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

January 31, 1992

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I. INTRODUCTION

This is my second semi-annual Report to the Court under paragraph 299 of the Settlement Agreement. In my first Report, dated May 31, 1991, I noted a severe lack of community-based services and a parallel lack of capacity to coordinate the delivery of such services. I also noted that these services would not be developed overnight; the Consent Decree anticipates substantial compliance with its terms by September 1, 1995. Substantial progress has been made in some areas. On the other hand, progress has been slow in many areas and specific problems which I reported previously persist.

In section II (A) I review the development of the Implementation Plan. On November 27, 1991 I approved, or approved subject to certain conditions, the majority of the Plan. The current version of the Plan is a significant improvement over the Plan submitted last January and will be subject to further revision and supplementation. The Plan provides for initiation of the development of a comprehensive mental health system, but has not yet blossomed into its full potential in that it does not provide a complete picture of the comprehensive mental health system to be developed.

The development of Individualized Support Planning and Community Support Workers is one of the major approved components of the Plan. Planning for the development of crisis intervention resolution services, vocational services, treatment services, recreational, social and avocational opportunities, and family support services are among the areas approved. A significant area not approved in large part was the planning for housing and residential support services. I found that planning in these areas did not provide adequate assurances that individuals will be able to remain in their homes, to the extent possible, without being forced to move as their service needs change. I also disapproved the plan for reducing AMHI's census. I found the Plan to be formalistic, carrying with it the potential to force inappropriate downsizing at AMHI. I noted that the reduction in AMHI's census is not an isolated event required by the Settlement Agreement, but rather is required to be coordinated with the overall effort to establish and maintain a comprehensive mental health system.

In section II(B) I review use of Planning Proposals, the established mechanism for processing plans for the downsizing of AMHI. In my last Report to the Court, I noted that the most significant failure of process was the Department of Mental Health and Mental Retardation's failure to communicate fully its planning activities. Regrettably, this remains a major problem. In this section I note that in the Fall of 1991 the Department of Mental

Health and Mental Retardation successfully sought to deappropriate funds effective in the Spring of 1992 for four half-way houses at AMHI. This was accomplished in spite of the fact that no Planning Proposal was filed regarding this significant downsizing effort. I also note that during the current legislative session the Department is seeking elimination of 144.5 positions at AMHI, which would eliminate all nursing facility beds at the Institute. No Planning Proposal has been filed regarding this major initiative. I conclude in this section that the combination of the Department's failure to submit, and have approved, its plans for downsizing AMHI, together with its ability to reduce bed capacity at AMHI through deappropriation of funds, turns the planning process upside down. Instead of the budget following sound, approved planning, the budget cuts can force premature downsizing. These problems are the subject of a specific recommendation outlined in section VI of this Report.

The Department of Mental Health and Mental Retardation and the Department of Human Services file Quarterly Reports outlining their progress in implementing the Settlement Agreement. These Reports are briefly reviewed in section II(C). I report in this section that DMH&MR's Quarterly Report is frequently unclear as to whether specific tasks have been completed. It does appear from the Report, however, that the development of the Individualized Support Planning process and the completion of patient assessments have

been delayed. The lack of patient assessments was cited as a major deficiency in my last Report to the Court. On the other hand, the Reports show significant adherence to the plans for the development and implementation of standards governing the Augusta Mental Health Institute.

The Department of Human Services' most recent Quarterly Report outlines the Department's progress with clarity. The Department's Quarterly Report claims a fairly good completion rate for the listed tasks.

In January, 1992 I held four public forums in the AMHI catchment area and solicited written comments regarding the Defendants' progress in implementing the Settlement Agreement. Summary of the public's input is found in section II(D). To a significant extent, consumers, family members, and providers were apprehensive and angry. This has been largely precipitated by the dual threats of cuts in community-based services and simultaneous downsizing of AMHI. Particular note was made of the proposed termination of the Alternative Living Program and the absence of the development of any new alternative services to replace the ALP. Nonetheless, the Consent Decree is still viewed by many as a source of hope.

In section III, I review the processing and resolution of specific issues. Among the many items discussed is AMHI's clarification of its Admissions Policy. AMHI has clarified that it will go as far over its census as is necessary to accommodate all presenting "dire emergencies". Also noted is the Commissioner of the Department of Mental Health and Mental Retardation's involvement in dealing directly with Tri-County providers to explore options for the improvement and the local availability of emergency mental health services.

Funding for the Consent Decree is reviewed in section IV. I note that, on balance, the first regular session of the 115th legislature produced significant funds to initiate implementation. I also note that during the Fall special session the legislature deappropriated, among other things, funds for running most of AMHI's half-way houses. I note further that cuts have been proposed for the consideration at the second regular session of the legislature which are potentially devastating and represent a major retreat in the State's commitment to persons with mental illness. In this section I review the fact that the proposed cuts will deprive thousands of people, both children and adults, of needed services. I state my belief in this section that the impact of the simultaneous downsizing of AMHI and reduction in community-based services will result in additional wide-spread injury to persons with mental illness.

In section V, I make some general observations regarding the Augusta Mental Health Institute. In that section I note that the census has continued to trend downward at AMHI since my last Report, but that the rate of decrease has slowed since I wrote my last Report. The decline in census is generally attributable to the fact that, almost on a monthly basis, the total number of discharges from AMHI has slightly exceeded the admissions. I also note in this section that in June, 1991 the Civil Rights Division of the United States Department of Justice closed its investigation at AMHI and BMHI. The Department of Justice made special note of the Settlement Agreement, stating that the Agreement requires a level of commitment to patients that the Department of Justice believes will ensure that conditions at AMHI will continue to improve. Also reviewed is the fact that plans to perform "on-site" privatization at AMHI were dropped in December, 1991. On-site privatization would have consisted of turning over the operation of AMHI to private operators. I note that dropping the on-site privatization effort has been beneficial in establishing a somewhat more stable work environment at AMHI. Apparently "off-site" privatization is under consideration by DMH&MR with respect to the nursing facility beds at AMHI. This is discussed in more detail in sections II(B) and IV.

In spite of the apprehension and fear among many members of the public, it important to note that support for the goals of the

Consent Decree and interest in the mental health system continues to grow. The attendance and level of participation at the recent public forums was very high. Consumers sponsored an extremely successful conference in Bethel, Maine on November 15-17, 1991. The efforts of the Alliance for the Mentally Ill of Maine continue to grow. The Alliance has recently published a resource guide of services in Maine.

Moreover, community-based hospitals are beginning to take a broader role in serving people with mental illnesses. Kennebec Valley Medical Center and Southern Maine Medical Center, with the assistance of the Department of Mental Health and Mental Retardation, had Certificate of Need applications approved to expand their mental health services. Included in their plans are the addition of beds for involuntary committed individuals. The Aroostook Medical Center has also added beds for involuntarily committed individuals. Although the total number of beds is small, this represents a breakthrough for general, community hospitals.

Other hospitals are playing constructive roles in different ways. Maine Medical Center, for example, has recommended through its mental health planning task force that the hospital expand its community role in the planning for mental health services and in assuring the appropriate integration of those services with Maine Medical Center's programs. All of these factors indicate that

community commitment to the goals of the Consent Decree is growing and that the conditions for the development of more community-based services are beginning to materialize.

In my last Report to the Court I noted two critical elements to the implementation of the Consent Decree. The first was that the development of community-based services must proceed vigorously and without delay. The second was that the downsizing of the Augusta Mental Health Institute must be carefully linked to the development of a comprehensive mental health system. I noted that the efforts to create such a system could be undermined, however, if premature downsizing of AMHI is allowed to destabilize the system during the transition to a more community-based system. Throughout this Report, I continue to emphasize these points.

