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

February 12, 1993

INDEX

I. INTRODUCTION

This is my third Report to the Court. In previous reports I have highlighted problems regarding the lack of timely and adequate planning, the slowness and inadequacy of the development of needed resources, and related problems associated with the downsizing of AMHI. These problems have persisted. They are currently overshadowed, however, by an ominous program of service cuts which will dismantle the already weak foundation of Maine's mental health system. The Settlement Agreement requires that the downsizing of AMHI be accompanied by increasing community services as alternatives to hospitalization. Instead, community services are under attack.

In Section II, I review proposed budgets cuts affecting the mental health system. I conclude that the budget proposals, if enacted, would create a grim environment for people with mental illnesses. The budget, as currently structured, is a major retreat from the State's commitment to this population. Among the most devastating cuts is the proposed deappropriation of funding for community mental health services. Seven hundred and fifty thousand dollars is proposed to be eliminated for the remainder of the fiscal year 1993 and a reduction of over 2.4 million dollars is proposed for fiscal years 1994 and 1995. The Department of Mental Health and Mental Retardation projects that these reductions will result in the worsening of overcrowding in emergency rooms of local hospitals, increases in hospitalizations, suicides, and

homelessness, an increase in numbers of involuntarily committed individuals, and an increase in numbers of persons with mental illnesses being inappropriately placed in correctional facilities. Proposed cuts in DMH&MR's budget would also place children in jeopardy. Cuts of $744,330 and $771,697 are proposed for FY '94 and FY '95, respectively.

Deep cuts in services and the entire elimination of programs are proposed for the Department of Human Services. Many of these cuts would negatively affect class members. Sharp reductions in Medicaid services, general assistance, AFDC, adult and elder services, the low-cost drug program for the elderly, and elimination of the Maine Health Program are among the proposed cuts. Among the most draconian of the cuts is the proposal to limit individuals to a maximum of two prescription medications per month under the Medicaid Program.

The Department of Human Services anticipates that these cuts will create a complex scenario of cost shifting as access to the delivery system is drastically reduced for the adult population. DHS further predicts that as a result of these cuts the cost of emergency and acute care will rise and that persons dependant upon medication may relapse into an acute care state and will require an inpatient admission.

DHS also projects that enormous pressure will be placed on hospital emergency rooms and out-patient units. The Department also notes

that without personal-care services, many eligible persons may deteriorate to a condition which requires nursing home care.

It should be noted that the above assessments made by both the Department of Mental Health and Mental Retardation and the Department of Human Services concern their own budgets. The combined impact of these cuts would be an unconscionable assault on people with mental illness.

In Section III, I summarize the public's input presented in conjunction with the five public forums I sponsored in the fall of 1992. The forums were marked by an increase in the anger and disappointment of consumers, family members and providers. One consumer summarized the situation in a nutshell, "are you hearing -- consumers are experiencing no improvement". Members of the public continue to identify long lists of needed services. It seemed to be a universal observation that the mental health system is on "overload". Complaints regarding the current mental health system covered a wide variety of issues; all commentators found the current system highly inadequate and the proposed cuts in services to be unthinkable. I am deeply concerned about the rising level of despair that I sensed.

In Section IV of this Report I undertake a fairly intensive review of the Defendants' progress in implementing the Implementation Plan. The primary focus is upon the Department of Mental Health and Mental Retardation, including AMHI. In this section I note

that the Department's documentation of compliance with the Implementation Plan has been highly uneven and, overall, unsatisfactory. I have noted in the past that the Implementation Plan is still largely a "plan to plan". Unfortunately, the Department is severely behind in its planning in several critical areas including housing, residential and support services, and crisis intervention and resolution services. The failure to complete the assessments of patients at AMHI remains and impediment to sound planning. The development of the individualized support planning process (ISP) is also far behind schedule and is an impediment to sound planning and resource development.

I note in Section IV that progress in developing community-based hospital options, particularly for people in need of involuntary hospitalization, is proceeding very slowly. With the exception of the new program which appears to be ready to begin at the Kennebec Valley Medical Center in Augusta, community hospitalization options for involuntarily committed individuals are not materializing. AMHI and the Jackson Brook Institute (JBI) remain the mainstays for involuntary hospitalization.

I also note in Section IV that some services have been developed. Transitional residential beds for children have been added, as have community support workers and crisis workers. At a number of places in this Report I note that members of the public have raised some concerns regarding the overall effectiveness of these new services. For adults a limited number of housing/residential

facility options have been made available. Additionally, approximately 22 community support workers (CSWs) have been added state-wide, although at this point they appear not to be fulfilling all the responsibilities required of CSWs by the Settlement Agreement. Some progress has been made in areas of vocational services and family support services, although none of the services are being developed in accordance with existing timetables.

I review in Section IV the extensive performance requirements of AMHI. Improvements in certain areas continue to be noted; there are physical plant improvements, improvements regarding seclusion, restraint, and protective devices, and reported compliance with staff/patient ratios for general medicine physicians, nurses, social workers, and mental health workers. Staffing ratios are not being met for psychiatrists, psychologists, and recreational/occupational therapists/aides. I note that there are many areas in AMHI's plan that have not been implemented. I also note that in spite of these problems, however, it is my overall impression that AMHI has significantly improved and is moving toward the provision of treatment which responds to the needs of individuals and away from the provision of mere custodial care.

I also note in Section IV that the Department of Mental Health and Mental Retardation is severely deficient in the areas of quality assurance and internal monitoring as well as planning, budgeting, and resource development. These areas require the determination of the system and resources necessary to monitor agencies providing

mental health services and obtaining the resources to implement the system. They also require upgrading the Implementation Plan through the assessment of information based upon ISP data. Failure to have implemented these areas severely limits DMH&MR's infrastructure and deprives it of the mechanisms otherwise necessary to implement the Implementation Plan.

In Section V, I review two Planning Proposals which were filed during the past year -- the Alternative Living Program Planning Proposal and the Nursing Facility Planning Proposal. In summarizing my Review of the Alternative Living Program Planning Proposal, I note that I did not approve the Proposal. Among the reasons for not approving the Proposal were that it did not adequately deal with issues regarding hospitalization, crisis services, and housing and residential support services. In spite of my disapproval of the Proposal, the Alternative Living Program at AMHI was closed pursuant to a deappropriation of funds.

I approved the Nursing Facility Planning Proposal. Under that Proposal, actual replacements for nursing facility beds at AMHI would start to become available in the spring of 1994. Approval of the Planning Proposal was given with the recognition that additional planning may be required to meet the needs of class members for nursing care, geriatric care, or care associated with the end stages of degenerative diseases.

In Section VI, I review the processing and resolution of specific issues. Among the items discussed is the Court's Order of July 8, 1992. I note in Section VI(C) that I sought the Court Order because the Department of Mental Health and Mental Retardation had:

1) failed to abide by existing agreements and requirements for downsizing AMHI and developing a comprehensive mental health system;

2) consistently filed plans which were extremely late;

3) proceeded to terminate bed capacity at AMHI when its plans to do so had been specifically disapproved;

4) phased out beds at AMHI without filing any plans and;

5) terminated services at AMHI before alternative services had been made available.

As I note in this section, the parties agreed to the entry of the Court's Order. The Order, which is Attachment #1 to this Report, requires that:

-- Planning Proposals be filed prior to the initiation of any substantial activity in furtherance of plans to reduce bed capacity at AMHI;

-- the Defendants refrain from all irrevocable acts which would diminish DMH&MR's bed capacity prior to the Master's approval of a Planning Proposal relating to the downsizing;

-- the Defendants fully inform the Legislature regarding the impact of budget requests upon the Settlement Agreement, including specific disclosure of the status of any relevant Planning Proposals.

In Section VII, I review census management and general conditions of operation at AMHI. AMHI's census continues to decline. The average census dropped from 294 in January 1991 to 230 in January 1992 to approximately 215 by November 1992. AMHI continues to rely very heavily upon the Jackson Brook Institute in order to divert individuals away from admission to AMHI. For 1992, the average number of people diverted from AMHI to JBI was 58 per month. This is very close to the average number of people admitted to AMHI per month. For fiscal year 1992, $1,176,018 was expended on diverting individuals to hospitals other than AMHI. Bed availability at both AMHI and JBI is frequently limited.

I reported in my last Report to the Court that the work environment at AMHI had been extremely stressful. Unfortunately, this condition persists. Furlough days continue to have a negative impact upon patients and staff. Morale appears to remain low.

In Section VIII, I review issues regarding staffing at the Department of Mental Health and Mental Retardation. In October 1992 I undertook an extensive inquiry of the Department regarding the adequacy of its staffing. The inquiry was stimulated by my preliminary observations regarding the Department's apparent inadequate capacity to perform basic work. The Department identified deficiencies relating to the areas of Residential Support Services, Management Information System Services, Crisis Intervention and Resolution Services, Individualized Support

Planning Services, Community Hospital Services, and State Hospital Services.

I note in Section VI that the current fiscal strategy appears to one of maintaining vacant positions for long periods to generate "savings", eliminating needed positions, and not creating needed positions. In this section I expressed my opinion that a comprehensive mental health system will require highly coordinated mechanisms for assuring quality of services and promoting the necessary planning and development of resources. I conclude that I do not see the current fiscal strategy as resulting in any genuine cost savings. Rather, inefficient, uncoordinated, and deficient services are likely to result in greater overall costs to the mental health system.

II. FUNDING

Budget documents have been submitted to the 116th Legislature dealing with funding for the remainder of fiscal year 1993 (ending June 30, 1993) and for fiscal years 1994 and 1995 (July 1, 1993 through June 30, 1995). These budget proposals, if enacted, would create a grim environment for people with mental illnesses. These budgets, as currently structured, are a major retreat from the State's commitment to this population.

The Department of Mental Health and Mental Retardation has developed a recommended "Part II" budget which seeks additional resources. It would help alleviate the injury necessarily attendant to the proposed budgets. The Part II budget, however, has not been submitted to the Legislature by the Governor. Nonetheless, it is also reviewed below. Facts and conclusions reported upon below and attributed to DMH&MR and DHS are from the proposed budgets submitted to the Legislature or from precursory documents submitted to the Bureau of the Budget.

A. DMH&MR FY '93 Emergency Supplemental Budget

Currently the majority of budget initiatives for the remainder of FY '93 are included in L.D. No. 27. Standing out among the proposed cuts is the deappropriation of $750,000 through an "across-the-board" reduction in community mental health services

and delaying start up of a group home. It also includes defunding contracted services for the development of the ISP process, a critical component of the Settlement Agreement. The Department foresees the following impact of these cuts:

> Based on input from local communities, these reductions would result in the following: worsening of over-crowding in emergency rooms of local hospitals; increases in hospitalizations, suicides, and homelessness; loss of ability to meet licensing standards; inability to meet the mandates of the Consent Decree including implementation of ISP; increase in numbers of involuntary commitments; straining of already reduced administrative levels to the point of disfunction; severe reduction in services to rural areas; elimination of services to special populations and minority groups; and increased numbers of persons with mental illnesses inappropriately placed in correctional facilities.

In addition to these cuts, the Department has imposed a freeze on nursing home admissions at both the Augusta Mental Health and the Bangor Mental Health Institutes in order to save an additional $500,000. The Department notes in its October 26, 1992 letter that much of the projected shortfall is directly related to delays in reducing the nursing home census at AMHI and BMHI. Stated otherwise, the shortfall is in large part directly related to the premature defunding of the nursing facility beds at the State's Institutes. The Supplemental Budget seeks $1,845,000 largely to fund nursing facility services at AMHI for the remainder of FY '93. This issue is also discussed in Section V(B) of this Report, Nursing Facility Planning Proposal.

B. **DHS FY '93 Emergency Supplemental Budget**

The supplemental budget for the Department of Human Services proposes massive cuts in a broad variety of programs. Most notable is the proposed deappropriation of funds for prescription drugs. Under this proposal, Medicaid support for prescription drugs for adults, except when in certain institutions, would be limited to no more than two prescriptions per month.

I am not aware of any precise statistics maintained regarding the number of class members who are Medicaid-eligible. It is reasonable to assume, however, that the vast majority of class members are Medicaid-eligible. The loss of medications would in all likelihood have cataclysmic consequences. It is hard to imagine any single area of service of which the loss would be more devastating than the termination of medications for individuals suffering from severe mental illnesses. This cut is further discussed regarding DHS's budget for FY '94/'95 at Section II(D). I recently testified before the Appropriations Committee of the 116th Legislature concerning the severity of this proposed cut and the severity of the proposed cuts for community-based services in DMH&MR's proposed budget.

C. **DMH&MR, FY 1994/1995 Budget**

The FY '94/'95 budget (State of Maine Budget Document, 1994 - 1995, submitted by Governor McKernan, January 1993) seeks reductions of

approximately 13 million dollars in FY '94 and 15.8 million dollars in FY '95. A memorandum of October 1, 1992 from Associate Commissioner Ronald Martel to John Nicholas, State Budget Officer, states that these cuts require "significant and dramatic reductions" which in turn require "drastic measures". The Department's budget for FY '94/'95 is reviewed below by subject area.

The budget seeks to reduce state-wide service levels for community mental health services by 5% ($2,414,179 in FY '94; $2,438,041 in FY '95). These cuts would result in services being denied to over 1500 individuals. This would be in addition to cuts in services to 2000 people as a result of previous deappropriation of funds during the past biennium for community mental health services. It is projected that approximately 100 jobs in communities will be lost as a result of these cuts. Additional job losses for working consumers will result from the elimination of vocational and other mental health support services which currently help consumers to maintain jobs. The Department further projects that the increased strain that this will place on consumers and their families will result in the incarceration of individuals or the need for institutionalization that would otherwise be unnecessary.

The Department also seeks to cut services for children in the amounts of $744,330 in FY '94 and $771,697 in FY '95. The majority of cuts would affect adolescents who were previously hospitalized at AMHI, at risk of hospitalization, in state custody or at risk of

being placed in state custody. These cuts will affect approximately 12 severely emotionally disturbed adolescents who will not receive community-based residential services. If these children are otherwise to be served, the state will be forced to make out-of-state placements or pay for inpatient hospitalization.

The remainder of the youth-targeted cuts involve withdrawing DMH&MR support from an inter-departmental funding consortium involving Merry Meeting Farm Group Home (Lincoln County) and Powell Memorial Center (Aroostook County). These programs assist youths on adjudicated status or receiving services to avoid commitment to the Maine Youth Center and/or DHS custody. The other cut involves the termination of funding to Northern Maine General Hospital for its crisis stabilization services, thereby eliminating crisis stabilization capacity for children in northern Maine.

The DMH&MR budget also seeks to reduce its community training initiatives by 50% ($217,782 in FY '94; $150,967 in FY '95). This would include the elimination of geriatric training programs for nursing and boarding homes. This reduction is particularly untimely in light of the Department's program to place its nursing facility patients in community-based nursing facilities.

Additional reductions are planned for vocational and day services ($182,588 in FY '94; $210,086 in FY '95). Included in this proposal is the elimination of a case management program for deaf persons with mental illness and the elimination of vocational

opportunities. The elimination of these meaningful activities is seen as increasing the potential for avoidable involvement with law enforcement and/or psychiatric hospitalization.

The Department seeks to eliminate 4 administrative positions ($202,805 in FY '94; $195,241 in FY '95). Two of these positions, Programmer and Analyst, were recently authorized as part of a supplemental request to meet Consent Decree requirements to develop a management information system. The loss of these positions will seriously affect the Department's ability to monitor client/patient services and to plan for the development of services which have proven effective.

Also sought is the elimination of hearing officer services to hear consumer grievances. The Department reports that this would undermine its measures to protect the rights of recipients of mental health services.

Proposed reductions would eliminate 25% of the family respite services administered by the Alliance for the Mentally Ill of Maine. These funds provide respite services for families needing reprieve from caring for consumers. Respite permits families to continue to care for family members, relieving strain on alternatives such as hospitals, shelters, law enforcement and general assistance. ($50,000 in FY '94; $50,000 in FY '95).

The Department seeks to cut contracted professional services for AMHI by reducing its psychiatric staff and nursing staff. (These cuts comprise the majority of cuts of $250,116 in FY '94 and $228,831 in FY '95). AMHI is currently not meeting its psychiatrist/patient ratios. In addition to violating Consent Decree requirements, psychiatric staff reduction could also jeopardize Medicare certification and Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) certification. Reductions in contracted nursing coverage will stress the Institute during the most difficult to fill shifts, evenings and nights.

D. Department of Human Services' FY '94/'95 Budget

One of the largest single categories of deappropriation sought by DHS is the elimination of some Medicaid eligibility categories and reductions in services and payments (Medical Care-Payments to providers). Total proposed service cuts for FY '94, not including nursing facilities, would be $100,068,556 (deappropriation of state funds, $38,106,106, plus deallocation of federal matching funds, $61,962,450), and $109,548,595 for fiscal year 1995 (deappropriation of State funds, $41,716,105, plus deallocation of federal match, $67,832,490). Included in these cuts is the reduction of medication availability. A maximum of 2 prescription medications per month would be reimbursable.

DHS anticipates that these cuts will create a complex scenario of cost shifting as access to the delivery system is drastically reduced and altered for the adult population. The Department further predicts that as a result of these cuts the cost of emergency and acute care will rise and that persons dependant upon medication may relapse into an acute care state and require inpatient admission. It also projects that enormous pressure will be placed on hospital emergency rooms and out-patient units and that there will be pressure on hospitals to supply drugs and medical equipment and supplies. The Department also notes that without personal care services, many eligible persons may deteriorate to a condition which requires nursing home care.

In addition, the Department seeks to fully deappropriate the General Assistance Program. Expenditure reductions would be $8,984,089 in both fiscal years 1994 and 1995. The elimination of this program would disproportionately affect persons suffering from severe and prolonged mental illnesses. The General Assistance Program serves low income individuals and families who are ineligible for other welfare programs or whose income is insufficient to meet expenses for basic necessities such as food, shelter, and medical treatment. The Department projects that the elimination of the General Assistance Program will be likely to increase the number of homeless people in Maine. It is also projects the worsening of the desperate financial situation of persons whose ability to provide for themselves financially is marginal at best.

The Budget proposal also seeks to deappropriate funds by eliminating special needs payments and reducing AFDC benefits. $4,800,000 would be deappropriated in fiscal years 1994 and 1995 with the additional loss of $7,109,042 per year in the federal match. The Department concludes that these cuts will increase the number of persons who are homeless or involved in other service systems.

Also proposed is the deappropriation of funds for several programs operated or funded by the Department's Bureau of Adult and Elder Services. These cuts, totalling $220,695 in FY '94 and $187,401 in FY '95, include losses of $100,000 per year for adult protective Consent Decree case services. This represents a 50% reduction in funds available to implement provisions of the Settlement Agreement which affect adult protective services.

