REPORT TO THE COURT

Bates et al. v. Glover et al.

Kennebec County Superior Court, Docket No. CV-89-88

To Justice Bruce W. Chandler

From Gerald Rodman, Master

May 31, 1991

TABLE OF CONTENTS

I. Introduction & Summary

My experiences during my first half year as Master have confirmed the wisdom and vision of the requirements of the Consent Decree. I have held public forums across the state, listened to the concerns of consumers of mental health services, their family members, providers of mental health services and others. I have also visited many sites where services are currently being provided that offer a glimpse of the future.

There are some people today who are well served by the mental health system. They are living in places they can call "home", receiving support when needed. Some have jobs or are working with a little support, enabling them to be productive. It has been a source of great joy to meet people who are living in their own communities with a sense of dignity and self-worth.

Unfortunately, while some people with mental illness receive needed support in the community, many do not. There is a severe lack of community-based services and a parallel lack of capacity to coordinate the delivery of such services. In planning to meet the needs of people with mental illness, the Defendants have correctly identified several critical services which are greatly needed. Among others, these include: housing, crisis intervention and resolution services, vocational training and opportunities, and respite services for care-givers. Comments at Public Forums confirmed the critical need for all of these services. These necessary services, and the capacity to coordinate their delivery, however, will not be developed overnight.

This is the first of semi-annual reports, under paragraph 299 of the Settlement Agreement, regarding the Defendants' compliance with the Consent Decree. Areas of compliance and non-compliance are discussed in Section II. Section II reviews the Defendants' progress towards creating a revised Implementation Plan that reflects the concerns of the Plaintiffs as well as extensive comments submitted at the Public Forums. Section II also reviews compliance problems, most significantly, the Defendants' failure to retain a panel of professionals to complete assessments of the needs of individual class members. A second serious problem has been the Department of Mental Health & Mental Retardation's failure to produce required analysis, reports and documentation in a timely manner. I conclude that understaffing at the administrative level has contributed significantly to this problem. I also discuss the Department of Mental Health & Mental Retardation's failure to communicate its activities to the Master. I note that the Department has pledged its cooperation with respect to this problem.

I also review, in Section II, specfic proposals submitted by the Defendants to close portions of the Augusta Mental Health Institute. I note that I approved those portions of the proposals for which alternative, community-based services were developed and disapproved those for which adequate alternatives had not been developed.

Section III reviews areas of agreement and significant issues discussed during the first six months of the process. This section reveals that the parties have been able to work cooperatively in processing and resolving a wide variety of issues.

In Section IV, I discuss Consent Decree-related funding requests by the Department of Mental Health & Mental Retardation and the Department of Human Services for fiscal years 1992 and 1993. The consent Decree requires substantial compliance with its terms by August 1, 1995. It is not expected, therefore, that requested funds for fiscal years 1992 and 1993 will constitute all funds necessary to comply with the Consent Decree. Even when viewed as

funding to begin the implementation of the Decree, however, the budget requests are extremely modest, especially in the areas of housing and residential support, crisis intervention and resolution services for adults, and community support worker services for adults. In some of these significant areas requested funds are one-half, or less, of the funds originally proposed in January, 1991 by the Defendants.

In Section IV, I also review proposed reductions in AMHI staffing. I note the Defendants have not demonstrated that the development of community-based services will compensate for the loss of services resulting from the proposed elimination of 131.5 positions at AMHI on July 1, 1991.

In Section V, I review two major initiatives at AMHI to control its census and to coordinate its services with those of community providers--the admissions protocol and the diversion policy. I note that the diversion policy is a valuable tool for improving communications and coordination with community providers. I also observe, however, that this program is not a substitute for the need to develop additional, community-based services; rather, its long-term success depends upon the development of such services. In this section I also discuss AMHI's admission policy, highlighting its value in assisting AMHI in providing quality care. I also warn that community-based providers will not be able to tolerate persistently escalating pressure to care for persons who historically have been cared for at AMHI, without the development of additional community-based services.

In Section VI, I briefly review past efforts to downsize the Augusta Mental Health Institute and to develop community-based services. Historically, deinstitutionalization efforts in Maine have been unsuccessful for a number of reasons, including the failure to articulate a clear vision of the system and the failure to link the development of services with the needs of individuals.

Also in Section VI, I conclude that the Consent Decree will address many previous mistakes. For this and other reasons, the State has an unprecedented opportunity to create a comprehensive mental health system that will meet the needs of individuals in their communities and prevent unnecessary institutionalization. I note, however, that the efforts to create such a system could be undermined if premature downsizing of the Augusta Mental Health Institute is allowed to destabilize the system during the transition to a more community-based system.

To move forward to implementing the Consent Decree, two components are critical. First, the development of community-based services must proceed vigorously and without delay. Second, downsizing of the Augusta Mental Health Institute must be carefully linked to the development of a comprehensive mental health system that meets the individual needs of people with mental illnesses.

II. MONITORING CONSENT DECREE COMPLIANCE

The Defendants are currently working on developing an approvable Implementation Plan. The approved Implementation Plan will be a "blue-print" for the development of a comprehensive mental health system and once developed and approved, will be a statement of tasks and outcomes against which compliance will be judged. The development of the Implementation Plan and its associated Planning Proposals are discussed below in section A.

General observations about the Defendants' compliance with the Consent Decree to date appear in section B. This section also references the Quarterly Reports submitted by the Defendants. Ultimately these Reports will be a major compliance-monitoring tool, outlining the Defendants' progress in implementing the Implementation Plan.

A. Implementation Plan and Planning Proposals

A key document defining the Defendants obligations under the Consent Decree is the "Implementation Plan" (referred to as "general plan" in the Settlement Agreement). The Implementation Plan now being revised by the Defendants will detail the efforts that they will undertake to meet all their obligations under the agreement. Pursuant to paragraph 35 of the Settlement Agreement, the Implementation Plan shall include descriptions of efforts in developing, funding, maintaining, monitoring and evaluating a comprehensive mental health system which meets the terms of the Settlement Agreement. The initial Implementation Plan was filed, as required, with the Court on January 1, 1991. In order to maximize public input with regard to the Implementation Plan and to give the Defendants an opportunity to draft a superior plan, a process was established for the development and review of the Implementation Plan.

The Defendants' initial January 1, 1991 Implementation Plan was the focal point of ten Public Forums held around the state in February and March 1991. Representatives of the Defendants formed a panel to listen to and respond to comments made by the public. The Department of Mental Health & Mental Retardation had multiple representatives at each forum representing a variety of speciality areas. Public comments were recorded and an inventory of several hundred public comments was made by the Department of Mental Health & Mental Retardation at the conclusion of the forums.

