IV

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on February 2, 1989, in Room 113 of the State Office Building, Augusta, Maine

Carmen M. Thibodeau

TABLE OF CONTENT

Augusta, Maine
February 2, 1989
9:20 a.m.

SEN. GAUVREAU - Will the Committee please come to order. Good morning. My name is Paul Gauvreau, I'm the Senate Chair of the Joint Standing Committee on Human Resources. To my immediate left is Rep. Peter Manning who serves as House Chair of this Committee. Today the Committee will continue the hearings into the Augusta Mental Health Institute. Before we resume questioning of Mr. Daumueller, I would point out that we now envision the hearings to go through today. Appropriations is meeting this afternoon and, as we know, the Department is scheduled to make its presentation regarding its supplemental budget. I've spoken with Appropriations this morning, they are amenable to really having the Department present to them at our convenience. It would seem logical for us to try to finish with Mr. Daumueller and allow Commissioner Parker a chance to respond to items she feels are appropriate to respond to and if we can do that this morning or early in the afternoon so we can give her a break and she can go upstairs to Appropriations later on in the afternoon. We would expect then to - if that can't happen, we would recess until Appropriations was completed with its review of the Department budget and we would then readjourn later this afternoon to complete the presentation of Commissioner Parker. On Monday we will readjourn and at that point we will hear presentations from advocacy groups and we will then go through Tuesday. We have invited the Department of Human Services to make a

presentation and we may well also invite the local probate judge who has, as you know, indicated a reluctance to refer wards in his custody or jurisdiction to AMHI. We would hope then to be in a position to conclude the hearings at the early part of next week. We have spoken to leadership in the House and Senate and we have been told that if necessary we should go on in Tuesday - through Tuesday and then allow Legislators to join the Maine Development Foundation -- later that day and the hope we can conclude our work early next week. That is the agenda we have at the present time.

I would also like to make a personal observation. I had occasion to read an article in one of the papers yesterday that dealt with some comments that certain legislators have made regarding these hearings. I'm certainly mindful that due to the sensitive nature of the discussions there is some controversy attendant to these hearings. But I was particularly disappointed in remarks of some legislators to the effect that the pace of these hearings was not at a very fast rate and I've thought about this a lot. We are dealing here with a population which is highly vulnerable and I think all of us realize that. I can't think of anything that comes before our Committee, any topic, which should be more insulated from the fracas of partisan politics than dealing with the stewardship of people in our acute mental health hospitals. It has certainly been a long-standing tradition for this Committee. Certainly when Sen. Gill chaired

the Committee and under Rep. Manning's leadership, Rep. Nelson, myself that this Committee has always done its work in a thorough disinterested and non-partisan fashion and I certainly pledge that will be the tone that this Committee will do its work this year. And so in that light I was disappointed by the remarks of some that - expressing irritation at the pace of the hearings. I think the people of Maine expect and, in fact, demand that this Committee and the Legislature do a thorough and comprehensive job of review so that we can, in collaboration with the Executive Branch of Government, fashion the most appropriate and responsive recommendations to ensure that we upgrade the conditions at AMHI.

With that we will now proceed to -

REP. MANNING - There will be a break because unfortunately the House three weeks ago had scheduled the House photo of - so sometime after the session ends today the Legislature - I mean the House members will have to leave and we'll be gone for probably twenty-five minutes and this is something that couldn't be delayed. The House photo is something that - it's a tradition in the Legislature and unfortunately it's very difficult to get scheduled. Last year - last - the 113th it took us until the second regular session because of people out sick, people away on business or something else, so where it was early in the session they scheduled it, so that's unfortunate, but we will be breaking.

SEN. GAUVREAU - And, also, I should note that the Senate does have some confirmation and some roll call votes during the course of this morning's session, so although we are all excused from attending the sessions, we will be notified -- roll call votes and I understand the Senate, around 10:30 or 11:00, will be considering certain judicial confirmations. With that why don't we then resume the questioning of Mr. Daumueller and if memory serves me correct, and it may not, Rep. Burke was poised to ask certain questions of Mr. Daumueller when we last broke and I believe that Rep. Dellert and Sen. Titcomb had also requested leave to ask questions, so why don't we proceed in that order.

