinical records will be randomly selected. It is expected that the site review will take one to two days.

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
& SUBSTANCE ABUSE SERVICES
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ANGUS S. KING, JR.
GOVERNOR

MELODIE J. PEET
COMMISSIONER

KENNETH DYM
PROGRAM MANAGER
MENTAL HEALTH SERVICES

REPORT ON THE SITE REVIEW OF THE KENNEBEC VALLEY MENTAL HEALTH CENTER

OVERVIEW

On September 27 and 30, 1996, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) conducted a site review of the Kennebec Valley Mental Health Center (KVMHC). The members of the review team were:

- Kenneth Dym, MSW.............Program Manager for Mental Health Services
- Cathy Bustin Baker...............Director, Office of Consumer Affairs
- Richard Fortier, M.D.............Consultant to DMHMRSAS
- Reid Scher, MSW..................Team Leader, Mental Health Services, Region I
- Joan Smyrski, MA.................Program Director, Crisis Services

Mr. Dym chaired the review team.

This site review was requested by the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services. The review was designed to be a programmatic, administrative, and clinical assessment of KVMHC. This review was not a licensing review nor was it intended to replace or supersede the licensing review. Additionally, the review did not re-open, or re-focus on, the investigation of any past incident or case.

The methodology used by the team is outlined on the attached sheets describing the nature of the review. The review team met with the following people:

- Psychiatrist from KVMHC
- The executive team, including John Shaw, executive director, Karen Mosher, Ph.D., Neil Colan, Ed.D., Lorna Bradstreet, and Robert Long
- Clinical and program staff, including the assistant director of CSP, two CSP workers, the director of Emergency Services, two emergency service workers, two residential staff, two outpatient clinicians, a community support worker, and two emergency services workers.
- Over 20 clients, representing various parts of the agency, including: residential, emergency services, CSP, medication services and outpatient. Both men and

The team reviewed the following written material:

- Twenty (20) charts randomly selected from pre-determined categories: clients on clozaril, clients also being seen at other agencies, clients who have utilized crisis services, clients for whom trauma is an issue, clients who represent the "typical" recipient of services at KVMHC.
- Policies and Procedures
- Various clinical forms
- Clinical incident reviews
- Strategic Plan, 1995 - 1997
- Medication Clinic Design Project
- Annual Report, 1994, 1995

FINDINGS

Uniformly, the staff the review team met with appeared open, forthright, non-defensive, and interested in improving the quality of care delivered to the clients of the Kennebec Valley Mental Health Center. Staff acknowledged from the outset difficulties in inter-agency coordination, availability of psychiatric time, risk management protocols and procedures, and clinical incident review procedures. These points will be detailed in the report. However, it should also be stated, over the past 12 to 18 months KVMHC has initiated an extensive internal review and is currently in the process of implementing a number of administrative and programmatic changes designed to ameliorate some of these situations. This too will be detailed in the report.

Client reports: The review team met with clients in a variety of formats: individually, in groups; with a single member of the review team and with pairs of reviewers. Consumers generally had positive things to say about the programs. One person who attends a day program, stated "coming here makes me feel safe;" another said, "without this place, I would be dead;" a third said that therapy had been "very helpful" in helping her control some of her aggressive impulses; and a fourth claimed that she had fewer hospitalizations since she had been attending programs at KVMHC. Every person said they were, for the most part, satisfied with the services and the program. They thought staff was responsive, listened to them, and communicated well.

On the other hand, almost every client felt they did not have enough time with the physician. Appointments were either spaced too far apart and/or they were too short. (One client did say, however, depending on the her situation, the psychiatrist would spend as much time as necessary). One person commented that he stopped taking medications at one point and no one asked why. He thought this should have been a "red flag" to alert staff to potential problems. Another said if he ever misses a blood work for the clozaril, he always receives a phone call from a case manager within 24 hours.

Approximately half the clients spoken to reported having some additional or other services provided elsewhere, e.g. private psychiatrist or a different agency. However, no one stated they felt this to be a problem. In one group of five clients, in which three people received their medication from a private psychiatrist, all said the coordination of treatment appeared to be OK. At the same time, only a few clients stated they received any education regarding their medication. Most said they received some information from the pharmacy. KVMHC staff state that each client does receive a written statement explaining their medications. Clearly, this is not sufficient.

The clients' response to the crisis response system appeared mixed. Everyone had a telephone number they knew to call if they were in crisis. In fact, most had two or three numbers, but no one could say with any precision why they would use one crisis number as opposed to the other -- or what each crisis/emergency program was designed to do. A few clients stated that if they were in a crisis, they could directly call their therapist or psychiatrist and that this had been extremely useful. Some said they were given a telephone number to call -- a "hotline" -- and that he did not use it because he did not like the anonymity of the telephone. Although not stated overtly, it did appear as if clients felt it took too long for a crisis worker to respond to a phone call. One person mentioned 10-15 minutes, another gave an example of 45 minutes. Also, clients did not like the system in which they called a crisis number and then had to wait for a return call. They would have preferred to speak directly with the worker.

Three clients from a residential facility were interviewed. All three reported strong satisfaction with their apartments and felt comfortable in knowing staff were available when needed. All three openly stated they initially had fears of leaving AMHI. Yet they appreciate having the privacy of their own room coupled with the opportunity to socialize.

Finally, to a person, clients were extremely bothered and disturbed by the stigmatization of people with mental illness. This especially came up regarding the murder of the two nuns. They felt this event, and the attending media/political coverage, unfairly placed all people with mental illness, and especially those in the Waterville area, under a spotlight which only led to further discrimination and stigmatization.

Crisis management: The emergency services provided by KVMHC is 7 days a week, 24 hours a day. The director of emergency services estimates they have 1800 - 2000 contact hours per year and average four to five adults per day. This is an area which requires significant improvement -- not necessarily because the staff appear to be poorly trained or lacking in experience and not because the program appears to be poorly administered. Rather, the overall crisis response system is fragmented, not sufficiently integrated, and woefully under-resourced, especially in psychiatric time and coverage. This emerged clearly, as stated above, when clients stated they were not sure which number to call and which number was for what service.

KVMHC emergency service staff are based in the local hospital's emergency room. Although they have a good enough working relationship, control clearly lies within the emergency room.

For a physician to see a client often takes a long time. In addition, psychiatrists are not on call for face-to-face contacts, although they are available by telephone. Consequently, a person in crisis is generally not immediately seen by a psychiatrist. In addition, if a client of KVMHC is seen in the emergency room "after hours," the physician or emergency worker does not have access to the client's records even though (for Waterville) they are in a building across the street. Nor is any of this information computerized. So the emergency room staff (including the physician) is working either by memory or without any records. Once the client is discharged from the emergency services there is not sufficient follow-up. Emergency services does not have the capacity to function as a short term crisis unit and it is not always clear if the person is picked up immediately in the KVMHC programs. Furthermore, there continues not to be any systematic way to insure the person will immediately be seen for a psychiatric evaluation. An individual seen in the emergency room will receive a referral to the mental health center, but to the intake worker and not necessarily to the psychiatrist. The lack of post crisis follow-up, coupled with minimal efforts in the area of crisis prevention, represents a major problem for crisis management services.

The emergency services staff also appears under-resourced. At times, only one person is on coverage. Clearly, therefore, if two crisis occur at the same time, one person potentially has to wait an inordinate amount of time. Or if a person in crisis has to be seen by hospital staff, who might also be otherwise occupied, there could be a long wait. The emergency services director recognized this problem, realized people in crisis, were kept waiting, but had no immediate solution. In addition, within the emergency services, there are no staff specifically trained in working with children and adolescents. Families are always involved if a child enters the emergency room, but the lack of trained personnel is a serious gap. In addition to requiring training in handling children in crisis, the director of emergency services felt his team needs training in the treatment of substance abuse and trauma. The staff has no experience with advanced directives and minimal experience developing crisis prevention plans.

Other apparent problems within the emergency services include:

- barriers of communication between state and private workers
- barriers of communication between workers from different agencies
- issues of confidentiality especially when multiple agencies are working with the same client
- Diversionary funds are controlled by state crisis workers, not by the emergency services workers. Again this leads to fragmentation
- somewhat as an aside, as it does not directly bear on the services provided by KVMHC, apparently the crisis bed unit also has no psychiatric coverage

In concluding this section, it need be emphasized that the problems with the crisis/emergency system appear to be system-wide rather than specific to KVMHC. The problems seem to be twofold:

- Multiple agencies are involved (including the emergency room of the hospital) leading to a lack of coordination and integration.

- A severe lack of psychiatry, thereby not allowing clients, in crisis, to receive immediate medical assistance

Psychiatry and Medication management: KVMHC does not have a medical director, nor do they have a full time psychiatrist. KVMHC does, however, employ a full time nurse practitioner who can prescribe medication. Still, psychiatric coverage/consultation is available no more than half the time. This is problematic, for it prevents clients from seeing psychiatrists in a timely and sufficient manner. The psychiatric/medication clinics are quite high volume with four patients scheduled per hour. For people who are stable on medications, this is not necessarily a problem. But to allow 15 minutes to conduct an assessment on a new client, or to work with a client in crisis, is not sufficient. The lack of psychiatry in the crisis services has been detailed above. The problem also occurs during the normal intake process. A non-medical clinician conducts the screening interview and then triage the client to the appropriate services, e.g. clinic, community support. There is no input or review from a psychiatrist (or from a multi-disciplinary team) regarding the decision. Finally, there does not appear to be an adequate system by which psychiatry and clinical staff communicate with each other. For example, a community support worker stated he mainly knows about medication changes if a client informs him. Psychiatrists do not appear to be readily available for immediate medication evaluations and adjustments.

The executive leadership is aware of the problems detailed above. Recently, KVMHC hired a psychiatrist to work 2 additional half-days per week. And the child and family program has been able to secure child psychiatry services. John Shaw, executive director, states KVMHC has been attempting to hiring additional psychiatrists for a considerable period of time, but without good success. And indeed, this is a severe problem in many parts of the state.

Regarding the administration of medication, the clozaril clinic seems to be working well. There are clear procedures for responding to low white blood counts (both the patient and the prescriber are called) and for non-compliance with lab work (the patient, or other responsible person is called, as is the pharmacy). In addition, KVMHC is just in the process of instituting an entirely new procedure for their medication clinic. The new procedures are designed to improve monitoring, streamline the triage process, and improve communication among all the providers. Two nurse managers have been hired to oversee the program which should provide more clinical and administrative oversight.

Intake process: The current intake process is fragmented and of varying quality. KVMHC has proposed a "single point of entry" and envisions a uniformed admissions process so that regardless what service component the individual is seeking (e.g. community support, outpatient services, medication management) the process will be uniform and thus, more expedient. They plan to have three levels of intake: standard (one to two weeks); urgent (one to three days); and emergency (immediate). Intake forms have been redesigned and appear to be more comprehensive than in the past. However, questions regarding sexual and physical abuse are not present in the new forms.

Community support services: As with a number of other programs at KVMHC, community support services is undergoing changes. They are considering a new structure whereby they would be adding staff (a program manager and several support workers), expanding the outreach component and providing more extended evening and weekend coverage. Case loads are approximately 17 - 20 clients per worker.

As with risk management and crisis services, however, community support is fragmented and lacks overall coordination. Four agencies provide these services to the same geographical area, sometimes to the same person. Neither clients nor staff were able to say why someone received services from one agency and not from another. At present there is a long waiting list for services, not just at KVMHC, but at all four agencies. This is extremely problematic:

1. People potentially are not receiving necessary and appropriate services.
2. Not providing community support services, places an undue burden on other parts of the system, most notably crisis management, emergency services, and psychiatric assessment and monitoring.
3. It severely limits the service system's ability to provide adequate, up-to-date, risk management
4. People may easily be "slipping through the cracks."

Several areas identified in which staff required additional training were: suicide prevention, trauma, treatment plan development, mental status formulation, and risk management. There appears to be little contact between community support and outpatient services, and between community support and substance abuse services. This leads to the question: how much clinical presence, back-up and sophistication exists within the community support program. Also, the communication between community support workers and the psychiatrist, seems undefined and irregular. There does not appear to be any systematic way by which community support workers and psychiatrists discuss cases.

Risk management: An improved risk management system, according to the executive team of KVMHC, remains a priority for the center. At the heart of the risk management program, to repeat what has been stated above, must be available psychiatry. In addition, staff could be clearer on what to do in crisis, or potential crisis, situations, i.e. which emergency team to access, how to secure a psychiatric assessment, what are the protocols to follow if someone is in crisis, etc. Also, for risk management to be successful, there must be adequate and sufficient communication. In an area with multiple agencies, this can be problematic, for information can almost never be shared fast enough. This is true, even though there are regularly scheduled coordinating meetings among the agencies to discuss high risk cases. (What this team was not able to ascertain -- due to time constraints -- was the effectiveness and thoroughness of this multi-agency meeting. Possible follow-up questions would include: do all the agencies attend [including the state crisis workers], how many cases are regularly reviewed, upon review of a case, how is accountability determined and monitored, what is the follow-up for cases reviewed, what is the level of clinical sophistication in the assessment of these high risk cases.) Finally, throughout the charting, there appeared to be a lack of good, helpful mental status examinations. For a number of charts, there was no mental status available, either at intake or at the 90 day summaries. A number of staff upon being interviewed did not appear to have a clear, structured way to assess high risk clients -- or what precisely to do once they were identified.

Child and family services: This program, which is actually a component of outpatient services treats primarily a non-psychotic, non-DMH population. It has a contract with DHS and does treat a good deal of children with histories of abuse and trauma. A child psychiatrist works with the program, although there is not nearly sufficient time. Over the last six months, the program has expanded from being clinic based into the community. Currently, they have a number of people working directly in the local schools and in some local health facilities. Although there is ostensibly no waiting list, in that everyone upon first contact receives an appointment date, a client can wait a fairly long time before he/she is first seen. A telephone triage is completed at first contact to determine if the caller is in an emergency situation or not. If so, he/she would be seen more immediately. KVMHC is attempting to shorten the wait time by providing referrals to other agencies or practitioners and by hiring additional staff. According to the director of this service, they cannot hire sufficiently fast enough.

Outpatient services: This program is designed to provide outpatient therapy services to adults in the Waterville and Augusta areas. Waiting lists average about three to four weeks. There is a strong focus on brief treatment and staff are considering moving from a specialist approach to a more generalist model. Currently, the program is undergoing an internal review with the attempt to improve the coordination of referrals, shorten the waiting list, review program development, and identify systemic issues. Outpatient services does not appear to be well integrated or coordinated with crisis and community support services.

Substance abuse services: In response to a perceived need, especially within the dually diagnosed population, KVMHC is in the process of developing a more comprehensive substance abuse program. They have three or four staff who are licensed and experienced in substance abuse counseling, one of whom also has an MSW. A day treatment program is being proposed and apparently will be ready to begin in the near future. The program will have three levels of intensity and will serve some individuals who have a dual diagnosis. The new intake form, developed for all new clients to KVMHC, has a section on substance abuse and according to the clinician interviewed, the number of referrals through this mechanism has been steadily increasing. In addition, at a weekly meeting in which clinical and CSP staff review all new cases, the question of substance abuse is continually raised. At the same time, according to staff, substance abuse treatment and prevention, needs to be more fully integrated within CSP programming and case management.

Special events/clinical incident review: KVMHC maintains a special events committee, with three levels of review (depending upon severity). This appears adequate. The center maintains records of special events, keeps some statistics regarding category of incident, and annually summarizes them in a report. Three special events reports were reviewed. In each case, the report was quite short and obviously just a quick summary of a larger discussion. There appeared to be adequate representation among the participants, e.g. medical director, clinical director, clinicians), but the reports themselves were virtually lacking in detail as to what might have led to the incident or what steps or intervention should be taken subsequent to the incident. For example in incident #040596, it states recommendations were made, but does not spell them out. Accordingly, it does not state what changes should be made to the treatment plan. Even though more detailed accounts may be within the peer review process, the treatment plan, with future recommendations, should be included in the incident review.

Policy and procedures manual: The policy and procedure manual seemed reasonably organized, coherent, useful, and complete. The section on coordination of services contained solid guidelines. The intake process appeared clear and the manual does contain a section on risk management. The medication guidelines appeared sufficient. There were provisions for no-shows. In particular, the guidelines for clozaril appeared comprehensive. Notably missing from the manual were sections on levels of care or criteria for admission or discharge, e.g. under what circumstances should a person be referred to individual, group or family therapy; or what are the level of care protocols for discharge from a particular program. In addition, it would be helpful if the guidelines including more timelines, i.e. what is the time period under which something must be completed.

Chart reviews: The team reviewed approximately twenty charts. For the most part, charts contained all the "proper" information: intakes, treatment plans, progress notes, 90 day summaries medication sheets, etc. An important exception, however, was the lack of a formal, complete mental status, especially at the 90 day review. Treatment and service plans contained multiple goals and objectives and were all updated on a quarterly basis. Progress notes contained content for each client record and each record contained recent updates of assessments. They had the necessary signatures and were consistent with the requirements.

The greatest area of concern was the extent to which the records reflected an ongoing assessment of the clients' status, without containing goals for, or evidence of, forward movement in clients' lives. With some exception, the great majority of goals related to symptom reduction, such as a decrease in depression or a general statement such as an increase in activities in the community to decrease social isolation. From a rehabilitative perspective, there was little in the records to indicate a direction toward a positive change in individual's lives outside of a general lessening of discomfort.

The records frequently recorded a limited amount of change. Goals for clients were frequently carried forward from quarter to quarter, sometimes for years with little change. This occurred largely due to the fact that goals tended to be ongoing symptomatic and life issues that were not detailed enough to be responsive to the limited changes achieved by the client. It is also due to the lack of goals that related to specific quality of life and rehabilitative issues such as employment, that are amenable to being broken out into specific steps that can be measured and regularly re-assessed.

Another major concern relates to progress notes. While they contained content pertaining to each client contact and were responsive to client crises, the progress notes were frequently a statement of how the client is doing at that point in time. There is often little or no indication of the work being done with the client or efforts of the client to achieve progress or change. Rather the notes are a type of "mini-assessment" and status report.

There is a sameness to the treatment plans. They are basic, complete, but unimaginative. Whereas they contain some important information, they do not really document change. In addition, they are not detailed enough. The plans do not list measurable, quantifiable goals and objectives. For example, a plan might say, "will work towards increasing activities in her life and add some structure." Instead, the plan should list some clear objectives about which activities she will add to her life and what specific steps she will take to achieve this goal. Another example: a treatment plan states, "will discuss the impact of current life changes on her mood." By itself, this is a questionable goal for it is not clear how discussing the impact will bring about any desired changes or what the changes are. Is the goal to discuss or is it to ameliorate a painful situation. It is not clear. The treatment plans need to better define the specific nature of the problem and, incrementally, what steps will be taken to resolve the stated problem. In addition, the progress notes, while up-to-date, did not often reflect back to the treatment plan.

Often, when charts demonstrate this form of sameness and static quality, they indicate a lack of consumer involvement in the development of the treatment plan. What does the individual *really* want, how does he/she see him/herself proceeding, what types of steps need to be undertaken to achieve any particular goal? Discussing impacts, monitoring medication, attending therapy are staff issues -- not usually the concerns of the clients. Treatment plans need to more accurately reflect the actual, real, and current, bio-psycho-social needs of the individual.

draft

CONCLUSIONS AND RECOMMENDATIONS

Many of the problems noted above are not "new" to the staff and executive management team at the Kennebec Valley Mental Health Center. To their credit, they began developing new approaches and systems 12 to 18 months ago. Some, like the medication clinic, the unified intake, and the increased emphasis on substance abuse treatment are just beginning. Over time, these should make a difference in the overall quality of care delivered by the agency. In addition to the those mentioned, the agency must immediately address problems of risk management and assessment.

Other issues appear "larger" than just this agency. For example, the need for an increased psychiatric presence is a state-wide problem (indeed it is problem in many rural and semi-rural areas throughout the entire country). Yet it is one that must be addressed if comprehensive crisis and outpatient services are to be delivered. Also, the problems posed by multiple agencies doing the same or similar work, e.g. case management and crisis intervention, go beyond KVMHC's individual capacity to solve.

Some of the issues raised are hardly unique to KVMHC. In mental health centers throughout the country, treatment plans, especially for clients who have long term problems, often have a static, non-changing quality, month after month, year after year. In no way should this serve as an excuse, or imply that treatment plans of this ilk are sufficient. They are not. KVMHC must provide the requisite supervision and training to staff, to make sure they can competently develop and implement meaningful treatment plans.

In addition, the following recommendations are offered:

1. Working in conjunction with DMHMRSAS and other community organizations, KVMHC must increase the amount of available psychiatric time. Psychiatrists must be more involved in the intake process, crisis intervention, and emergency services. Not to offer immediate psychiatric assessments, evaluations, and interventions to an individual in crisis, is provide less than adequate crisis services.
2. Working in conjunction with DMHMRSAS, the entire crisis management program must be re-defined. Presumably with the recently issued RFP for crisis services, some of the problems mentioned will be addressed. KVMHC's staff should become more familiar with techniques such as advanced directives. They must develop a far greater expertise in the development of crisis management plans. This is true, not only for the emergency staff, but for all workers.
3. Working in conjunction with DMHMRSAS, and other involved agencies, an improved system of case management, and community support must be developed. The current system is unwieldy and cumbersome. Structurally, it guarantees breakdowns in communication, prevents coordinated and integrated care, leads to fragmentation of treatment.
4. Working in conjunction with DMHMRSAS and other local agencies, KVMHC

must address the problem of waiting lists. No doubt this is a complicated issue, involving multiple agencies, reimbursement structures, and shortages of resources. Nevertheless, long waiting lists are unacceptable and must be dealt with in the near future.

5. A risk management program must be implemented immediately. Staff must know how to assess danger and what to do if someone is at risk. Most immediately, intakes, 90 day summaries, and other assessments must contain an adequate and useful mental status. The risk management program must include a system for tracking, so that staff is continually aware of the clients' mental status and bio/psycho/social condition.
6. Many of the clients spoken to stated their only source of medication education came through their pharmacy. This is not sufficient. KVMHC should develop and initiate a program whereby clients are regularly educated about their medications. Clients should be aware of what medications they are taking and at what dose. They should know what symptoms the medications are being prescribed for and what the medications are designed to do. Additionally, clients should be aware of any side effects, interactions with other medications (or foods, etc.) And finally, clients should know precisely what to do if they are experiencing side effects which are too extreme or uncomfortable.
7. As noted above, treatment planning must involve consumers more. The goals and objectives must be realizable and reflect real needs. There must be much greater specificity. If additional training is required, KVMHC should provide it.
8. The intake forms should include a section on trauma and physical and sexual abuse. Correspondingly, intake workers, and most likely all staff, need to become more aware of these issues -- how to ask the proper questions, what to do with the information, how to formulate and implement an appropriate treatment plan.
9. Staff consistently identified certain areas in which additional training is necessary: risk management, trauma, substance abuse, suicide prevention. KVMHC should provide this training as soon as possible. Training by itself, however, is not sufficient. These are issues and areas of concern that require continual, on-going, monitoring and supervision. This is especially true for the community support programs which often serve those at highest risk. Case managers must receive good clinical supervision. There must be a clinical presence in the provision of all services.
10. Substance abuse assessment and treatment should be more integrated into the community support programs and into the outpatient services. Training and on-going supervision is probably required in the area of dual diagnosis.
11. The policy and procedure manual should include sections on levels of care for all services. Specifically, the agency should maintain criteria for admission, continued stay, and discharge.
12. The clinical incident review should be fuller, more complete, and richer in detail. A review should contain, at a minimum: a description of the incident, the events leading up to the incident, relevant historical material (e.g. past behaviors of a

similar nature), the client's mental status at time of incident, treatment plan at time of incident (including medication), clinical intervention at time of incident, proposed interventions and treatment plan, and implications, if any, for agency policy or in working with other clients.

13. Immediately, KVMHC must develop a system by which clients' records are available, 24 hours a day, 7 days a week, to emergency service workers (including emergency room physicians and physicians on call). In Waterville, the buildings are literally across the street, so access to client charts should not pose any problem. Even for Augusta, only 25 - 30 minutes away, the distance is not prohibitive. For emergency services to treat the client without access to his/her most immediate history -- including current medication and medication history -- is inadequate treatment. It can lead to poor, uninformed decisions. Why keep up-to-date charts if they cannot be used in emergency situations?
14. The Department of Mental Health, Mental Retardation, and Substance Abuse Services should re-visit Kennebec Valley Mental Health Center in approximately six months to review their proposed program and administrative changes.
15. KVMHC has begun a QA/QI system, although it is in its early stages. This should receive strong support from the agency's administration. Included in this should be regularly scheduled client satisfaction surveys and measures.

To conclude, the Kennebec Valley Mental Health Center offers a full range of outpatient and crisis services. There is an awareness of some of the areas which need improvement and they have begun to develop strategies and programs to address these problems. Staff uniformly appeared excited about the changes and welcomed the new approaches. Staff were also quite candid about what they thought still needed to be done. As stated, they appeared open and non-defensive, willing to discuss new suggestions and alternative ways of programming. KVMHC has begun to make major changes. Yet, as this reports indicates, there is much more to be done.

OFFICE OF
THE GOVERNOR

NO. 10 FY 95/96
DATE May 20, 1996

AN ORDER CREATING THE MAINE TASK FORCE ON MENTAL HEALTH

WHEREAS, a comprehensive, effective community-based system of care for Maine citizens with serious mental illness is essential for the well-being of all the people of the State of Maine; and

WHEREAS, the development and operation of such a community-based mental health system will occur within parameters established by legislative policy, financial constraints and legal obligations; and

WHEREAS, in developing this system within these parameters and defining the appropriate role of state institutions within that system, it is desirable to involve participants with a wide variety of perspectives,

NOW, THEREFORE, I, Angus S. King, Jr., Governor of the State of Maine, do hereby establish the Maine Task Force on Mental Health.

Purpose

The Task Force's charge is to make recommendations on how best to serve the needs of Maine citizens with serious mental illness through the development of a community-based system of care.

To carry out the purpose of the Task Force, the members shall address the following goals:

- identify strategies to support the implementation of the mental health system plan developed during the past year;
- improve the interconnections between the judicial and correctional systems and community-based agencies;
- explore options for integrating consumers of mental health services into community settings;
- discuss the needs of stakeholders, including consumers, family members, providers and community members within the mental health system;

- define the appropriate role for state hospitals, and
- develop a plan to move from bridge to permanent funding for community systems of care

To carry out the purpose of the Task Force, the members shall use the best information from all sources and in a variety of forms including data and information about existing services throughout the state; expert input regarding state-of-the-art mental health systems throughout the country; existing financial and client profile data; as well as data and information developed by the Task Force.

Membership

The Task Force shall be composed of no more than 21 members drawn from mental health constituent groups and broader community interests. The role of all members is to serve and represent the best interests of the State as a whole.

The Speaker of the House and President of the Senate will appoint a member from the House and Senate respectively. All other members shall be appointed and serve at the pleasure of the Governor. The Task Force shall disband upon the discharge of its duties outlined below or October 1, 1996, whichever occurs earlier.

The Chair of the Task Force shall be designated by the Governor and the Commissioner of the Department of Mental Health and Mental Retardation.

Timeline for Recommendations

The Task Force shall make its recommendations to the Governor no later than October 1, 1996.

Meetings

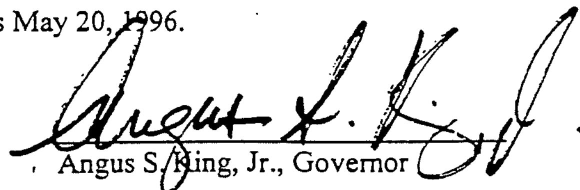
The Task Force shall meet as often as necessaryto complete the assigned duties. All meetings shall be open to the public and held in locations determined by the Task Force.

Staffing/Funding

The Department of Mental Health and Mental Retardation shall provide staff to the Task Force, within existing resources. Public members may be compensated for reasonable travel expenses by the Department of Mental Health and Mental Retardation upon demonstration of need.

Effective Date

The effective date of this Executive Order is May 20, 1996.



Angus S. King, Jr., Governor

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Governor's Task Force on Mental Health Recommendations

October 22, 1996

RECOMMENDATIONS
TASK FORCE ON MENTAL HEALTH

The Task Force on Mental Health has been charged with making recommendations on how best to serve the needs of all Maine citizens with serious mental illness through the development of a community-based system of care. Members were asked to serve and to represent the best interests of the state as a whole. The Task Force endorses the "Final Consolidated Plan for Implementing Settlement Agreement to the AMHI Consent Decree", submitted by DMHMRSAS on May 3, 1996 ("the Department's Plan"), as a template for providing mental health care to all who need the services. This Plan is a shift in the culture of mental health service delivery toward an integrated system driven by the needs of the consumers and their families, and stressing broad participation in decision-making, access, coordination, and accountability. As the Task Force developed its recommendations, all members focused on providing a continuum of care for people with mental illness: strong community support programs including crisis response, case management, single point of entry, outpatient services, rehabilitation and job training, housing and transportation as well as the availability of institutional care.

Our recommendations speak to the Governor's charge to: "make recommendations on how best to serve the needs of Maine citizens with mental illness through the development of a community-based system of care. To carry out the purpose of the Task Force, the members shall address the following goals:

- Identify strategies to support the implementation of the mental health system plan developed during the past year;
- Improve the interconnections between the judicial and correctional systems and community-based agencies;
- Explore options for integrating consumers of mental health services into community settings;
- Discuss the needs of stakeholders, including consumers, family members, providers and community members within the mental health system;
- Define the appropriate role for state hospitals; and
- Develop a plan to move from bridge to permanent funding for community system of care."

This report is organized into three sections: Community systems necessary to meet the needs of stakeholders, including children; interconnections with the judicial and correctional systems; and finance recommendations, including a plan to move from bridge to permanent

funding. A fourth section, which represents a minority report in variance from the majority of the Task Force members appears at the end of this report, before the "Appendix". The guiding principles which were used in developing recommendations serve as organizers for the first section of the report.

AN INTEGRATED COMMUNITY-BASED SYSTEM OF CARE

FOCUS The system must focus on the needs over the individual's life span, with the objective of fostering recovery and independence. Mental illness is often episodic, therefore, treatment and services must be provided on a timely basis and be flexible in number, duration and intensity.

- Priority must be given to establishing service parity across age groups - children, adolescents, adults, and the elderly.
- Treatment programs must be developed which recognize the long-term impact of trauma (emotional, physical, sexual, neglect) , and its relationship to mental illness.
- Treatment programs must be developed which recognize the long-term impact of substance abuse/addiction and its relationship to mental illness.
- A priority must be given to providing affordable access to psychiatric services in all parts of the state.
- Crisis services, tailored to each major age group, must be available throughout the state and available on a timely basis.
- Core services (single-point of entry, crisis services, case management, housing, psychosocial rehabilitation, outpatient services) must be available in all parts of the state and be able to be accessed within reasonable periods of time, according to service standards developed and monitored by the State.
- Individual evaluations must be comprehensive in nature and include, without limitation, psychiatric status, medical status, dental needs, immunization, spiritual condition, and living circumstances.

STATE ROLE The State of Maine has an historical and continuing responsibility for assuring that all individuals whose safety is in jeopardy or whose basic needs cannot be met, due to mental illness, have a system of services and supports which facilitate their recovery and independence, while assuring their civil rights.

Adults

- The State must provide care, in an appropriate facility, for two distinct adult populations:

1. the forensic population, committed to State care through order of the Court; and,

2. those people needing a safe place for rest and recovery, during limited periods of time when their needs cannot be met in a community setting (the "safety net population"). The majority of the Task Force agrees that given the physical plant limitations and the difficulty of converting the existing Augusta Mental Health Institute (AMHI) and Bangor Mental Health Institute (BMHI) facilities, a specific timetable must be established to close AMHI first and BMHI second, while simultaneously expanding community-based acute care beds and mental health services. AMHI should be closed no later than 10/1/97 and BMHI no later than 10/1/2000.

In order to implement the closure of AMHI and BMHI, the following steps must be taken.

A) Evaluate the need for crisis care beds by updating, by 2/1/97, the prior hospital studies (completed in 1992) analyzing the need for acute psychiatric inpatient care. Such an evaluation must be done on a regular basis to assure that the system continues to meet the needs of consumers.

B) Develop, by 7/1/97, a statewide network of community-based crisis services, including hospital and residential care beds as set forth in the Department's Plan.

C) Expand the appropriate range of accessible community-based services throughout the state by 7/1/97, as set forth in the Department's Plan.

D) Transfer all patients who are clinically determined not in need of hospital care to appropriate community settings by 7/1/97.

E) Close AMHI by 10/1/97 and serve the needs of the forensic and safety net populations by:

1. obtaining any necessary approvals to allow the transfer to BMHI, on an interim basis, patients and vital programs that cannot otherwise be served in the community; and/or,

2. providing long-term and acute care beds, run by DMHMRSAS, by leasing space in underutilized hospitals throughout the state.

F) Evaluate, by 7/1/97, the long-term options for serving the needs of the forensic and safety net populations. Such options include replacing the existing physical plants with one or more new or rehabilitated facilities located in the state, either operated or overseen by the Department.

1. By 7/1/97, develop a plan to fund and develop such facilities by 10/1/2000.

2. Close BMHI by 10/1/2000 and provide services in new facilities.

All consumers

- The State must actively promote a statewide system of residential long-term care.

- As elements of the State system, all providers (including both service providers and operators of acute care crisis facilities) must operate according the standards established, published and monitored by the State (including, for example, a system of best practices, a protocol for seclusion and restraint, and opportunities for access to the outdoors). Crisis facilities must adhere to an no-reject, no-eject policy. A grievance policy must be established and maintained, to ensure consistent service quality throughout the state.

- A two-tier system of care is unacceptable. Sufficient resources must be allocated to meet the needs of all people with mental illness, not just people included in the AMHI class. Such funds must be distributed equitably and effectively to all regions.

- The State must provide access to AMHI recreational facilities for Augusta-area mental health agencies and consumers.

Children

- The State must plan and develop a system of in-state facilities and services to serve the needs of children and adolescents. Treatment of seriously mentally ill children and adolescents outside of the state is not acceptable in a family- and community-centered continuum of care. In addition, existing services should be adequately funded.

PLANNING System planning at all levels must be a collaborative effort, engaging consumers, family members, parents of children, providers and the larger community.

- The Quality Improvement Councils (QICs) are a good model for fulfilling the goal of collaborative planning and ongoing quality review.

- The Regional Director will monitor the QICs to assure that all stakeholder interests are being adequately represented by the QICs, as intended by statute.

- Outreach and education are key elements of the role of the QICs and should be emphasized.

- The QICs must ensure that communication among contracting agencies and network elements is adequate and ongoing (e.g. establish a mailing list of contracting agencies and network elements, provide copies of agendas, minutes).

- Recognizing the importance of consumer and family input to the QICs, transportation to QIC meetings must be ensured for those wishing to attend.

Children

- Develop an immediate response approach to a situation by creating/enhancing family-centered in-home stabilization services and longer term family supports.

- Institute training and support to allow parents to become their child's case manager.

- Form public/private partnerships (including parents of children with special needs) to develop strategies ensuring broad coverage of community and family-based behavioral health services.

ACCESS Regardless of their legal or financial status, all persons needing services must have equal access as close to their home of choice as possible.

- Transportation must be recognized as an essential service and provided for in programs and budgets supported by the State.

- Core services must be provided in each region, including single point of entry, crisis stabilization services, community-based crisis beds, access to a State facility as a safety net, case management, medication management, and rehabilitation services (including consumer organizations, vocational training). These services must be structured and delivered in a manner appropriate to each region, recognizing that needs and service capacity differ in each region. Money should be allocated to each region to support demonstration programs.

- Ability to pay and/or legal status must not be the sole factor is providing service delivery.

Children

- Create a gateway to services that eliminates the need to fill out volumes of forms for every service provider, and assures timely access to necessary services. The use of a Management Information System and comprehensive intake procedures in the Local Service Networks provide an arena for this process.

- Increase access and availability of case management or service coordination for families that cannot be their own case managers.

- Institute a policy of inclusion. The ultimate decision regarding whether a child and family receive help must be determined by the issues they present, not by a predefined category for labels and services. Available funding must support the service decision, not drive it.

- Establish, by Executive Order, a policy declaring that no child shall be removed from the custody of his or her parents in order to get needed services.

CHOICE The individual consumer, in collaboration with his or her individually-selected team (which may include family, friends, clinicians), must be responsible for the development and ongoing evaluation of the treatment and recovery plan.

- Advance directives (statement of beliefs, medication choice, designated advocate, choice of service provider and location, terminal illness plan) must be aggressively encouraged as an integral part of the individual service plan. Copies of advance directives must be maintained with the case manager, psychiatrist, and client-designated treatment team leader.

- Information about the range of service and treatment options (e.g. medical options, support groups) must be made available so informed choices can be made by the individual.

RECOVERY Because of the shame attached to mental illness, consumers experience an acute loss of the sense of self and dignity. Therefore, an adequate range of opportunities for meaningful activity and personal growth must be an integral part of each individual's treatment and recovery plan and must be available throughout the state.

- As a priority, the State must significantly increase the financial support provided for rehabilitation programs and supports. Currently only approximately 5% of the State's mental health expenditures are spent on recovery. Additional investment would improve an individual's chance of becoming independent and avoiding further State expenditure for acute care.

- As an integral part of increased State support for the recovery process, active outreach efforts must be made to educate the business community and seek commitments for job opportunities for those individuals seeking independence.

- The State should create a transitional funding program to provide incentives and support for people who would otherwise lose their benefits due to earned income.

EFFECTIVE The system at all levels must be adequately funded, well-managed, and responsive in order to be effective.

- Since the State spends a significant amount of money on the mental health system, it is essential that data be developed in order to determine the extent of the population to be served, the needs to be met, and system improvements needed. An analysis must be conducted annually to measure the effectiveness of the investment made. Effectiveness of all programs, including demonstration grants, must be measured in terms of client outcomes (e.g. reduced homelessness of people with mental illness, improved quality of life, increased income).

- The State must define standards and establish a system for training mental health workers to assure that adequate skills are available throughout the community service network. Such training should be interactive and should include consumers in all levels of training.

- The State, along with all service providers, should assure the quality and consistency of mental health services available in the community network by increasing the wage levels of programs supported by State resources, with the specific objective of reducing the turnover of community case workers and crisis workers.

- While it is important to assure that consumers have a choice of service providers, it is also important to control duplication of services in order to minimize the administrative cost of duplicative services, which drains dollars from direct services.

- The State must reexamine its own administrative structure to provide for greatest efficiency.

- Effective management of the system must not overshadow the importance of consumer choice and collaboration among providers.

- The system exists to serve the needs of consumers, and standards for response must be defined for each service and monitored by the State for compliance.

- The State must determine a measure to establish that the system is adequately funded.

Children

- Provide for a more equitable distribution of workloads among case managers.

CONFIDENTIALITY **The individual's treatment record and choice to use services provided by the system is a private matter and confidentiality must be assured at all levels.**

- As the State develops and improves its management information system, it is essential that consumer confidentiality be assured at all levels. While patient information may be included in analysis of the system (e.g. the number of patients with mental illness who received rehabilitation services and were placed in jobs at a certain wage level), individual names and client-identifying information are not necessary and must not be identified in the analysis developed.

LIVING CHOICE **Every individual has the right to live and heal, without prejudice, in the community of his/her choice anywhere in the state.**

- Funds to develop and support community living options are limited at all levels of government. Proactive efforts must be made to reexamine the cost elements of providing

such housing, with aggressive efforts and new strategies employed to reduce costs when funds could be better allocated to serve more people (e.g. reexamining building requirements).