The Defendants are currently revising the Implementation Plan based, in part, upon comments made at the public forums. These revisions are being reviewed by the Plaintiffs as they are made. June 1, 1991 is the due date for the submission of a revised Implementation Plan. Upon submission of the revised Implementation Plan, the Plan will be subject to my review for approval in accordance with the procedures set out in the Settlement Agreement.

In the absence of an improved Implementation Plan it was necessary to devise a process to review specific proposals of the Defendants concerning "downsizing" of AMHI. To this end, the parties and the Master agreed that the Defendants would submit "Planning Proposals" which would describe any proposed downsizing initiatives. To date, two Planning Proposals have been submitted. One Planning Proposal sought to close the Adolescent Unit effective June 15, 1991. Another Planning Proposal sought to eliminate a 35 bed ward in the Greenlaw Nursing Facility.

On April 5, 1991, I disapproved the Planning Proposal for the Adolescent Unit finding, among other things, that the proposed closing date preceded the proposed development of alternative services. Presently, I am working with the parties to ensure that the Defendants continue to provide appropriate services to adolescents as community-based alternatives are developed for adolescent class members. On May 8, 1991, I approved the Planning Proposal for the Greenlaw Nursing Facility regarding the transfer of 17 of the 35 licensed beds on the ward to a nursing home in Gorham Maine, based, in significant part, on showing that alternative, community-based services had been developed for 17 individuals. I disapproved that portion of the proposal which sought to eliminate the other 18 beds on the ward, finding that alternative services had not been developed to replace these 18 beds.

B. Compliance Issues, Quarterly Reports

Some progress has been made in the early phases of implementation. The most significant activity undertaken by the Defendants to date has been the on-going development of the Implementation Plan. The Defendants have also met some of the earlier compliance dates established under the Settlement Agreement.

The Defendants have struggled, however, to meet their obligations in certain areas. Because the majority of responsibilities have fallen upon the Department of Mental Health & Mental Retardation, this has been most evident with respect to this department. The Defendants have had difficulty in meeting deadlines and in producing fully developed materials. Examples of items that were late and/or deficient include the following: 1) The original Implementation Plan filed on January 1, 1991, as required by the Settlement

Agreement, did not include required cost data. (A supplemental document was submitted on January 24, 1991 containing the required information, see Fiscal Supplement to Implementation Plan); 2) The Department of Mental Health & Mental Retardation's Quarterly Report on progress in complying with the Settlement Agreement was filed late and deemed "unacceptable", as is more fully discussed below; 3) A staffing proposal outlining potential reductions in the work force at AMHI scheduled to be submitted by the Department of Mental Health & Mental Retardation by May 14, 1991, was not submitted on time; 4) A standing request of January 27, 1991, seeking the continuous provision of budget related materials was not complied with; the materials were collectively submitted in May 1991; and 5) The review panel to be convened under paragraph #45 of the Settlement Agreement by October 1, 1990 to assess individuals hospitalized at AMHI has not yet been made operational.

The single most significant problem in the production of adequate and timely materials is the lack of staff at the administrative levels of the departments involved. This has been most evident with respect to the Department of Mental Health & Mental Retardation, where a small number of individuals are continually called upon to produce a significant amount of work.

Certain past problems in compliance have reflected a lack of full adjustment by the Department to the role of the Master with respect to the implementation of the Consent Decree. The most significant of these problems has been the Department of Mental Health & Mental Retardation's failure to communicate fully its activities regarding its Planning Proposals. With

respect to the Planning Proposal to close a ward at the Greenlaw facility, the full scope of the proposal was not fully described and, later in the process, activities were commenced to implement the proposal prior to its approval. With respect to the Planning Proposal to close the Adolescent Unit, the proposal was not filed until after a determination had been made to close the unit. The Department of Mental Health & Mental Retardation has now pledged to proceed cooperatively and to be more thorough in its communications, and has acknowledged that, unless approval is granted as part of an approved Implementation Plan, Planning Proposals must be approved prior to their implementation.

The single most significant area of non-compliance concerns individual patient assessments. Paragraph 45 of the Settlement Agreement requires the Defendants to retain a panel of professionals by October 1, 1990 to assist the Defendants in developing their plan for reduction of AMHI's census, and to assist the hospital in developing clients' specific plans. Pursuant to paragraph 46 of the Settlement Agreement, the panel was to have prepared its initial recommendations by March 1, 1991. To date, the Defendants have not secured the commitment of all necessary professionals to serve on the panel and have not succeeded in obtaining agreement among potential panel members as to what protocol shall be used for the patient assessments. Resolution of these problems is expected to occur in the near future. The absence of these patient assessments constitutes a serious impediment to the Defendants' planning requirements under the Settlement Agreement.

Quarterly Reports filed by the Defendants are key to monitoring compliance. Paragraph 280 of the Settlement Agreement requires the Defendants to file Quarterly Reports describing instances of compliance with the Settlement Agreement, to enumerate areas of non-compliance, and to provide explanations for non-compliance and a description of efforts to be undertaken to come into compliance. These reports are subject to the Master's approval.

The first Quarterly Reports filed by the Department of Mental Health & Mental Retardation and the Department of Human Services are attached. The Department of Mental Health & Mental Retardation's Quarterly Report was filed by agreement of the parties and the Master as "unapproved", pending submission of the next regularly filed Quarterly Report. Among the problems noted with the Quarterly Report was that it did not discuss progress being made with respect to all identified goals and did not include any documentation which would demonstrate compliance with certain of the requirements of the Settlement Agreement.

III. PROCESSING AND RESOLUTION OF SPECIFIC ISSUES

A. Review By Subject Area

The section of the Settlement Agreement pursuant to which this Report is filed requires a listing of disputes and interpretive questions resolved. These, and related matters, are briefly summarized below by category; references are to the date of the relevant lawyers' meetings with relevant paragraphs cited from the notes of those meetings. Any additional references are independently noted.

Implementation Plan

The development of the Implementation Plan was the subject of several agreements relating to: the necessity of including cost data in the Implementation Plan; the participation of the Defendants at Public Forums held to provide for public review of the Implementation Plan; and the review by Defendants of comments made by the public. Further processes were established to integrate the Plaintiffs into the review process so that they could work with the Defendants as individual portions of the Plan were being revised. It was agreed that the revised Implementation Plan would be submitted for approval by June 1, 1991. (11/29/90, #2; 12/13/90, #4; 1/10/91, #1,2; 1/24/91, #2; 2/21/91, #4; 3/7/91, #4; 3/21/91, #7,8; 4/4/91, #3; 4/18/91, #14).

Training Plans

The Implementation Plan, as filed, did not have a separate section dealing with training. Because training is important to so many components of the Consent Decree, it was agreed that the Defendants would submit independent training work plans. In addition, the Department of Human Services was granted an extention of time in which to complete its training program so that the training program would be in concert with other requirements of the Settlement Agreement. (2/7/91, #8; 3/7/91, #5; 3/21/91, #1; 4/18/91, #10; 5/2/91, #1d).

