STATE OF MAINE
113TH LEGISLATURE
SECOND REGULAR SESSION

COMMISSION TO REVIEW OVERCROWDING AT THE AUGUSTA MENTAL HEALTH INSTITUTE AND THE BANGOR MENTAL HEALTH INSTITUTE

December 1987

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SUMMARY

The Commission to Review Overcrowding at the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute (BMHI) was established by the First Regular Session of the 113th Legislature because of the increased patient load in the two institutes. The critical aspect of the understaffing at AMHI was eased by the addition of temporary positions and limited new community residential development. However, this temporary solution did not address the underlying pressure of overcrowding on staff at the institutes and the consequent problems that staff burnout, turnover and low morale can have on the delivery of good professional care.

The charge given to the Commission was to make a broad examination of the services available to mentally ill individuals. This is the first of two reports and it concentrates on the causes and consequences of the overcrowding at the two state mental health institutes.

The report reviews the place of the two institutes in the historical development of services for mentally ill individuals in Maine. Testimony provided the Commission defined the present mission of the institutes as "the delivery of inpatient and related services to individuals with severe mental illness whose needs cannot be met in less restrictive settings or for whom specialized services are not readily available in a community based facility". Variation in the patient census since the 1950s was examined at both institutes as well as the demographic characteristics of their present populations.

The impact of the high patient censuses on patients has been a reduction in therapeutic and rehabilitative programming as staff are moved to ward duties to meet the institutes' primary responsibilities of custodial care and safety of patients. The staff have experienced a reduction in the time and continuity in their therapeutic interaction with patients often caused by temporary reassignments to meet staff shortages in other areas of an institute. The Commission felt that this part of the problem may be addressed through a better analysis by each institute of their use of overtime hours. Where there is a regular and predictable need, the use of part-time employees may be preferable to requiring overtime by existing staff.

Placed in the context of a larger system of services, the Commission perceived the overcrowding at the institutes as a symptom of a continuing lack of community resources and that the solution to the present problem cannot be to provide additional beds and staff at the two institutes. The possibility of reconverting some of the buildings which have been taken over as office space for other state agencies was examined but not considered appropriate. The architectural design of the buildings does not lend itself to therapeutic programs and efficient use of staff. New resources, of the

amount needed to renovate any existing buildings would be better directed toward the development of community based services.

The task of the Commission in 1988 will center on two issues: first, to encourage the department and the institutes to develop a staffing plan which will deal with the pressures resulting from overtime and overcrowding at the institutes; and second, to recommend a policy for the development of adequate community based services which will provide needed additional support, programs and protection for mentally disabled individuals. It would appear the study by this Commission will coordinate well with the major planning initiative being implemented by the Department of Mental Health and Mental Retardation with the active involvement of the Plan Development Committee of the Mental Health Advisory Council. These two efforts will produce for the Governor and Legislature a comprehensive blueprint for services for mentally disabled individuals. This blueprint should provide for the coordination of sufficient community-based programs with the two mental health institutes to prevent the reoccurrence of the overcrowded conditions experienced by the Augusta and Bangor Mental Health Institutes in recent years.

I. INTRODUCTION

The Maine Commission to Review Overcrowding at the Augusta Mental Health Institute and the Bangor Mental Health Institute was established by the first session of the 113th Legislature (Resolve 1987, c. 56). The impetus for its formation was the sharp increase in the patient census at the two State mental health institutes which was seen as posing "a hazard on the health and safety of both patients and staff."

The charge of the Commission was to examine "overcrowding at the Augusta Mental Health Institute and the Bangor Mental Health Institute, including: the adequacy of programming and treatment alternatives for residents; the adequacy of current facilities, including space and environmental requirements, staffing patterns and patient-staff ratios; the impact of overcrowding on institution staff; safety of patients and community; community treatment and support services vital to the ongoing care of the mentally ill; the existing availability and scope of these community services; the relationship between the adequacy of these services and the existing conditions at the Augusta Mental Health Institute and the Bangor Mental Health Institute."

The Commission was to submit two reports to the Legislature. This first report, to be presented to the Second Regular Session of the 113th Legislature, details "conditions and practices at the two mental health institutes and make recommendations directed at alleviating these conditions."

The second report is to be submitted prior to September 1, 1988 "detailing results and recommendations of the study of community mental health and support services."

HISTORY

Until the 1960's, to speak of mental health services in Maine was essentially to speak of the two State psychiatric hospitals, with most mental health services provided by or through these facilities. Augusta Mental Health Institute (AMHI) was established in 1840 as the Maine Insane Hospital, Bangor Mental Health Institute (BMHI) some years later in 1901 as the Eastern Maine Insane Hospital. While the philosophies of mental health care varied throughout the years, the purpose of these facilities remained basically protective and custodial.

Few other mental health services existed. The Soldier's Home, now the Veterans Administration Hospital at Togus, was established shortly after the Civil War. Utterback's, a small private hospital, was operated in the Bangor area during the 1950's and 60's. In 1958 the first community clinic was established in the Lewiston-Auburn area. Shortly after, other

clinics began opening throughout the state, including some run by AMHI and BMHI. In addition, in the late 1960's psychiatric in-patient units began opening in a few of the state's general hospitals.