- The State must develop a plan for assuring a range of community living options throughout the state and avoid concentrations of housing in individual communities or neighborhoods.

- Every consumer discharged from any facility must be placed in decent, safe and affordable housing. The State must develop a housing voucher program to assure that individuals are able to live in stable environments as they heal and move toward independence.

INTERCONNECTIONS BETWEEN THE JUDICIAL, CORRECTIONAL, and MENTAL HEALTH SYSTEMS

Testimony provide by Chief Justice Wathen, Judge Courtland Perry, Commissioner Joseph Lehman, and law enforcement officials Richard Mears and Peggy Kelly formed the basis for the following recommendations.

- The State shall enforce Public Law 431, which states that "a person with serious mental illness may not be detained or confined solely because of that mental illness in any jail, prison, or other detention or correctional facility unless that person in being detained or serving a sentence for commission of a crime." Included in P.L. 431 are strategies for preventing imprisonment of persons with serious mental illness in addition to cooperative planning procedures and planning provisions.

- The Department of Mental Health shall develop policies and procedures to meet the treatment needs of persons who have serious mental illness and are incarcerated in local and state correctional and juvenile facilities. The Legislature shall allocate resources necessary to implement such policies and procedures.

- DMHMRSAS shall work with the criminal system to develop policies, procedures, and resources to ensure cross-system training regarding mental illness and substance abuse among criminal justice, police, mental health and other agency personnel, (i.e. hospital emergency room staff, homeless shelter workers, and crisis intervention staff).

- DMHMRSAS will ensure that judges have prompt access to professional expertise in mental health and substance abuse issues in order to have appropriate information to use in the dispositions of cases.

- Funding shall be provided to ensure that pretrial evaluations of criminal defendants and presentence information and recommendations will be provided to the court system when appropriate.

- DMHMRSAS will assure that each QIC has at least one representative with knowledge of the criminal justice system in its membership.

- DMHMRSAS will streamline regulation of private mental health providers to the greatest extent possible.

FINANCE AND BRIDGE FUNDING

- DMHMRSAS must be made the "lead" agency for decisions related to the financing of mental health, mental retardation, and substance abuse services for both adults and children. Furthermore, Medicaid resources to pay for these services, including "seed" money, should be transferred to the control of DMHMRSAS.

- Develop incentives for businesses to provide all employees with health insurance.

Children

- Develop reimbursement strategies to support the use of technology for providing professional consultation in rural areas.

- Develop recommendations regarding costs and funding for increased children's services.

- Increase allocations to children's services as a commitment to prevention that will ease the pressure on the adult system in the future.

- Dedicate new allocations to increasing community supports for children and their families.

- Create flexible funding to address the needs of children. Encourage and expand existing local case review committees as natural forums for making these decisions with families.

- Replace the current practice of contracting for prepackaged services with a family-centered system of care in which specific services are purchased from the widest possible range of vendors to meet particular needs of individuals and families.

- Reduce Medicaid dependence by ensuring payments by private insurance carriers for all services which are reimbursable through Medicaid.

- Create a standard reimbursement form for all services. Payment should be made by one entity in each Local Service Network, simplifying the process, ensuring prompt payment for services and providing local accountability.

- Ensure that pooled state funds are available cross-departmentally and make the use of funds sufficiently flexible to address the needs of children whose needs are not the sole jurisdiction of one state agency, or whose needs are otherwise not being appropriately addressed through usual state government procedures.

Bridge Funding

- The State must have a long-term philosophical and financial commitment to improving the mental health system while concurrently maintaining the existing system.

- The State must plan for the capital investment of developing one or more State-supported facilities to replace AMHI and BMHI.

- Any savings from downsizing or closing AMHI and BMHI must stay in the mental health system and not be recaptured to the State's General Fund and reallocated.

- The Task Force has not established that the resources available ($17.9 million available now and which will recur in the next biennium and an additional $6.9 million available now and which will not recur) are adequate to fund a statewide system of community-based services. The community services as identified and prioritized in the Plan which will most effectively reduce hospitalization at AMHI and BMHI, as well as in community-based hospitals, must be identified, prioritized, funded and implemented as soon as possible. Additional resources must be requested from the Legislature if necessary since transfer of patients from hospital to community-based services will not result in federal disproportionate share hospital payments but may, for Medicaid-eligible clients, be covered by Title XIX Medicaid reimbursement.

IS THE MENTAL HEALTH OF MAINE CITIZENS OUR HIGHEST PRIORITY?

MINORITY REPORT
THE GOVERNOR'S MENTAL HEALTH TASK FORCE

Honorable Beverly Bustin-Hatheway, A.F.S.C.M.E.
Mary Anne Turowski, M.S.E.A.-S.E.I.U., Local 1989

A State "Mental health system must provide assistance in a brief crisis; periodically or over a lifetime, depending on the individual consumers need [i].

The Majority report fails to adequately address the needs of clients who need hospitalization at critical points in their lives.

Maine's two state mental health institutions, AMHI established in 1840 and BMHI in 1901, provide in-patient and outpatient services to over 2000 consumers per year. These services include acute and long term inpatient psychiatric care, out-patient psychiatric and medical assessments and evaluation; day hospital programs; administration and dispensing of prescription drugs and the attendant medical supervision that is most often required (particularly important for the uninsured), crisis intervention, and referral services for clients and community providers. ***These services, as configured, are not replicated in the community. There is no assurance that services equal or better than those now provided at the state's institutions will exist in the communities at any reasonable date certain.***

DMHMRSAS'S May 3rd 1996 AMHI Consent Decree Implementation Plan proposes development of 14 additional short-term crisis beds statewide and 38 total community hospital-based acute involuntary beds in the AMHI catchment area. It is speculative, at best, to presume that these community-based services proposed by DMHMRSAS will be in place and viable by the proposed AMHI closure date of 10/01/97. ***The other presumption the report makes is that the development of these community-based services will diminish and/or replace the need for the types of services being provided by the two state hospitals. Without substantiating the viability and the actual impact of the loss of these services it is premature to propose closure of either facility as a means to an end.***

We believe that the demand for beds at AMHI/BMHI must be depressed for a minimum of six months and be correlated with the development of new and/or additional services in the community prior to any savings transferred for other uses. The Court must be convinced needed expansion of community-based services has occurred and has resulted in reduced demand at AMHI and BMHI.

No one knows the quality or the quantity of services presently available in Maine. Consequently a precipitous event such as the proposed closing of state institutions could have not only disastrous consequences on the ability of the community system to provide appropriate services to those who will need them but will also, as recent experience has shown, increase the likelihood of tragic consequences that otherwise would have been avoided.

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Maine's State hospitals are treatment facilities, not residential facilities.

A presumption in the Majority report is the notion that state hospitals simply provide a residence for persons with mental illness. The Majority mistakenly concludes that once community services are on-line the inpatient population at AMHI can be discharged and AMHI closed. In fiscal year 1995, AMHI had 388 admissions, and BMHI had 300 admissions[ii], belying the presumption of a static, residential population with non-reoccurring episodes of mental illness. The majority of people who are treated at both hospitals have "placements" just like most Mainers: they live in apartments and homes, with family and friends, or already reside in group homes or supported living arrangements. Another segment of this population inhabit homeless shelters, correctional facilities and the streets, in part because of the lack of community supports and services. ***But it is also the episodic nature of certain mental illnesses, compounded by substance abuse, resistance to medical and psychiatric treatment, and other factors, that often complicates and inhibits effective and successful treatment. It is this same characteristic that can defy community treatment, pharmacological advancements and short-term hospitalizations, resulting in a need for treatment facilities like AMHI and BMHI.***

These hospitals actively treat patients with serious mental illness. These individuals require the most resources of any patient group about l/2 of whom will take longer than thirty days to recover to the point of safe discharge. Research currently being done in this area indicates that patients in state hospitals are significantly more ill than patients in the second level of care at community hospitals. The AMHI patient mix is about 50% acute and 50% chronic. BMHI serves an inpatient population that is approximately 25% acute and 75% chronic.

AMHI serves a population base of about 800,000 people. The AMHI admission rate, until last year, was double that of BMHI. The demand for acute care services provided at AMHI is more than double it's northern counterpart . As of 10/25/96, there is a waiting list of fourteen people from a single southern Maine facility awaiting admission to AMHI. This admission demand emphasizes the ongoing need for continuing a quality inpatient mental health service for two-thirds of the state's population until such time there are viable alternatives.

At least a quarter of the people admitted to state hospitals are unpredictable to the point of dangerousness to themselves or others. They need intensive psychiatric care. People are admitted In all cases at AMHI and to a lesser extent at BMHI, when all other less restrictive community treatment interventions have either failed or are insufficient to properly care for these persons.

There are three major populations of mental health consumers for whom State facilities may be the most appropriate providers of care:

1. Forensic--for persons adjudicated as not criminally responsible for crimes committed while mentally ill.

2. Acute voluntary and involuntary patients, for whom community hospitals and crisis beds are inappropriate placements.

3. Long-term acute voluntary and involuntary patients. Community hospitals and crisis beds are designed for short-term acute care of thirty days or less and for rapid reentry to less restrictive community settings. Consumers who need a safe and secure place for recovery and treatment and who may require stays longer than thirty days are members of this population.

The safety net role played by State Government in the delivery of these services is crucial in determining the entire landscape of mental health services in Maine. The removal of AMHI and BMHI from the array of available services will seriously compromise the continuum of care in our State.

It is critical to underscore the importance of state-operated facilities as an alternative to the private sector. Publicly funded services delivered by the private sector within the parameters of billable Medicaid hours, profit margins, or hospitalization determined by insurance policies is not always the most effective way to treat mental illness. Though the public sector should be cognizant of costs, it has the ability to allow treatment of those individuals who need recovery within an environment not driven by the bottom line.

"Although alternative treatment settings allow diversion of many types of patients from state hospitals, expanded community-based services and alternative inpatient beds have not diverted some patient subgroups, including recidivists and patients with behaviors that present risks in other settings. Plans for meeting the clinical needs and behavioral challenges posed by such patients must be part of any further deinstitutionalization or privatization efforts." (Psychiatric Services 47:255-262.1996)

Maine must envision a continuum of mental health care that offers an array of services to consumers and includes in that array state facilities as a choice for consumers.

Mentally ill Maine citizens deserve to be treated as close to their home communities as possible with full access to respectful high quality acute psychiatric care.

Having two state hospitals is a necessity, not a luxury. Maine is the most rural of the New England states and has more land area than all of the others combined. When it was realized that a large number of patients at AMHI were from the northern part of Maine, BMHI was established. The policy makers at that time recognized the therapeutic value of patients being treated as close to their homes as was possible. It is difficult to believe that the philosophical resolve and financial resources in 1901 was somehow greater than today.

An article that appeared in the New England Journal of Medicine[iii] suggests that a state must provide 15 involuntary psychiatric beds per 100,000 population if adequate community services are available. If adequate community services are not available than the state must provide for 31 beds per l00,000. That means that Maine should be supplying 390 involuntary beds, including the forensic population. Only 2 states have less beds than recommended - Vermont which has slightly less and Puerto Rico which has 7 per l00,000 but despite a remarkably supportive family structure, has not been able to close its state hospital. Maine is now approaching 13 beds per l00,000 as it closes the social learning unit at AMHI. No State has closed its last functional state hospital with the exception of Rhode Island, which merged its state hospital with a general hospital funded by the state and continues to deliver the service.

Research currently under peer review and submitted for publication shows a need for a minimum of 100 involuntary beds and a maximum of 175 for AMHI's catchment area. The department is currently only attempting to set up 38 beds. Before AMHI is allowed to reduce or eliminate their services to this population, we must make sure these l00 beds are available in the community.

The Majority report conflicts with the A.M.H.I. consent decree in at least three important areas. The consent decree requires that:

I. Clients be served in their catchment area. To transfer AMHI patients to BMHI should AMHI close is a "subterfuge" as AMHI Consent Decree Courtmaster Rodman has suggested, and flies in the face of a consent decree that establishes community-based treatment as a baseline;

1.1 Transport to BMHI from AMHI catchment area is more costly in time and money so that patients will not seek treatment. The consequences of not seeking treatment because of these barriers necessarily means people becoming more ill before seeking treatment. Consequently the recovery is longer.

2. Adequate community services must be available in the community before discharge to that community. Success of community-based services, in part, can be measured by a decline in admissions at either State hospital;

3. Funding must be available in the catchment area for the full range of services including essential hospital services whether by community hospitals or state hospitals. Before closing of either state institution we must first determine it's impact on the community mental health system. A premature closing removes this specialized hospital care from the full range of services that may later prove to be sorely needed but not available.

RECOMMENDATIONS;

It is critical to remember that it was the poor condition of the entire Maine mental health system that caused events to occur which lead to the AMHI Consent Decree. As Maine citizens we have witnessed all too often the consequences of allocating resources that were too little too late. The consequence of this omission has resulted in tragedies occurring yearly in our communities, spanning one administration to another, irrespective of political affiliations.

Downsizing should only occur consistent with a measurable and incremental reduction in the need and demand or utilization for the services provided by these facilities. We further suggest that this data be evaluated at specific intervals, and downsizing occur predictably as demand milestones are evaluated and achieved. Empty beds are a clear indicator that hospital services are no longer necessary, and downsizing is appropriate at that time.

Those services must be designed to reduce the demand for hospitalization while ensuring high quality care. Therefore, the State must have a long-term philosophical and financial commitment to improving the mental health system while concurrently maintaining the existing system. Additional moneys allocated by the Legislature (17.9 million) and a reinvestment account established by statute are positive steps in funding a comprehensive community-based mental health system.

This administration has an opportunity to create a fully responsive system of mental health, one that reflects and addresses the needs of Maine's mentally ill. This system should be:

of measurable high quality;

appropriate to meet the needs of Maine's citizens;

dynamic in its operation so as to be able to change as individual needs and/or regional circumstances shift;

operated upon a sound economic basis, relatively free of the deleterious influence of the change and chances of politics.

We firmly believe the implementation of the following recommendations will resolve most if not all of the fundamental weaknesses that have undermined nearly all previous planning efforts.

1. Initiate a full and objective mental health systems analysis rigorous enough to withstand scrutiny of people with opposite view points, free of obvious conflicts of interest and that guarantees "disinterested results".

1.1 Analyze the prevalence and incidence of different types of mental health and related problems, by Mental Health Region (MHR).

1.2 Examine the service need implications of the problems, in terms of types and quantities of service required by each MHR.

1.3 Identify the service gaps-the types and amounts of services consumers are currently receiving compared to what they need and ideally should be receiving.

1.4 Analyze the ways in which problems and service needs are distributed across the different populations of people.

1.5 Determine the budgetary and other resource implications of closing the gaps.

2. Define the consumers, what services do they need, and what services does the Mental Health Region (MHR) offer them?

2.1 Collect demographic information by MHR of age, race, sex, education, income level, and the severity and nature of the mental disorder.

2.2 Determine the services that specific consumers need. Conduct a "pattem-of-use" study. Compare who uses which services with who needs the services to determine the availability and accessibility of those services.

3. A detailed profile of public and private providers must be compiled in each MHR.

3.1 Assemble data on the percentage of staff focusing on inpatient, outpatient, residential, education, prevention, and individual consultation/therapy; the numbers and types of clinicians providing which services; and the mix of private versus public vendors.

3.2 Collect data on staff-patient ratios, staff turnover, and service consistency can provide valuable information on how efficiently a program is operating.

4. A comprehensive analysis and listing of funding sources must be completed.

Knowing the answer to this question will allow the DMHMRSAS and legislators to determine strategies to change the mix of revenues or to target certain sources to maximize the revenues.

4.1 For each agency identified in number three, above, determine the percentage of their budgets derived from state, federal, or local municipal allocations, grants, third-party insurers, client payment, or federal reimbursements.

5. Determine by MHR, what happens to the consumer as a result of the service?

It does not matter how inexpensive or well-run a program is if it does not have any effect on the consumer.

5.1 Client outcome and satisfaction with services- Determine each consumers ability to get along in daily life by determining their abilities to: buy groceries, write a check or use an ATM machine, ask for help, use a phone and public transportation, take medications (where appropriate) achieve the level of social skills necessary to make friends and get along with others. Determine the presense /degree of psychiatric symptoms if any.

6. Conduct a detailed cost analysis of the full range of services in each MHR.

If costs can't be measured they can't be managed.

The legislature must have an idea of the money required to accomplish a goal if they (we) are to make responsible decisions.

6.1 Compute the cost per unit of service for each agency by MHR.

6.2 Determine the cost per episode and cost per outcome.

6.3 Compare the cost of services delivered in a variety of settings and agencies to find the most effective and efficient methods of service delivery.

CONCLUSIONS

By proposing the closures of AMHI and BMHI, the State is abandoning its role as the only source of long term inpatient psychiatric care that is provided regardless of the ability to pay Precipitously closing the two institutions at a date certain does not keep faith with the needs of persons with mental illness.

State Government is in a period of change where all state agencies are required to put all programs under the discipline of strategic planning and performance budgeting. The recommendations in this report include; a determination of consumer needs across the State; a fact based comparison of performance measures; a comprehensive cost analysis and detailed profiles of available and needed services. Only after examining this quality information will we be able to build a comprehensive mental health system for Maine. This fundamental information so necessary for strategic short and long term mental health planning has been sadly absent up to this time.

"Those who cannot remember the past are condemned to repeat it... George Santayana"

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[i] Mental Health Financing and Programming- National Conference of State Legislatures
[ii] AMHI and BMHI Admissions and Census - Historical Data-Maine Department of Mental Health
[iii] New England Journal of Medicine, Guderman-1984.

APPENDIX

OFFICE OF
THE GOVERNOR

NO. 10 FY 95/96

DATE May 20, 1996

AN ORDER CREATING THE MAINE TASK FORCE ON MENTAL HEALTH

WHEREAS, a comprehensive, effective community-based system of care for Maine citizens with serious mental illness is essential for the well-being of all the people of the State of Maine; and

WHEREAS, the development and operation of such a community-based mental health system will occur within parameters established by legislative policy, financial constraints and legal obligations; and

WHEREAS, in developing this system within these parameters and defining the appropriate role of state institutions within that system, it is desirable to involve participants with a wide variety of perspectives,

NOW, THEREFORE, I, Angus S. King, Jr., Governor of the State of Maine, do hereby establish the Maine Task Force on Mental Health.

<u>Purpose</u>

The Task Force's charge is to make recommendations on how best to serve the needs of Maine citizens with serious mental illness through the development of a community-based system of care.

To carry out the purpose of the Task Force, the members shall address the following goals:

- identify strategies to support the implementation of the mental health system plan developed during the past year;
- improve the interconnections between the judicial and correctional systems and community-based agencies;
- explore options for integrating consumers of mental health services into community settings;
- discuss the needs of stakeholders, including consumers, family members, providers and community members within the mental health system;

- define the appropriate role for state hospitals, and

- develop a plan to move from bridge to permanent funding for community systems of care

To carry out the purpose of the Task Force, the members shall use the best information from all sources and in a variety of forms including data and information about existing services throughout the state; expert input regarding state-of-the-art mental health systems throughout the country; existing financial and client profile data; as well as data and information developed by the Task Force.

Membership

The Task Force shall be composed of no more than 21 members drawn from mental health constituent groups and broader community interests. The role of all members is to serve and represent the best interests of the State as a whole.

The Speaker of the House and President of the Senate will appoint a member from the House and Senate respectively. All other members shall be appointed and serve at the pleasure of the Governor. The Task Force shall disband upon the discharge of its duties outlined below or October 1, 1996, whichever occurs earlier.

The Chair of the Task Force shall be designated by the Governor and the Commissioner of the Department of Mental Health and Mental Retardation.

Timeline for Recommendations

The Task Force shall make its recommendations to the Governor no later than October 1, 1996.

Meetings

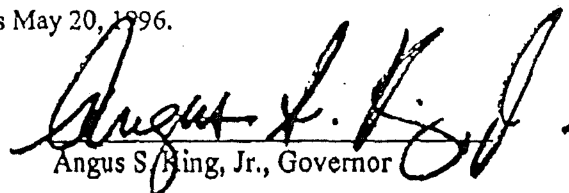
The Task Force shall meet as often as necessaryto complete the assigned duties.. All meetings shall be open to the public and held in locations determined by the Task Force.

Staffing/Funding

The Department of Mental Health and Mental Retardation shall provide staff to the Task Force, within existing resources. Public members may be compensated for reasonable travel expenses by the Department of Mental Health and Mental Retardation upon demonstration of need.

Effective Date

The effective date of this Executive Order is May 20, 1996.



Angus S. King, Jr., Governor

MAINE TASK FORCE ON MENTAL HEALTH

Jane Holt deFrees, CHAIR

Senator Chuck Begley

Beverly Bustin
American Federation State, County, Municipal Employees

William L. Caron, Jr.*
Public Member

Mary Anne Chalila
Maine Municipal Association

Debbie Dembski
Consumer of Oxford Hills for Resources and Education

Zahira DuVall
Coalition for the Psychiatrically Labeled

Representative David Etnier**

Pat Hunt
United Families for Children's Mental Health, Inc.

Susan Joyce
Consumer

Dennis King
Public Member

Grace Leonard
Mental Health Advisory Board

John D. McElwee, Esq.
Public Member

Edward McGeachey, III
Maine Hospital Association

Janet E. Ordway, M.D.
Maine Psychiatric Association

Carl Pendleton**
Sweetser Children's Services

Anne B. Pringle
Public Member

Joel N. Rekas*
Maine Coalition for the Homeless

Judith L. Regina
Maine Sheriff's Association

Mary Anne Turowski
Maine State Employees Association

Mal Wilson
Alliance for the Mentally Ill of Me

* William Caron and Joel Rekas were unable to fully participate in the process due to personal circumstances

**Representative Kyle Jones was replaced by Representative Etnier. Lynn Duby was replaced by Carl Pendleton.

INTERCONNECTIONS AMONG THE JUDICIAL, CRIMINAL JUSTICE AND MENTAL HEALTH SYSTEMS

The interconnections subcommittee convened several times during the summer months to meet with representatives from the judicial and correctional systems. Chief Justice Wathen, Judge Courtland Perry, Commissioner Joseph Lehman, and law enforcement officials Richard Mears and Peggy Kelly provided excellent testimony.

While approximately 6-8% of persons with mental illness are incarcerated in jails throughout the state of Maine, Kennebec County has sustained a 10% rate. The 6-8% figure is reported nationally. The following points of contact between criminal justice and mental health systems yield particular issues that should soon be addressed.

INITIAL CONTACT

Issues:

- Many of the mentally ill individuals with whom the police come into contact are not accepted at any placement other than the jail. They are often rejected by specific facilities or programs as: too dangerous, not sick enough, too sick, suffering from drug/alcohol addiction, or failing to meet specified treatment criteria. As such, real alternatives for diversion may not exist or be perceived as inaccessible.

- Despite research data to the contrary, there is a general public perception that most mentally ill persons are violent and dangerous. The police officer may share the public's misperception, or be influenced by the public's fear.

- Dispositions for persons with mental illness may be a low priority to the police. Oftentimes seriously mentally ill people are inappropriately channeled by the police into the criminal justice system.

Recommendations:

- Have a 24-hour referral/evaluation/diversion (R.E.D.) program available to the police.

- Utilize special teams (e.g., specially trained civilian personnel or specially trained police personnel) to respond to calls regarding mentally ill persons in the community.

- Since the mentally ill may be denied treatment due to the hardship imposed on the police in transporting these individuals to the mental health providers, it is recommended that mutual agreements for the transport of mentally ill persons be worked out between local agencies, including: the police, hospitals, crisis centers, parents, and mental health providers.

- Since co-morbidity of the mentally ill offender is an increasing problem, it is recommended that treatment facilities should not refuse a referral because of the comorbidity of the referred person.

- Police officers should be trained to enhance their recognition and identification of the seriously mentally ill. Training should assist the police officers in:

  - differentiating between mental and physical illness
  - being aware of available resources for this population, and
  - identifying co-occurring alcohol/drug/mental health disorders.

INTAKE INTO CORRECTIONS

Issue

- Those admitted to jails or prisons often may not receive adequate or timely screening for mental health needs, and those who are in need of services are rarely diverted into appropriate mental health or substance abuse facilities or programs.

Recommendations:

- Individuals admitted into a jail will receive professional and timely mental health screening, preferably within four hours, but no longer than within a twenty-four-hour period.

- Families should be involved in screening as soon as possible in order to assume that the fullest range of relevant information is available.

- Specific laws and procedures need to be reviewed to determine which **confidentiality protections** promote the well-being of persons in the criminal justice system, and which ones inhibit needed services. Available need to know data should be retrievable both within and across service systems.

- All jails should have access to immediate detoxification, substance abuse, and mental health services when needed. Incentives need to be developed and be available for inter-agency collaboration for serving clients with multiple needs. Medicaid costs get cut off for pretrial and other brief incarcerations. There should be financial incentives for community mental health centers to provide mental health services (including screening) to local jails. Funding sources to jails should consider mental health services equivalent to other medical services in regard to reimbursement for those services.

- Cross-training and/or orientation programs need to be offered for mental health and criminal justice professionals.

CORRECTIONS SERVICES

Issues

- Although mental health services to persons with mental illness who are incarcerated are legally mandated, the delivery of these treatment services is inconsistent and, as such, persons with mental illness may be at risk of substantial physical and/or psychological harm. Inmates are subject to decompensation and resultant

psychiatric crisis as a result of the extremely stressful environment inherent in correctional facilities.

- Failure to document and communicate crisis information and responses increases the likelihood that the inmate who has mental illness will harm himself or others after shifts change. Crisis workers will respond to jails and collaborate with jail personnel about crisis management.

- Many persons with mental illness are also alcohol or substance abusers. Individuals experiencing co-morbidity frequently are only treated for one of these two very serious problems, whereas successful intervention requires help for both concerns.

Recommendations

- Corrections has an obligation to provide housing options which will protect inmates assessed, on a case-by-case basis, to be at risk of physical or psychological harm by providing:

  - observation
  - support
  - protection
  - centralized mental health services

- Crisis intervention needs to be immediately accessible 24 hours a day.

- All crisis intervention activities need to be documented in writing and communicated across shifts.

- Jails should create mental health service responds utilizing current community mental health resources. These professionals should spend adequate time in the jail and should provide linkage for inmates with mental illness through community based providers.

- Drug and alcohol services should be integrated with mental health services to those individuals with comorbidity.

- Special populations (i.e., deaf, developmentally disabled, and cultural and ethnic minorities) should receive services appropriate to their needs. These services should accommodate for barriers to treatment such as, but not limited to, language differences, sensory impairments, and/or cultural differences.

- Correctional officers need to be trained to:

  - identify signs of emotional disturbance
  - access the appropriate resources available
  - inform clinicians in a behaviorally specific manner about what led the officer to suspect mental illness

COMMUNITY LINKAGES

Issues

- Between 42 and 58% of people who have mental illness have been arrested at least once. The large majority of inmates identified in correctional facilities as having mental illness are released with no formal plans or arrangements for community mental health services. Due to the large number of people regularly entering and leaving the jail, **jail release procedures tend to be chaotic.**

- There is no advocate for the offender with mental illness who makes certain that he/she receives essential services upon release. In addition, **no one is responsible or accountable for the continuity of mental health services** between the community and correctional facilities.

Recommendations

- **The rights of the mentally ill should be expanded to include the need for continuity of care** by expanding the definition of the treatment system to include law enforcement, probation, courts and correctional facilities.

- Correction facilities should be held accountable for developing collaborative relationships with community based mental health services.

- **Any release plan** should be reviewed and agreed upon with the offender, the family, when appropriate, the defense attorney, probation, the court, and involved mental health services.

- The release/transfer plan should be developed by the offender, mental health and criminal justice staff, to include:

  - appointments with community mental health providers
  - prescriptions and/or medications
  - family involvement
  - housing arrangements
  - transportation
  - entitlement plans

Those advocating for mental health services for offenders with mental illness who are in jail should make presentations at conferences for county officials, judges, professional organizations, and civic groups, and seek support for holding statewide conferences focused on meeting the needs of this population.

Academic institutions should develop a curriculum to train individuals to possess the professional skills to work with persons with mental illness within the jail settings.

Maine Task Force for Mental Health

Findings & Recommendations
Regarding

Services For Children

October, 1996

BACKGROUND

For over a decade Maine has developed the framework for a state-of the-art system of care coupled with the development of a broad array of services. While the system was created in response to their needs, it is not consistently available for far too many Maine families. Due to a variety of administrative and statutory limitations, the system lacks the ability to reach its maximum potential for providing quality services for children and families. A fundamental change in policy is needed.

The following findings and recommendations are based on testimony and other input from parents of children with emotional, behavioral, mental health and/or developmental issues, as well as others who work in a child serving capacity (mental health professionals, law enforcement, education, clergy, and representatives of the community-at-large.) These findings are strongly reinforced by the following publications: *Commission on Children who are in Need of Supervision* (Report to the 114th Legislature, March 1989); *Violence Among Children, Adolescents and Young Adults in Maine - Parts I and II* (1994); *Focus Group Results: Parents of Children With Special Needs* (DeSisto,1995); *United Families' Report to the 117th Legislature* (1996.) *Task Force on Adolescent Suicide* (Report, 1996); and Legislatively Mandated Children's Service Plans (1986-1996)

STATEMENT OF POLICY
****

The strength, core and central focus for Maine's system of family and children's services must be family centered. Child and family "centeredness" must be measured by sound public policy, good legislation, efficient administration, and every interaction of those providing care. While preventing family dissolution must be a goal of such a system, to do so must never be at the expense of children's safety. Family centered means a strong commitment by all those involved to enhancing the quality of family life; families have the best knowledge of their strengths and needs, and are our most important resource. Professionals are valued consultants who help families reach their goals. On an individual basis this means they ask, "How can I be of service?" What do you need?'. On a public policy level this mandates that all program decisions are made with predominant consumer input and continuous feedback, all funding decisions are based on strengthening families and including them, and all planning is truly a partnership. This is our definition of a responsive and responsible QUALITY system of care, one that Maine can be proud of, now and in the future. Such a system supports the efforts of the Children's Cabinet and the Healthy Families / Healthy Start model of care.

A FAMILY CENTERED system of care has the following attributes and benefits:

- Programs are cost effective.

- Parents are actively invested in improving outcomes for their children and themselves.

- Independence and personal responsibility are increased because of a true partnership of rights and responsibilities.

-The vast majority of services occur where families live, play, and work.

-Positive outcomes are easier to measure because they involve particular actions and specific changes.

-Expensive out of home and institutional placements are the exception, not the norm.

-Services are prompt and based on need at the time. The system has a no reject / no eject policy.

-Dollars and services follow the child and family throughout their time of need and are not confined to program boxes, labels, and categories. Services are individualized and flexible for each child and family. No two services are ever quite the same just as no two people are the same.

-Quality assurance is customer based.

-Financial incentives for expensive institutional/out of home placement are reduced or eliminated.

The following Findings and Recommendations are a beginning step in establishing this future direction for Maine's children and families in need of services.

FINDINGS and RECOMMENDATIONS

Maine's system of care for children is fragmented. Conflicting requirements of funding sources and state agency responsibilities do not support a system of care, instead they make children and families fit into arbitrary categories and qualifications for services and frequently do not meet the actual identified needs of children, families and caregivers. The result is a system that all too often is ***confusing, inequitable, challenges the integrity of families and is wasteful of precious resources.***

I - CONFUSION

access

In order to get help, families must comply with a number of community agencies' practices and procedures. Information is not available which maps a route for families to take in order to get the help they are seeking and there is no defined single point of entry. Families are required to repeatedly tell their stories in order to see if the sought-after service lies behind the door upon which they are knocking -- opened to them **only** by their ability to meet established criteria.

Recommendation: Create a gateway to services that eliminates the need to fill out volumes of forms for every service provider and assures timely access to necessary services. The use of a Management Information System and comprehensive intake procedures in the Local Service Networks provide an arena for this process.

labels

Children qualify for differing levels and types of service based on their diagnosis not on the strengths and needs of the individual child and family. Frequently children are labeled in order to access funding.

Recommendation: Institute a policy of inclusion. The ultimate decision regarding whether a child and family receive help must be determined by the issues they present, not by a predefined category of labels and services. Available funding must support the service decision, not drive it.

reimbursement

The current system of reimbursing for services is complex. Procedures for requesting payment involve multiple parties, forms and processes resulting in payments being delayed and families losing trusted caregivers. This creates excessive administrative expenses for agencies. Such service interruptions and loss of providers do not promote the continuity of care which is vital for children and their families.

Recommendation: Create a standard reimbursement form for all services. Payments should be made by one entity in each Local Service Network, simplifying the process, ensuring prompt payment for services and providing local accountability.

Develop reimbursement strategies to support the use of technology for providing professional consultations in rural areas.

II - INEQUITABLE RESOURCES

State funding for services within the Department of Mental Health, Mental Retardation and Substance Abuse Services has remained disproportionate between children and adults. Additionally, when Children's Services assumed responsibility for **ALL** children with special needs (mental health / developmental) relative funding remained constant, even though the **number of children increased** and their presenting issues were more complex. The "flat" funding which has prevailed for the children's system has not been responsive to the level of need which Maine's children and families are experiencing, and in actuality is a decrease.

Within Children's Services (DMHMRSAS) the department's funding is inequitable based on population labels. The 1994 Legislative transfer of responsibility for children with developmental issues from the Bureau of Mental Retardation to the Bureau of Children with Special Needs came with promises of funding and staff to follow. Those promises were not fully honored, leading to an enormous drain on already insufficient resources for children. - a sad disservice to all children.

Standards for workloads allowing for quality service delivery vary sharply within the department's programs for children. For example case loads for case managers / service coordinators for some populations have a ceiling of 15, while others are responsible for 60 or more, as waiting lists abound.

Recommendations: Support DMHMRSAS in making children an equal priority with the other mandated population groups it serves.
Increase allocations to Children's Services as a commitment to prevention that will ease the pressure on the adult systems in the future.
Dedicate new allocations to increasing community supports for children and their families.
Increase access and availability of case management or service coordination for families that cannot be their own case managers.
Institute training and support to parents to become their own case manager.
Provide for more equitable distribution of workloads among case managers.

The fact that families in Maine are frequently forced to confront the option of relinquishing custody of their children in order to access necessary services is, at best, appalling. Having a broad array of services available **to children who are in state custody, and** *unavailable* **to equally needy children** whose families are seeking assistance, continues to undermine the value of preventing family dissolution. The voluntary agreement option which was designed to address this problem and is administered by the Department of Human Services (DHS). This option is humiliating and demeaning to families and reflects the tragic status of the availability of children's services. The process for obtaining such an agreement is lengthy, and children continue to get sicker as a result of the prolonged wait for services, and the worry they experience about the uncertainty of their future. This agreement represents an unfortunate use of Department of Human Services (DHS) resources.

Recommendation: Establish, by Executive Order, a policy declaring that no child shall be removed from the custody of his or her parents in order to get needed services.
Transfer the projected level of State and Federal resources necessary to fulfill the intent of Maine's legislation which currently mandates voluntary custody from DHS to the Children's Services line in the DMHMRSAS budget.

III - CHALLENGES TO FAMILY INTEGRITY

Some children enter state custody as a result of the symptoms / behaviors of brothers, sisters or others who have mental health needs. Parents, (even though they may be desperately seeking services for the child) are often perceived as *unable to control* this behavior, therefore unable to keep the "healthy" siblings out of jeopardy. This situation results in children's removal from families through no fault of their own, and fosters the potential for future serious mental health problems for the family.

Recommendation: *Develop* an *immediate response* **approach to the situation by creating / enhancing family centered in-home stabilization services and longer term family supports.**

Maine's educational system is inappropriately saddled with the responsibility of being the gatekeeper to many services for children with special needs, including the most restrictive and intensive forms of mental health treatment. Frequently diagnostic and treatment decisions made by the system are in direct conflict with recommendations made by mental health professionals and families. This situation only tends to produce frustration between the families and schools. While waiting for systems to be responsive to their needs, youth often see their only option as "dropping out".

Recommendation: Create pooled flexible funding to address the needs of children.
Provide increased funding for alternative education opportunities.
Encourage and expand existing local case review committees as natural forums for making these decisions with the families.
Provide appropriate education to all teachers regarding children's mental health.

Many times Maine's parents are responsible for the safety and actions of their children without adequate laws to support them, and protect their children, in this task. It is important to recognize the ineffectiveness of the system for children and youth who have runaway or are homeless; have been repeatedly aggressive or assaultive; have been habitually truant; are not being consistently served by systems; will not accept services which keep them safe or are in families at risk.

Recommendations: Revisit the work of the CHINS Commission. *(see page 1)*
Increase support for primary prevention, early identification & intervention, crisis stabilization and transition efforts.

IV - WASTE OF RESOURCES

The current system offers a limited array of services that often do not meet the needs of children but continue to be utilized because they are the only options available. This uses expensive resources without producing the desired positive outcomes. Often these services are bundled in such a way as to require that a family access all services in order to obtain the one or two they need, creating more waste. The "one-size-fits all" nature of most services misses the mark for many families.

Recommendations: Replace the current practice of contracting for pre-packaged services with a family-centered system of care in which specific services are purchased from the widest possible range of vendors to meet particular needs of individuals and families.

Medicaid, a Federal / State program, is Maine's largest single health care payor, and is under the jurisdiction of the Department of Human Services. Currently Medicaid funds a wide range of mental health/developmental services for which DMHMRSAS pays the state share. Medicaid resources are heavily and disproportionately invested in expensive out of home / out of state placements and psychiatric inpatient hospitalization. Children enter hospitals and specialized treatment settings at costs which often exceed $250,000 per child, per year and often stay longer than necessary simply due to a lack of community based, family centered options. While families who live in closest proximity to services which are provided in bordering states should be able to choose those services, children are frequently placed in treatment options outside of Maine due to laws which do not allow for them to be held in secure facilities in-state. Funds wasted in excessive use of institutional placements are better spent in a managed system of care with family centered services and appropriate financial incentives to keep children in their own homes and communities. The responsibility for financing and developing a system of care are lodged in **two separate departments** of state government. Unfortunately, DMHMRSAS has **statutory authority** for developing systems of care while having **little control** over Medicaid expenditures (DHS).

Recommendations: Develop and support treatment options and transitional facilities which will support Maine's children in returning to their state, communities and families.
Reduce Medicaid dependence by ensuring payment by private insurance carriers for all services which are reimbursable through Medicaid.
Develop incentives for businesses to provide all employees with health insurance coverage
Develop a mechanism making DMHMRSAS the major gatekeeper and resource manager for children's Medicaid funded behavioral health services. This may be accomplished through the use of statutory changes and/or expansion of existing administrative agreements between DHS and DMHMRSAS.

Managed care will play a larger, and eventually dominant, role in the provision of behavioral health services for all of Maine's citizens. Many existing private managed care plans are notorious for their capitation, co-insurance requirements and other limitations on behavioral health in particular. These practices ignore the tremendous potential for a public - private partnership of mutually investing in the long term cost avoidance benefits of coverage for preventative, family centered support services as an integral part of generally accepted health insurance coverage.

Recommendation: Form a public /private partnership (including parents of children with special needs) to develop strategies ensuring broad coverage of community and family based behavioral health services.

Maine's agencies can begin to lead the way to a more hopeful future for its children by ensuring that their policies and procedures strengthen and support families.