II. MONITORING THE CONSENT DECREE

This section of the Report deals with my various duties in monitoring the implementation of the Consent Decree. One very important component has been my oversight of the development of the Implementation Plan. The Plan has now been approved in significant part. Outlined below in subsection A., Implementation Plan, I discuss highlights of approved and disapproved sections of the Plan. I also discuss specific and general conditions which I have made components of approval of the Plan. It should be noted that the Defendants have filed responses to my Review of the Implementation Plan and that those responses are currently under consideration. In subsection B., Planning Proposals, I discuss both the utilization, and the failure of utilization of Planning Proposals, by the Department of Mental Health and Mental Retardation. Planning Proposals are the main tool for reviewing proposals to downsize AMHI. In subsection C., Quarterly Progress Reports, I review the progress, as reported by the Defendants, in implementing the Implementation Plan. In subsection D., Public Input, I discuss the public's input with regard to the Consent Decree. This input was provided through a series of public forums and through the solicitation of written comments.

A. Implementation Plan

The first version of the Implementation Plan was filed in January 1991. Since that time, the Plan has been the subject of nearly continuous review and revision. Because implementation has preceded on a parallel course with the development of the Implementation Plan, some of the tasks outlined in the Implementation Plan were completed before final approval of the Plan had been given. The current version of the Implementation Plan is a significant improvement over the Plan submitted last January.

The Plan was submitted for my approval pursuant to paragraph 35 of the Settlement Agreement. In a document previously filed with the Court, Review of Implementation Plan Submitted by the Department of Mental Health and Mental Retardation and the Department of Human Service, November 27, 1991, (Review) I exercised my authority pursuant to paragraph 35 and either approved, or approved subject to certain conditions, the majority of the Implementation Plan. The Defendants filed their Responses to my Review of November 27, 1991 on January 10, 1992. The Defendants objected to certain provisions of the Review, but largely agreed to the conditions set forth or agreed to submit additional plans. Certain areas remain in dispute and are currently the subject of informal dispute resolution.

To a certain extent, the Implementation Plan is still a "Plan". More detailed plans will be developed as scheduled in the Implementation Plan or because I have required further planning as a condition of approval of the Plan. As additional planning is accomplished, the Implementation Plan should blossom into its full potential and a better picture of the comprehensive mental health system to be developed pursuant to the Settlement Agreement should emerge. As I noted in the Introduction to my Review, the Implementation Plan does not yet present "the big picture". It does, however, provide a start for the development of a comprehensive mental health system. Highlighted below are some of the major areas of approval and disapproval contained in the Review.

Major Approvals

Individualized support planning (Implementation Plan, section II) is identified by the Settlement Agreement at paragraph 72 as "the principal tool through which class members' needs are identified" and is thus "a critical element in assuring that the comprehensive mental health system is responsive to class members' actual needs". An important element of the Individualized Support Planning (ISPs) process and the service delivery process is the community support worker (CSW). These workers are to be made available to each class member who wishes to have a CSW. CSWs are

members of the team which develops ISPs, may be responsible for coordinating and delivering services, and are responsible for identifying unmet service needs so that the Defendants can plan for the development of additional services.

Hospital treatment and discharge plans and team coordinators are another essential component in the development of a comprehensive mental health system. Team coordinators enhance treatment, assessment, planning and integration of community-based service personnel into the care patients receive at AMHI. Coordinators will orchestrate the care the patient receives at AMHI and advocate on behalf of the patient for services in the community. This process is intended to ensure continuity of care. The promise of the Implementation Plan, regarding ISPs, CSWs, team coordinators, and hospital treatment and discharge plans were largely approved. Through their Response to a condition specified in the Review, the Department of Mental Health and Mental Retardation has agreed to accelerate its schedule for the development of ISPs and CSWs. This is a welcome amendment to the Plan.

Community hospitalization (Settlement Agreement, section III) is an important component of the Agreement. The Agreement requires that the Defendants make reasonable efforts to fund, develop, recruit and support local community acute psychiatric

hospitalization options so that class members who require inpatient psychiatric care may receive the necessary hospital services in, or reasonably near, their home communities. The Department of Mental Health and Mental Retardation has given priority consideration to expanding involuntary hospitalization capacity in general and free-standing psychiatric hospitals in the community. In the AMHI catchment area the Department estimates the need for thirty-seven (37) to forty-five (45) involuntary psychiatric beds in community settings. This component of the Implementation Plan was largely approved, conditioned upon the Defendants submission of a more detailed plan for the development of these beds.

In addition to community hospitalization, many other services need to be developed to form a complete adult community mental health system. These include crisis intervention and resolution services (Settlement Agreement, section III(d)), vocational services (Settlement Agreement, section E), treatment services (Settlement Agreement, section F), recreational, social, and avocational opportunities (Settlement Agreement, section G), family support (Settlement Agreement, section H) among others. Plans for the development of these services were all largely approved. Other important components of a comprehensive mental health system, housing services and residential support services, were found to be the subject of inadequate planning and were therefore disapproved in significant part. These services are discussed below under the title "Major Areas of Disapproval".

Other important components of a comprehensive mental health system are dealt with in section VI of the Implementation Plan, Mental Health System. These include: Client Rights (section A); Substance Abuse (section B); Training and Human Resource Development (section C); and Public Education (section D). Planning to meet individuals' rights is largely embodied in the development of regulations entitled Rights of Recipients of Mental Health Services (adults' rights) and Rights of Recipients Who Are Children In Need of Treatment (children's rights). Planning for the development of these rules was approved. Training and Human Resource Development Plans include enhancement of post-secondary education programs to address recruitment needs of community providers, the development of credentialing criteria, and training for health service providers on the terms of the Consent Decree and required performance obligations. These plans were approved.

Another important area in the development of a comprehensive mental health system which does not involve the direct provision of services is public education. The Department of Mental Health and Mental Retardation states that its public education programs will address the myths and stigma associated with mental illness. This section of the Implementation Plan was approved.

Regarding section VI(E) of the Implementation Plan, Quality Assurance and Internal Monitoring, the Settlement Agreement

requires that the Defendants design a comprehensive system by September 1, 1991. I approved this component of the Implementation Plan conditioned upon the Department's developing an interim plan for Quality Assurance and Internal Monitoring by February 1992 and a final system by September 1, 1992. The Department of Mental Health and Mental Retardation has noted on many occasions that its own lack of infrastructure is a major barrier to satisfying its obligations under the Settlement Agreement. In its Response, the Department has agreed to the condition that it develop an interim plan for Quality Assurance and Internal Monitoring pending development of its final plan.

I disapproved that component of section VI(F) of the Implementation Plan, Planning, Budgeting, and Resource Development, which relates to the development of Regional Boards because the Plan failed to provide for the Department to retain authority for its responsibilities under the Consent Decree, or to provide for a transfer of these responsibilities to the Regional Boards. My disapproval was not a comment on the potential value of Regional Boards. Rather, it reflected my disapproval of the Department's failure to take necessary steps to assure that the creation of Regional Boards will not be done in a manner that avoids responsibility for implementation of the Settlement Agreement. In their Response, DMH&MR indicated that it intends to retain its authority to implement the Agreement. While further planning will

be required to assure this result, the Department's response leads me to believe that this issue is now susceptible to resolution. (For this reason I have included it under the title of "Major Approval" in this Report).

One of the most extensive components of the Implementation Plan, is section V(B), Standards Governing AMHI. This section of the Plan includes planning for, among other things: the assurance of comfort and privacy for patients; meeting DHS licensing and life safety codes standards; developing standardized admission and discharge criteria; providing patient services which meet needs identified in an individuals hospital treatment and discharge plan; meeting standards for the prescription and administration of psychoactive medications; and assuring compliance with all seclusion, restraint and protective devices standards. Almost all of the fifty-four individual plans for this section were unconditionally approved.