The availability of improved treatment options coupled with criticisms of massive overcrowding at State facilities, of the cost of institutionalization, and of custodialism led to the beginning of a local and national movement to return patients to the community. The development, in the early 1950's, of drugs for the treatment of mental illness provided new hope for the treatment and control of patient symptoms.

With the passage of the federal Community Mental Health Centers Act in 1963, federal funding was assured for the provision of several basic mental health services in the community and lead to the expansion of the existing community services into a statewide network of community mental health centers. Underlying the Community Mental Health Centers Act was the concept that residents within any mental health service area were entitled to quality mental health services as close to home as possible regardless of ability to pay.

However, the patient census at the two State mental health institutes did not clearly reflect these changes. The average daily census at the two hospitals, at it highest in 1955 with a combined total of 3,004 patients, did not substantially change until the early 1970's. Even in 1971, for example, the combined census was 2,460 patients.

The new drug therapies, mental health centers, and a conscious policy decision to move patients from the institutes to the community produced a rapid decrease, beginning in the early 1970's, in the populations at both institutes. By the late 1970's it became evident that a broad range of community support services was needed to help patients adjust and live in the community. At this time, Maine began its development of a comprehensive supportive community-based mental health system for persons with severe and prolonged mental illness with impetus and funding from the major federal Community Support Systems initiative. These efforts have continued despite federal block grant legislation enacted in 1981 which effectively negated the short-lived Mental Health Systems Act, reducing federal support and responsibility for high-risk population groups.

New themes such as least restrictive alternatives, psycho-social rehabilitation, integration, natural support systems, and patient rights have emerged to define the philosophy and place of those services. At present, an adequate number and range of community mental health services have not been developed to meet all the basic income, housing, vocational, supportive, rehabilitation, and treatment needs of mentally ill individuals.

II. DESCRIPTION OF AMHI AND BMHI

The state mental hospital in Augusta was established in 1840 and the hospital in Bangor was established 60 years later in 1901. The two hospitals divide responsibility for the treatment of adult patients in the state. AMHI is responsible for the eleven southern, midcoast, and western counties of Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo and York. BMHI is responsible for the remaining 5 northern and eastern counties of Aroostook, Hancock, Penobscot, Piscataquis, and Washington.[1] In addition to these geographic service areas for adult mental health services, AMHI has a statewide responsibility for adolescent services. Services for preschool and school aged children have been or become the responsibility of the schools, community agencies, or other non-state institutions.

MISSION

The mission of AMHI and BMHI is to provide inpatient and related services to individuals with severe mental illness whose needs cannot be met in less restrictive settings or where services are specialized and not readily available in a community based facility. Services are aimed at those who are most in need. This would include involuntary patients or those who would meet the involuntary criteria, those needing a secure setting, forensic patients, and individuals with specialized needs. The general mission of both facilities is similar, with the exception of adolescent services which, as previously mentioned, are provided only at AMHI.

Both institutes provide inpatient services within the context of the broader mental health system and are seen as a necessary and important part of that system which attempts to provide services in the least restrictive setting. Both facilities attempt to redirect inappropriate admissions to more appropriate community-based services and seek to achieve rapid stabilization and return to the community whenever the patient's condition allows. To bring about this early return to the community both facilities have written agreements and cooperative arrangements with community mental health centers and other providers of mental health and other support services.

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1. In serving its 5 county area, BMHI defines eight distinct regions. Penobscot and Aroostook Counties are both divided in two. The Bangor area presents quite distinct service demands from the outlying rural areas. The central Aroostook County area around Presque Isle, Caribou, and Fort Fairfield are different from the St. John Valley. Finally, while relatively small in numbers, the native American communities have unique governmental and cultural systems which require special consideration.

PATIENT ADMISSION AND CENSUS TRENDS

Examining the average patient census at the two institutes since 1950, the population at AMHI peaked at 1,840 in 1956 and at 1,202 in 1965 at BMHI.[2] In 1963, a major federal initiative in mental health care provided the opportunity for states to establish community-based mental health centers. Maine actively took advantage of this opportunity and established regional community mental health centers which led to the rapid decrease in the population at both mental health institutes starting in the early 1970's. The population at AMHI dropped from 1,553 in 1970 to 427 in 1975. The population at BMHI dropped from 1,058 to 385 during that same five year period. In the remainder of the decade AMHI dropped an additional 128 and BMHI 60.

More recent experience shows a pattern of increased admissions at AMHI. From an average census of 277 in FY 84, the AMHI census climbed to 361 in FY 87. In March of 1987, the census for that month was 382 with a daily peak of slightly over 400.[3] After March the census dropped to the mid-300's with occasional daily peaks into the 370's.