EXAMINATION OF MR. DAUMUELLER BY REPRESENTATIVE BURKE

Q. Thank you and memory did serve you correctly.

Good morning, Mr. Daumueller.

A. Good morning.

Q. Basically, just to return to what we started to ask yesterday, you gave us quite a detailed review of your Friday reports which indicated on numerous occasions that you needed increased staffing, that there were serious problems that - on the February 26 one that the Commissioner should be involved in drawing up a plan to meet the problems that were encountered through Medicare review and I asked you what resources you had available to you in trying to meet the deficiencies that the Medicare review brought out.

A. Yes.

Q. Can you answer that again?

A. Well, basically the resources that were available to the Department under the -

Q. I'm sorry, you need to get towards the microphone because I don't think people in the back can hear you.

A. Okay. Basically the resources available to the Department of Mental Health and Mental Retardation were the resources that we could draw upon and that would mean if there were people in other facilities that we could call upon or contract monies or - monies or positions or whatever that we could move from one place to another. As it turns out, that actually worked out to one half time contract, all other dollars to fund one contract.

Q. One half time?

A. Yes. And of course -

Q. Physician?

A. Physician.

Q. And no new staffing of any other sort.

A. Right. The physician contract, of course, is a function not only of dollars but availability, so, I mean, there's two things that played in - particularly into the physician recruitment or acquisition problem. But there were - there was no - going to the Legislature at that time was not an option.

Q. Who decided it was not an option?

A. Well, the Commissioner - I think that was - it was clear from

conversations with the Commissioner that that was not an option.

Q. So, in essence, just to be clear on what you're saying, you specifically asked the Commissioner if it was an option to go to the Legislature to ask for more staffing and you were refused. The Commissioner was always apprised of exactly what you felt you needed in order to pull AMHI back on line.

A. She knew the areas that we needed to address, mainly physicians, clerical and activity staff. We talked about numbers and we talked about how many that might be. The way those - the way requests like that usually come about is that you sit down and you discuss the situation and then you are given the go ahead to go - to work something - you know, work up a request and usually that would be an associate commissioner and myself and whoever else would be involved. Then you would come back and present the request and go - that would then go to the Governor's office and if he were to approve it, then it would go to the Legislature. And clearly that was not an option at that time, going to the Legislature.

Q. Okay. But you and your associate superintendent felt as though this was a critical enough need that it should be brought to the Legislature and you were refused.

A. I think the question was are we going to be able to go, you know, is that an option and I think - maybe I'm too much of a team player or maybe I didn't make the case strong enough, I mean, I think I have to take my own - take some responsibility for that, but it was my impression that that was not going to be

an option that she would be able to pull off.

Q. So in your professional judgment then the plan that you ultimately brought down to Boston -

A. Had serious flaws, the serious flaws being not adding any clerical staff, not adding any activity staff and the - you know, adding a half time contract in the time frame that we had was reasonable, but it wouldn't project to HCFA that we were making a real strong effort in that area I don't think. And so our effort, in my opinion, while we did put the best spin we could on it, we tried to put the best face on it and try to sell it as hard as we could and went, you know, forward full bore, had some serious weaknesses or soft spots, if you will. Now, there's no one, including myself, prior to them coming back on the resurvey who could for sure tell whether or not we would - we would gain certification. We had an up and down history with HCFA. They don't give you -- numerical answers to your questions, in other words. How much understaffing - how much understaffed do you think we are for your purposes and they say, well, we'll let you know when we survey you. So if there are no guarantees when you say, well, three people will do it or five people or seven people, so they get at your staffing through the medical record documentation is basically what happens. So I'm not going to say - and it wouldn't be accurate - that I could guarantee that we would get Medicare under these conditions, because I think to some extent we were all surprised by the - let's say

the tenacity or the verocity of the surveyor's review of our facility. So I think we felt we probably weren't as in bad a shape as they felt we were. But clearly when they tell you that you're suffering from staffing shortages and they cite you for not having staffing, that is going to be a weak area when you don't add any staff. We did make some rearrangements, but there again there was - they weren't particularly significant.