Defendants' Quarterly Progress Reports

It was agreed to file as "unapproved" the Department of Mental Health & Mental Retardations' first Quarterly Progress Report. It was noted that the next Quarterly Report would be filed at a time when a revised and improved Implementation Plan would allow for a more meaningful reports. This also provides the Department with an opportunity to remedy cited deficiencies in the report. Other agreements were reached with respect to further processing of the Department of Human Services' Quarterly Report. (4/18/91, #9).

Communications

A variety of agreements were reached relating to communications among the parties and master. Lead counsel were designated to ensure smooth communications, routine meetings were established with lawyers to conduct business, representatives of the Department of Mental Health & Mental Retardation and the Department of Human Services were invited to attend these meetings to facilitate better communications. (11/9/90, #9,11; 11/29/90, #1; 12/13/90, #2; 12/27/90, #3; 2/14/91, #5; 11/29/90, #8; 2/14/91, #3).

Proposals To Downsize AMHI

It was agreed that initial proposals to downsize the Institute will first be presented as a "Concept Paper". This paper is to be presented to the Plaintiffs and the Master when a proposal is best described as "at the idea stage." At such time as the concept becomes further developed the proposal is more formally presented as a "Planning Proposal" (11/29/90, #9; 2/21/91, #7). (Planning Proposals are considered to be subsets of the Implementation Plan and as such are subject to the Master's approval).

Specific Planning Proposals

The proposal to close the Adolescent Unit was the subject of extensive discussion at meetings (2/21/91, #6 and 3/7/91, #16), as was the Planning Proposal to downsize the Greenlaw nursing facility (12/13/91, #7, 8; 2/27/91, #2; 11/11/90, #4; 1/24/91, #1; 3/7/91, #5; 5/2/91, #5). These proposals are discussed in more detail in this Report at Section II.

Alternative Living Program

The Defendants filed a concept paper regarding the alternative living program. This paper has been the subject of subsequent meetings, but no Planning Proposal has been filed to date. (3/7/91, #15).

Department of Human Services Quarterly Patients' Reports

Pursuant to agreement, the Plaintiffs worked with the Defendants to draft a format for the Quarterly Reports required to be filed by the Department of Human Services for its wards who are class members. An extension of time was agreed upon allowing the reports to be filed in three increments during the month of April as opposed to requiring that all be filed April 1, 1991. (2/7/91, #7; 3/21/91, #2; 4/18/91, #4).

Adolescent Reports

Paragraph 231 of the Settlement Agreement requires that the Defendants file monthly reports with the Master and Counsel for Plaintiffs on any action taken by the Defendants to mobilize the resources necessary to effect timely discharges of patients in the Adolescent Unit. It was agreed with respect to these reports that if the Plaintiffs were interested in receiving specific details regarding these efforts that a request for such specifics should be contained in the notices that Plaintiffs file with Defendants. (1/24/91, #3).

Department Of Human Services Access To Medical Records

With respect to its wards who are at AMHI the Department of Human Services has had some difficulty in accessing their medical records. The Department has been working with AMHI to gain more timely access to records. Progress has been made on this matter. (3/21/91, #2; 4/4/91, #6; 4/18/91, #7; 5/2/91, #1a).

Informing Class Members Of Their Rights Under The Consent Decree

Several efforts were made to ensure that class members are aware of their rights under the Consent Decree. The Plaintiffs agreed to disseminate a variety of printed materials to class members and also make available a toll-free number for anyone who wishes to speak to Plaintiffs' Counsel with their concerns regarding the Consent Decree. Additionally, the Defendants agreed to periodically make available to the Plaintiffs the master list of class members and to include those class members' addresses to the extent that they are reasonably ascertainable. (3/7/91, #7; 3/21/91, #9; 4/18/91, #1).

Client Confidentiality

A few agreements were reached in order to protect confidential information relating to class members. (1/11/91, #5; 2/21/91, #5).

Training By Consumers

Paragraphs 121 and 214 of the Settlement Agreement contain provisions regarding training by consumers. It was agreed, with respect to both of these paragraphs, that the Defendants will consult with the Plaintiffs' designee or designees prior to taking any initiatives regarding training by consumers. With respect to paragraph 121 it was agreed that the consumers who provided training would by self-selected and that every effort would be made to promote training in communities by consumers from those communities. (3/7/91, #6).

Rights Regulations For Children and Adults

The development of these regulations has been the subject of an on-going process during which the Defendants and Plaintiffs have cooperated closely in resolving differences regarding these regulations. These regulations are now ready for conditional approval by the Master subject to successful completion of their promulgation pursuant to the Administrative Procedure Act. (2/7/91, #1; 3/7/91, #7; 3/21/91, #11; 4/4/91, #1; 4/18/91, #2).

Emergency Contingency Plans

Regarding the potential failure of supplemental funding for fiscal year '91, it was agreed that the Defendants would assess all potential health and safety threats to class members and develop contingency plans in the case of actual failure of funding. The contingency planning was abandoned when necessary supplemental funding for fiscal year '91 was realized. (3/7/91, #8; 3/21/91, #11)

Class Members At Homestead

It was agreed that Defendants would provide the Plaintiffs their plans for the future care of the 6 class member children who will be removed from the Homestead residential treatment center as result of the state's termination of its contract with Homestead. Plaintiffs also requested that the Defendants be required to show that individualized support planning be utilized in placing these children. I was unable to identify any requirements of the Settlement Agreement which would compel the Defendants, at this time, to utilize an ISP planning process for the 6 class members. It was agreed,

however, that the Defendants would continue to provide all lawfully disclosable planning materials to Plaintiffs. It was also agreed that the Plaintiffs and Defendants would work on clarifying issues regarding planning for adolescents as part of their ongoing review of the Implementation Plan. (3/7/91, #11; 4/18/91, #11; 5/2/91, #2).

Assessments Of AMHI Patients

A series of meetings were held to promote the development of the patient assessment process required by paragraph 45 of the Settlement Agreement. (12/13/90, #5; 2/14/91, #4; 2/21/91, #8; 3/7/91, #12; 5/2/91, #4).

With respect to paragraph 45 of the Settlement Agreement, the Defendants submitted that only patients that fit the categories listed in paragraph 43 of the Agreement and whose length of stay exceeded 150 days pursuant to paragraph 44 of the Agreement need to be assessed. The Plaintiffs maintained that all patients are appropriate for assessment under paragraph 45. It was agreed the panel convened under paragraph 45 would be asked to assist in development of a plan for assessing patients which would meet the goals of the Settlement Agreement but which would not necessarily subscribe to either of the alternative interpretations of the paragraph 45. Since the panel has not yet been convened, this issue has not yet been resolved. (12/13/90, #6).