Major Areas of Disapproval or Conditions to Approval

I did not approve the housing services and residential support services components of the Implementation Plan (sections III(B) and III(C)). In my Review I noted that the housing models proposed by the Defendants did not establish to any decree of certainty that the housing would be provided in a manner that could accommodate

varying levels of assistance. Developing housing models which allow for such flexible assistance would permit individuals, to the extent possible, to remain in their homes and have their service needs met without being forced to move. Neither the Housing section nor the Residential Support section provided any assurance that this requirement of the Settlement Agreement (paragraph 32b and 93) would be met. In their Response, DMH&MR has agreed to do additional planning addressing these areas.

One component of section IV of the Implementation Plan, Children's Services, sought to phase-out the "Bridge Program" effective December 1, 1991. The Bridge Program was designed to allow the Defendants to cease utilizing the Adolescent Unit at AMHI. While the Defendants have retained capacity to admit adolescents at AMHI, no adolescents have been admitted to that unit since March, 1991. The Bridge Program, unlike the Adolescent Unit, does not require admission to AMHI in order to provide services to adolescents. In the Review, I questioned both the scope and accessibility of the services proposed to replace the Bridge Program. I specifically disapproved the proposed termination date of December 1, 1991 for the program and reminded the Defendants of the necessity for filing a Planning Proposal at such time as they are ready to seek approval for the termination of the program. On January 15, 1992, the Defendants filed a new proposal to terminate the Bridge Program. On January 31, 1992 I issued my Review of Children's Implementation Plan of January 15, 1992. In that Review

I largely approved the plan to phase-out the Bridge Program as alternative services are developed.

I also disapproved the plan for reduction of AMHI's census, Implementation Plan, section V(A). This section of the Plan presented a formalistic approach for the downsizing of AMHI. I rejected this approach and noted that I would not sanction or approve an artificial reduction of AMHI's census or capacity to deliver services. I further noted that the reduction in AMHI's census is not an isolated event required by the Settlement Agreement. Rather, the Settlement Agreement requires that reduction of AMHI's census and admissions shall be undertaken as part of an overall effort to establish and maintain a comprehensive mental health system. I further stated my intention not to independently credit, for purposes of determining compliance with the Settlement Agreement, reductions in AMHI's census. Rather, I noted that credit towards compliance will only be given where such reductions are part of an overall effort to establish and maintain a comprehensive mental health system.

I also noted, however, that AMHI would not be required to maintain an artificially high census. I noted that the proper exercise of AMHI's authority to admit patients and discharge patients, when exercised in balance with the availability of community resources, may allow for a natural decrease in AMHI's census as more services become available.

The Department of Human Services' component of the Implementation Plan, at pages 28 & 29, outlines a plan to develop, recruit, fund, or support housing where other community services are reasonably available. One component of this plan is to develop housing resources for children. The Plaintiffs had requested that the Department of Human Services' class member wards have their needs met initially by December, 1992. The Department of Human Services objected, stating that it is not required by the Settlement Agreement to meet the needs of class member children in its custody on an accelerated basis prior to September 1, 1995 due to the closing of the Adolescent Unit, nor was it required to meet 100% of the needs of these children by September 1, 1995 in order to comply with the Settlement Agreement. In the Review, I expressed my reservations about deferring planning for class member children until 1995. As the Department of Mental Health and Mental Retardation noted at page 126 of its Implementation Plan, by July 1995 there will be a projected total of only 12 class member children. This compares to a total of 176 class member children as of August 1, 1991. I noted that if the Defendants' obligation is to develop a "comprehensive system of services" by September 1, 1995, they may have obligated themselves to do very little. I withheld approval of this component of DHS's Plan pending submission by the parties of their legal positions as to when the Defendants are obligated to develop a comprehensive mental health system for class member children. The Defendants have noted their objections to my observations.

General Conditions

Several specific conditions were attached to individual components of the Implementation Plan. They appear in the Review of the Plan in the discussion of each section to which they are applicable. In addition, general conditions were made applicable to the entire Implementation Plan. These are found in section VIII of the Review. One of these general conditions is discussed below.

The Defendants maintained that if they successfully complete the tasks associated with a given outcome that they should be deemed in compliance with the Settlement Agreement with respect to that outcome. I found that the Implementation Plan, in general, did not detail the comprehensive mental health system to be developed with sufficient particularity such that completion of the tasks established by the Defendants would necessarily result in the development of comprehensive mental health system as required by the Settlement Agreement. I found this principle to be so critical to ultimate compliance with the Agreement that I noted that should Defendants ultimately prevail on their legal claim with respect to this point, the Implementation Plan would be deemed disapproved.

B. Planning Proposals

The established mechanism for processing plans for the downsizing of the Augusta Mental Health Institute is the development of Concept Papers and Planning Proposals. Concept Papers are to filed by the Defendants when an idea conceiving the potential downsizing of AMHI is at an early stage of consideration. The Concept Paper is filed in order to allow the parties and the Master an opportunity to comment generally upon the contemplated activity. At such time as the concept takes on more detail, but still at an early stage of consideration, the Defendants are to file a Planning Proposal for review and approval.

In my last Report to the Court, I noted that the most significant failure of process was the Department of Mental Health and Mental Retardation's failure to communicate fully its activities regarding its plans. I noted in that Report that the Department commenced activities to downsize the Greenlaw Nursing Facility (by planning to move patients permanently and entering into a contract with a provider) prior to approval of its Planning Proposal. I also noted that the Department did not file its Planning Proposal to close the Adolescent Unit until after the determination had been made to close the Unit. I further noted in that Report that the Department had pledged to proceed cooperatively and to be more thorough in its communications. While the Department has been cooperative in certain areas, its

compliance with its requirement to file Concept Papers and Planning Proposals has been poor. The following exemplify this problem.

Inpatient services for adolescents at AMHI have been replaced by a program (the "Bridge" or "Adolescent Community Support Program") which provides for a variety of services, none of which require admission to the Augusta Mental Health Institute. The Department of Mental Health and Mental Retardation formed a specific proposal to terminate the Bridge Program and outlined its plan in a document entitled "Proposal to Downsize Adolescent Community Support Program at AMHI Homestead House" dated October 5, 1991. The document was not provided to the Plaintiffs or the Master, however, until November 21, 1991. Even then, the document was submitted only because counsel for the Department, upon discovery of the document, recognized the need to submit it. In response to my request that the Department not proceed with the "Bridge" downsizing plan, the Commissioner responded on November 25, 1991 that the Department intended to proceed with the downsizing plan as described in the October 5, 1991 Proposal. On November 25, 1991 the downsizing plan had not been approved. It was specifically disapproved in my Review of November 27, 1991. As late as December, 1991 the Commissioner defended the non-disclosure of the proposal to eliminate the Bridge Program, referring to the October 5, 1991 Proposal as an "in-house" document. (Notes of 12/4/91 meeting). On January 15, 1992 the Department filed a Planning Proposal.

During the Fall of 1991 the Department of Mental Health and Mental Retardation submitted to the Legislature a budget request seeking to deappropriate funds for four half-way houses at AMHI. These four half-way houses constitute the majority of the Alternative Living Program at AMHI. The Legislature authorized the deappropriation effective in the Spring of 1992. No Planning Proposal was filed regarding this significant downsizing effort.

The Department of Mental Health and Mental Retardation has also proposed, for the Legislature's consideration during the pending session, the elimination of 144.5 positions at AMHI which would eliminate all nursing facility beds at the Institute. In spite of this concerted activity, the Department has not filed a Concept Paper or Planning Proposal regarding this major initiative.