Q. And certainly your recommendation that you needed 206 new -

A. That was much later in the game. I mean, that was in the fall.

Q. That was when you actually assessed the entire - you sat down and went through the entire facility and figured out where the deficiencies were?

A. That, too, was done, not as part of an open process with all staff being involved and this is me sitting down, because, well, at the time it would not have been the proper procedure to come out with and work up a large proposal at the same time we were putting a proposal before the Legislature, because that would be somewhat undercutting the - what we had on the table. But every time I've looked at our staffing and said what would the ideal situation be, it's always come up in my calculations to be close to, you know, within 10%, 200 positions, for roughly 383 patients. And that's just the fact of the matter. I mean, if you want one level of care throughout the facility and if you want certification and accreditation in a smooth pace and good communication and good documentation, you have to have the people to do it. For

example, right now, even today we're still running 25 people on overtime just one to ones and CORs and things like that having to do overtime on a 24-hour period. That's 25 people. When we were doing the study on the Commission - for the Commissioner on Overcrowding, it was less than that. I think it turned out to be 20 or maybe even less than that at times. So there's a lot of pressure and as time went on obviously the pressure and the expectations increased, so the amount that I think you could, quote, unquote, get away with escalated.

Q. So the proposal that was brought to the Legislature even in late summer or early fall, you still didn't feel that that was adequate.

A. That was not a proposal that was going to give us ideal staffing all the way around, no.

Q. Did you communicate that with the Commissioner?

A. Yes. Now, what - to be very clear what I did do, as I said yesterday, I submitted a proposal for 18 positions to deal with the Medicare specific recommendations and another proposal to deal with what I considered overcrowding issues and the development of a float pool to take care of overtime, and so forth. Those two pieces of paper went together, okay? One of those pieces of paper, the 18 positions, was forwarded to the Governor. Another was not. And the one proposal then as put into the contingency fund, the other was not. The one started off in roughly July, the other did not. And that's where we started. So my thinking

was we're going to revisit what we did in 1987, staff up Stone North Upper and do some backfilling of some positions and help with the overcrowding once again, some augmentation in some other areas. Now, that's how it was presented. We - it gets a little complicated, but the bottom line is then there was a go-ahead to - from the Governor's office to pursue a larger proposal and that, I believe, happened after the class action grievance that the union forwarded and there was a bunch of press activity at that time. The senior management team at that time was down at Sebasco Estates and - doing a senior management team retreat, as a matter of fact. That was the day before I was going out to Wisconsin for two weeks and during my trip out in Wisconsin I was maintaining phone contact and Rick Hanley and Victor Perreault were dealing with the staff request. And I was convinced at the time that there was no way on earth that we could not not put this over-crowding piece on the table, because things were that bad and I said so and I said if we didn't do it, it would blow up in our faces and it wasn't forwarded. Now, after Sebasco Estates things loosened up and in the conversation when I was out in Wisconsin with Ron Welch it came up that what we want to do as - put this in as a joint commission or a JCAHO proposal. At that time I said, well, that's really an overcrowding proposal. It doesn't - it wasn't intended to be the JCAHO, but if that's what you have to do to sell it, go ahead, but throw some more support in there and, you know, some things that will help us with JCAHO and work

with Rick and Vic on that end of it.

Q. So in essence -

A. And that's basically how - and looking back if I wanted to shoot myself, I think probably that's where I would do it is saying, yeah, go ahead and - go ahead with it because I also said that we've got to have those positions, we cannot not get those positions, so if that's what it's going to take to get it through, let's do it.

Q. So in essence you were being told don't ask for this right now, we'll ask for it later as part of a bigger package or we'll tell the Legislature we're under pressure for JCAHO approval.