List Of AMHI Patients Who Could Live In Community Settings

Paragraph 94 of the Settlement Agreement states that as of the date of the Agreement there are patients at AMHI whose treatment or discharge plans state that they could live in community settings, but for the lack of available appropriate housing. The Plaintiffs and Defendants developed a confidential list of approximately 150 individuals who could appropriately be discharged from AMHI if appropriate alternatives existed. (12/13/90, #1; 2/7/91, #9; 3/7/91, #3).

AMHI's Admission Policy

The Admissions Policy at AMHI has been the subject at several lawyers' meetings and other meetings as well. This matter is discussed more fully in Section V of this report. (2/21/91, #9; 3/7/91, #9; 4/4/91, #5).

AMHI Staffing

The Defendants agreed to provide by May 14, 1991, a detailed assessment of staffing reductions at AMHI which would be warranted as a result of the development of alternative services. At that time the Department noted that it was developing a restaffing proposal for AMHI but that it did not account for the development of alternative services. (4/4/91, #4; 4/18/91, #6).

Legal Effect Of Transfer Of 17 Beds To Gorham Manor

At issue was whether the 17 licensed beds transfered from the Greenlaw nursing facility to Gorham Manor would be counted towards AMHI's obligation to reduce its licensed bed capacity. My initial assessment of this matter was that as long as the beds are maintained in the community as proposed, they would probably be considered as community-based beds and not AMHI beds within the meaning of paragraph 40 of the Settlement Agreement. For purposes of paragraph 40, I noted that the analysis of whether any beds are attributable to the Augusta Mental Health Institute most probably would not focus on the technical license status of those beds, but rather on whether the beds are in fact community resources within the meaning of the Consent Decree. (3/21/91, #5).

Information Gathering By The Master

The Defendants have raised concerns about my gathering information for a variety of reasons. Among them are, that I may prejudice myself with respect to given subject matter, that it may interfere with managements' relationship with its staff, and that it may impede the ability of Defendants' staff to perform their duties. Specific accommodation was reached with respect to the concern about unduly burdening the staff. It was agreed that when I requested information which will require a substantial amount of time to prepare, those requests would be channeled through appropriate supervisory people. This agreement was reached in order to allow the effected workers to balance their workloads with my requests for information so that both could be accommodated. With respect to the other concerns, I have maintained that my duties under the Settlement Agreement require and permit a broad range of information-gathering initiatives and that I will continue to appropriately exercise these responsibilities. (2/7/91, #2; 2/21/91, #2,9; 3/21/91, #4, 13).

Master Testifying Before The Legislature

Upon my stating that it was my desire to testify before the legislature with regard to matters concerning the Consent Decree, objections were raised by Counsel on behalf of the Attorney General's Office. Based upon the potential implications of this objection I reluctantly decided not to testify. (2/21/91, #3; 3/21/91, #13; see also letter of February 21, 1991 from Attorney Bergeron to Gerald Rodman, letter of February 26, 1991 from Gerald Rodman to Attorney General Carpenter, and letter of March 14, 1991 from Gerald Rodman to Senator Conley and Representative Manning).

Recommendation Regarding Certificate Of Need

And Hospital Development Account Legislation

I issued an "informal" recommendation regarding suggested exemptions from health planning laws for Consent Decree related projects. The recommendation was presented to the Defendants for their consideration. (4/4/91, #7; 4/18/91, #12); (see Memorandum to Plaintiffs' & Defendants' Counsel, 4/11/91).

Memorandum Recision

It was agreed that the Department of Mental Health & Mental Retardation would rescind a memorandum dated January 30, 1991 which, on its face, accorded inappropriate priority to class members. (2/21/91, #1; 3/7/91, #1).

B. Table Of Settlement Agreement Sections Affected

Section 16, 22 - regarding effective date of grievance and complaint procedures (12/13/90, #9).

Section 40 - regarding legal effect of transfer of 17 Greenlaw beds (3/21/90, #5).

Section 45 - regarding assessment of AMHI patients (12/13/90, #6).

Section 94 - regarding list of AMHI patients who could reside in the community (12/13/90, #1).

Section 121 - regarding training by consumers (3/7/91, #6).

Section 214 - regarding training by consumers (3/7/91, #6).

Section 231 - regarding the filing of monthly reports concerning discharging of patients in the Adolescent Unit (1/31/91, #3).

Sections 255, 269 - regarding do not resuscitate orders (11/29/90, #4; 12/13/91, #10).

Section 261 - regarding timetable for training (3/21/91, #1; 4/18/91, 10).

Section 280 - regarding the filing of quarterly patient reports (1/11/91, #7).

Section 281 - regarding the Department of Human Services case plan (11/29/90, #6).

Section 281 - regarding timetable for submission of quarterly patient reports (3/21/91, #2).

Section 298 - regarding Master communicating potential findings to parties prior to formal adoption (11/29/90, #8).

IV. FUNDING

A. Overview

The Department of Mental Health & Mental Retardation and the Department of Human Services have proposed specific Consent Decree-related funding for fiscal years 1992 and 1993. The vast majority of such funds have been requested by the Department of Mental Health & Mental Retardation.

The Consent Decree requires substantial compliance with its terms by August 1, 1995. At this point, however, funds are requested only for fiscal years 1992 and 1993. It is not expected, therefore, that the current requests constitute all, or even the majority, of the funds necessary to comply with the Consent Decree. Even viewed in this light, the funds requested for implementation of the Consent Decree are extremely modest.

The Department of Mental Health & Mental Retardation is currently seeking total additional funds of $14,628,672 for Consent Decree-related purposes for fiscal years 1992 and 1993. Additionally, it is seeking $7,161,113 for similar purposes for persons not covered by the Consent Decree. (The total of requested funds is $21,789,785). These requested funds are outlined in the Department of Mental Health & Mental Retardation's May 21, 1991, "Final" Part II Budget Summary for FY '92 and FY '93. The current proposed Consent Decree-related expenditures are less than those outlined in the Fiscal Supplement to the Implementation Plan filed by the Defendants on January 21, 1991. The Fiscal Supplement, which was made widely available to the public and widely commented upon at the Public Forums, sought a total of approximately $18,288,672* for Consent Decree-related purposes.

(*This figure does not include $1,500,000 to be requested by the Bureau of Public Improvements for FY '92 for fire safety services at AMHI, see Fiscal Supplement, page 29).

The majority of the reduction in Consent Decree-related expenditures between the original budget of $18,288,672 and the current budget of $14,628,672 is due to reduced requests for housing and housing support funds, and community support worker funds.

Generally speaking, the requested funds are for categories of services needed to implement the Consent Decree. These areas include, among others, housing, residential support services, vocational support, community support worker services, and crisis intervention and resolution services. These proposed expenditures are discussed in more detail below.