In addition, the following cuts may affect persons suffering from severe and prolonged mental illnesses, including class members:

* reduction of the low-cost drug program for the elderly (Drugs for Maine's Elderly) $1,400,000 in FY '94 and $1,500,000 in FY '95;

* reduction in funds for nursing facilities, (intermediate care payments for providers), $41,400,000 in FY '94 and $57,300,000 in FY '95 and associated deallocation of federal matching funds yielding additional reductions of $61,962,450 in FY '94 and $67,832,490 in FY '95;

* elimination of state funds for the Maine Health Program which provides Medicaid coverage to approximately 2,700 otherwise uninsured individuals, $3,881,000 in FY '94 and $3,925,000 in FY '95.

Poverty tends to follow mental illnesses. Finding and maintaining employment can be extremely challenging for individuals with severe and prolonged mental illnesses. For this reason, among others, people with mental illnesses are particularly reliant upon these State-funded services. The nature and magnitude of these proposed cuts will in all likelihood be devastating to this segment of the population. The arbitrary reduction of certain services, such as prescription medications, is likely to result in eminently preventable deaths.

E. Part II FY '94/'95 Budget - New and Expanded Requests

The Department of Mental Health and Mental Retardation submitted, by memorandum of December 11, 1992, a recommended Part II Budget to the Bureau of Budget. At this point there is no indication that this budget has been sanctioned by the Governor. Nonetheless, the Part II Budget deals with several critical areas of service development and is therefore briefly discussed below.

The recommended Part II Budget seeks $7,387,006 in FY '94 for Consent-Decree related purposes and $8,061,727 in FY '94 for other

purposes. The budget also seeks $11,345,657 for Consent-Decree related purposes in FY '95 and $5,438,340 for other purposes in FY '95. The "other" expenditures are largely to fund parallel services for individuals not covered by the Consent Decree.

The recommended budget also includes funds to support the continuation of nursing facility beds at AMHI through fiscal year 1994. These funds would at least partially replace funds which were prematurely deappropriated during a previous legislative session. It should be noted that funds are not sought for fiscal year 1995, even though the current projection is that a substantial portion of the alternative beds will not be available until approximately mid-fiscal year 1995. (See Section V(B), Nursing Facility Planning Proposal).

The recommended Part II Budget identifies several critical areas in which services are urgently needed. The budget proposal includes, for example, a request for emergency crisis services. Specific crisis programs sought to be developed are community-based residential options and increased psychiatrist and crisis staff availability to handle the "ever growing volume of mental health consumers in need".

The Department also seeks funding in order to develop a variety of housing opportunities and so that it may provide flexible, intensive supports to allow adults with serious mental illnesses to live in community settings. In some instances the support would be

comprised of around-the-clock supervision, for others the supports would be intermittent.

It has been my observation that the lack of housing and support services is a major impediment to the development of a comprehensive mental health system. The development of needed housing options, support services, and emergency crisis services is a critical element in providing some relief for the crises currently facing the mental health system, as well as being needed in the long term development of a genuinely comprehensive mental health system.

The recommended Part II Budget also proposes some remedial action regarding the lack of administrative resources within DMH&MR. Department staffing is discussed generally in Section VIII of this Report. As discussed in that section, comprehensive planning, resource development, quality assurance, and information management have been sorely lacking. Among the positions sought are a resource development manager, data entry systems manager, comprehensive health planner, and Medicaid quality assurance specialist. In my estimation these positions have been appropriately selected to address, at least partially, Departmental staffing deficiencies.

The recommended Part II Budget also seeks to fund a variety of services for children. Among the services are crisis intervention services, community support worker services, and twenty-four hour

individualized therapy. Also sought is funding for the Bath Children's Home. The home is a transitional housing program which serves approximately 48 severely emotionally disturbed and homeless youth. The Department considers the home to be an alternative to inpatient psychiatric care and involvement of the juvenile justice system.

III. PUBLIC INPUT

A. General Comments

In October and November 1992 I held five public forums and solicited written comments regarding the Defendants' progress in implementing the Settlement Agreement. The forums were held in Rumford, Portland, Lewiston/Auburn, Bangor, and Augusta. Upon review of my last Report to the Court, it is striking that the same concerns were being raised again. What was so disquieting, however, was the sharp increase in the anger and disappointment of consumers, family members and providers. One consumer who spoke at the Augusta forum summarized the content and tone of many individuals who spoke when she noted that things were very bad one year ago (when I sponsored the last forums) and that there is no discernable difference now. "Are you hearing -- consumers are experiencing no improvement", she stated pointedly.

Some family members felt they were running out of time and energy to care for their relatives with mental illness. In Lewiston a mother noted her exhaustion after years of providing care with little assistance. She wondered when, if ever, the promised mental health system would be developed. She was in despair.

In reference to the Consent Decree's requirement that a comprehensive mental health system be developed, a group of concerned consumers representing the 100 Pine Street Social Center

in Lewiston stated in their written testimony that "We find the mental [health] services more confusing than comprehensive. We experience services change on a personal level and are feeling uncertain about our future services".

At least two factors appear to play a prominent role in the anxiety consumers, family members, and providers are feeling about the future. One is the erosion of an already inadequate system of community-based services and the other is the difficulty in accessing psychiatric hospitalization. Consumers representing 100 Pine Street said, "We don't want services expanded at the cost of existing ones. These services are essential in longer times between hospital stays".

Proposed cuts in services were the source of great concern among the public. Regarding proposed cuts by the Department of Human Services it was felt at the Portland forum that the cuts would tremendously enlarge the group of people in need of services. Regarding the Department of Mental Health and Mental Retardation's proposed cuts in community-based services the following comment is typical: "we are now told that the community may well have to absorb an additional 2.7 million for this fiscal year and anywhere from 5% to 20% in the next biennium. All this in the context of a massive assault witnessed by community services last year" (letter from the Executive Director, Kennebec Valley Mental Health Center). A more detailed analysis of the proposed cuts is found in this Report at Section II. Appearing below is an outline of some of

the more specific concerns identified by members of the public. These concerns are broken into two rough categories, mental health services for adults and mental health services for children.

B. Mental Health Services for Adults

At each forum the public presented long lists of services which need to be increased for individuals with severe and prolonged mental illnesses. Specifically identified services included:

-crisis services,
-housing,
-support services which will allow people to remain in their homes,
-day-treatment services,
-family support services,
-psycho-social rehabilitation services,
-clinical psychiatric services,
-substance abuse services.

The vast majority of these services are expressly identified as needed services in the Settlement Agreement and Implementation Plan. The message from the public is clear; the State needs to get on with the development of these needed services.

Elderly adults were among those specifically identified as being victimized by lack of progress. The Executive Director of Senior Spectrum and the Center Director for the Southern Kennebec Senior Center wrote:

As Central Maine's Area On Agency on Aging, we have in the last few years been confronted by:

* increasing severity of elderly needs,
* expanding numbers of senior citizens as their population percentage grows,
* worsening economic situation of these elderly people,
* government funding cutbacks.

At the same time, as a result of deinstitutionalization, our senior center in the capitol area is frequented by former AMHI patients who have few other options. They come to us for meals and attention and to sleep behind the building during good weather..... We are on system overload.

Other individuals testified that available services were inadequate for their particular illness. Individuals diagnosed with multiple personality disorder noted that they had been sent out-of-State for treatment and that they were in need of a cohesive program of services here in Maine.

Access to, and the adequacy of, psychiatric hospitalization continues to be a major concern. Many people noted that it is difficult to obtain access to psychiatric hospital services, particularly at AMHI. There was also substantial dissatisfaction with some of the community hospitalization programs. Some people in the Lewiston/Auburn area found St. Mary's Hospital to be inadequately responsive to their needs. At the Augusta forum dissatisfaction was expressed with the quick turn-around time at the Jackson Brook Institute. JBI was also criticized for providing

poor discharge planning. In addition, consumers complained that there was little help available in transitioning to community life after leaving AMHI.

Several people expressed dissatisfaction with the role jails are playing in the mental health system. Some complained that jails are becoming "holding pens" for persons with mental illnesses; one consumer complained that the jails are becoming the primary care takers for people with mental illnesses. It was widely felt that proposed cuts in services would further exacerbate this problem.

People pointed out that many providers will not participate in the Medicaid program because of the low rate of reimbursement. One case manager wrote, "many of my clients have severe tooth decay and medical needs but Medicaid will not reimburse doctors enough for them to receive these needed services". People found the prospect of erosion of Medicaid coverage to be unthinkable.

It was noted that the general stigma which is associated with mental illness continues to be a barrier in the development of a comprehensive mental health system. In Portland, stigma and hate crimes were identified as problems. In a letter from a Belfast couple the NIMBY (not in my back yard) syndrome was identified as an impediment to the development of homes for the homeless and people with mental illness. In the kennebec valley area it was noted by the Executive Director of Kennebec Valley Mental Health Center that while some strides have been made in reducing

discrimination against persons with mental illnesses, negative attitudes still persist which deter the growth of the individual. Several people noted the need for educating the public on mental health issues; specifically identified was the need for education of police, hospital staff, and school system personnel.

C. Mental Health Services For Children

All commentators considered the services available for children to be highly inadequate. Several people commented that children are being housed in emergency shelters because there are no other services available. It was routinely pointed out that shelters do not have the staff necessary to provide for the mental health needs of these children. Family members and providers complained that the needs of children appear to be escalating while there is erosion of the basic infrastructure of services. It was noted, for example, that the Department of Corrections stopped funding home-based services for children. Such home-based services were identified as one of the services needed in a comprehensive system of services for children.

Parents pointed out that children are still being sent out-of-State to remote and costly facilities. It was felt that these services should be provided in-State so that the child support services would be more readily available.

Crisis services were found to be highly inadequate. While acknowledging the beginning of the development of a crisis system for children, parents were highly critical of the lack of availability and accessibility of these services. At the Rumford forum, parents noted that crisis services were in reality available only 40 hours per week and that they may have to wait one day to two weeks for follow-up services. They also noted that the crisis services, being centered in Lewiston, are 45 minutes to 2 hours away. The parents emphasized that when they called in need of crisis assistance they needed help "now".

Parents and providers were unanimous in their observation that AMHI's Adolescent Unit has not been adequately replaced. Central to this problem is the observation that the facilities developed at the behest of the Department of Mental Health and Mental Retardation have not been willing to admit, or continue to serve in times of difficulty, children with high needs. In essence, it was felt that the very problems that required the use of facility-based services are the very factors which the programs utilized to screen out children. The Executive Director of Youth and Family Services Inc., stated the problem this way:

> The current status of the system of care for the children and families covered by the Consent Decree is woefully inadequate. With the closing of the AMHI Adolescent Unit came the opening of the Transition and Crisis Beds Program. As you are aware, there was significant delay in the opening of the Transition Beds Programs. Once open, however, this agency's case management program has been either unable to place a child in the programs because the children were "behavioraly disordered", or unable to keep the child in the program(s) because the

child's "behavior is beyond our control to manage". In both circumstances the child is returned home due the lack of resources. In short, the transition bed programs are not meeting needs of the children they were designed to serve. If there is any kind of behavioral component concurrent with or as a component of the mental illness, there are no transition programs available.

Parents generally noted that no one is currently willing to serve children with long-term needs. Parents and providers complained that although there have been many shifts in the services available, there has been no overall improvement in the system of care. Youth and Family Services Executive Director concluded, "expanding the existing system of care should be the priority of the State of Maine. Absent increased mental health resources, these children will cycle in and out of inappropriate placements until one becomes seriously injured or killed".

IV. IMPLEMENTATION PLAN REVIEW

A. Overview

This section of the Report constitutes my first intensive review of the Defendants' progress in implementing the Implementation Plan. The review focuses primarily on DMH&MR's progress to date. The Department of Human Services maintains significant responsibilities under its component of the Implementation Plan. Many of its responsibilities, however, require antecedent activity by DMH&MR, such as the development of the ISP process. Primary attention is given, therefore, to DMH&MR. The references in this section are to the five major components of DMH&MR's portion of the Implementation Plan. These sections are:

II -- Individualized Support Planning;
III -- Adult Community Mental Health Services;
IV -- Children's Community Mental Health Services;
V -- State Hospital Services; and
VI -- Mental Health System.

The Defendants are required to submit documentation to demonstrate that the tasks required in the Implementation Plan have been performed. These documents are placed in what is known as the "evidence file". References to "evidence", "file", "evidence file", "documents", or "documentation" have the same meaning for all practical purposes. As noted throughout this section of my Report, DMH&MR's documentation of compliance with the Implementation Plan has been highly uneven and, overall,

unsatisfactory. Efforts to remedy this problem are outlined in this Report at Section VI(A)(5).

As I noted in my Review of the Implementation Plan of November 1991, the Plan contains some "hard" components, but also contains many "soft" components, the latter being what I have referred to as "plans to plan". As appears below, significant planning still remains to be done. All references below are to DMH&MR's Quarterly Report of October 1992 unless otherwise noted.

Each section or subsection of the Implementation Plan has one or more outcomes. Each outcome in turn has its own specific tasks which are intended to at least partially outline the needed activities to accomplish the stated outcome. Each task has a specific due date; the focus of this analysis is upon those tasks whose performance is recently or past due. I have not attempted to report upon every task required in the Implementation Plan; rather, I evaluate a number of tasks for many of the required outcomes of the Implementation Plan in order to relay the flavor of the degree of progress in implementation.

In Section IV(A) I review the Individualized Support Planning (ISP) process. The ISP is the principle tool through which class members' needs are identified. ISP development is far behind schedule. This is a major impediment to implementation of many provisions of the Settlement Agreement. The development of community support workers (CSWs), a critical component of the ISP

process, is also significantly behind schedule. Completion of the outcomes regarding hospital treatment and discharge planning is dependant upon progress in development of ISPs and CSWs as well as on patient assessments at AMHI. The assessments are also severely behind schedule and major objectives regarding hospital treatment and discharge planning have not been met.

Section IV(B) of this Report relates to adult community mental health services - Implementation Plan Section III. Planning for community hospitalization is behind schedule. Moreover, there has been no significant development of community-based hospital beds for involuntarily committed individuals. In AMHI's catchment area, AMHI and Jackson Brook Institute (JBI) remain the mainstays for involuntary hospitalization. DMH&MR has yet to file an approvable housing and residential support services component to its Implementation Plan. This is a major failure. Housing and residential support services are critical elements in the development of a comprehensive mental health system. No plan has been filed regarding crisis intervention and resolution services. This is also a major failure in the planning process. These services are also critical to the development of a comprehensive mental health system.

Other adult community mental health services required to be developed pursuant to the Implementation Plan and also discussed in Section IV(B) include: vocational services; treatment services; recreation, social and avocational opportunities; family support

services; and services for special populations. None of these services are being developed in accordance with existing timetables.

In Section IV(C) I review the Children's Plan (Implementation Plan Section IV). The Plan calls for the current addition of 14 community support workers state-wide. Twelve have been added to the system, eight in AMHI's catchment area. Fourteen crisis workers have also been hired, eight in AMHI's catchment area. A number of housing/residential services were developed; while late coming on line, they are currently operational. They are listed in Section IV(D)(2) of this Report. Some questions regarding the efficacy of these services have been raised, (see this Report Section III, Public Input).

In Section IV(D) I review state hospital services (Implementation Plan Section V). This broad-based section has sixty-two outcomes regarding the provision of services at AMHI. Poor documentation makes it particularly difficult to evaluate progress in implementation. I attempt to portray briefly a sense of the progress being made by highlighting a few areas. For example, outcomes relating to AMHI's physical plant show a mixed performance. Significant work has been done regarding comfort, privacy, and attractiveness in living areas. On the other hand, ventilation of smoking areas is far behind schedule. Likewise, regarding the requirement that standardized admission and discharge criteria be developed, documentation indicates that standardized

criteria exist for admissions, but not for discharge. AMHI is required to continuously review voluntary patient status and to review treatment discharge plans every six months; all tasks pursuant to this outcome appear to be late and/or incomplete. AMHI is required to offer complete physical examinations to each patient. Completion of this outcome is claimed, but documentation is very sketchy.

Documentation supports claims of completion for at least some of the tasks regarding AMHI's assurance that dental needs of adult patients are met. Several of the tasks regarding AMHI's assurance of compliance with all seclusion, restraint, and protective devices standards are claimed as completed. Submitted documentation supports the conclusion that staff is trained in accordance with an established curriculum. On balance, submitted documentation supports the conclusion that AMHI has established a data-base system for monitoring the use of psychoactive medications at AMHI.

As reported, staff/patient ratios are being met for general medicine physicians, nurses, social workers, and mental health workers. Ratios are not being met for psychiatrists, psychologists, and recreational/occupational therapists/aides. It should be noted that staff/patient ratios alone are a very crude source of information. For example, psychiatrist coverage is reported at a 20% deficit. Many of the psychiatrists, however, are hired under short-term contracts. This can have a significant negative impact on continuity of care. The ratios are also based

upon the total number of hours of work provided. Thus, for example, when mental health workers work long hours to meet the required ratios, the fact that they may be tired and overworked during those excess hours would not be reflected in the staff/patient ratio.

In my detailed review of Section V of the Implementation Plan, summarized above, significant problems are noted regarding both implementation of the Settlement Agreement and documentation of progress being made. In spite of these problems, however, it is my overall impression that AMHI has significantly improved and is moving towards the provision of more treatment in responding to the needs of individuals and away from the provision of mere custodial care.

The next area I review is Implementation Plan Section VI (Mental Health System). This catch-all section deals with six topics: Clients Rights (Section VI A); Substance Abuse (Section VI B); Training and Human Resource Development (Section VI C); Public Education (Section VI D); Quality Assurance and Internal Monitoring (Section VI E); Planning, Budgeting, and Resource Development (Section VI F). Regarding clients' rights, DMH&MR has not promulgated the required "Rights" regulations. I am currently mediating disputes regarding promulgation of these regulations. Some progress has been made in addressing service needs for individuals with co-existing mental illness and substance abuse disorders. A new program appears to be ready to begin at Kennebec

Valley Medical Center in Augusta. The program at Southern Maine Medical Center, which was discussed in my previous Report to the Court, has been placed on indefinite hold, according to recent informal information. Substantial progress appears to have been made in amending contracts which prohibit exclusion by community-based providers of individuals with dual disorders and in development by DMH&MR of standards regarding non-exclusion of such individuals.

Completion is claimed for most of the tasks regarding training and human resource development, but supporting documentation is sketchy. Submitted documentation does indicate that video tapes have been used in training, for certain purposes, of community mental health service providers. Claims of completion for many of the tasks regarding public education is not accompanied by any documentation. Documentation does demonstrate that an informational video targeted to the school-age population (KID-TV video) has been developed and disseminated.

Compliance with the subsection regarding Quality Assurance and Internal Monitoring is severely deficient. Specific tasks requiring the determination of the system and of the resources necessary to monitor agencies providing mental health services and obtaining the resources to implement the system have not been completed. This is a critical component of the Implementation Plan.

Another critical provision is the subsection dealing with Planning, Budgeting, and Resource Development. Implementation of tasks set out in this subsection is material to the rational development of resources. This subsection requires upgrading the Implementation Plan through the assessment of information based upon ISP data, among other things. Such tasks have gone largely undone. This subsection also requires the development of a centralized system for planning, budgeting, and development of resources. This system has also not been developed. This subsection also requires the development of a mental health information systems plan, including the acquisition of software and hardware. This objective has not been met. Failure to implement these sections (Section VI(E) - Quality Assurance and Internal Monitoring; Section VI(F) - Planning, Budgeting, and Resource Development) severely limits DMH&MR's infrastructure and deprives it of the mechanisms necessary to otherwise implement the Implementation Plan.

