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STATE OF MAINE
ONE HUNDRED AND SIXTH LEGISLATURE

COMMITTEE ON APPROPRIATIONS AND FINANCIAL AFFAIRS

December 31, 1974

TO: Chairman, Legislative Council

FROM: Senator Joseph Sewall, Chairman
Committee on Appropriations and Financial Affairs

SUBJECT: Report on Study Order to the Legislative Council

In accordance with Study Order (HP 2091) on future role of the Augusta and Bangor Mental Health Institutes, please find attached a copy of the interim staff report on its review of Maine's Mental Health Care Delivery System. This study was discussed and accepted.

It is suggested that this study be referred to the next Appropriations Committee for their consideration in reviewing these changes in the next biennium.

Encl.

STATE OF MAINE

Inter-Departmental Memorandum

Date December 13, 1974

To Members of the Committee on Appropriations and Financial Affairs Dept.

From George H. Viles Dept. Legislative Assistants

Subject Study of Maine's Mental Health Care Delivery System

At this point in my study of Maine's Mental Health Care Delivery System, I am not able to recommend changes in the organization of service delivery which would provide for a more effective use of existing resources. The study has not proceeded further because some information about the current system is lacking, national comparisons need to be made and a wider variety of alternatives need to be costed and reviewed so that the effects of any decision on clients, personnel, plant use, and the local economy will be fully understood. Further, a new superintendent, Joseph Saxl, has only recently been hired at the Bangor Mental Health Institute. His arrival has provided new leadership for a rather demoralized institute and offers the opportunity for greater coordination with the mental health centers served by the Institute. Mr. Saxl should be allowed to participate in planning for the system.

I do have suggestions regarding the organization of the Department of Mental Health and Corrections, planning requirements, and the use of resources available to the mental health care delivery system. The Bureau of Mental Health should be "expanded" so that it will have greater monitoring, technical assistance and planning capabilities; funds for this should be reallocated from the institutes. A planning requirement should be specifically imposed, with a preliminary plan and alternatives submitted to the Legislature by April, 1976.

The Legislature should consider giving the Bureau of Mental Health broad flexibility over the use of a percentage of its resources to provide for a more effective use of resources and reduce the need for additional mental health funds beyond inflation offsets.

The Advisory Committee on Mental Health should be restructured and given more explicit duties so that its influence on the system is enhanced in relation to service providers. Finally, I would suggest that a client advocacy system be extended to the community, providing greater system accountability to the client and further assurance to the Legislature that clients are being appropriately served. Funds for an expanded client advocate program should also be drawn from the institutes.

A more detailed discussion of these suggestions follows:

I. Expansion of the Bureau of Mental Health.

A. Current Organization and Authority

The Bureau of Mental Health is charged by statute with responsibility for the direction of the mental health programs in the institutions within the Department of Mental Health and Corrections and for the promotion and guidance of community mental health programs. (34 MRSA c. 181) The Department may cooperate with other agencies in providing mental health services throughout the state. The Department is directed to license providers of mental health services, other than licensed hospitals and other medical care facilities, and other than psychologists and psychiatrists in their individual or corporate professional practices. The Department is directed to adopt and promulgate rules, regulations and standards relating to the administration of mental health services. (34 MRSA c. 183)

The Department, through the mental health institutes, is given authority for:

1. the supervision of patients who have left the institution with a view to their safe care at home, suitable employment and self-support under good working and living conditions, and prevention of their relapse and return to public dependency.

2. informing and advising any indigent person, his relative or friends, and the representatives of any charitable agency as to the mental condition of any indigent person, as to the prevention and treatment of such condition, as to the prevention and treatment of such condition, as to the available institutions or other means of caring for the person so afflicted and as to any other matter relative to the welfare of such person. (34 MRSA c. 185)

The key state administrators in the mental health care delivery system are the director of the Bureau of Mental Health, the superintendents of the two mental health institutes, the chief of community mental health services and the coordinator of children's mental health services. The director is appointed by the Commissioner of Mental Health and Corrections, subject to the Personnel Law, and must be a psychiatrist. (34 MRSA §2002) Each superintendent is appointed by the Commissioner with the advice and consent of the Advisory Committee on Mental Health; a superintendent is appointed to an initial two year term and then continues in the appointment "until a successor is appointed and qualified or during the pleasure of the Commissioner and the Advisory Committee on Mental Health". A superintendent must be a qualified psychologist, or a person with a master's degree in social work, public administration or public health. (34 MRSA §2102)

B. Analysis

The authority of the Bureau of Mental Health over Maine's Mental Health Care Delivery System would appear to be quite broad. In addition to its statutory authority, the Bureau has broad discretion in the administration of funds appropriated for community mental health services and funds generated by the Mental Health Improvement Fund. The Bureau also exercises authority over federal funds for mental health services by agreement with the Department of Health and Welfare. However, an explicit statutory requirement for system planning is lacking.