It is important to note that the Department's budget proposals are not taken lightly by the Legislature. The Department's requests for appropriations made during the first regular session of the 115th Legislature were uniformly accepted. Similarly, the Department's requests for deappropriation of funds made during the recent special session of the 115th Legislature resulted in the sought-after cuts. The combination of the Department's failure to submit, and have approved, its plans for downsizing AMHI, together with its ability to reduce bed capacity at AMHI through deappropriation of funds, turns the planning process upside down.

Instead of proposing a budget following sound, approved planning, the Department has proposed budget cuts forcing the downsizing of AMHI. This process is inconsistent with the most basic principles established by the Settlement Agreement, namely that the downsizing of AMHI is to be done in the context of the development of a comprehensive mental health system and in accordance with approvable plans; see Settlement Agreement paragraphs 31 & 35. This extremely serious problem is the subject matter of a specific recommendations outlined in section VI of this Report.

C. Progress Reported In Quarterly Reports

The Department of Mental Health and Mental Retardation and the Department of Human Services file Quarterly Reports outlining their progress under the Settlement Agreement. The Departments' Quarterly Reports of October, 1991 are briefly reviewed below.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

The Department's Report is presented under five broad headings which parallel the headings of the Department's Implementation Plan. The Department's Quarterly Report is frequently unclear in terms whether specifically identified tasks have been completed. I brought this concern to the attention of the Department and anticipate that the next Quarterly Report will be more informative. To the extent that compliance is indicated in the following summary, such compliance is based upon the Department's claims only. Recitation of those claims does not necessarily reflect my agreement with those claims at this time.

1. Individualized Support Planning

Individualized Support Plans are to be developed by a team consisting of the class member, the community support worker and other individuals with whom the class member has authorized the exchange of information and who are needed to ensure that the class

member's needs are adequately assessed and that appropriate recommendations are made. ISPs are to be based upon consideration of a broad array of class members' needs; services are to based upon those needs rather than on what services are currently available. This section also addresses the provision of community support workers who have major responsibilities for developing and implementing ISPs.

While the Department's Report does not clearly indicate chronological progress, it appears that the development of the ISP process and the determination of needed community support worker services are behind schedule. Additionally, patient assessments, originally due on 3/1/91 have been delayed until at least 1/1/92. These delays can have a major negative effect upon the development of other services because the information provided by these assessments and ISPs will be important in determining the future need for services. In my Report of May, 1991 I cited the failure to complete the patient assessments (due on 3/1/91) as a significant element of non-compliance with the Settlement Agreement.

The need for timely development of ISP's and related need-assessments affects the entire fabric of the Implementation Plan. If services are to be individually oriented, the development of services and programs must take into account the needs of individuals detailed in the ISPs and patient assessments.

By proceeding without clear determinations of individuals' needs the Defendants run the risk of recreating and reinforcing a system driven by what services happen to be available ("provider-oriented system") rather than a system driven by what services are needed ("consumer-oriented system").

2. Adult Community Mental Health Services

The Settlement Agreement emphasizes downsizing AMHI and creating a more community-based system of services. This section deals with those community-based services. These services include: community hospitalization, housing services, residential support services, crisis intervention resolution services, vocational services, treatment services, recreation/social/avocational opportunities, family support services, standards for community programs, special populations, and contract compliance.

A substantial portion of the tasks due under the Implementation Plan are reported as being late. On the average, overdue tasks are 4.5 months late, with some tasks being 7 months overdue because of their dependency on individual planning which, as outlined above, is running behind schedule. The community hospitalization component notes completion of only one of the 7 tasks due. The Department is requesting that a current 7 month delay in recreational/social/avocational opportunities be extended to a 13 month delay, again, a result of the delinquent patient

assessments. Implementation of the Plan for Special Populations is also substantially behind schedule (7 months). This is reportedly also due to its dependence on the late patient assessments.

Vocational services, family support services, contract compliance, and standards for community programs are all reported as being on time. There are no currently due tasks regarding crisis intervention and resolution services or treatment services. As discussed above in section II(A), the housing services and residential support services component of the Implementation Plan were largely disapproved. As previously noted, the Department will be submitting revisions of these components of the Implementation Plan.

3. Children's Community Mental Health Services

This section deals with those mental health services which a child, including an adolescent, needs in the community. These services include many service areas listed above under Adult Community Services. (The Department of Human Services Quarterly Report also concerns community services to children). The Department reports that it is largely progressing on schedule. As discussed in section II (A), portions of the Children's Community Mental Health Services Plan were disapproved. The Department filed, on January 15, 1992, a revision of its Children's Plan.

One of the more significant developments in community-based services is the addition, primarily through contracts with community agencies, of community support workers and crisis workers for children. The Department is currently recruiting and providing training for these positions. Most of the crisis workers have already been hired. This has occurred recently and therefore is not reflected in the October, 1991 Quarterly Report.

4. State Hospital Services

This large section deals with planning for reduction in patient census at, and the development and implementation of standards governing, the Augusta Mental Health Institute. As noted above in section II(A), the specific plan for reduction of AMHI's census was disapproved in my November, 1991 Review of the Implementation Plan. The rest of the State Hospital Services section regards standards which govern AMHI. The Department reports a significant completion rate for the approximately 90 tasks which were due to have been completed by October, 1991. Two items are overdue by 7 months or more due to the aforementioned lack of patient assessments. Standards governing the treatment of nursing home patients also appears to be mostly on schedule with only 2 of 14 tasks overdue by more than one month.

5. Mental Health System

This section covers system-level functions which are not direct client care, but which have a significant impact upon direct care. Included in this section are: client rights, substance abuse, training and resource development, public education, quality assurance and internal monitoring, and planning, budgeting and resource development.

The Department reports a very high completion rate in many areas, including the completion of tasks not yet due. The Department is currently proposing to file a Motion to Amend Settlement Agreement seeking an extension of deadlines for education and training requirements established by the Settlement Agreement. It is worth reiterating that, in the absence of the main planning tools, ISPs and patient assessments, needed to shape the new comprehensive mental health system, many tasks may need to be reviewed when actual individual needs are determined.

DEPARTMENT OF HUMAN SERVICES

The DHS Report covers activities in five broad areas for which the Department acknowledges responsibility under the terms of the Consent Decree: 1) coordination with other public and private agencies to develop a comprehensive system of mental health services; 2) assurance of appropriate services to class member children in its custody or guardianship; 3) assurance of

appropriate services to adult class members who are public wards; 4) coordination by the Bureau of Rehabilitation with the Bureau of Mental Health to develop a continuum of vocational services for class members; and 5) the exercise of regulatory responsibilities to assure that services provided in facilities licensed by DHS comply with the terms of the Consent Decree.

The Department of Human Services has completed a high percentage of the tasks due under the Implementation Plan as of October 21, 1991. Generally, the Department of Human Services appears to be in control of the procedures and plans necessary to implement its responsibilities. A major area of concern is DHS's ability to assure services to class member children in its care. This is compromised by the late development of the ISP process. Initiation of the ISP process for class member children is overdue. This will affect timely completion of future tasks. This problem is discussed in more detail in the section dealing with DMH&MR's Quarterly Reports. The Department also reports being behind schedule in its effort to assist DMH&MR to provide public education programs on mental health and the rights of consumers.

The clarity and forthrightness of the Quarterly Reports of the Department of Human Services is greatly appreciated. Its precise reporting and willingness to clearly state its progress creates a sense of the process working to create improved mental health system.