B Implementation Plan Section II, Individualized Support Planning

1. Individualized Support Plans and Community Support, Implementation Plan Section II(A)

Individualized Support Planning is described in Section VI of the Settlement Agreement. Each class member who desires an individualized support plan (ISP) is entitled to one. ISPs are to be based upon consideration of the class member's housing, financial, social, recreational, transportation, vocational,

educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs, as well as their potential need for crisis intervention and resolution services (Settlement Agreement, Paragraph 61). Services are to be based upon the actual needs of class members rather than on what services are currently available.

A description of unmet service needs are to be forwarded to the Commissioner of the Department of Mental Health and Mental Retardation by the community support worker (CSW) so that the Defendants will utilize this information in the development of new services (Settlement Agreement, Paragraph 63). The development of the individualized support planning process is obviously a critical element in the development of a comprehensive mental health system. As appears below, implementation of the ISP process is seriously behind schedule.

The planning process got off to a poor start. The ISP work group was supposed to have met, pursuant to task #1, on January 12, 1990. It did not meet until November 1990. A draft version of the ISP format and protocol was to have been completed by April 1, 1991; it was not developed until June 3, 1992.

Subsequent to the development of the standard ISP format, the ISP process was to have been piloted in the community and AMHI by November 15, 1991 (task #5). The Quarterly Report indicates that the pilot was completed on April 1, 1992. Pursuant to task #6,

special protocols were to have been developed within the ISP process to assure that adolescent class members have a smooth transition from the children's mental health system into the adult system. These protocols were due on January 1, 1992; to date, there is no evidence that these protocols have been developed.

Task #7 calls for the revision of state Medicaid plan requirements and relevant rules to make ISP and CSW functions reimbursable. This important task was scheduled for completion on March 1, 1992. The new due date is March 1, 1993 (lawyers' meeting notes 11/30/92, #3).

Tasks #8 and #9 seek to institute a process for coordination between AMHI discharge plans and the ISP and to institute a process for coordination between community inpatient discharge plans and the ISP. These tasks were due on June 1, and July 1, 1992 respectively. The new due dates were December 1, 1992 and January 1, 1993, respectively (lawyers' meeting notes, 11/30/92, #3).

Pursuant to task #10 a pilot information system was to have been developed by January 1, 1992 which utilized ISP data for contract management, quality assurance and planning purposes. The Department asked for a one-year extension to January 1, 1993 to complete this task. It is unclear how the Department could achieve compliance with this task by even the new proposed date. As discussed in other sections regarding budgeting and staffing, management information systems positions have been eliminated and

existing positions have gone unfilled and are proposed for elimination by the Department. The Quarterly Report states, "until a definite hearing date for Consent Decree related data processing staff can be established, a realistic implementation schedule for a pilot ISP need information system cannot be specified".

Tasks #11 to #15 concerns providing training regarding the ISP process and providing notification to class members of their right to an ISP. These tasks were due from February 1, 1992 to December 1, 1992. The new due date is June 1, 1993 (lawyers' meeting, 11/30/92, #3).

The consequence of these delays is that the Department will not be providing individualized support plans to class members in accordance to the schedule established under task #16. The original schedule has been revised as follows:

	Original	Revised date
by	1/1/93, 25% of class members	6/1/93
	9/1/93, 50% of class members	1/1/94
	3/1/94, 75% of class members	7/1/94
	9/1/94, remaining class members	1/1/95

(See lawyers' meeting notes of 11/30/92, #3, adopting DMH&MR's new proposed dates).

As noted in other sections of this Report, the ISP process is an important feature of many components of the Implementation Plan. This is particularly true because the ISP process "is the principal tool through which class members' needs are identified" and is "a critical element in assuring the comprehensive mental health system is responsive to class members' actual needs" (Settlement Agreement, paragraph 72). The significant delays in implementing this process are a major impediment to implementation of the Settlement Agreement.

2. Community Support Workers, Implementation Plan Section II(B)

This section has a single outcome which is ultimately to make community support workers (CSWs) available to all class members desiring a CSW. Community support workers are intended to be critical individuals in the development and carrying out of individualized support plans. The tasks of this section detail a process by which class members needing CSW services are identified, Medicaid is adjusted to reimburse CSW functions, CSWs are trained in their new job, and methods are put in place to ensure that services are delivered. As with the development of the ISP process, the program to develop community support workers is significantly behind schedule.

Among the impediments to implementation is the failure to have revised Medicaid state plan requirements and relevant rules to make ISP and CSW functions reimbursable (task #2). This task was due

March 1, 1992; the new due date is March 1, 1993 (lawyers' meeting, 11/30/92, #3). Implementation of new contracts and requirements designating community support worker agencies was due on July 1, 1992 in regions V and VI and July 1, 1993 in regions III and IV (task #6). The new due date is July 1, 1993 (lawyers' meeting, 11/30/92, #3). The overall schedule for making community support workers available to all class members desiring a CSW is found in task #8. This schedule has been revised and parallels the new due dates for ISPs and CSWs outlined in the previous section of this Report (lawyers' meeting, 11/30/92, #3).

Progress has been made in establishing some new community support worker positions. Pursuant to task #4, it was planned to establish up to 22 new positions by March 1, 1992. According to the Quarterly Report, 13.5 new positions were established during the second and third quarter of FY '92. Eight and one-half additional positions are to be added by January 1, 1993. A summary of CSWs added to the system in FY '92 is appended to this Report as #2. Of course, in the absence of the development of the ISP process and the lack of rules making CSW functions fully reimbursable, it does not seem possible that these positions could currently provide the full range of CSW functions anticipated by the Settlement Agreement. DMH&MR acknowledges that most persons who should be performing the functions of community support workers are not known by their appropriate titles due to the failure to date to have amended the Medicaid reimbursement rules (letter of 9/11/92, Bergeron to Rodman).

3. Team Coordinators and Hospital Treatment and Discharge, Implementation Plan Section II(C)

This component of the Implementation Plan contains three outcomes. The first outcome deals with including client-specific ISP and hospital treatment and discharge plans in the overall comprehensive plan required by Paragraph 43 of the Settlement Agreement. A key provision in developing the client-specific plans is the assessment of individuals at AMHI by a professional review panel. The slowness in generating these assessments has been the subject of my previous Reports to the Court. Pursuant to Paragraph 46 of the Settlement Agreement, the recommendations of the panel were to have been completed by March 1, 1991. In the Department of Mental Health and Mental Retardation's 1992 October Quarterly Report it is indicated that the initial group of assessments are 35% completed. (Outcome 1, task #3). The lack of patient assessments, as with the lack of ISPs, constitutes a significant impediment in the planning process.

Outcome 2 deals with AMHI hospital treatment and discharge plans (Settlement Agreement Paragraphs 75-82). Among other things, the Settlement Agreement requires that while class members are admitted to AMHI, they shall receive treatment according to a written individualized treatment and discharge plan (Settlement Agreement Paragraph 75). Pursuant to Paragraph 82, all AMHI patients were to have treatment and discharge plans by January 1, 1992. Pursuant to Settlement Agreement Paragraph 75, the treatment and discharge plan is to be incorporated into the class member's ISP as a discrete

sub-part. Because the hospital treatment and discharge plan is supposed to be a component of the class member's ISP and involves the class member's community support worker, the goals of this outcome cannot be met in the absence of the development of the ISP/CSW process. Outcome 2 also addresses the interface between AMHI staff (in particular the "team coordinators") and community providers (in particular the community support workers). (See Outcome 2, tasks #2, #3, and #4). Task #3 of Outcome 2, requiring that team coordinators will be assigned to all psychiatric units, has been completed.

The third outcome deals with AMHI's assuring that individual treatment and discharge plans focus on the strengths of, and respect for, the patient pursuant to Paragraphs 151 and 152 of the Settlement Agreement. Because the treatment and discharge plan is a component of the ISP, full compliance with this section is not currently possible. The Department states, however, that "interim" ISPs are completed for any patient being readied for discharge on the Nursing Home Unit. Tasks relating to the development of a treatment plan training manual and protocol, and implementation of training programs for staff functioning as treatment plan coordinators, are claimed to be completed. (Tasks #2 and #4). Task #5, which requires the Medical Records Department to monitor treatment plans for adherence to Consent Decree standards, is also claimed as completed and ongoing.

C. Implementation Plan Section III, Adult Community Mental Health Services

1. Community Hospitalization, Implementation Plan Section III(A)

This section of the Implementation Plan has two outcomes. The first seeks to develop, recruit, and support local community acute care psychiatric hospitalization options. The second seeks to develop a process for coordinating the community hospital treatment and discharge plan and the individualized support plan.

The first outcome, for all practical purposes, has developed along two tracks. The first involves a specific plan to analyze AMHI admission data, determine the number of short-term acute community hospital beds needed, and develop those beds. The other has been a somewhat ad hoc process of encouraging general hospitals with psychiatric units to serve individuals in need of involuntary hospital care. Some of these efforts have been memorialized at task #12, Outcome 1. This task seeks to establish community-based inpatient programs for individuals with both substance abuse problems and mental health needs. Both Southern Maine Medical Center and Kennebec Valley Medical Center have received Certificates of Need for these services. SMMC is planning to add, among other things, two beds for involuntarily committed individuals, and KVMC is planning to add, among other things, three beds for involuntarily committed individuals.[1]

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[1] Recent informal information indicates that SMMC may not develop these involuntary beds.

Penobscot Bay Medical Center has also been granted a Certificate of Need to add 9 beds to its mental health unit. These 9 beds will serve, in part, individuals who are dually diagnosed with substance abuse problems and mental health needs and will serve involuntarily committed individuals. These services at PBMC are not expected to be available within the next several months.

The other component of this outcome, the more comprehensive effort at developing community-based inpatient hospital capacity for involuntarily committed individuals, is substantially behind schedule. The first step of this process, the analysis of bed utilization information at AMHI, was submitted in May 1992. This information was originally due on September 1, and October 1, 1991 (Outcome 1, tasks #1, and #2). One component of task #2 was to determine the number of beds needed in order to shift the short-term acute hospitalization functions from AMHI to community hospitals. This task was claimed as having been completed in the October 1992 Quarterly Report. However, in response to my inquiry of May 21, 1992 (letter to Theresa Laurie, Consent Decree Coordinator DMH&MR) it was stated that the analysis presented was "not an analysis of the need for involuntary beds throughout the communities which comprised the AMHI catchment area but rather a summary of the use of short-term involuntary psychiatric beds at AMHI" (letter of June 11, 1992, Laurie to Rodman). It appears, therefore, that the analysis required under tasks #1 and #2 did not generate a determination of the number of beds needed in the community.

The next steps in the process under Outcome 1 are to meet with community hospital representatives to determine the feasibility of developing increased hospitalization options and to develop, in conjunction with interested providers, hospital-specific plans. These two tasks were due on October 1, and December 1, 1991 respectively (tasks #3 and #4). Nine general hospitals in southern Maine formed a consortium to study the feasibility of providing increased community-based acute psychiatric care for AMHI class members. The Department of Mental Health and Mental Retardation submitted, on November 19, 1992, a "Feasibility Study, Session II: Decision Analysis and Implementation Requirements" dated September 18, 1992.

The Feasibility Study assumed that all AMHI class members with a length of stay up to 90 days would be admitted to community-based acute general hospitals. Further assuming a 90% occupancy level, the Feasibility Study projected the need for 71 involuntary beds in the AMHI catchment area. Since the completion of the Feasibility Study, no hospital-specific plans have been developed. It should be noted that the consortium of southern Maine hospitals is a consortium of general hospitals and as such does not include the Jackson Brook Institute in South Portland. JBI has been a key element in AMHI's strategy of census reduction. The role of JBI is discussed in more detail in Section VII(A). To date, JBI is the only hospital in AMHI's catchment area other than AMHI which admits involuntarily committed patients.

Paragraph 83 of the Settlement Agreement mandates that the Defendants require community hospitals to develop hospital treatment and discharge plans in coordination with ISPs for all class members whose admissions are funded by DMH&MR. Outcome 2 deals with this mandate. As previously discussed, the ISP process is significantly behind schedule. This factor, possibly in conjunction with other factors, has significantly delayed this outcome. Thus, the training of all affected community hospitals which was to have occurred by March 1, 1992 has not yet been initiated. Implementation of the finalized ISP format on a state-wide basis was to have begun on July 1, 1992. To date "ISP information sessions" have been held, but implementation has not begun.

2. Housing and Residential Support Services, Implementation Plan Sections III B & C

Pursuant to Paragraph 93 of the Settlement Agreement, the Defendants "shall fund, develop, recruit and support a variety of housing options which can accommodate varying levels of supportive assistance to clients, depending upon client need". In addition, services to meet individuals' needs, including the need for housing:

> must be delivered according to flexible models which accommodate changes in individual class members' needs and the variation and intensity of their needs. The services shall 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 (Settlement Agreement #32b).

In my Review of November 27, 1991 of the Defendants' proposed plan for housing, I found that they failed to demonstrate that their proposal met these requirements.

Paragraph 97 of the Settlement Agreement outlines the general requirements for residential support services. That paragraph requires that the Defendants:

> shall fund, develop, recruit and support residential support services for delivery in variety of home settings, including the client's private home or an agency owned or operated apartment or home. The services shall be designed to provide the client with the support and supervision appropriate to his level of independence. The services shall be flexible so that the support and supervision shall may be initiated or discontinued, increased or decreased as the class member's needs change and so that the class member is not required to move to another setting as his/her needs change.

As noted in my Review, the Defendants failed to design a system for residential support services which met this requirement. I also noted in my Review, however, that the Defendants had committed themselves, as part of their residential support services plan, to explore innovative residential support services models from other states and to determine the appropriateness of such models for Maine. Based upon the promised performance of this task, I withheld approval of the Residential Support Services section of the Plan pending completion of this task. The task was due on January 1, 1992. Unfortunately, the Defendants did not complete the task.

In order to remedy the Defendants' failure to have submitted approvable housing and residential support services plan, it was agreed that the Defendants would file approvable plans by August 3, 1992 (lawyers' meeting, 6/11/92, #1). The Defendants did not submit plans as agreed.

The Department of Mental Health and Mental Retardation has drafted a "housing policy". This policy, albeit largely a philosophical statement, discusses housing and its relationship to support services. This draft has not been submitted as part of the Department's draft Implementation Plan for housing and residential support services. The draft housing policy does demonstrate, however, that DMH&MR has begun to identify those services which are needed to enable individuals to successfully reside in housing in their communities. These services include educational and vocational services, daily living skills services (budgeting, shopping, cleaning, transportation, etc.), crisis intervention and stabilization services, social and leisure activities, medication monitoring, and therapy and counseling.

The Department states in its draft housing policy that individuals may require and will choose one of the highly intensive, structured mental health residential facilities. It is the opinion of the Department that few consumers of mental health services will require such highly specialized types of residential programs. The Department notes that the housing needs of the great majority of consumers have not been met. As noted below, however, the vast

majority of the Department's efforts to date have been focused upon the development of highly intensive, structured mental health residential facilities. Funds which were to have been used for a rental subsidy program were used instead for costs associated with supporting mental health residential facilities and to pay for hospitalization of individuals, primarily at the Jackson Brook Institute (supplemental response to request for information, Laurie to Rodman, 11/5/92).

The attached summary of "residential funding" outlines the DMH&MR's expenditures for adults for fiscal year 1992 (see Attachment #3). Residential housing/facilities which were newly developed in fiscal year 1992 are marked "yes". As appears in the attachment, half of the new "beds" are in the nature of supported apartments, and the other half are either for boarding homes (14 beds) or intensive group homes (26 beds).

3. Crisis Intervention and Resolution Services, Implementation Plan Section III (D)

The key task of this section requires the development of a plan to develop crisis intervention and resolution services in all regions of the AMHI catchment area (task #8). This plan was due on September 1, 1992. It has not yet been filed. DMH&MR cites two problems in its initiation, delays in establishing a pilot program in Cumberland County and financial constraints.

The model crisis pilot program in Cumberland County is supposed to be a broad-based system of crisis intervention and resolution services. Pursuant to task #6, these services are to include:

1. a 24-hour hotline,
2. walk-in crisis triage services, providing immediate evaluation and consultation;
3. mobile outreach services providing high level support to intervene and resolve crises at home;
4. community crisis stabilization residential beds for intensive support, structure, and supervision in order to assist persons in psychiatric crisis to re-establish community functioning; and
5. a psychiatrist on call 24 hours.

This program was to have been developed by April 1, 1992. To date, the only operational component is the 24-hour hotline which began in October 1992. DMH&MR notes that although the pilot program in Cumberland County is not complete, crisis service needs are evident. Given this fact, the Department has offered no plausible reason for its failure to have developed a plan for the development of crisis intervention and resolution services in the AMHI catchment area. The Department stated that it should have its plan available by January 15, 1993 (memorandum of 10/26/92, Bergeron to Rodman).

Attached to this section is a summary of crisis services available in FY '92. Note that services are very uneven throughout the State. Some areas are still without crisis beds. Some specific

concerns regarding crisis services are outlined above in Section III, Public Input.

4. Vocational Services, Implementation Plan Section III (E)

The key provisions of the vocational services plan are to expend funds for vocational rehabilitation purposes, assimilate information from a variety of sources, and prepare further budgets for additional vocational services. The vocational services plan is a joint work plan between DMH&MR and DHS.

For fiscal year 1992, $508,703 was appropriated to the Bureau of Rehabilitation within DHS for vocational services. Of that amount, the Bureau expended only $158,703. The Director of the Bureau has indicated that referrals for services were slow initially; in response DHS issued a Request for Proposal for community-based providers to provide vocational services in order to utilize appropriated funds. The Bureau was initially unable to execute a contract pursuant to the RFP because a freeze on contracts was issued by the Governor in May 1992. That contract is now operational. The Director also noted that the Bureau was able to do only limited outreach and recruitment because of several vacancies in counselor positions. This was stated to be due largely to the inability of the Bureau to obtain approval by the Governor and the Bureau of Human Resources to fill these positions. The Bureau expected to have all positions filled in November 1992.

The Director did not anticipate that there would be a large sum of unexpended monies in fiscal year 1993, as there was in fiscal year 1992 (memorandum of October 28, 1992, Tetley to Coulombe; lawyers' meeting notes, November 2, 1992).

The second major focus of planning regarded gathering and assimilating information regarding the need for vocational services. These required activities are found in tasks #14, 17, 18, 20, and 21. Several of the tasks require the generation of information through the ISP process in order to ensure that class members' choices for vocational goals are included in the development of vocational plans. As discussed above, the ISP process is greatly behind schedule. Other tasks, such as coordinating information systems to track vocational services, client demographics, and fiscal activity are also behind schedule. The coordination of information systems was due on January 1, 1992. The integration of the ISP process with vocational rehabilitation planning was due on April 1, 1992.