As noted in the interim report to the committee on September 23, the Bureau has not exercised its authority broadly. The Bureau has been most concerned in supporting the development of the Mental Health Care Delivery System rather than in controlling or monitoring it. The Bureau has also lacked personnel resources to carry out fully its responsibilities for standard setting and enforcement, for providing technical assistance, and for program and system planning and development.

Some of the problems which have developed as a result include the financial crisis at Tri- County Mental Health Center, the problems regarding the use of Medicaid funds for day treatment, a delay in implementing the licensure requirement of mental health services (now in preparation for implementation in early 1975), and a poorly developed planning process. The planning process has been improved with the recent organization of the State Mental Health Program Directors groups and the gradual implementation of the statewide mental health information system.

It would appear that the role of the Bureau should now be to consolidate and upgrade the mental health care delivery system that is now in place, i.e. the state mental health institutes, the eight community mental health centers, and various other agencies. The strong concensus of the Advisory Committee on Mental Health, the Maine Council of Community Mental Health Centers, and the State Mental Health Program Directors is that a new emphasis should be placed on requiring accountability for the use of mental health resources as well as providing technical assistance to service providers. The Bureau of Mental Health must be strengthened so that it can do this.

C. Recommendation.

1. Improve the capability of the Bureau of Mental Health.

In the current year, approximately $650,000 in institute resources have been reallocated to the community mental health centers. This reallocation is expected to continue at a higher level next year. Such a use of funds is appropriate, but only if the Bureau/Department has the capability to determine if the resources are effectively used, and to direct the use of those resources in the future. The first priority for the reallocation of institute funds must be the Bureau of Mental Health and the Department.

There is some question whether the Bureau of Mental Health should develop its own capability or whether it should utilize the services of the Bureau of Administrative Services in the Department. It would seem that the Bureau of Mental Health could use three positions in the areas of planning, program development, and general management on a full time basis. The information system resources could perhaps best be shared. This question needs further analysis.

In its Part II budget, the Department is asking for some $161,560 for fy '75-'76 to fund some 14 additional positions for general administration. The positions include:

General Administration	Budget ExaminerII
Research and Evaluation	Psychologist Systems and Process Analyst Statistician Trainer and Implementation Coordinat 3 Computer Programmers 3 Clerks
Planning	Departmental Planning Coordinator Planning Associate Clerk Steno

I would recommend that funds for these positions for the Bureau of Administrative Services or funds for similar positions in the Bureau of Mental Health be drawn at least in part from the budgets of the mental health institutes. These positions are needed if the Bureau is to provide proper guidance for the mental health care delivery system.

II. Planning Requirements

A. Current Planning Efforts

Currently, the state mental health plan is being updated, with its last major revision occurring some five years ago. The plan appears designed to meet federal requirements rather than to guide the use of state resources. Planning meetings of the State Mental Health Program Directors Group (i.e. the directors of community mental health centers, the institute superintendents, and the director of mental health) have been held, but their scope has been limited.

B. Recommendation

A mental health planning requirement should be included in the statutory responsibilities of the Bureau of Mental Health. The Bureau of Mental Health should be required to submit a report on the plan and the current status of the mental health care delivery system to the Governor and the Legislature at the beginning of each biennium.

More immediately, the Bureau should be required to submit a preliminary plan and alternatives to the Legislature by April, 1976. A more comprehensive plan should be developed for submission to the 108th Legislature.

The mental health care delivery system does have adequate resources for planning - if they are allocated properly. In particular, the institute superintendents and their staffs can be utilized by the Bureau, along with the staff of an expanded Bureau. Community mental health centers and other service providers can also contribute to the process.

The preliminary planning needs to be done before more funds are appropriated to support the mental health system.

A review of the data on the current system indicates that service priorities need to be established, personnel and plant use need to be examined in conjunction with the continuing census decline. It is not clear that resources are being used effectively now.

Several alternatives must be examined for treatment and cost implications and presented to the Legislature, along with more information on current services delivered and current client groups. Information on mental health needs may need to be correlated with area socio-economic factors as it is possible that some mental health funds may be most appropriately shifted to education, job development, housing, etc..