D. Public Input

In January, 1992 I held four public forums in the AMHI catchment area and solicited written comments regarding the Defendants' progress in implementing the Settlement Agreement. The comments covered a very wide range of issues. The President of the Greater Rumford Alliance for the Mentally Ill wrote about the total lack of basic community services in Oxford County, including the lack of twenty-four hour crisis services, case management services, housing opportunities and other services. She stated:

> Our citizens are hurting; some are taking their own lives. Our mental health needs have been grossly neglected by the State. We solicit your help to create some balance in the distribution of mental health funds and services.

Providers of services echoed these concerns. Nine clinical directors co-signed a letter stating that adequate alternative community programs have not been put into place and that "closing doors to existing services before opening the doors to new services will put the lives of our patients in jeopardy". Consumers expressed similar fears. The following statement was typical:

> I know for a fact that people are turned away every day. Do you know what it is like not to have anywhere to go in a crisis? How can the State go against the Consent Decree and also downsize AMHI down to 70 beds? Where will all these people go? Does anyone who isn't mentally ill, or have an ill relative, care?

There were some expressions of hope. One member of the Portland Coalition for the Psychiatrically Labeled stated, "as long as we have the Consent Decree, we have hope". Others noted that there are high quality services currently available, such as the crisis service run by the Bureau of Mental Health in York County, but that such services are in short supply.

Consumers, family members, and providers continue to note the lack of a broad base of services and opportunities including housing opportunities, vocational opportunities, crisis services, transportation, and hospital beds. Also noted was a lack of public education to help dispel the stigma associated with people who suffer from mental illness. Exemplifying this problem was the opposition in Portland to the development of a group home in the Parkside neighborhood. Others noted the lack of training and educational opportunities for individual practitioners in the mental health field.

Shelter workers were very concerned about the lack of adequate housing for all individuals and in particular for non-class members. It was stated that shelters can not accommodate some individuals with severe mental illness and that those people also can not gain ready access to hospital care. It was noted that even where there are existing services, some of those services are being eroded. For example, it was reported that the Department of Mental Health and Mental Retardation has not filled vacant positions in

the Portland crisis program. This is reported to have caused a diminution of services in the Portland area. It is also reported to have affected York County, because workers in York County have been required to help provide coverage in Portland.

Recent budget cuts were also the source of discouragement and dismay. Deappropriation of funds to run 4 half-way houses at AMHI was termed a "disaster". It was noted that the State had not prepared for the closing of the half-way houses through the development of alternative community-based resources. Consumers and providers complained about recent reductions in Medicaid funding. Several consumers complained about the co-pay requirements for many services. The president of the Maine Chapter of the American Psychiatric Association stated that these types of cuts may reduce access to services because more psychiatrists will decline to participate in the Medicaid Program.

III. PROCESSING AND RESOLUTION OF SPECIFIC ISSUES

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. In subsection A, Review by Subject Area - General, I review many of the issues resolved in the usual routine of negotiation. All references in this subsection are to the date of the relevant lawyers' meetings, with specific paragraph citations to the meeting notes. Any additional references are independently noted. In subsection B, Review by Subject Area - Resolutions of Issues Arising Pursuant to Implementation Plan Review, I highlight areas of resolution specifically linked to the process of reviewing the Defendants' Implementation Plan. Citations in this section are to my Review of November 27, 1991 unless otherwise specifically noted. In subsection C, Resolution of Disputes Pursuant to Paragraph 294 of the Settlement Agreement, I review a formal submission for dispute resolution because of the importance of issues involved. Other disputes submitted pursuant to paragraph 294, are pending resolution but are not discussed in this Report. While final resolution of the issues highlighted in this section have not been achieved they are included because of their importance. They are of particular importance because they involve AMHI's Admission Policy and the difficulty of accessing emergency services in the Tri-County area.

A. Review by Subject Area - General

Facilitating the development of an approvable Implementation Plan remained a high priority. Paragraph 35 of the Settlement Agreement requires that this Plan be submitted to the Court, counsel for the Plaintiffs and to the Master for his approval. Re-drafts of the Implementation Plan originally filed in January of 1991 were filed in June and August of 1991. In order to promote the development of the Plan, frequent meetings were held throughout the summer, in place of regularly scheduled lawyers' meetings, in order to focus the Defendants' energies on this important project. A final version of the Implementation Plan was filed by the Department of Human Services and the Department of Mental Health and Mental Retardation in October 1, 1991 for my review. In my formal Review of the Plan I required additional activity by the parties, including additional planning and the briefing of legal issues. It was agreed that all activities required by the Review prior to January 10, 1992 would be extended until January 10, 1992. (6/13/91, #1, 3; 10/10/91, #4; 10/24/91, #3; 11/4/91, #10; 12/13/91, #5).

Quarterly Reports

The filing of the Defendants' second Quarterly Reports, due July 1, 1991, was waived. This enabled the Defendants to focus on the development of the Implementation Plan. The filing of the

October 1, 1991 Quarterly Report was extended until October 21, 1991 and the January 1, 1992 Quarterly Report was extended until January 31, 1992. Thereafter, the filing of Quarterly Reports will be due on April 15, 1992 and July 1, 1992. The filing on July 1, 1992 will bring the Defendants back into schedule for the filing of the Quarterly Reports. (6/13/91, #1; 9/6/91, #4; 10/24/91, #1; 12/13/91, #7).

Rights Regulations

Both the child and adult "Rights Regulations" were given conditional approval. Ultimate approval is conditioned upon successful completion of the Administrative Procedure Act process and upon a determination that the regulations have maintained their consistency with the Settlement Agreement through the Administrative Procedure Act process. (5/16/91, #1).

Training Plans

The Department of Human Services proposed to provide training in a variety of areas prior to the time the Implementation Plan was approved. The Department's training proposal was approved. (5/16/91, #2; 6/31/91, #6).

Communications

It was agreed that I would contact the Assistant Attorney General representing Commissioner Glover prior to scheduled meetings with the Commissioner. (9/16/91, #1).

Expert Assistance

Obtaining expert assistance to assist in matters relating to implementation of the Settlement Agreement has been under discussion since approximately August, 1991. The Department of Mental Health and Mental Retardation is currently suggesting that expert assistance is needed in these areas: 1) assessment of mental health system capacity with respect to projected and recently identified community mental health program needs; 2) suggesting program models; and 3) assisting in the development of costs estimates. (9/6/91, #2; 10/10/91, #9; 11/21/91, #6; letter of 10/17/91, Rodman to Glover; memo of 11/5/91 Rodman to Counsel; letter of 12/2/91, Glover to Rodman; letter of 12/13/91 Rodman to Glover).

AMHI Reorganization

In the fall of 1991 AMHI underwent an internal reorganization. The key components of the reorganization included the creation of two community back-up divisions, each including an Admissions Unit

and a Pre-discharge Unit, and the creation of a Psycho-social Rehabilitation Unit. I had expressed some concerns regarding the consistency of the proposed reorganization with the Consent Decree, particularly concerning a retention of capacity to serve geriatric patients and adolescents. Superintendent Breslin addressed my concerns in a memorandum of August 9, 1991. Based upon that memorandum, I found that there was nothing inherently inconsistent with the Consent Decree in the reorganization proposal and that I was satisfied with the specific representations made about the Greenlaw Nursing facility and the Adolescent Unit. (9/6/91, #3; memorandum of 8/6/91, Rodman to Breslin; memorandum of 8/9/91, Breslin to Rodman).

Advocates Attending Hearings

The Rights of Recipients of Mental Health Services regulations require that advocates attend hearings as observers when a recipient refuses representation by counsel. The chief advocate sought to have that regulation made permissive rather than mandatory. All parties agreed that the proposed change in the regulations, if enacted, may constitute a diminution in the rights guaranteed to clients as specified in paragraph 29 of the Settlement Agreement. I wrote to the chief advocate informing him of the position of the parties. (9/6/91, #5).