Pursuant to the plan, the Departments were to have developed a budget request for the second regular legislative session of the 115th Legislature by December 1, 1991 and for the first regular session of the 116th Legislature by November 1, 1992 (tasks #11 and #21). No budget was presented to the second regular session of the 115th Legislature and, to date, no affirmative budget has been developed for the 116th Legislature.

5. Treatment Services, Implementation Plan Section III (F)

This section of the Implementation Plan outlines a series of steps to assess the need for treatment services and to make those services available. Tasks #2, #4, and #5 rely heavily upon the ISP process to generate unmet needs data. Pursuant to the schedule established by these tasks, 25% of all identified treatment needs were to have been met by January 1, 1993 and then an additional 25% of all needs met each year thereafter until 100% of needs are met by September 1, 1995.

Pursuant to task #2, priority for meeting treatment needs is to be given to discharged class members identified as being at imminent risk of hospitalization and to those who need community treatment options in order to be safely discharged from AMHI. The status report for this task indicates that currently community-based agencies submit unmet needs data to the Bureau of Mental Health for consideration in budget development. However, there is no indication that a budget has been submitted to meet these needs. In addition, this task and other tasks do not have the benefit of ISP data. The status report for this task indicates that completion is "pending ISP implementation".

The status report for task #4 indicates that data is anticipated to be generated pursuant to the ISP process by September 1, 1993. It was due January 1, 1993. Given the lack of ISP data and the lack

of a proposed budget, it does not appear that the January 1, 1993 goal of meeting 25% of identified treatment needs will have been met.

The coordination of information for use in planning and resource development for unmet treatment needs is to be generated through a management of information system (MIS) pursuant to task #3. This task was due on August 1, 1992. As discussed in Sections VI(F)(6) and VIII, however, development of the MIS is severely challenged.

6. Recreational, Social, and Avocational Opportunities, Implementation Plan Section III(G)

The focus of this section is to assist consumers in developing leisure skills and improving the quality of their leisure time. Programs are to be sponsored which allow consumers to utilize, improve, or gain recognition of their avocational talents. Funds appropriated for fiscal years 1992 and 1993 appear to have been partially utilized by supporting social clubs beginning in FY '93. The Department reports that awards were made on approximately June 30, 1992 to two organizations, the Together Place in northern Maine and the Portland Coalition in southern Maine. The due date for this task was December 1, 1991.

Pursuant to tasks #2 and #5, assessments of need for recreational, social, and avocational opportunities were to have been made. Pursuant to task #5, development of a budget was to follow the

review of this information. Part of that information was to have been obtained by completing the assessments of individuals at AMHI. These assessments were due on March 1, 1991, but have not been completed. Pursuant to task #5, ISP information was also to have been utilized in determining need. To date, no ISP data has been generated. No budget requests have been made since the original budget was developed for fiscal years 1992 and 1993 as discussed above.

Compliance with the contracts to provide for these opportunities was to have been accomplished through Bureau of Mental Health staff visits to the social clubs at least twice annually. This was to have commenced on August 1, 1992. As of October 1, 1992 no compliance visits, as required by task #8, had occurred. The Department cites lack of staffing for this omission.

7. Family Support Services, Implementation Plan Section III(H)

This section of the Implementation Plan seeks to fund, develop, recruit and support family support services. The tasks of this section with past due dates show that some items have been completed, others are in progress, and others have yet to be initiated.

Pursuant to a contract with the Alliance for the Mentally Ill of Maine (AMI), a directory of regional resources has been developed. Under task #3, the due date for this directory was March 30, 1992.

Although a little behind schedule in its completion, the directory is a significant accomplishment for people seeking information on the availability of mental health services in their region.

Pursuant to task #5, the Department was to develop a program designed to educate families on mental illness from the prospective of professionals, other families and consumers, and implement a program through a contract with AMI. This program was to have been implemented by November 1, 1991. It is currently in progress. Family members were trained to be trainers in October 1991 and local training sessions began in early 1992.

Task #8 requires the development and delivery, in coordination with AMI, of a training program for existing mental health professionals and the delivery of psycho-educational programs to families. This task was due on October 1, 1992. DMH&MR reports that this program is "under preliminary consideration". This is taken to mean that there has been no initiation of this program.

In accordance with task #10 DMH&MR, through AMI, was to have begun making respite services available to families beginning January 1, 1992. The Department notes that difficulty in identifying insurance coverage has delayed implementation. Respite providers in central Maine have been recruited and their training initiated as of September 21, 1992. Services in central Maine were slated to be available in November 1992. No date for implementation in other areas has been identified by the Department.

Pursuant to task #13, the Department is to devise a method for determining unmet needs for respite services in conjunction with AMI. This was due on September 1, 1992. To date, this task has not been initiated. It should be noted that the person responsible for carrying out many of the tasks in this section is the Director of Office of Community Support Services. This position has been vacant for the past two years (letter of 10/28/92, Laurie to Rodman). Although the Department does not identify all the causes of the delays in implementing the tasks of this section, staffing shortages are suspected to be a contributing factor.

8. Standards for Community Programs, Implementation Plan Section III(I)

This section involves a single outcome which is the development of operating standards for licensed agencies. Preliminary work, such as identifying the types of agencies which require standards, has been completed. Advanced tasks such as field testing standards have not been completed. Field testing was to have been completed by August 1, 1992. Additionally, pursuant to task #7, final revisions to the standards were to have been completed and submitted for rule-making by September 1, 1992. This has not occurred and the Department does not expect to submit the standards for rule-making until March 1, 1993.

9. Special Populations, Implementation Plan Section III(J)

The Settlement Agreement, at paragraph 86, notes that some class members may require highly specialized services which either are currently unavailable or insufficiently available within the State of Maine. These class members, referred to as "special populations", include the following: a) certain class members diagnosed with mental retardation, other developmental disabilities, traumatic brain injury, dementia, or a primary diagnosis of substance abuse or dependence; b) other class members who have experienced long-term institutionalization who will require specialized services upon discharge to the community; and c) other class members who may need intensive support adjusting to a community-based service system who in the past relied upon hospitalization.

The section of the Implementation Plan dealing with special populations has two outcomes. Outcome 1 deals with population of individuals identified above under **a** and Outcome 2 deals with individuals identified under **b** and **c**. Outcome 1 seeks to develop services by undertaking an initial assessment of information regarding needs and then budgeting for the development of additional services (tasks #1 - #3). Thereafter, AMHI patient assessment and ISP information is to be utilized to ascertain additional unmet needs and to budget for those needs (task #4 - #11). The initial budget was to have been developed by December 1, 1991. No budget was generated pursuant to this task. The

second budget was to have been developed by December 1, 1992 pursuant to task #10. No budget was prepared to meet the requirements of this task.

A plan was to have been prepared by March 1, 1992, pursuant to task #6, summarizing identified needs and specifying related services. Pursuant to the Department's memorandum of 10/26/92, the plan is now estimated to be ready in January, 1993.

Outcome 2 of this section deals with providing services for individuals identified under **b** and **c** above. This outcome seeks to assess the needs of AMHI patients (task #1), budget for identified needs (task #2), retain consultants to provide recommendations for program models to meet the identified needs (task #3), and issue requests for proposals to develop the needed services. The due dates for these tasks were, respectively, February 1, 1992, March 1, 1992, September 1, 1992, and October 1, 1992. All of the tasks have either been delayed or not yet initiated.

10. Contract Compliance, Implementation Plan Section III(K)

This section has a single outcome requiring that agencies meet all applicable sections of the Settlement Agreement. Task #2 seeks to develop interim contract language putting providers on notice of changes required by the Consent Decree. This was due on May 1, 1991. In accordance with the Quarterly Report it was completed in

accordance with a departmental plan of October 1, 1991. The remaining tasks, #3 - #8, seek to implement policies and procedures in order to enforce compliance among providers. The latest of these tasks was due on February 1, 1992. The Department notes that contract language is "amended as needed" (task #5); it further notes, however, that it does not anticipate having a promulgated standard mandating compliance with DMH&MR contracts until July 1, 1993 (task #3).

D. Implementation Plan Section IV, Children

This section of the Implementation Plan is divided into two major sections. Section A deals with offering ISP services. Section B deals with implementing new children's mental health services. Part A is comprised of three separate outcomes, which are discussed as a whole below.

1. Implementation Plan Section IV(A), Individualized Support Planning

Generally, children class members have been informed of their rights regarding ISP and CSW services. Follow up on difficult to locate class members, however, appears to be behind schedule. Pursuant to Outcome 1, task #7, the Department of Corrections was to have been requested to assist in locating class members as of November 15, 1991. Based upon the status report, this appears not

to have occurred. Pursuant to Outcome 2, task #14, the Department reports that it has completed ISPs for 105 of the 131 individuals (80.2%). Assessments of the ISP process are behind schedule (Outcome 2, task #11; Outcome 3, task #10). Pursuant to Outcome 3, task #10, the ISP process was to have been assessed by March 15, 1992 subsequent to the first three months of field operations. This assessment was to have been followed by report and plan. No such documents have been filed to date.

One of the important tasks in Part A is the development of additional community support worker capacity. Pursuant to Outcome 2, task #9, 14 personnel are to be added state-wide. Twelve CSW full-time equivalents are reported to have been added. The latest of these was hired March of 1992. Four were hired in children's area I, northern Maine, and 8 were hired in AMHI's catchment area, children's areas II and III.

2. Implementation Plan Section IV (B), Children's Comprehensive Development Plan

The two outcomes of this subsection deal with service development; they are collectively discussed. Hospital services are discussed at Outcome 1 (a) and Outcome 2 (d). The goal of these tasks is to enter into formal written agreements with the Jackson Brook Institute, St. Mary's Hospital, and Acadia Hospital. Formal agreements were due no later than December 1991 for JBI and St. Mary's. Acadia Hospital just recently opened. The Department is projecting formal agreement with Acadia Hospital in early 1993.

The Department reports that neither JBI nor St. Mary's desires to enter into a formal agreement. As a result, there are no formal agreements regarding either admission roles or discharge responsibilities for any of the three hospitals at this time.

The following housing/residential services, as outlined in Outcome 1 (b), have been developed:

-- Dirigo Place, Lewiston, 7 transitional residential beds, opened September 10, 1992,

-- Aspen Ledge, Hamden, 6 transitional residential beds, licensed July 13, 1992,

-- Janus House, Bangor, 6 beds for dually-diagnosed children with substance abuse problems, licensed September 15, 1992, 4 beds operational,

-- Roy House, Dixfield, 6 beds for non-adjudicated sexual offenders, licensed August 20, 1992,

-- Meadowview House, Augusta, 4 beds for longer-term transition from inpatient hospitalization, fully operational.

All these facilities were behind schedule in their development, but are now mostly operational. Both Dirigo Place and Aspen Ledge were intended to include two crisis beds each. Those beds are currently being used as transition beds due to DHS concerns regarding the licensure of crisis beds in transitional residential housing. Temporary accommodation of these concerns may be made through policy revisions at the two facilities. DHS states that it will be reviewing with DMH&MR potential need for statutory or regulatory changes to address this problem (letter of October 8, 1992, Coulombe to Rodman).

Outcome 1 (c) deals with the development of crisis intervention and prevention services. This section notes that a total of 6 individuals have been hired to serve northern Maine (children's area I) and a total of 8 individuals have been employed by community agencies serving the AMHI catchment area (children's areas II and III).

Pursuant to Outcome 2 (c), draft standards for children's services were to have been completed by September 1992. Appeal of an RFP issued for consultant services to assist in development of children's standards resulted in a DMH&MR decision not to issue a contract and to proceed with development in-house. The Department does not anticipate having the draft standards ready before March 1993.

Pursuant to Outcome 2 (b), DMH&MR is to prepare a priority list of resource development recommendations based upon unmet needs. These unmet needs are summarized in a memorandum of October 19, 1992 from Director Durgan to Commissioner Glover. Among the unmet needs identified are:

-- individualized foster home placements,

-- community support workers,

-- crisis intervention workers,

-- individualized therapies and programs to avoid emergency hospitalization,

-- structured community programs teaching independent living skills.

The budget proposal for FY '94-'95 currently before the Legislature does not address these unmet needs. Also attached is a summary of BCSN contracts for FY '92 which identifies existing and new services for the three children's areas of the State (see Attachment #4).

E. State Hospital Services, Implementation Plan Section V

This section of the Implementation Plan contains three subsections. Subsection A, Plan For Reduction of AMHI Census, was rejected in my Review of the Implementation Plan of November 1991. The Review outlines the reasons for not accepting this component of the Implementation Plan. Subsection B, Standards Governing AMHI, is a broad-based collection of 54 outcomes regarding the Augusta Mental Health Institute. Subsection C contains 8 outcomes regarding Standards for AMHI's Nursing Facility Beds and Care of Geriatric Patients. As noted generally in Section IV(A), the lack of quality documentation regarding completion of many of the tasks in these sections has made monitoring the status of these tasks extremely difficult. Subsection D, Standards Governing Treatment of Forensic Patients, has no independent outcomes.

It should be noted that AMHI was excused from its reporting requirements for the October 1, 1992 Quarterly Report except for matters relating to staff ratios. As a result, this information is not as current as that for other sections of this Report.

1. Standards Governing AMHI -- General (Section V B)

The 54 outcomes which make up Section V(B) are not formally categorized by subject area. For the purpose of this Report, however, this section is divided into 9 categories. The outcomes involved in these informal groupings are indicated in parenthesis.

a. Physical Plant (Outcomes 1 - 8)

These outcomes show a mixed performance in dealing with AMHI's physical plant. Completion of scheduled work relating to comfort, privacy and attractiveness in living areas (Outcome 1) is reported as completed. Likewise, asbestos removal or abatement (Outcome 8) is reported as being on schedule. On the other hand, pursuant to Outcome 3, it appears that funding has not been secured to meet all current life safety code requirements for patient living and sleeping areas. Also, ventilation of smoking areas, as required by Outcome 6, is far behind schedule; installation and testing of air exchanges in 4 smoking areas was to be completed by December 31, 1991.

b. Admission, Treatment and Discharge (Outcomes 9,10,11, and 13)

Outcome 9 deals with the development of standardized admission and discharge criteria. AMHI reports compliance with this outcome, but material submitted in support indicates that the standardized

criteria deal only with admission and not discharge. Claims of completion are made for substantial portions of Outcomes 10 and 11, yet very little supporting documentation has been provided substantiating these claims. For example, Outcome 11 requires that AMHI shall have in place a protocol which ensures that a community-based support worker has been contacted to ascertain that lesser restrictive alternatives to AMHI admission have been fully explored. This task (task #1) was due on September 1, 1991 and is claimed as having been completed, but there is no documentation to back up this claim.

c. Treatment (Outcomes 12, 14, 15, 16, 18, 20, and 21)

Pursuant to outcome 12, AMHI is required to continuously review voluntary patient status and to review treatment and discharge plans every six months. All tasks pursuant to this outcome appear to be late and/or incomplete. Task #3 requires that AMHI contract with outside practitioners to perform the required reviews. This is the only task for which AMHI claims completion. The status report for this task, however, indicates that AMHI has only secured the agreement of one person to do consultations "on difficult cases". AMHI indicates that it has received no response from the Maine Psychiatric Association in its efforts to contract with outside practitioners. AMHI's securing of consultations on difficult cases does not appear to rise to the level of a review of treatment and discharge plans every six months. AMHI identifies all other tasks under this outcome as being delayed.

Outcome 14 deals with providing patients with services that meet their needs as identified in their hospital treatment and discharge plans; it also requires that patients be given a schedule of therapeutic, rehabilitative, and recreational activities available at AMHI. Eight of the eleven tasks comprising this outcome were due by July 1, 1992. Most tasks remain incomplete. Completion is claimed regarding tasks #4 and #9, which involve allocation of resources for programming and implementation of a weekly therapy schedule.

Outcome 15 requires AMHI to make services available to meet patients' needs. The final due date for this outcome was January 1, 1993. The individual tasks underlying this goal are severely behind schedule, however. Among other things, the critical individual assessments of AMHI's patients was to have been completed on March 1, 1991. It remains far from completion. Completion is claimed for task #2, which requires that all Primary Therapeutic Coordinators be trained in identification of and reporting of patient unmet needs, so that results can be translated into resource development and service provision. Supporting documentation does not indicate, however, that resource development and service provision.

Outcome 16 requires that AMHI offer a total of three hours per week of counseling, one of which is to be provided by credentialed staff. This was to be made available by January 1, 1993. The due dates for all the underlying tasks have passed. Among these tasks

are efforts to document hours of counseling provided; assign existing professional staff to assure 1 1/2 hours per week of counseling; and assess the feasibility of developing a certification program in counseling for mental health workers (task #3, #4, and #5 respectively). The status reports for these tasks indicate that they are "in development", delayed while a definition of "counseling" is pursued, and that new avenues for mental health worker certification are "being reviewed".

Outcome 18 requires that AMHI engage independent consultants for patients who are not responsive to treatment. The due date for completion of this outcome was January 1, 1992. Pursuant to task #2, a reporting format and protocol are to be developed for physicians to report to the clinical services director on patients for whom treatment efforts have been unsuccessful. No documentation has been submitted indicating that such a format and protocol have been developed. The status report for this task states that patients who had been recommended for consultation made such substantial improvement that consultation was no longer needed. On the other hand, task #3 requires that a contract be completed with independent consultants specializing in treatment alternatives, yet only one physician has shown an interest in consulting. AMHI notes that there has been "no interest whatsoever" from the Maine Psychiatric Association.

Outcome 20 requires that treatment be delivered consistent with the patient's clinical capacity and that for patients who lack clinical

capacity, their status be reviewed every sixty days. AMHI claims completion with this outcome. Outcome 21 requires that AMHI meet listed standards for the prescription and administration of psychoactive medications. Compliance with this outcome is also claimed.

d. Patients' Physical Needs (Outcomes 17, 24, 26, 27, 29, and 31)

Outcome 17 requires that AMHI employ an adequate number of nutritionists and dietitians to assure that all patients nutritional and dietary needs are individually assessed and met. Specific tasks include establishing a clinical dietitian and three diet coordinators, making operational a "tray-line" service, providing individual assessments of patients' nutritional and dietary needs, and providing nutritional screening upon admission (task #2 through #5 respectively). Completion for all tasks is claimed except for the tray-line, which was not reported as being fully operational. Some questions regarding the claims of completeness exist. For example task #2, which requires establishing a clinical dietitian and conversion of three cooks to three diet coordinators, is summarized in the status report as the establishment of three diet coordinators without mention of a clinical dietitian.

Outcome 24 requires that AMHI offer complete physical examinations to each patient, including a complete pregnancy test for women of

child-bearing age when appropriate. Completion of the tasks comprising this outcome are claimed. Documentation provided in support of these conclusions runs from none to sketchy.

Outcome 26 requires that AMHI not deny access to health care in the community solely because the class member is a patient at AMHI. Most of the tasks associated with this outcome are claimed as completed; documentation substantiates compliance with at least some of the tasks.