In addition to admission and census statistics, there seems to be increasing pressure on the Intermediate Care Facilities (nursing home sections) at both institutions as indicated by substantial waiting lists. However, these programs do not go over their bed capacities because of the specific regulations governing nursing homes. This artificially holds the census below demand and shifts the problem of caring for these individuals to other areas of the hospital. Because beds must be held for nursing home patients who are temporarily off the unit in the infirmary or at a general hospital, the census at times appears to be under the rated capacity. However, for all practical purposes these units at both facilities are at 100% capacity most of the time, and are thus not able to routinely accept emergency geriatric patients who must either be admitted to another unit or remain in the community.

Both institutes also describe situations where there are periodically more patients assigned to certain services or wards than there are beds. The point was also made that the institutes cannot operate at 100% capacity and retain flexibility to take in emergency cases or take patients returning from a trial visit or convalescent status.

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2. See Table 1 in Appendix A for information on population, census and admissions trends from 1950 to 1987
3. See Table 2 in Appendix A for information on the monthly census at AMHI for 1987.

In analyzing census and admission figures, it is important to keep in mind that they do not reflect the total patient load of the institutes. Patients who are on trial visits or convalescent leave are not counted as part of the daily census. If a patient on convalescent leave returns to an institute, they are counted in the daily census but they are not counted in the admission statistics. Many of these patients who are on leave continue to receive medication and other day or outpatient services from the institutes on a regular basis. Some discharged patients also receive after-care services not reflected in routine hospital statistics.

During the period from 1970 to the present, Maine population increased from slightly under 1 million to nearly 1.2 million. Over the same period the patient populations at both mental institutes decreased dramatically. In recent years, there is some indication that the there is an increase in demand for institutional placements. The precise relationship between recent population changes and pressure on admissions to the institutes requires further study.

DESCRIPTION OF CURRENT PATIENT POPULATION

Admissions by County.[4] About 30% of the 1226 admissions to AMHI in 1987 came from Cumberland County. Another 20% came from the Kennebec County 12 % from Androscoggin County, and 9% from York County. This leaves 20% from the remaining 4 counties in its catchment area and 3% each from other parts of the state, out of state or incomplete data.

Forty-five percent of the 287 admissions to BMHI in 1987 resided in Penobscot County and another 23% from Aroostook

Another 24% are spread over the remaining three counties in BMHI's catchment area and 8% come from outside their catchment area.

Admissions by Age.[5] The bulk of admissions at both institutes is between 20 to 44 years of age. Sixty-one percent of the admissions at AMHI in 1987 (70% of the population 19 years and over) were between 20 and 44 years of age. At BMHI 66% of 379 admissions were between 20 and 44 years of age. Seventeen percent of the admissions at AMHI are under age 20

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4. See Table 3 in Appendix A for admissions by counties. County.
5. See Table 4 in Appendix A for admissions by age. In this table the data from BMHI are based on additions which include new admissions plus 92 who had returned from trial visits in the community. The Figures from AMHI are based on admissions only.

which is expected given their statewide responsibility for the treatment of adolescents. BMHI, with its larger geriatric program, admits more older people than AMHI (17% are age 55 or older at BMHI compared to 11% At AMHI).

Admissions by Sex and Marital Status.[6] The two institutes have a nearly identical division between male and female patients with 55% male and 45% female. Fifty-three percent of the admissions to AMHI were never married, 28% separated or divorced and 12% married. At BMHI 39% were never married, 35% separated or divorced and 16% married. The marital status at BMHI was presented separately for males and females. The major differences between the two groups were that 55% of the males were never married as opposed to 20% of females. Sixteen percent of the females but no males were widowed.

Admissions by Primary Diagnosis.[7] Based on primary diagnosis, the two institutes have the same top two disorders (bipolar and schizophrenia) comprising 46% of 1139 admissions at AMHI and 36% of 379 admissions and returns from trial visits at BMHI. The most frequent diagnosis is bipolar disorder (24% at AMHI and 21% at BMHI). Twenty-two percent of the cases at AMHI were schizophrenic disorders, 17% adjustment disorders and 7% schizoaffective disorders. At BMHI, 16% were schizophrenic disorders, 9% adjustment disorders and 16% schizoaffective disorders. None of the other diagnostic categories accounted for more than 5% of the admissions at either institute with the exception of the broad classification of "other psychotic" at BMHI.

New Admissions Versus Readmissions.[8] Over the past four years the distribution of admissions at AMHI according to whether they were new admissions or readmissions ranged from 30% new admissions and 70% readmission to 40% new admissions and 60% readmissions. At BMHI the variation was from 45% new admissions and 55% readmissions to 57% new admissions and 43% readmissions.

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6. See Table 5 in Appendix A for admissions by sex and marital status.
7. See Table 6 in Appendix A for admissions by primary diagnosis. This categorization under estimates the role of substance abuse and dual diagnoses. In this table the data from BMHI are based on additions which include new admissions plus 92 who had returned from trial visits in the community. The Figures from AMHI are based on admissions only.
8. See Table 7 in Appendix A for admissions by new admission or readmission.