Legal Status of the Office of Substance Abuse

The Office of Substance Abuse was a component of the Department of Human Services at the time the Consent Decree was signed, but is not now affiliated with any of the Defendants. We reached no agreement as to whether the Office should be formally added as a Defendant at this time. Assistant Attorney General Carmen Coulombe reported, however, that she will act a liaison for all matters concerning the Office of Substance Abuse which regard the Consent Decree. (10/10/91, #2; 10/24/91, #5).

Maine Health Care Finance Commission Testimony

I provided written testimony concerning two approved Certificate of Need applications under review by MHCFC for adjustment to the Certificate of Need Development account. The applications under review were Kennebec Valley Medical Center's proposal to establish a comprehensive medical detox, evaluation and treatment program and Southern Maine Medical Center's proposal to offer an alcohol/substance abuse program. We agreed that it would be appropriate for me to affirm to the Commission the need for the type of service capacity proposed by these two hospitals. (10/10/91, #5; 11/4/91, #9).

Contracts for Residential Treatment Facilities

We reviewed the fact that proposed contracts for certain residential treatment facilities contained language giving preference to AMHI and BMHI residents. We discussed whether there may be better predictors than residency at AMHI and BMHI for determining appropriateness of placement in residential treatment facilities. The Department of Mental Health and Mental Retardation agreed that it will discuss this issue further before signing final contracts. (10/10/91, #7; 10/24/91, #4).

Orders Restricting Disclosure

Pursuant to paragraph 292 of the Settlement Agreement, all reports submitted to the Master shall be made available to all parties to this action, subject to the right of Defendants to seek an order restricting disclosure to counsel of documents defined at 32 M.R.S.A. §3296 and 24 M.R.S.A. §2510 (3). We agreed to a specific system regarding access to the documents and authorization to disclose contents of the documents pending the issuance of an order by the Master. That process is outlined in an addendum to the meeting notes of 12/13/91. (11/4/91, #5; 12/13/91, #4).

Certificate of Need Process

Certificate of Need applications filed with the Department of Human Services by health-care providers for new or expanded services can have material significance regarding the implementation of the Settlement Agreement. Consequently, to ensure that all involved have an opportunity to review these applications, the Department of Human Services agreed to provide the Plaintiffs and the Master with all potentially relevant Certificate of Need applications, as they are filed. (11/21/91, #4).

B. Review by Subject Area - Resolutions of Issues Arising Pursuant to Implementation Plan

The process of reviewing the Implementation Plan embodied numerous resolutions of issues involved in the planning process. The areas of dispute resolution listed below are highlights among the many issues resolved. For a complete picture of issues resolved, and under consideration, reference should be made to Review of Implementation Plan submitted by the Department of Mental Health and Mental Retardation and the Department of Human Services, November 27, 1991, and to Defendants' Responses of January 10, 1992 to the Review.

Individualized Support Plans and Community Support Workers

I found that the schedule proposed by the DMH&MR for the development of ISPs and CSWs was too slow to meet the requirements of the Settlement Agreement. Consequently, I conditioned approval upon the Department's adopting the schedule under which all class members who wish to have ISPs and CSWs would have them by September 1, 1994 or upon adoption of an approved alternative schedule. DMH&MR agreed to this condition (Review, pages 3,5 DMH&MR Responses 1/10/92).

Housing

As requested by the Plaintiffs, I found that the models proposed by the Defendants for housing did not satisfy the requirements of the Settlement Agreement. Specifically, I found that the models did not demonstrate that they would be "flexible so that support and supervision may be increased or decreased as the class members' needs change and, to the extent possible, without requiring the class member to move to another setting" as is required by the Settlement Agreement at paragraph 32b. I also found that the models did not demonstrate that they could be accommodating of "varying levels of supported assistance to clients" as required by paragraph 93 of the Settlement Agreement. DMH&MR has agreed to submit additional plans. (Review, pages 10-13; DMH&MR Response, 1/10/92, page 1).

Residential Treatment Facilities

I found, as requested by the Defendants, that the Defendants may develop certain housing options in which the individual will not necessarily have the right to continue to reside as their needs change. This class of housing is identified under paragraph 93 of the Settlement Agreement as "out-of-home" housing. Issues as to whether any specifically identified "out-of-home" housing options are consistent with the Settlement Agreement, remain outstanding. (Review, pages 14-16; DMH&MR Response, 1/10/92, pages 1,2).

Obtaining Funding

Pursuant to paragraph 268 of the Settlement Agreement the Defendants shall prepare budget requests which are calculated to meet the terms of the Settlement Agreement and take all necessary steps and exert good faith efforts to obtain adequate funding from the Legislature. I found that this requirement does not describe the totality of efforts which Defendants must undertake to meet their requirements under the Settlement Agreement. I found that failure to receive legislative funding will not relieve Defendants of the obligation to undertake alternative efforts such as seeking alternative sources of funding and utilizing methods which do not require legislatively-appropriated funds. The Defendants agreed in part with this condition, stating that "failure to receive adequate funding does not necessarily relieve the Defendants of their obligations under the Settlement Agreement". (Review, page 22, 72, DMH&MR Response, 1/10/92, pages 3,4).

Draft Standards

The Plaintiffs requested that the Defendants be required to submit draft standards for community programs with their Quarterly Reports. I agreed with the Defendants that I did not have the authority to approve these draft regulations, but I found that I have the authority to require their being filed with the Quarterly Reports for the purpose of monitoring progress in compliance with

the Settlement Agreement. DMH&MR has agreed to this requirement. (Review, pages 24, 25; DMH&MR Response, 1/10/92).

Individualized Support Planning For Children

My review of the Children's Services section of the Implementation Plan raised questions regarding whether the Department of Human Services may directly provide community support worker services to children and whether community support worker services could be provided by more than a single individual. These issues were resolved by the Department of Human Services and the Department of Mental Health and Mental Retardation by reaching an agreement that the Bureau of Children With Special Needs of DMH&MR would provide community support worker services to class member children in DHS custody. (Memorandum of December 13, 1991, Coulombe to Rodman; Review, pages 27-29).

Staffing Ratios -- Reporting Requirements

The Plaintiffs requested that in the Department's reporting of staff/patient ratios specific information be included which would establish the reliability of the ratios. I determined that I have the authority to determine the status of progress regarding compliance with the Settlement Agreement and determined that such information should be included in the Defendants' Quarterly Reports. DMH&MR has agreed to provide this information. (Review,

pages 46-48; DMH&MR Response, 1/10/92).

Quality Assurance and Internal Monitoring

I noted that a lack of infrastructure in the Department of Mental Health and Mental Retardation is an impediment to the Department's developing a system of quality assurance and internal monitoring. I required, therefore, that DMH&MR design a system for quality assurance and internal monitoring which detailed a cohesive infrastructure for accomplishing these goals. DMH&MR has agreed to this. (Review, pages 53,54; DMH&MR Response, 1/10/92).

Regional Boards

The Plaintiffs requested that I not approve the section of the Implementation Plan dealing with planning, budgeting and resource development due to perceived problems in the development of Regional Boards. The Plaintiffs see the proposed Regional Boards as being transferees of interest with respect to powers now invested in the Department of Mental Health and Mental Retardation. I found that the Department had not taken necessary steps to assure that the creation of regional boards would be done in a manner which maintained responsibility for implementation of the Settlement Agreement I therefore disapproved that component of the Plan regarding the establishment of Regional Boards. As discussed

above in section II(A), the Department has indicated a willingness to take necessary steps to assure that responsibility is retained by the Department. (Review, pages 54,56; DMH&MR Response, 1/10/92, page 3).