Outcome 29 states that AMHI should develop transfer and referral agreements with area hospitals, clinics, and specialists to assure that all medical needs of the patients are met. The first two tasks of this outcome require an initial assessment of unmet needs and an assessment of willingness of providers to provide necessary treatment. Neither of these tasks appears to have been completed. The last task (task #3) requires the development and signing of written agreements with providers. Apparently AMHI is attempting to negate this task unilaterally. It is claimed that "it is probably stigmatizing" to enter into such formal agreements.

Outcome 31 requires that AMHI assure that dental needs of adult patients are met. Completion is claimed for all tasks comprising this outcome. Documentation supports some of these claims. There is evidence that transportation to community dentists is provided (task #1) and that AMHI has developed policies to assure maintenance of standards (task #3). On the other hand, task #2,

which requires that additional professional and technical time be made available through a dentist, dental assistant, and hygienist, is accompanied by documentation indicating that only oral hygienist hours have been increased. Tasks #4 and #5 require increased contractual services in a variety of areas. Documentation for these tasks consists of a memo which states that the services are provided. No documentation has been submitted specifying the availability of increased contractual services.

e. Patient Abuse Prevention (Outcomes 33 through 40)

Outcome 33 requires that staff report instances of patient abuse, neglect and exploitation, and notify a variety of appropriate individuals, and file reports. Completion of all tasks is claimed. Documentation, however, is spotty. Pursuant to task #2, for example, there is an attendance list for required training, but no curriculum indicating the content of the training. There is documentation supporting development of a reporting format as required by task #3. On the other hand, no documentation was provided to substantiate that reports have been provided to the Bureau of Elder and Adult Services, Child and Family Services, or patient advocate.

Outcome 34 requires that the results of investigations into reports of patient abuse, neglect, or exploitation be provided in writing to the patient, patient's guardian, or designated representative.

The file does contain letters which have been sent to various patients regarding the results of investigations into complaints.

Outcome 35 requires that employees be relieved of direct-care duties pending investigation into allegations of abuse, neglect, or exploitation. It also requires that employees be terminated upon a finding of sexual/physical abuse resulting in serious injury to, or death of, a patient, or serious neglect or a finding of serious exploitation. Documentation indicates that there are specific cases in which actions against individuals have been implemented. Documentation is lacking, however, which indicates that existing protocols and policies at AMHI are in accordance with the Settlement Agreement as required by task #1.

Outcome 36 requires that no AMHI employee terminated for patient abuse, neglect, or exploitation be rehired. All tasks comprising this outcome are claimed as completed/ongoing. Documentation demonstrates that lists of individuals have been compiled. The documentation does not establish that the lists were sent to the individuals identified in tasks #2 and #3 under this outcome.

Outcome 37 requires that each employee, before hire, be informed of the provision for investigation of allegation of patient abuse, neglect, or exploitation and the associated penalties. It appears that this outcome is being complied with.

Outcome 38 requires that allegations and findings of patient abuse, neglect, and exploitation be collected and analyzed, and that training be provided based upon the analysis and findings. Completion is claimed with all tasks for this outcome. The file contains a form upon which reports can be made. However, there is no documentation indicating that information has been analyzed or training implemented as required by tasks #2 and #3.

Outcome 39 requires that all instances of serious injury and of disappearance or death of a patient be reported to AMHI's Superintendent, the Commissioner of DMH&MR, and the patient advocate. Notification of the patient guardian or designated representative is also required. All three tasks of this outcome are claimed as completed; no documentation regarding any of the tasks has been submitted, however.

Outcome 40 requires that serious patient injury, disappearance or death be reviewed by independent professionals and that, based on analysis of these results, training programs and other steps be initiated. AMHI claims completion with the five tasks comprising this outcome. The status report for task #1 indicates that death reviews are performed through contract with the Maine Medical Association. No mention is made of how reviews of serious injury or disappearance are handled. Tasks #2 and #5 indicate that findings will be analyzed in order to take subsequent steps; no analyses or subsequent steps are documented. Task #3 requires that results of reviews be forwarded to the Office of the Attorney

General and then to the Court Master. The reviews which I have received were provided to me pursuant to my direct requests; no reviews were sent to me as a matter of routine pursuant to this task. I have reason to believe that AMHI is now more alert to this requirement.

f. Patients' Rights (Outcomes 19, 22, 28, and 32)

Outcome 19 requires that entitlements and basic human rights shall not be treated as privileges which patients must earn. The three tasks of this section require, respectively, that AMHI designate a staff member to monitor patient rights, conduct reviews to assure that this outcome is met, and amend any policies not meeting this standard. The first two tasks are claimed as completed and the third is stated to be "in process". There is no documentation supporting any of these claims with the exception of a document which provides a description of AMHI's clinical executive committee. No further discussion of what the committee has accomplished with respect to this outcome is provided. (AMHI has agreed to revise its "privileges" policy. See Section VI(A)(9) regarding Settlement Agreement Paragraph 159.

Outcome 22 requires that AMHI shall meet all standards relating to emergency orders. Pursuant to Paragraph 165 of the Settlement Agreement, an emergency exists when a patient exhibits behavior due to mental illness which places him or others at risk of imminent

bodily injury. Task #2 requires that AMHI's policies and procedures relating to emergency orders be reviewed and adjusted as necessary. This task is claimed as completed and the evidence file contains a section of the AMHI procedures manual which outlines a process for relating to emergency orders. Task #3 requires a system of chart review to assure that the conditions precedent to emergency orders are met and proper procedures are followed. This task was due on November 1, 1991; the status report indicates a system would be implemented in June 1992, but to date the file contains no supporting documentation.

Outcome 28 requires that AMHI shall assure that when physical harm occurs, and when complaints or signs occur, the incident is immediately reported and examination and follow-up care occurs. This outcome has two tasks which regard reviewing policies and procedures and providing training. Both are claimed as being completed. No supporting documentation has been provided.

Outcome 32 requires that AMHI assure compliance with all seclusion, restraint, and protective devices standards. Six of the ten tasks comprising this outcome are claimed as completed. The documentation, taken collectively, indicates that a NAPPI (Non-Abusive Physical and Psychiatric Intervention) curriculum is being utilized for training staff as referenced in tasks #2 and #3. Documentation indicating completion of the other tasks is lacking. The latest of these tasks was due on March 1, 1992.

g. Medication and Monitoring, Record Keeping and Standards (Outcomes 23, 25, 30, and 54)

Outcome 23 relates to paragraph 168 of the Settlement Agreement which requires establishment of a data-base system for monitoring the use of psychoactive medications at AMHI. This outcome includes tasks for increasing the pharmacist position hours, adding a computer work station for the pharmacy, and improving medical staff procedures. On balance, the documentation submitted supports the claim that these tasks have been completed.

Outcome 25 requires that the charts of patients with specialized needs be boldly flagged and that the staff be trained to observe signs and symptoms of medical problems. The last of the four tasks of this section was due on February 1, 1992. AMHI has claimed completion with three of the four tasks, but no documentation has been submitted regarding any of the four tasks.

Outcome 30 requires that AMHI meet medical charting requirements consistent with professional standards. The tasks currently due under this outcome require the development of a training curriculum, completion of mandatory training utilizing a consultant, and in-house training. Documentation submitted indicates that a curriculum has been developed and that mandatory training did take place. There is no documentation regarding the utilization of a consultant or in-house training follow-up.

Outcome 54 requires that AMHI meet listed standards for patient records. Most of the six tasks comprising this outcome are claimed as completed. The file, however, is almost devoid of documentation. The task which is closest to being documented is #6, which requires that AMHI acquire a centralized dictation system to facilitate quality, completeness and legibility of medical records. Documentation supporting the claim of completion for this task is a requisition to purchase a dictating system dated September 30, 1991. Informal information indicates that this project is completed.

h. <u>Staff/Patient Ratios (Outcomes 41 through 47)</u>

As previously noted, AMHI was exempted from its October 1992 reporting requirements; the exception to this exemption was the requirement that it report on staffing ratios. Documentation and follow up inquiries indicate that staff/patient ratios are being met for general medicine physicians, nurses, social workers, and mental health workers. Ratios are not being met for psychiatrists, psychologists, and recreational/occupational therapist/aides.

Pursuant to Outcome 41, the required physician-to-patient ratio, 8:00 a.m. to 4:00 p.m., weekdays, is 1:75. Ratios computed for sample weeks in June 1992 and September 1992 showed ratios of 1:49 and 1:45, respectively. Pursuant to Outcome 42 the ratio of psychiatrists to patients, 8:00 a.m. 4:00 p.m., weekdays, is

required to be 1:25. Sample weeks show the actual ratio to be running from 1:29 to 1:32. This represents approximately a 20% deficit in psychiatric coverage. Both general medicine physician coverage and psychiatric coverage appear to be adequate for hours other than 8:00 a.m. to 4:00 p.m., when one physician is required to be either on duty or on call.

Outcome 43 requires staffing ratios for psychologists of 1:25 from 8:00 a.m. to 4:00 p.m., weekdays. Sample weeks from June to August 1992 show ratios of 1:50, 1:61, and 1:65 respectively. This averages significantly less than 50% of required psychologist coverage. Outcome 44 requires nursing coverage to be 1:20 from 8:00 a.m. to 4:00 p.m., seven days per week, with one assigned per unit during all other hours. These ratios have been met or exceeded.

Outcome 45 deals with social worker ratios which are to be maintained at 1:15, 8:00 a.m. to 4:00 p.m., weekdays. Staff ratio reports indicate that for the week of September 5, 1992, a ratio of 1:09 was maintained. Some questions exist as to whether all the individuals included in this ratio function as social workers. Mental health worker staffing, which is covered under outcome 46, requires a ratio of 1:06 during the day shift, seven days per week, and 1:08 for all other hours. Documentation indicates that these ratios are being met.

Recreation/occupational therapist/aides are to be maintained at a 1:08 ratio overall. Documents indicate that the current ratio is 1:13. Additionally, it is possible that some staff members are included in this category, such as a beautician and a barber, who may be inappropriately included. The second task of Outcome 47 requires that staff be assigned to assure that evening, weekend and holiday treatment and programmatic needs are met. This task is claimed as completed; supporting documentation, however, does not substantiate this in a concrete manner.

It should be noted that Paragraph 204 of the Settlement Agreement excludes certain employees from being counted in staff ratios. Those who are not to be counted include individuals who have not completed at least 90% of their orientation training and those who are performing staff development, quality assurance or similar duties. No documentation has been provided regarding the exclusion of these individuals from the computation of staff ratios. As a result, it is possible that the actual ratios have been overstated.

i. Personnel (Outcomes 48 through 53)

Outcome 48 deals with the qualifications of staff and pertains to Settlement Agreement Paragraphs 105, 106, 107. These paragraphs require up-to-date job descriptions, appropriate licensure, and a method for credentialing health workers. Tasks #1 and #2 require a job description manual and written statement of qualifications.

Completion of these tasks is claimed, but no documentation has been submitted. Credentialing of mental health workers, dealt with in tasks #3 and #4, is documented.

Outcome 49 deals with the recruitment of qualified staff. Task #1 requires, among other things, a departmental committee on recruitment of psychiatrists; no information is provided regarding such a committee. Task #4 requires the expansion of internship programs to all major clinical disciplines. Neither the status report nor the file indicates that the internship programs have actually been expanded. Task #5 requires the conduct of intensive college and university outreach. This task is claimed as complete; the file, however, contains a memorandum of March 1992 stating that there is no need to do outreach because there are no funds to hire individuals.

Outcome 50 requires that AMHI meet defined personnel standards. Tasks #1 and #2, respectively, require at least annual performance reviews and investigation of complaints regarding deficient performance. These tasks are reported as complete/ongoing. Task #1 is not accompanied with any relevant documentation; task #2 is supported by an evaluation form.

Outcome 51 requires that all employees at AMHI receive a copy of the Settlement Agreement. These copies appear to have been distributed at a Consent Decree training session. Outcome 52 requires that AMHI provide an overview of the Settlement Agreement

to all staff and provide training on the terms of the agreement. Completion of all four tasks comprising this outcome is claimed. The documentation for this is uneven. The videotape which is the subject of task #2 has been viewed by this office. The question and answer pamphlet to be compiled pursuant to task #4 has not been filed.

Outcome 53 requires that AMHI meet all listed training requirements. The due date for this outcome was September 1, 1991. Completion with most of the tasks comprising this section has been claimed; however, no documentation has been presented.

2. Standards Governing the Geriatric and Nursing Home Patients, Implementation Plan Section V(C)

This section contains eight outcomes. Most of the outcomes restate components of outcomes dealt with previously under Section V(B). Additionally, many activities regarding nursing facility beds at AMHI are discussed in this report at Section V(B) regarding the Nursing Facility Planning Proposal. Some of the outcomes of this section are briefly highlighted below.

Outcome 1 requires assessment of all AMHI patients who require nursing home care. As discussed in my Review of the Nursing Facility Planning Proposal, these assessments have taken place (task #1). Task #2 of Outcome 1 requires the involvement of a gero-psychiatric specialist; task #3 of Outcome 3 requires the

involvement of a psychiatrist specializing in geriatric psychiatry. This office has been informed that the gero-psychiatric specialist has been replaced by a gero-psychiatric team. This office has requested, but has not received, a statement of the qualifications of those serving on this team. The psychiatrist specializing in geriatric psychiatry is identified as Dr. Wehry. It is my understanding that subsequent to the due date of task #3, Outcome 3, September 1, 1991, Dr. Wehry's work hours at AMHI were substantially reduced. I am currently unclear on the impact of this reduction.

Outcome 4 requires that AMHI attempt to locate, whenever possible, community services close to the home community of discharged nursing home patients. Pursuant to this outcome, task #2 requires that resources be identified which will accept DMH&MR referrals of persons needing nursing facility care. This task is claimed as complete but there is no documentation for this task.

Outcomes 5 and 6 regard training of AMHI nursing home staff, and the retention of a nationally recognized consultant to develop a training program in geriatric psychiatry. Tasks comprising these outcomes are generally claimed as completed. The evidence file contains information regarding psychiatric certified nursing aide training and some information regarding record keeping training. Otherwise, documentation has not been provided substantiating completion of other tasks within these outcomes.

Outcome 7 requires that AMHI retain a nationally recognized consultant to assess patient records in the nursing home and to prepare findings and recommendations. These findings and recommendations were performed by a team led by Dr. Barry Fogel. These findings and recommendations are discussed in more detail in my review of the nursing facility planning proposal. Documentation indicates that AMHI has successfully completed these tasks.

3. Standards Governing Treatment of Forensic Patients, Implementation Plan Section V(D)

This section has a single outcome which requires that all standards pertaining to the treatment of forensic unit patients be consistent with those applicable to all other patients, and that AMHI's Forensic Treatment Unit shall meet the standards of the Settlement Agreement. This outcome contains one task which is simply a statement that the Forensic Treatment Unit is included in each outcome/task applicable to all patients, with the exception of census reduction. Consequently, no independent review is made of standards applicable to the treatment of forensic patients.

F. Mental Health System -- Implementation Plan Section VI

This section of the Implementation Plan contains six different subsections pertaining to various obligations of the defendants under the Settlement Agreement. Each subsection is reviewed below:

1. Client Rights -- Section VI(A)

The outcomes of this section concern revising two sets of regulations, The Rights of Recipients of Mental Health Services and Rights of Recipients Who Are Children In Need of Treatment. These rules were to have been finally approved by February 1, 1992 (Outcome 1) and all compliance systems were to have been in place no latter than March 1, 1992 (Outcome 2).

The Department of Mental Health and Mental Retardation decided not to amend the regulations as required by the Settlement Agreement as a result of objections from community hospitals and practitioners to the application of the seclusion and restraint provisions to community hospitals. These seclusion and restraint provisions are the same provisions applicable to the Augusta Mental Health Institute and are outlined in the Settlement Agreement at Section IX(H).

In September 1992 I sponsored a round-table discussion with the plaintiffs, defendants, and several psychiatrists, including the chiefs of psychiatry of most of the hospitals with psychiatric units in the AMHI catchment area. This discussion was utilized to initiate a mediation process between the plaintiffs and defendants to facilitate resolution to this matter. The mediative phase of this process is nearing completion.

2. Substance Abuse -- Section VI(B)

The first of the two outcomes of this subsection addresses class members with co-existing mental illness and substance abuse disorders. It is further divided into tasks which deal with community hospitalization, housing and residential development, treatment services, recreational/social/avocational services, public education, family support, and AMHI.

Task #2 of Outcome 1 seeks to establish a regional capacity to provide short-term detoxification, stabilization and assessment services within community hospital and/or crisis intervention settings. DMH&MR notes that Certificate of Need approval has been granted for Kennebec Valley Medical Center in Augusta and Southern Maine Medical Center in Biddeford to provide these services. The projected start-up date for Kennebec Valley Medical Center is January 1993. Southern Maine Medical Center has placed these services on indefinite hold according to recent reports. (These projects were discussed in my previous report to the court).

The objective of task #3, Outcome 1, which regards housing and residential development, is to assure that developed services do not exclude persons with co-existing mental illness and substance abuse disorders. The last of the tasks under this section were to have been completed by July 30, 1992. Substantial process seems to have been made in amending contracts which prohibit exclusion by community-based providers of individuals with dual disorders, and

in the development by DMH&MR of standards regarding non-exclusion of such individuals. The Department has not accomplished task #3(b), which requires that each funded agency adopt a written protocol which calls for non-exclusion of individuals with co-existing disorders.

Task #4 of Outcome 1 regards assuring that substance abuse information is integrated with treatment services. Progress is reported in amending contracts to require appropriately trained staff, establish dual diagnosis as a core training requirement, and develop licensing and quality assurance standards.

Tasks #5 and #6 regard disseminating information on the importance on chemical-free options in recreational and social activities and incorporating information on the possible benefits of "12 step programs" in trainings. All tasks are claimed as completed; the last task being due on July 1, 1992. There is no supporting documentation, however, for any of these tasks. Tasks #7 and #8 regard including information on dual disorders in public education and family education. Documentation supports the conclusion that some activity in these areas has taken place. The documentation, however, is sketchy.

Tasks #10 and #11 require the provision of technical assistance and training regarding adolescents with dual disorders. These tasks were due no later than June 30, 1992. Documentation supports compliance with these tasks.

The second outcome of this section regards assuring that the service needs of class members with a sole primary diagnosis relating to substance abuse or dependence are addressed. One of the key tasks of this section, task #1d, is to develop a mechanism to ensure that class members with a sole diagnosis of drug dependence are able to access all the services available to the class as a whole. This task was due on March 30, 1992. The status report for this task indicates that some training was delivered to AMHI admission staff and community agency staff regarding the identification of treatment needs of substance abusers. It does not appear that a "mechanism" as anticipated by task #1(d) has been developed.

3. Training and Human Resource Development -- Section VI(C)

This subsection has two outcomes; the first deals with the development of clinical affiliations and internship programs and intensive college and university outreach. All tasks for this outcome are reported as completed. Documentation for the claims of completion is not substantial. Some of the tasks are not supported by any of the documentation. Documentation for other tasks lack adequate detail. For example, task #6 requires the development of certification requirements for para-professional staff in community programs. The evidence file for this task contains a publication which recognizes specific degrees issued by the University of Maine and the University of New England. It does not include the called-for certification requirements.