Length of Stay.[9] Based on date of discharge, 24% of 1381 discharges at AMHI had stays of 14 days or less; only 16% had stays of over 90 days. At BMHI, 25% of 209 discharges had stays of 14 days or less and 43% had stays of over 90 days. Date of discharge does not accurately reflect the actual time patients are resident at the institutes since it includes times spent on convalescent and other leaves. As indicated by data from AMHI, when the length of stay is based on the last day a patient is physically present at the institute, 56% stayed 14 days or less and only 5% stayed over 90 days.

IMPACT ON CLIENT LEVEL

The increase in daily census experienced by AMHI in 1987 or the excess of patients to beds experienced periodically on certain units affects the quality of services available to the patients. Space also becomes a problem. More patients are crowded into the same ward area. In addition, when extra beds are placed in existing sleeping areas, ward activity space is taken over to provide for more bed space, or patients are moved to other wards at night wherever there is an empty bed. The physical surroundings and space provided has an impact on the therapeutic program for a patient. Crowding, disruptions, and lack of personal space resulting from a bed assignment on another ward add to the patients' disorientation and hamper the general therapeutic environment.

The particular issue of overcrowding on the nursing home services creates a slightly different problem. Nursing home regulations limit the number of beds that a facility may utilize and prohibits additional placements. This means that there are waiting lists. The alternative placements for those on the waiting list are often less appropriate. The use of the infirmary at AMHI or even less appropriate placements on a general psychiatric unit can cause numerous patient care problems. These problems are particularly serious for the frail elderly.

IMPACT ON THE SERVICE LEVEL

Increases or fluctuations in the daily census in an institute or on one of the wards can dramatically affect its therapeutic capacity. The priority of custodial care and assuring the safety of patients takes away from other therapeutic activities. Space set aside for therapeutic programs is converted to ward and bed space. Staff are reassigned from therapeutic programs to other ward duties.

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9. See Table 8 in Appendix A for data on length of stay of discharged patients.

Staff are assigned to too many patients so that they no longer have the time to talk with individual patients or to seek out quieter or less demanding patients. They are also removed from their regular assignments where they know the patients and the therapeutic program and assigned on a temporary basis to other wards or duties. This creates stress and to some degree danger for the staff because, as one staff person said "if there is any trouble, we may not even know the names of the patients."

Staff to patient ratios give a general idea of the stress placed on them.[10] In examining staff to patient ratios it must be kept in mind that the hospital is staffed 24 hours a day, 365 days a year. Staff work 8-hour days and 40-hour weeks with vacation and holiday leave. The ratio has declined significantly since 1984 at AMHI. Starting with what was a twelve year high of slightly over two staff per patient in 1984, the ratio has fallen to 1.7 per patient in 1987. Coupled with the perception that the severity of the mental disorders of the patients has also increased, the numbers again suggest an increased stress on staff. Staff-patient ratios at BMHI indicated an increase in the ratio over the past six years reaching nearly two staff per patient in 1987.

The high use of overtime at the institutes indicates that sufficient staff are not available to cover expected vacation, holiday, and sick leave. This creates a built-in demand for overtime, double shifts or working on days off. In a stressful job, sufficient time off between shifts, avoidance of fatigue from long shifts, and recuperative value of holidays and vacation days is important. Some overtime is desired by some staff to increase earnings even if it is stressful. However, the occasional requirement that they work a double or extra partial shift without prior notice creates serious dissatisfaction. The resulting fatigue and dissatisfaction further impinge on the quality of the therapeutic program.

IMPACT AT THE SYSTEM LEVEL

The high census at the two institutes is an indication of general demand for services on the total mental health system. If community-based services are inadequate to handle the demand for outpatient treatment and support, then the institutes come into play in instances where community placement would have been more appropriate.

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10. See Table 9 in Appendix A for staff patient ratios.

The general consensus of the Commission is that the goal should be to increase the availability and scope of community services. They felt that more of the demand for service could be handled outside the two institutes. The institutes' role should center on cases where there is a need for a more restrictive or specialized environment for treatment than is available in the community.

The de-institutionalization movement was successful in redirecting the focus of treatment of mentally ill individuals from central institutions to the community. However, as the the Chair of the Plan Development Committee of the Governor's Mental Health Advisory Council, Thomas Kane, told the Commission, the initial redirection of services toward the community level "failed to recognize that these patients being de-institutionalized needed more than the clinical services - day treatment, outreach and medication programs - which the CMHC's provided. They also needed housing, transportation, social-recreational activities, support groups, health care, vocational and pre-vocational training, etc." These needs exist even though the community mental health system has grown in the past few years.

The total revenues of the seven community mental health centers increased from $12.2 million in FY 84 to $15.1 million in FY 87, an increase of 23.8% over those four years. During this same period, the budgets of the two State mental health institutes rose from $26.1 million to $33.0 million (26.4%). The primary components of the increase in community services were Medicaid, which increased from $1.0 million to $3.0 million, and insurance reimbursement, which increased from $760,000 to $985,000. Town and county funding remained static during this period at about $370,000 each year and revenues from state and federal funds administered by the Department of Mental Health and Mental Retardation rose from $7.1 to $7.9 million (9.9%).