Other parts of the budget, however, propose cuts which would have an impact upon the ability of the affected agencies to meet the requirements of the Consent Decree. For example, the Department of Mental Health & Mental Retardation would suffer a net loss of administrative personnel. The Department states, "eliminating these positions will seriously compromise our ability to manage an ever increasing workload brought about by the Consent Decrees in both mental health and mental retardation, expansion of community services and quality assurance/data management necessary to satisfy administrative and legal requirements." (Departmental statement--Department of Mental Health & Mental Retardation, L.D. 927, page 8). Additional, deep cuts are also proposed in the staffing of the Augusta Mental Health Institute. These proposed cuts are discussed in this report at Section V.C.

References to comments made regarding funding are to comments made at Public Forums or submitted in writing pursuant to the Public Forums. As previously noted, these have been catalogued by the Department of Mental Health & Mental Retardation in its "Inventory of Public Comments". Comments not made at, or pursuant to, the forums are independently referenced.

B. Funding Requested By Category, Department of Mental Health & Mental Retardation

1. Bureau of Mental Health

a. Administration

The Department of Mental Health & Mental Retardation seeks additional administrative funds for FY '92 in the amount of $829,250 and for FY '93 in the amount of $661,200. This includes funds for three full-time staff for the development of a management information system. The Consent Decree requires that there be an integrated information system that collects information on individual class members' needs, services provided, and service costs in both community and hospital settings. Mandated quality assurance and monitoring functions also require basic informations system support. The Department does not currently have a management information system.

The Department also seeks two additional staff positions in FY '92 and one additional staff position in FY '93 for quality assurance monitoring and evaluation. These individuals will assess the utility of services being provided to class members. They will also be responsible for developing licensing standards for agencies, a data collection and reporting capacity, and an annual statistically significant study of class members. The Maine Commission on Mental Health, in its second annual report, February 19, 1991, at pages 5 & 6, notes that the Department's current capacity to perform its quality assurance functions is strained. The Commission notes that over 33% of the agencies surveyed by the Department were issued either conditional or provisional licenses. The Commission further notes that the seriousness of cited violations demands a level of monitoring of, and technical assistance

to, licensed mental health care providers that is currently beyond the Department's capabilities. The Consent Decree brings additional requirements for quality assurance. The Commission does not believe that the requested positions will be sufficient to meet the full range of responsibilities which fall to the Department. I concur in this assessment.

The Department also seeks a housing coordinator, either under contract or as a departmental employee. Among other things, this person will be responsible for managing all departmental efforts pertaining to the development of residential options for all persons served by the Department.

b. Community Support Workers

The Fiscal Supplement proposed funding for thirty-eight additional community support workers state-wide. Thirty-five of the community support workers would be assigned to the AMHI catchment area. It was anticipated that approximately 880 individuals would be served by these community support workers. For FY '92, additional funding would have been $983,400 and for FY '93, $991,500. Pursuant to the Settlement Agreement, each class member who wants a community support worker is ultimately entitled to one. It is unknown what percentage of class members (as of May 5, 1991, there were 2,376 class members) wanting a community support worker would be served by the original request.

Funding is now proposed in the amount of $398,400 for FY '92 and $540,700 for FY '93. This is less than one-half of the originally proposed amount. It is assumed that the number of individuals served would accordingly be reduced by more than one-half.

Community support workers are to play a critical role in the development of Individualized Support Plans for class members and in the coordination of services for class members. Community support workers are also to perform an important role in assessing deficiencies in service availability. These assessments will enable the Defendants to identify areas in which additional services are needed. (See generally, Settlement Agreement, Section VI.C.). The current budget request is a major retreat from the original proposal to develop this essential component of a comprehensive mental health system.

c. Community Hospitalization

The Department is proposing to continue funding through fiscal years '92 and '93 at fiscal year '91 level, i.e., no additional funding is proposed. Funds for each year would be $1,229,752. The majority of funds historically have gone to the Jackson Brook Institute to support acute involuntary inpatient treatment. These funds are used as part of AMHI's diversion program. The diversion program is discussed in more detail in this report at Section V.B.

d. Housing And Residential Support Services

The Department of Mental Health & Mental Retardation originally sought $1,146,904 for FY '92 and $2,809,588 for FY '93 for room and board costs. Additionally, $987,825 was requested for FY '92 and $1,513,283 was requested for FY '93 for services associated with housing programs. These funds, totaling $6,457,600, would have supported a total of 240 additional supported housing beds in the community.

Among all the various services and programs proposed to be developed pursuant to the Consent Decree, housing has been the need most frequently cited by consumers, providers, and other members of the public. Without exception, those commenting upon the scope of the need for housing have concluded that the funding proposed in the Fiscal Supplement would not be sufficient to meet the need for additional housing. The Plaintiffs have found the housing proposal to be inadequate because it targets "priority members of the class". (Plaintiffs' comments to Implementation Plan, 3/18/91, pages 5, 7). The Department of Mental Health & Mental Retardation notes that a comprehensive range of housing options does not exist anywhere in the state. (Annual Report on services contracted with community-based agencies, 1/31/91, page 35)

The Department now seeks funding in the amount of approximately $936,000 for FY '92 and $1,235,000 for FY '93 for room and board costs and approximately $380,000 for FY '92 and $1,140,000 for FY '93 for services associated with housing programs. (These figures include funds from several line-items on the Department of Mental Health & Mental Retardation's May 21, 1991 Part II budget, including residential, pre-development, psycho/geriatric, family respite, MSHA 1%, MH/MR placements and supported housing). This yields a total expenditure of approximately one-half of the original proposal. All available information indicates that this request will fund only a small fraction of the need for housing and residential support services.

e. Crisis Intervention and Resolution Services

Additional funds of $300,000 were sought for FY '92, and $600,000 for FY '93 for these services. This funding was requested solely to continue and expand an emergency response program in the Cumberland County area. Next to housing, crisis intervention and resolution services are the most frequently cited service needs. All commentators agree that the need for additional crisis intervention and resolution services goes well beyond that for which funding is currently being requested. No funds for this category are requested in the Department's most recent budget. The Department states, however, that the Cumberland program will be funded with other resources. The Department acknowledges that additional crisis intervention programs need to be developed; it cites, for example, the need for a program in the mid-coast area. (Annual Report on Services Contracted With Community Based Agencies, 1/31/91, page 35)

The primary purpose of crisis intervention and resolution services, according to paragraph 99(e) of the Settlement Agreement, is to avoid hospitalization through community-based resolution of crises. The current budget request fails to address the need for more of this critical service, thereby missing an opportunity to avoid what would otherwise be unnecessary hospitalizations.