Outcome 2 deals with the provision of training on the terms of the Consent Decree and required specific performance obligations of community mental health service providers. The majority of tasks under this outcome are claimed as complete. The documentation is generally sketchy. For a few tasks the documentation is good. Examples are tasks #5 and #6 which require the development of videotape delivery mechanisms, schedules for viewing the videotapes, and development of a handout identifying critical areas in greater detail.

4. Public Education -- Section VI(D)

The single outcome of this section is to provide a variety of public education programs regarding mental illness. The majority of the nine tasks comprising this outcome are claimed as complete. There is no documentation for at least five of the nine tasks (tasks #5 - #9). The latest due date for any of the tasks in this section was July 1, 1992. For some of the tasks there is evidence of at least partial completion. For example, task #2 requires the development and dissemination of informational videos and printed materials focusing on stigma and targeted to the school-age population. There is documentation of the development and dissemination of a KID-TV video, but no documentation regarding development and dissemination of printed materials.

5. Quality Assurance and Internal Monitoring -- Section VI(E)

Quality Assurance and Internal Monitoring are critical elements in the development of a comprehensive mental health system. As is discussed below, this area is severely deficient.

The first of the four outcomes of this subsection requires the monitoring and evaluation of all mental health services. Tasks #3 and #4 are critical, they require a determination of the system and resources necessary to monitor agencies providing mental health services (due date - 12/1/91) and obtaining the resources and implementing the system (due date - 9/1/92). Neither of these tasks appears to be anywhere near completion.

The second outcome requires the design of a comprehensive system of monitoring, evaluation, and quality assurance which has the capacity to collect and report data using an electronic data base. Much of the preliminary work is reported as having been completed or partially completed. It is reported pursuant to task #5 of Outcome 2 that two quality assurance staff were hired in February 1992. There is no documentation, however, demonstrating that the monitoring, evaluation and quality assurance system has been implemented as required by task #5.

Outcome 3 regards the submission of Quarterly Reports outlining compliance with the Settlement Agreement. The defendants are generally submitting Quarterly Reports as required by the

Settlement Agreement. As previously noted, however, there are significant problems, particularly regarding the Department of Mental Health and Mental Retardation, in the quality of the reporting.

Outcome 4 requires an annual review of class members to determine whether their individual needs and rights are being protected under the Settlement Agreement. The first task of this outcome requires the determination of the general scope and method of review. This preliminary task, which was due on February 1, 1992, has not been completed. The second task requires the development of a process for measuring clients' rights protection. Documentation supports that both a form and a process for accomplishing this objective have been developed. Tasks #4 to #7 deal with the development and analysis of an annual survey. The last of these due dates was October 1, 1992. None of these tasks have been initiated.

6. Planning, Budgeting, and Resource Development -- Section VI(F)

This subsection is also critical to the development of a comprehensive mental health system. Implementation of the outcomes comprising this subsection is material to the rational development of resources. As noted below, implementation has been slow and uneven. Outcome 1 requires the development of a general plan (Implementation Plan) detailing efforts to meet all obligations under the terms of the Settlement Agreement. As noted elsewhere in

this Report, and in my previous Reports to the Court, the Department of Mental Health and Mental Retardation has not submitted approvable components for many areas required to be covered by the Implementation Plan. Outcome 1 includes a series of tasks (#9 - #13) to upgrade the Implementation Plan. These include assessing information based upon ISP data, revising the Plan, and submitting budgets. These tasks, all of which have past due dates, have gone largely undone. DMH&MR cites the State's fiscal conditions as precluding budget requests which were to have been made by December 1, 1991. As has been previously observed, the lack of ISP-generated information has also been an impediment to planning and resource development.

Outcome 2 requires the development of a centralized system for the planning, budgeting and development of resources. This outcome is heavily dependant upon the generation of ISP data and patient assessment data at AMHI. Failure to have completed the ISP and assessment work is intimately related to the majority of tasks (#1 - #14) which were due on or prior to December 1, 1992.

Outcome 3 requires the implementation of a mental health information system. Pursuant to task #5, DMH&MR has developed a draft report describing the content, coverage, process, and schedule for implementing a client-related information system. Development of the actual mental health information systems plan, including the acquisition of software and hardware, as outlined in tasks #6 through #9, has not been completed. The last of the due

dates in tasks #6 through #9 was September 1, 1992. The Department notes that it has not had adequate staff to do this task because of budget cuts. It has attempted to ameliorate the problem through the use of consultants. (Memorandum of 10/2692, Bergeron to Rodman).

Outcome 4 requires the development of information on the availability and effectiveness of programs and services for use in individualized support planning. It appears that none of the four tasks which are due have been initiated.

V. PLANNING PROPOSALS

A. Alternative Living Program Planning Proposal

On May 19, 1992 the Department of Mental Health and Mental Retardation filed its Planning Proposal for terminating three of the four remaining "half-way houses" on AMHI's campus. Three of the half-way houses of the Alternative Living Program, Norton, Homestead, and North Gate, had closed prior to the filing of the Planning Proposal. No Planning Proposal was filed with regard to those three houses. The failure of the Department to file the Planning Proposal in a timely fashion was discussed in my previous Report to the Court and was the subject of several meetings (lawyers' meetings of 1/23/92 - #6, 2/27/92 - #6, 4/7/92 - #3). Failure to file the Planning Proposal for closure of the Alternative Living Program was one of the reasons that I sought an Order of the Court to prevent future abuses. The Court issued its Order on July 8, 1992. Facts summarizing problems with the Department's planning process are outlined in my Recommendations and Affidavit appended to the lawyers' meeting notes of July 2, 1992. They are discussed in this Report at Section VI(C).

The Planning Proposal was not approved. In my Review of June 12, 1992 I noted that the Planning Proposal did not adequately deal with issues regarding hospitalization (pages 7 and 8), crisis services (pages 8 and 9), and housing and residential support services (pages 10 and 11). I also noted that the Planning

Proposal required the shuffling of individuals to interim locations while alternative placements were developed (page 5).

I did find that there were some positive features to the proposal. They included the use of wrap-around funds to be made available to community support workers to provide for individual needs (page 12). I also noted the development of services to be provided through contracts with providers throughout the State which would improve an individual's daily living, community living, socialization, recreational, educational, and vocational skills. The focus of these services are to be on direct skill teaching in the individual's environment (page 14).

Although the Planning Proposal was not approved, Defendants did make commitments in the Proposal which are important to the well-being of class members. In my Review I considered all affirmative representations made in the Planning Proposal to be a component of the Defendants' Implementation Plan until amended in accordance with the provisions of the Settlement Agreement. These include, but are not limited to: access to the Augusta Mental Health Institute's hospital beds, the availability of community support workers, individualized support plans, the availability of independent day-living services, and the operation of North Gate until the O'Brion Street Program is made available to those residents.

B. Nursing Facility Planning Proposal

On June 30, 1992 the Department of Mental Health and Mental Retardation filed its formal Planning Proposal (entitled "Plan for Transfer of Nursing Facility Capacity to Community Providers") to transfer most or all of AMHI's nursing facility beds to other providers. Subject to certain conditions, I approved the substance of the Proposal on August 10, 1992.

The Planning Proposal sought to establish additional nursing facility capacity in communities for individuals with mental illness by transferring 71 nursing facility beds from AMHI to community-based providers, and/or by utilizing existing capacity in community-based nursing facilities. (A parallel plan has been proposed for Bangor Mental Health Institute but was not submitted or reviewed as a component of the Implementation Plan under the Settlement Agreement). Pursuant to the proposal, 19 beds would be retained at AMHI but would not be "staffed", i.e. AMHI would retain its licensed bed capacity for the 19 beds, but would not utilize them.

The Proposal sought to establish three distinct types of nursing units: specialized nursing units, specialized and secure nursing units, and dementia units. Specialized nursing units would provide a secure setting with staff specially trained in the care of residents. Gorham Manor, which was the subject of a previously

approved Planning Proposal, is an example of this type of unit. The second type of unit, specialized and secure nursing, is for the most severely challenged individuals requiring a high level of direct-care staff with specialized training. The third type of unit is the dementia unit, serving individuals with mid and late-stage dementing illnesses.

Proposals to provide these nursing facility services were solicited through the issuance of Request for Proposals. Four proposals have been received in response to the Request for Proposals. These proposals seek to establish one or more of the required units in the following locations: Biddeford, Augusta, Waterville, and Bangor. On their face, these proposals do not appear to be competitive with one another. Applications sponsoring these proposals will be filed with the Department of Human Services in order for it to conduct Certificate of Need (CON) reviews. Decisions should be made on non-competing proposals by March 31, 1993. If necessary, competing proposals will be decided by May 30, 1993. A memorandum from DMH&MR states that a preliminary review of each of the four applications indicates that the majority project very high development costs as well as high operating costs (memorandum of November 24, 1992, Martel to Rodman).

One of the conditions for approval of the Planning Proposal was that DMH&MR provide a detailed account of costs (and savings) associated with the Planning Proposal. (Review of Nursing Facility

Planning Proposal, page 14). The Department's memorandum further notes that, based on current information, it cannot detail the projected costs and compare those to the existing costs at AMHI and BMHI.

According to the October 24, 1992 memorandum, the earliest of the facilities would be opening in the spring of 1994; two of the facilities would not open until December of 1994. These projections are substantially later than the projection made in the Nursing Facility Planning Proposal, which projected development of all the beds by late July 1993. This is a particular problem because funds for running the nursing facility beds at AMHI were deappropriated from AMHI's budget in anticipation of eliminating nursing facility beds by the end of fiscal year 1993; $1,871,827 (involving 108 positions) was deappropriated. (Addendum to Nursing Facility Planning Proposal).

In a letter of September 2, 1992 the Department noted that funding for all 108 positions would terminate by early October 1992. The Department noted that it would continue to fund the positions by transferring funds from other line items in the budget. The recent emergency supplemental budget request for FY '93 seeks reappropriation of funds for the nursing facility beds at AMHI.

In my Review of the Nursing Facility Planning Proposal, pages 12 and 13, I noted that the Proposal may not provide all needed

services. Therefore, approval of the Planning Proposal was given with the recognition that additional planning may be required to meet needs of class members for nursing care, geriatric care, or care associated with the end stages of degenerative diseases.

VI. PROCESSING AND RESOLUTION OF SPECIFIC ISSUES

The section of the Settlement Agreement pursuant to which this Report is filed requires the listing of disputes and interpretive questions resolved. These, and related matters, are briefly summarized below. 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.

A. Miscellaneous

1. Training Requirements -- Extension of Time for Compliance

The DMH&MR sought to amend the Settlement Agreement by seeking additional time in which to comply with training requirements outlined in the Settlement Agreement at Paragraphs 118 to 129. It was agreed that the Defendants would not file a motion to amend the Settlement Agreement with the Court and that the Plaintiffs would forebear from taking any action based upon the Defendants' non-compliance with these due dates established by the Settlement Agreement, should new dates be established agreeable to the Plaintiffs and the Master. (Draft motion to amend Settlement Agreement 1/9/92; memorandum of 1/21/92, misdated as 1991, Bailey to Bergeron; LM 1/23/92, #1).

2. Implementation Plan Sections II(A) and (B) -- Request for Extensions of Time

DMH&MR sought extensions of the due dates under these sections of the Implementation Plan (letter of October 9, 1992). I was initially reluctant to grant extensions of time where there was risk of setting a new date which itself would not be met because the conditions causing the original delay had not been remedied. The Department made additional submissions on October 26, 1992 and November 9, 1992 and subsequently it was agreed that new due dates would be established for many of the tasks in these sections. The new due dates were needed in order to establish clear, new, target dates for completion of tasks relating to the development of the ISP process, for the associated development of information systems, and for bringing on line community support workers. The new agreed-to dates for the development of the ISP process and for bringing on line community support workers are outlined in this Report's Section IV(A). (LM, 10/15/92, #2; LM, 11/30/92, #3).

3. Department of Human Services Training Plan

It was agreed to allow DHS to revise its schedule to deliver its training in February and March 1993 to accommodate delays in the development in the ISP process (LM, 9/3/92, #1).

4. Relief From Reporting and Other Requirements

Because of the Defendants' staffing/time constraints, the Plaintiffs and Master agree to the following:

-AMHI was exempted from its quarterly reporting requirement for the third quarter of 1992 (October 1, 1992 Quarterly Report); AMHI was not exempted, however, from reporting of staff/patient ratios (letter of 8/31/92; LM, 7/9/92, #4; LM, 9/3/92, #4).

-DHS was granted relief from the requirement of paragraph 256 of the Settlement Agreement which requires that caseworkers make twice-monthly visits to class member public wards. It was agreed that one of the monthly visits could be made by a case-aide so long as caseworkers attended the treatment team meetings. It was agreed that neither the Plaintiffs nor the Master would seek enforcement of the provision of paragraph 256 regarding the Departments utilization of case-aids during the remainder of fiscal year 1993 (LM, 8/6/92, #1; LM, 9/3/92, #2).

-Pursuant to the Implementation Plan, DMH&MR is responsible for the development of a pilot information system for contract management, quality assurance and planning purposes. Several tasks in Section II(A), Outcome 1 and Section VI(F) of the Implementation Plan relate to this directive. One key task, task #10 of Outcome 1 of Section II(A), it had a due date of January 1, 1992 which was not met by the Department. It was agreed that the Department would submit new tasks which would consolidate and rationalize the existing tasks relevant to the goals of Section II(A), Outcome 1 in Section VI(F). The Department will submit new proposed due dates for newly proposed tasks (LM, 12/16/92, #2).

5. Evidence File

The need to improve the quality of the evidence file has been the topic of repeated discussion. The evidence file is that body of documentation that the Defendants are required to compile and submit to demonstrate progress in complying with the Settlement Agreement. Several problems have been identified regarding the "evidence file". Documents are frequently unrelated to the specified tasks and frequently do not support claimed completion of specified tasks. An additional problem is that the evidence file has been poorly managed.

To begin to address the most basic issues regarding the integrity of the file, it was agreed that each document placed in the file would have: 1) a title, 2) the name of the author or authors, and 3) its date of creation. It was also agreed that there would be a master index to the file which would identify the documents by use of the above information and would also include the date of entry into the evidence file. It was also agreed that there would be a sign-out sheet for all material which is taken from the evidence file, with material removed being identified by the specific tasks to which the documentation relates.

Stemming from the identification of obvious problems with the evidence file, counsel for the Department of Mental Health and Mental Retardation agreed to supervise the development of a comprehensive index. He also indicated that he will assist DMH&MR

to understand what constitutes adequate evidence of compliance. He also noted that he would be meeting with departmental employees in an effort to upgrade the submission of supporting documentation regarding compliance with specific tasks under the Implementation Plan (LM, 7/23/92, #8; LM, 8/6/92, #2; LM, 9/3/92, #6; LM, 10/15/92, #3). It is hoped that these measures will bring substantial improvements to the Department's documentation of its compliance with the requirements of the Settlement Agreement.

6. DHS Public Ward Check List

The Department of Human Services and Plaintiffs reached an agreement regarding DHS's utilization of a check list with respect to its class member public wards. The Plaintiffs assisted in the development of the check list. It is my estimation that the check list has been a component in the improvement in the functioning of DHS guardianship for its class member public wards (LM, 2/27/92, #3).

7. Housing and Residential Support Services

In the absence of an approved plan for housing and residential support services, these services remained the object of our attention. The Plaintiffs were particularly concerned with the development of "residential treatment facilities". Among their

concerns were that these facilities might not provide for flexible services and that they might not represent the least restrictive alternative for individuals. (LM, 2/27/92, #8; memorandum of 2/25/92). A series of meetings was held from March to May 1992 to promote resolution of these matters. One result of this process was DMH&MR's commitment to allow individuals residing in residential treatment facilities to enter into leases if desired. (Memorandum of 6/18/92, Bergeron to Bailey).

It was also agreed that the DMH&MR would file its final version of the Housing and Residential Support Services sections of the Implementation Plan by August 3, 1992 for my review (LM, 6/11/92, #1). As noted in Section IV (B)(2) the Department did not file its Plan as agreed.

8. <u>Tri-County Emergency Services</u>

I reported in my last Report that DMH&MR was attempting to upgrade the involvement of St. Mary's emergency room regarding the medical triaging of patients. The Department reported that, beginning July 1, 1992, a seclusion room would be made available at the emergency room and that medical screening of individuals would take place for individuals who might otherwise have been automatically referred for mental health services (LM, 7/9/92, #1).

9. Settlement Agreement Paragraph 159

This paragraph of the Settlement Agreement requires that certain entitlements and basic human rights not be treated as privileges. We discussed AMHI's "privileges" policy in light of paragraph 159. It was agreed that the existing "privileges" document would be changed from a privileges to a "rights" document. It was further agreed that the document would be revised for inclusion in the January 1993 Quarterly Report (memorandum of 7/17/92, Rodman to parties; LM, 7/23/92, #3; LM, 8/6/92, #4).

10. Community Support Worker -- Medicaid Regulations

Both Plaintiffs and myself noted that there appears to be confusion over the role of community support workers. Informal reports indicated that individuals who were supposed to be performing as community support workers were not performing all required duties and were not being properly identified as community support workers. The Department of Mental Health and Mental Retardation responded by letter of September 11, 1992 that the key problem had been the Department's failure to amend Medicaid reimbursement rules to provide reimbursement for community support worker services. DMH&MR provided proposed Medicaid rules under a cover memorandum of November 18, 1992. Promulgation of the regulations is anticipated by approximately March 1993 (LM, 9/3/92, #8; LM, 9/17/92, #2; LM, 11/2/92, #2; LM, 11/30/92, #2).

11. Settlement Agreement Paragraph 206 -- Licensure and Certification of AMHI Staff

The first issue regarding the application of paragraph 206 involved its footnote, which contains some limits to the application of Paragraph 206. It was agreed that this footnote was intended to be limited to identifiable psychologists(s) employed at AMHI at the onset of the Settlement Agreement. The second issue concerned the application of Paragraph 206 to mental health workers. Paragraph 206 requires appropriate licensure, certification or registration of all persons at AMHI who, if they perform similar duties in the community, would be subject to such requirements. Apparently, there are no analogous community-based positions for AMHI mental health workers. It was agreed that this matter is dealt with by Paragraph 207, which requires the Defendants to implement standards for credentialing mental health workers. DMH&MR noted that all mental health workers are certified nurses aides and that plans are underway to have them meet mental health rehabilitation technician I level certification (LM, 9/3/92, #9).