An alternative such as providing intermediate and long term

care and treatment in Aroostook County, having the Augusta Mental Health Institute serve the Mid-Coast Mental Health Center in place of the Bangor Mental Health Institute, and changing the relationship/organization of the Counseling Center and the Bangor Mental Health Center needs a thorough analysis, along with other system wide alternatives.

III. Increased Flexibility in the Use of Existing Resources

A. Current Needs and Reallocation

During this past summer, representatives of the community mental health centers noted several times that there were adequate funds in the state mental health care delivery system if they were allocated properly. Since then, this statement has been qualified by the potential difficulties surrounding the use of Medicaid funds and a moratorium on Title VI Social Service grants.

As already noted, this year some $650,000 of institute resources have been reallocated to the community mental health centers, primarily through utilizing state personnel lines in the centers. This procedure has caused considerable delay in getting resources into use, primarily because of the time necessary to go through the state personnel system.

Resource sharing of this type also means that some state employees work in the centers, subject to the direction of the centers. There is some potential conflict in this arrangement.

There may also be a need for "resource sharing" between the Department of Mental Health and Corrections and other departments.

B. Recommendation

In order to provide a more timely and effective use of mental health funds throughout the Mental Health Care Delivery System, it has been suggested by various Bureau personnel that future appropriations to the institutes be made with the proviso that the Director of the Bureau of Mental Health, with the approval of the Commissioner (and/or the Governor and Council), be allowed to transfer up to 20% of those resources to the grant-in-aid program. It has also been suggested that the Bureau be allowed to reclassify a certain percentage of positions in the institutes, within the funds available and the position counts authorized. It is recommended that the Legislature experiment with providing greater flexibility to the Bureau in the use of a certain percentage of its funds.

There should be requirements that funds are not to be used in such a manner as to require increased appropriations in succeeding years or to radically change the organization of service delivery without legislation. Any shift of funds to the community mental health centers should not be made without performance requirements set and enforced by the Bureau.

C. Effect

Such flexibility could reduce or remove the need for increased mental health funds beyond the inflation offset. It would also encourage better management of existing resources by giving the institute superintendents more flexibility to seek ways in which funds may be freed up and services upgraded.

Whether additional appropriations for mental health are needed in 1975-76 depends greatly on the condition of the Mental Health Improvement Fund. Its revenues may be four to five hundred thousand dollars greater this year than expected, and next year's estimate may be low by two to five hundred thousand dollars.

If 20% flexibility in the use of institute funds is provided, some $3,000,000 would be involved. The wise use of these funds, provided other appropriations were not significantly increased, would provide for greater discipline and efficiency in the Mental Health Care Delivery System.

IV. Restructuring the Advisory Committee on Mental Health

A. Current Organization and Role

The Advisory Committee on Mental Health consists of nine members appointed by the Governor for three year terms. The committee is to be composed of members whose chief employment is outside of State Government. The committee's duties are to "assist" the Bureau and to participate in the hiring and firing of the two institute superintendents.

The Bureau appears to have kept the Advisory Committee reasonably well informed, in view of the wide range of information to be considered. I am not sure that the Advisory Committee has played a significant role in advising the Bureau on major policy issues. This may be particularly true with the development of the Maine Council of Community Mental Health Centers and the State Mental Health Program Directors group. These two groups appear to have more of an influence in shaping policy.

The membership currently reflects service providers, community mental health center boards, the Legislature, and the general public or consumers.

B. Recommended Organization and Role

I would restructure the membership as follows:

1. the commissioners of the departments of Health and Welfare and Education and Cultural Services, or their designates.

2. 4 members who shall be employees of human service agencies or in the professions associated with mental health, appointed by the Governor for three year terms.

3. 5 members of the general public , including board members of community mental health centers, appointed by the Governor for three year terms.

4. One member of the House of Representatives appointed by the Speaker of the House and one member of the Senate appointed by the President of the Senate.

The duties of the committee should include:

1. to review and comment to the Director of the Bureau of Mental Health and the Commissioner of Mental Health and Connections on rules, regulations, standards and policies developed by the Bureau before their implementation.

2. to review and comment to the Director and the Commissioner on grants proposed to be made by the Bureau.

3. to review and comment annually to the Director and the Commissioner on the state mental health plan.

4. to review and comment to the Governor and the Legislature on the Bureau of Mental Health's biennial report on the state mental health plan and the current status of the mental health care delivery system.

5. to initiate studies on its own motion, with reasonable assistance from the Bureau.