A. No.

Q. Okay.

A. No. We said we want to frame this as a joint commission proposal.

Q. Hm-mm.

A. Okay? None of that other stuff was said.

Q. Okay.

A. And I said, this is not - this was submitted as an overcrowding proposal, but if that's what we have to do to sell it, it's so important we cannot not do it, because we absolutely need those positions. The other part of it is in - as I think I mentioned yesterday, that as I was presenting it, I was presenting that proposal as a way of getting to the 114th Legislature as a - you know, this will carry us through just like the 1987 thing did

and then it aimed for staffing ratios and things like that in the next Legislature. And I thought that would probably do it. And then the proposal was widened and the community piece was added and the Bangor piece was also added. I'm not sure when the go aheads on those pieces occurred, but it was some time, I think, in those two weeks. That in some respects alleviated my anxiety a little bit because, you know, there's a workload reduction piece in there, too, so that made it much more palatable and easier for me to deal with and I thought, well, okay, what we have to do now is bridge and hold together - hold AMHI together for - you know, maybe till spring of this year. And, as a matter of act, you know, if everything would come on line in the spring of this year, I think we'd be looking a lot better. What I mean by coming on line is I mean that in-patient piece and the reduction in workload, the reduction of 400 admissions and the reduction of census that would be - as part of that whole package, the most direct, of course, being the in-patient piece. And so I - you know, that's basically how it happened.

Q. So why then do you feel that you were dismissed? Do you feel as though you were pushing for more staff or pushing a proposal that was not - that they did not wish to back or, I mean, I'm -

A. Okay, over the summer we had a number of unfortunate incidents, which obviously would bring, you know, negative light on any administrator. And the other aspect of it was the - well, what

I feel is an all consuming concern over getting recertified for Medicare and the pace that that was occurring and I think probably what would be viewed as maybe foot dragging and not being cooperative on my part and I viewed it as trying to point out some of the problems and deficiencies that our system still had that - and we were not ready for Medicare for a whole variety of reasons, not the least of which is, again, unprecedented workload. I don't know if anybody has talked about admission statistics, but if you take calendar year 1986, there were 1,078 admissions, the next year, '87, there was 1,324, I think, and the year after was 1,524, so between '86 and - that's a 50% increase in admissions. Many of those admissions have medical problems. One of the - you know, over the summer the concentration, the emphasis became highly medical and it was to some extent in the early Medicare surveys. And, you know, I guess my feeling was that that area is still problematic and I think in terms of getting AMHI back on track, if there was anything that I guess I would do is I would quickly address the need for medical attention and that means MDs, doctors, you know, I would say straight out two doctors, two MDs through contract or through employment, whichever the case may be, or contract with a clinic or whatever kinds of coverage would basically - at least two more physicians to take care of and make sure that medical problems are followed up with. Right now I have two doctors, Dr. Castellanos and Dr. Rogers. And that's - now when one of those people go on vacation,

occasionally we can backfill. There's one individual who will come in and provide some coverage and that - but if that isn't available, then you've got one MD for the entire facility. And the - with the level of problems that are being identified with the difficulty and the patients that we get, their difficulty in expressing their medical needs in a coherent fashion and giving a good medical history is highly suspect. So on top of the need to provide medical services for three hundred and, let's say, eight people or seventy, depending on what the census is, we have a very difficult time in getting a decent straight history from them. So you have to, you know, do a great deal more investigative and detective -

Q. Okay. What I hear you saying, and feel free to correct me if I'm wrong, is that when we lost Medicare certification, even before we lost Medicare certification or just after losing it, you went in and said, this is what we will need in order to attempt to regain certification. In terms of staffing you were told you can have one more half time psychiatrist. You went down with such a plan - I mean, the plan was otherwise developed, but you went down with such a plan to Boston. They said we'll come and look at it again. They came. You weren't dead sure, but you were pretty sure that they probably would not recertify you given that there was no new staffing and the overcrowding situation remained essentially the same.

A. Yes, we had some bad conditions in terms of the numbers of

people -

Q. Okay. After certification was definitely lost in May, you went back and said, we need almost a hospital revamping, we need to get the whole hospital in line, not just Medicare. We shouldn't be just concentrating on Medicare assignment.