12. Forensic Unit -- Application of Paragraph 40

Pursuant to Paragraph 40 of the Settlement Agreement, the Forensic Treatment Unit at AMHI is to be limited to individuals who are admitted under Title 15, MRSA Chapter 5 or who are under sentence to, or committed to, a State or County correctional facility. The Plaintiffs noted that there were some individuals ("non-legal holds") in the Forensic Treatment Unit who do not meet this

requirement. The Plaintiffs requested that certain of these individuals be offered the opportunity to leave the Forensic Treatment Unit pending further placement. The Plaintiffs did note, however, that the restrictions of Paragraph 40 may be unduly narrow in certain circumstances. It was agreed, therefore, that AMHI would submit a plan regarding placement of non-legal holds on the FTU by January 16, 1993. This plan will be submitted for approval as a component of the Defendants' Implementation Plan. This dispute was submitted by the Plaintiffs pursuant to Paragraph 294 of the Settlement Agreement (Plaintiffs' letter of December 10, 1992; Defendants' memorandum of December 15, 1992; LM, 12/16/92, #1a).

13. Settlement Agreement Paragraph 69 and 87 -- Summary Eviction of Individuals From Group Residences

The Plaintiffs complained that individuals at the O'Brion Street residence have been summarily denied re-admission. Allegations are contained in the Plaintiffs' letter of December 10, 1992. The Plaintiffs requested that the Defendants be required to bring all recently developed group residences into compliance with Paragraph 69 of the Settlement Agreement. Paragraph 69 sets requirements regarding the discontinuation or interruption of services by certain community providers. DMH&MR acknowledged that it does not have a contract with O'Brion House. The Department agreed to report back a proposed date by which O'Brion House would have a contract with the Department.

In order to guide the Department in the exercise of its authority to grant permission to community providers to reject the residency of a given individual, it was agreed that there was a need to develop a protocol. This matter will be pursued during regularly scheduled meetings in January, 1993. This dispute was submitted by the Plaintiffs pursuant to Paragraph 294 of the Settlement Agreement. Plaintiffs also requested that the Defendants retain experts, pursuant to Paragraph 87 of the Settlement Agreement, to assist current and future providers to meet the needs of residents (LM, 12/16/92, #1b).

B. Disputes Regarding My Review of November 1991 Of The Implementation Plan

The Defendants invoked informal dispute resolution procedures by their respective memoranda of January 10, 1992 in response to my Review of the Implementation Plan of November 27, 1991. In general, there was a significant degree of accommodation to the requirements and conditions contained in the Review. Among the areas involved in dispute resolution were the following:

1. DMH&MR originally proposed to resubmit the housing component of their plan by July 1, 1992. (As noted in Section IV(C)(2), no plan was filed on July 1, 1992 or at subsequent later dates as promised by DMH&MR).

2. The Defendants objected to the condition attached to the reduction of AMHI's census to the extent that it stated "the termination of services at AMHI be done only pursuant to the approval of a planning proposal for the termination of such services" (emphasis added). I clarified this condition by

stating that it related to "downsizing" resulting from the reduction of bed capacity.

3. The Defendants also objected to my disapproval of the regional board component of Section VI(F) of the Implementation Plan. Disapproval of this section stemmed from my concern that DMH&MR might not retain all necessary authority, with the establishment of regional boards, to implement the Settlement Agreement. The Department agreed to pursue the incorporation of language in proposed legislation concerning the establishment of regional boards which would allow the Department to retain all necessary authority.

4. Several general conditions were attached to my Review at Section VII. The Defendants objected to condition #3 regarding their obligations to try to obtain funding for the implementation of the Settlement Agreement. This issue was at least partially resolved through the Court's issuance of its Order of July 8, 1992.

5. DHS objected to the potential application of paragraphs 281 and 34(a) of the Settlement Agreement to class member children in DHS custody. DHS also objected to the suggestion that DHS class member children may be entitled to have their needs met prior to September 1, 1995. In spite of processing these matters, there has been no resolution to date.

6. The general Implementation Plan was supplemented with the children's component of the Plan on January 15, 1992. I substantially approved this component of the Plan in my Review of January 31, 1992. In the Review I approved the conflict resolution process outlined in the Part I Addendum "conditioned upon the Defendants' amending it to clarify that children are entitled to utilize the grievance and complaint procedure....". DHS was concerned that this condition was intended to permit children to directly access the grievance and complaint procedure. I clarified that this condition was not intended to alter the role of legally responsible persons in utilizing the grievance and complaint procedures on behalf of the children (LM 1/23/92, #3; LM 2/27/92, #1, #7).

C. Court Order Of July 8, 1992

The parties agreed to the entry of an Order by the Court to assist in remedying failures by the Department of Mental Health and Mental Retardation to properly plan for the downsizing of AMHI. The factual basis for the agreement regarded five findings that I had made. They were that the Department had:

1) failed to abide by existing agreements and requirements for downsizing AMHI and developing a comprehensive mental health system;

2) consistently filed plans which are extremely late;

3) proceeded to terminate bed capacity at AMHI when its plans to do so had been specifically disapproved;

4) phased out beds at AMHI without filing any plans and;

5) terminated services at AMHI before alternative services had been made available.

(Recommendation of 7/2/92, appended to lawyers' meeting notes of 7/2/92). Appended to the same notes is my Affidavit, which detailed the specific facts underlying the above-listed findings. In order to insure there was an agreed-to basis in fact underlying the proposed Order, the Defendants stipulated to the accuracy of the facts contained in the Recommendations and Affidavit. It was agreed that should these underlying facts be the subject matter of future action, the Defendants could supplement, but not controvert, facts contained in the Recommendation and Affidavit.

The Court's Order, which is attached as #1, includes provisions requiring that:

-- Planning Proposals be filed prior to the initiation of any substantial activity in furtherance of plans to reduce bed capacity at AMHI;

-- the Defendants refrain from all irrevocable acts which would diminish DMH&MR's bed capacity prior to the Master's approval of a Planning Proposal relating to the downsizing;

-- the Defendants fully inform the Legislature regarding the impact of budget requests upon the Settlement Agreement, including specific disclosure of the status of any relevant Planning Proposals.

Issuance of the Court's Order concluded the process of resolving disputes over the Recommendations contained in the Report to the Court of January 31, 1992.

VII. OBSERVATIONS REGARDING THE AUGUSTA MENTAL HEALTH INSTITUTE

A. Census Management

AMHI's census continues to decline. In January 1991 the average daily census at AMHI was 294. In January 1992 the average daily census was 230. This decrease is somewhat in excess of what would have been expected from just the loss of beds due to the transfer of 17 nursing facility beds to Gorham Manor and the closing of AMHI's Adolescent Unit. AMHI's average monthly census from January 1992 through November 1992 was as follows:

January	230.0	July	196.8
February	231.6	August	204.8
March	234.1	September	208.5
April	228.3	October	214.2
May	216.5	November	214.7
June	198.4		

The sharp drop between April 1992 and June 1992 (228 to 198) would appear to be due, for the most part, to the closing of the Alternative Living Program.

DMH&MR's freeze on nursing facility bed admissions will necessarily work to keep AMHI census at a level somewhat lower than it would be otherwise; however, it would be difficult to quantify this factor. AMHI maintains 90 licensed nursing facility beds, but, as of January 13, 1993, had a nursing facility census of only 47. While AMHI's occupancy rate for November 1992 was just under 83%, most of

these vacancies resulted from open nursing facility beds. The 169 licensed hospital beds at AMHI (which together with the nursing facility beds comprise all of the beds at AMHI) have a very high occupancy rate. For example, as of January 13, 1993, AMHI's overall occupancy rate was 80%, which reflected a 52% occupancy rate in its nursing facility beds, and a 95% occupancy rate for its hospital beds.

In order to manage its census, AMHI continues to rely heavily upon its diversion program. AMHI diverts individuals from AMHI by seeking both hospital and non-hospital services elsewhere. The only hospital in AMHI's catchment area which accepts any significant number of involuntarily committed individuals is the Jackson Brook Institute (JBI). The vast majority of individuals diverted from AMHI for hospital services go to JBI. From January 1992 through November 1992 the following number of people were diverted from AMHI to JBI:

January	1992 - 44	July	1992 - 71
February	1992 - 52	August	1992 - 52
March	1992 - 46	September	1992 - 74
April	1992 - 60	October	1992 - 54
May	1992 - 46	November	1992 - 53
June	1992 - 87		

For 1992, the average number of people diverted from AMHI to JBI was 58 per month. This is very close to the average number of people admitted to AMHI per month. For fiscal year 1992, $1,176,018 was expended on diverting individuals to hospitals other than AMHI. This was over $400,000 more than anticipated for

diversion expenditures for FY '92. Of the total amount expended for diversion hospitalization in AMHI's catchment area approximately 65% went to JBI (letter of 8/26/92, Bergeron to Rodman; memorandum of 11/5/92, Laurie to Rodman).

The availability of beds at AMHI and JBI is tracked on a daily basis. The most recent monthly report of bed availability is attached as #5. It should be noted that bed availability is determined by ascertaining the open number of beds at 11:00 a.m. each day. As a result, this data presents only a snapshot of a given day; bed availability can change during the course of a day. The attachment shows the available number of beds at AMHI's two admissions units (CBU - North and CBU - South) and for JBI. A negative number indicates that the corresponding admissions unit at AMHI or JBI was over-census. As can be seen from the attachment, there is frequently limited bed availability for individuals in need of involuntary hospitalization. These bed availability summaries are produced monthly as part of the C.L.A.S.S. committee process.

B. General Conditions of Operation

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) conducted a full survey of AMHI in November 1991. As a result of that survey a number of significant deficiencies, termed "Type I Errors" by JCAHO, were noted.

Deficiencies were noted in the areas of monitoring and evaluation of staff, drug use evaluation, emergency services, and staff privileging policies, among others.

JCAHO conducted a focused survey (surveying for correction of Type I matters) on August 31, 1992. In its official accreditation report of October 2, 1992 JCAHO removed the Type I recommendations which it had previously placed upon AMHI's accreditation. AMHI reported that this constituted the removal of all Type I recommendations (memorandum of 10/14/92, Ayer to Rodman).

The Department of Human Services conducted its licensing survey of AMHI on April 27, 1992. Among the deficiencies found by the Department were: lack of evidence of quality assurance review for contracted radiology and pathology services; cancellation of 77% of scheduled staff in-service trainings; physical plant deficiencies; exposed pipes in stairwells and entrances of certain buildings; lack of a system for retrieving medical record information by physician; diagnosis or procedure; and failure of the utilization review committee to meet as frequently as required. Most of the physical environment deficiencies appear to be associated with an aged physical plant.

I reported in my last Report there had been a statistically identifiable decrease in the use of seclusion and restraint measures at AMHI. Statistics compiled over the past year indicate that the use of seclusion and restraint has remained reasonably

stable. In the five months preceding December 1992, there was an identifiable increase in the total number of seclusion episodes; the average duration of the seclusions were shorter than in the past, however, and therefore the total number of hours of seclusion remained stable.

I also reported in my last Report that the work environment at AMHI had been extremely stressful. Unfortunately, this condition persists. AMHI received some relief when the number of furlough days for direct-care staff was reduced. Furlough days, however, continue to have a negative impact upon patients and staff. Morale appears to remain low.

VIII. DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION STAFFING

The Department of Mental Health and Mental Retardation responded on October 28, 1992 to an extensive inquiry I had made regarding the adequacy of DMH&MR staffing. The inquiry was based upon a number of observations I had made over the prior two years. Among the observed deficiencies were, and continue to be, inadequate planning for the development of needed mental health resources, inadequate development of resources, lack of a solid information base (i.e., the need for a management information system), and lack of quality assurance activity. The fact that the inquiry was directed at DMH&MR does not imply that the Department of Human Services is without staffing deficiencies; I simply elected to make a focused inquiry of DMH&MR based upon the observations reported above.

The Department hired a housing coordinator in September 1992 . The position had been vacant for nine months. Prior to September 1992, no one within DMH&MR had specific responsibility for this area. The Department continues to lack the necessary staffing to plan for and develop residential support services. These services are critical to enable people to successfully reside in their housing.

The Implementation Plan requires the establishment of a management information staff. This is to include a director of MIS, a computer programmer and half-time systems analyst. The position of director of MIS was abolished shortly after its creation; it was never filled. The systems analyst and computer programmer

positions were authorized effective January 1992, but have remained vacant. They are proposed for abolition in the current budget request. Obviously, the Department's capacity to manage information is severely strained.

The Department was authorized to hire a Director for a Division of Research and Quality Assurance beginning in March 1992; the position has remained vacant. The Department states that it is currently recruiting for this position. The Department makes particular note of the need for an additional quality management specialist with a specialty in children and adolescent quality assurance programming.

The Bureau of Mental Health within the Department has been short of personnel because the Director of the Office of Community Support Services had functioned as the Acting Director of the Bureau beginning in November 1991, thereby leaving the Office of Community Support Services position vacant. The Superintendent of AMHI, Linda Breslin, now holds a new position which combines oversight of AMHI and BMHI with the duties of the Director of the Bureau. Having one person with responsibility for both State Hospital and community services offers at least theoretical improvement in the coordination of services. This consolidation, however, results in the loss of another position, further straining already thin human resources.

In the addition to the areas noted above, the Department also highlights its shortage of staff in the areas of: crisis intervention and resolution services, individualized support planning, community hospital services, and state hospital services. The Department's total need for additional human resources is modest in terms of the number of additional staff (and/or consultants). The functions to be carried out by these individuals, however, are extremely important in the development of a comprehensive mental health system. As noted in this Report, current budget proposals seek to further diminish the Department's human resources.

A truly comprehensive mental health system will require highly coordinated mechanisms for assuring quality of services and promoting the necessary planning and development of resources. The current fiscal strategy appears to be one of maintaining vacant positions for long periods to generate "savings", eliminating needed positions, and not creating needed positions. I do not see the strategy as resulting in any genuine cost savings. Rather, inefficient, uncoordinated, and deficient services are likely to result in greater overall costs to the mental health system.

ADDENDUM

This Addendum is for two purposes: first, to address comments of the Department of Mental Health and Mental Retardation and the Department of Human Services regarding the draft of this Report which was submitted to the parties for their review; and second, to briefly to discuss recent submissions of the Department of Mental Health and Mental Retardation.

Comments of the Parties

This Report reflects a moderate number of changes made at the request of the involved departments. Also, additional material which the Defendants requested be added to the Report is so added through incorporation in this Addendum. Additionally, certain requests which I did not honor are outlined and discussed below.

The Department of Mental Health and Mental Retardation objects to the inclusion of Section IV, Implementation Plan Review, in this Report. Among the objections are that there is new evidence which has been added to the evidence file and that some of my interpretations of the evidence which has been reviewed could be interpreted as findings of non-compliance. I have chosen to leave Section IV in this Report. As I noted in the Report, the evidence reviewed was that available when the October 1992 Quarterly Report

was submitted. Recently submitted evidence will be reviewed and reported upon in my next Report to the Court. Moreover, if the Defendants feel that any of the new evidence is of particular importance I will file an interim report on matters covered by such evidence at the request of any of the parties. Most importantly, it is my obligation pursuant to paragraph 299 of the Settlement Agreement to report to the court regarding details of "the progress achieved by the Defendants with implementing the terms of this agreement". Section IV was specifically included as part of my fulfillment of this obligation.

I noted in many places in this Report that the Department of Mental Health and Mental Retardation was behind in its planning efforts. This fact was summarized in part in the Introduction to this Report at page 4 where I state "unfortunately, the Department is severely behind in its planning in several critical areas including housing, residential and support services, and crisis intervention and resolution services. The failure to complete assessments of patients at AMHI remains an impediment to sound planning". The Department has requested that I change these sentences to reflect planning documents recently submitted by the Department. The Department also notes that it has lacked cooperation of outside professionals generating the assessments referenced above. I have chosen to leave the sentences in the Introduction because I believe that they remain accurate statements. I note my pleasure, however, with the fact that the Department has submitted planning documents in areas that are

critical to implementation of the Settlement Agreement. These plans are briefly discussed below under the title Recent Submissions. Those plans which are intended to become part of the Defendants' Implementation Plan will be subject to formal review. Subsequent to formal review, should any of the parties request that an interim report be filed with the court regarding those plans I will file an interim report. Otherwise, they will be reported upon in my next regular Report to the Court.

In this Report, at page 36, I stated that the Department of Mental Health and Mental Retardation has not promulgated certain required "Rights Regulations". The Department feels that this statement standing alone may be misleading. The Department states "those regulations were proposed, and you and the plaintiffs' counsel were not satisfied with the results of the APA process". This statement is accurate. The Department did proposed certain regulations but declined to promulgate them in light of many negative public comments which were made regarding some of the regulations. As also noted on page 36, I am currently mediating disputes regarding the promulgations of these regulations.

The Department of Mental Health and Mental Retardation notes that the rescheduling for the development of the ISP process will need to result in the rescheduling of other associated tasks. The Department specifically points to the schedule for meeting all identified treatment needs as discussed in this Report at Section IV.C.5., at page 56. I agree that delays in implementing the ISP

process will result in other delays for which new schedules should be established. As discussed in this Report at Section IV.B., the ISP and CSW schedule of implementation was revised at the Department's request. It is anticipated that future requests will also result in revised schedules for other tasks.

The Department of Human Services notes that as the budget is processed changes may occur in the budget as outlined in this Report. In terms of reporting, the budget does present somewhat of a moving target. The budget outlined in this Report is the Governor's proposed budget. The Department notes its belief, for example, that the proposal to limit individuals to a maximum of two prescriptions per month under the Medicaid program is no longer under consideration by the Legislature, at least with respect to fiscal year 1993. At this writing, however, the Legislature has taken no formal action with respect to most items in the FY '93 budget and has not yet begun processing the FY '94/'95 budget. The Department's statement that the two prescription per month limitation is no longer under consideration for FY '93 is, nonetheless, encouraging.

At page 65 of this Report I discussed reasons for the delay in licensing of new facilities, Dirigo Place and Aspen Ledge. The Department of Human Services has provided a detailed statement of reasons for the delay which I accept. The Department states:

> In the fall of 1992, members of the Interagency Licensing Team (BCFS, BCSN, BMH, and OAS) examined whether or not changes were needed in residential child care regulations before

programs such as Dirigo Place and Aspen Ledge could provide short-term stabilization and crisis services. It was later determined by the Team that the residential child care facilities could provide short-term crisis services with existing rules if the facilities modified certain existing policies (letter of 10/8/92 Coulombe to Rodman). Dirigo Place and Aspen Ledge began the process of submitting this documentation in November, 1992. Approval of the crisis beds has been delayed, in part, because subsequent to October each program has had to also demonstrate compliance with certain regulatory requirements applicable to other aspects of their programs (one program had a staff vacancy and the other had to expand upon certain written policies and procedures).

At page 104 of this Report I noted that the Departments have been given relief from reporting and other requirements from time to time. The Department of Human Services notes that they were also granted relief from the preparation of Quarterly Ward Reports. It was agreed that the Department would file its Reports on a six-month basis. (Lawyers' meeting 9/3/92, #3).

Recent Submissions

Recently, three documents of note have been submitted by DMH&MR: 1) Housing and Residential Support Plan, 1/29/93; 2) Psychiatric Emergency and Crisis Stabilization Services Plan, 1/29/93 (copy of plan submitted to the Standing Committee on Human Resources, Maine State Legislature); and 3) Final Report, Consortium of Southern Maine General Hospitals - Study to determine Feasibility for the Development of Acute Psychiatric Inpatient Care.