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June 6, 1996

State Senator Joan Pendexter - Senate Chair
Representative Michael Fitzpatrick - House Chair
Joint Standing Committee on Human Resources
State House
Augusta, ME

Dear Senator Pendexter, Representative Fitzpatrick and members of the Committee:

Enclosed is the report of the Review Team which was charged with investigating the death of Wrendy Hayne. As you know, both our Department and the Department of Mental Health and Mental Retardation were initially precluded from circulating the report due to the provisions of Title 34-B MRSA §1207. Section 1207 provides that "All orders of commitment, medical and administrative records, applications and reports, and facts contained in them, pertaining to any client shall be kept confidential and may not be disclosed by any person ... ."

All interested parties as defined by statute agreed to the release of the full report. An Assistant Attorney General of this Department went to court on June 5th to request judicial authorization for its release. Following a hearing, the Court granted our request. For your added information, also attached is a copy of the Order submitted to and signed by the Court.

Sincerely yours,

Andrew Ketterer
Attorney General

Printed on Recycled Paper

STATE OF MAINE
KENNEBEC, ss.

MAINE DISTRICT COURT
DISTRICT SEVEN
DIV. OF SO. KENNEBEC
CIVIL ACTION
DOCKET NO.

IN RE: REPORT OF INDEPENDENT REVIEW TEAM) ORDER AFTER HEARING

Through Petition dated June 4, 1996, the Commissioner of the Department of Mental Health and Mental Retardation, Melodie Peet, has asked this Court to authorize release of the confidential report of the Independent Review Team. As noted in the Commissioner's Petition, the Independent Review Team, chaired by Don McDowell, President of Maine Medical Center, contains significant amounts of patient-identifying information and thus release of the full report is allowed only to those individuals or entities deemed to have access to such information pursuant to 34-B M.R.S.A. § 1207. The specific request of the Commissioner is that the full report be released to the Legislature's Health and Human Services Committee, the Committee with legislative oversight of both AMHI and the Department of Mental Health.

Appearing before the Court were Christopher C. Leighton, Assistant Attorney General, representing the Commissioner; Janice and Donald Burns, the mother and stepfather of Wrendi Hayne, represented by Eric Mehnert, Esquire; and Pasquale J. Perrino, Esquire, representing Harold Pulsifer.

After reviewing this Petition with the parties, it is the Court's understanding that the parties are waiving any possible procedural defect with this Petition and are agreeable to this Court entering an order allowing the release of this report to the Health and Human Services Committee. The Court is also persuaded that there is good cause for the release of this report to the Committee in order to further its

work as the Legislative Committee charged with legislative oversight of both AMHI and the Department of Mental Health. In addition, both Mr. Perrino and Mr. Mehnert, on behalf of their clients,[1] have agreed to waive any right their clients have to confidentiality in this report and are agreeable to the general release of this report to each other and the media.

THEREFORE, based upon the above, the Court hereby enters the following order:

1. Pursuant to 34-B M.R.S.A. § 1207(1)(C), the report may be released to the members of the Legislature's Health and Human Services Committee;

2. Similarly, the report may be released to Eric Mehnert, Esquire, and Pasuale J. Perrino, Esquire. The Department of Mental Health, or the Attorney General's Office, is directed to provide this report to the aforementioned attornies first, then to the Committee, and after providing these parties with a reasonable time to review the report, DMH or the Attorney General's Office may release the report to the media; and

3. Any patient-identifying information regarding patients other than Wrendy Hayne or Harold Pulsifer is to be redacted and is not subject to release absent further order of this Court.

Dated: ____________________

____
COURTLAND D. PERRRY, II
JUDGE, MAINE DISTRICT COURT

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[1] Mr. Parrino has submitted to the Court the written release of Harold Pulsifer's mother, Avis Swift, legal guardian of Mr. Pulsifer, in which Ms. Swift consents to the release of the report to the Legislative Health and Human Services Committee.

CONFIDENTIAL UNTIL 12:30

Report to Commissioner Melodie Peet,
Department of Mental Health and Mental Retardation,
Regarding the Review of the Death of Wrendy Hayne

INTRODUCTION

This report has been prepared by a team appointed by Commissioner Melodie Peet of the Department of Mental Health and Mental Retardation. The Independent Team was asked to review the recent death of Wrendy Hayne, a patient of the Augusta Mental Health Institution. The members of the committee are:

Dr. David Moltz - Medical Director, Shoreline Community Mental Health Services
Ms. Nancy Thomas, Resident Advocate, Pineland Center
Major James O'Farrell - Department of Corrections
Ms. Fran Vanecek - Retired Director of Nursing, Bangor Mental Health Institute
Mr. Don McDowell - President, Maine Medical Center (Chair)

The Team wishes to thank the employees of the Department and Augusta Mental Health Institute for their total cooperation during this most difficult review. It was obvious that the incident had affected all those involved very deeply and being asked to recount the details was very distressing, but the Team felt responses were candid and they painted a reasonably clear picture of the issues surrounding the most unfortunate event.

In this report we will begin by stating the "charge" that was given to the Committee by the Commissioner. Then we will describe the process used, make some general comments, report the Team's findings and end with several recommendations.

The charge to the Committee was made by Commissioner Peet at the first meeting of the Team on April 17, 1996. It was

Charge: The Independent Review Team is charged with investigating the circumstances surrounding the death of Wrendy Hayne. In particular, the Review Team will focus upon the following issues:

- adequacy and quality of care and treatment which was rendered or should have been rendered in this case;
- the adequacy of the facility's security system;
- the adequacy of staff coverage on the two units in question at the time of the incident.

At the April 17 meeting, the Commissioner added the desire of the Department to also receive any recommendations that the Team may believe appropriate as a result of their review. It should be noted here that the charge deals explicitly with the "circumstances surrounding the death of Wrendy Hayne". It did not include a review of care in general nor did it include general issues of security and staffing. The Team's review dealt exclusively with the charge as presented.

The process of review centered on interviews, record review and policy review. Specifically, the Team met on April 17, April 24, May 2, May 9, and May 15. Individual members of the committee met with interviewees on other occasions to review specific issues for the Team. Interviews with employees were usually held with a member of the appropriate union present and a representative of the Department present. At the meeting on April 17, the Team met with the Commissioner, other members of the Department and a representative of the Attorney General. At the meeting on April 24, the Team met with senior administrative and clinical leaders of AMHI and toured the facility, with emphasis on the areas critical to the event. At the meeting on May 2, two members of the Team met with AMHI patient advocates and the entire Team met with nine members of the care teams assigned to Ms. Hayne and Mr. Harold Pulsifer. On May 8, two members of the Team met with the mother and stepfather of the deceased, along with her attorney and a friend. On May 9, the Team met with ten members of the AMHI staff, both clinical and service. On May 15, the Team met with one clinical staff member but spent the majority of the day outlining this report. Minutes were kept of these meetings but they are not in detail as each member of the Team maintained detailed notes. To aid in understanding the sequence of events, we have attached a chronology as the team understood it (Exhibit A).

In addition to the interviews, individual members of the Team reviewed in detail the institutional medical record for Ms. Hayne and Mr. Pulsifer. Also reviewed were the applicable policies of the institution, the AMHI Consent Decree, Rights of Recipients of Mental Health Services, all relevant incident reports of the institution relating to either Ms. Hayne or Mr. Pulsifer, and staffing and acuity documents.

We would recommend that this report be shared with the parents of Ms. Hayne and with the involved employees at AMHI prior to its release, in part or totally, to the public.

FINDINGS: CONCERNING TREATMENT

This section reports findings related to the first item in the charge to the team: "Adequacy and quality of care and treatment which was rendered or should have been rendered in this case." Because most of the information on which the findings are based is protected by confidentiality, this section will consist primarily of the team's findings and conclusions, without the specific information from which they have been derived. For purposes of clarity this section will be divided into findings related to the treatment of Wrendy Hayne, those related to the treatment of Harold "Peter" Pulsifer, and those related to treatment issues concerning their relationship.

It should be noted that, while we believe that these findings and conclusions are significant, it is impossible to state that any of them, separately or together, contributed directly or causally to the outcome.

CARE AND TREATMENT OF WRENDY HAYNE

1. High quality of care and treatment. Overall, the Review Team was extremely impressed by the care and treatment of Ms. Hayne. She benefitted from a skilled and committed staff who were clearly devoted to her welfare and well-being. Her unit staff, including the psychiatrist, had worked together for many years, and her treatment team offered supportive and consistent treatment planning and care. Because she was on involuntary status, there were frequent reports to the court on her clinical status and on her treatment plan, which was therefore subject to careful review. Medication was appropriate and helpful, and over the past five years, as a result of medication and the treatment by clinical staff, her condition had improved in very significant ways. Ms. Hayne's staff was aware of the negative aspects of her relationship with Mr. Pulsifer, and individually and as a group they repeatedly attempted to intervene for her security and protection.

2. Lack of notification concerning change in status. We found one deficiency in Ms. Hayne's care. On April 2, 1996 it was ordered that Ms. Hayne have 1:1 staffing whenever she left the unit. This was for her protection, following an incident with Mr. Pulsifer on that date. On the afternoon of April 4 the 1:1 coverage was discontinued, and replaced with 1/2 hourly check-ins. It is clear both from the record and from interviews with staff that this change was at Ms. Hayne's request, and out of concern that she not be punished for Mr. Pulsifer's behavior. However, this change was made without notifying Mr. Pulsifer's unit staff, and without notifying Ms. Hayne's mother, who was her guardian. By policy, the guardian is to be notified of any changes in privilege level, and it appears to the Review Team that this was such a change. In addition, if Mr. Pulsifer's staff had been notified, they might have made compensatory changes in his status to increase their level of observation and monitoring.

Although the Review Team believes that this was a significant deficiency in Ms. Hayne's care, we wish to reiterate that this occurred in the context of a long and very positive course of treatment.

3. Lack of support for family. Although it is not directly related to Ms. Hayne's care, the team was concerned that there was no support offered to Ms. Hayne's family by clinical or administrative staff following her death. The family was notified of her death in an impersonal manner, and in spite of long involvement of her family with the treatment staff, that notification was their last contact with AMHI.

CARE AND TREATMENT OF HAROLD PULSIFER

4. Lack of effective treatment planning. Although Mr. Pulsifer improved clinically over the course of hospitalization, he appears to have reached a plateau, with little improvement or change over the past 1 1/2 years. Treatment was stymied by his refusal to participate in treatment planning or discharge planning. His treatment staff believed that without his participation no plans could be made, so he lived in the institution in a kind of limbo, with no clear direction for treatment or discharge. Because his status was voluntary, there was no requirement for court review, which might have challenged this lack of direction.

Staff opinion as to Mr. Pulsifer's clinical status was diverse and inconsistent; some appeared to feel that he could be discharged in spite of his reluctance, while others felt that he would decompensate clinically if forced to live on his own. He appeared to benefit from the structure of the institution, and he clearly did not want to leave; however he refused to participate in any of the activities that were part of that structure, unless Ms. Hayne was also participating. This stalemate was reinforced by the perception of the treatment staff that if "backed into a corner" he could become violent. The result was that he was very much left on his own, and in effect dictated the terms of his stay at the institution.

5. Failure to meet the requirements of the Consent Decree. The AMHI Consent Decree states: "The superintendent shall require that any voluntary patient whose treatment and discharge plan has not been reviewed during any six month period by the Maine District Court or pursuant to this subsection, be examined by two AMHI psychiatrists or psychologists who are not directly involved in the patient's treatment. If either of these examiners determines that the patient objects to hospitalization or does not require further hospitalization, the superintendent shall require that discharge or involuntary commitment proceedings be initiated, whichever is appropriate given the examination findings."(Par. 148) The Decree goes on to require, in paragraph 149, that if these examiners find the person to be appropriately admitted and not objecting to hospitalization, the superintendent shall retain an independent psychiatrist not employed by the Department to examine the patient to address appropriateness of hospitalization.

Although the record reflects regular assessments done by psychiatrists assigned to Mr. Pulsifer's unit, the Review Team found no record of any examinations by psychiatrists or psychologists not involved in his treatment. A note by his treating psychiatrist from October, 1995 stated that Mr. Pulsifer was clinically able to leave but was refusing discharge, and that a referral had been made "to hospital administration" for guidance because of implications in regard to the Consent Decree requirement that patients who are clinically able to leave be discharged. However, there is no record of any action being taken in response.

In January, 1996 the case was referred by treatment staff to the Director of Community Mental Health Services in the Department of Mental Health and Mental Retardation, as one of a number of cases presenting difficulty in discharge planning. However, the cases were apparently referred to her as a group, and she never met with Mr. Pulsifer, or considered his case separately from the group of 15 cases of which he was a part. This may have been because he refused to meet with her; this is not clear.

It is not known whether these referrals were specifically aimed at meeting the Consent Decree requirement quoted above. In any event, the necessary examination did not occur. It is very possible that if this requirement of the consent decree had been met, the treatment impasse described in the previous finding might have been avoided.

6. Turnover of psychiatric staff. In January, 1996 Mr. Pulsifer's unit was closed and he was transferred to another unit. However, a number of staff transferred with him, and this change was probably less important in terms of impact on his treatment than the frequent changes in psychiatrists on his treatment team. Because of difficulty recruiting staff psychiatrists, especially in this time of uncertainty about AMHI's future, the administration has relied on temporary locum tenens psychiatrists, who may stay for as little as 2 weeks or up to 6 months before moving on and being replaced by another temporary psychiatrist. From October, 1995 to April, 1996 Mr. Pulsifer had five different psychiatrists in charge of his care. This is in marked contrast to Ms. Hayne's unit, which benefitted from having the same psychiatrist throughout her stay. As a key member of the treatment team, the psychiatrist sets the tone and direction of treatment. In the Review Team's opinion, these frequent changes in psychiatric staffing allowed Mr. Pulsifer's treatment to remain diffuse and unfocused. For example, if a clear decision had been made to press a treatment issue, or to set a date for discharge, Mr. Pulsifer might have gone along with it. Alternatively, he might have decompensated or become violent, as the staff feared; however then at least his status would have been more clear. A different plan would have resulted, such as change to involuntary status, transfer to a closed unit, or changes in medication; in any event, a clear treatment plan would have emerged. In the absence of psychiatric leadership, no such decision was made, and his treatment remained unfocused and without direction.

7. Lack of oversight or consultation. Related to the lack of direction noted above is the absence of effective consultation when treatment was stalemated. Referrals for guidance on the issue of discharge status are discussed in finding #5, above. In addition, referral for clinical guidance is appropriate when treatment is not progressing for any reason. However, Mr. Pulsifer's case was not brought to the attention of the Clinical Director for consultation and direction until the situation had escalated, only a few days before Ms. Hayne's death. Input would have been more useful long before, when treatment and discharge planning were at a standstill.

CARE AND TREATMENT RELATED TO THE RELATIONSHIP BETWEEN MS. HAYNE AND MR. PULSIFER.

8. Failure to anticipate danger. When the relationship between Mr. Pulsifer and Ms. Hayne first developed, some staff felt that it was positive for each of them to become close to another person. However, over the course of a year Mr. Pulsifer's behavior in relation to Ms. Hayne became progressively more possessive, controlling and dominating. Although she continued to seek him out at times, Ms. Hayne frequently complained to her treatment staff about threats that he made to her. Her staff also noted behavior that they characterized as "stalking". Although Ms. Hayne was not necessarily reliable in her reporting, her treatment team increasingly saw evidence on their own of Mr. Pulsifer's obsessive, angry and controlling behavior.

Mr. Pulsifer's treatment team also had evidence available to them, including their own sense of danger if he was pushed or confronted, and his controlling and dominating behavior when involved in work projects on the unit. These observations could have alerted them to the need for effective action. However Mr. Pulsifer's team members, including on at least one occasion the psychiatrist in charge, limited their interventions to warnings and voluntary restrictions on his interaction with Ms. Hayne. When threats and incidents were reported to Mr. Pulsifer's unit, he was typically questioned by his treatment staff, and sometimes restricted to the unit overnight, until the treatment team could meet the next day; but no definitive or effective action was taken in response to these incidents (In November, 1995, following an incident, a plan was developed to limit visits to Ms. Hayne's unit to specified hours with staff supervision; however Mr. Pulsifer's cooperation was limited, and in any case this did not affect their interaction off the unit.). Even after the last incident, several days before Ms. Hayne's death, the only practical consequence for Mr. Pulsifer, beyond warnings and instructions to keep away from her building, was the doctor's order for hourly check-ins.

The relationship demonstrated a pattern which is classic for cases of domestic abuse, including possessive, dominating and controlling behavior by Mr. Pulsifer; fear and yet continuing involvement by Ms. Hayne; escalation over time in these patterns; and minimization by Mr. Pulsifer. Yet this pattern does not appear to have been clearly recognized by Mr. Pulsifer's treatment team, and an effective, coordinated response was not developed.

9. Failure to develop new responses. As noted above, when Mr. Pulsifer's threats or threatening behavior were reported to his treatment team, the usual response was to warn or encourage him to change his behavior, with few or no consequences attached. Since the threats and behavior continued, it would have been appropriate to reconsider these interventions and change them; however this was not done, in spite of the failure of the interventions to change his behavior.

A particularly problematic example of this pattern of warnings without effective consequences attached, occurred in the joint treatment planning meeting several days before Ms. Hayne's death. Mr. Pulsifer was warned by a treatment team member to stop his threatening behavior, and was told that Ms. Hayne's mother, who was her guardian, wanted the couple separated and was considering getting a restraining order against him (Ms. Hayne's mother has since denied that she made any such statement.). This statement of threat to the relationship, without concomitant action to control his behavior, may have contributed to the escalation into lethal violence.

10. Failure to respond to criminal behavior. On many occasions in the months preceding Ms. Hayne's death, Mr. Pulsifer's behavior was characterized as "stalking" her. This was dealt with within the parameters of the treatment situation; although incident reports were written and the Department of Human Services was notified on at least four occasions, the police were not involved at any time. This contributed to the minimization of the seriousness of the occurrences. If police were involved and charges placed, Mr. Pulsifer might have taken the consequences of his behavior more seriously.

11. Lack of effective communication and collaboration between units. Although there were regular reports from Ms. Hayne's unit to Mr. Pulsifer's unit concerning problems in their relationship, there is little evidence of an effective working relationship or collaboration between the treatment teams. An emergency "joint treatment planning meeting" on Mr. Pulsifer's unit was attended by only one staff member from Ms. Hayne's unit, and in any event that was held only following the incident several days before Ms. Hayne's death. An ongoing collaborative relationship in which both units felt equally responsible for managing the relationship and for developing a coordinated response does not appear to have existed.

RECOMMENDATIONS: CONCERNING TREATMENT

Again, it is important to state that none of the recommended changes, alone or together, might have prevented the tragic outcome of this case. However, we believe that they would all lead to better patient care and treatment.

1. Develop stability in staffing, especially psychiatrists. This is crucial to effective treatment, and the current system of rotating locum tenens staffing is inadequate. It may be that hiring staff psychiatrists will not be possible until the future of AMHI is decided; however every effort should be made to change the present staffing pattern.

2. Train treatment staff in recognizing and intervening in abusive relationships. Recognition of a pattern of abuse as it develops may lead to more appropriate and effective interventions.

3. Respond to criminal behaviors through police and the criminal justice system. In a treatment setting, criminal acts are often responded to as therapeutic issues. This does not lead to effective consequences, or encourage individual responsibility for actions. This change in approach should be reflected in policies and procedures, and should be reviewed by the law enforcement agency having jurisdiction prior to final approval and implementation.

4. Clarify policies and procedures concerning notification of guardian about changes in status. At least some staff believed that it was not policy to notify the guardian when 1:1 supervision was discontinued. This is contrary to the Team's interpretation of policies as written. This should be clarified and appropriate training provided.

5. Empower treatment teams to take extraordinary steps to protect patients in their charge. While few if any staff could have predicted the level of danger that was present, many staff, especially the 3-11 p.m. shift staff on Ms. Hayne's team, felt that she was endangered by the relationship and that more should have been done to protect her. There should be an explicit policy encouraging any member of a treatment team to report directly to the highest level of administration if necessary to ensure effective action in situations they perceive as dangerous or potentially dangerous.

6. Develop more effective ways for treatment teams to collaborate. This may involve regular joint treatment meetings, regular communication between units, or other measures.

7. Comply with the Consent Decree requirement for assessment of voluntary patients in order to determine the appropriateness of continued hospitalization.

8. Clarify policies for treatment and discharge planning when the individual will not participate in planning. It does not seem adequate or appropriate that treatment or discharge planning can come to a standstill if the individual will not cooperate in the process. In addition, the Clinical Director or other clinical administrative personnel should be formally consulted when treatment is stalemated for this or any other reason.

9. Develop policies for providing information and support to family members following critical incidents involving patients. This should be included as a standard of care.

10. Decide on the future of AMHI as soon as possible. It is not the purpose of the Review Team to make recommendations on what this decision should be. However it is clear from our review that an atmosphere of tension and uncertainty permeates the institution, affecting both patients and staff, and that this will not be resolved until a decision is made about the future status of AMHI. In the interim, patients will be anxious about their future, it will be difficult to recruit and retain appropriate staff, and care and treatment will suffer as a result.

FINDINGS: CONCERNING SECURITY

This section reports findings related to the adequacy of the facility's security system as it impacted this incident.

1. AMHI is a relatively open campus, as many patients are free to move from place to place without restriction for most of the day. Therefore, there is not a security system issue, per se, that impacts directly on this incident as both patients, at the time of the incident, were allowed to leave their buildings so long as they maintained contact with their unit at pre-set times.

2. Mr. Pulsifer was reported to have in his possession a set of keys that allowed him access to the room in which the incident occurred. This fact indicates a breach in security as it is impacted by key control. A basic ingredient in good physical security is key control. The control of keys should be a cornerstone of a security system. A tour by one of the team members of the facility on April 24 revealed practices such as leaving keys in doors and leaving keys unattended on desks. Discussions with officials indicate staff are permitted to leave AMHI grounds with their keys and if they are lost or forgotten, they are issued a new or a loaner set. There is little or no effort made to recover lost keys. There is no regular process for collecting keys from employees who terminate from the institution, meaning that keys are in the community at large. AMHI has developed a new policy and is in the process of re-keying the various buildings.

RECOMMENDATIONS: CONCERNING SECURITY

It is not clear that access to the locked room would have prevented the incident, but we believe the following recommendations will be generally helpful in maintaining a safe environment:

1. There should be an overall review of the safety and security system at AMHI to determine whether it is adequate. The Institute does not have a dedicated security force at the present time and it may be helpful to assign some existing staff to security functions.

2. There should be major revision of the key control policy (that is in process). The policy should cover all locks (security, padlocks, utility rooms, emergency exits, etc.). It should provide that <u>all</u> keys are accounted for at all times with a reporting of lost or stolen keys immediately. Processes should be in place to determine if security is compromised with a lost or stolen key. Employees should be trained in key control in that keys should not be left exposed, keys should be kept on the person, and care should be exercised to protect keys when opening doors.

FINDINGS: CONCERNING STAFFING

This section of the report deals with the issue of staffing of the two units at the time of the incident.

1. Staffing of the units. The Consent Decree's *Standards Governing Augusta Mental Health Institute* section ix at paragraph 202 required that there be 1 MHW for each 6 patients and 1 RN for each 20 patients.

Staffing on April 6, 1991 was as follows:

PSL (Ms. Hayne's unit) census on April 6, 1996: 21

MHWs required 3.3/ on duty 4 (in compliance)
RNs required 1.1/ on duty 1 (.1 supplied by NOD, see note)

One patient on half-hour checks (Ms. Hayne)

SNU (Mr. Pulsifer's unit) census on April 6, 1996: 26

MHWs required 4.2/ on duty 5 (in compliance)
RNs required 1.6/ on duty 1 (.6 supplied by NOD, see note)

One patient on hourly checks (Mr. Pulsifer)

NOTE: The Nurse on Duty, who is on call for all six units, is counted as providing the fractional amounts of RN time called for by the Consent Decree formula (.1 RN on PSL, .6 RN on SNU). This appears reasonable since both these units are unlocked and patients are free to leave as they wish as long as they abide by any reporting back requirements ("checks") assigned them by their team. Staff on duty confirm that there were no indications of any need for additional staff on that day prior to the event.

After review of the staffing assignments, acuity documents and interviews with those on duty on April 6, 1996, it is determined that there was sufficient nursing staff on duty on that day to satisfy the requirements of the Consent Decree and the needs of the patients.

2. Psychologist staffing. We also noted that the Consent Decree requires one Psychologist for each 25 patients. PSL with 21 patients had none assigned. SNU with 26 patients had a psychologist who shared his time between SNU and another unit and did participate in Mr. Pulsifer's treatment planning.

RECOMMENDATIONS: CONCERNING STAFFING

There were no recommendations concerning staffing.

Exhibit A

CHRONOLOGY

The following chronology is intended only to orient the reader to the sequence of events.

1982	Wrendy Hayne was admitted to AMHI and remained there except for a brief discharge in 1989.
1992	Harold Pulsifer was admitted to AMHI for the fifth time.
Early 1995 (approx.)	Ms. Hayne and Mr. Pulsifer's relationship began to develop.
Summer 1995	Ms. Hayne and Mr. Pulsifer were observed yelling at each other on occasion. Another patient said they were hitting each other during one incident.
11/95	On at least two occasions, Mr. Pulsifer's unit was notified that he was "stalking" and/or making verbal threats to Ms. Hayne.
Late 12/95	Complaints of "stalking" and verbal threatening continued. Ms. Hayne's staff started what they called a "stalking book" in which they documented these incidents. Staff devised a plan for Mr. Pulsifer to meet with Ms. Hayne at her unit for one hour daily under staff supervision.
1/11/96	Stone South Upper closed, and Mr. Pulsifer moved to Stone North Upper.
4/2/96 Morning	Ms. Hayne reported that Mr. Pulsifer threatened to hit her if she went shopping. His unit was notified, and an order was entered for 1:1 supervision whenever she was off the unit.
4/2/96 Afternoon	Incident occurred in which Mr. Pulsifer grabbed a card out of Ms. Hayne's hand, ripped it up, and acted in a threatening manner toward her and her accompanying staff.
4/3/96	Joint team meeting was held in which Mr. Pulsifer was instructed to stay away from Ms. Hayne's building, and was restricted to hourly check-ins with staff.
4/4/96	Ms. Hayne's off-unit 1:1 was discontinued at her request, and replaced with check-ins every half hour.
4/6/96 1:00 p.m.	A search was initiated when Ms. Hayne did not return for her half-hourly check.
1:25 p.m.	Mr. Pulsifer was seen leaving a locked storage room where Ms. Hayne's body was found minutes later.
Approx. 3 hours later	Mr. Pulsifer was found hiding in a bathroom in the same building.

MAINE MEDICAL CENTER

May 28, 1996

Commissioner Melodie Peet
Department of Mental Health & Mental Retardation
State House Station 40
Augusta, Maine 04333

Dear Commissioner Peet,

Attached is the report of the Review Team you appointed on April 12 to review the death of Wrendy Hayne. Each team member has read the report and believes it is an accurate summary of our findings and we are in agreement on the recommendations.

We thank you and your staff for cooperating with us during this most difficult time.

Dr. David Moltz

Major James O'Farrell

Ms. Nancy Thomas

Ms. Fran Vanecek

Mr. Don McDowell

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Enclosure

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August 15, 1996

Sharon Burns, Clerk
Maine District Court
145 State Street
Augusta, ME 04330

Re: Petition For Disclosure of Confidential Records

Dear Ms. Burns:

Enclosed for filing please find a Petition To Authorize Release of Confidential Records and a draft order. Faxes of these document were provided to Lawrence Bloom and Eric Mehnert, counsel for Janice Burns, and to Pat Perrino, counsel for Harold Pulsifer. I understand that counsel for Ms. Burns are available for the proposed hearing date, Wednesday, August 21 at 2:00 p.m., but I have not yet heard from Mr. Perrino. Going forward on this hearing depends upon Mr. Perrino agreeing to attend as it will be necessary for the parties to waive the procedural defects that come with this type of "hurry-up" proceeding. I will let you know if Mr. Perrino can attend as soon as I hear from him.

I will be away on vacation next week. Linda Pistner, Chief Deputy Attorney General, will appear on behalf of the state.

As always, my thanks to both yourself and to Judge Perry for your willingness to accomodate the state in this very important matter.

Sincerely,

Christopher C. Leighton
Assistant Attorney General

Printed on Recycled Paper

CCL/cdl
cc: Lawrence Bloom, Esquire
Pasquale Perrino, Esquire
Linda Pistner, Chief Deputy Attorney General
Jane Orbeton, Legal Analyst, OPLA ✓

STATE OF MAINE
KENNEBEC, SS.

MAINE DISTRICT COURT
DISTRICT SEVEN
DIV. OF SOUTHERN KENNEBEC
CIVIL ACTION
DOCKET NO. CV-

IN RE: Release of Confidential Mental Health Records) PETITION TO AUTHORIZE RELEASE OF CONFIDENTIAL RECORDS

NOW COMES the Petitioner, Melodie Peet, Commissioner of the Department of Mental Health and Mental Retardation, and the Maine Legislature's Health and Human Services Committee, represented by Christopher C. Leighton, Assistant Attorney General, and whom respectfully requests this Court to order, on a limited basis, the release of records otherwise confidential pursuant to 34-B M.R.S.A. § 1207(1)(C). The good reasons for granting this request are set forth below.

I. FACTUAL BACKGROUND

On April 6, 1996, Wrendy Hayne, a patient at the Augusta Mental Health Institute ("AMHI") and a class member under the AMHI Consent Decree was murdered. As a result of this tragedy, the Legislature's Health and Human Services Committee, the Committee charged with oversight of AMHI and the Department of Mental Health, undertook a review of the death of Wrendy Hayne. As part of this review, the Health and Human Services Committee has requested access to the records of Wrendy Hayne, and have been in contact with the personal

representative of Wrendy Hayne.[1] A court order is appropriate to resolve any possible legal issues which may be generated as the result of the release of these documents from the representatives of Wrendy Hayne to the Committee, and to provide access to other documents which may not be part of the Wrendy Hayne file.

II. ARGUMENT.

A. The Records of Wrendy Hayne.

Records of patients at AMHI are confidential but may be released pursuant to court order. Title 34-B M.R.S.A. Section 1207(1)(C) states as follows:

> 1. **Generally.** All orders of commitment, medical and administrative records, applications and reports, and facts contained in them, pertaining to any client shall be kept confidential and may not be disclosed by any person, except that:
>
> > C. Information may be disclosed if ordered by a court of record, subject to any limitation in the Maine Rules of Evidence, Rule 503;

In the present case, the personal representative of Wrendy Hayne desires to release her daughters' record to the Committee. As set forth in the attached draft order, the personal representative will determine which documents to turn over to the Committee, and the order will further govern the protections afforded these documents once they are turned over to the Committee. This order will allow a more full release of said records to the Health and Human Services Committee, and

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[1] Janice Burns, the mother of Wrendy Hayne, has been named personal representative of Wrendy Hayne's estate. She is represented by Lawrence Bloom, Esquire and Eric Mehnert, Esquire. Ms. Burns has provided the Department with a release for her daughter's AMHI records. A copy of these records have been provided to counsel for Ms. Burns.

should better enable them to carry out their important duties in this case.

B. <u>The Critical Incident Book.</u>

The Health and Human Services Committee is aware, as are others, of the existence of a critical incident book, one that has been named in the press as a "stalking" book. This has not been made a part of the record of Wrendy Hayne or Harold "Pete" Pulsifer. Rather, is it a record of the unit on which Wrendy Hayne was placed.[2] Both the personal representatives of Wrendy Hayne, and presumably counsel for Harold Pulsifer, desire to have access to this book. Therefore, the Petitioner is requesting that a copy of said book is made available to Eric Mehnert or Lawrence Bloom, counsel for Janice Burns, to Pasquale Perrino, Esquire, counsel for Harold Pulsifer, and to the Health and Human Services Committee.[3] Again, the draft order reflects the protections that are to be put into place should the court order the release of said book.

III. RELEASE OF THE INDEPENDENT MEDICAL REPORT

On August 5, 1996 the Commissioner received the report of the independent medical examiners. This report, which is a separate report from the earlier

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[2]The attorneys for Ms. Burns, and presumably the attorney for Harold Pulsifer, may not agree with this characterization. However, resolution of this issue is not necessary for ruling on this petition.

[3]Mr. Perrino was contacted by telephone regarding the proposed filing of this Petition. Mr. Perrino was very clear that he would object to any release of the "stalking" book.

McDowell commission report[4], was created pursuant to paragraph 199 of the AMHI Consent Decree which requires this type of review in all instances of serious injury or death to a patient. The Commissioner has requested that it be released to the Committee, to the personal representative of Wrendy Hayne, and to Mr. Pulsifer's attorney. It is not known at this time if these parties have any objection to it being made public.

IV. <u>CONCLUSION</u>

For the above-stated reasons, this Court should grant an order of disclosure pursuant to 34-B M.R.S.A. 1207(1)(C), and should also grant the protections for said records outlined in the draft order which is submitted with this Petition.

Dated: August 12, 1996.

____
Christopher C. Leighton
Assistant Attorney General
Dir,., Health & Institutional Care Division
Department of Attorney General
Six State House Station
Augusta, ME 04333-0006
Tel. (207) 626-8540

---

[4]Both reviews were requested pursuant to this provision of the Consent Decree.

RECEIVED
ATTORNEY GENERAL
SEP 16 1996

STATE OF MAINE
KENNEBEC, SS.

MAINE DISTRICT COURT
DISTRICT SEVEN
DIV. OF SOUTHERN KENNEBEC
CIVIL ACTION
DOCKET NO. aug-96 CV-173

re supplemental order signed 9/19

IN RE: RELEASE OF CONFIDENTIAL MENTAL HEALTH RECORDS

ORDER AFTER HEARING

By a Petition dated August 15, 1996, the Commissioner of the Department of Mental Health and Mental Retardation, and the Legislature's Joint Standing Committee on Health and Human Services (117th Legis.) (hereafter "the Committee"), have asked this Court to enter an order to authorize release of certain confidential records relating to Wrendy Hayne, some of which also relate to Harold Pulsifer.

The Petition addresses three types of documents, all of which contain information that is confidential under the terms of 34-B M.R.S.A. § 1207: 1) the individual patient record of Wrendy Hayne, maintained by the Augusta Mental Health Institute ("AMHI"); 2) two independent medical reviews conducted following Ms. Haynes' death pursuant to the requirements of paragraph 199 of the AMHI Consent Decree; and 3) the critical incident book.

The Petition was heard on August 21, 1996, at which the following counsel appeared: Linda Pistner, Chief Deputy Attorney General, and Katherine Greason, Assistant Attorney General, representing Mental Health Commissioner Melodie Peet and the Committee; Lawrence Bloom, Esq., representing Janice and Donald

Burns; Pasquale J. Perrino, Esq., representing Harold Pulsifer; and Thomas Goodwin, Assistant Attorney General representing the State in the criminal case against Mr. Pulsifer. It is the Court's understanding that the parties are waiving any possible procedural defect with the filing of this Petition in order to allow its hearing on an expedited basis. Having reviewed the Petition and having considered the arguments of the parties, the following rulings are made.

A. The Individual Patient Record of Wrendy Hayne.

Individual patient records of Wrendy Hayne maintained by AMHI during her admissions to that hospital have been provided to Janice Burns, the mother of Wrendy Hayne and personal representative of her estate. These records, from which information concerning other patients has been redacted, have been provided to Ms. Burns pursuant to a release that she has given AMHI. Ms. Burns, in turn, wishes to give some part of these records to the Committee. No one present having expressed any objection, and the Court having found that there is good cause for release of these records to the Committee in order to further its work, the following order is entered as to these records:

1. Pursuant to 34-B M.R.S.A. § 1207(1)(c) such records as may be provided to the Committee by Janice Burns as personal representative, parent, and next friend of Wrendy Hayne, may, in her discretion, be released to the members of the

Committee. These records may be divided into two groups by Ms. Burns or her attorneys:

(a) Records which Ms. Burns is willing to release to the Committee for executive session only but no further; and

(b) Records which Ms. Burns is willing to release to the Committee and to the public.

2. The patient-identifying information contained in documents described in 1(a) above is to remain confidential, and the Committee members are not to release this information to or discuss it with anyone other than members of the Committee, the Committee staff, any experts retained by the Committee to review said patient-identifying information, or other individuals authorized in writing by Ms. Burns or by 34-B M.R.S.A. Section 1207 as having access to this information.

3. Deliberations on any patient-identifying information contained in documents described in 1(a) above shall be conducted in executive session pursuant to the Freedom of Access Law, 1 M.R.S.A. § 405(6)(F). Individuals present in said executive session shall be informed that information from these records shall not be further disclosed outside of said executive session.

4. Documents described in 1(b) above may be released by the Committee to the public.

5. Nothing in this portion of this order shall be construed as requiring the release of any documents by Ms. Burns to the Committee, or by AMHI or the Department of Mental Health to Ms. Burns.

B. The Independent Medical Reviews Undertaken Pursuant to the Consent Decree.

Commissioner Peet seeks an order authorizing her release to the Committee of the documents that constitute the independent medical review conducted pursuant to paragraph 199 of the AMHI Consent Decree and prepared by Eastern Maine Medical Center and Maine Medical Center. During the hearing, the only objection to this request was raised on behalf of Mr. Pulsifer by his counsel, Mr. Perrino, who seeks the opportunity to redact information from these documents prior to their release. The Burns' requested the opportunity to review these reports prior to their release. The Court then directed the parties to file any requests for the redaction of information from these reviews not later than 12:00 noon on Thursday, August 22, 1996.

Filings were submitted on behalf of Harold Pulsifer, whose counsel sought redaction of certain portions of each of these reports, and on behalf of Janice and Don Burns. Counsel for the Burns' subsequently agreed to the release of the independent medical reviews with the redactions requested by Mr. Perrino, while reserving the Burns' rights to pursue objections to the redactions. Accordingly, the

Court finds that there is good cause for the release by Commissioner Peet to the Committee and the public of the independent medical reviews, provided that they are redacted as requested by counsel for Mr. Pulsifer. The Burns' retain the right to pursue any objections they may have to the redaction of any information from these documents.

C. The Critical Incident Book.

Both Mr. Perrino, on behalf of Mr. Pulsifer, and Mr. Goodwin, on behalf of the State of Maine in the criminal case against Mr. Pulsifer arising from Ms. Hayne's death, object to the release of the critical incident book in any fashion in which its contents may become public on the grounds that the dissemination of this information will jeopardize the opportunity for a fair trial. The Court will take the request for release of the critical incident book to Ms. Burns and the Committee under advisement pending an opportunity for an in camera review of the document.

Dated: August 30th, 1996

COURTLAND PERRY
JUDGE, MAINE DISTRICT COURT

State of Maine
Kennebec, s.s.

Seventh District Court
Division of So. Kennebec
Docket No. AUG-96-CV-173

In re: Disclosure of information under 34-B M.R.S.A. §1207

SUPPLEMENTAL ORDER

On August 21, 1996, the court heard the petition of the Commissioner of the Department of Mental Health and Mental Retardation, and the Legislative Committee on Health and Human Services for the disclosure of information covered by 34-B M.R.S.A. §1207.

The court's initial order was issued on August 30, 1996. Remaining for determination is whether there should be disclosure of the "critical incident" or "stalking" book, so-called, and if so, under what conditions.

The court has undertaken an in camera review of the "critical incident" book, which consists of three hand written pages.