C. Resolution of Disputes Pursuant to Paragraph 294 of the Settlement Agreement

On November 8, 1991 I held a conference regarding concerns which had arisen about increased pressure on the mental health system. In attendance at the conference were many providers of mental health services and Department of Mental Health and Mental Retardation employees who were experiencing, first hand, the current problems of people in need of mental health services. The conference included the Commissioner of Mental Health and Mental Retardation and the Superintendent of AMHI as well as counsel for both the Plaintiffs and Defendants. Conference participants reported several problems in the mental health system. Among them were that people were being held in emergency rooms for increasingly long periods, and in greater numbers and, at the same time, that access to involuntary beds had become increasingly more difficult. All participants in the conference who were polled responded that the current mental health system posed a substantial risk of serious harm to people with mental illness and that the risk was greater than it had been one year previously.

Subsequent to the conference I requested that the Department of Mental Health and Mental Retardation and the Superintendent of AMHI formulate proposals to deal with some of the identified problems. I also requested that AMHI clarify its Admission Policy

regarding its commitment to admit people who are in "dire emergencies". By letter of November 25, 1991 the Defendants responded that, although they were committed to addressing the problems identified in my memorandum of November 13, 1991, they would not comply with my request to submit a plan to implement short-term solutions. The Defendants' response did include a memorandum providing some clarification of AMHI's Admission Policy. That memorandum stated, among other things, that AMHI would go as far over the census limit as is necessary to accommodate all presenting "dire emergencies". The same policy was stated to apply to "priority patients".

Pursuant to the November 8, 1991 conference the Plaintiffs submitted a request, under paragraph 294 of the Settlement Agreement, that I convene a formal discussion regarding AMHI's Admission and Diversion Policy and other related matters. Among the goals identified by the Plaintiffs were: 1) that the admissions protocol be applied consistently and that patients who are appropriate for admission, in a state of emergency, and for whom no lesser restrictive alternatives are immediately available, be admitted to AMHI; 2) that steps be taken to find alternatives to the current emergency services delivery system in the Tri-County Area; and 3) that inter-hospital transfers (particularly between Jackson Brook Institute and AMHI) be minimized.

The Department of Mental Health and Mental Retardation has reported progress in dealing with these issues. The Commissioner reported that he would take a team of individuals to St. Mary's Hospital and the local Community Mental Health Center in December, 1991 to begin to explore options for the improvement of the local delivery of emergency mental health services in the Tri-County Area. The Commissioner's involvement in dealing directly with Tri-County providers is a significant and positive initiative. The Department also reported that it has a established system for identifying individuals who should be directly admitted to AMHI without first being diverted to other hospitals. This should assist in minimizing unnecessary inter-hospital transfers.

IV. FUNDING

A. Authorized Budgets

The 115th Maine Legislature, at its first regular session, appropriated the funding requested by the Department of Mental Health and Mental Retardation and the Department of Human Services for implementation of the Settlement Agreement. An outline of the requested funding appears in my prior Report to the Court of May 31, 1991. The DMH&MR's funding for Consent Decree related purposes for fiscal years '92 and '93 was approximately 14.5 million dollars. Areas funded included housing, residential support services, vocational support, community support worker services, crisis intervention and resolution services, and improvements at AMHI. Some funds were also appropriated to the Department of Human Services for Consent Decree related purposes. The largest appropriation was for vocational services in the amount of approximately 1.6 million dollars for fiscal years '92 and '93.

The first regular session also ended with some significant cuts in areas of significance to the Consent Decree. Through the elimination of 10.5 positions for fiscal year '93 (15 positions in fiscal year '92) the Department of Mental Health and Mental Retardation suffered a net loss of administrative personnel. The Department had previously noted that the elimination of these

positions would seriously effect its ability to manage its work load. The Augusta Mental Health Institute lost a total of 131.5 positions for fiscal year '93 (91.5 positions in fiscal year '92). (The Bangor Mental Health Institute lost 56 positions for fiscal year '93, including 47 positions in fiscal year '92). In addition, across the board cuts will affect mental health programs. One percent will be deducted from all accounts in fiscal year '92 and two percent from all accounts in fiscal year '93. On balance, the first regular session produced significant funds to initiate implementation of the Settlement Agreement.

A fall 1991 special session of the 115th Legislature resulted in additional cuts. The Bureau of Elder and Adult Services of the Department of Human Services lost 4.5 positions through deappropriation of funds previously appropriated for Consent Decree related purposes. In addition, Medicaid funding was reduced, through a requirement of a co-payment for Medicaid ambulatory, psychologist and substance abuse services. The co-payment requirement is an across-the-board reduction in Medicaid payments to providers which will affect class members among other Medicaid beneficiaries. The total deappropriation is $334,492.

Significant cuts were also made in the Department of Mental Health and Mental Retardation's budget. DMH&MR lost an additional 4 administrative positions, including the previously authorized Director of Management Information Services position. Also lost

was an additional $180,000 which had been appropriated as part of the Management Information System which is a specific component of the Implementation Plan for the Settlement Agreement. The Augusta Mental Health Institute also suffered additional personnel losses from deappropriation for 25 positions. Seventeen and one-half of these positions are specifically linked to the demise of the majority of AMHI's Alternative Living Program, a series of "halfway houses" on the grounds of AMHI. (Significant cuts were also made at the Bangor Mental Health Institute where 18.5 positions were eliminated).

The cuts resulting from the special session are of particular concern. First, the cuts at AMHI, and in particular the elimination of almost the entire Alternative Living Program, were not part of the overall plan for the downsizing of AMHI. Second, in tandem with the unplanned for downsizing of AMHI, was the reduction in funding for community-based services embodied in the co-payment requirement for Medicaid services. This combination of events, led me to make a Finding of Non-Compliance with the Settlement Agreement. The Finding of Non-Compliance was directed towards both the Department of Mental Health and Mental Retardation and the Department of Human Services for their activities in proposing and/or promoting these budget cuts.

Paragraph 31 of the Settlement Agreement states that improvements in the quality of care to class members can only be

achieved by reducing AMHI's census and admissions, reallocating AMHI's resources and increasing community services as alternatives to hospitalization. The simultaneous reduction in services at AMHI and reduction in payments to community-based providers is inconsistent with this principle. Among the provisions of the Settlement Agreement which I found to have been violated by the Departments' activities with respect to these budget cuts included; paragraph 33 which requires DMH&MR to establish a comprehensive mental health system in accordance with the terms and schedule set out in the Settlement Agreement; paragraph 30a which requires DHS to design, recruit, develop and fund programs which are needed for a comprehensive mental health system which receive departmental funding or are subject to departmental oversight; paragraph 34b which requires DHS to institute appropriate mechanism to assure that mental health services receive maximum federal financial participation and; paragraph 268 which requires the Defendants to prepare budget requests which are calculated to meet the terms of the Settlement Agreement and to take all necessary steps and exert good faith efforts to obtain adequate funding from the Legislature. The Defendants have filed formal objections to my findings.

These cuts highlight the need to rationalize the budget process with the planning requirements of the Settlement Agreement. Specific recommendations in this regard appear in this Report at section VI.

B. Pending Budgets

Budget cuts proposed for consideration by the 115th Legislature at its second regular session are potentially devastating and represent a major retreat in the State's commitment to persons with mental illness. Included in the proposed cuts is a reduction of almost 1.4 million dollars for community services. The Department of Mental Health and Mental Retardation's proposed budget indicates that this cut will have a direct impact on two to three thousand persons and will seriously jeopardize its commitment to the Settlement Agreement. These cuts will leave approximately two thousand or more persons who do not have Medicaid, including working poor, families and children at risk, without access to publicly supported counseling services. The cuts will also leave nearly ninety adults with psychiatric disabilities without the specialized rehabilitative services they need.