The hospital study is the Final Report of the Hospital Consortium; a preliminary study by the Consortium is discussed in this Report to the Court at page 48 (Section IV.C.1). The Consortium's Final Report is not a product of the Defendants and does not include anything in the nature of a Planning Proposal for any potential reduction in bed capacity at AMHI associated with the development of community-based hospital beds. The Final Report is taken as evidence, however, that the Department of Mental Health and Mental Retardation has met with community hospitals to determine the feasibility of developing community hospitalization options as required by the Implementation Plan, III.A., Outcome 1, Task #3 (due date - 10/1/91).

The Psychiatric Emergency and Crisis Stabilization Plan appears to have been submitted as part of DMH&MR's planning obligations under Implementation Plan Section III.D., possibly pursuant to task #8 (due date 9/1/92). The Housing and Residential Support Plan was specifically submitted for approval as part of the Implementation Plan (Section III. B&C). This Plan is described as a "Phase One" plan and relates only to individuals who have recently been at AMHI for stays of 150 days or more. Crisis service planning is discussed in the Report at Section III.C.3, beginning at page 52. Housing and Residential Support Services are discussed in Section III.C.2., beginning at page 49.

2/12/93
DATE

Gerald Rodman, Master

STATE OF MAINE
KENNEBEC, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-89-88

PAUL BATES, et al.,

Plaintiffs

v.

ROBERT GLOVER, et al.,

Defendants

ORDER PURSUANT TO PARAGRAPH 12 OF SETTLEMENT AGREEMENT

Defendants Department of Mental Health & Mental Retardation, its Commissioner, and the Superintendent of AMHI shall forthwith abide by the following requirements regarding planning, budgeting, and resource development:

1. The Defendants shall file Planning Proposals in a timely and meaningful fashion. Planning Proposals shall be subject to the Master's approval as components of the Defendants' Implementation Plan. Approval of Planning Proposals shall be required prior to the reduction of bed capacity at the Augusta Mental Health Institute. Planning Proposals shall be filed prior to the initiation of any substantial activity in furtherance of plans to reduce bed capacity. An example of such activity is the issuance of requests for proposals relating to Augusta Mental Health Institute bed capacity reduction.

Budget requests, whether seeking appropriation, deappropriation or reallocation of funds, which relate to the subject matter of a Planning Proposal, shall be fully described in the Planning Proposal. All Planning Proposals

shall be filed at the earliest possible date and in no case shall be filed less than thirty (30) days before submission of the biennial budget to the Legislature, and for all other budget submissions, no later than simultaneously with the submission of the budget request to the Legislature.

2. The Defendants shall refrain from all irrevocable acts, such as entering into binding contracts which would effect a transfer of bed capacity from AMHI or otherwise diminish its bed capacity, prior to the Master's approval of a Planning Proposal relating to that bed capacity reduction.

3. The Defendants, when communicating with the Legislature regarding budget requests, shall take all actions necessary to ensure 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.

Nothing contained in this Order shall be construed as diminishing any existing obligations under the Settlement Agreement or incurred through processes established thereunder.

July 8, 1992
Date

Bruce Chandler, Justice
Superior Court

BUREAU OF MENTAL HEALTH
COMMUNITY SUPPORT WORKERS
FY92

AMHI AREA AGENCIES	FUNDING	# OF WORKERS	# NEW	DATE STARTED
Kennebec Valley Mental Health Center	$518,557	25	1	March 1992
Tri-Counth Mental Health Services	737,138	12	2+2	March + July 1992
Community Counseling Center	6,000	1		
Counseling Services, Inc	746,244	28	1	March 1992
Shoreline Community Mental Health Services	147,419	7	2	March 1992
Mid-Coast Mental Health Center	451,029	8		
Holy Innocents	882,195	25	8	March 1992
DHRS (Waterville)	89,563	6	1	March 1992
Motivational Services	198,173	7		
Kennebec Valley Regional Health Agency	324,814	22	1	March 1992
Pine Tree Society	20,000	1		
TOTAL	$4,121,132	142	18	

NON-AMHI AREA AGENCIES	FUNDING	# OF WORKERS	#NEW	DATE STARTED
Aroostook Mental Health Center	$449,612	12	2	January 1992
Community Health & Counseling Services	918,876	31	2	March 1992
Opportunity Housing, Project Maison	21,271	1		
Central Maine Indian Association	58,248	1		
TOTAL	$1,448,007	45	4	

ATTACHMENT #2

bmh\cdcsw rev. 11/2/92

#	AMHI AREA AGENCY	FY92 Funding	Facility/Project Name	Beds	Type	New in 92	New $	Rent Subsidy	Capital Funding Source
4-2-004	Tri-County M H Services	$260,691	306 Pine St	6	Intensive MH group home				
5-2-006	Counseling Services, Inc	308,938	Crescent Place	6	Intensive MH group home				
			Bacon St Apts	6	single-site suppt'd apts	Yes	4,725	4,725	MSHA 1%
			Woodbridge Road	7	MH boarding home for homeless MI	Yes	46,750		HUD McKinney
6-2-007	Bath-Brunswick MHA	49,950	not a facility	N.A.	Initial funding for suppt'd hsng prog	Yes	49,950		
6-2-008	Mid-Coast MHC	50,000	not a facility	N.A.	Initial funding for suppt'd hsng prog	Yes	50,000		
5-2-017	Shalom House, Inc.	930,242						33,447 **	
			Shalom House	15	transitional resid. facility (1/2 way house)				
			Shalom Apts	11	single-site suppt'd apts				
			Brackett St	14	single-site suppt'd rooms				
			Clark St	6	Intensive MH group home				
			Spring St	8	SRO w/ supports & on-site mgr.				
			Vaughn St	6	SRO w/ supports & on-site mgr.	Yes	26,853		HUD McKinney
			Stevens Ave.	20	single-site suppt'd apts				
			Suppt'd Apts	11	scattered site apts	1 add'l site	*		
			O'Brion St	6	Intensive MH group home	Yes	60,000		CROP
5-2-018	Ingraham Volunteers	212,322	The Bridge	11	short-term transitional				
			Ray House	7	MH boarding home for homeless MI	Yes	60,000		BMH $ (assume existing HUD)
3-2-027	Motivational Services	717,917							
			Elm St House	11	Intensive MH group home (elderly)				
			Middle St House	8	mid-term transitional				
			46 Middle St Apts	5	single-site suppt'd apts				
			Sunrise House	5	Intensive MH group home (deaf)				
			Family Care Homes	2	short-term foster home setting				
			Pleasant St House	6	Intensive MH group home	Yes	29,899		CROP
4-2-036	Area IV MH Services	53,434	not a facility	N.A.	housing finding & support service				
5-2-039	York County Shelter	61,615	York County Shelter	N.A.	shelter				
		25,000	Mousam St Project	6	mixed model: SRO & efficiency	Yes	25,000		MSHA 1%
4-2-040	RAFTS - 47 Wood St.	12,853	Wood St	6	MH boarding home				
			Bradley St	6	MH boarding home				
3-2-052	Medical Care Development	54,324	109 Davis Ave, Auburn	8	Intensive MH group home	Yes	54,324		CROP + HUD McKinney
5-2-070	Goodwill Industries	99,943	Caron St	6	MH boarding home (deaf)				
3-2-088	KVMHC - Residential	82,000	Silver St	5	single-site suppt'd apts	Yes	12,000	41,450	MSHA 1%
			Union St	7	single-site suppt'd apts				
5-2-106	Creative Health Foundation	184,585	Beach St	6	Intensive MH group home (elderly)	Yes	109,139		CROP
			81 Ocean St	6	single-site suppt'd apts	Yes	16,650	16,650	MSHA 1%
			Sawyer St	6	MH boarding home (BMH buys 2 beds)				
	Total:	$3,103,814		239			545,290	96,272	

* Funding for the additional site, as well as O'Brion Street, was not new money but resulted from increased federal PNMI to the agency freeing up state general funds.

** This rental subsidy program was not new in FY92.

#	NON-AMHI AREA AGENC	FY92 Funding	Facility/Project Name	Beds	Type	New in 92	New $	Rent Subsidy	Capital Funding Source
1-2-001	Aroos Mental Health Ctr	$441,198							
			Skyhaven Transitional Resid.	12	transitional resid. facility (1/2 way house)				
			Caribou Apts	10	single-site suppt'd apts				
			Supported Housing	n/a	to be developed FY93 (total 19 units in County)				
			Madawaska Group Home	6	MH boarding home				
2-2-002	CH & CS	176,970	Orono Group Home	8	mid-term transitional				
			Transitional Apts	6	single-site suppt'd apts				
2-2-012	Charlotte White/Penquis	32,128	Capt. Miller House	5	single-site suppt'd apts	Yes	32,128		MSHA 1%
2-2-030	Together Place	4,000	Center Ave Housing	5	limited equity cooperative (start-up $)	Yes	4,000		Local bank w/ Fed Home Loan Bank
2-2-047	Opportunity Housing	28,411	Three Hudson St	6	MH boarding home				
3-2-052	Medical Care Development	166,645	Bucksport Group Home	6	Intensive MH group home	Yes	166,645		CROP
	Total:	$849,352		64			202,773	0	

ATTACHMENT #3

BCSN CONTRACTS - ACTUAL FY 92

AREA III

Southern Maine - Region V

INFRASTRUCTURE (Existing Services)		CONSENT DECREE (New/Allocated to Area III)	
Homebased Services	143,492	Crisis Services	269,240
Day One, Sweetser Children's Services		Sweetser Children's Services	
Residential Services	368,000	Case Management	284,170
Sweetser, (RTC) Spurwink (RTC) Merrymeeting Farms		Sweetser Children's Services	
Outpatient Services	392,000	Residential Services	
Community Counseling Center, York County Counseling, W. Maine Institute, YWCA		(Available to Area III)	
		Transition & Crisis	
Family Support	84,562	Acadia - Area I (Aspenledge)	
Freeport Community Services PROP, Youth Alternatives		NAFI - Area II (Dirigo Place) Meadowview - Area II	
		Specialized Treatment Residence	
Day Treatment	179,535		
		Dual Diagnosis - Atrium - Area I (Janus House)	
Spurwink School, Sweetser Children's Services		Non-Adjudicated - Area II (Roy House) Sexual Perpetrator	
Respite	57,000	Individualized Support Services (Available to Area III: See Statewide Allocation*)	
American Red Cross/Portland Chapter, Woodfords (See Statewide Allocation for additional Respite*)		a. Wrap-Around Funds*	
		Child & Family Support Services	
Family Mediation	102,249	b. Family Support Services*	
Youth Alternatives		Information & Referral Flexible Recreation Programs Intensive Family Counseling Family Support Groups	
INFRASTRUCTURE TOTAL	1,326,838	CONSENT DECREE TOTAL	553,410

TOTAL, AREA III $1,880,123

* See Table 5. for Statewide Allocation

BCSN CONTRACTS - ACTUAL FY 92

AREA I

Northern Maine - Regions I and II

INFRASTRUCTURE (Existing Services)		CONSENT DECREE (New/Allocated to Area I)	
Homebased Services	369,244	Crisis Services	377,678
Aroostook Mental Health Center, Families United, St. Michaels Center		Community Health & Counseling	
Outpatient Services	92,645	Case Management	222,953
Aroostook MHC Community Health & Counseling		DHRS - St, Michael Center	
Residential Services	203,204	Residential Services (Located in Area I Available Statewide:)	
Powell Memorial, Community Health & Counseling, Reallocated New Development		Transition & Crisis Residence	356,722
Day Treatment	191,533	Acadia (Aspenledge)	
Aroostook MHC, CH&CS, So. Penobscot Regional Program		Dual Diagnosis Residence	353,067
Family Support	13,492	Atrium (Janus House)	
Aroostook MHC		INDIVIDUALIZED SUPPORT SERVICES (Available to Area I: (See Statewide Allocation*)	
Family Mediation	57,126	a. Wrap-Around Funds*	
Penquis CAP		Child & Family Support Services	
Respite Services*		b. Family Support Services*	
UCP of NE Maine, Special Children Friends, Pine Tree Chapter/American Red Cross	81,130	Information & Referral Flexible Recreation Programs Intensive Family Counseling Family Support Groups	
(See Statewide Allocation for Additional Respite*)			
INFRASTRUCTURE TOTAL	1,008,374	CONSENT DECREE TOTAL	1,310,420

TOTAL, AREA I $2,318,794

* See Table 5. for Statewide Allocation

BCSN CONTRACTS - ACTUAL FY 92

AREA II

Central Maine - Regions III, IV, VI

INFRASTRUCTURE (Existing Services)		CONSENT DECREE (New/Allocated to Area II)	
Homebased Services	452,683	Crisis Services	297,711
Youth & Family Services Tri-County MH Services Shoreline Community MHC Home Counselors		Tri-County MH Services Consortium	
		Case Management	228,627
Outpatient	340,587	Tri-County MH Services Consortium	
Kennebec Valley MHC Youth & Family Services Tri-County MHC		Residenitial Services (Located in Area II Available Statewide:)	
Day Treatment	151,799	Transition & Crisis Residence	404,354
Spurwink: Randolph, Freeport Winthrop Schools RETC Lewiston Mid Coast MHC		North American Family Institute	(Dirigo Place)
Respite Services*	46,000	Non-Adjudicated Sexual Perpetrator	318,050
The Children's Center Mid Coast American Red Cross		Rumford Group Home	(Roy House)
(See Statewide Allocation for additional Respite*)		Individualized Support Services (Available to Area II: See Statewide Allocation*)	
Residential Services		a. Wrap-Around Funds*	
Spurwink, Meadowview I and II (Nash House)	457,052	Child and Family Support Services	
		b. Family Support Services*	
		Information & Referral Flexible Recreation Programs Intensive Family Counseling Family Support Groups	
INFRASTRUCTURE TOTAL	1,448,121	CONSENT DECREE TOTAL	1,248,742

TOTAL AREA II $2,696,863

* See Table 5. for Statewide Allocation

MEMORANDUM OF AGREEMENT

I. Statement of Intent

The purpose of this Agreement is to specify procedures to be followed by the Department of Mental Health and Mental Retardation, Bureau of Children With Special Needs, and the Department of Human Services, Bureau of Child and Family Services, regarding the formulation and implementation of individualized support plans (ISP) for AMHI class members who are in the custody of the Department of Human Services.

II. Role of BCSN Community Support Worker

The BCSN community support worker shall be responsible for all duties of the community support worker as specified in the Settlement Agreement in Bates, et al. v. Glover, et al., including the development of individualized support plans for adolescent class members who are in the custody of the Department of Human Services. Additionally, the BCSN community support worker is responsible for the following:

1. Providing consultation on mental health issues to caseworkers for class members under DHS child protective or substitute care services; and

2. Participating in the DHS administrative review planning process.

III. Role of DHS Caseworker

In coordinating their services with those provided by BCSN's community support worker, DHS caseworkers shall have the following responsibilities:

1. Incorporating information received from the BCSN community support worker regarding the mental health treatment needs of the child into the DHS case planning system;

2. Attending individualized support planning meetings called by the BCSN community support worker;

3. Inviting BCSN community support workers to DHS case planning meetings and administrative case reviews;

4. Assisting the BCSN community support worker in gaining access to relevant information in client files;

5. Notifying the community support worker, in advance when possible, of changes in the DHS case plan or in the child's status, which will have an impact on the child's ISP, including, but not limited to, changes in custody or placement.

IV. Conflict Resolution Protocol

Both parties to this Agreement recognize that proper planning and coordination of efforts between BCSN and BCFS should minimize any conflicts between the ISP and the DHS case plan. As these plans are developed, the goal should be to secure consensus, agreement, and, if necessary, compromise between the DHS caseworker and the community support worker. Should these efforts fail to result in compatible ISPs and DHS case plans, the parties to this Agreement will attempt to resolve such conflicts by referral to the persons specified below until a resolution is found:

1. Local DHS supervisor/CSW vendor supervisor;

2. DHS regional manager/BCSN school age children services coordinator;

3. BCSN Bureau Director/BCFS Bureau Director, or their designee; and

4. Commissioner of DMH&MR/Commissioner of DHS

When the resolution of a conflict results in a suggested change to the ISP, the community support worker will reconvene an ISP meeting with the goal of obtaining the ISP team's approval of the suggested resolution. If the ISP team does not adopt the suggested change, DHS may file a grievance or may refer a case to the Office of the Attorney General for appropriate resolution pursuant to the terms of the Settlement Agreement.

If the suggested resolution would require a change to the DHS case plan, DHS will take reasonable steps necessary to effect a change in that plan or, if unable to change the plan, DHS will refer the case to the Office of the Attorney General for appropriate resolution pursuant to the terms of the Settlement Agreement.

V. Responsibility for Payment

Subject to available resources, BCSN assumes responsibility for payment of services for non-DHS class members. Subject to available resources, DHS will be responsible to pay for DHS class member services obtained in accordance with the ISP and will pay for unmet needs for DHS class members when such services are recommended in the ISP.

VI. Resource Development Planning

Both parties to this Agreement are responsible for resource development planning based on class member ISP unmet needs. When this unmet needs data is compiled, both parties shall reconvene on an annual basis to determine what budget requests will be needed to satisfy those unmet needs, with the goal of collaborating whenever possible, and avoiding duplicative efforts. BCSN will be responsible for resource development for non-DHS class members, while DHS will be responsible for resource development for

VIII. Access to Services

In addition to making community support workers available to all DHS adolescent class members, BCSN crisis intervention and diversion services will be available to DHS when a proper referral is made for such services. Additionally, DHS will have access to BCSN residential services, consistent with program criteria and priority, at a per diem cost determined by BCSN with the vendor. Likewise, BCSN will have access to DHS residential services, consistent with program criteria and priority, at a per diem cost determined by DHS with the vendor.

DATED: January 23, 1992

DIRECTOR
Bureau of Children With Special Needs

COMMISSIONER
Department of Mental Health and Mental Retardation

DATED: 1/24/92

DIRECTOR
Bureau of Child and Family Services

COMMISSIONER
Department of Human Services

ATTACHMENT #5

BEDS AVAILABLE AT AMHI ADMISSION UNIT
& JACKSON BROOK INSTITUTE
AT 11:00 AM November 1992

	CBU-North	CBU-South	JBI		CBU-North	CBU-South	JBI
11/01	1	1	1	11/16	2	-2	1
11/02	1	2	0	11/17	3	-1	0
11/03	-1	0	0	11/18	4	0	1
11/04	-1	1	1	11/19	2	-1	1
11/05	0	0	2	11/20	3	-2	1
11/06	1	1	2	11/21	3	-1	0
11/07	-1	0	2	11/22	3	-1	0
11/08	-1	0	2	11/23	2	0	4
11/09	1	1	0	11/24	3	2	4
11/10	-1	-1	1	11/25	2	6	3
11/11	0	-2	1	11/26	1	5	3
11/12	-1	-2	3	11/27	1	4	3
11/13	1	0	2	11/28	2	3	2
11/14	-1	-1	2	11/29	2	2	3
11/15	2	-3	3	11/30	1	3	2