A. No, no.

Q. No, okay.

A. That's not true.

Q. Okay.

A. We set about immediately after that - the May 27th - to develop a plan to regain Medicare as quickly as possible, worked very closely with Ron Welch on developing that eighteen position proposal. Independent of that process, that's - I put together the overcrowding piece.

Q. Okay. You put together overcrowding piece, you went back to the Commissioner with the overcrowding piece.

A. Yes.

Q. You were turned down on the overcrowding piece.

A. Yes.

Q. Okay. You then began to feel as though none of your initiatives to pull the entire hospital on line were being accepted, but rather just - the emphasis is purely on regaining Medicare certification.

A. I was - yes, I think I was getting a bit frustrated at that time, yes.

Q. Okay. And at that time you also felt that they were trying to regain Medicare certification essentially with bandaid measures, eighteen staff here, you know, that kind of thing?

A. Yes, the point that I did try to go back to is that Medicare, yes, there are positions that directly affect Medicare and we can be directly excited in the survey, but there are also other conditions that play into Medicare having to do with the rush in the rest of the hospital and what's going on there and, you know, pulling back and forth and how that - so it works together. A hospital is a - it's a system and it's tough to separate out one section, but we did the best we could to separate out and focus directly on that eighteen positions for Medicare. I will say that, yes, that's - we expected that probably we'd get Medicare at that time.

Q. Essentially I want to know - I think the Committee wants to know, the Commissioner was always apprised of exactly what you felt the deficiencies in the entire hospital were and essentially said or outrightly said, go to the Legislature with a package requesting 206 new positions is out of the question.

A. That - to say it precisely that way wouldn't be correct. What would be correct is that we were all aiming towards working with the community, coming up with a smaller hospital, so we were all kind of on the same wavelength. We were trying to not over-emphasize the institute but keep it certainly safe and with reasonable quality. I had for the longest time talked about - I

mean, I've always talked about ideal staffing ratios and talking about the two to one staffing ratio, and so forth and so on, as would be at least where we should be in the middle corridor. The 206 is later in the fall and that is would - you know, she would not have been aware of that figure. I had mentioned the figure actually of 196 before, but, I mean, it's not - I did not go to her and say, we have to have 206 people. I think it's always been more a matter of, well, this is pretty much out of the question. I mean, to really staff up the facility is so far out of the question and it's such a high dollar amount that it's much better to go with the reduction in census approach. And so, there again, I guess I can, you know, take - shoulder some of the - some of the blame for that, too. I guess I should say, here's your $4 million request and, you know, demand that it be funded. I don't know that prior to - I don't know that in June if that would have been forwarded that any of us - you know, I probably would have been laughed out of this room if I was here. I think since the events of the summer, I think things have been brought into focus and I think maybe there's a different level of consideration.

Q. Okay.

A. One thing about - really what we're facing is the same thing that the whole - you know, you've heard of deinstitutionalization. We're going to take money from the facilities, we're going to put them in the institution. The big mistake that everybody makes is

that you don't double fund and put the money in both places until it happens. We're going through that right now and if there was any point, I guess, that I could make is I think what you have to do now is do some double funding and not worry about whether it was her fault or his fault, but say, what do we need to do now and let's do it. And double funding for at least a certain amount of time, and it's probably going to be two years, quite frankly, let's do that and bite the bullet and put some money in the budget and, you know, two years from now I think you all maybe pat yourself on the back and say it was a darned good thing.

Q. I understand your feeling of saying maybe I didn't make my case strong enough or we were also looking at building up community servicesand things like that. What I'm trying to find out and I'm not trying to say is it - whose fault is it, but what I am trying to find out is were there staffing requests made that were never brought to us. Was the Legislature never given the opportunity to say, yes, we think community services are important, but we also realize that there are some people who will be institutionalized who will need a good solid institution, who need the - the institution itself needing good staffing, so on and so forth. We - were we ever given the opportunity through the Commissioner to even hear that request?