The Department provides funding to other agencies in addition to the community mental health centers. As the Bureau of Mental Health has sought providers of the non-clinical services listed above, the number of such agencies has grown. In FY81, the Bureau of Mental Health funded eleven agencies, while it currently funds forty-one agencies. Last year (FY87), these other (non-CMHC) agencies provided $6.3 million in services to mental health clients, of which $2.3 million was provided by the Department.

Comparing the budgets for the two institutes with the money available for community services, the institutes receive a major portion of the resources. If the supports and supervision available in the institutes are to be provided in the community, the budget for community services will probably have to be increased. The final allocation of resources must be related to an assessment of the appropriateness of institutional versus community treatment on a person by person basis.

PHYSICAL STRUCTURE

The commission visited both institutes and had discussions with staff and patients. During the 1970's the patient populations at both institutes declined dramatically. The institutes have consolidated their services and the buildings they no longer use have been converted to office space for other governmental agencies. In response to a question whether this office space could be reconverted to ward or program areas to deal with the overcrowding, the superintendents opposed considering reconversions. They felt that the architectural style of the buildings was more easily adapted to office space than it was to the therapeutic program needs of a residential institute.

In touring the buildings, many of the Commission members felt that the atmosphere created by the physical structure of the buildings that are used for patient wards and activities did not support the therapeutic goals of the institutes. The fact that many of the wards had not been remodeled for many years did not help. The nursing home and elderly programs at the two institutes had waivers in order to meet medicaid eligibility requirements. However, without the waivers, the physical space used by these programs would not have met medicaid standards.

The overall goal should still be to improve the availability and scope of community services in order to alleviate the need for as many admissions to the institutes as possible. However, in implementing services for the population that does need an institutional setting, attention must be given to the physical setting of facilities used so that they support the therapeutic goals of the programs and allow for an efficient use of staff.

III. SUBCOMMITTEE ON STAFFING AT AMHI AND BMHI

In both the Commission's visits to AMHI and BMHI, staff express similar concerns regarding the staffing situation at the institutes. First, understaffing appears to be a general concern at the two institutes. Staff and administration agree that while present staffing patterns allow them to carry out the custodial and protective functions of the institutes, they are not able to carry out fully desired therapeutic goals. This pressure on staff is exacerbated by what is generally felt as the increased severity of the mental disorders among the patients remaining in the institution.

Second, the staffs and administrations at both institutes recognize the negative effect that a rising census can have on the quality of services provided by the institutes and the stress placed on staff.

Third, there is a built-in understaffing of both institutes. The general minimum ratio for adequate coverage

presented to the subcommittee was that for direct care staff excluding physicians, there needed to be about 1.65 employees for every full-time position at the institutes. The additional staff support is needed to cover vacation days, paid holidays, sick days, days lost due to workers compensation-covered injuries, and training or continuing education days. At both institutes the present number of staff is not sufficient to adequately cover all needed positions without using overtime.

Finally, there is a periodic demand for additional staff created by the need for one-to-one coverage of a patient or the need to have a staff member act as an observer for patients who need to be placed in isolation rooms. These duties are in addition to the regular ward duties of staff.

The first two concerns are general problems which are not the focus of this subcommittee. The first requires a policy commitment to maintain a higher staff to patient ratio either by increasing staff or reducing patient census. The second is of a periodic nature, unless it becomes a chronic understaffing problem.

The third and fourth concerns are of a slightly different nature in that they are continuing chronic problems where the position need is recognized but the staff is not available. Generally one of three solutions is used to solve the immediate shortage:

1. Existing staff on the ward reassign priorities to cope with the additional duties with no increase in help,
2. Staff are pulled from one ward to another according to priority needs, or
3. Staff are asked to work overtime.

Each of these solutions places additional stress on staff.

The complaints from staff heard by the committee seemed to highlight their dissatisfaction with being pulled from their regular ward assignment to cover another ward or to be required to work an overtime shift on short notice. The staff do not like to be taken away from their present assignment as it may disrupt a therapeutic relationship or activity they have set up with patients on their own ward. They also feel that their effectiveness on the new ward is reduced because they are not familiar with the patients and the therapeutic program. They also do not appreciate having their personal lives disrupted by being mandated to work overtime on short notice. Complaints were not directed as much at voluntary overtime though some questions were raised about staff effectiveness at the end of a 16-hour day or during the next regular shift when the staff person had had only 8 hours off.

The coverage of a ward with reduced staff or the temporary reassignment of staff to another ward are management techniques to meet the minimum goals of providing custodial and protective services to patients. A certain amount of overtime is often

desired by staff to increase yearly earnings. It is only perceived as excessively burdensome if it occurs too often or is mandated and interferes with other personal or family obligations.

A possible partial solution to the problem is to develop a pool of additional "intermittent" workers who would be willing to come in to work an uncovered shift, during vacation periods, or on a special duty coverage. At both institutes the amounts for overtime have increased over recent years. The amount at AMHI, excluding fringe benefits, increased from $192,849 in 1979 to $639,699 in 1987. The amount for overtime was a little over 4% of their regular budget for salaries. At BMHI they reported a similar increase and overtime costs of $666,760 in 1987.