The court finds that the Legislative Committee on Health and Human Services is carrying out its oversight responsibility in connection with the Augusta Mental Health Institute and the Department of Mental Health and Mental Retardation, and as part of the discharge of that responsibility, it is reviewing the course of treatment accorded to Wrendy Hayne, and the circumstances which obtained in reference to her care and supervision preceding her death on April 6, 1996. The court finds that there are criminal charges presently pending against an AMHI patient relative to the death of Wrendy Hayne.

The court finds that access by the Legislative Committee on Health and Human Services to the "critical incident" document is necessary to the Committee's evaluation of the care and supervision accorded to Wrendy Hayne. The court further finds that disclosure of the "critical incident" document to the Legislative Committee on Heath and Human Services should be limited to the use by that Committee of the document only in executive session, in order to preserve the integrity of the pending criminal proceeding, and to protect the right of the defendant in that proceeding to a fair trial. The court further finds that disclosure of the "critical incident" document to counsel for the defendant in the pending criminal proceeding and to counsel for the personal representative of the estate of Wrendy Hayne is appropriate but should be subject to no further disclosure by them. IT IS THEREFORE ORDERED THAT a copy of the "critical incident" or "stalking" book, so-called, shall be released to the Legislative Committee on Health and Human Services conditioned as follows: the Committee shall use and deliberate over the referenced document in executive session only and not otherwise, pursuant to Maine's Freedom of Access law, 1 M.R.S.A. §405(6)(F). Individuals present in said executive session, which may include the Committee staff and any experts retained by the Committee to review records, shall be informed that information from these records shall not be further disclosed outside of said executive session. IT IS FURTHER ORDERED THAT a copy of the referenced document shall be released to P.J. Perrino, Jr., Esq.,

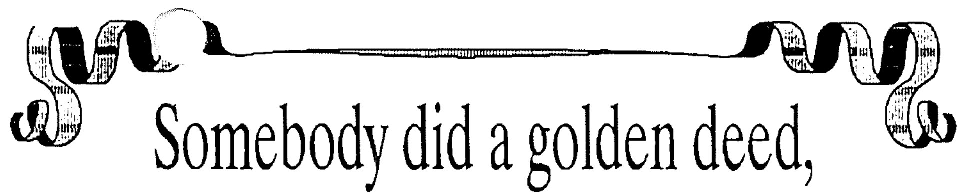
counsel for the defendant in the pending criminal proceeding, and to Eric M. Mehnert, Esq. and Lawrence P. Bloom, Esq., counsel for the personal representative of the estate of Wrendy Hayne, whose use of the referenced document should be consistent with the intent of this order.

This order is not intended to predetermine the rights, if any, of any person concerning access to or use of the "critical incident" document in any civil proceeding that may be initiated subsequent to the issuance of this order. Any such further access or use may be addressed under 34-B M.R.S.A. §1207 in any such civil proceeding.

ORDERED; the clerk shall enter the following in the docket:"SUPPLEMENTAL ORDER, dated September 19, 1996, is incorporated in the docket by reference. This entry is made in accordance with M.R.Civ.P. 79(a) at the specific direction of the court."

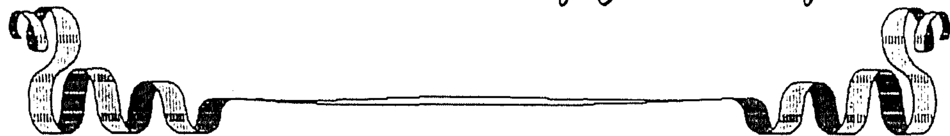
DATED: September 19, 1996

Courtland D. Perry, Judge
Maine District Court



Somebody did a golden deed,
Somebody proved a friend in need.
Somebody sang a beautiful song;
Somebody smiled the whole
day long;
Somebody thought "tis sweet to live";
Somebody said "I'm glad to give".
Somebody fought a valiant fight,
Somebody loved to shield the right.
Was that somebody you?

Wrendy Jane Hayne



Mama and Don
Here's a poem.
"The Road of Loneliness"

Too many times have I walked this road,
it's the road of loneliness;
where it ends nobody knows.
You could keep walking
or meet a friend;
you never know where this road might end.
It's the road of loneliness
far out of the way
and
everyone has been there or
will be there
someday.

WAIVER OF CONFIDENTIALITY

Patient's name: Wrendy Jane Hayne
Birthdate: 10/3/62
Social security number: 005-44-4600

(√)YES ( )NO 1. I, Janice Bruns, (patient) or (guardian for or personal representative of the patient Wrendy Hayne), waive the rights to confidentiality provided by 42 U.S. Code §290dd-2 and regulations promulgated under that provision, and 22 MRSA §1828 and 34-B MRSA §1207, and rules adopted under those provisions, and agree that the Joint Standing Committee on Health and Human Services of the 117th Legislature and the joint standing committee of the 118th Legislature having jurisdiction over human resources matters (hereinafter referred to as the Committee), may use the following mental health records and the information contained in them for the purposes and in the manner stated below.

(√)YES ( )NO 2. This waiver applies only to the following mental health records and information, which I will deliver to the Committee:
Portions of Wrendy Hayne's records from year 1989 until her death (4/6/96).

(√)YES ( )NO 3. I understand that I have the right to review all records prior to their release. I will complete such a review prior to delivering any records to the Committee.

(√)YES ( )NO 4. I have authorized the release of these records to me by (the Augusta Mental Health Institute) or (enter name of other provider N/A) by executing a separate waiver form on AUG 16, 1996 (date), a copy of which is attached to this waiver and incorporated by reference.

(√)YES ( )NO 5. To the extent that the above described mental health records contain information regarding alcohol or drug treatment that is protected by 42 C.F.R., Part 2, I specifically authorize release of such information to the Committee and use of it by the Committee pursuant to section 6 unless I have designated those records for confidential review and use under section 7. Unless otherwise allowed by law or unless I have expressly authorized further disclosure of alcohol and substance abuse records, further disclosure by the Committee is prohibited by 42 C.F.R., Part 2.

(√)YES ( ) NO 6. Except as provided in section 7, I authorize use of the released records and information for the following purposes and in the following manner:

A. I authorize the Committee to review such records and information in public sessions pursuant to 1 MRSA chapter 13, subchapter I for the purposes of their review of the mental health system and to make copies and release them to the public.

B. I authorize the Committee to use such records and information in drafting a report, recommendations and legislation provided that this is done without any direct or indirect reference to any identifiable mental health patient (except that reference may be made by name to the patient Wrendy Hayne

C. The review of such records and information and all consideration of them must be completed by June 30, 1997.

(√)YES ( ) NO 7. With regard to released records specifically designated in writing by me as available for review only in executive session, the following provisions apply:

A. I authorize the Committee to review such records and information only in executive session pursuant to 1 MRSA §405, sub-§6, paragraph F, and to make only such copies of records and information as may be necessary to the work of the committee.

B. I authorize the Committee to use such records and information in drafting a report, recommendations and legislation provided that this is done without any direct or indirect reference to any identifiable mental health patient.

C. For the purposes of records subject to this section, the following persons have the same access to such records and information as the Committee and have the right to be present at executive sessions held by the Committee: nonpartisan staff assigned to the committee, members of the Office of the Attorney General, up to 3 consultants retained by the committee for the purposes of their review of the mental health system, the patient and patient's guardian or representative(s) whose records and information are being discussed, and any person who provided treatment to the patient who is invited to the committee session by the Committee pursuant to section 8. I specifically prohibit any person receiving confidential records and information under this section from making any disclosure outside of the executive session.

D. The review of such records and information and all consideration of them must be completed by June 30, 1997.

(✓)YES ( )NO 8. In the review and consideration by the Committee of records and information under sections 6 and 7, I give permission to all persons who participated in patient treatment for Wendy Hayne (name of patient) at Augusta Mental Health Institute to discuss mental health records and patient information with the Committee.

(✓)YES ( )NO 9. This waiver may be revoked at any time by a written revocation. Such revocation prohibits further disclosure but does not invalidate any action taken by the committee pursuant to the waiver prior to the date of revocation. Unless previously revoked this waiver expires June 30, 1997.

(✓)YES ( )NO 10. I authorize a Court to review the released records and information in camera if necessary in making a decision to issue a court order pursuant to 34-B MRSA §1207, sub-§1, paragraph C.

Dated: Aug. 16, 1996

Signature of Patient or patient's Guardian or Representative: Janice A. Burns

ame of person signing, and capacity: Janice A Burns (guardian & executor)

Witness: Jane [illegible]

oolagenl/jowaiv

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

August 30, 1996

Senator Joan Pendexter, Chair
Representative Michael Fitzpatrick, Chair
Health and Human Services Committee
State House, Room 436
Augusta, Maine 04333

Dear Senator Pendexter and Representative Fitzpatrick:

Following the death of Wrendy Hayne, the Department asked for an independent review of the adequacy of Wrendy Hayne's medical care at AMHI. As is the case when any patient dies while in AMHI's care, the Department requested that the Maine Medical Association provide the review. The MMA assigned the review to a committee in accordance with the MMA's standard procedures. The committee provided its report of the review to the Department, along with a consultative report from an additional psychiatrist. These documents together constitute the report of the independent review sought by the Department.

The report of the independent review can be released if release is ordered by a Court. At a hearing last week in District Court in Augusta, the Attorney General's office presented to the Court a motion on behalf of this Department and your Committee that certain records related to Ms. Hayne be released to the Human Resources Committee. The motion included the Commissioner's request that the report of the independent review be released. The Court agreed to the release of the related information contained in the review. Mr. Pulsifer's criminal defense counsel subsequently requested redacting of information that could be harmful to the defense of the criminal case pending in relation to Ms. Hayne's death. A copy of the report of the independent review as redacted is enclosed.

Please do not hesitate to contact me if you have further questions.

Sincerely,

Melodie J. Peet

Melodie J. Peet
Commissioner

cc: Linda Pistner

PRINTED ON RECYCLED PAPER

PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX:

EASTERN MAINE MEDICAL CENTER

489 STATE STREET
BANGOR, MAINE
04401-6674

State Forensic Service
Department of
JUL 25 1996
Mental Health & Mental Retardation

May 1, 1996

Ulrich B. Jacobsohn, M.D.
Medical Director
Department of Mental Health
and Mental Retardation
State House Station #40
Augusta, ME 04333

RECEIVED
AUG 5 1996

RE: Wrendy Hayne DOB: 10/03/96
Case# 50575 DOA. 02/04/89
AMHI DOD: 04/06/96

Dear Dr. Jacobsohn:

This 33 year old female with a diagnosis of chronic undifferentiated schizophrenia was a long-time resident of AMHI. Her mental illness started at age 15 against a background of sexual abuse at age 5 and a family history of mental illness. Her admission to AMHI was precipitated by a hitchhiking trip across the country. In addition to the schizophrenia, she had a background of chronic anxiety and delusional thinking, but no recorded depression. She was said to be oriented with an intact memory, but of less than average intelligence.

At the time of death her medications were Clozaril 700mg/day, Thorazine 225 mg/day, Depakote 750 mg/day and Thorazine 75 mg prn for agitation.

She had developed a friendship with a male, who is also a patient at AMHI, who was described in the notes as being very jealous and threatening if she saw any other males. Because of this, she was only allowed to visit with him with direct continuous observation. She herself was on continuous observation until 4/4/96, when that was lifted and replaced with half-hour checks. She apparently was under this regimen until the day of her death, [redacted]

The switch from continuous observation to half-hour checks on 4/4/96, appears to have been appropriate, but raises the question of whether the visitation with the male friend were still supervised.

Wrendy Hayne
AMHI
May 1, 1996

We felt that this case warranted review by a second psychiatrist and have asked Dr. Edward H. Robinson to arrange for review of the records by another psychiatrist.

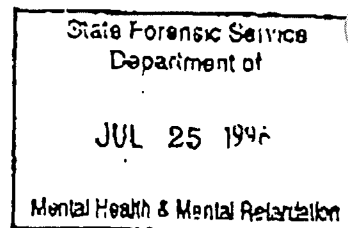
Respectfully Submitted,

Franklin E. Bragg, M.D., Chairperson
(Internal Medicine)
Ann M Hanlon, M.D.
(Family Practice)
Edward H. Robinson, M.D.
(Psychiatry)

FEB:wld

cc: Commissioner - DMHMR

Jonathan E. Morris, M.D., M.P.H.
McGeachey Hall #425
216 Vaughan Street
Portland, Maine 04102



June 22, 1996

Franklin E. Bragg, M.D.
489 State Street
Bangor, Maine 04401

re: Wrendy Hayne
Case: 59575
Augusta Mental Health Institute

DOB: 10/03/62
DOA: 02/04/89
DOD: 04/06/96

Dear Dr. Bragg:

After considerable time spent reviewing Ms. Hayne's recent medical records on-site at the Augusta Mental Health Institute (AMHI) and over the past several weeks at home once her chart materials were released to us, we find substantial evidence in support of her reported diagnosis of Schizophrenia, Undifferentiated, Continuous (DSM-IV 295.90). However, we note that her history of episodic assaultiveness, family history of Bipolar Disorder, alleged promiscuity with a history of childhood sexual abuse, history of the use of psychoactive recreational substances, anxiety, and irritability could conceivably suggest alternative diagnoses including Bipolar Disorder, Schizoaffective Disorder, Post-Traumatic Stress Disorder, and Substance Use Disorder.

Ms. Hayne's psychopharmacologic medication regime at the time of her death, while not resulting in the remission of her symptomatology, reportedly was the most efficacious combination reached after years of adjustment. These medications included Clozapine, Valproate, and Chlorpromazine.

During her time as a patient in the Psychosocial Learning (PSL) Program, Ms. Hayne clearly received individualized, compassionate, and comprehensive care from a staff that seemed devoted to providing her the best possible treatment. Ms. Hayne was noted to exhibit considerable improvement in the areas of social skills and social interactions while in the PSL environment, although she was far from being ready for discharge into a less restrictive setting such as a community facility at the time of her death.

Recognizing the clarity of hindsight, outside of severely restricting Ms. Hayne to her treatment unit, we are unconvinced that her treatment team could have further assured her safety at the end. Summarizing her care at AMHI over the years, Ms. Hayne received good treatment from a concerned and committed staff.

Sincerely,

Jonathan E. Morris, MD, MPH

Jonathan E. Morris, M.D., M.P.H.

Edward H. Robinson

Edward H. Robinson, M.D.

LAWRENCE P. BLOOM
ATTORNEY AT LAW
66 WINTHROP STREET
AUGUSTA, MAINE 04330

LAWRENCE P. BLOOM
ERIC M. MEHNERT
Of Counsel
GERALD F. KAPLAN, J.D., M.D.*
Of Counsel
*admitted in Pennsylvania only

TELEPHONE (207) 623-1455
FAX (207) 621-0353

September 5, 1996

HAND-DELIVERED

Senator Joan M. Pendexter
Representative Michael J. Fitzpatrick
Joint Standing Committee on Health and Human Services
State House
Augusta, Maine 04333

Dear Senator Pendexter, Representative Fitzpatrick and Members of the Committee:

This letter is transmitted with Volume 9 of Wrendy Hayne's medical record and governs the use of Volume 9.

Enclosed are over 300 documents which constitute Volume 9 of Wrendy Hayne's medical records at AMHI. (These have been bate stamped from 3084 to 3409). We are numbering each and every document received from AMHI pursuant to our request for Wrendy's AMHI records.

Janice Burns has not executed her right to withhold any document. In other words, every document received by her from AMHI in Volume 9 is now being released to the Health and Human Services Committee. Any copies of original documents that may be missing in this transmittal are solely on account of AMHI, not Janice Burns.

For example, you may recall that I informed the co-chairs last Friday that page 1586 of Wrendy's Progress Notes was missing. Our staff has informed me that a number of pages are missing which can be definitively ascertained. Unfortunately, we have no way of telling what pages may be missing from the fourteen volumes we have received to date.

With respect to missing Progress Note page 1586, we have just received it today. As our file had already been bate stamped, Progress Note page 1586 has been bate stamped as 3210-A. Pages that we identify as missing, and subsequently receive, will have a similar designation with letters. Please note that the enclosed bate stamped document, #3211, has been previously provided to the Committee and designated Progress Note page 1587.

For the time being, these documents are being released to you pursuant to paragraph 7 of the signed Waiver of Confidentiality and only for the purposes of review by the Health and Human Services Committee in confidential session pursuant to 1 M.R.S.A. §405, sub-§F. As specified in the signed waiver, Janice Burns does not waive rights to confidentiality of this document under 34-B M.R.S.A. §1207, sub-§1 beyond confidential review by the committee. The document, while in the possession of the committee, qualifies for the confidential record exception to public records in 1 M.R.S.A. §402, sub-§3, paragraph A, i.e., it is not a public record.

I would be remiss if I did not express our utmost disappointment with the news that we received from the co-chairs last week seemingly indicating that the Committee's work would be ceasing shortly. The Burns have expended much time attending the hearings trusting that their daughter's care at AMHI would receive a thorough review by the Committee. Likewise, counsel for the Burns have spent an enormous amount of time in an effort to aid the Committee by attending hearings, having lengthy and numerous conversations with Attorneys Oberton, Reinsch, Pistner, and Leighton who advise the Committee, and participating in Court proceedings. These efforts were expended in reliance upon an understanding that the Committee would meet well into the fall. Wrendy Hayne was murdered, not because she was a Republican or a Democrat, but because she was mentally ill and living in the State's custody. She was a victim in April. She falls victim again, not to a mentally ill patient, but rather to partisan politics.

Should the Burns decide to re-classify Volume 9 for public disclosure, I will promptly inform the Committee of such a decision.

Very truly yours,

Lawrence P. Bloom

LPB/llc
Enclosures
cc: Don & Janice Burns

LAWRENCE P. BLOOM
ATTORNEY AT LAW
66 WINTHROP STREET
AUGUSTA, MAINE 04330

LAWRENCE P. BLOOM
ERIC M. MEHNERT
Of Counsel
GERALD F. KAPLAN, J.D., M.D.*
Of Counsel
*admitted in Pennsylvania only

TELEPHONE (207) 623-1455
FAX (207) 621-0353

September 13, 1996

VIA: TELEFAX

Jane Orbeton, Esq.
Maine State Legislature
Office of Policy and Legal Analysis
State House Station 13
Augusta, Maine 04330

Re: **Wrendy Hayne**

Dear Jane:

Please find three documents from Wrendy Hayne's medical record to be distributed today to the Health and Human Services Committee. These are the last three pages in Volume 12.

The three documents are entitled Sleep/Wake Monitor Sheet. One is dated April 5, 1996 and the other two are dated April 6, 1996.

Please note that these documents do not have a bate stamp number. As you know, many documents had been sequentially numbered. However, due to the extremely high costs incurred in copying the almost 3,500 pages in Volumes 1 - 9, the completion of the copying (and therefore numbering) project is essentially contingent on the longevity of the Committee.

Most importantly, these documents are being released for public review pursuant to §6 of the signed Waiver of Confidentiality. Accordingly, Janice Burns waives her rights of confidentiality of this document under 34-B M.R.S.A. §1207, sub-§1.

Finally, I wanted to confirm in writing that Mrs. Burns accepts the Committee's invitation to them at today's hearing. Despite the fact that she had previously released some 300 pages (Volume 9) to the Committee for executive session only, she is willing to discuss in public session any portion of Wrendy's record which is relevant to the Committee's main inquiry. I trust that the Committee will avoid public disclosure of extraneous issues which are of a sensitive and personal nature and which could be unnecessarily embarrassing to Mrs. Burns and a stain on Wrendy's memory. I would request that Mrs. Burns not address the Committee until I arrive.

Please forward a copy of this letter to the members of the Committee. I thank you for your consideration.

Very truly yours,

Lawrence Bloom/llc

Lawrence P. Bloom

LPB/llc
Enclosures

SLEEP / WAKE MONITOR SHEET

4-5-96

JUDY
WAYNE

Write something each hour as to what Wrendy has done. If SHE sleeps write that. If she went off unit write off unit. If she went to an activity write what it was -

CONFIDENTIAL
NOT TO BE RELEASED WITHOUT PERMISSION OF DMH / COPY

Time	
12 mn	Up to Bathroom - Coloring -
1 am	Up Watching TV
2 am	Up Watching TV
3 am	Pt sleeping in bed.
4 am	Pt laying on bed listening to radio.
5 am	Up in her rm -
6 am	Pt OOB in dayroom
7 am	in front of bed
8 am	in front of bed - on/off unit [illegible] break. [illegible]
9 am	in bed
10 am	in bed -
11 am	in bed
12 n	in bed -
1 pm	In bed
2 pm	
3 pm	In bed
4 pm	In bed
5 pm	in bed
6 pm	in bed
7 pm	Sleeping
8 pm	In Bed
9 pm	In Bed
10 pm	Bed
11 pm	Bed

SLEEP/WAKE MONITOR SHEET

WRENDY HAYNE

7/6/96

Write something each hour as to what Wrendy has done. If SHE slept put that. If she went off unit write off unit. If she went to an activity write what it was.

CONFIDENTIAL
NOT TO BE RELEASED WITHOUT PERMISSION OF AMHI
COPY

12mn	Up - ret'd to bed.
1am	To bed Sleeping
2am	Sleep
3am	In bed asleep
4am	In bed sleeping
5am	Sleep
6am	In bed asleep
7am	Sleep
8am	- in her room sleeping
9am	- Sleeping in her room
10am	Sleeping
11am	Sleeping in her room
12n	Up, ate lunch + Rec'd meds
1pm	Sleeping in her bed
2pm	Sleeping in her bed
3pm	In Room not sleeping
4pm	[illegible]
5pm	Sleeping
6pm	
7pm	Up about,
8pm	listening TV
9pm	UP about Ward
10pm	sleeping
11pm	

SLEEP / [illegible]

WENDY PAYNE

Write something each hour as to what Wendy has done. If she slept write that. If she went off unit write off unit, if she went to an activity write what it was.

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Time	
12 mn	In bed Sleeping
1 am	In bed Sleeping
2 am	In bed Sleeping.
3 am	In bed sleeping
4 am	Sleeping
5 am	Sleeping
6 am	Sleeping
7 am	Sleeping
8 am	O.O.B for meds & Breakfast then Back to Bed
9 am	In bed asleep
10 am	↑ to smoke back in her room laying on her bed
11 am	in Bed
12 n	OOB - To canteen
1 pm	at the canteen
2 pm	
3 pm	
4 pm	
5 pm	
6 pm	
7 pm	
8 pm	
9 pm	
10 pm	
11 pm	

ANDREW KETTERER
ATTORNEY GENERAL

Telephone: (207) 626-8800
FAX: (207) 287-3145

REGIONAL OFFICES:

96 HARLOW ST., SUITE A
BANGOR, MAINE 04401
TEL: (207) 941-3070

59 PREBLE STREET
PORTLAND, MAINE 04101-3014
TEL: (207) 822-0260

STATE OF MAINE
DEPARTMENT OF THE ATTORNEY GENERAL
6 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0006

September 20, 1996

Eric M. Mehnert, Esquire
Lawrence P. Bloom, Esquire
Hawkes & Mehnert
66 Winthrop Street
Augusta, ME 04330-5506

RE: Wrendy Hayne - Further Request for Release of Records

Dear Attorneys Mehnert & Bloom:

In your letter of September 9, 1996, you submitted a list of "records" which you believe should be provided to you and your clients. Below please find my formal response to your request.

First, and speaking generally, it does not appear that any of the documents you have requested formally meet the definition of patient record. This is significant, because the release that you provided to this Office, as well as the Court's current order regarding release of Ms. Hayne's record, do not necessarily encompass documents outside what is traditionally considered to be her record. However, and as I have indicated to you orally, this may be a discussion we can avoid at this time by providing you with portions of some of the documents that relate directly to Ms. Hayne. To illustrate: you have asked for a copy of the Unit Shift Report. This report, completed by the charge nurse on each unit for all patients, is a communication tool among staff on all shifts. To the extent that it contains information directly concerning Ms. Hayne, I propose to make this information available to you without deciding whether or not the information is part of Ms. Hayne's "patient record".[1] I want to make it clear that by providing this information to you, we are not in any way waiving the State's ability to raise this issue in any future proceeding, i.e., we are not waiving the right to seek to protect

[1] This avoids another trip to the District Court to secure a further order from Judge Perry regarding the release of AMHI records.

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information deemed confidential pursuant to 34-B M.R.S.A. § 1207 or other such statute. We simply hope to facilitate, in a fair way and with an eye to the law, your client's access to their daughter's "record".

1. **Unit Shift Report**. As indicated above, the portions of this document that are relevant to Ms. Haynes on the date of her death will be provided to you.

2. **Patient/Staff Assignments**. The documents showing staff/patient assignments include the names of all patients on the unit. We will provide you with a copy of the patient/staff assignment sheet for Ms. Hayne's unit on the date of her death, but with other patient names removed.

3. **Individualized Worksheets**. I am not entirely certain what you mean by this term. Could you provide a description of what you believe you are looking for in this area?

4. **Critical Incident Report**. You have already indicated in your letter of September 9 that you have a copy of the Critical Incident Report. This report, also known as, and misnamed as, the "stalking book", was provided to you in a recent proceeding before Judge Perry.

To be fair, you may be referring to the report that is completed by the Nursing Supervisor on duty which provides some record of critical events that occur on the ward during that shift. However, it appears this information is confidential pursuant to 24 M.R.S.A. § 2510.

5. **O.D. Book**. This notebook is maintained by the physician's assistant on evenings and nights. To the extent that it provides information about Ms. Hayne on the day of her death, it will be provided to you. Information relating to any other patients will be redacted.

6. **McDowell Report**. I am certain that you already have a copy of this report, and you will be receiving nothing further from the Department regarding this report. This is because any other documents created by the McDowell Committee are *not* in the possession and control of the State. In your letter of August 14 you indicated that you "do not understand" why the State will not turn over documents from the participants of the McDowell Committee. While the McDowell Committee may have been "appointed" by the Governor and the Commissioner, legal authorization for this committee is found in the Consent Decree in Section IX(J), "Patient Injury and Death", paragraph 199. Thus, pursuant to this Superior Court order, this committee is defined as an independent committee and thus is not an agency of State government. It is my view that I have no more authority than you to

request, or require, members of the McDowell Committee to turn documents over to you.

7. **Bouffard, Estabrook, Williams Report.** As this report is part of a personnel investigation, any documents created as part of this process are confidential pursuant to 5 M.R.S.A. § 7070 and will not be released to you.

8. **Peer Review.** In your letter of August 14 you indicated that you have "no idea" as to how peer review documents are protected. The answer is found in Section 3296 of Title 32 which states:

> All proceedings and records of proceedings concerning medical staff reviews and hospital reviews conducted by committees of physicians and other health care personnel on behalf of hospitals located within the State, when such reviews are required by state, federal law or regulations or as a condition of accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association Committee on Hospital Accreditation are confidential and shall be exempt from discovery without a showing of good cause.

Therefore, pursuant to this statute,[2] the Department will not be turning over any documents or records regarding any peer review conducted by AMHI medical staff regarding one of its physicians.

9. **Memos.** This request is overly broad. While we can guess what you mean by "memos", we do not believe it appropriate to engage in some extended search through numerous files outside of Ms. Hayne's patient record to find documents which could be categorized as "memos". In addition, "memos" that are located outside of Ms. Hayne's record may be confidential for any number of reasons. Therefore, unless you can be more specific, we will not respond to this request.

10. **Individual Patient Report.** We do not understand what you mean by this term. It may be that you are referring to the Unit Shift Report, and we have already indicated that we will provide you relevant, non-confidential information from that report.

Thank you very much for your patience in this matter. We will begin reviewing the documents and providing you with copies of them (under the

---

2 *See also* 24 M.R.S.A. § 2510.

conditions outlined above) in the very near future.

Sincerely,

Christopher C. Leighton
Assistant Attorney General
Dir., Health & Institutional Services Unit

CCL:bjw
cc: Katherine Greason, Assistant Attorney General

HAWKES & MEHNERT

ATTORNEYS AT LAW

66 WINTHROP STREET

AUGUSTA, MAINE 04330

ERIC M. MEHNERT
CYNTHIA M. MEHNERT

LAWRENCE P. BLOOM
of Counsel

TELEPHONE (207) 623-1455
TELEFAX: (207) 621-0353

September 20, 1996

Senator Joan M. Pendexter
Representative Michael J. Fitzpatrick
Joint Standing Committee on Health and Human Services
State House
Augusta, Maine 04333

Re: **Wrendy Hayne**

Dear Senator Pendexter, Representative Fitzpatrick and Members of the Committee:

Please find enclosed 49 pages from Wrendy Hayne's medical record at AMHI. Janice and Don Burns have spent a great deal of time to review, once again, the volumes from which these documents have been culled. It is ironic that these documents are being given to the Committee on a day when the life of this Committee is in danger because our representatives allow politics and personalities to be the dominating forces, instead of one's own conscience. It is inconceivable that recommendations will issue forth today, while the Committee has just begun to receive crucial documentation.

The Burns and counsel have worked extremely hard over the past three months to assist the Committee in its inquiry. We are just now getting to the heart of the matter, and yet it appears that partisan politics, and not a sense of justice, dictate the course of this Committee. The mental health system broke down for Wrendy Hayne. The political system now abandons her parents.

These documents are from Volumes 3 - 8. Volumes 3 - 8 were reviewed this week by Janice and Don Burns who believe these selected documents would be of more interest to the Committee than the 2300 pages that constitute the entirety of Volumes 3 - 8, especially in light of talk that the Committee's investigative phase may be ending any day.

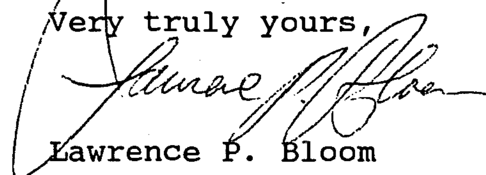
We are prepared to turn over to the Committee next week selected portions, or all, of Volumes 1 and 2. Selected portions will be turned over if the Burns are able to re-review those volumes and choose pages which will aid the Committee's inquiry. Should the Burns be unable to conduct a further review of these two volumes, we will transmit the 739 pages which make up those volumes. Additionally, it is our hope, depending on the longevity of the Committee, to be able to share relevant portions of Volumes 10 - 14 at some point in time.

The review of Wrendy's medical records has been extremely taxing, both physically and emotionally, for the Burns. Furthermore, it is not a comfortable process for the family to release documents for public review. However, the Burns have subjected themselves to the process so that the Committee's investigation can be thorough and its recommendations based on all of the facts.

The Committee went to Court to obtain the so-called "Stalking Book." One wonders if any portion of the recommendations was based on this just-released document, released for Executive Session only. How can recommendations be complete, even if only the larger systemic problems were the focus, without examination of the memoranda which Commissioner Peet, in her September 13 letter to the Committee described as "documents of internal communication between staff at AMHI" and which relate "to the care and treatment of Harold 'Pete' Pulsifer, and to the care, treatment and death of Wrendy Hayne"? This Committee has impressed us with its hard work and dedication well beyond the legislative session and straight through the summer. The Burns have placed their faith in you, their elected representatives, to see that the systemic issues within AMHI are addressed. Your efforts and time are appreciated.

The documents being released today can be released for public review pursuant to §6 of the signed Waiver of Confidentiality. Accordingly, Janice Burns waives her rights of confidentiality of this document under 34-B M.R.S.A. §1207, sub-§1. A listing of the individual document numbers is attached to this letter.

Very truly yours,



Lawrence P. Bloom

LPB/llc
Enclosure
cc: Don & Janice Burns

#3 - lack of notification of guardian

01525
02703
02706
02707
02735
[illegible]764
[illegible]946
02947

#4 - inaccuracies

00815
00816
00817
00818
01160
01161
01485
01523
01524
01528
529
01530
01531
01532
01533
01534
01535
01536

Miscellaneous

01101
01148
01209
01219
01220
01349
01350
01483
01484
01489
01507
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HAYNE WRENDY
1?HAYNE, WRENDY 26/F/US

#59575
59575
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10 03 62/007 54 5926
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01525

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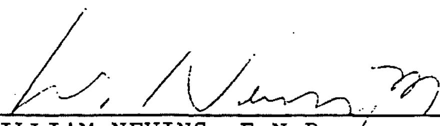
Augusta Mental Health Institute

Physicians Psychiatric Progress Notes

MARCH 20, 1990

The patient's care and condition is reviewed today in preparation of continuing titration for a Clozaril trial. Patient denies any discomfort. Condition is essentially unchanged from last note on brief examination. Schedule is continued with a target of 300 mg. at two weeks time.



WILLIAM NEVINS, F.N.P.

MILES SIMMONS, M.D.

ew
r&t-3/22/90

HAYNE WRENDY
1?5101 26/F/US

55575
C? 64 89/INVDCT/2/N/C/P
1? ?3 62/??7 54 5926
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02703

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AUGUSTA MENTAL HEALTH INSTITUTE
Box 724
AUGUSTA, MAINE 04330

PROGRESS NOTES

(must be addressographed
Patient Name:
Medical Record Number

UNIT SLP PAGE 1180

DATE	TIME	TYPE	
10/12/93	8 am	MD	No changes. Remains delusional, auditory hallucinations,
			apisodes of acut anxiety and agitation but not agressive
			or assaultive. Follows directions participating in a mi-
			nimum of activities.
			WBC of 10/6/93 = 10500
			Clozaril, 700 mgs/day
			Thorazine and Depakote renewed.
			Hermoza
10/12/93	7:25p	NSG	O. @ around 7pm today a housekeeper
			spotted Wrendy hitch-hiking on the
			main ave. Approached her and asked
			where she was going - Client stated
			she was going to [illegible] or maybe
			some place else. Client was wearing
			jeans and a T shirt - Ø ~~[illegible]~~ coat. The
			housekeeper insisted she return to
			the SLP unit, in which she did so.
			Talked c̄ client R/T dangers of hitch-
			hiking and elopement. Client has
			remained on unit through-out this
			eve. In good control and quiet.
			P. Continue to monitor - check
			follow 1° V's as ordered. T. Massenko

PHMCY = Pharmacy
M.D.= PHYSICIAN
P.E.= PHYS. EXTENDER
Nsg.= NURSING
Psy.= PSYCHOLOGY
S.S.= Social Service
MHW = Mental Health Workers
DTY = Dietary
TCN = Team Conference Note
SRC = Single Room Care
COR = Constant Observation
Rst.= Restraint
G.T.= Group Therapy
F.T.= Family Therapy

Form 337 Revised 6/90
Medical Record Form

WAYNE WRENDY
105101

02706

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PROGRESS NOTES

(must be addressographed)
Patient Name: Haynes Wrendy
Medical Record Number ______

UNIT SLP PAGE 103

DATE	TIME	TYPE	
10-14-93	7-3	NSG	cont
			̄s permission. re- sexual abuse - physical
			abuse - AIDS. Wrendy stated "I was going
			to LaVerdiere's or some place else."
			Did not acknowledge to me any of the
			dangers. (A) - (-) movement toward goal.
			(P) Cont ̄c P° ds + monitor behavior.
			Follow NCP + Rx plan -
			Doreen McFarland RN
10-14-93	3pm	MHW	S. Pt came in the office and
			said Jon I was Raped By
			a nother P.t. 2 days ago.
			at this time I called the
			nurse J. Santucci to office and
			she took over.
			Jon R Marks
			MHW 10-14-93
10-14-93	1730	NSG	S- "He punched me in the mouth, nose & eyes" "We were
			walking back from the canteen & I went blind. When
			I opened my eyes, he was on top of me" ... "We both
			were blind & we panicked" ... "I didn't tell you because
			I didn't want you to think you'd been raped too."
			O- Pt approached Jon Marks MHW ̄c the allegation
			that she had been raped by a male pt. from the
			Forensic Unit. Marks reported the incident to me &
			I then met ̄c the pt. to follow-up. Pt. repeated the
			(cont) - J. Santucci RNC

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02707

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PROGRESS NOTES

(must be addressographed
Patient Name:
Medical Record Number

UNIT SLP PAGE 1104

DATE	TIME	TYPE	
10/14/93		(cont)	allegation - stating that she had been both physically &
			sexually assaulted. Her statement was that she & a male
			peer had been walking from the canteen to this building
			when the assault took place. She alleges that he beat
			her about the face & neck, strangled her, covered her mouth
			c his hand, then raped her. She answered affirmatively
			to the specific question of whether sexual intercourse took
			place. Her report is laced c many conflicting & seemingly
			ly delusional statements; i.e. "I was blind; he was blind
			we both went blind; we panicked; maybe I wanted it;
			I didn't want you to think you had been raped, too." Dr.
			Davis was notified & met c Wendy Marks MHW, & myself.
			She deferred the physical exam @ this time. Denies any
			physical injury & there are no visible s/s of physical
			assault as she describes it. Dr. Davis informed the
			pt. that he & his nurse will perform a follow-up exam &
			lab work indicated tomorrow a.m. Pt. agrees to this.
			Appropriate notifications were made: Kay Grant RN
			Forensic Unit, Mary Small RN/ADON, Evelyn Potter RN
			Janice Burns pt. guardian/mother, & DHS. Mrs. Burns
			agrees to planned follow-up. The alleged perpetrator
			has medical records [redacted] A - no s/s of injury at
			this time. Pt. appears to be in no emotional dis-
			tress @ this time. P- Dr. Davis to follow-up medically. Pt.
			restricted to unit until evaluation tomorrow. Will
			utilize female staff off unit to smoke. J. Cantrell RNC

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Medical Record Form

HAYNE WRENDY
1C5101 26/F/US

59575
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PORTLAND/MH CTR

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Patient Name:
Medical Record Number

02735

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PROGRESS NOTES

UNIT SLP PAGE 1133

DATE	TIME	TYPE	
			Weekly Note by MHW's on 11-7 Shift
11-8-93	11-7	MHW	S- Sleeping patterns
			O- Wrendy appears to be sleeping well on this shift. No problems to note.
			A- 1/2's are done per Drs Order as pt is on elopement list and for her personal safety.
			P- Continue to monitor and report any changes in behavior — Andrea [illegible] MHW 2
11-11-93	12AM	MHW	O ® Pt requested and received her PRN
	PRN		of Sudafed 30mg PO/PRN for
Medication			c/o - nasal congestion as approved
[illegible]			by B. Roberts LPN with good effect. at 11:30pm — [illegible]
11/11/93	2:30 am	WSG	S. [illegible] gave me $10 - I bought 2 pair of socks c it"
			O. Pt has been up tonight unable to sleep. Pt states that a new friend she has from SSU gave her $10 today. —
			A. Unable to sleep.
			P. Monitor Wrendy's relationship c her newfound friend - and document her behavior. Encourage to get a good night's rest — Barbara Roberts
11/11/11	2:45p	NCS	S/ "We were just taking a walk"
			O/ Client failed to return to SLP @ 2pm check. She was found on Arsenal St. and taken back to the unit by staff. Client was

cont pg 1134 T.M. [illegible]

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Medical Record Form

HAYNE WRENDY
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Patient Name:
Medical Record Number

02764

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PROGRESS NOTES

UNIT S2P PAGE 162

DATE	TIME	TYPE	
11/15/93	1.30pm	MD	Received telephone call from patient who accompanied Ms. Hayne on Thursday, when the incident in the bridge occurred. This patient sounded quite anxious and upset. He wished to know why he was not allwed to come to the Unit to visit our patient. He expressed his regret for having asked her to go off grounds with him, he did not realized how ill she was. We informed him that we felt he was unwise having taken her out without informing anyone on the staff but we did not hold him responsible for her attempt to jump. We expressed to him that our patient was now quite anxious and we preferred he would abstain from seeing or meeting her for the time being. He asked to meet with me to speak but I stated it would be better that he speaks to his own doctor. He his doctor felt it necessary he would communicate with me. Patient seemed to be relieved and satisfied with my explanation.
			[signature]

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Medical Record Form

HAYNE WRENDY
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39375
02 C4 89/INVDCI/2/N/C/P
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PORTLAND/MH CTR

(must be addressographed)

02946

Augusta Mental Health Institute
Box 724
Augusta, Maine 04330

PROGRESS NOTES

Patient Name:
Medical Record Number

UNIT SLP PAGE 1339

Date	Time	Type	
7-5-94	3-11	NSG.	(cont from pg 1337) writer reminded client of her hx of seizures c/T a CT [illegible]. Wrendy listened calmly + then she agreed to take her [illegible] meds which she did; [illegible] [illegible] talking about her meds making her "stranded" and she was going to take them anymore. [illegible] this time, writer gave verbal [illegible] [illegible] [illegible] [illegible]; client seemed to [illegible] [illegible] reassurance. and has not c/o being "stranded" remainder of shift. No noted elopement attempt. (A) delusional but calm; compliant c [illegible] meds only c encour from staff (P) cont to monitor [illegible] [illegible] [illegible] [illegible] Kathy Giroux [illegible]
7-6-94	3[05] pm	Nsg	Staff was called to lobby of [illegible] building to assess Wrendy [illegible] apparent seizure activity. Wrendy was unresponsive to verbal stimuli c eyes rolling back. Wrendy was brought back to [illegible] and had another episode while sitting outside of [illegible] office [illegible]. After brief [illegible] Wrendy [illegible] [illegible] [illegible] [illegible]

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MR337

HAYNE WRENDY
105101 26/F/US

59575
02 C4 89/INVOL/2/N/C/P
10 03 62/007 54 5926
PORTLAND/MH CTR

(must be addressographed)

Patient Name:
Medical Record Number

02947

Augusta Mental Health Institute
P.O. Box 724
Augusta, Maine 04330

PROGRESS NOTES

UNIT SLP PAGE 23 [illegible]

Date	Time	Type	
7-6-94	3-11pm	Nsg	suspicious and insulating about the
			unit. No further suicidal noted thereby.
			1/2 hr checks maintained. [illegible]
7-6-94	3-11	nsg	Dr. Hermida discussed c Wrendy
	945p		D/Cing her 4PM CLZ dose to 8pm
			per clients request. writer took
			TO from Dr. Hermida and CLZ
			order stands as CLZ 350mg PO
			@ 8am + 8pm to start tomorrow;
			Wrendy was informed by writer
			of this change in med x; Wrendy
			to obs. has been ↓ delusional,
			pleasant + cooperative. attended
			Beano; med/meal compliant; ∅
			noted elopement attempts thus
			far in shift; 1/2° ✓s maint as
			ordered — Libby Furrow LPN
7-7-94	7-3	Nsg	1/2 hr checks maintained. Slept most of the
			day. Did not come to dining room for meals.
			Sleeping in sitting room @ this time. [illegible]

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Revised 6/90
MR337

HAYNE, WRENDY T.
MR. #: 59575
UN #: 105101
DOA: 2/4/89
DATE OF UPDATE: 3/2/93

00815

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AUGUSTA MENTAL HEALTH INSTITUTE
P.O. Box 724
Augusta, Maine 04332

HISTORY OF INTERVAL UPDATE

TAKEN BY: L. Clifton Graves, LSW

DATE OF BIRTH: 10/13/62.