Other proposed cuts include further reductions in substance abuse services. The Department of Mental Health and Mental Retardation notes that this reduction will have a drastic impact on services to dually-diagnosed individuals, including class members. Also proposed for elimination is the group home at the Bath Children's Home; the deappropriation of approximately $218,000 will eliminate this services for 8 girls between the ages of 10 and 16, many of whom have histories of emotional, physical and sexual abuse. Referrals for the group home have traditionally come from

the Department of Human Services, emergency shelters and mental health agencies.

The Department of Mental Health and Mental Retardation is also proposing to eliminate the services it provides to nursing home patients at AMHI. This is to be achieved by eliminating 144.5 positions. As discussed in section II(B) of this Report, the Department has neither filed, nor had approved, any plans for this elimination of its nursing facility beds.

The Department, in its memorandum accompanying the budget document, stated that it will be requesting a revision of the Implementation Plan "to the extent that budget reductions make such revisions necessary". Additionally, the Department states that it may seek to amend the Consent Decree to enlarge the time for coming into substantial compliance with its terms.

In my first Report to the Court of May 1991 I identified two critical components in implementing the Settlement Agreement. First was that the development of community-based services must proceed vigorously and without delay. The second was that the downsizing of the Augusta Mental Health Institute must be carefully linked with the development of a comprehensive mental health system that meets the needs of people with mental illness. I noted that efforts to create such a system could be undermined if premature downsizing of AMHI is allowed to destabilize the system during the

transition to a more community-based system. Recently enacted budget cuts, together with the proposed budget cuts, will have the effect of simultaneously downsizing AMHI and cutting community-based services for children and adults. The current community-based system of services for individuals with mental illness is inadequate; this system needs to be strengthened, not cut. I believe that the impact of the simultaneous downsizing of AMHI and reduction in community-based services will result in additional widespread injury to persons with mental illness, including class members.

V. OBSERVATIONS REGARDING THE AUGUSTA MENTAL HEALTH INSTITUTE

Census Management

The census at AMHI has continued to trend downward. In my last Report to the Court I noted that the census in April of 1991 was 276. The single largest monthly decrease in census occurred between April and May, 1991. The May census was 258. I believe that this substantial drop was due to the approved transfer of 17 licensed beds, and 17 nursing home residents, from the Greenlaw Nursing Facility at AMHI to Gorham Manor in Gorham, Maine. AMHI's census for November 1991 was 244. Factoring out the 17 transferred patients, the rate of census decline has been slower over the past one-half year than it had been since the adoption of the Diversion Policy in approximately March, 1989. Generally stated, the small monthly declines in census are a result of the fact that discharges slightly exceed admissions on a monthly basis. The reduction of 17 licensed beds in the nursing facility at AMHI remains the only reduction in bed capacity which I have approved at AMHI since I began my duties in November, 1990.

From a statistical perspective, two significant trends emerge which may relate the decrease in the rate of census decline. One is that the short-term trend shows there to be fewer discharges on a monthly basis and the other is that there is an increase in the average length of stay (LOS) of AMHI patients. I am not aware of

any scientific evaluation of these phenomena, however, at least two factors may be operative. One is that the average patient at AMHI may be more chronically ill as AMHI continues to screen individuals for admission carefully. Another factor may be the lack of community-based resources due to their saturation through the absorption of individuals who can no longer gain access to AMHI. Related statistics involve the community length of stay. (The time which individuals reside in their community before returning to AMHI). Short-term trends indicate that people who are returning to AMHI after having been in the community only three days or less, and individuals returning to AMHI having been in the community for only thirty days or less, is decreasing.

AMHI's Admissions Policy is an important factor in determining whether an individual will be admitted to the Institute. In my Report to the Court of last May I indicated that I had been encouraging AMHI to review its Admissions Policy. While this process has been somewhat slow and uneven, the November, 1991 Conference and subsequent request by the Plaintiffs for dispute resolution regarding the Admissions Policy (discussed in this Report at section III(C)) has helped focus upon this issue with positive results.

General Conditions of Operation

Among the significant events of the past half year was the notification by the Civil Rights Division of the United States Department of Justice that it had closed its investigation at the Augusta Mental Health Institute and the Bangor Mental Health Institute. By letter dated June 12, 1991, the Department of Justice stated that it had observed a substantial change for the better and the conditions at both AMHI and BMHI. The Department of Justice noted that corrective actions had been taken to improve the physical plant and to ensure resident safety. Quality assurance procedures were also found to have been implemented and suicide identification and management was found to have become a priority. The Department of Justice found the Settlement Agreement to be of specific importance, noting that the Agreement requires a level of commitment that the Department of Justice believes will ensure that conditions at AMHI will continue to improve. Additionally, JCAHO reviewed the operations at AMHI on November 14 and 15, 1991. JCAHO's Report has not yet been issued, but I suspect that it will also indicate material improvements at AMHI.

Among the areas of improvement which are somewhat statistically identifiable are the decrease in use of seclusion and restraint. Both the absolute number of restrictive restraint episodes and the total number of restrictive restraint hours are

down significantly from just the previous year. Also, use of seclusion ("SRC") has markedly decreased both in the total number of episodes and total number of hours. The decrease in the use of both seclusion and restraint exceeds that which would be anticipated based solely upon the decrease in AMHI census over the past two years.

The work environment at AMHI has been extremely stressful. Layoffs, forced leaves, and the threat of massive "privatization" have been disquieting factors in the AMHI work environment. At the November 8, 1991 Conference, AMHI's Superintendent termed the staffing "adequate". The Settlement Agreement sets certain required staff/patient ratios, but those ratios are not required to be met until September 1, 1992. Two psychiatrist at AMHI will be resigning shortly. The current work environment will make it extremely challenging to find permanent replacements.

One affirmative action has been the abandonment of plans to perform "on-site" privatization at AMHI. The Department of Mental Health and Mental Retardation reported in December, 1991 that active consideration is no longer being given to abandoning the State's operation of the Augusta Mental Health Institute. This fact has been beneficial in establishing a somewhat more stable work environment. With respect to accessing and developing resources "off-site", it has been reported to me, mostly from sources other than the Defendants, that this has been the subject

of active consideration with regard to the nursing facility population at AMHI. As noted elsewhere in this Report the Defendants have not submitted proposals for any downsizing regarding this population. I will continue to pursue this issue to try to ensure that any downsizing occurs within the planning parameters of, and in accordance with the goals of, the Settlement Agreement.

VI. RECOMMENDATION

I am recommending that the Court issue an order pursuant to paragraph 12 of the Settlement Agreement requiring:

1) that the Department of Mental Health and Mental Retardation file Planning Proposals in a timely and meaningful fashion, and that budget requests, whether seeking appropriation, deappropriation or reallocation of funds, which relate to the subject matter of the Planning Proposal, be fully described in the Planning Proposal which shall be filed no less than 45 days before submission of the budget request;

2) that the Department of Mental Health and Mental Retardation refrain from all irrevocable acts, such as entering into binding contracts, in furtherance of any downsizing initiatives prior to the Master's approval of its Planning Proposal;

3) that the Department of Mental Health and Mental Retardation immediately seek reappropriation of funds for running all half-way houses at AMHI for which Planning Proposals have not been approved;

4) that the Defendants, when submitting budget requests to the governor and to the budget office, and when otherwise communicating with the Legislature regarding budget requests, shall take actions necessary to assure that the Legislature is fully informed as to the impact the budget request will have on implementation of the Settlement Agreement, including specific disclosure regarding the status of any relevant Planning Proposals.

The specific facts regarding the planning and budgeting problems which underline this recommendation, and references to all relevant documents, are found in this Report, Report to the Court of May 31, 1991, and Recommendation to the Court of April 25, 1991, regarding the transfer of residents from the Greenlaw Nursing Facility.