Data from AMHI on the number of overtime hours for nurses and mental health workers over the last 5 months indicate an average of 2380 hours per month. This represents an equivalent of 20 full-time equivalent employees if vacation and other time is included. Of these nearly 12,000 hours over the last 5 months only 27 were actually mandated. BMHI reported an average of 3411 overtime hours over a three month period, July 1 through September 30, representing an equivalent of 30 full-time positions. On a monthly average, 173 hours were mandated overtime or about 5% of the total overtime hours.

Both institutes have lists, by reverse seniority and ward assignment, of individuals who will be called if mandated overtime is necessary. Individuals can be moved to the bottom of the list if they volunteer before their turn to be mandated comes up. This is an effective administrative method of limiting the need to mandate that staff stay.

To get a more accurate picture of the need for overtime and the possibility of using the present overtime expenditures to develop a float, and/or intermittent staff, pool, additional information needs to be collected from both institutes.

General increases in the staff-patient ratio could also be accomplished by a reduction in the patient census. The most appropriate method of reducing the patient census is through the development of additional community resources. The general consensus of the Commission was for the allocation of any additional resources toward community services. A major need in most areas of the state is for the creation of a system of appropriately staffed, therapeutic boarding homes.

IV DESCRIPTION OF COMMUNITY SYSTEMS[11]

As part of its initial overview of the service system for mentally ill individuals in the state, the Commission heard

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11. See Appendix B for a list of individuals who presented testimony to the Commission.

from advocates and community providers from four areas of the state. In the continuation of the Commission's investigation, they will explore these programs in more depth as well as programs available in other parts of the state. This initial review focused on what kinds of services are possible to deliver in the community and the range of services needed. It did not include an assessment of the scope of services required to meet demand. The general tenor of the presentations was optimistic about the possibility of developing effective community-based services. As a cautionary word, however, Dr. Meredith reminded the Commission that the quality of life of a patient may not be better in a boarding home if the only activities are "a TV set and a coke machine." The goal is to make available to patients in the community the same range of support and supervision services available in the institutions.

V. CONCLUSIONS

In the Commission's review of the overcrowding at AMHI and BMHI, the Commission members agreed that one of the major causes of overcrowding or increased demand for placements at the two institutes was the lack of community facilities and services. If additional resources are to be allocated, consideration should be given to the expansion of community services as a way of alleviating overcrowding at the institutes and providing treatment, support, and rehabilitative services and also supervision for mentally ill individuals in the least restrictive environment.

As part of developing a complete system of services, it must be recognized that certain mentally disabled persons require the protections and close supervision afforded by the two institutes. These patients deserve the opportunity to receive adequate treatment programs within the institutes. In order for these programs to be as effective as possible, the architectural design of the facilities should be considered as part of the therapeutic environment.

In supporting the development of community options, the Commission cautions that the mistakes of previous efforts to develop community placements during the de-institutionalization period of the 1970's not be repeated. Community placement should be predicated on the availability of adequate and appropriate services, supervision, and case management to address both the mentally disabled person's needs and the concerns of other individuals in the community.

APPENDIX A

Table 1:

Annual Admission and Average Daily Census
by Fiscal Year

YEAR	State Population	AMHI Admissions	AMHI Census	BMHI Admissions	BMHI Census
1950	914,950	373	1,646	330	1,153
1951		421	1,694	333	1,119.1
1952		425	1,729	338	1,106.5
1953		416	1,767	358	1,118.1
1954		451	1,800	362	1,142.7
1955		405	1,830	395	1,152.7
1956		481	1,840	427	1,164
1957		423	1,795	410	1,157.5
1958		483	1,797	490	1,168.2
1959		562	1,786	475	1,166.2
1960	970,689	551	1,749	513	1,160.8
1961		592	1,747	612	1,161.3
1962		853	1,758	675	1,161
1963		899	1,711	728	1,181.6
1964		989	1,652	747	1,198.8
1965		1,069	1,620	757	1,202.4
1966		1,038	1,558	806	1,174.2
1967		1,177	1,580	792	1,159.9
1968		1,145	1,608	837	1,154.1
1969		1,177	1,615	849	1,168.4
1970	993,722	1,207	1,553	903	1,058.4
1971	1,012,292	1,315	1,529	983	931
1972	1,025,846	1,186	1,273	828	712.9
1973	1,038,399	1,101	743	865	536.5
1974	1,050,326	807	520	907	461.2
1975	1,062,822	806	427	853	384.9
1976	1,074,872	878	371	667	309.8
1977	1,087,906	992	338	593	306.9
1978	1,101,479	1,093	315	684	314.2
1979	1,115,374	1,057	299	693	333.6
1980	1,125,027	996	295	723	324.8
1981	1,132,849	933	302	618	318.9
1982	1,136,199	1,115	299	435	301.8
1983	1,145,730	1,242	286	403	303.3
1984	1,156,485	1,405	277	288	290.3
1985	1,163,849	1,347	308	299	281.2
1986	1,173,731	1,129	332	301	280.1
1987		1,203	361	287	277.6

Table 2:

Monthly Admission and Average Daily Census
for FY 1986-87 for

Augusta Mental Health Institute

MONTH	CENSUS	ADM
J86	331	105
A86	345	97
S86	354	96
O86	352	79
N86	358	88
D86	355	89
J87	364	114
F87	366	114
M87	382	122
A87	361	110
M87	359	114
J87	351	110
J87	347	113
A87	350	104

Table 3:

Average Daily Census for FY 1986-87 and Population by County

Augusta Mental Health Institute

County of Admission	Population	Number of Inpatient Admissions
Cumberland	230,800	355
Kennebec	113,400	247
Androscoggin	101,150	151
York	157,500	113
Somerset	47,750	56
Franklin	29,350	26
knox	35,600	42
Lincoln	29,200	26
Oxford	50,600	47
Sagadahoc	30,550	29
Somerset	47,750	56
Waldo	30,000	19
Out of Catchment Area	----	40
Out of State	----	42
Insufficient Data	----	33
Total	903650	1226

Bangor Mental Health Institute

County of Admission	Popluation	Number of Inpatient Admissions
Penobscot	138,600	130
Washington	34,350	27
Piscataquis	18,200	14
Hancock	45,100	28
Aroostook	87,300	65
Out of Catchment	----	23
Total	323,550	287

Table 4:

Annual Admission for FY 1986-87 by Age

Augusta Mental Health Institute

Age	Number	Percent
5-9	1	0.08%
10-14	61	4.98%
15-17	98	7.99%
18-19	48	3.92%
20-24	174	14.19%
25-34	342	27.90%
35-44	235	19.17%
45-54	131	10.69%
55-64	77	6.28%
65-74	40	3.26%
75+	19	1.55%
Total	1226	100.00%

Bangor Mental Health Institute

Age	Number*	Percent
5-9	0	0%
10-14	0	0%
15-17	2	.5%
18-19	10	2.6%
20-24	46	12.1%
25-34	133	35.1%
35-44	72	19.0%
45-54	51	13.5%
55-64	40	10.6%
65-74	15	4.0%
75+	10	2.6%
Total	379	100.00%

* Figures include new admissions and those returning from trial visits.

Table 5:

Annual Admission for FY 1986-87 by
Sex and Marital Status

Augusta Mental Health Institute

Sex	Number	Percent
Male	669	54.57%
Female	557	45.43%
Total	1226	100.00%

Marital Status	Number	Percent
Never Married	660	53.83%
Married	149	12.15%
Separated	44	3.59%
Divorced	302	24.63%
Widowed	37	3.02%
Unknown	34	2.77%
Total	1226	100.00%

Bangor Mental Health Institute

Sex	Number	Percent
Male	162	56.45%
Female	125	43.55%
Total	287	100.00%

Marital Status	Number	Percent
Never Married	113	39.37%
Married	47	16.38%
Separated	22	7.67%
Annulled	1	.35%
Divorced	78	27.18%
Widowed	20	6.97%
Remarried	2	.70%
Unknown	4	1.39%
Total	287	100%

Table 6:

Annual Admission for FY 1986-87 by
Diagnostic Category

Augusta Mental Health Institute

Diagnosis	Number	Percent
Bipolar	278	24.41%
Schizophrenic	245	21.51%
Adjustment Disorders	191	16.77%
Schizoaffective	74	6.50%
Major Depressive	56	4.92%
Drug	53	4.65%
Conduct Disorders	43	3.78%
Other Psychotic	35	3.07%
Alcohol	26	2.28%
Mental Retardation	22	1.93%
Dysthmia	19	1.67%
Prim Degen Dementia	15	1.32%
Personality Disorders	15	1.32%
Schizophreniform	13	1.14%
Other Organic disorders	12	1.05%
Paranoid	11	0.97%
Alch Related Organic	8	0.70%
Other Childhood Disord	5	0.44%
Anxiety	4	0.35%
No Mental disorder	4	0.35%
Diagnosis Deferred	3	0.26%
Eating, Movmnt O Phys	2	0.18%
Somataform	2	0.18%
Attention Deficit	1	0.09%
Anxiety-Child	1	0.09%
Mult Infact Dementia	1	0.09%
Total	1139	100.00%

Table 6: (con't)

Annual Admission for FY 1986-87 by
Diagnostic Category

Bangor Mental Health Institute

Diagnosis	Number*	Percent
Bipolar	78	20.58
Schizoaffective	61	16.09%
Schizophrenia	59	15.57%
Other Psychotic	35	9.23%
Adjustment	34	8.97%
Alcohol Abuse	17	4.49%
Other Organic	15	3.96%
Major Depressive	14	3.69%
Alcohol Related Org. Ment.	9	2.37%
Primary Degen. Dememtia	9	2.37%
Dysthmia	8	2.11%
Schizophreniform	8	2.11%
Diagnosis Deferred	7	1.85%
Substance (drug) relat	5	1.32%
Paranoid	5	1.32%
Personality & Other Impulse	4	1.06%
No Mental Disorder	3	.79%
Anxiety	3	.79%
Mental Retardation	2	.53%
Autism & Pervasive Dev.	1	.26%
Multi-Infarct Dementia	1	.26%
Dissociative	1	.26%
Total	379	101%

*Figures include new admissions and those returning from trial visits.