f. Vocational Services

Additional funding of $200,000 for FY '92 and $400,000 for FY '93 is sought for vocational services. The Department reports that these funds would result in the employment of at least 60 additional people. All of those commenting on the need for vocational services found the

requested funds to be very insufficient. The new budget request includes $410,000 for FY '92 and $960,000 for FY '93, but this amount also includes an unspecified sum for day treatment services.

g. Treatment Services

Treatment services include out-patient clinical services and day treatment services. Funds for these services are provided through contracts to ten community agencies. Funding for these services in fiscal year '91 was $4,814,438. Funding is proposed to be continued at a very small increment above this level for fiscal years '92 & '93.

h. Social, Recreational, and Avocational Services

No additional funds are being sought for FY '92/'93. Currently funded are seven social clubs for persons with severe mental illnesses. All areas of the state do not have clubs available. The Department has stated that the presence of adequate and accessible social clubs is extremely spotty and that approximately $300,000 per year will be necessary for the development of a social club in Portland and another in the Bath/Brunswick area. (Annual Report on Services Contracted With Community Based Agencies, 1/31/91, page 37).

i. Family Support Services

No additional funds for family support services are sought for FY '92/'93. The existing level of funding provides for the operation of the state level activities of the Alliance for the Mentally Ill of Maine, Inc. and local operations of ten affiliate groups through out the state.

j. Substance Abuse Services

A variety of substance abuse services are proposed to serve approximately 350 class members over the next two fiscal years. The Department of Mental Health & Mental Retardation requested $328,500 for FY '92 and $565,000 for FY '93. The Department estimates that approximately $1,500,000 would be needed to expand substance abuse (dual-diagnosis) services as outlined in the Maine Dual Disorders Monograph, Volume VI, September, 1990. It is not known what percentage of this amount would be needed to serve class members. (Annual Report on Services Contracted With Community Based Agencies, 1/31/91, page 88).

2. Bureau of Children With Special Needs

The Department seeks $1,800,000 in additional funds for FY '92 and $2,400,000 for FY '93. Amounts for the various categories listed below have changed but the total dollar amount is the same. Proposed funding for many of the services does not include services to those children who are in the care of either the Department of Human Services or the Bureau of Mental Retardation of the Department of Mental Health & Mental Retardation. This excludes from coverage approximately 54 of the approximately 190 class members who are adolescents. It is obvious, therefore, for at least this reason, that the requested funding will not be adequate to serve all adolescent class members.

Provision of services to children has been the subject of extensive comment. In general, commentators have noted a severe lack of services for children. Funding for case management has been particularly singled out as inadequate. As noted below, more money has been shifted to this service.

a. Case Management Services

An additional $312,000 was sought for both fiscal years '92 & '93 to provide a total of 13 case managers state-wide. These services are targeted for children who have severe emotional/behavioral disturbance, who have been in multiple previous placement, and who require extensive programming in the areas of mental health treatment, behavioral and daily living skill development, and educational/pre-vocational training. The current budget request now seeks $740,000 for FY '92 and FY '93 for those services. This increase over the requested funding proposal will assist in addressing a major concern regarding the inadequacy of case management services.

b. Family Support & Respite Services

Additional funds are proposed for family support and respite services in the amount of $188,000 for FY '92 and $188,000 for FY '93. These funds are designed to assist parents and other family members in non-emergency situations, by providing temporary respite and by assisting family members to organize and participate in self-help support activities and parent-to-parent network groups.

c. Crisis Intervention

The Department originally requested $615,000 for FY '92 and $565,000 for FY '93 in additional funds for crisis intervention. These funds would have provided for 14 crisis workers and at least 4 crisis beds state-wide. These services provide intervention to families with

children with severe emotional disturbance or behavioral handicaps at times when it becomes impossible for family members to control the situation. The current budget request now seeks an additional $1,060,000 for both fiscal years '92 and '93. This reflects a shift in priorities away from residential support services towards crisis intervention in fiscal years 1992 and 1993.

d. Community Residential Support Services

Additional funding of $735,000 was sought for FY '92 and $1,335,000 for FY '93. These funds would have provided for the operation of a variety of newly-developed residential facilities, some of which would be in each area of the state. The facilities themselves would be developed utilizing funds from the Maine State Housing Authority Mental Health Bond Issue. Up to 20 beds would have been developed in FY '92 with an additional 15 beds developed in FY '93. Some of the funds would be used to purchased up to 750 bed days per year of inpatient psychiatric hospital care from existing hospital facilities in Cumberland and York Counties. The funding would also have encompassed the related family counseling and post-discharge after-care.

The new budget request is for $0 in FY'92 and $600,000 in FY '93. As noted above, this reflects a shift in priorities away from residential "facilities" and towards crisis services for children.

C. AMHI Funding

1. Funding Requested for AMHI

In the Fiscal Supplement, the Department sought additional funds for the Augusta Mental Health Institute in the amount of $1,204,036 for FY '92, (not including $1,500,000 to be requested by BPI for fire safety/fire alarm system, see Fiscal Supplement, page 29) and $337,186 for FY '93. These funds were for fire safety, improvement of the environment at AMHI, life safety/suicide prevention, compliance with training requirements and licensing standards, consultation services, dental services, and a program for converting existing positions to team coordinator positions responsible for the development of individual patient treatment and discharge plans.

The recent budget request seeks $1,171,536 for FY '92 and $269,686 for FY '93. The reduction in requested funds of approximately $100,000 affects the areas of therapeutic environment, training, and consultation.

2. Proposed Staffing Reductions At AMHI

The Settlement Agreement at paragraph 41, sets as a goal the reduction of AMHI's non-forensic population to 200 by August 1, 1992. In their Implementation Plan, the Defendants propose a variety of activities to meet this goal. These include closing the Adolescent Unit, transferring a number of nursing facility patients to community-care providers, transferring the alternative living program to a privately operated authority, and developing 12 acute involuntary admissions beds in general community hospitals. The Implementation Plan does not identify staffing reduction targets associated with these proposals.

The Part I Budget Recommendation for fiscal years 1992 and 1993, however, specifically seeks to eliminate 131.5 positions at the Augusta Mental Health Institute. (Eight positions have already been eliminated when vacated under the early retirement incentive program). (Justification Statement, DMH&MR, LD 927, page 49). The Justification Statement for the proposed staffing reductions states that 26 of those positions are associated with the closure of the Adolescent Unit; 42 positions would be eliminated as the result of the closure of a ward of the Greenlaw Nursing Home; and 13 positions would be eliminated as a result of the closure of two 6-bed half-way houses. The statement adds that the other positions identified for abolishment would be spread over several psychiatric programs and would result primarily in reduced direct care coverage. (Justification Statement, DMH&MR, LD 927, page 49).