The committee should meet at least six times a year.

This restructuring of the Advisory Committee on Mental Health provides specific duties for the committee and for a broad representation of the parties concerned with mental health. Though the Maine Council of Community Mental Health Centers and State Mental Health Program Directors groups will continue to play an active role in shaping the Mental Health Care Delivery System, the Advisory Committee will serve to balance the perspective on the system by involving other parties as well.

V. Client Advocacy

A. Description and Current Organiziation

The task of a client advocate is to aid clients where their rights to a high quality of treatment and care or their other civil and legal rights are being denied to them. They operate within careful guidelines as advocates, and do not otherwise infringe upon the roles of administrators, clinicians, and other authorities and service providers. The client advocates cooperate with agencies in seeking to resolve grievances at the lowest possible level of responsibility or service delivery, and by assisting the agencies in developing standards to protect the rights of clients.

A client advocacy program in Maine was developed first in the State's mental health institutes in 1971 and 1972, and was extended to State correctional facilities in the fall of 1972. There are currently 4 advocates serving at the institutional level who are responsible to a chief advocate in the central office of the Department of Mental Health and Corrections. The chief advocate reports directly to Commissioner Kearns.

The Department also awarded a grant to the Maine State Bar Association to provide for certain legal services to the clients of the Department and to the advocates. The Bar Association used these funds to select and employ an attorney to assist the advocacy program.

There is no statutory basis for the advocacy program at present.

The eight community mental health centers have developed "aftercare programs" aimed at assisting mental health clients in the community. A similar program has been established by the Bureau of Mental Retardation through grants to local agencies, often to the community mental health centers. Although personnel in these programs often serve as advocates for their clients, particularly those in nursing, boarding, and foster homes, their main role is to provide or coordinate services and they are not as independent from agency involvement as client advocates.

Commissioner Kearns has asked that community mental health centers move more rapidly toward developing a system of client advocacy. The centers have responded in some degree by organizing consumer groups or studying the issue.

Though the mental health centers are concerned, client advocacy is not a primary concern for them, and perhaps it should not be. An advocacy system developed within a center may be too easily dominated or distorted by other concerns and priorities of the center; a monitoring or advocacy process should not be so closely linked with service delivery. Further, development of an advocacy system within a center means added expenditures which are not fee generating or are not easily reimbursable at a time when center funding is becoming more difficult.

A statewide client advocate system will help avoid the development of "back wards" of mental health clients in the community. The system will help to make mental health care providers accountable to the client, as well as giving the executive and legislative branches of government some reassurance that services are being provided.

B. Recommendation

It is recommended that the client advocate system be extended to include not only state institutes in the Department of Mental Health and Corrections but also to include other agencies licensed by or receiving support from the State for service to client groups served by or under the jurisdiction of the Bureau of Mental Health, and possibly the Bureau of Mental Retardation and the Bureau of Corrections as well. Nursing, boarding and foster homes with clients receiving state or federal assistance should also be subject to the client advocate system.

The Office of Client Advocacy should be established by statute within the Department of Mental Health and Corrections. The chief advocate would be appointed by the commissioner for a term of 3 years.

An additional six to eight client advocates should be hired to provide for adequate regional coverage.

The client advocates would be responsible to the chief advocate, who would be responsible to the commissioner. Client advocates would have the authority:

1. to inform clients of their rights

2. to assist agencies in the development of standards to protect the rights of clients

3. to receive complaints from clients, represent clients in resolving a complaint with agency officials, refer complaints, or assist clients in advancing formal grievance proceedings

4. to initiate investigations where it appears that the rights of clients are being denied

5. to inspect such agency files, records and reports, where not otherwise prohibited by law, as may be necessary to assist the client advocate in the performance of his or her duties.

The chief advocate would develop necessary guidelines, rules and regulations governing the activities of the client advocates. These would be subject to the approval of the Attorney General as to matters of law and to the approval of the commissioner.

The chief advocate would provide reports regularly on the activities and findings of the Office of Client Advocacy to the commissioner and the advisory committees of the department.

Additional expense with the expansion of the patient advocate system would be approximately $110,000 for salaries. Total personnel expense for the program would be about $171,000, using the salary ranges recommended by the present chief advocate.

Funding for this program should be taken at least in part from the institute budgets. If the system is not expanded to include mental retardation and corrections clients, then six to eight additional client advocates may not be cost justified. In that case, perhaps two or three additional client advocates should be employed with a responsibility to mental health clients in the community.