A. In other words, was there a piece of paper that came in to - put on Susan Parker's desk and said here's - no, but what there were were conversations, is it possible to go back and

reinstitute the twenty-one limited period employees, yes, there was. Was there conversation about the activity staff in needing to put some people on, whether they are limited period or full time or whatever, yes, there was.

Q. So you made multiple requests for increased staffing, whether on paper or verbally.

A. Yes.

Q. And these requests were, in fact, turned down.

A. Yes. And I was not - I don't know how much she had to - you know, whether that was all hers, I don't know. I don't have the -

Q. Or whether that came from the Executive -

A. Yeah, I do not have -

Q. I understand.

A. Knowledge of the relationship or any instructions or whatever that are -

Q. Okay. Thank you. That's all I have.

A. Other than the ace - what I already talked about.

Q. Okay. Thank you. That's all I ahve.

SEN. GAUVREAU - Rep. Dellert?

BY REPRESENTATIVE DELLERT

Q. Thank you, Mr. Speaker.

Mr. Daumueller, to carry on with Rep. Burke, did you actually send a memo to Susan asking her for certain specific people?

A. No.

Q. Never specifically.

A. Not a memo, no.

Q. Did you -

A. We sat down in her office and talked about that, yes.

Q. I know, but did you ever sit down, write a memo, documented for the number of staff, where they were needed in all those instances.

A. In the - not in February and not - no.

Q. On those 206 that we're talking about now, you had a memo that said if we do not pass the 2.6 million, if the Governor - the Governor's package does not pass, then this is the plan we should have and did you involve all the staff in that plan or was that your plan?

A. No, we didn't. In fact, there was some concern about the existence of that memo and how widely it would be distributed and I assured the Commissioner that it was only us - three or four people.

Q. So, therefore, that was your idea, those 206 people.

A. Yes.

Q. So, therefore, is the paper correct in saying that we need 206 people now?

A. I think if - every time I've looked at it it comes out somewhere 10%, plus or minus, on that number and I think if you look at that number it talks about 35 - 25, 35 nurses, it talks about 25 nurses and you already heard me say, as a result of the joint commission which came in December, that it might be more like 30 to 50 nurses,

very well 50 - very well maybe 50.

Q. Right. Then who said in December that we needed 30 to 50 nurses?

A. The HAP surveyor - Hospital Accreditation Program surveyor, the nurse surveyor from joint commission when asked the question - she talked about nursing staffing and when asked the question, well, what does that mean, she said, well, you probably need about twice as many nurses as you have and with the type of patients you have and the acuity that you ought to at least have a nurse in every unit on every shift, particularly with the type of medications that are being distributed. You have medications that are being distributed by mental health workers who are not closely supervised or may be supervised by a nurse that's like through another doorway, so that she saw it as a significant problem. In looking then at the staffing pattern, I asked Vera Gills, whose the professional consultant for nursing, how many nurses would it take to come up with this, you know, one per every area and it came up to be 50. Now - well, that's how I did it.

Q. But that was just one person on the Commission - JCAH - that said that.

A. That's right.

Q. I'd like to go back to the rape case. You have a very fine procedure manual and policy - policy and procedure manuals over there, very effective. Do all the staff know about those

procedures and policies?

A. Well, there is a - every staff is to sign off that they have read various policies and procedures, so there's a sign-off and that's kept, so it's there. It's the expectation that the staff do read the policy manuals. As human nature is, you may find people who will sign off that they've read something and haven't read it.

Q. All right. Did the nurse the night of the rape know of these procedures? That's on page 19.10 in your procedure manual. Had she read that - the way of reporting those procedures?

A. I don't know the answer to that specific question, I honestly don't. I know that - I will tell you about - you know, the thing about the rape case is that that incident was screwed up from the moment it started till the moment it ended, whenever you might say it ended and, you know, I was part of that and there were a lot of people along the way and we would freely admit that that was poorly handled and the communication didn't flow. There were a number - you know, a number of key mistakes. There has been some remedial action taken in a number of areas, but clearly that was certainly not the high point of good procedural work.