To the extent that the potential closing of various units, wards and houses at AMHI are used to justify staff reductions, it is stressed that, at this time, the only approved closure at the Augusta Mental Health Institute has been for 17 beds of the 35 bed unit in the Greenlaw Nursing Home referenced in the Justification Statement. Additionally, even if alternative services are developed to replace the services proposed to be terminated or reduced at AMHI, these services will not be developed by July 1, 1991, the proposed effective date for the elimination of 131.5 positions. As a result, the proposed layoffs would result in a substantial reduction of services at AMHI prior to the time that alternative community-based services are developed.

The Defendants were requested to provide an analysis of the proposed staffing reductions. In my request for the analysis I emphasized that any proposed staffing reductions should be carefully evaluated with respect to the creation of community service capacity. Also requested was a analysis of the timing of the availability of additional community services. (Letter of 4/16/91).

The analysis, submitted on May 22, 1991, does not demonstrate any meaningful relationship between the proposed elimination of 131.5 positions at AMHI on July 1, 1991, and the development of additional, community-based services. The analysis does not directly address staffing reductions at AMHI, but hypothisizes how much AMHI's census would be reduced with the development of community-based services. The analysis states, "In 1992, should BMH (the Bureau of Mental Health) succeed in developing the community residential capacity described, AMHI would have decreased its census by 60 persons". The FY '92 and FY '93 AMHI census reduction/resource reduction chart (which outlines census reduction but not resource reduction) is one component of the analysis. It projects the placement of individuals in community-based treatment facilities beginning in late 1991 and throughout 1992 and beyond. No analysis is presented demonstrating how the elimination of 131.5 positions, on July 1, 1991, is consistent with the development of these alternatives with respect to either: 1) the timing of the layoffs relative to the development of these services, or 2) the number of layoffs which would ultimately be warranted as a result of the development of these services.

Additionally, the analysis assumes certain events which may not occur. For example, the FY '92 census reduction/resource reduction chart references the placement of some of AMHI's nursing facility patients in community settings. Such placement, however, may be difficult to accomplish. To date, the Department has secured the agreement of only one nursing facility to accept transfers of AMHI's nursing facility patients as part of a permanent transfer arrangement for a substantial number of AMHI's licensed beds.

D. Funding--Department of Human Services

The most recent budget submission of the Department of Human Services outlines additional funding for fiscal years 1992 and 1993 in four major areas. The Department is seeking $400,000 in both fiscal years 1992 and 1993 for housing for adolescents. This project is described at page 11 of the Department of Human Services' Fiscal Supplement. The Department is also seeking $483,904 for fiscal year '92 and $1,120,748 for fiscal year '93 for vocational services. This is currently described on page 15 of the Department of Human Services' Fiscal Supplement.

The Department is also seeking $150,000 in FY '92 and $250,000 in FY '93 to purchase services which allow their clients to remain in the least restrictive setting. Approximately 400 clients are estimated to benefit from these services over fiscal year 1992 and 1993. The funds will be targeted to clients being discharged from AMHI. Additionally, the Department is seeking a total of 12 1/2 positions in FY '92 and FY '93 at a cost of $186,709 and $392,853 respectively for case workers, case aids, and clerical positions to maintain ratios required by the Consent Decree and to comply with reporting requirements required by the Consent Decree. These latter two areas were not originally accounted for in the Fiscal Supplement.

V. CURRENT INITIATIVES TO MANAGE AMHI'S CENSUS

The Institute put into operation two major initiatives that have had a profound effect upon AMHI's census. One is an aggressive diversion policy initiated in March 1989 to divert potential admissions away from AMHI and toward either local psychiatric inpatient units or community-based crisis units. (Maine Comprehensive Mental Health Services Plan - Adult Mental Health Services, 9/90, "Comprehensive Plan", pages 100, 214; Departmental statement-DMH&MR, LD 924, page 49). The other major influence on AMHI's census has been the establishment of an admissions protocol in February 1990. The admissions protocol was established to more clearly define AMHI's priority population and to establish definitive admitting criteria. (Comprehensive Plan, page 101).

A. Admissions Policy

The Institute sees a need to define its mission, upgrade its care, and bring into balance its relationship with community-based providers. Few people disagree with the need for AMHI to meet these objectives. Many are concerned, however, with the rapidity with which the Institute has moved. The following comment is typical:

> "The state institution has served as a last resort for consumers and their families. Whether this is a role that the state institution should have is not the point. The issue is that the fractured, ill-planned community system has grown up and around AMHI and BMHI. One can not take away from the state institution without reconfiguration of the community system". (Letter of February 12, 1991 from the Alliance for the Mental Ill of Maine, Michael J. Fitzpatrick, Executive Director).

Some providers of mental health services in the community are critical of the admissions protocol, finding that it has put a strain on community resources and has yielded no benefit. Other providers have suggested that the admissions protocol has put some pressure on community providers, but that after a period of adjustment, they have been able to adapt and upgrade their own services to meet the increased demands placed upon them. For example, Dr. Edward McCarthy, a psychiatrist with Maine Medical Center, concluded that AMHI's policies (including the diversion program discussed below) have benefited patient care in the greater Portland area. He points specifically to the fact that community-based providers are now obliged to evaluate patients more carefully and that, in some instances, patients gain access to services which are more appropriate to their needs than those services available at AMHI. He further noted that Maine Medical Center's reliance on AMHI has been reduced. Dr. McCarthy also observed, however, that there remain individuals with certain diagnoses who are not adequately served by the system. (Grand Rounds, Video available).

Both critics and proponents of the policy made legitimate points. It is important that AMHI establish an environment in which it can provide quality care. Additionally, there does appear to have been some benefit from AMHI's placing pressure on the communities to accept a greater role in providing care for people with mental illnesses. On the other hand, AMHI cannot define its mission in isolation from the mental health system as a whole. The total capacity of the system, including the state institutions and community-based services, is collectively inadequate to meet existing needs. As appears in the chart at the end of this section, AMHI's census has decreased by 25% since March 1989. Community-based providers will not be able to tolerate persistently escalating pressure to care for those persons who historically

have been cared for by AMHI without the development of additional community-based services. In the transition phase to a more community-based system of care AMHI must remain an available resource to serve those who ultimately should be served in the community.

During the past several months I have encouraged the Institute to be flexible with its admissions protocol during this transitional period. Recently, the Institute has drafted revisions in its admissions protocol to promote discussion of this issue. The protocol has been presented to the Central Maine Clinical Directors Group for its input.

It is necessary to have a balanced approach to admissions at AMHI. This approach must continue to promote the positive aspects of AMHI's admission protocol while accomodating the fact that the mental health system currently lacks sufficient alternatives to hospitalization at AMHI.