CITIZENSHIP: U.S..

LEGAL STATUS: District Court Committed for up to six months, starting on 2/24/93.

SOCIAL SECURITY #: 007-54-5926.

MEDICARE #: None.

MEDICAID #: None.

ADDRESS PRIOR TO ADM.: N.A.

SOURCE OF INCOME: None.

AMOUNT OF INCOME: None. (Note: Family provides spending money and items but Ms. Hayne has no personal income. She would be eligible for Medicaid and SSI outside of AMHI.)

DATE INFORMATION WAS OBTAINED: The month of February, 1993.

SOURCE OF INFORMATION:

1. AMHI Chart.
2. Conversations with Ms. Hayne
3. Conversations with her mother.
4. Conversatoins with her step-father.

PATIENT'S MARITAL STATUS: Never married.

NEXT OF KIN: Janice Burns, Mother
155 High St.
South Portland, Maine 04106
Phone#: 207-799-9586.

GUARDIAN: Janice Burns,
Address as above.

GUARDIAN AD LITEM: N.A.

PRESENTING PROBLEM: Ms. Hayne had been in Portland on short leave in February of 1989, when she was admitted to P-6 for "uncontrolable behavior." This led Ms. Hayne to be

HAYNE, WRENDY T.
MR. #: 59575
UN #: 105101
DOA: 2/4/89
DATE OF UPDATE: 3/2/93

00816

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HISTORY OF INTERVAL UPDATE

"readmitted to AMHI on emergency involuntary papers from P-6. She has spent almost all of the period from August, 1980 to the present as an AMHI patient.

PRESENT ILLNESS: The onset of the current mental illness was noted by Ms. Hayne's mother to date, prior to age 15. A steady and marked deterioration and abiltiy to function was noted at about age 15.

Ms. Hayne has made a good deal of progress in the past year on the Social Learning Program. She has, in the past, been a regular user of single room care. Since transferred to Social Learning Program, she has not needed that modality. She is increasingly able to assist us in managing her behavior. Elopment is a periodic issue, however, for most of the time Ms. Hayne is cooperative with regular check-in times.

PREADMISSION SITUATION: As noted this patient has been an almost continuous AMHI patient since 1980.

FAMILY HISTORY: Is as outlined in initial history, which is included in the chart.

BIRTH AND EARLY DEVELOPMENT: Ms. Hayne was born full term "in a difficult induced birth." Her birth weight was reported to be six pounds, three ounces. Developmental milestones are reported to be normal with walking noted at approximately ten months and reportedly Ms. Hayne was a bright child but not particularly outgoing and did not make friends easily.

EDUCATIONAL HISTORY: Reportedly Wrendy did well in school until the 10th grade. In the 10th grade she dropped out of school.

OCCUPATIONAL HISTORY: Ms. Hayne has a very limited work history. At age 12 and 13 she did some baby sitting. She has worked as a phone solicitor for approximately two months and has done "some odd jobs" and "summer work." There is no significant work history since the onset of her illness.

MILITARY HISTORY: None.

RESIDENTIAL HISTORY: Ms. Hayne has been an almost continuous resident of the Augusta Mental Health Institute since 1980. Her family home is in the Cumberland County area, specifically around Portland.

HAYNE, WRENDY T.
MR. #: 59575
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HISTORY OF INTERVAL UPDATE

LEGAL INVOLVEMENT: Ms. Haye is currently District Court committed for treatment.

RELIGION: No noted issues regarding religion.

MEDICAL HISTORY: See Medical Summary, included in this chart. In essence Ms. Hayne is quite healthy and presents no substantial medical problems other than those occasioned by her tobacco use and its potential, injurious, long term effects.

ETOH, DRUG AND TOBACCO USE: Ms. Hayne does smoke. Her family reports that Ms. Hayne has smoked since age 13 and used various drugs since age 14. Drug abuse is not a noted problem since transfer to the Social Learning Program.

HISTORY OF ABUSE: There is a report at age five that Ms. Hayne and her brother Aaron were sexually molested by a stranger in a "nearby abandoned building."

PERSONAL CHARACTERISTICS: Ms. Hayne enjoys poetry and often has a poetry book that she has taken out of the library. Ms. Hayne makes only limited use of available activities. She enjoys her family's visits. Ms. Hayne often dresses in a flamboyant manner.

COMPREHENSIVE HISTORY OF EMOTIONAL PROBLEMS: The noted onset of this patient's illness was in high school. From 10th grade on there was a noted deterioration. Involvement with steet drugs is reported. There is note of her being "kidnapped" and "sexually molested" at age five and this may have had an impact on emotional problems and development. Step-father, Jim Emerton, is described as physically abusive and alcoholic in previous histories.

ASSESSMENT AND SOCIAL WORK PLAN:

Strengths, Assets and Liabilities: Ms. Hayne enjoys reading poetry. She enjoys dress and makeup. She is friendly and polite when making requests and has some intermittent insight into her illness. Her impulsively leaving the hospital and hitchhiking is her biggest liability at this point.

HAYNE, WRENDY T.
MR. #: 59575
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DOA: 2/4/89
DATE OF UPDATE: 3/2/93

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HISTORY OF INTERVAL UPDATE

Identified Needs: Continued support for the patient and her family. Continued care plan which may need to include assurances regarding involuntary care and realistic discharge planning.

Determination of Need for Family Involvement: The family is this patient's sole source of income. Her mother is her guardian. Ms. Hayne looks forward to family visits and to visits home. The family needs support and assurance as they fear that no care system other than continued involuntary stay at AMHI will be safe for their daughter.

Social Work Plan: The guardian is clear in stating that she is not comfortable with any level of care other than court committed involuntary stay and as there is no community residence providing involuntary care, there can be no active discharge planning.

The Treatment Plan and Long-Term Goal Transition to the Community: The primary means of working on that goal is to inform the family of gains that the patient has made and what potential there is for community care will continue to provide opportunity for support if social skills building work-"the tea group" and other settings on the ward.

LCG:ls

d & t-3/2/93

L. Clifton Graves, LSW

HAYNE, WRENDY
MR #59575
PRIMARY THERAPIST: William Lajousky
ADM DATE: 2/4/89
DATE OF CONFERENCE: 4/12/91

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INDIVIDUAL TREATMENT & DISCHARGE PLAN

PROBLEM: #4 Delusions.

GOAL/DISCHARGE CRITERIA: Wrendy will make no statements (asking if head is attached) by end of 90 days.

OBJECTIVE:1 Wrendy will state once daily that she knows that her head is attached by end of 90 days.

TREATMENT INTERVENTIONS: Dr. Veregge will prescribe antipsychotic medication for the purpose of extinguishing Wrendy's delusional thinking regarding her head. He will meet with her for 10 minutes each week to discuss her treatment, i.e., benefits and side effects of medication.

RESPONSIBLE PERSON: Dr. Veregge.

START DATE: 4/12/91.

TREATMENT INTERVENTION: William Lajousky will assure Wrendy that her head is attached when asked, during morning meeting and all other daily interactions. (U. Bickford)

RESPONSIBLE PERSON: William Lajousky.
U. Bickford, BSW

START DATE: 4/12/91.

(cont'd)

Objective 2: To attend 12 hrs of therapeutic recreational programming and for each hour attended remain oriented to activity or topic of conversation for 15 minutes without asking if her head is attached within 90 days.

Treatment Interventions: Rehabilitation Service Staff will:

- Personally invite Wrendy to 2 programs each day.
- Reassure her that her head is attached, if she asks during her attendance and then reorient her to the activity or topic of conversation.
- Record her attendance and ability to remain oriented and refrain from verbalizing statements about her head during her hospitalization on stat sheets and monthly notes.

HAYNE, WRENDY
MR #59575
PRIMARY THERAPIST: William Lajousky
ADM DATE: 2/4/89
DATE OF CONFERENCE: 4/12/91

Page 3

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INDIVIDUAL TREATMENT & DISCHARGE PLAN

PROBLEM: #9 Poor grooming and hygiene.

GOAL/DISCHARGE CRITERIA: Wrendy will select and wear one clean outfit each day by end of 90 days.

OBJECTIVE: Wrendy will select and wear one clean outfit every other day by end of 30 days.

TREATMENT INTERVENTIONS: Kim Evans, MHW I will encourage and supervise Wrendy each day in her grooming and selection of clothes. Her (Wrendy's) privileges will be contingent upon her compliance.

RESPONSIBLE PERSON: Kim Evans, MHW I

START DATE: 4/12/91.

TREATMENT INTERVENTION: William Lajousky will verbally praise Wrendy when she is appropriately groomed and dressed each morning during our morning meetings. (U. Bickford)

RESPONSIBLE PERSON: ~~William Lajousky Jr.~~ U. Bickford, BSW

START DATE: 4/12/91.

HAYNE, WRENDY

#59575

01485 Physicians Psychiatric Progress Notes

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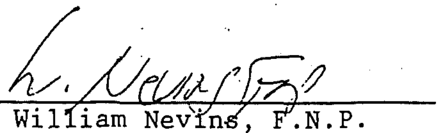
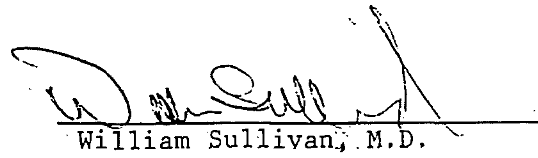
FEBRUARY 2, 1989

It started at approximately 10 A.M. today, when I was notified that the patient had run away from the staff escorted group in transit from an activity for treatment by heading down some side stairs. Subsequent search of the area and the grounds were conducted without success. I called the home of the patient's guardian/mother, Janice Burns, notified her of the patient's departure, including that it had been reported to me that she was appropriately dressed for the outside Winter weather, that I believe an APB should be initiated. Mrs. Burns agreed and it was done. Over the next few hours an intense amount of interest and manpower was injoined in the search, until Mrs. Burns called me back at approximately 1:30 to tell me that the patient had called her from Longfellow Square in Portland. Mrs. Burns attempted to locate Wrendy there, but could not find her. She further reported that she had called the Portland Police, and had been unable to obtain their help in the search. I asked that AMHI authorities contact Portland Police to reiterate an APB and help with the locating of the patient if possible. Sometime thereafter Mrs. Burns called again to say that Wrendy had resurfaced again at her Grandmother's home in the Portland area, was in an agitated, distressed, and psychotic state. Refused to accompany her to the hospital for examination. Mrs. Burns had called P-6 to illicit their help and advice, and they recommended that she be brought to the Emergency Room. I recommended same and agreed to call her back shortly when I had explored Administrative sources for other possibilities of transport and/or evaluation. Subsequently I discovered that the phone number that Mrs. Burns had given me to her mother's home was incorrect, so I called the Portland Police Department to explore with them what to do or if they had any knowledge of the situation as it existed. The police representative reported to me that Mrs. Burns had just called to report that she was enroute to Maine Medical Center, Emergency Room, with the patient. Sometime again afterward, Mrs. Burns called, indicating that they were not in fact on their way to the hospital, and had been awaiting more information from me. I further exhorted the Burns' to ask for help from the local Police Department if they felt that the patient was by the nature of her behavior, presenting a danger to herself or others, which in my opinion she may well, for the patient to be brought to the Emergency Room to be evaluated for need for emergency involuntary hospitalization and transport to AMHI. Mr. Burns grudgingly agreed, hoping to find another way of helping his step-daughter, and asked if I would phone in a presciption to a neighborhood pharmacy for a PRN medication. I did so by calling CVS at Pine Tree Shopping Center, at their recommendation ordered Thorazine 100 mg. every four hours, PRN for agitation times three. I then called back the Burns', notified them that this prescription was being prepared and renewed with them their options and my recommendations that they have the patient transported either by themselves or by the police to the emergency room.


William Nevins, F.N.P.


William Sullivan, M.D.

WN/ew
r-2/3/89
t-2/6/89

HAYNE, WRENDY

#59575

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Augusta Mental Health Institute

Physicians Psychiatric Progress Notes

October 5, 1990 PSYCHIATRIC REASSESSMENT

This young woman was transferred from the Young Adult Treatment Program, where she was admitted on 2/4/89. She has been in the hospital on and off, for many years. She will be seen for treatment-plan review on 10/11/90, when her parents can be here to participate.

She has been on Clozapine for the past several months, and has improved dramatically. Previously, she would be unaware of her surroundings, would go around the ward unclothed, would get into fights, and had a number of persecutory ideas. These are not all clear, as yet (see below).

She was originally assigned to the "Blue" Team, headed by the physician extender. However, her parents objected to this, and she was recently switched to the "Red" Team, which I direct.

MENTAL STATUS EXAMINATION: She appears her chronological age, is not so emaciated as she had been in past years, makes good eye contact, and is appropriately dressed and groomed. Motor activity is not unusual. There is no tremor nor other uncontrolled activity. She is fairly attentive during the interview, tries to be cooperative, and shows no unusual mannerisms. She gives the impression of being impatient, however. Flow of thought is somewhat constricted, but response time is prompt. Verbal production is also constricted, but there is no loosening of associations. Speech is clear, coherent, goal-directed, in a soft voice, with no language deviations. Mood is euthymic; she gives the impression of insouciance. Affect is somewhat blunted. She denies frank hallucinations. She has the idea that her head is being squeezed, that others are going to eat her alive, or are eating her alive. She often has a feeling of parts of her body falling off. There are no feelings of thought insertion or extraction, no obsessions nor compulsions. She denies suicidal and homicidal ideas. Sensorium is clear, orientation correct in the three spheres. Remote and recent memory are difficult to assess. I have the impression that there are large gaps in her distant memory, however, probably due to her illness. She was unable to sit still for tests of retention and recall and any of the tests of intellectual functioning. An effort will be made to get formal testing for her. Insight and judgment are partially preserved.

She has a guardian to make treatment decisions for her.

STRENGTHS & ASSETS: She has a supportive family. She presents well physically, and is capable of some warmth.

DIAGNOSIS: Schizophrenia, Undifferentiated, Chronic.

(Cont'd)

HAYNE, WRENDY

#59575

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Augusta Mental Health Institute

Physicians Psychiatric Progress Notes

10/5/90 (Cont'd) - Page 2

No problems other than those on the present problem list are noted. Her treatment plan from Stone South Middle is being continued unchanged until her treatment-planning review.

r&t-10/5/90

DONALD BYERS, M.D./pcb
Clinical Director
Adult Treatment Program - SSU

105101 26/F/US

59575
C2 C4 89/INVDCT/2/N/C/P
1C C3 62/007 54 5926
(must be addressographed)
Patient Name: Wrendy Hayne
Medical Record Number

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PROGRESS NOTES

UNIT 5SM PAGE 1

DATE	TIME	TYPE	
4 II 89	1613	ADM	ID: This is the third AMHI admission of this 26 year old never married woman referred from MMC. She is a Portland resident and is adm. E I with no legal charges pending.
			Referral Source: MMC had attempted to tx this pt. on P6 where she went there voluntarily day before yesterday (the day before she was scheduled to return to AMHI from a short leave). They found they were unable to manage her on P6 due to her uncontrollable behavior & referred her here on PI.
			CC: "Why are you here?" "For hitchhiking" "What would you like from being here?" "To go home"
			She says she is here for hitchhiking because when she ran away a long time ago (from AMHI) she was brought back.
			Hx of Present illness: All that is known is [illegible] above. Pt. is an extremely [illegible] informant.
			Psychiatric, medical, personal & family hx are dealt c in considerable detail in the record of her hospitalization here beginning 8 VIII 87.
			MSE: General appearance is rather juvenile for her

over

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G.T.= Group Therapy
F.T.= Family Therapy

Form 337 Revised 10/88
Medical Record Form

105101 26/F/US

59575
C2 C4 89/INVDCT/2/N/C/P
1C C3 62/007 54-5926
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Patient Name:
Medical Record Number

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PROGRESS NOTES

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UNIT SSM PAGE 2

DATE	TIME	TYPE	
			eye but not unusual - blue jeans, a non-descript
			[illegible] jacket, long stringy, unkempt hair. She
			makes fair eye contact and seems flat, sullen
			and withdrawn. Her verbal responses are laconic
			although they seem related to the content of the
			question. Speech is soft and quite clearly articulated.
			She denies depression with a short shake of the head
			but she does not smile. She appears sad and her
			movement of skeletal musculature seems minimal.
			Stream of mentation seems minimal without
			betrayal of her thought processes. Visual & auditory hallucinations
			are denied. She is preoccupied with the time of
			day & how long till meal time. February 4,
			Saturday 1989. AMHI. 11th grade. Did not like
			school [illegible]. Thinks there is nothing
			wrong with her. Would not like to go home and
			get a job. Remembers 4 objects after five
			minutes.
			She denies knowledge of strengths
			Dx: Schizophrenia, undifferentiated by hx (R/O
			personality disorder)
			(1.)
			Plan: Return to SSM from whence
			she departed
			(2) Try to develop therapeutic alliance
			[illegible] MD

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105101 .26/F/US

59575
C2 04 89/INVDCT/2/N/C/P
10 03 62/007 54 5926
PORTLAND/MH CTS
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Patient Name: Wayne Wrenaly
Medical Record Number 59575

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PROGRESS NOTES

UNIT SSM PAGE 3

DATE	TIME	TYPE	
2-4-89	4:40 pm	Nsg	Initial Nursing Assessment. This is the 15TH AMHI admission for this 26 year old white petite female. From Portland, Me. She was referred by Dr. Carlyle Voss M.D. of Maine Medical Center on E.I certificate, because she is noted to show signs of severe schizophrenia, she has delusions, is expressing homicidal feelings, and is assaultive c others. Transported to A.M.H.I. by CCSD. During the interview she was cooperative. When asked why are you here? Pt stated "For hitchhiking." Then when asked what she would like to get from being here? stated "To go home." She then stated "I ran away from here a long time ago." During the interview pt denies any suicidal/homicidal ideations. Denies hallucinations (auditory or visual). Denies any depression. Pt affect is labile, eye contact is fair. She was unable to sit still during the interview continuously Δ'd positions. Pt has a history of sexual abuse, but wouldn't talk about it. Also has a history of ETOH and drug abuse. Pt is NKA to medications or foods. She is oriented X3. Hygiene is good, and was dressed appropriate for the weather. Pt eloped from AMHI on 2/2/89 and hitchhiked to Portland. She was seen seen at MMC-ER @ 6:05 pm and (Cont) Richard Mansfield RN

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105101 26/F/US

59575
C2 C4 89/INVDCT/2/N/C/P
10-03 62/007 54 5926
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Patient Name: Hayne, Wendy
Medical Record Number 59575

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01531 **PROGRESS NOTES**

UNIT SSM PAGE 4

DATE	TIME	TYPE	
2-4-89	4:45 pm	Nsg	Initial Nursing Assessment Cont.
			admitted to P6 where she stayed until
			her admission here, as they were unable
			to manage pt on P6. Pt was returned
			to the ward checked for harmful objects
			none was found, Placed in room 218
			Section I and placed on 1/4° V's as she
			is an elopement risk. Pt denies
			having a mental illness. For further
			information see Dr. admitting note.
			Richard Mansfield RN
2-4-89	5:30 pm	Nsg	Recieved a call from pt step father inquiring
			about pt meds. Also to inform us that pt
			had recieved 400mg of CPZ from 12 mn to 1 pm
			there is no documentation to confirm or
			deny this Richard Mansfield RN
2/4/89	3-11	MHW	Pt. maint on 1/4° V's since admission to unit. Pt.
			ate supper, spent some time in dayroom
			smoking + watching T.V. Has been in room
			bedrifting quietly since after supper
			Wayne A McLeod MHW 2
2/4/89	9pm	MHW	P.T. verb. An order was obtained to hold
			P.T's 8pm meds as she was sleeping soundly
			and was difficult to arouse — [illegible] Watkins MHW 1
2/5/89	6am	MHW	1/4° V's Maint 11-7 Shift pt awaken at 5:45 AM
			asked if she was alright pt responded she
			was fine went back to sleep [illegible] MHW
2/5/89	12 noon	Nsg	Family desire in the past that Wendy not be on
			anti parkinsonians and lack of admission physical

Marginal signatures: Richard Mansfield; Mary Edwards RN

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59575
02 C4 89/INVDCT/2/N/C/P
10 C3 62/007 54 5926
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Patient Name: Wayne, Wrendy
Medical Record Number 59575

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01532 PROGRESS NOTES

UNIT 55M PAGE 5

DATE	TIME	TYPE	
2/5/89	12 noon	Nsg.	reported to the [illegible] who will report some
			[illegible] MD [illegible]
2/5/89	2 PM	Nsg.	I conferred with Dr Meng who spoke by
			telephone with pts stepfather re: medications
			last evening. Pt rec'd one dose of Artane @ 8 AM.
			In view of previous decision per anticholinergic
			(order 1/6/88) will request team clarification
			with family ca ant. No c/o EPS by pt.
			Caroline [illegible] RN
2/5/89	MHW	2 00 pm	V/s taken & charted B/P 108/60 P 84 R 20 T 98.6
			Shirley Stephens MHW
2/5/89	4 30 pm	[illegible]	1/4° Ds done from 3-4 30 pm: Pt. has been escalating this
			period becoming increasingly hostile and threatening.
			Pt has been offered medication several x's since
			4 pm med-serve with the result being her threatening
			staff and peers, and refusing medications. She was
			approached by staff and was offered medications
Richard Mansfield LPN			po @ 4 35 pm. Pt. exploded becoming verbally abusive
			yelling "I'm Wrendy, and I'm here, there and over in
			there!" Pt took medications po with much encouragement
			and continued to escalate. She was directed to
			bedroom to ↓ stimuli. She was verbally abusive and
			threatening to peers and staff on way to room.
			When outside of bedroom, pt exploded punching
			door-frame and screaming obscenities. She was restrained
			NAPPI technique by writer and Wayne MacLeod and Diane
			Wright and escorted to quiet-room. She was placed
			in quiet-room by writer, Wayne MacLeod, Diane Wright, Shari
			Watkins and Rick Mansfield LPN/chg @ 4 30 pm (continued) [illegible]

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59575
02 04 89/INVDCT/2/N/C/P
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PROGRESS NOTES

Patient Name: Hayes, Wendy
Medical Record Number 59575
UNIT 55m/440
PAGE 6

DATE	TIME	TYPE	
2/5/89	4:40pm	SRC	(continued from pg. 5) - Pt. was searched for harmful
			objects, shoes removed and placed in SRC locker, was told
			door would remain unlocked, and that needs would
			be met, 1/4 0's continued for duration, Rick Mansfield LPN/chg
			present during incident —— [signature]
2-5-89	7 PM	NSG	Pt. seen in QR. she is much calmer at this
	5-7 PM		time. She was toileted and given fluids
			during this time period. Thorazine 100mg P.O.
			PRN was given at 5pm which she took. Pt.
			was [illegible] and was observed at one
			point to openly masturbate while in QR. At 5PM
			she contracted to maintain control of her
			behavior. Good effect noted from meds. Released
			to ward status. 1/4 0's to continue as when
			she was in QR. —— Rick Mansfield LPN
2-5-89	9:30 pm	NSG	1/4 0's maintained. Pt has been up and about the
			ward since she has been out of QR.
			Socialized some with peers. Resting in
			bed since 8:45 pm. —— Rick Mansfield LPN
2/5/89	9:45pm	[illegible]	Pt sleeping - hard to rouse. P.E. Not done. R.J. [illegible] PAC
2/6/89	11-7	MHW	1/4 0's Maint. Pt appeared to sleep
			well all night until 2:30AM. Since then
			has been in + out of her room. No
[illegible] Edwards RN			problems. —— [signature] MHW
2/6/89	1000	M.D.	Interview in Team. Limited but brighter affect, delusional about
			being killed + eaten here, [illegible]. Doesn't want
			to take [illegible], denies she needs it although she seems
			restless. Denies sexual activity recently. Restlessness is
			[illegible]. Will [illegible] Artane PRN. [signature]

PHMCY = Pharmacy
M.D.= PHYSICIAN
P.E.= PHYS. EXTENDER
Nsg.= NURSING
Psy.= PSYCHOLOGY
S.S.= Social Service
MHW = Mental Health Workers
T.A.= Therapeutic Activities
DTY = Dietary
TCN = Team Conference Note
SRC = Single Room Care
COR = Constant Observation
Rst.= Restraint
G.T.= Group Therapy
F.T.= Family Therapy

Form 337 Revised 10/88
Medical Record Form

HAYNE WRENDY
105101 26/F/US

59575
02 04 89/INVDCT/2/N/C/P
10 ?3 62/007 ?54 5926
PORTLAND/MH CTR

Augusta Mental Health Institute
PROGRESS NOTES

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01534

Page 7 Unit SSM/HATP

Hayne Wrendy 59575

Date	Time	Type of Note	
2/6/89	3:05 PM	NSG	Pt very agitated screaming & having delusions someone was messing in her head. Given Thorazine 100mg PO @ this time — Richard Mansfield
2/6/89	7am-3pm	MHW	(out of sequence)
			1/4 V's maint. pt up & about ward very happy and friendly c staff & peers. Went to morning meeting no problems to note — Shirley Stephens MHW
2-6-89	9:50 PM	NSG	1/4 V's maintained. Good effect noted from 3pm Thorazine. Has been up and about the ward sitting in day room not socializing c staff or peers. Rested in bed at intervals. No problems noted this shift. — Richard Mansfield LPN
2/7/89	11-7	MHW	1/4 V's maint. Pt. appeared to have slept no problems noted. — Donald Johnson MHW
Mary Edwards RN			
2/7/89	9:15 AM	NSS	Med Review: multivitamins ? po q AM. Laura Moody — M. ? M.D.
2/7/89	7-3	MHW	1/4 V's — Pt dressed and room clean, ADL's done. Able to hold pleasant conversation c writer — Marie Morin MHW
2/7/89	3:10 PM		[illegible] to interview today. Wrendy [illegible] [illegible] not to talk [illegible] [illegible] [illegible]. No evidence of [illegible] [illegible]
2/7/89	9:25 pm	NSG	Pt had an outburst at staff when she was asked to get her meds, but quickly calmed down. Has been in good control. No problem noted at this time. — [illegible] RN
2/7/89	11pm	MHW	P.T. ↑ agitation requested and recieved Thorazine 100mg PO PRN @ 5 pm c good effect — [illegible] MHW
2/8/89	11-7	MHW	Shift note. 1/4 V's maint. Pt. appeared to have slept. no problems noted. — Donald Johnson MHW
Mary Edwards RN			
2/8/89	9:30 A	NSG	Wrendy is having a difficult morning — yelling + screaming "Someone take my f— head!" Frequently reassured that hasn't happened — She requested a prn but before I could get to med room — she started — (cont'd)

M.D. = PHYSICIAN S.S. = SOCIAL SERVICE TCN = TEAM CONF. NOTE F.T. = Family Therapy
Nsg. = NURSING D.C. = DIRECT CARE (MHW) SRC = SINGLE ROOM CARE G.T. = Group Therapy
Psy. = PSYCHOLOGY A.T. = ACTIVITY THERAPY Rst. = Restraint S/O = Special Observe

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01535

Haynes Wrendy

Page 8 Unit SSM

Date	Time	Type of Note	
2/8/89	9:30 A	NSG	(cont'd) yelling + screaming - she stated "I don't Need no f— [illegible] get out of my face." Did go to her room + did lay down for awhile and did settle down some. Refused eye clinic appointment @ 9:45 A will reschedule - Wrendy is expecting her mother to see her today. Wrendy is doing better as far as ADL - c̄ a lot of encouragement Will give her tea + cigarette p̄ room completed + this works real well c̄ her. She's doing better c̄ grooming. Did go AWOL LAST WEEK (see old chart for details) — Bonita [illegible] LPN
~~2/8/89~~	~~11:00 pm~~		~~[illegible]~~
2/8/89	8:30 pm	NSG	Pt in good control. Quiet, keeping to self. No problems to note at this time. [illegible] RN
2/8/89	9:35 p	[illegible]	Pt requested & rec'd her prn [illegible] 100 mg po @ 6pm for agitation. Appears effective. [illegible]
2/8/89	11-7	MHW	1/4 [illegible] Maint 11-7. for Smoking Hazard. No Smoking Violations Noted this Shift. Scott Ward MHW I
			[illegible] E. Boucher [illegible] 2/9/89 11-7 Shift
2/9/89	7-3	MHW	[illegible] No smoking violations noted this shift. [illegible] MHW I
2/9/89	8:40 pm	NSG	Pt agitated & verbally abusive before 4pm meds. Given 4pm meds & went to room. Calmed down after 15 minutes & was in good control. Has been quiet rest of shift & spending time in her room. [illegible] RN
2/10/89	6:30 AM	MHW	[illegible] maint (11-7) Pt slept all night. [illegible] MHW I [illegible]
2/10/89	11:30 am	Psy	Applic. for District Court commitment is filed because of inability to care for self & danger to others. ~~Pt interviewed & advised.~~ [illegible] PhD

Medical Record Form 37 Revised 5/81

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PROGRESS NOTES

01536

Wendy Hayne

Page.......................... Unit ....

Date	Time	Type of Note	
2/10/89			Special Progress Note
			This 26 y.o. single woman, who is under guardianship of her mother, was admitted 2/4/89 on Emergency Involuntary status. She has lengthy history of AMHI hospitalization, with Diagnosis of Schizophrenia, chronic Undifferentiated type. She ran away from staff 2/2/89, went to Portland where she was hospitalized same day at Maine Medical Center saying that a spell had been cast on her making her suffer from "telepathy". At MMC she showed poor impulse control, incontinence, screaming and talking of killing others. She was referred back to AMHI 2/4/89. Since returning to AMHI she has exhibited delusional ideation, severely disorganized thought processes, poor impulse control with threats of assault to others, periodically screaming at others, has accused others of stealing her head. She continues to suffer from Schizophrenia to extent that she is unable to care for herself or to protect herself from impairment or injury. Applic. for District Court commitment is initiated under paragraphs A & C.
			Thomas Kinney Ph.D. Psychologist

Medical Record Form
337 Revised 5/81

M.D. = PHYSICIAN S.S. = SOCIAL SERVICE TCN = TEAM CONF. NOTE F.T. = Family Therapy
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Addressograph

AUGUSTA MENTAL HEALTH INSTITUTE

Individual Medical/Psychiatric
Nursing Care Plan

Page: ____

Nursing Diagnosis/ Problem	GOALS	Interventions	PROBLEM (Resolved) Refer to RX Plan
Date: 11-24-95 alteration in safety As evidenced by: States male client threatens her if she goes anywhere s̄ him Date Initiated: 11-24-95 Date Resolved: ____ Patient Name: Wendy Plan of care reviewed with patient/family/significant other: Initial: ____ Date: ____	Wendy will spend time by self & bodys	① Staff will enc Wendy to spend time c̄ friend ~~by self~~ from 1-2:30 & 6:30-8P. If she is threatened she is ask to ~~seek~~ seek out staff immediately. ② Explain to Wendy that she is allowed to be any where on grounds by self if she so desires s̄ threats ③ Staff is to notify ASU (ref. male client) if any threats are made to her - ④ Observe for S+S of threats or abuse from male client.	This has been D/C 12-15-95 Diane McLean 2-4-96 Reviewed Faylene Jones RN

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HAYNE W
105101 26/F/US

59575
02 04 89/INVDCT/2/N/C/P
10 03 62/007 54 5926
PORTLAND/MH.CTR

AUGUSTA MENTAL HEALTH INSTITUTE
INDIVIDUAL PLAN OF CARE/TREATMENT (IPCT)

Patient's Signature: Wendy [signature] Date:

Attending Physician: [signature], MD Date: 7/26/90

Diagnosis: Schizophrenia [signature: Donald Byers, MC] 10-4-90

Pro. No.	PROBLEM	GOAL/OBJECTIVE	APPROACH	CPT-	hrs wk	RESPONSIBILITY code	name	Date Start	Date Stop
4	Delusional- pt often expresses the thoughts that someone has taken her brain or switched heads with her, or that she is not Wendy. She says the voices tell her this and asks if it is true.	within 90 days Wendy will be able to tell staff that she recognizes these thoughts are part of her illness and not really happening.	1) Whenever Wendy and staff I will re-direct her by telling her these thoughts are due to her illness and that she needs to stay compliant c̄ med. regimen to decrease the amount of auditory hallucinations which tell her these things. I will continue to assure her that she is safe here and that no one will hurt her, kill her, or can take her head or brain away. I will talk c̄ her on a 1:1 basis and also encourage her to discuss her feelings in the AM Group		3°	SS.	Harold F. Gluck	7/19/90	10-4-90
			2) As Wendy's mental health improves to the point where transition to the community is feasible, I will discuss c̄ her the options available. With the help of the aftercare community, we will explore the merits of these options and try to provide some choices that meet both her needs and her wants.		1/2°	S.S.	Harold Gluck	7/19/90	10-4-90
9	Unable to care for self- Wendy will need a supervised structured living situation since she needs encouragement on a daily basis to perform ADL's and routine activities	In preparation for when Wendy is able to leave AMHI, she will work with me in finding a living situation where she can get the supervision and assistance to teach her more self reliance	We talk about this now in group and will continue to explore this.			MHW	Marie [illegible]		10-4-90
							[signature]		10-4-90

[signatures:] Harold F. Gluck MSW; [illegible] Jones CTRS

Form 125-c (new)

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PATIENT NAME: WRENDY HAYNE
MR #: 59575
UNIQUE #: 105101
UNIT: SLP
TEAM COORDINATOR: Michael Gilbert, MHW III
ADM DATE: 2/4/89
DATE OF CONFERENCE: 11/18/92

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MASTER PROBLEM LIST

PROBLEM	AS EVIDENCED BY	
#5 - Leaving grounds without permission. DATE: 2/15/92	A. Called guardian from Burger King on 2/15/92 for a ride back to AMHI. B. Hitchhiked to mother's house on 4/1/92. C. Hitchhiking on Stone Street, 4/17. D. Hitchhiked to grandmother's house on 5/20/92. E. Continues to attempt leaving as of this review.	Priority Code 1 Discharge Goal Reached ____ Restated: 5/27/ Subsumed Under Problem # ____
#6 - Poor eating skills. DATE: 11/18/92	A. Eats too fast.	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____
#7 - Needs reminders to dress accordingly for the weather. DATE: 11/18/92	A. Will sneak out without wearing shoes, socks, boots, or jacket at times.	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____
#8 - "I'm bored." DATE: 11/18/92	A. "I only look forward to coffee and cigarettes." B. Spends a lot of time in her bed-room.	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____

PRIORITY CODES:

1. Problem requiring immediate attention/care.
2. Problem being referred for treatment.
3. Problem which is currently being deferred.
4. Problem is minor and/or does not require treatment.

continued

NAME: HAYNE, WRENDY
MR #: 59575
UN #: 105101
UNIT: SOCIAL LEARNING PROGRAM
TEAM COORD: DOREEN MCFARLAND, RN
ADM DATE: 2/4/89
CONF DATE: 2/17/93

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MASTER PROBLEM LIST

PROBLEM	SUB-PROBLEMS	
#5 Leaving grounds without permission DATE: 2/15/92	Continues to attempt leaving as of 1/14/93. She hitchiked to ~~Portland~~ Gardiner on ~~12/7/92.~~ 1-14-93	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____
#6 Poor eating skills DATE: 11/18/92	A. Eats too fast.	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____
#7 Needs reminding to dress accordingly for weather DATE: 11/18/92	A. Will sneak out without wearing shoes, socks, boots or jacket at times.	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____
#8 "I'm bored" DATE: 11/18/92	A. "I look forward to coffee and cigarettes." B. Spends a lot of time in her bedroom.	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____

PRIORITY CODES:

1. Problem requiring immediate attention/care.
2. Problem being referred for treatment.
3. Problem which is currently being deferred.
4. Problem is minor and/or does not require treatment.