Table 7:

Annual Admission for FY's 1983-84 to 1986-87 by New Admissions versus Readmissions

Augusta Mental Health Institute

FY	New Admission Number	New Admission Percent	Readmission Number	Readmission Percent	Total
FY84	534	38.01%	871.0	61.99%	1405
FY85	478	35.49%	869	64.51%	1347
FY86	344	30.47%	785	69.53%	1129
FY87	488	39.80%	738	60.20%	1226

Bangor Mental Health Institute

FY	New Admission Number	New Admission Percent	Readmission Number	Readmission Percent	Total
FY84	131	46%	157	55%	288
FY85	157	53%	142	48%	299
FY86	173	58%	128	43%	301
FY87	160	56%	127	44%	287

Table 8:

Annual Discharges for FY 1986-87 by Length of Stay

Augusta Mental Health Institute

Length of stay	Number*	Percent
03 days or less	165	11.94
04 to 07 days	410	29.67
08 to 10 days	129	9.33
10 to 14 days	69	4.99
15 to 30 days	200	14.47
31 to 90 days	267	19.32
91 to 180 days	82	5.93
6 mos to 1 year	46	3.33
1 year to 1.5 years	12	.87
1.6 years to 2 years	2	.14
Total	1382	100.00%

* Figures are based on last day physically present not date of discharge.

Length of stay	Number**	Percent
03 days or less	97	7.02
04 to 07 days	145	10.50
08 to 10 days	51	3.69
10 to 14 days	40	2.90
15 to 30 days	395	28.60
31 to 90 days	278	20.13
91 to 180 days	149	10.79
6 mos to 1 year	108	7.82
1 year to 1.5 years	92	6.66
1.6 years to 2 years	26	1.88
Total	1381	100.00%

** Figures are based on date of discharge not last day in hospital.

Table 8: (con't)

Annual Discharges for FY 1986-87 by
Length of Stay

Bangor Mental Health Institute

Length of stay	Number*	Percent
3 & Under days	25	12.0%
4-7 days	14	6.7%
8-14 days	12	5.7%
15-30 days	15	7.2%
31-90 days	53	25.4%
91-180 days	42	20.1%
181-365 days	31	14.8%
1-1.5 years	1	.5%
1.5-2 years	2	1.0%
Over 2 years	14	6.7%
Total	209	100%

* Length of stay refers to days from date of admission to date of discharge, including days patient was out of the hospital on leave, trial visit, etc.

Table 9:

Staff-Patient Ratios for FY 1986-87

Augusta Mental Health Institute

FY	Staff	Staff/Patient
FY80	597.0	2.02
FY81	567.0	1.88
FY82	565.0	1.89
FY83	561.5	1.96
FY84	561.5	2.03
FY85	561.5	1.82
FY86	611.5	1.84
FY87	611.5	1.69

Bangor Mental Health Institute

FY	Staff*	Staff/Patient
FY82	533.5	1.66
FY83	533.5	1.62
FY84	552.5	1.81
FY85	552.5	1.88
FY86	558.5	1.90
FY87	556.5	1.93

* "Staff" is defined as legislatively allocated F.T.E. positions, including vacant positions. During this period, vacancies have ranged from 19 to 32.5 as of the end of each fiscal year, with an average of 25.

APPENDIX B

LIST OF PRESENTORS

September 15, 1987

William Daumueller - Superintendent AMHI
Charles Meredith - Superintendent BMHI
Susan Parker - Commissioner DMH&MR
Frank Schiller - Executive Director, Maine Council of Community Mental Health Services
Martin Gouzie, Project Director, BMH Crisis Stabilization Program

October 27, 1987

Richard Estabrook, Office of Advocate, DMH&MR
Tom Ward, Patient Advocate, AMHI
Richard Roelofs, Patient Advocate, BMHI
Susan Wygal, Director, Office of Community Support Systems, DMH&MR
Joan Smyrski, Mental Health Program Coordinator, Mental Health Services Area III, DMH&MR
Bob Weingarten, Executive Director, Motivational Services, Inc., Augusta
Robert Small, Crisis Intervention Manager, Tri-County Mental Health Services

November 10, 1987

Thomas Kane, DSW, Chairman, Plan Development Committee, Mental Health Advisory Council
Robert Vickers, Director, Aroostook Mental Health Center
Ron Thurston, Maine Health Care Association
James Castle, President, Maine Hospital Association
Michael J. DeSisto, Ph.D, Director, Maine-Vermont Research Project
Susan Parker, Commissioner, DMH&MR

November 24, 1987

Jo Dolley-Hoguet, Director of Admissions, BMHI
Marjorie Hill, Mental Health Program Coordinator, Mental Health Service Area II, DMH&MR
Robert Croce, Community Support Director, Community Health and Counselling Services, Bangor
Roger Griffith, Director, Together Place, Bangor
Dennis King, Administrator, Jackson Brook Institute, Portland

2730*