B. Diversion Policy And Associated Policies And Programs

A key to AMHI's diversion efforts has been the C.L.A.S.S. committee (community linkage, assessment and stabilization services committee). The committee began in late February 1989 to assist the Department of Mental Health & Mental Retardation in providing alternatives to AMHI admission. The Department reports that this program has diverted over 2400 potential admissions into community hospitals and crisis stabilization units. (Paper-Diversion Program, DMH&MR).

C.L.A.S.S. works by using a special fund appropriated by the Legislature to purchase inpatient psychiatric hospital services at local hospitals. It facilitates alternative placements through a network which consists of: 1) admission and emergency room physician and social workers at community hospitals; 2) emergency workers at community mental health agencies; 3) crisis stabilization staff; 4) AMHI admission staff and outreach liaisons;

and 5) community support and case management staff in community agencies. (Comprehensive Plan, page 100).

The Department has also run or supported other associated initiatives intended to alleviate reliance upon AMHI. One program is the intensive case management program (ICM). This program provides services to persons with severe and disabling mental illness, who may be at risk for homelessness. These services consist of assessment, service planning, linkage to services, and on-going monitoring. The priority population for these services are those persons who are returning to the community following inpatient care at AMHI or BMHI. (Paper - Bureau of Mental Health Client Certification for Intensive Case Management Program). Additionally, the Department has established five crisis stabilization programs. (Paper - DMH/MR Crisis Stabilization Program).

The Department has also been working with a variety of organizations and providers to enhance the development of community-based services. This includes involvement with the Maine Hospital Associations' Task Force on Mental Health and several community hospitals and nursing homes. To date the Department has met with little success in recruiting additional facilities to take involuntarily committed patients. Currently, the Jackson Brook Institute remains the only private facility which accepts involuntarily committed patients. No additional involuntary patient bed capacity has been added at the community level. The Department did successfully work with a private nursing home provider, Gorham Health Care, Inc., to establish 17 additional community-based nursing home beds. To date, no other nursing facilities have been willing to enter into similar arrangements.

The Department's efforts at improving communication and coordination with community-based providers are essential in the development of a comprehensive mental health system. They are not a substitute, however, for the need to develop additional community-based services; rather, the long-term success of these efforts is dependent upon the development of such services.

AMHI CENSUS, JANUARY '88 - APRIL '91

From AMHI Monthly Statistical Tables

'88		'89		'90	
January	365	January	368	January	336
February	351		363		327 * (2)
March	366		368 * (1)		322
April	366		353		327
May	365		340		325
June	369		340		300
July	348		331		294
August	345		335		302
September	357		338		301
October	369		372		296
November	372		346		293
December	365		321		292

'91	
January '91	294
Feb	288
March	279
April	276

*1 Diversion Policy Activated.

*2 Admissions Protocol Activated

VI. THE CONSENT DECREE IN HISTORICAL CONTEXT

Over the past three decades, AMHI has been dealing with deinstitutionalization and its aftermath. Past deinstitutionalization policies were ultimately unsuccessful. It is important to be aware of the reasons for these failures to avoid repeating the mistakes of the past.

The focus of the early 1960's was "Operation Out", an intensified effort to move patients to boarding homes and foster homes. By the mid to late 1960's, however, "Operation Out" had lost its momentum. This was followed by the major period of "deinstitutionalization" from 1971 to 1974, when the inpatient census at AMHI plummeted from 1500 to 350. (A history of the Augusta Mental Health Institute, Fuller and Howard, page 11). The aftermath of this period of deinstitutionalization, however, saw readmissions to AMHI dramatically increase. (Relationships Between First Admissions and Re-admissions to the Augusta Mental Health Institute and State Population, Lowell, page 22). Additionally, beginning in 1983, first admissions to the Institute also began to increase significantly. This occurred in spite of the expansion of community-based services, including an increase of professional service providers, the growth of community mental health centers and the opening of a private, 81 bed psychiatric hospital. (Lowell, page 2).

By the mid 1980's the admission rate at AMHI had surpassed all previous records and the Institute stopped accepting voluntary admissions. (Fuller and Howard, page 11; Lowell, page 13). The pressure, however, continued; in the June, 1988 summary section of AMHI's monthly statistical tables it was noted that persistent admissions pressures were resulting in overcrowding which "continued to stress staff and patients alike.....".

One analyst, Dr. Michael J. DeSisto, who has conducted a comparative study of the mental health systems in Maine and Vermont, identifies six areas which, over the past three decades, resulted in the breakdown of the system at

AMHI during the 1980's. They are: 1) a lack of integration of system elements around the needs of specific patients; 2) unclear roles and responsibilities for elements of the system; 3) lack of a clearly articulated vision of the system; 4) lack of policy continuity; 5) program planning and system development unrelated to the assessed needs of specific groups of patients; and 6) a lack of data-based system monitoring. (Perspectives on Rural Mental Health, page 59, DeSisto, Harding, Howard and Brooks; in press, 1991, Kennebec Press).

Fortunately, the Consent Decree is responsive to the historical problems which have resulted in failures of past deinstitutionalization efforts. The Decree articulates a vision for the future and mandates a comprehensive system which is designed to meet the needs of individuals. In addition, it requires the needed data-based monitoring system and provides for the assessment and continuing reassessment of the system in order to adjust to the changing needs of consumers of mental health services.

There are, however, significant challenges to implementation of the Consent Decree. The state's fiscal problems will put additional pressure on the mental health system. It will be necessary to distinguish between reductions at the Augusta Mental Health Institute resulting from sound planning under the Consent Decree from reductions prompted by purely fiscal considerations. The type of deinstitutionalization which occurred in the 1960's and 1970's must not be repeated. The requirement of the Consent Decree that the reduction of AMHI's census shall be "part of an overall effort to establish and maintain a comprehensive mental health system" must be enforced. (Settlement Agreement, paragraph 31). It will be necessary to maintain the capacity of the Augusta Mental Health Institute to serve those

who will ultimately be served in their communities during the transition to a more community-based system. The premature downsizing of the Augusta Mental Health Institute before coordinated community-based services are operational would result in the repetition of historical mistakes that have rendered past deinstitutionalization efforts unsuccessful.

Despite these challenges, the Consent Decree, together with other factors bode well for the future. The state has taken a more active role in assessing, monitoring, and improving its mental health system. Among the institutional manifestations of this increased involvement are the Systems Assessment Commission and the Maine Commission on Mental Health. Also, consumers of mental health services are becoming more involved in shaping a comprehensive mental health system. Providers of mental health services have also been involved in the emerging system, as is evidenced by the participation of such groups as the Portland Providers' Group and the Central Maine Clinical Directors' Group. The Commissioner of the Department of Mental Health & Mental Retardation has also brought together a broad base of participants in the "Visions Conference" to deal with issues important to the future of the mental health system. These factors place Maine in an historically unparalleled position to develop a comprehensive mental health system.

May 31, 1991

Date

Gerald Rodman, Master