NAME: HAYNE, WRENDY
MR #: 59575
UN #: 105101
UNIT: SOCIAL LEARNING PROGRAM
TEAM COORD: DOREEN McFARLAND, RN
ADM DATE: 2/4/89
CONF DATE: 2/17/93

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MASTER PROBLEM LIST

PROBLEM	SUB-PROBLEMS	
MEDICAL PROBLEMS: #1 Myopia	As identified by AMHI clinic and is in treatment with glasses.	Priority Code ____ Discharge Goal Reached ____ Subsumed Under Problem # ____
#2 High-risk medication, Clozaril DATE: 11/20/91	A. As identified by medical profession; is closely monitored through weekly blood work, the lab, Dr. Herminda, the clinic team and the pharmacy. B. Medication renewed weekly if lab results permit. C. Low seizure threshold.	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____
#3 Smoking while taking birth control pills	Resolved. Norplant inserted 12/23/92.	Priority Code ____ Discharge Goal Reached ____ Subsumed Under Problem # ____
#MXVIII Constipation	See medical summary of 3/23/92.	Priority Code 1 Discharge Goal Reached ____ Subsumed Under Problem # ____

PRIORITY CODES:

1. Problem requiring immediate attention/care.
2. Problem being referred for treatment.
3. Problem which is currently being deferred.
4. Problem is minor and/or does not require treatment.

HAYNE, WRENDY
MR #59575
UN #105101
SOCIAL LEARNING PROGRAM
TEAM COORDINATOR: Dorene McFarland, RN
ADMISSION DATE: 2/4/89
CONFERENCE DATE: 11/14/95

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ADDENDUM TO ITDP OF 10/16/95
MASTER PROBLEM LIST

Page_____ of_____

PROBLEM	AS EVIDENCED BY (OPTIONAL)	
#4 Alternation in sleep pattern. DATE		Priority Code_____ Discharge Goal Reached_____ Subsumed Under Problem #_____
# DATE		Priority Code_____ Discharge Goal Reached_____ Subsumed Under Problem #_____
# DATE		Priority Code_____ Discharge Goal Reached_____ Subsumed Under Problem #_____
# DATE		Priority Code_____ Discharge Goal Reached_____ Subsumed Under Problem #_____

PRIORITY CODES:
1. ACTIVE
2. DEFERRED
3. STABLE WITH TREATMENT
4. INACTIVE

HAYNE, WRENDY
MR #59575
UN #105101
SOCIAL LEARNING PROGRAM
TEAM COORDINATOR: Dorene McFarland, RN
ADMISSION DATE: 2/4/89
CONFERENCE DATE: 11/14/95

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ADDENDUM TO ITDP OF 10/16/95

PROBLEM # 4:
Alteration in sleep pattern.

GOAL/DISCHARGE CRITERION:
The patient will feel rested and be able to maintain her ADL's.

OBJECTIVE # 1:
Wrendy will feel rested upon awakening.

INTERVENTION:
1. R.N. will initiate a baseline to monitor sleep pattern times two months to evaluate for further intervention.

RESPONSIBLE PERSON: Dorene McFarland, R.N.
START DATE: 11/14/95

INTERVENTION:
2. Alice Dufresne, MHW will attempt to wake up Wrendy at 8 a.m. for breakfast and meds and attempt to keep her up.

RESPONSIBLE PERSON: Alice Dufresne, MHW I
START DATE: 11/14/95

INTERVENTION:
3. Nursing staff will sit with Wrendy when she is awake and functioning to discuss activities to keep her motivated.

RESPONSIBLE PERSON: Dorene McFarland, R.N./Alice Dufresne, MHW I/Dan Truman, MHW.
START DATE: 11/14/95

INTERVENTION:
4. Staff will encourage Wrendy to go to bed at a reasonable time, i.e., between 9 and 11 p.m.

RESPONSIBLE PERSON: Dan Truman, MHW
START DATE: 11/14/95

M Hermida MD
MANUEL HERMIDA, M.D.

DMcF/jo
d 11/14/95
t 11/20/95

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"This is a treatment plan on Wrendy Haynes that was held on 3/28/96. This was not dictated on that day because I was called away for a home emergency and due to the circumstances on that weekend the team was not sure if it should be dictated - post-dated."

DM

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HAYNE, WRENDY
MR #59575
UN #105101
SOCIAL LEARNING PROGRAM
TEAM COORDINATOR: Dorene McFarland, R.N.
DATE OF ADMISSION: 2/4/89

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INDIVIDUAL TREATMENT AND DISCHARGE PLAN

ADDENDUM

An error was made in dictating Wrendy Hayne's treatment plan. The day the treatment plan was held was April 4, 1996 at 9 a.m., not March 28 as previously dictated. It was an error on my part by looking at the wrong week on the calendar to confirm the date.

DM/jo
d 5/1/96
t 5/1/96

DORENE MCFARLAND, R.N.

MANUEL HERMIDA, M.D.

HAYNE WRENDY
105101 26/F/US

59575 HAYNE, WRENDY
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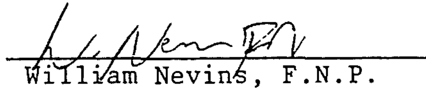
Augusta Mental Health Institute

Physicians Psychiatric Progress Notes

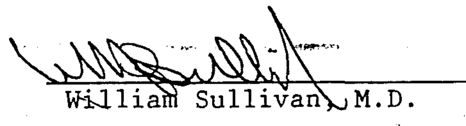
MARCH 23, 1989

Lengthy interview with the Byrns' today at their request when they called this morning. This was tantamount to a treatment planning session that the rest of the team was unable to attend due to the abruptness of the meeting. I reviewed with the Byrns' the status of instructions/order given by Judge Poulin, in that we are awaiting the opinion of the Attorney General's office at the recommendation of Dr. Jacobsohn. The Byrns' are unhappy with this and indicated that they had different information which later they are hoping to clarify with acting Superintendent, Rick Hanley.

We had a lengthy interview and discussion of Wrendy's condition and agreed to: 1. At the request of the Byrns', Wrendy will be reminded for approximately a week, that she will after one week's time, not get her $1.00 a day spending money unless she attends her 8:30 team/patient's meeting. 2. We agree that medication will be tapered at the request of the Byrns' to a regimen of Thorazine 75 mg. every 4 hours PRN for severe agitation; Thorazine 100 mg. at 8 and 8; and Moban 50 mg. at 8 and 8 and 25 mg. at 4 P.M. The Byrns' indicated that they are generally encouraged and pleased with Wrendy's care but displeased with what they feel is an ongoing problem with disappearance of Wrendy's clothing. We have explored at different avenues, trying to effect this problem without any real success. They indicated a will to discuss it further with the Superintendent.



William Nevins, F.N.P.



William Sullivan, M.D.

ew
r&t-3/24/89

HAYNE, WRENDY

#59575

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Augusta Mental Health Institute

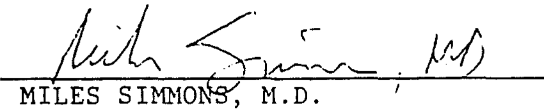
Physicians Psychiatric Progress Notes

AUGUST 18, 1989

Team attempted to see Wrendy during team meeting this morning but she refused. Her care is discussed and her recent behavior of sleeping more during the day was explored. Beside the initiation of Benadryl by Dr. Rohm seems most likely to have caused her to be sleepy. It is pointed out to me that in the transcription for renewal of Moban that the order of the dosages were altered so that a small dose was given at noon rather than at 4 o'clock. I believe this to have been a transcription error, find no harm or altered daily dose to have been given the patient but I will initiate medication error form.

I've yet received no word from the Burns' about alternative treatment planning meeting times.

WILLIAM NEVINS, F.N.P.



MILES SIMMONS, M.D.

ew
r&t-8/23/89

HAYNE, WRENDY

#59575

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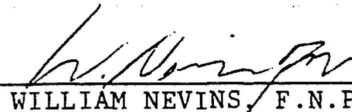
Augusta Mental Health Institute

Physicians Psychiatric Progress Notes

MARCH 16, 1990

The patient is interviewed briefly this morning. Pleasant, responsive, and cooperative in superficial conversation. She denies any difficulty with the introduction of Clozapine and has, I believe, first acquired her level II today. I spoke at length last night with patient's stepfather over questions raised during recent visit by the mother and stepfather. In question is whether or not the patient should be receiving 75 mg. I.M. in place of 100 mg. PO given the absence of acute psychotic behavior, severe agitation, or imminence of harm that would necessitate sedation. I think this is a valid point, and though I have told Mr. Burns that I'm not aware that it was being given as such, I've traced through the old medical record and found that the original order was mine. We did discuss that I see no harm for the medication to be delivered this way and that the dosage is consistent with that that I have treated Wrendy for so long in the past. The parents also had questions about concurrent use of Thorazine and Clozaril. I explained that we believe and expect that there will be no synergistic effect between the two, and that there's no contraindication, but given the accepted practice of monopharmacy in the ~~will to~~ determine whether or not Clozaril is an instrument of change, I'm sure that it's consistent with Dr. Simmons plan to eventually taper Thorazine. Mr. Burns and I agreed that there was no rush for this to happen and I recommended that we speak about this again next week as they expect to visit. In the meantime, I will reduce the regular backup I.M. dosage of Thorazine, and the PRN I.M. will remain at 75 mg. as an appropriate dosage to address acute symptoms specified. Continued Clozaril schedule is prescribed at incremental dosages intermit next week with a target dose of 300 mg. in two weeks time.



WILLIAM NEVINS, F.N.P.

MILES SIMMONS, M.D.

ew
r&t-3/19/90

59575
02 04 89/INVDCT/2/N/C/P
10 03 62/007 54 5926
PORTLAND/MMC

(must be addressographed
Patient Name:
Medical Record Number

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02182 PROGRESS NOTES

UNIT PSL PAGE 590

DATE	TIME	TYPE	
10/14/91	3-11	Nsg	(S): "Why do I still have my head"
	1855pm		(O): pt. made above statement to writer, writer assured pt that her head was still present which seemed to accept (A): pt delusional concerning the loss of her head throughout the [illegible]. Otherwise appropriate (P): Cont to monitor + reassure pt PRN — L. [illegible] LPN
10/16/91	3:15PM	R.S	See Incident regarding Wendy on Special Service Section (Rehab Services). [illegible] MHW
10/17/91	10:55 AM	MHW	Writer was in south end dayroom, playing cards c̄ another peer, when a maint. worker who was working in this pts rm. noticed an ash-tray + cig butts on the floor behind her bed. This was reported to this writer @ 10:45 am. Writer informed RN Doreen McFarland. [illegible] Hanson MHW
10/18/91	11-7	Nsg	S – "My mother is coming tomorrow – don't pretend to be my mother." O – Up all nt. watching T.V. + pacing about unit. Eyes wide & staring. A – Delusion of [illegible]. P – Cont c̄ P.O.C. Joyce Campbell LPN
10/18/91	9PM	Nsg	It was reported to writer that Wendy was in the smoking room and could not be aroused. When staff responded Wendy was found c̄ her head on the table ≡ in an apparent deep sleep. (Cont) [illegible] RN

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Form 337 Revised 6/90
Medical Record Form

HAYNE WRENDY
105101 26/F/US
59575
02 04 89/INVDCT/2/N/C/P
10 03 62/007 54 5926
PORTLAND/MMC
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Patient Name
Medical Record Number

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02184 PROGRESS NOTES

UNIT PS2 PAGE 592

Cont p 5911

DATE	TIME	TYPE	
10/19/91	12:10 Am	NSG	as it was at KVMC and I redirected their
			call to House P.A. for more information.
			[signature]
10/19/91	1 Am	NSG	Spoke c̄ E.R. physician, Dr Hom. She
			stated that Wrendy would require a
			repeat CAT Scan (this A.M.) She stated
			that she did experience a seizure and
			hospital staff would continue to monitor
			Neuro signs, vital signs, LOC and
			will maintain at hospital this weekend
			c̄ 1:1 staff. [signature]
10/19/91	3-11 10:30p	Nsg	1:1 maint @ KVMC MHW Kelleher
			reports pt slept most of shift + up @
			x's + requested cig x pt was
			told that she did not have cigs @
			the hospital. pt was fairly agreeable
			to this although MHW Kelleher asked
			KVMC staff if pt could smoke they
			stated would get an order [signature]
10/20/91	11-7	MHW	S- Wrendy's sleeping patterns
			O- Pt was sleeping a fair amount on
			this shift. When pt is up + about she
			is quiet + observant of others behaviors
			A- I believe Wrendy sleeps a great
			deal of the time
			P- I will continue to urge Wrendy to try
			to rest more at night + to get more involved
			Andrea Colby

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PROGRESS NOTES

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UNIT SLP PAGE 1086

DATE	TIME	TYPE	
9/22/93	1830	Nsg	S "Why do you look like me? You took my head & thoughts!
			O - Pt. observed pacing hallways rapidly. Each time
			she passed this writer she made statements as above.
			Pacing was observed x20 min - pt. became ↑ingly
			agitated. Was not responding to verbal intervention.
			↑ suspicious of staff. Ativan 2mg po given @ 1603.
			A - calmer @ this time. ↓ suspicious & agitated. P. Cont
			to monitor. [signature] RNC
9-23	0600	Nsg	S "That's my forehead - can't you give it back?"
			O pt. pacing, relating troubled thoughts to
			staff c 0100. Alternating laughter c angry
			affect. Verbal reassurances to little use at
			resolving thoughts A further assistance to re-
			gain thought process, due to agitated/anx-
			ious state necessary P Ativan 2g prn added
			to interactions by staff to help calm c de-
			sired result obtained - bedresting by 0145
			Sue [signature] LPN
9/23/93		MHW	Unable to wake for 8AM meds. Several
			attempts made to no avail. Sheila Andrews MHW

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UNIT SLP   PAGE 113

DATE	TIME	TYPE	
10-18-93	3-11	NSG	15 min Vs 1:1 off unit main @ Wendy
	9:30pm		calm + pleasant; pt ↑ drowsy p̄ supper
			pt retired to her room and remained there
			since 530PM Ⓐ ? ↑ drowsy SE of Ati prns
			rec. on previous shift for ↑ agitation or 2°
			to lack of sleep for several hours Ⓟ cont
			to monitor —— Libby [illegible] RN
10/19/93	9:53 am	SW	Conference call with Mrs Burns and Ms Hagley
			re investigation of Wendy Hayne's alleged
			rape. Mrs. Burns expressed concern that
			AMHI is not treating the event as strongly
			as she would like. She stated a feeling that
			this is different from other "sexual encounters"
			in that Wendy has never "cried rape" before.
			She was assured that an investigation was
			underway and she would be advised of the
			outcome. —— Cliff Graves LSW

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HAYNE WRENDY
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PROGRESS NOTES

UNIT SLP PAGE 1125

DATE	TIME	TYPE	
10-27-93	3-11	NSG	(con't from pg 1124) examine to the extraction area: ate well; Ⓐ ō noted difficulties re. tooth extraction Ⓟ cont to monitor —
			—— Libby Furrow LPN

Name:	Wrendy Haynes	MR#:		Date:	10-27-93
Group:	Tea Group		Time spent in group:		less than 15 min

Wrendy walked into the tea group meeting x2, to obtain cups of coffee / tea. Upon obtaining her beverages she promptly left the group after accusing one of the male members of looking at her abdomen.

Signature: R Turner LSW

DATE	TIME	TYPE	
10-28-93	3-11	NSG	1° (sm)aint Wrendy has been pleasant + cooperative; attended Dance @ Center; dress + make up appropriate; on time for 1° V ins; ō c/o discomfort re. tooth extraction ō noted swelling etc. cont to monitor as ordered — L Furrow LPN —

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WAYNE WRENDY
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PROGRESS NOTES

UNIT SLP PAGE 1134

DATE	TIME	TYPE	
			cont. 1133
			O. [illegible] c̄ another client from SSU..
			They apparently were [illegible] walking
			and talking - argument APD
			reports that a call had been
			made that the pair had an
			argument on the memorial bridge
			A. Client failed to return to unit
			for 2pm checks - Ground search
			was done by staff - Client was
			returned to unit @ 2:45p by
			P. Hunt & P. Pulitzer. MHW's -
			Mother to be notified by on-
			coming nurse L. [illegible] - N.O.D.
			notified by this writer - Client
			will be restricted to unit this
			eve. until evaluated by
			physician in a.m. - T. Maschke

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HAYNE WRENDY
105101 26/F/US

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PROGRESS NOTES

UNIT SLP PAGE 1135

DATE	TIME	TYPE	
11-11-93	3pm	MHW	O. When writer was coming to work I saw this pt with another pt # [redacted] this male and pt were struggling. I went to the police station to report this. Pt was returned to ward and put on 15 min (cs). I talked with pt about what I saw. Her statement was "I want to die I was going to jump off the bridge I want to die". This was reported to the LPN and pt was put on 1-1. Nursing note to the above will be my pt note. [signature] MHW 3
11-11-93	4-5pm	MHW	1:1 maintained. Wendy has been placed on a 1-1. Pt very agitated this 1° from 4-5 PM. Called this writer a "bitch". She stated I was lying to her & that somebody had taken her head. Tried to re-assure her that she had her own head & body. Pt ate a gd. supper but started crying near the end of her supper meal. Taken down to the smoke rm. for a cig. — Joan Cummings MHW

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PROGRESS NOTES

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UNIT SLP PAGE 1136

DATE	TIME	TYPE	
11-11-93	6pm	MHW	1-1 maint. Pt laying on bed c eye closed during this hour. Eric Mac[illegible]
11-11-93	3-11	NSG	Writer rec. a report from Ed Mason that Wrendy was seen by MHW Marks on the Memorial Bridge c SSU client pt # [redacted] apparently the two were involved in some type of struggle, when writer interviewed Wrendy she stated the following when asked what had occurred on the bridge "I was trying to jump off and he stopped me." "I want to die" Wrendy denied any other intentions of self harm stating "I can't think of any other way right now" Writer contacted SSU nurse Diane Topiano who stated that pt # [redacted]'s account of the events on the bridge coincided c Wrendy's statements. Wrendy was placed on 1:1 immediately @ 345 pm; Writer contacted the following regarding the above situation K Whitzell (nurse manager Tim Garland PA, Shanti Rausch NOD, Joyce Chase DNS, Janice Burns (guardian and Dr. Hermida. Dr. Hermida noted to con't c the 1-1 and also felt until further notice/evaluation pt # [redacted] should Ø have contact c Wrendy. (con't to pg 1137) Kithy Furrow RN

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PROGRESS NOTES

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UNIT SLP PAGE 1137

DATE	TIME	TYPE	
11-11-93	3-11	NSG	(Continuing 1136) writer contacted SSU
	cont		nurse to inform her of Dr. Hermida's
			request; Wrendy ō return to the
			unit has been somewhat agitated @
			X's making delusional type statement
			angry affect @ X's and other X's weeping
			writer spoke c̄ Wrendy and reassure
			ed that she was ø on 1-1 for punish-
			ment but to keep her safe. Client
			Con'ts to make statement to her at-
			tempt to jump off the bridge. At
			rec'd a prn of ativan @ 4:45 PM;
			cont to monitor as ordered
			Libby Furrow LPN
11-11-93	6-7PM	MHW	1:1 maintained. Pt slept this hour.
			Joan Cunningham MHW
11-11-93	8pm	MHW	1-1 maintained. Pt had HS Meds. Laying
			on bed c̄ eyes closed. Sue Mac[illegible]
11-11-93	9PM	MHW	1:1 maint. Pt slept the whole hour.
			Joan Cunningham MHW II
11-11-93	10p	MHW	1-1 maint. Pt slept the hour. Sue MacLennan
11-11-93	10?p	NSG	1-1 maint Wrendy has spent most of
			shift ō rec pen. Wrendy unwilling due
			↑ tired to speak c̄ PA Garland when
			he arrived; ø further statements of self
			harm thus far cont to monitor
			Libby Furrow LPN

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105101

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UNIT SLP PAGE 1163

DATE	TIME	TYPE	
11/16/93	8 am	MD	UTILIZATION REVIEW NOTE. (11/13/93)
			Patient needs longer hospitalization. She has a diagnosis of Schizophrenia, Chronic Undifferentiated. She is being treated with Clozaril, Thotazine and Depakote. She is quite delusional, suffers auditory hallucinations and as a consequence of these symptoms often she had serious episodes of agitation and acute anxiety. At these moments she could become agressive and even assaultive. She can not be treated in an outpatient basis as she needs almost continued supervision as she can not take proper care of herself. LOS = 90 days.
			[signature]
			EXTENDED STAY REVIEW This case has been reviewed and is certified for an additional 90 days. The next review date is 2/11/94 [signature] Utilization Review 11/15/93 Date

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02 04 89/INVDCT/2/N/C/P
10 03 62/007 54 5926
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PROGRESS NOTES

Patient Name:
Medical Record Number

UNIT 5UP PAGE 1436

Date	Time	Type	
12-3-94	3-11 10pm	NSG	1/2° VS maint: (D) Wendy up/about on/off unit: med/meal compl., delusional at times but calm, pleasant; required reminders to return to unit on x for 1/2° VS (A) ø noted elopement attempts thus far; mood stable (P) cont to monitor as ordered - Libby Furrow LPN
12-4-94	11-7 6am	NSG	1° VS maint (D) Wendy up for a short x 1st of shift; calm, pleasant - delusional statements but accepting staff reassurance (A) up 1st of shift, overall slept (P) cont to monitor - Libby Furrow LPN
12-4-94	2:30pm	Nsg	S. "Thank you for cleaning up my room, you did a good job." O. Wendy was appreciative of staff cleaning up her room and doing her laundry this weekend. 1/2° VS maintained. Ate lunch this morning. A. affect pleasant when ... P. Cont to monitor for safety per plan [illegible]
12-4-94	3-11 10pm	NSG	1/2° VS maint (D) Wendy up/about unit, @ canteen, also to [illegible]; attended meds, meals + Beano; overall pleasant to group. (A) ø noted elopement attempts thus far in shift (P) cont to monitor as ordered - Libby Furrow LPN

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HAWKES & MEHNERT

ATTORNEYS AT LAW
66 WINTHROP STREET
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ERIC M. MEHNERT
CYNTHIA M. MEHNERT

LAWRENCE P. BLOOM
of Counsel

TELEPHONE (207) 623-1455
TELEFAX: (207) 621-0353

September 27, 1996

VIA: REGULAR AND CERTIFIED MAIL

Angus S. King, Governor
Office of the Governor
One State House Station
Augusta, Maine 04333

Andrew Ketterer, Esq.
Attorney General
State House Station #6
Augusta, Maine 04333-0006

Melodie Peet, Commissioner
Mental Health, Mental Retardation
& Substance Abuse
P.O. Box 724
Augusta, Maine 04333

Rodney Bouffard, Acting Superintendent
Augusta Mental Health Institute
P.O. Box 724
Augusta, Maine 04333

Re: **Wrendy Jane Hayne / Notice of Claim Pursuant to Title 14 M.R.S.A. § 8107 Maine Tort Claims Act**

Dear Governor King, Attorney General Ketterer, Commissioner Peet and Mr. Bouffard:

The Estate of Wrendy Jane Hayne, Ms. Janice Burns, 155 High Street, South Portland, Maine, individually and as personal representative of the Estate of Wrendy Jane Hayne, and Mr. Donald Burns, 155 High Street, South Portland, Maine, individually and as step-father of Wrendy Jane Hayne, have retained attorneys Eric M. Mehnert and Lawrence P. Bloom, of Hawkes and Mehnert, 66 Winthrop Street, Augusta, Maine, to represent them and the estate in claims asserted below.

The Estate and Mr. and Ms. Burns, as parents, step-parents, heirs, and personal representative of Ms. Hayne claim that through negligence, malpractice, tortious interference of a fiduciary relationship (between the victim and her legal guardian), negligent misrepresentation, malfeasance, misfeasance, fraudulent misrepresentation, violation of AMHI policy, violation of state and federal law, violation of the Consent Decree, and patients' rights violations, Augusta Mental Health Institute, its employees or its agents, caused Ms. Hayne's death on or about April 6, 1996.

Such actions include, without limitation, negligence in the ownership and maintenance of a public building; tortious interference with a contract; failing to properly supervise staff; failing to exercise professional judgment; failing to abide by policy and law in not obtaining consent from Ms. Hayne's guardian for a change in the treatment plan (including without limitation the removal of one on one supervision for Wrendy); failing to use appropriate care regarding the level of Ms. Hayne's supervision after being informed of Mr. Pulsifer's threats to her; failing to facilitate meaningful communication between Ms. Hayne's staff and Mr. Pulsifer's staff despite the knowledge of Pulsifer's continual threatening behavior towards Ms. Hayne; failing to use appropriate care regarding the level of Mr. Pulsifer's supervision after being informed of his threats to Ms. Hayne; failing to adequately train staff; failing to train staff in issues of domestic abuse and the subsequent failure to recognize the characteristics of domestic abuse and violence in the relationship between Ms. Hayne and her killer; failure to adequately train and supervise temporary doctors at AMHI; invading the privacy Wrendy Hayne and her mother, Janice Burns, and breaching confidential information (by allowing union reps access to Hayne's confidential treatment information) subsequent to the murder; failing to maintain adequate security thus allowing Mr. Pulsifer to obtain possession of a master key used to unlock a storage room where he murdered Ms. Hayne; failing to change door locks (until after the murder) despite the knowledge that numerous keys were unaccounted for; failure to follow the Consent Decree by neither discharging Mr. Pulsifer from AMHI nor providing him a treatment plan; negligent and intentional infliction of emotional distress on Hayne's mother, Janice Burns and upon Don Burns, in misrepresenting the victim's condition to her mother and the negligent infliction of emotional distress upon Janice and Don Burns.

Furthermore, other negligent actions include, without limitation, violation of Restatement of Torts 2nd §§ 319 and 320 which state:

<u>**Restatement 2nd Torts**</u>

§319 Duty of those in Charge of Person Having Dangerous Propensities

One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm.

§320 Duty of Person Having Custody of Another to Control Conduct of Third Persons

One who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal power of self-protection or to subject him to association with persons likely to harm him, is under a duty to exercise reasonable care so to control the conduct of third persons as to prevent them from intentionally harming the other or so conducting themselves as to create an unreasonable risk of harm to him, if the actor;

(a) knows or has reason to know that he has the ability to control the conduct of the third persons; and

(b) knows or should know of the necessity and opportunity for exercising such control.

The responsible parties we understand are:

Governor Angus King
Melodie Peet
Kathleen Whitzell
Rodney Bouffard
Diane Gilbert

Dr. Manuel Hermida
Dr. Gordon Clark
Dr. Walter Lowell
Kathy Guilbault
CompHealth

We have information which leads us to believe that the following individuals may also be responsible.

Dr. Small
Dr. Safier
Dr. Renshaw
Lori Hunt
Bruce Coffin
Doreen McFarland
Charlie Steen
Rita Brandt
Dr. George Davis
Dr. Owen Buck
Dr. Whelan
Dr. Castellanos

We understand there are others who are responsible, but their names are not available to us at this time. We have not received all of the requested information from the State which has claimed confidentiality regarding certain patient and hospital records and has claimed contractual and statutory prohibitions on release of relevant employee information. Additionally, it is believed that persons with vital information are reluctant to divulge information due to threats of discipline and a fear, engendered by the Attorney General's office, of personal involvement and potential liability in a lawsuit.

As a direct and proximate result of these actions by the aforementioned individuals and the Augusta Mental Health Institute, Wrendy Hayne was murdered by Harold Pulsifer on or about April 6, 1996.

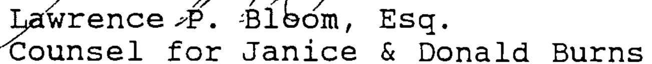
The Plaintiffs seek the maximum monetary amounts for the tortious acts authorized by Maine Law, Title 18-A M.R.S.A. § 2-804, _et seq._ and 14 M.R.S.A. § 8104-D and § 8105, as damages in the amount of $300,000.00 or the full limits of any insurance policies which cover this loss, whichever is greater. This does not limit

the damages which we will seek to recover for the concomitant federal civil rights violations for which we will seek in excess of seven million dollars in compensatory and punitive damages against the responsible individuals. Further, this does not limit the damages which we will seek to recover for violations of the Americans with Disabilities Act.

If you want to discuss resolution of this matter, please contact the Plaintiff's attorneys as listed below.

Sincerely,

Eric M. Mehnert, Esq.



Lawrence P. Bloom, Esq.
Counsel for Janice & Donald Burns

cc: Janice and Donald Burns

PROCEDURES FOR HOLDING EXECUTIVE SESSIONS TO CONSIDER CONFIDENTIAL INFORMATION

1. The committee convenes a public meeting. The committee conducts any public business it wishes to before going into executive session.

2. A member moves to go into executive session under 1 MRSA §5, sub-§6, paragraph F in order to review and discuss information protected by the confidentiality provisions of 34-B MRSA§1207, sub-§1.

3. Three-fifths of the members present and voting vote to go into executive session. The vote is recorded.

4. The committee adjourns its public meeting and goes into executive session.

5. The committee determines that only persons appropriate to the executive session are present. The committee reviews the requirements of the executive session, confidentiality laws, procedures for handling confidential documents, and penalties for disclosure. Staff distribute confidential materials to committee members and any other persons entitled to review them. The committee conducts its executive session business, discussing only the matter mentioned in the motion. Members return confidential materials to staff. No official committee action may be taken in executive session.

6. The committee returns to public meeting. Any official committee action is taken by motion and vote in the public meeeting.

Joint Standing Committee Process

Standard procedure under 3 MRSA §165, requesting information from departments and individuals. Could consider confidential information in executive session, procedures drawn from Freedom of Access Law, 1 MRSA § 401 et seq., and investigating committee procedures, 3 MRSA § 411 et seq. Court orders may be obtained on behalf of the committee to allow it access to confidential information. The Court would balance the private harm against the public interest. Office of the Attorney General could provide legal representation.

Investigating committee procedures could be used if the full legislature granted investigating and subpoena power to the committee. Vote of the Legislature required on a joint resolution. Process would follow 3 MRSA §165, sub-§7 and 411 et seq. Court orders could be obtained to enforce subpoenas and directions from the committee. A party seeking to protect information would file a motion to quash the subpoena in Superior Court. A decision of the Court would then be needed for the information to be released to the committee. The Court would balance the private harm against the public interest. Office of the Attorney General could provide legal representation. An investigating committee proceeds under statutory rules, must keep a complete record and produce a transcript and must pay witnesses a fee and expenses.

Recent history - Paul Gauvreau, who was the Senate chair of the Human Resources Committee during the AMHI heat deaths investigation recalls that the Legislature passed a joint resolution granting investigating and subpoena power to the committee. He does not recall that the subpoena power was used.

From: Jane Orbeton, OPLA

HEALTH AND HUMAN SERVICES COMMITTEE
MEETING JULY 19, 1996
DECISIONS AT THE MEETING AND TASKS FOR 7/26 MEETING

1. An opinion was requested from Jane Orbeton on whether the Freedom of Access Law allows the committee to guard as confidential any information gathered through a toll free telephone line provided to the public by the committee.

2. Linda Pistner, Deputy Attorney General, representing the office at the meeting advised the committee that the Attorney General will assist the committee in obtaining the parts of the report done by the Kennebec Valley Mental Health Center on the Bechard incident that the Attorney General's Office believes are open to the public since the report is in the possession of the Department of Mental Health, Mental Retardation and Substance Abuse Services and is therefore subject to production under the Freedom of Access Law. To do this, the office will (a) complete its own determination of what is confidential and what is open to the public in the report, (b) attempt to reach agreement with the attorney for the KVMHC on what may be released, and (c) notify the KVMHC that it intends to release the portions that it considers to be open to the public and allow the agency the opportunity to obtain a court order to protect from disclosure any portions of the report that they believe are not open to the public. This action will help to carry through on the request of the committee for the report made by Jane to KVMHC and to the Department during June.

3. The committee agreed to have Jane to send a letter to the Department of Mental Health, Mental Retardation and Substance Abuse Services requesting employee disciplinary action information resulting from the Hayne murder and subsequent investigation, pursuant to 5 MRSA § 7070, understanding that there is a 120 day time period that must pass in cases of appeal. Jane needs to research this statute, send the request, and provide information to the committee.

4. The committee voted unanimously to request the Attorney General's Office to take the following actions. Linda Pistner, Deputy Attorney General, attended and provided information and advice throughout the meeting to the committee.

(a) Assist the committee in obtaining a waiver of statutory confidentiality of patient records and information from Mark Bechard, and whatever court order might be required, to permit committee consideration of the records and the

internal report of the Kennebec Valley Mental Health Center. The committee's first choice is to consider this information in a public forum. Second choice is a private forum, executive session, pursuant to 3 MRSA §165, sub-§7 and 3 MRSA chapter 21. Linda Pistner expressed the general agreement of the Attorney General to pursue this for the committee. She expressed 2 concerns: (1) that the committee choose a member to approach Mark Bechard about signing a waiver as this is a non-attorney task, and (2) that if he chooses not to sign and the committee has not obtained subpoena power and issued a subpoena, the Attorney General will be unable to make an argument for the release of the information as there will be no legal basis on which to proceed. Jane will discuss with the chairs who will make the waiver request to Mr. Bechard's attorney and the language of any waiver. Jane and Linda will work together to ensure that the request, waiver form and any court documents express the intentions and accomplish the purposes of the committee.

(b) Assist the committee in obtaining a waiver of statutory confidentiality of patient records and information from Wrendy Hayne and Harold Pulsifer to permit committee consideration of patient records in public or, if necessary, in executive session. The committee also asked for assistance in obtaining from the Department and from AMHI an inventory of information that may assist the committee as to these patients and the murder and subsequent investigations, action and reports. Motion passed unanimously. Linda Pistner concerns about who should request the waivers apply here as they do regarding Bechard. Linda explained to the committee that state and federal confidentiality law may limit the contents of an inventory list. Jane will discuss with the chairs who will make the waiver requests to the attorneys for Ms. Hayne and Mr. Pulsifer and the language of any waivers. Jane and Linda will work together to ensure that the requests, waiver forms and any court documents express the intentions and accomplish the purposes of the committee.

(c) Assist the committee in obtaining a waiver of statutory confidentiality of patient records and information from the estate of Marlene Cunningham to permit committee consideration of patient records and any other information prepared by AMHI or the Department as a result of her death, and any court orders that may be required. Such consideration to be held in public or, if necessary, in executive session. Motion passed, all in favor except

Representative Fitzpatrick. Jane will discuss with the chairs who will make the waiver request to the estate of Ms. Cunningham and the language of any waiver. Jane and Linda will work together to ensure that the request, waiver forms and any court documents express the intentions and accomplish the purposes of the committee.

5. Copies of information distributed to the committee in past weeks and at the meeting will be placed in a file under the name of the committee in the State Law Library in Augusta. The public may review the documents there and make copies for a nominal charge.

6. The committee asked Jane to arrange for the following agenda for the next meeting, July 26 at 9:30am in Room 228 of the State House:

(a) Discussions with Kennebec Valley Mental Health Center regarding the following:

Their policy and procedures on medication monitoring (ie for clozapine), the rights and responsibilities of the agency and the Department pursuant to their contracts with the Department, the provision of community based services (service delivery, staffing, supervision of clients and staff, activities, costs), procedures for crisis intervention and interaction with municipalities and crisis service providers, crisis management, communications with the Department.

(b) Discussions with the Department about the following:

Out-of-state placements (numbers, reasons, choices, costs), the role of acute care and long-term care hospitals and the role of AMHI, the use of the safety net beds at AMHI, discussion of patient rights and patient cooperation and medical programs, LD 1704 and how are services being delivered and how will they be delivered in the near future, procedures for auditing financial information regarding contracting agencies, how the Department monitors contracts for services, communications with agencies, any other issues arising from the discussions with the KVMHC.

AGENDA - MEETING JULY 19, 1996
JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

jsc powers 3 § 165 subs 1, 2 + 4
jsc invest. powers subs 7

9:30	Discussion of procedural issues Confidentiality (DHS, DMHMR, fedl, employee Patient records and information Subpoena powers balancing - voly + mandatory disc. Factual questions and policy considerations Personnel records, talking with employees and discipline Other
10:00	Linda Pistner, Deputy Attorney General Legal issues
10:30	Julie Armstrong, Chief Counsel, Bureau of Employee Relations Restrictions on information pertaining to employees and committee discussions with employees
11:00	Committee discussion with Commissioner Melodie Peet Update on AMHI conditional licensing Progress on hiring the clinical director Employee matters at AMHI Transferring AMHI positions to the community Other

AGENDA - MEETING JULY 19, 1996
JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

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HEALTH AND HUMAN SERVICES COMMITTEE
MEETING JULY 26, 1996
DECISIONS AT THE MEETING AND TASKS FOR 8/2 MEETING

1. The committee decided to continue their effort to obtain patient waivers to allow review of patient mental health records on Wrendy Hayne, Pete Pulsifer, Mark Bechard and Marlene Cunningham. With regard to the waiver, the committee still prefers a public session. If not agreeable to the patient or patient's family or the court, the committee will proceed in a private session, held pursuant to 1 MRSA §405 and Joint Rule 313, attended by the committee members, nonpartisan staff, one partisan staff member designated by the President of the Senate and one designated by the Speaker of the House, up to 3 consultants retained by the committee, a representative of the Attorney General, and a person from the union representing any employee testifying before the committee, if required by contract or statute. The committee intends to speak with employees or providers who cared for the patients. The committee intends to write a report, make recommendations and may prepare legislation. These work products would contain no reference direct or indirect to any patient and would not comment directly on specific incidents. Jane and Linda Pistner, Chief Deputy Attorney General, will have a waiver ready for the chairs to use in approaching the patients and their families by Tuesday evening. Once the waiver is signed, Linda will apply for a court order granting access to the records.

2. Unfinished business (see also 3 below):
   - Report from Jane on confidentiality of 800 telephone number information.
   - Report from Linda Pistner on union presence at the McDowell task force sessions and on the office's with the attorney for the Kennebec Valley Mental Health Center, Steve O'Donnell, about release of the center's Bechard incident review.
   - Jane will to get crime statistics, particularly data connecting crime to mental health status.

3. The committee asked Jane to arrange for the following agenda for the next meeting, August 2 at 9:30am in Room 228 of the State House:

(a) Beginning at 9:30 sharp, information from the Kennebec Valley Mental Health Center regarding the following:
Their policy and procedures on medication monitoring (ie for clozapine) and job descriptions of clozaril case managers. Do all clozaril clients have community case managers?

(b) Discussions with the Department about the following:
Out-of-state placements (numbers, reasons, choices, costs), the role of acute care and long-term care hospitals and the role of AMHI, the use of the safety net beds at AMHI, discussion of patient rights and patient cooperation and medical programs, LD 1704 and how are services being delivered and how will they be delivered in the near future, procedures for auditing financial information regarding contracting agencies, how the Department monitors contracts for services, communications with agencies, any other issues arising from the discussions with the KVMHC. Discussion of materials provided at the July 26th meeting. Discussion of the Behavioral Health Network contract and whether the data base will belong to the State. Will anyone else have access to it? Discussion of medication management and case management oversight. Is there a required protocol on clozaril medication management (blood count and compliance)? What happens if a client does not take medication? What are the departments procedures for overseeing an agency? New hiring and contracting for case managers.

(c) Discussions with Dick Thompson, State Purchasing Agent, regarding sole source contracting and the Behavioral Health Network contract. See department note above. The committee asked Jane to get information on the Behavioral Health Network: its structure and organization, board of directors, budget, members, employees, office location, contracts with the department (is there in them an identified profit line?).

MODE = MEMORY TRANSMISSION START=JUL-29 13:26 END=JUL-29 13:35

FILE NO.= 083

NO.	COM	ABBR/NTWK	STATION NAME/ TELEPHONE NO.	PAGES	PRG.NO.	PROGRAM NAME
001	OK	☎	74268	003/003		
002	OK	☎	74268	003/003		
003	OK	☎	98724522	003/003		
004	OK	☎	73145	003/003		
005	OK	☎	76578	003/003		

-POLICY & LEGAL ANALYSIS -

************************************* -2072871275 - ***** - 2072871670- *********

Post-it™ Fax Note 7671

Date 7/29	# of pages ▸ 2
To Sandy Spencer	From Jane Orbeton
Co./Dept.	Co.
Phone #	Phone #
Fax # 287-4268	Fax # 287-1275

Post-it™ Fax Note 7671

Date 7/29	# of pages ▸ 2
To Katie Fulham	From Jane Orbeton
Co./Dept.	Co.
Phone #	Phone #
Fax # 287-4268	Fax # 287-1275

Post-it™ Fax Note 7671

Date 7/29	# of pages ▸ 2
To John Shaw	From Jane Orbeton
Co./Dept.	Co.
Phone #	Phone #
Fax # 872-4522	Fax # 287-1275

Post-it™ Fax Note 7671

Date 7/29	# of pages ▸ 2
To Linda Pistner	From Jane Orbeton
Co./Dept.	Co.
Phone #	Phone #
Fax # 2873145	Fax # 287-1275

Post-it™ Fax Note 7671

Date 7/29	# of pages ▸ 2
To Dick Thompson	From Jane Orbeton
Co./Dept.	Co.
Phone #	Phone #
Fax # 287-6578	Fax # 287-1275

Decisions and Information Requests
at August 2 Meeting of
Health and Human Services Committee

1. John Shaw will provide information on: (1) alert status and emergency procedures; (2) upon no-show for clozaril blood count work, how quickly does the agency act, what does it do, what are the shortest and longest times until resumption of blood count work and re-entry onto medication;

2. The committee agreed to proceed with requesting patient mental health record waivers. The committee agreed, with regard to the circulated waiver: (a) to change paragraph 8 to a general category of patient care providers, (b) on paragraph 10 to delete partisan staff, (c) on paragraph 9 to require revocation in writing, (d) on paragraph 10 to add "when the committee is in executive session, (e) to change in paragraph 9 the "reliance" language, perhaps to "pursuant to it" (Jane will try to reach an agreement with Lawrence Bloom, attorney for Mr. & Mrs. Burns), (f) change the waiver expiration date to 6/30/97, (g) in paragraph 11 restrict court review to in camera.

3. Questions remain about:

(a) whether the committee will seek a court order authorizing disclosure, pursuant to 34-B §1207,
(b) whether execution of a waiver under §1207, in waiving confidentiality, makes any records turned over to the committee public records under the Freedom of Access Law,
(c) presence of patient representatives and employee union representatives at any executive sessions under Freedom of Access Law.

4. Questions requiring Jane's attention:

(a) Can the committee obtain non-patient records from AMHI?
(b) What is the authority of the committee and the power of a waiver at the end of the 117th and into the 118th Legislature?
(c) With DMHMRSAS, what happens to the database when the Behavioral Health Network ((BHN) contract terminates?
(d) Does HMO Law apply to BHN?
(e) With Linda Pistner, what is the effect on the BHN contract of "approved as to form, by AG" and "Rod Bouffard signing for Wayne Douglas."?
(f) Does BHN require licensing?

5. DMH&MR&SAS will find out whether the department intends to recoup from BHN funds paid by BHN to Dr. Clark.

g:oplalhs/commttee/hum/dec&infodoc/JO/vmp/August 6, 1996

Aug 2

AGENDA
Health and Human Services Committee
Room 436, ~~July 31,~~ 1996

9:30 **Information from Kennebec Valley Mental Health Center on medication monitoring and community case managers.**

10:00 **Update from Jane Orbeton and Linda Pistner on progress toward obtaining access to patient records and information**

10:30 **Discussions with the Department of Mental Health, Mental Retardation and Substance Abuse Services regarding:**

Out-of-state placements (numbers, reasons, choices, costs), the role of acute care and long-term care hospitals and the role of AMHI, the use of the safety net beds at AMHI, discussion of patient rights and patient cooperation and medical programs, LD 1704 and how are services being delivered and how will they be delivered in the near future, procedures for auditing financial information regarding contracting agencies, how the Department monitors contracts for services, communications with agencies, any other issues arising from the discussions with the KVMHC. Discussion of materials provided at the July 26th meeting. Discussion of the Behavioral Health Network contract and whether the data base will belong to the State. Will anyone else have access to it? Discussion of medication management and case management oversight. Is there a required protocol on clozaril medication management (blood count and compliance)? What happens if a client does not take medication? What are the departments procedures for overseeing an agency? New hiring and contracting for case managers.

11:30 **Information about the Behavioral Health Network. Discussion of contract between the Department and the Behavioral Health Network.**

MEMORANDUM

TO: Members, Health and Human Services Committee
FROM: Jane Orbeton, Legal Analyst
DATE: August 20, 1996
RE: Committee business

Since I will be away when you meet on the 23rd, I am writing this memo. It will update you on events since the meeting on August 2nd and provide answers to questions posed of me at that meeting.

1. The waiver of confidentiality and court order to enable the committee to discuss and use confidential records.

a. The waivers. A waiver has been signed by Mrs. Burns to permit the committee to use patient records of Wrendy Hayne. The waiver allows public use of some information and executive session use of any information designated as confidential. When the records are delivered to the committee I expect some records to be for full public access and some to be restricted for committee executive session only. A clear designation by the patient representative will be critical. The waiver is revocable at any time. No other waivers have been signed.

b. The court orders. The Attorney General's Office applied to the District Court in Augusta for approval of the waiver of confidentiality of patient records for Wrendy Hayne. The application to the court also addresses release of the stalking book. Linda Pistner will brief the committee on progress in this area.

2. Procedures for handling mental health patient records delivered to the committee.

a. Public access information. Patient records that are delivered to the committee with a full waiver to permit public access will be copied and distributed to members of the committee and to the public. A numbering system for the pages will have to be used on the records. No special protections apply to committee use of these records.

b. Restricted access information. Patient records that are delivered to the committee with a limited waiver to permit committee access only will be processed thru the same numbering system as the public access documents. They will then be copied for members of the committee and others permitted by court order or committee executive session procedure under 1 MRSA §405, sub-§6, paragraph F. Copying will be done by employees of the Department of Administrative and Financial Services. These employees are bound by departmental confidentiality requirements. The original and all copies, including any misprints, will be returned to the committee. Access to these copies will be restricted. They will be delivered to committee meetings in sealed envelopes and must be returned to sealed envelopes at the end of the meeting and collected for safe keeping. They will be locked in secure storage at the State House between meetings.

3. Obtaining non-patient records from AMHI.
The committee requested records noted on the 3rd page of the submission provided by the Department: unit shift report, patient/staff assignments, individualized shift work sheets, "critical incident report," "OD" book, the McDowell report, the "Bouffard, Estabrook, Williams report," peer review, memos, individualized patient report. The McDowell report we have already received. I do not know if these others are public records, or if they are available to the committee or protected from disclosure to the committee. I asked the Department for these records and Linda Pistner for legal advice on their availability. I understand that there may be an objection from another patient. Linda will provide up to date information.

4. The powers of the Legislature and the waiver.
The 117th Legislature may meet and its members may act up through its last day, December 3. The 118th Legislature will be sworn in on December 4, followed by adoption of the joint rules and, after that date, appointment of committees.

5. The Behavioral Health Network contract.
The Department contract with the Behavioral Health Network specifies that the database belongs to the Department, see pages 10 and 11 of the contract. The contract notation "approved as to form by the Attorney General" and the signature notation "Rod Bouffard signing for Wayne Douglas" have no effect on the legality of the contract. The reference to the Attorney General's Office is left over from a previous era. It has no legal effect. I understand from the Department that Rod was authorized to sign for Wayne.

The Behavioral Health Network is a corporation licensed under 13-A MRSA. It would need to be licensed as a health maintenance organization only if it were to operate as an HMO: providing health care through a network of providers for a prepaid premium. In short it would have to obligate itself to provide services for a fixed price to the consumer, like an insurance company. My conclusion is that state law does not require the Behavioral Health Network to be licensed as an HMO in order to provide the services it has undertaken in the contract with the Department.

The Department has been asked whether they are seeking to recoup funds paid to Dr. Clark by BHN under the BHN contract.

6. Linda Pistner will have information on the following:
a. The waiver and court order to permit committee use of patient records, paragraph 1.
b. The legal review of non-patient records, paragraph 3.

AGENDA
HEALTH AND HUMAN SERVICES COMMITTEE
MEETING AUGUST 23, 1996, ROOM 228

9:30am	Update from Linda Pistner on the court order waiving confidentiality of patient records
10:00am	Update from Peggy Reinsch and Lisa Copenhaver of OPLA on issues and questions from the August 2 meeting
10:30am	Update from the Department of Mental Health, Mental Retardation and Substance Abuse Services on the status of AMHI and medical staffing
11:00am	Discussions with the Department on patient deaths and review of the operation of community mental health agencies

MEMORANDUM

To: Joint Standing Committee on Health and Human Services
From: Jane Orbeton, OPLA
Date: September 4, 1996
Re: Mental Health Review

The following information is provided as a result of issues raised at the August 23rd meeting of the committee. The next meeting of the committee for purposes of reviewing the mental health system is Friday, September 12th, immediately after the committee review at 9am of the appointment of Lynn Dube as director of the Office of Substance Abuse.

1. A request was made that all documents distributed to the committee and to the public through the committee be pre-screened for confidentiality purposes. Every attempt will be made to do this. Prior distribution to legal staff (OPLA and the Attorney General's Office if appropriate) will make this go more quickly.

2. A question was asked about the handwritten memo, how it could be confidential if distributed to the committee. 1 MRSA §402, sub-§3 defines public records. In subsection 1 it excepts "records that have been designated confidential by statute." A patient could execute a limited waiver of rights to confidentiality of records and information so that they are still confidential under 34-B MRSA §1207, while granting to the committee access to the documents. These documents would need to be discussed in executive session only. A patient could grant a full waiver so that records become public and can be discussed in public. The committee should not have possession of records when no waiver has been signed by the patient.

3. A request was made for guidance regarding confidentiality. OPLA staff will be happy to provide this. Specific instructions will depend on what types of information we obtain, under what types of waivers and court orders. Copies of prior letters to the committee from Jane dated July 26th and 31st are a good starting point. 1 MRSA §405 and Joint Rule 313 contain provisions on executive sessions and committee procedures for handling confidential information.

4. Linda Pistner agreed to put together a list of non-patient records that are not being released to the committee and to list the basis for not releasing each record.

5. A question was raised about the legal authority of Rod Bouffard to sign the Behavioral Health Network contract for Wayne Douglas. 34-B MRSA §1204, sub-§1 grants to the commissioner general powers to "perform any legal act relating to the care, custody, treatment, relief and improvements of residents of the state...." This provision includes the power to contract for services. 34-B MRSA §1204, sub-§3, paragraphs A and B allow the commissioner to delegate powers and duties to associate commissioners and allow the commissioner to empower associate commissioners to further delegate those powers. (A copy of the law, as amended this last session, is attached.) If the commissioner has delegated the power to contract for services to Wayne, this provision would allow Wayne to delegate that power to Rod Bouffard.

6. Whether the Behavioral Health Network needs to be licensed as an HMO depends on whether BHN provides health care services to enrolled participants for a predetermined premium. A copy of 24-A MRSA §4202-A defines HMO and sets out those requirements. In the contract with the Department the BHN duties are specified in the section entitled III. Service Specifications, which runs for 8 pages and contains 20 project tasks (see pages 2 through 9 of the contract). None of the tasks is actual health care service delivery. It is my reading that under this contract BHN does not provide health care services (medical, dental, or hospital services to prevent, alleviate, cure or heal human illness or injury), does not serve enrolled participants and does not charge a predetermined premium. My advice to the committee is that BHN is not providing the health care services directly to the consumer, at a prepaid premium price, that would qualify it as an HMO and require it to be licensed. A copy of the articles of incorporation of the Behavioral Health Network of Maine is attached.

7. The committee requested that Wayne Douglas provide information about the Department's ownership of the BHN contract database and BHN's not retaining it, which will include a penalty clause.

8. The committee asked Wayne Douglas to provide information on BHN, the 7 regions, the distribution of class members around the state, and assessment rates.

9. The committee asked Wayne Douglas to speak with the Attorney General's Office about conflict of interest, the BHN contract, and Dr. Clark's duties and reimbursement.

10. The committee requested that Bill Thompson provide information about the AMHI management decision, including whether the medical director is a state employee or a contract employee.

11. The committee requested that Sue Bell report on the funding problems in the Medical Examiner's Office.

12. The committee asked Katie Fullam to provide information on the progress of the Maine Task Force on Mental Health, chaired by Jane Holt deFrees, of Rumford. Created by Executive Order dated May 20, 1996, the task force is required to report its recommendations on the mental health system to the Governor by October 1, 1996. A copy of the Executive Order is attached.

13. Commissioner Melodie Peet has sent to the committee copies of the independent medical reviews done after Wrendy Hayne's death by Doctors Franklin Bragg, Ann Hanlon, Edward Robinson, and Jonathan Morris. Release of these reviews to the public was authorized by Judge Courtland Perry, of the Maine District Court. Copies of the reviews are enclosed. They are public documents.

g/oplalhs/com/hum/cor/8-27hum

(5) To be eligible for appointment as associate commissioner for systems operations, a person must have training and experience in general management or administration.

Sec. K-15. 34-B MRSA §1204, sub-§2, ¶C, as amended by PL 1993, c. 410, Pt. CCC, §11 and PL 1995, c. 395, Pt. G, §11 and affected by §20, is repealed and the following enacted in its place:

C. The commissioner shall appoint the following officials to serve at the commissioner's pleasure:

(1) Associate Commissioners;

(2) Superintendent, Augusta Mental Health Institute;

(3) Superintendent, Bangor Mental Health Institute;

(4) Superintendent, Pineland Center;

(5) Director, Mental Retardation Facility;

(6) Director, Elizabeth Levinson Center;

(7) Assistant to the Commissioner for Public Information;

(8) Assistant to the Commissioner;

(9) Director, Bath Children's Home. This subparagraph is repealed on July 1, 1996;

(10) Regional Directors; and

(11) Director, Office of Substance Abuse.

The Director of the Office of Substance Abuse must be reviewed by the joint standing committee of the Legislature having jurisdiction over human resource matters prior to taking office.

Sec. K-16. 34-B MRSA §1204, sub-§3, ¶¶A and B, as enacted by PL 1983, c. 459, §7, are amended to read:

A. The commissioner may delegate powers and duties given under this Title to the associate commissioners~~, bureau directors~~ and chief administrative officers of state institutions.

B. The commissioner may empower the associate commissioners~~, bureau directors~~ and chief administrative officers of state institutions to further delegate powers and duties delegated to them by the commissioner.

Sec. K-17. 34-B MRSA §1204, sub-§8, as enacted by PL 1989, c. 933, §2, is amended to read:

8. Physicians. ~~Employees~~ Department employees in the classifications of physician I, II and III ~~within the Department of Mental Health and Mental Retardation~~ are unclassified state employees, as defined by Title 26, section 979-A, subsection 6, and are members of bargaining units, subject to Title 26, chapter 9-B. An employee in any of these classifications ~~shall~~ must, as a condition of continued employment, maintain necessary clinical privileges to practice medicine in that employee's position as determined by the respective medical staff and the superintendent of the facility. Any termination of employment due to a loss of clinical privileges to practice medicine as referenced under this paragraph is not subject to the grievance procedure under any collective bargaining agreement.

Sec. K-18. 34-B MRSA §1205, sub-§1, as amended by PL 1989, c. 731, §1, is further amended to read:

1. Establishment. The Office of Advocacy is established within the Office of Advocacy and Consumer Affairs of the department solely to investigate the claims and grievances of clients of the department, to investigate with the Department of Human Services, as appropriate, all allegations of adult and child abuse in state institutions and to advocate on behalf of clients for compliance by any institution, other facility or agency administered, licensed or funded by the department with all laws, administrative rules and institutional and other policies relating to the rights and dignity of clients.

Sec. K-19. 34-B MRSA §1207, sub-§5, ¶D, as enacted by PL 1993, c. 593, §1, is amended to read:

D. By September 1, 1994, the department shall adopt rules to implement this subsection. The rules must include, but are not limited to, an appeal process for persons who are denied access to information under paragraph B. The appeal process must determine whether the person requesting information is a person who lives with or provides direct care to a client, whether disclosure of the information is in the best interest of the client and whether denial of access to the information will result in significant deterioration in the client's daily functioning. The commissioner shall appoint an advisory committee pursuant to Title 5, section 12002, subsection 1, paragraph A to assist the department in the development of the rules. The members of the advisory committee are not entitled to reimbursement for expenses or legislative per diem. The advisory committee must include, but is not limited to, proportionate representation from each of the following:

MEMORANDUM

To: Members, Joint Standing Committee on Health and Human Services
From: Jane Orbeton, OPLA
Date: September 9, 1996
Re: Confidential Information and Committee Procedures

In its review of the mental health system, the Health and Human Services Committee will be reviewing documents protected by confidentiality laws. This memo briefly explains the protections granted by confidentiality statutes and the legal effect of waivers of confidentiality. Then the memo discusses committee procedure when reviewing documents for which confidentiality has been fully or partially waived.

I. Confidentiality

Mental health patient records are confidential under 34-B MRSA §1207, sub-§1, unless the client or authorized person has given informed written consent or a court has ordered disclosure. (There are other exceptions not relevant to the committee's work.)

If the client or authorized person has consented to full public disclosure or a court has ordered full public disclosure, the records are no longer confidential. They become public records when they are held by the committee. The committee may review and discuss them in public proceedings and is required to make them available for review by the public.

If the client or authorized person has signed a partial waiver they have consented to disclosure to the committee with some stated restrictions on further disclosure by the committee. If a court has ordered disclosure under some restrictions, once again the waiver of confidentiality is only partial. In these situations, the records retain some of the confidentiality protections granted by the statute. These rights to confidentiality must still be protected.

II. Committee Procedures

Committee review of records subject to a partial waiver or a court order of disclosure under some restrictions is governed by the terms of the waiver or court order, the Freedom of Access Law (1 MRSA chapter 13, subchapter I), Joint Rule 313 and whatever procedures the committee adopts. Copies of 1 MRSA §405 and Joint Rule 313 are attached.

The Freedom of Access Law, in 1 MRSA §405, sub-§6, paragraph F allows the committee to meet in executive session to review records for which access by the general public is prohibited by statute. 1 MRSA §405 also specifies the procedures for executive sessions. The committee must start its meeting in a public meeting. A member must move to go into executive session, indicating the precise nature of the business to be considered in executive session. 3/5 of the members present and voting must vote to go into executive session. The vote must be held in public and must be recorded. As final official actions may not be taken in executive session, the public body must reconvene in public session, and take any action by vote in public. Care must be taken in this motion and in any discussion not to mention any information that is confidential.

The statute is very specific that only the confidential matter stated in the motion, and no other matters, may be considered in the executive session.

1 MRSA §405 does not provide a complete description of the committee procedure required for executive sessions. Decisions will need to be made within the Health and Human Services Committee about who may attend, how information is to be gathered and how discussion is to proceed. To the extent that the committee is discussing information covered by a waiver or a court order, the committee must abide by any limitations on who may attend the session contained in the waiver or order. Anyone attending the session is bound by the same confidentiality restrictions and is subject to the same penalties for disclosure as the committee. I suggest that each meeting begin and end with a discussion about confidential information and the importance of nondisclosure, a warning about the handling of confidential materials, and a reminder of the penalties for disclosure.

III. Handling of confidential materials

I suggest the following procedures for handling confidential materials.

At the beginning of the committee's work with confidential materials, members of the committee will be asked to sign statements that they agree to review any confidential materials in strictest confidence and to maintain their confidentiality. The statement will contain a reminder of the penalties for disclosure. **Disclosure violates 34-B MRSA §1207 and carries a penalty of up to 1 year in jail and a fine of up to $500. Disclosure that violates a court order is also punishable as criminal contempt of court and may qualify for severe sanctions.**

OPLA will have confidential documents copied using security precautions and will store confidential records in a secure place. All materials will have a gold cover sheet giving the name of the member to whom they are distributed and displaying the warning that the materials are confidential. Members will have access to the materials at work sessions, at the conclusion of which the materials will be returned to OPLA. Between work sessions, members may sign out materials from OPLA, review them in the State House in a manner and in an environment that maintains their confidentiality, and return them the same day before 5pm. Members will be responsible for all materials that they sign out.

At the conclusion of the committee's work on a particular matter, steps must be taken to safeguard confidentiality of documents. Joint Rule 313 offers the committee the choice of destroying materials, protecting them by some other method or returning them to the person who provided them to the committee. I suggest that the safest choice is to have OPLA destroy all confidential materials.

g/oplalhs/com/hum/corr/9-4hum

AGENDA

Health and Human Services Committee
Meeting September 13, Room 436, State House

9am	Review of Commissioner Melodie Peet's appointment of Lynn Duby as Director of OSA, pursuant to 34-B MRSA §1204.
	§1207 requires the Health and Human Services Committee to review the appointment of the director of OSA prior to the director taking office. When OSA moved from the Governor's Office to the Department of Mental Health, Mental Retardation and Substance Abuse Services, the committee vote and Senate confirmation were removed from the procedure.
10am	Discussion of the committee's review of the mental health system.
	Review of issues requiring answers or work after August 23rd meeting. See attachment, pages 1 thru 24.
	Plan for the committee's work: purpose, report, schedule and completion date. See attachment, page 25.
	Plan for reviewing confidential records. See attachment, pages 1 and 2 and page 26.
11am	Discussion with Janice Burns, mother of Wrendy Hayne.

Requests made at the September 17th meeting of the Health and Human Services Committee

1. The committee would like to speak with a person from AMHI to explain AMHI patient records.
2. The committee would like to speak with a person from AMHI to discuss key policy and access to the canteen.
3. The committee would like to speak with the Advocate's Office, specifically advocate Matt Cushner and supervisor Richard Estabrook.
4. The committee would like a briefing on performance of the different agencies working under the Behavioral Health Network contract and compliance with Judge Mills schedule in court.
5. The committee would like Jane to speak with the Department about how the committee may begin discussions with employees at AMHI.
6. The committee would like information from the Department about voluntary and involuntary commitments, and AMHI practice and policy in their use.
7. The committee would like information from the Department about staff training and development at AMHI.
8. The committee would like information from the Department and the Advocate's Office about relationships between themselves and patients' families.
9. The committee would like to discuss with Linda Pistner and the Department the letter of September 13th from Commissioner Peet about access to non-patient records.
10. The committee would like information from the Department about AMHI practice and policy and the law on guardian notification.
11. The committee would like information from AMHI and the Department on practice and policy when there is a relationship or safety problem between two residents of an institution.
12. The committee would like from the Department or from Jane a list of staff cuts, identifying positions, at AMHI as a result of the Productivity Realization Task Force bills.
13. At the meeting on September 13th the committee asked for a list of top clinical staff positions at AMHI and the people who held those positions in April.
14. Requests outstanding from the August 23rd meeting are listed in the attached memo dated September 4th.

marked 9/20

AGENDA
Health and Human Services Committee, September 20
9:30am, Room 436 State House

1. Discussion with Linda Pistner of the letter from Commissioner Peet dated September 13th, responding to the committee's request for records.

2. Discussion with the Advocate's Office regarding advocate/family/patient/institution interaction, Richard Estabrook and Matt Cushner for the Advocate's Office.

3. Discussion with AMHI about:
   - patient records
   - key policy and access to the canteen
   - voluntary and involuntary commitments
   - staff training and development
   - guardian notification and consent, according to law, policy and practice
   - policy and practice when interaction between 2 patients poses a problem

4. Discussion with the Department about performance under the Behavioral Health Network contract and compliance with Judge Mills' orders in *Bates v. Peet et al.*

5. Discussion with Jane Orbeton about:
   - procedures for the committee's talking with employees at AMHI
   - list of top clinical staff position employees at AMHI in April, 1996
   - identification of position cuts at AMHI
   - update on outstanding issues from 8/23 meeting

STATE OF MAINE
DEPARTMENT OF
MENTAL HEALTH, MENTAL RETARDATION,
AND SUBSTANCE ABUSE SERVICES
40 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0040

ANGUS S. KING, JR.
GOVERNOR

MELODIE PEET
COMMISSIONER

September 13, 1996

Honorable Joan Pendexter, Chair
Honorable Michael Fitzpatrick, Chair
Health and Human Services Committee
State House
Augusta, Maine 04333

Dear Senator Pendexter and Representative Fitzpatrick:

As you have requested, the following is a description of the non-patient chart documents previously identified for the Committee.

1. Unit Shift Report: This document is completed by the Charge Nurse on each unit for each patient. It records, on an abbreviated basis, critical information that is planned to occur or actually did occur for the patient during that shift. It is a communication tool between staff on all shifts. It serves as the basis for the change of shift report that occurs at 6:45 am; 2:45 pm and 10:45 pm each day. It is written so that it may be referred to as needed from day-to-day. It is maintained in the unit Nursing Office. (This form is labeled: Patient Profile/Pertinent Patient Data)

2. Patient/staff assignments: These forms are completed on each unit by the Charge Nurse or designee. The forms list each patient's name and the staff member primarily responsible for care of that patient during that shift of duty. It also lists other tasks and the staff assigned to complete them each shift. (This form is labeled: Assignments, and includes a shift designation)

3. Individualized shift work sheets: These are notes developed by the Charge Nurse that summarize the information the nurse received from the off-going charge nurse. This is not a designated AMHI form. Most Charge Nurses have approached this information gathering in different ways and usually these notes are not retained by the facility but are the personal notes of the charge nurse.

4. "Critical incident report": This report is completed by the Nursing Supervisor on duty on evenings, nights, weekends and holidays. It provides a "thumbnail" sketch of critical events, such

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PHONE: (207) 287-4223 (Voice) (207) 287-2000 (TTY) FAX: (207) 287-4268

as: fires, high profile incidents, security issues, that may occur which involve patients, staff or visitors. It is maintained in the Nursing Supervisor's Office.

5. "OD" book: This "Officer of the Day" notebook is maintained by the PA (Physician's Assistant) on evenings and nights and is left at the AMHI switchboard during week days. It is used as a communication tool among the three PA's who work during that time each week. Examples of information that might be recorded are information received by telephone on pending admissions and calls received by the PA regarding inpatient needs.

6. Administrator on Call Book: There are designated department heads who act in the absence of the Superintendent on evenings and weekends. A composition type notebook serves as the recording document for calls received and actions taken during that time. Administrators on call follow-up the next working day to assure issues are addressed. It is maintained in the superintendent's office.

7. McDowell Report: The Commissioner appointed an independent review team, chaired by Don McDowell, to examine the issues related to the death of Wrendy Hayne. This report is the result of their review.

8. Bouffard, Estabrook and Williams Report: Following issuance of the McDowell Report, the Commissioner directed Rod Bouffard, Richard Estabrook, and Don Williams, employees of the Department of MH, MR and SAS to review the issues related to the care and treatment by AMHI staff of Wrendy Hayne and Harold Pulsifer. This report is the result of their investigation.

9. Peer Review: Three members of AMHI Medical Staff reviewed the issues related to the death of Wrendy Hayne and specifically the performance of Dr. Hermida and Dr. Renshaw. There is a peer review undertaken whenever a significant issue of medical care is raised. Peer reviews are maintained in the Medical Director's Office.

10. Miscellaneous Memos: These are memoranda related to the care and treatment of Harold "Pete" Pulsifer and to the care, treatment and death of Wrendy Hayne. These memoranda are documents of internal communication between staff at AMHI.

11. Individualized Patient report: This is the same as #1.

12. Death review report: This is a report completed under an arrangement with the Maine Medical Association. A subcommittee designated by that group completed a review of the care and treatment and death of Wrendy Hayne. This group reviews every patient death at AMHI.

Initial review by the Attorney General's Office suggests that the following confidentiality laws may limit the availability of the documents for review.

1. 34 - B M.R.S.A. Section 1207
2. 34 - B M.R.S.A. Section 1207
3. 34 - B M.R.S.A. Section 1207

4. 34 - B M.R.S.A. Section 1207, 24 M.R.S.A. Section 2510
5. 34 - B M.R.S.A. Section 1207
6. 34 - B M.R.S.A. Section 1207
7. Confidentiality issues concerning this report have already been addressed by District Court.
8. 34 - B M.R.S.A. Section 1207, 5 M.R.S.A. Section 7070; 24 M.R.S.A. Section 2510
9. 34 - B M.R.S.A. Section 1207, 5 M.R.S.A. Section 7070; 24 M.R.S.A. Section 2510
10. 34 - B M.R.S.A. Section 1207, 24 M.R.S.A. Section 2510
11. 34 - B M.R.S.A. Section 1207
12. Confidentiality issues concerning this report have already been addressed by District Court.

I hope this information is responsive to your request.

Sincerely,

Melodie J. Peet
Commissioner

MJP/dg

BEHAVIORAL HEALTH NETWORK OF MAINE
As of 9/6/96

Network	Total Number of Cases	Number of Contacts	Completed Assessments	Scheduled Assessments	Declined	Deceased	Out of State	Unable to Locate
Aroostook	31	31	12	0	6	0	2	11
Northeast	146	146	92	0	15	1	7	31
Ken-Som	607	585	302	33	118	11	17	104
Coastal	367	362	185	4	74	3	17	79
Tri-County	513	486	248	23	93	6	21	95
Cumberland	740	706	302	11	164	8	19	202
York	315	259	129	0	41	3	14	72
TOTALS	2,719	2,575	1,270	71	511	32	97	594

Orbeton, Jane

From: Waterbury, Jamie A.
To: Orbeton, Jane
Cc: Peet, Melodie; Spencer, Sandra C.; Douglas, Wayne R.
Subject: Top Clinical Staff at AMHI in April
Date: Tuesday, September 17, 1996 2:12PM

The following information is provided as requested:

Top clinical staff at AMHI in April:

Director of Nursing	Kathy Guilbault	- Still at AMHI
Clinical Director	Dr. Gordon Clark	- No longer at AMHI/or Dept.
Superintendent	Walter Lowell	- No longer at AMHI (but still employed by DMHMRSAS in different capacity)

If you need further information, please let me know. Thanks.

Position count at Augusta Mental Health Institute, 1995-97

PL 368, page 466,467	Part I Budget position count	4 general fund 550 other revenue

PL 368	Part I Budget pages 556, 567	-225
PL 395	Supplemental Budget page 680	+11
PL 395	Supplemental Budget pages 680, 681	- .5
PL 560	Productivity Realization Task Force bill pages 1435, 1436	-24
PL 665	Supplemental Budget page 1829	+31.5

Position count when delayed actions occur at AMHI during fiscal year 1996-97 — 342.5

	1996-97
MENTAL HEALTH AND MENTAL RETARDATION, DEPARTMENT OF	
Augusta Mental Health Institute	
Positions - Other Count	(31.5)
Personal Services	441,327
All Other	49,345
TOTAL	490,672

Provides for the allocation of funds for 5 Nurse II positions, 3 LPN positions, one Hospital Ward Clerk position, 13 Mental Health Worker I positions, one Clerk Typist II position, one Housekeeper I position, one Laundry Worker I position, one Food Service Worker position, 2 Physician III positions, one Habilitation Aide position, one Psychiatric Social Worker II position, one part-time Psychologist III position and one Carpenter position to keep one 15-bed unit open through January 31, 1997.

Bangor Mental Health Institute	
Personal Services	305,670
All Other	57,619
TOTAL	363,289

Provides for the allocation of funds as a partial offset to a deallocation in Part A to continue to staff Ward K-1 through January 31, 1997.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION TOTAL	853,961

Sec. KK-4. Allocation. The following funds are allocated from the Island Ferry Services Fund to carry out the purposes of this Part.

	1996-97
TRANSPORTATION, DEPARTMENT OF	
Island Ferry Service Exp.	
All Other	275,000

Provides for the allocation of additional funds resulting from a General Fund appropriation for the Maine State Ferry Service. Approximately $100,000 must be used for ferry maintenance and $175,000 must be used to reduce the cost of the proposed fare surcharge.

DEPARTMENT OF TRANSPORTATION TOTAL	$275,000

PART LL

Sec. LL-1. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Part.

	1995-96
ADMINISTRATIVE AND FINANCIAL SERVICES, DEPARTMENT OF	
Rainy Day Fund Program	
Unallocated	$17,500,000

PART MM

Sec. MM-1. 34-A MRSA §1210, sub-§2, as amended by PL 1995, c. 368, Pt. K, §3, is further amended to read:

2. Reimbursement. Except as provided in subsection 6-A, the department shall, under this section, reimburse each county quarterly for each actual day served at that county correctional facility by:

A. Persons convicted of a Class A, Class B or Class C crime sentenced after March 31, 1987, to serve a term of imprisonment pursuant to Title 17-A, section 1203, subsection 1 or section 1252, subsection 1; and

B. Persons convicted of a Class A, Class B or Class C crime sentenced after December 31, 1988, to serve a term of imprisonment pursuant

MAINE WASTE MANAGEMENT AGENCY
Administration - Office of the Executive Director

Other Participating Funds

* Other Special Revenue Funds		
Positions - Other Count	(3.0)	(3.0)
Personal Services	169,349	167,156
All Other	97,044	100,306
Fund Total	266,393	267,462

OFFICE OF PLANNING
Office of Planning

Other Participating Funds

* Other Special Revenue Funds		
Positions - Other Count	(4.0)	(4.0)
Personal Services	217,382	215,208
All Other	100,567	105,287
Fund Total	317,949	320,495

OFFICE OF SITING AND DISPOSAL OPERATIONS
Office of Siting and Disposal Operations

Other Participating Funds

* Other Special Revenue Funds		
Positions - Other Count	(4.0)	(4.0)
Personal Services	205,452	206,748
All Other	835,531	501,672
Capital Expenditures	7,000	7,000
Fund Total	1,047,983	715,420

OFFICE OF WASTE REDUCTION AND RECYCLING
Office of Waste Reduction and Recycling

Other Participating Funds

* Other Special Revenue Funds		
Positions - Other Count	(5.0)	(5.0)
Personal Services	265,107	263,348
All Other	690,718	1,021,425
Capital Expenditures	7,000	7,000
Fund Total	962,825	1,291,773

SUMMARY - MAINE WASTE MANAGEMENT AGENCY

Other Participating Funds

* Other Special Revenue Funds		
Positions - Other Count	(16.0)	(16.0)
Personal Services	857,290	852,460
All Other	1,723,860	1,728,690
Capital Expenditures	14,000	14,000
Umbrella Fund Total	2,595,150	2,595,150

SUMMARY - MAINE WASTE MANAGEMENT AGENCY

Positions - Other Count	**(16.0)**	**(16.0)**
Personal Services	**857,290**	**852,460**
All Other	**1,723,860**	**1,728,690**
Capital Expenditures	**14,000**	**14,000**
Umbrella Grand Total	**2,595,150**	**2,595,150**

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
Administration - Mental Health and Mental Retardation

* General Fund		
Positions - Legislative Count	(84.5)	(84.5)
Personal Services	4,603,712	4,561,224
All Other	700,260	719,884
Capital Expenditures	5,000	5,000
Fund Total	5,308,972	5,286,108

OFFICE OF ADVOCACY (MENTAL HEALTH AND MENTAL RETARDATION)
Office of Advocacy - Mental Health and Mental Retardation

* General Fund		
Positions - Legislative Count	(13.5)	(13.5)
Personal Services	681,617	678,803
All Other	28,173	28,815
Fund Total	709,790	707,618

AROOSTOOK RESIDENTIAL CENTER
Aroostook Residential Center

* General Fund		
Positions - Legislative Count	(21.0)	(21.0)
Personal Services	821,431	824,528
All Other	259,155	270,513
Capital Expenditures	6,000	5,700
Fund Total	1,086,586	1,100,741

AUGUSTA MENTAL HEALTH INSTITUTE
Augusta Mental Health Institute

* General Fund		
Positions - Legislative Count	(4.0)	(4.0)
Personal Services	139,588	139,325
All Other	19,906	20,400
Fund Total	159,494	159,725

Other Participating Funds

* Other Special Revenue Funds		
Positions - Other Count	(550.0)	(550.0)
Personal Services	16,046,381	15,934,9[illegible]
All Other	2,427,967	2,511,5[illegible]
Capital Expenditures	75,705	38,3[illegible]

Fund Total	18,550,053	18,484,827

SUMMARY - AUGUSTA MENTAL HEALTH INSTITUTE

Positions - Legislative Count	(4.0)	(4.0)
Positions - Other Count	(550.0)	(550.0)
Personal Services	16,185,969	16,074,244
All Other	2,447,873	2,531,972
Capital Expenditures	75,705	38,336
Program Total	18,709,547	18,644,552

Disproportionate Share - Augusta Mental Health Institute

* General Fund		
Personal Services	8,858,783	8,795,649
All Other	1,328,118	1,373,547
Capital Expenditures	41,795	21,164
Fund Total	10,228,696	10,190,360

BANGOR MENTAL HEALTH INSTITUTE
Bangor Mental Health Institute

* General Fund		
Positions - Legislative Count	(32.0)	(32.0)
Personal Services	1,294,559	1,288,590
All Other	456,736	464,994
Capital Expenditures	10,295	3,753
Fund Total	1,761,590	1,757,337

Other Participating Funds

* Federal Expenditures Fund		
Positions - Other Count	(0.5)	(0.5)
Personal Services	9,340	9,586
All Other	1,660	1,274
Fund Total	11,000	10,860
* Other Special Revenue Funds		
Positions - Other Count	(507.5)	(507.5)
Personal Services	14,505,071	14,452,063
All Other	2,246,974	2,291,029
Capital Expenditures	58,429	21,742
Fund Total	16,810,474	16,764,834

SUMMARY - BANGOR MENTAL HEALTH INSTITUTE

Positions - Legislative Count	(32.0)	(32.0)
Positions - Other Count	(508.0)	(508.0)
Personal Services	15,808,970	15,750,239
All Other	2,705,370	2,757,297
Capital Expenditures	68,724	25,495
Program Total	18,583,064	18,533,031

Disproportionate Share - Bangor Mental Health Institute

* General Fund		
Personal Services	7,987,652	7,956,373
All Other	1,284,901	1,306,660
Capital Expenditures	33,876	12,605
Fund Total	9,306,429	9,275,638

BATH CHILDREN'S HOME
Bath Children's Home

* General Fund		
Positions - Legislative Count	(18.0)	(18.0)
Personal Services	683,692	692,046
All Other	106,201	108,798
Fund Total	789,893	800,844

BUREAU OF CHILDREN WITH SPECIAL NEEDS (MENTAL HEALTH AND MENTAL RETARDATION)
Mental Health Services - Child Medicaid

* General Fund		
All Other	2,338,071	2,464,327
Fund Total	2,338,071	2,464,327

Mental Health Services - Children

* General Fund		
Positions - Legislative Count	(60.5)	(60.5)
Personal Services	2,897,717	2,880,657
All Other	8,861,089	9,330,468
Fund Total	11,758,806	12,211,125

Other Participating Funds

* Federal Expenditures Fund		
Positions - Other Count	(9.0)	(9.0)
Personal Services	456,598	464,388
All Other	4,970,756	5,044,354
Fund Total	5,427,354	5,508,742
* Federal Block Grant Fund		
All Other	518,332	518,332
Fund Total	518,332	518,332

SUMMARY - MENTAL HEALTH SERVICES - CHILDREN

Positions - Legislative Count	(60.5)	(60.5)
Positions - Other Count	(9.0)	(9.0)
Personal Services	3,354,315	3,345,045
All Other	14,350,177	14,893,154
Program Total	17,704,492	18,238,199

ELIZABETH LEVINSON CENTER
Elizabeth Levinson Center

Marine Development - Bureau of

All Other	210,000	210,000

Provides for the allocation of funds for allotments necessary to carry out the legislative intent of the seed lobster fund.

Marine Development - Bureau of

Personal Services	9,500	6,500

Provides for the allocation of funds for the upgrade of one Marine Resource Scientist I position to one Marine Resource Scientist II position.

Marine Patrol - Bureau of

All Other	111,000	111,000
Capital Expenditures	39,000	39,000
TOTAL	150,000	150,000

Provides for the allocation of funds to carry out the legislative intent of the watercraft fund.

Marine Sciences - Bureau of

All Other	25,000	25,000

Provides for the allocation of funds for allotments necessary to carry out the legislative intent of the shellfish fund.

Marine Sciences - Bureau of

All Other	5,000	5,000

Provides for the allocation of funds for allotments necessary to carry out the legislative intent of the toxin monitoring funds.

Marine Sciences - Bureau of

Personal Services	10,000	10,000
All Other	10,000	10,000
TOTAL	20,000	20,000

Provides for the allocation of funds necessary to carry out the legislative intent of the marine worm funds.

Marine Sciences - Bureau of

Capital Expenditures	100,000	100,000

Provides for the allocation of funds for creation of the boat sale conversion account.

Marine Sciences - Bureau of

All Other	100,000	100,000

Provides for the allocation of funds for allotments necessary to carry out the legislative intent of the gas tax fund.

Seafood Market Development

All Other	5,000	5,000

Provides for the allocation of funds to carry out the legislative intent of the seafood market development fund.

DEPARTMENT OF MARINE RESOURCES TOTAL	879,500	876,500

MENTAL HEALTH AND MENTAL RETARDATION, DEPARTMENT OF

Augusta Mental Health Institute

Positions - Other Count		(-148.0)
Personal Services		(1,614,736)
All Other		(32,029)
TOTAL		(1,646,765)

Provides for the deallocation of funds due to the closure of the geropsychiatric unit on July 1, 1996, involving 39 positions, and an admissions unit on March 1, 1997, involving 109 positions, contingent upon expanded community development. A total of 148 positions would be eliminated. Positions are on file with the Bureau of the Budget.

Augusta Mental Health Institute

Positions - Other Count	(-43.5)	(-43.5)
Personal Services	(1,172,060)	(1,172,060)
All Other	(35,298)	(35,298)
TOTAL	(1,207,358)	(1,207,358)

Provides for the deallocation of funds by

eliminating 43.5 positions within the hospital to reappropriate funds to expand community mental health services in compliance with the Augusta Mental Health Institute Consent Decree. Positions are on file with the Bureau of the Budget.

Augusta Mental Health Institute

Positions - Other Count	(-34.0)	(-34.0)
Personal Services	(369,713)	(782,765)

Provides for the deallocation of funds due to the closing of one long-stay unit in January 1996, involving 34 positions. Positions are on file with the Bureau of the Budget.

Bangor Mental Health Institute

Positions - Other Count	(-16.5)	(-16.5)
Personal Services	(205,540)	(431,707)
All Other	(47,475)	(112,799)
TOTAL	(253,015)	(544,506)

Provides for the deallocation of funds from the closing of one long-term psychiatric unit in January 1996, involving 16.5 positions. Positions are on file with the Bureau of the Budget.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION TOTAL	(1,830,086)	(4,181,394)

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Administrative Services - Professional and Financial Regulation

Positions - Other Count	(1.0)	(1.0)
Personal Services	76,550	73,950
All Other	83,860	64,790
Capital Expenditures	50,000	25,000
TOTAL	210,410	163,740

Provides for the allocation of funds to defray costs related to the reclassifications of one Receptionist position to one Clerk Typist III position, one Senior Administrative Secretary position to one Administrative Assistant position, one Account Clerk I position to one Information Systems Support Technician position, one Information Systems Support Specialist position to one Information Systems Support Specialist II position, and the transfer of one Senior Programmer position from the Bureau of Insurance, training supplies and computer equipment to enhance the current network system.

Accountancy - Board of

Personal Services	2,034	2,034
All Other	1,000	1,000
TOTAL	3,034	3,034

Provides for the allocation of funds to reclassify one Clerk Typist III position to one Board Clerk position, Total Quality Management, and to provide advancement career training for employees.

Architects, Landscape Architects, Interior Designers - Board of

Personal Services	2,034	2,034
All Other	19,000	19,000
TOTAL	21,034	21,034

Provides for the allocation of funds to reclassify one Clerk Typist III position to one Board Clerk position, Total Quality Management, career advancement training for employees, dues and out-of-state travel.

Barbering and Cosmetology - Board of

Personal Services	4,068	4,068
All Other	27,586	27,586
TOTAL	31,654	31,654

Provides for the deallocation of funds through the transfer of funds to the Bureau of Marine Patrol as part of the reorganization of the department.

Marine Patrol - Bureau of

All Other	74,780	75,176

Provides for the allocation of funds through the transfer of the seed lobster fund account from the Bureau of Marine Development as part of the reorganization of the department.

Marine Sciences - Bureau of

Positions - Other Count	(-4.5)	(-4.5)
Personal Services	(182,579)	(182,045)
All Other	(33,916)	(34,212)
Capital Expenditures	(40,622)	(40,622)
TOTAL	(257,117)	(256,879)

Provides for the deallocation of funds through the transfer of one Marine Research Scientist II position, 3 part-time Conservation Aide positions and one Marine Patrol Officer position to the Bureau of Marine Development. This transfers the Shellfish Fund as part of the reorganization of the department.

Marine Sciences - Bureau of

All Other	(26,210)	(27,497)

Provides for the deallocation of funds through the transfer of the Toxin Monitoring Fund to the Bureau of Marine Development as part of the reorganization of the department.

Marine Sciences - Bureau of

Positions - Other Count	(1.0)	(1.0)
Personal Services	43,368	44,653
All Other	98,914	99,968
Capital Expenditures	39,421	39,421
TOTAL	181,703	184,042

Provides for the allocation of funds through the transfer of one Marine Research Scientist II position from the Bureau of Marine Development. This transfers the Salmon Aquaculture Monitoring and Research Fund as part of the reorganization of the department.

Seafood Market Development

All Other	(50,514)	(51,035)

Provides for the deallocation of funds through the transfer of this program to the Bureau of Marine Development.

DEPARTMENT OF MARINE RESOURCES TOTAL	151,606	149,890

MENTAL HEALTH AND MENTAL RETARDATION, DEPARTMENT OF

Augusta Mental Health Institute

Positions - Other Count		(11.

Provides headcount to reflect the substitution of the closure of the geropsychiatric unit on July 1, 1995 with the closure of 15 admitting beds on July 1, 1996, and the substitution of the closure of an admission unit on March 1, 1997, eliminating 109 positions, with the closure of 25 admitting beds on March 1, 1997, eliminating 98 positions, contingent upon expanded community development. A total of 137 positions would be eliminated. Positions are on file with the Bureau of the Budget.

Augusta Mental Health Institute

Positions - Other Count	(22.0)	(-0.5)
Personal Services	560,263	(1,101)
All Other	297	1,101
TOTAL	560,560	-0-

Provides funds to adjust a previous deallocation to reflect the elimination of a total of 21.5 positions in fiscal year 1995-96 and 44 positions in fiscal year 1996-97, rather than the 43.5 positions originally planned, within the hospital to reappropriate funds to expand community mental health services in compliance with the Augusta Mental Health Institute Consent Decree. Positions are on file with the Bureau of the Budget.

Bangor Mental Health Institute

Provides clarification that a previous deallocation of funds from the closing of one long-term psychiatric unit in January 1996 involving 16.5 positions reflected position funding for 6 months with headcount authorized for 9 months. Positions are on file with the Bureau of the Budget.

Freeport Towne Square

All Other	96,085	97,094

Provides for the allocation of funds through a transfer from the Pineland Center special revenue account to establish the Freeport Towne Square workshop as a separate organizational structure.

Pineland Center

All Other	(96,085)	(97,094)

Provides for the deallocation of funds through a transfer of All Other to establish the Freeport Towne Square workshop as a separate organizational structure.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION TOTAL	560,560	-0-

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Administrative Services - Professional and Financial Regulation

Positions - Other Count	(2.0)	(2.0)
Personal Services	61,250	62,000

Provides for the allocation of funds to establish 2 Information Systems Support Technician positions as part of the reorganization of the department. These positions will serve as technical support for the department's computer users.

Banking - Bureau of

Positions - Other Count	(-1.0)	(-1.0)
Personal Services	(33,500)	(34,000)

Provides for the deallocation of funds through the elimination of one Bank Examiner position as part of the reorganization of the department.

Licensing and Enforcement

Positions - Other Count	(-0.5)	(-0.5)
Personal Services	(12,500)	(13,000)

Provides for the deallocation of funds through the elimination of one part-time Clerk Typist III position as part of the reorganization of the department.

Licensing and Enforcement

Positions - Other Count	(1.0)	(1.0)
Personal Services	33,250	33,800

Provides for the allocation of funds to establish one Pharmacy Inspector position to regulate a business that has greatly expanded. This is part of the department's reorganization.

Real Estate Commission

Positions - Other Count	(-2.0)	(-2.0)
Personal Services	(48,500)	(48,800)

Marine Sciences - Bureau of

All Other	17,588	35,000
Capital Expenditures	12,500	25,000
TOTAL	30,088	60,000

Provides for the allocation of funds to transfer allotment from the Division of Community Resource Development to the Bureau of Resource Management. This brings the dedicated accounts into alignment with the General Fund accounts.

Marine Sciences - Bureau of

All Other	34,838	69,983

Provides for the allocation of funds to transfer allotment from the Division of Community Resource Development to the Bureau of Resource Management. This brings the dedicated accounts into alignment with the General Fund accounts.

DEPARTMENT OF MARINE RESOURCES TOTAL -0- -0-

MENTAL HEALTH AND MENTAL RETARDATION, DEPARTMENT OF

Augusta Mental Health Institute

Positions - Other Count	(-17.0)	(-24.0)
Personal Services	(527,083)	(730,023)
All Other		(22,795)
TOTAL	(527,083)	(752,818)

Provides for the deallocation of funds through the elimination of the following positions: one Assistant to the Superintendent, one Director, Social Services, one Carpenter Supervisor, one Medical Records Administrator, one Rehabilitation Services Director, one Nurse Manager, one Chief Operations Officer, one part-time Clerk Typist III, one Custodial Worker II,

4,670	32,497
(4.0)	(4.0)
87,085	182,045
29,046	59,212
20,310	40,622
136,441	281,879
17,216	56,035

one part-time Food Service Worker, one Housekeeper II, one Institutional Custodial Worker, one Locksmith, one Medical Secretary, one Payroll Supervisor, one Plumber II, one Safety Compliance Officer, 5 intermittent Mental Health Worker I, one intermittent Nurse II, one Switchboard Operator and the reduction of 13 hours for 2 Clerk Typist III positions pursuant to plans submitted to the Productivity Realization Task Force and approved by the Governor. Also deallocates funds from the elimination of one Habilitation Aide position, one Mental Health Worker III position, one Mental Health Worker V position, one Nurse I position, one Nurse II position, one Psychiatric Therapy Instructor position, one Habilitation position, 5 intermittent Mental Health Worker I positions and one intermittent Nurse II position effective September 30, 1996 to maintain a reserve capacity for acute admissions until adequate community alternatives are in place.

Bangor Mental Health Institute

Positions - Other Count	(-38.5)	(-38.5)
Personal Services	(363,703)	(942,651)
All Other		(36,567)
TOTAL	(363,703)	(979,218)

Provides for the deallocation of funds through the reduction from full-time to part-time one Personnel Officer position and one Clerk Typist II position, and the elimination of the following positions: one Account Clerk II, 9 Mental Health Worker I, one Mental Health Worker II, 3 Nurse I, 3 Nurse II, 6 Nurse III, one Nurse IV, one Switchboard Operator, one Psychiatric Social Worker I, one Psychiatric Social Worker II, 2 LPN, one Custodial Worker II, one Custodial Worker III, one Laborer II, one Safety Officer, one Physician Assistant, 2 Ward Clerk, one Assistant Team Leader, one 18-hour-per-week Clinical Dietitian, and one part-time Psychiatric Nursing Instructor pursuant to the plans submitted to the Productivity Realization Task Force.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION TOTAL	(890,786)	(1,732,036)

PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF

Insurance - Bureau of

Personal Services	500	2,000

Provides for the allocation of funds for the reorganization of one Principal Insurance Examiner position to one Managing Insurance Examiner position as part of the department's productivity plan.

Insurance - Bureau of

Personal Services	450	1,800

Provides for the allocation of funds for the range change of one Insurance Rate Analyst position from range 21 to range 22 as part of the department's productivity plan.

Licensing and Enforcement

Positions - Other Count		(3.0)
Personal Services		89,989
All Other		43,500
Capital Expenditures		7,500
TOTAL		140,989

MEMORANDUM

To: Joint Standing Committee on Health and Human Services
From: Jane Orbeton, OPLA
Date: September 4, 1996
Re: Mental Health Review

The following information is provided as a result of issues raised at the August 23rd meeting of the committee. The next meeting of the committee for purposes of reviewing the mental health system is Friday, September 12th, immediately after the committee review at 9am of the appointment of Lynn Dube as director of the Office of Substance Abuse.

1. A request was made that all documents distributed to the committee and to the public through the committee be pre-screened for confidentiality purposes. Every attempt will be made to do this. Prior distribution to legal staff (OPLA and the Attorney General's Office if appropriate) will make this go more quickly.

2. A question was asked about the handwritten memo, how it could be confidential if distributed to the committee. 1 MRSA §402, sub-§3 defines public records. In subsection 1 it excepts "records that have been designated confidential by statute." A patient could execute a limited waiver of rights to confidentiality of records and information so that they are still confidential under 34-B MRSA §1207, while granting to the committee access to the documents. These documents would need to be discussed in executive session only. A patient could grant a full waiver so that records become public and can be discussed in public. The committee should not have possession of records when no waiver has been signed by the patient.

3. A request was made for guidance regarding confidentiality. OPLA staff will be happy to provide this. Specific instructions will depend on what types of information we obtain, under what types of waivers and court orders. Copies of prior letters to the committee from Jane dated July 26th and 31st are a good starting point. 1 MRSA §405 and Joint Rule 313 contain provisions on executive sessions and committee procedures for handling confidential information.

4. Linda Pistner agreed to put together a list of non-patient records that are not being released to the committee and to list the basis for not releasing each record.

5. A question was raised about the legal authority of Rod Bouffard to sign the Behavioral Health Network contract for Wayne Douglas. 34-B MRSA §1204, sub-§1 grants to the commissioner general powers to "perform any legal act relating to the care, custody, treatment, relief and improvements of residents of the state...." This provision includes the power to contract for services. 34-B MRSA §1204, sub-§3, paragraphs A and B allow the commissioner to delegate powers and duties to associate commissioners and allow the commissioner to empower associate commissioners to further delegate those powers. (A copy of the law, as amended this last session, is attached.) If the commissioner has delegated the power to contract for services to Wayne, this provision would allow Wayne to delegate that power to Rod Bouffard.

6. Whether the Behavioral Health Network needs to be licensed as an HMO depends on whether BHN provides health care services to enrolled participants for a predetermined premium. A copy of 24-A MRSA §4202-A defines HMO and sets out those requirements. In the contract with the Department the BHN duties are specified in the section entitled III. Service Specifications, which runs for 8 pages and contains 20 project tasks (see pages 2 through 9 of the contract). None of the tasks is actual health care service delivery. It is my reading that under this contract BHN does not provide health care services (medical, dental, or hospital services to prevent, alleviate, cure or heal human illness or injury), does not serve enrolled participants and does not charge a predetermined premium. My advice to the committee is that BHN is not providing the health care services directly to the consumer, at a prepaid premium price, that would qualify it as an HMO and require it to be licensed. A copy of the articles of incorporation of the Behavioral Health Network of Maine is attached.

7. The committee requested that Wayne Douglas provide information about the Department's ownership of the BHN contract database and BHN's not retaining it, which will include a penalty clause.

8. The committee asked Wayne Douglas to provide information on BHN, the 7 regions, the distribution of class members around the state, and assessment rates.

9. The committee asked Wayne Douglas to speak with the Attorney General's Office about conflict of interest, the BHN contract, and Dr. Clark's duties and reimbursement.

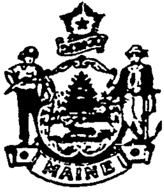
10. The committee requested that Bill Thompson provide information about the AMHI management decision, including whether the medical director is a state employee or a contract employee.

11. The committee requested that Sue Bell report on the funding problems in the Medical Examiner's Office.

12. The committee asked Katie Fullam to provide information on the progress of the Maine Task Force on Mental Health, chaired by Jane Holt deFrees, of Rumford. Created by Executive Order dated May 20, 1996, the task force is required to report its recommendations on the mental health system to the Governor by October 1, 1996. A copy of the Executive Order is attached.

13. Commissioner Melodie Peet has sent to the committee copies of the independent medical reviews done after Wrendy Hayne's death by Doctors Franklin Bragg, Ann Hanlon, Edward Robinson, and Jonathan Morris. Release of these reviews to the public was authorized by Judge Courtland Perry, of the Maine District Court. Copies of the reviews are enclosed. They are public documents.

g/oplalhs/com/hum/cor/8-27hum



Maine State Legislature
OFFICE OF POLICY AND LEGAL ANALYSIS
State House Station 13, Augusta, Maine 04333
Telephone (207) 287-1670
Telecopier (207) 287-1275

September 16, 1996

Jack Mara, Chair
Substance Abuse Services Commission
159 State House Station
Augusta, ME 04333

Dear Mr. Mara:

Thank you for sending your letter of September 11 regarding the appointment of the new director of the Office of Substance Abuse. The committee appreciated hearing from the commission at its review hearing on September 13th and was impressed with the testimony of Senator Albert Stevens on behalf of the commission.

In the past the Health and Human Services Committee has had review authority and the Senate has had confirmation powers with regard to the director of the Office of Substance Abuse. When the office was moved from the Governor's Office to the Department of Mental Health, Mental Retardation and Substance Abuse Services in the spring of 1996 the process was changed so that the committee has review powers only. We regret to inform you that the committee lacks authority to intervene in the appointment process and is unable to delay the appointment of the director.

At the hearing on September 13th the committee heard from other members of the public about the hiring process used by Commissioner Melodie Peet. Committee members questioned the commissioner about the process and were critical of her failure to follow standard procedures and include the Substance Abuse Services Commission and other members of the public. The committee encouraged the commissioner to meet with members of the Substance Abuse Services Commission prior to the next scheduled commission meeting, on October 7th.

Thank you for sending a letter and for authorizing Senator Stevens to appear for the commission.

Sincerely,

Joan M. Pendexter
Senate Chair

Michael J. Fitzpatrick
House Chair

RECEIVED
ATTORNEY GENERAL

SEP 16 1996

STATE OF MAINE
KENNEBEC, SS.

MAINE DISTRICT COURT
DISTRICT SEVEN
DIV. OF SOUTHERN KENNEBEC
CIVIL ACTION
DOCKET NO. aug-96 CV-173

IN RE: RELEASE OF CONFIDENTIAL MENTAL HEALTH RECORDS

ORDER AFTER HEARING

By a Petition dated August 15, 1996, the Commissioner of the Department of Mental Health and Mental Retardation, and the Legislature's Joint Standing Committee on Health and Human Services (117th Legis.) (hereafter "the Committee"), have asked this Court to enter an order to authorize release of certain confidential records relating to Wrendy Hayne, some of which also relate to Harold Pulsifer.

The Petition addresses three types of documents, all of which contain information that is confidential under the terms of 34-B M.R.S.A. § 1207: 1) the individual patient record of Wrendy Hayne, maintained by the Augusta Mental Health Institute ("AMHI"); 2) two independent medical reviews conducted following Ms. Haynes' death pursuant to the requirements of paragraph 199 of the AMHI Consent Decree; and 3) the critical incident book.

The Petition was heard on August 21, 1996, at which the following counsel appeared: Linda Pistner, Chief Deputy Attorney General, and Katherine Greason, Assistant Attorney General, representing Mental Health Commissioner Melodie Peet and the Committee; Lawrence Bloom, Esq., representing Janice and Donald

Burns; Pasquale J. Perrino, Esq., representing Harold Pulsifer; and Thomas Goodwin, Assistant Attorney General representing the State in the criminal case against Mr. Pulsifer. It is the Court's understanding that the parties are waiving any possible procedural defect with the filing of this Petition in order to allow its hearing on an expedited basis. Having reviewed the Petition and having considered the arguments of the parties, the following rulings are made.

A. The Individual Patient Record of Wrendy Hayne.

Individual patient records of Wrendy Hayne maintained by AMHI during her admissions to that hospital have been provided to Janice Burns, the mother of Wrendy Hayne and personal representative of her estate. These records, from which information concerning other patients has been redacted, have been provided to Ms. Burns pursuant to a release that she has given AMHI. Ms. Burns, in turn, wishes to give some part of these records to the Committee. No one present having expressed any objection, and the Court having found that there is good cause for release of these records to the Committee in order to further its work, the following order is entered as to these records:

1. Pursuant to 34-B M.R.S.A. § 1207(1)(c) such records as may be provided to the Committee by Janice Burns as personal representative, parent, and next friend of Wrendy Hayne, may, in her discretion, be released to the members of the

Committee. These records may be divided into two groups by Ms. Burns or her attorneys:

(a) Records which Ms. Burns is willing to release to the Committee for executive session only but no further; and

(b) Records which Ms. Burns is willing to release to the Committee and to the public.

2. The patient-identifying information contained in documents described in 1(a) above is to remain confidential, and the Committee members are not to release this information to or discuss it with anyone other than members of the Committee, the Committee staff, any experts retained by the Committee to review said patient-identifying information, or other individuals authorized in writing by Ms. Burns or by 34-B M.R.S.A. Section 1207 as having access to this information.

3. Deliberations on any patient-identifying information contained in documents described in 1(a) above shall be conducted in executive session pursuant to the Freedom of Access Law, 1 M.R.S.A. § 405(6)(F). Individuals present in said executive session shall be informed that information from these records shall not be further disclosed outside of said executive session.

4. Documents described in 1(b) above may be released by the Committee to the public.

5. Nothing in this portion of this order shall be construed as requiring the release of any documents by Ms. Burns to the Committee, or by AMHI or the Department of Mental Health to Ms. Burns.

B. <u>The Independent Medical Reviews Undertaken Pursuant to the Consent Decree.</u>

Commissioner Peet seeks an order authorizing her release to the Committee of the documents that constitute the independent medical review conducted pursuant to paragraph 199 of the AMHI Consent Decree and prepared by Eastern Maine Medical Center and Maine Medical Center. During the hearing, the only objection to this request was raised on behalf of Mr. Pulsifer by his counsel, Mr. Perrino, who seeks the opportunity to redact information from these documents prior to their release. The Burns' requested the opportunity to review these reports prior to their release. The Court then directed the parties to file any requests for the redaction of information from these reviews not later than 12:00 noon on Thursday, August 22, 1996.

Filings were submitted on behalf of Harold Pulsifer, whose counsel sought redaction of certain portions of each of these reports, and on behalf of Janice and Don Burns. Counsel for the Burns' subsequently agreed to the release of the independent medical reviews with the redactions requested by Mr. Perrino, while reserving the Burns' rights to pursue objections to the redactions. Accordingly, the

Court finds that there is good cause for the release by Commissioner Peet to the Committee and the public of the independent medical reviews, provided that they are redacted as requested by counsel for Mr. Pulsifer. The Burns' retain the right to pursue any objections they may have to the redaction of any information from these documents.

C. The Critical Incident Book.

Both Mr. Perrino, on behalf of Mr. Pulsifer, and Mr. Goodwin, on behalf of the State of Maine in the criminal case against Mr. Pulsifer arising from Ms. Hayne's death, object to the release of the critical incident book in any fashion in which its contents may become public on the grounds that the dissemination of this information will jeopardize the opportunity for a fair trial. The Court will take the request for release of the critical incident book to Ms. Burns and the Committee under advisement pending an opportunity for an in camera review of the document.

Dated: August 30th, 1996

COURTLAND PERRY
JUDGE, MAINE DISTRICT COURT

LAWRENCE P. BLOOM
ATTORNEY AT LAW
66 WINTHROP STREET
AUGUSTA, MAINE 04330

LAWRENCE P. BLOOM
ERIC M. MEHNERT
Of Counsel
GERALD F. KAPLAN, J.D., M.D.*
Of Counsel
*admitted in Pennsylvania only

TELEPHONE (207) 623-1455
FAX (207) 621-0353

September 13, 1996

VIA: TELEFAX

Jane Orbeton, Esq.
Maine State Legislature
Office of Policy and Legal Analysis
State House Station 13
Augusta, Maine 04330

Re: **Wrendy Hayne**

Dear Jane:

Please find three documents from Wrendy Hayne's medical record to be distributed today to the Health and Human Services Committee. These are the last three pages in Volume 12.

The three documents are entitled Sleep/Wake Monitor Sheet. One is dated April 5, 1996 and the other two are dated April 6, 1996.

Please note that these documents do not have a bate stamp number. As you know, many documents had been sequentially numbered. However, due to the extremely high costs incurred in copying the almost 3,500 pages in Volumes 1 - 9, the completion of the copying (and therefore numbering) project is essentially contingent on the longevity of the Committee.

Most importantly, these documents are being released for public review pursuant to §6 of the signed Waiver of Confidentiality. Accordingly, Janice Burns waives her rights of confidentiality of this document under 34-B M.R.S.A. §1207, sub-§1.

Finally, I wanted to confirm in writing that Mrs. Burns accepts the Committee's invitation to them at today's hearing. Despite the fact that she had previously released some 300 pages (Volume 9) to the Committee for executive session only, she is willing to discuss in public session any portion of Wrendy's record which is relevant to the Committee's main inquiry. I trust that the Committee will avoid public disclosure of extraneous issues which are of a sensitive and personal nature and which could be unnecessarily embarrassing to Mrs. Burns and a stain on Wrendy's memory. I would request that Mrs. Burns not address the Committee until I arrive.

Please forward a copy of this letter to the members of the Committee. I thank you for your consideration.

Very truly yours,

Lawrence Bloom/llc

Lawrence P. Bloom

LPB/llc
Enclosures

SLEEP/WAKE MONITOR SHEET

4-5-96

WRENDY AYNE

Write something each hour as to what Wrendy has done. If SHE sleeps write that If she went off unit write off unit. If she went to an activity write what it was -

CONFIDENTIAL
NOT TO BE RELEASED WITHOUT PERMISSION OF DMH / COPY

12 mn	up to Bathroom - Coloring
1 am	up watching TV
2 am	up watching TV
3 am	Pt sleeping in bed.
4 am	Pt laying on bed listening to radio.
5 am	up in her rm -
6 am	Pt OOB in dayroom
7 am	infront of bed
8 am	infront of bed - on/off unit at break. [illegible]
9 am	in bed
10 am	in bed -
11 am	in bed
12 n	in bed -
1 pm	In bed
2 pm	
3 pm	in bed
4 pm	in bed
5 pm	in bed
6 pm	in bed
7 pm	Sleeping
8 pm	In Bed
9 pm	In Bed
10 pm	Bed
11 pm	Bed

SLEEP/WAKE MONITOR SHEET

7/6/96

WENDY HAYNE

Write something each hour as to what Wrendy has done. If SHE slept put that. If she went off unit write off unit. If she went to an activity write what it was.

CONFIDENTIAL NOT TO BE RELEASED WITHOUT PERMISSION OF AMHI COPY

Time	
12mn	Up - ret'd to bed!
1am	In bed Sleeping
2am	Sleep
3am	In bed asleep
4am	In bed Sleeping
5am	Sleep
6am	In bed asleep
7am	Sleep
8am	- in her room Sleeping
9am	- Sleeping in her room
10am	Sleeping
11am	Sleeping in her room
12n	Up, ate lunch + Rec'd meds
1pm	Sleeping in her bed
2pm	Sleeping in her bed
3pm	In Room not Sleeping
4pm	Sleeping
5pm	Sleeping
6pm	
7pm	Up about
8pm	listening TV
9pm	Up about Ward
10pm	sleeping
11pm	

ENDY
AYNE

Write something each hour as to what Wendy has done. If she slept write that. If she went off unit write off unit, if she went to an activity write what it was.

CONFIDENTIAL
NOT TO BE RELEASED WITHOUT PERMISSION OF AMFII COPY A

Time	Activity
12 mn	In bed Sleeping
1 am	In bed Sleeping
2 am	In bed Sleeping.
3 am	In bed sleeping
4 am	Sleeping
5 am	Sleeping
6 am	Sleeping
7 am	Sleeping
8 am	OOB for meds & Breakfast then Back to Bed
9 am	In bed asleep
10 am	↑ to smoke back in her room laying on her bed
11 am	in Bed
12 n	OOB - To canteen
1 pm	Off the canteen
2 pm	
3 pm	
4 pm	
5 pm	
6 pm	
7 pm	
8 pm	
9 pm	
10 pm	
11 pm	

ISSUES RAISED AT THE SEPTEMBER 20TH MEETING OF THE HEALTH AND HUMAN SERVICES COMMITTEE

1. The Department of Mental Health, Mental Retardation and Substance Abuse Services was asked to provide information on AMHI records: what policies control record keeping, what types of information are kept in patient medical records and what types are kept in other places.

2. Non-patient record information was discussed and the letters from Commissioner Peet dated September 13 and Christopher Leighton dated September 20 were reviewed. Senator Pendexter summarized that the committee was interested in information relating to Wrendy Hayne consisting of (1) unit shift reports, (2) patient-staff assignments, (3) individualized shift work sheets, the officer of the day book (5), the administrator on call book (6), and background information from the McDowell task force (7). Mrs. Burns has asked for all of this information also. The committee will obtain any of this information from Mrs. Burns.

3. Richard Estabrook and Matt Cushner, of the Advocate's Office, are consulting attorneys (either within the Attorney General's Office or private attorneys, paid for by the State) about providing information to the committee. They will contact us as soon as they are able to speak with us.

4. The committee asked for periodic updates of the performance of assessments by members of the Behavioral Health Network and the Department of Mental Health, Mental Retardation and Substance Abuse Services.

5. At the beginning of the meeting the committee received 49 pages of Wrendy Hayne's medical records for review. Confidentiality is fully waived and the records are public records. Copies were sent to committee members and to the committee's consultant, Dr. Steven Katz, after the meeting. Copies were placed in the State Law Library for loaning out.

6. At the beginning of the meeting a copy of the critical incident book was delivered to Jane Orbeton for confidential review by the committee. Confidentiality is waived only to allow committee review of the document. The committee may review this document at a later date.

7. The draft report and recommendations distributed by some committee members has not been discussed in full committee.

Jane Orbeton, OPLA, 9/25

MEMORANDUM

To: **Joan Pendexter, Senate Chair**
Mike Fitzpatrick, House Chair
Members, Health and Human Services Committee
From: **Jane Orbeton, OPLA**
Date: **October 2, 1996**
Re: **Committee work**

I am enclosing copies of my summaries of the committee meeting on Monday and the tasks to be done for the next meeting. Also enclosed is a list of possible recommendations from the September 20th and 30th proposals. Because of the differences of opinion among committee members, I did not attempt a re-draft of the text of a report. This could be done later, particularly when you are closer to agreement.

I have received inquiries about scheduling for the committee and I replied that I would forward the requests to you.

1. Richard Estabrook has asked if the committee is still interested in speaking with him and, if so, when. His phone number is 287-4228.
2. Ken Dym, within the Department of Mental Health, Mental Retardation and Substance Abuse Services, has completed a site visit to the Kennebec Valley Mental Health Center and is ready to present information to the committee. We need to talk with him about a date. What do you wish to do? His phone number is 287-4271.

I will be out of the office from the 3rd of October until the 21st. I will be back on the 22nd. Peggy Reinsch, from OPLA, will be staffing the committee in my absence. Please do not hesitate to call on her. She has all of my committee materials and has been attending committee meetings for weeks. Peggy is also very well informed on the legal issues. She is looking forward to working with you.

Information requested at the September 30 meeting of the Health and Human Services Committee

1. The committee asked the Department of Mental Health, Mental Retardation and Substance Abuse Services for copies of the AMHI critical incident procedure and crisis reporting and communication policies.

2. The committee asked the Department for a list of the members of the Quality Improvement Councils at AMHI and BMHI.

3. The committee asked the Department for a list of active and inactive groups and councils advisory to the Department.

4. The committee asked Dr. Steven Katz for a list of the types of functions and authority of boards of visitors.

5. The committee asked the Department for a list of all organizations receiving funding from the Department for advocacy purposes and the funding provided this year.

6. The committee asked the Department for a list of all Department offices providing advocacy services to clients of the Department and the funding provided this year.

7. The committee asked Christina Lunner, representing the Maine Medical Association, to provide information on quality assurance planning and procedures for medical staff at AMHI.

Summary of the report-related discussions at the Health and Human Services Committee meeting September 30

1. Interest was expressed in recommending that AMHI examine its record keeping and adopt standardized procedures widely accepted for use in hospitals.

2. Interest was expressed in recommending that AMHI examine its policies on critical incidents, security, keys, authority and responsibility for patient care.

3. Interest was expressed in providing more oversight of AMHI through a board of visitors or a strengthened Quality Improvement Council. It appeared that it would be necessary to review the membership and functions of the current Quality Improvement Council and any other advisory groups and to provide specific functions, authority and access to the institution in order to accomplish the purpose of providing more oversight. Interest was expressed in assigning the tasks outlines in paragraph 1 (g) of September 30th draft (canteen, incident reporting/crisis communication, involuntary medication, sexual harassment/sexual relationships, criminal behavior within institution, communication with family/guardian) to the overseeing entity.

4. Interest was expressed in the Commissioner's reporting to the committee this fall on AMHI policy and procedures relating to the items in paragraph 1 (g) of September 30th draft (canteen, incident reporting/crisis communication, involuntary medication, sexual harassment/sexual relationships, criminal behavior within institution, communication with family/guardian).

5. Interest was expressed in examining the roles of departmental and independent advocates for clients of the department. Information was requested from the Department. Some members favored establishing independent advocates and some favored recommending consideration of the concept by the 118th Legislature.

6. Interest was expressed in committee briefings on the AMHI consent decree, the State's progress in meeting the terms of the decree and the plans and requirements for the future.

7. Interest was expressed in increasing legislative oversight of the department and services provided by the department. Connections were made between the September 30th proposal paragraph 4 and the September 20th proposal for a Serious Incident Team. Concern was expressed that legislation might be needed to enable a legislative committee to proceed without encountering the barriers faced by the committee: easier subpoena power, exceptions to confidentiality laws, process for becoming an investigating committee. The Commissioner and Jane Orbeton will work together to define terms needed for this proposal: what clients are covered, what incidents are covered?

8. Interest was expressed both in keeping and in removing the entries under the heading "Improvements to the Mental Health System Made by the 117th Legislature" in the September 20th draft report.

9. Interest was expressed in providing a positive statement in reply to the McDowell Task Force statement "....none of the recommended changes, alone or together, might have prevented the tragic outcome of this case." The suggestions for statement by the committee include:

a. "Had the McDowell Task Force's recommended changes, taken together, been in place at the time of Wrendy Hayne's death, it is more likely than not her death would not have allegedly occurred at the hands of Harold Pulsifer."

b. "Had the changes recommended by the McDowell Task Force been in place last winter and spring at AMHI the murder of Wrendy Hayne may not have taken place."

c. "It is the deep hope of the committee that actions will be taken as a result of these recommendations so that incidents such as the Hayne murder will not occur in the future."

10. Interest was expressed in recommending improvements in communications between the Commissioner and members of the Department and the Legislature. Some members suggested that the Commissioner improve the channels of communication between herself and those within her administration, including agencies providing mental health services on the local level. An agreement on wording was not reached.

11. Interest was expressed in finding a way for employees of the Department to speak with the committee. If this were done confidentially, it would require legislation. No agreement was reached.

12. Some members favored the recommendation that top clinical staff at AMHI at the time of the Hayne death be relieved of their positions. Some did not favor this. Some favored asking the Commissioner to look into whether these people had direct or indirect responsibility and to take appropriate action.

13. Some members favored reporting the top clinical staff to their professional boards. Some members favored asking the Commissioner to do this. Some favored expanding the list to all AMHI staff who were disciplined after the death.

14. Some members favored changes in the confidentiality laws to enable the committee to review in executive session deaths and serious incidents and to talk with the Department. Some wished to recommend to the 118th Legislature that the confidentiality laws as they pertain to mental health and mental retardation clients be reviewed and be amended where necessary in the interest of safety to patients, staff and public.

Possible Mental Health System Recommendations from the Health and Human Services Committee, Merged from September 20th and 30th Drafts

1. Action by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services

a. ensure that AMHI policies are followed and enforced

b. review the performance of management personnel responsible for care of Wrendy Hayne and possible disciplinary actions

c. pursue aggressively quality assurance and excellence of patient treatment

d. ensure communication and collaboration among units at AMHI

e. ensure staff training and development at AMHI

f. pursue collaboration between the department and the families and guardians of clients

g. strengthen policies and practices on enforcing criminal laws and cooperation with law enforcement

h. review policies on incident reporting, crisis communication, involuntary medication, sexual relationships, sexual harassment, criminal behavior, communication with families and guardians

i. improve communication within the department, with the Legislature and with community agencies

2. Action by the Department of Mental Health, Mental Retardation and Substance Abuse Services

a. create a Serious Incident Team to investigate all deaths and serious incidents involving clients of the department and to report to the HHS Committee within 5 days of the event

b. complete Waterville systems review and report recommendations to the HHS Committee

c. adopt outcome based contracting

d. impose on contracting agencies contract conditions to require cooperation with the department and with the Serious Incident Teams

e. establish a statewide 24-hour emergency phone service for clients, their families and the community

f. report to HHS Committee monthly and in writing quarterly

g. report to HHS Committee by 11/22 on:

- 24-hour emergency phone service
- progress on community collaboration
- Quality Improvement Councils
- Provider Service Networks
- progress with community hospitals on mental health in-patient treatment
- reviews of issues in paragraph 1 (h) above

3. Action by the Legislature

a. establish defined roles for entities delivering mental health services: state hospitals, community hospitals, community agencies and appropriate money for the delivery of services by those entities

b. establish independent oversight entities for the hospitals (built on Quality Improvement Councils or Boards of Visitors) providing specific functions and authority for access)

c. strengthen independent advocacy on behalf of clients of the department (built on current system or long term care ombudsman program model)

d. review/amend confidentiality laws to permit HHS Committee limited access to patient records in specific situations

e. review/amend laws to better enable legislative committees to perform their departmental oversight responsibilities (subpoena power, exceptions to confidentiality, confidentiality for state employees speaking with the committee)

f. review/appropriate funding for outpatient mental health services provided under court order

g. review rights of recipients of mental health services

h. review/enact laws on voluntary, involuntary and community commitment

i. review/enact laws on medication, in-patient and out-patient

j. HHS Committee review reports from the Serious Incident Team within 30 days

k. HHS Committee review the mental health consent decrees, including progress in complying, scheduled actions, positions of the parties, Court Master and courts.

l. HHS Committee review monthly progress reports and written quarterly reports from the Department

m. HHS Committee recommend collaboration between Department of Corrections and Department of Mental Health, Mental Retardation and Substance Abuse Services to ensure the provison of mental health services to persons within the correctional system.