Q. When did you call the police and the guardian?

A. I did not call the police and the guardian.

Q. Isn't that part of the procedure?

A. I'm sorry?

Q. Isn't that part of the procedure for you to do that?

A. For me to call, no. I would never call the police or the guardian.

Q. Who would do that?

A. Depending on the time of day, the NOD would probably do it or the physician or physician extender. Again, it depends a little on the time of day, you know, because if it happens in the daytime, it might be the social worker.

Q. But you were ultimately responsible for the procedure part of it.

A. Sure.

Q. When did you notify the Commissioner since it happened on Friday night.

A. I think probably the next Monday, in the morning report.

Q. And yet it should have been done - it says in your procedures, I believe, it should be done fairly soon after the -

SEN. GAUVREAU - Excuse me, do we have a copy of the procedures manual to which you're making reference?

REP. DELLERT - No. Would you like a copy of it?

SEN. GAUVREAU - Well, it's in your possession, I'd like to see that.

REP. DELLERT - No, I don't have it in my possession, I'm sorry.

SEN. GAUVREAU - I see. Well, perhaps I could ask then that sometime during the course of the hearings someone from the Department, perhaps today, can make available to the Committee the referenced -

REP. DELLERT - Page 19.10.

SEN. GAUVREAU - Okay, thank you very much.

REP. DELLERT - I'd like to ask about - some more about staff training. Do you conduct the staff training with your staff?

A. Do I conduct it?

Q. Yes, do you start the series of staff training? Do you make sure that there is staff training on all floors and on all shifts?

A. We have a staff development department that is responsible for setting out staff curriculum.

Q. Yes.

A. Okay, if -

Q. And particularly for the treatment plan for the admissions. Has that staff been trained for that?

A. Well, for that group we had a special training in - after the February survey and after that training and after the second decertification, one nurse was assigned full time to work on treatment planning and documentation with the admission unit.

Q. Did you do any post testing after to see how well they were doing in their training.

A. Post testing on training, well, there were audits that were conducted on various aspects, yes.

Q. On all levels, all shifts and all departments, do you kow?

A. What would happen is that Diane Duplessis and some other staff would do audits of records and look at records and see if people were doing well or not and then feed that back to those

people and the supervisors.

Q. I also wondered if those procedure manuals were on all floors or where would they have to go to look at the procedures?

A. Well, in your procedure manual there's - it lists all the areas, but there should be a procedural manual on every floor, yes. On every unit and then department heads and there's at least fifty, I think.

Q. I wonder, how often do you visit the wards, how often do you go on each floor?

A. Well, it depends on what's happening at the time, but I would try to get out at least once a week.

Q. On all shifts?

A. Well, I have visited on all shifts, yes.

Q. So that you would know how things were going?

A. Not as much as I'd like. I think that, you know - I think that I would have liked to have gotten out a lot more. I think - I felt a little office bound and buried, to tell you the truth, but I did get out and I think - especially when I felt I could.

Q. So how often would you say, once a week or -

A. Well, when you say every unit, every ward, how often. God, I don't know. I think it goes - it would go in spurts. There'd be times it would be, you know, three and four times a week and then there might be times when there wouldn't - you know, I wouldn't get out for a while, so, oh, geez, I don't know.

Q. I just wanted to -

A. Weekly or - you know, ten days or so, I couldn't give you an exact number on that.

Q. I wondered how familiar you were with some of the night problems.

A. The nights is the least - you know, obviously nighttime would be the least visited clearly. I think you'll find that a lot everywhere.

Q. Prior to your coming to AMHI, what was your hospital management experience?

A. An 88-bed acute facility.

Q. Did you have supervision over psychologists, psychiatrists, physicians?

A. Yes.

Q. Directly? Direct supervision?

A. Yes.

Q. Were you ever part of the JCAHO or Medicare -

A. Yes.

Q. Plan?

A. Yes.

Q. You had submitted plans on that before?

A. Yes. One of the three hospitals and three facilities in Wisconsin that were accredited under the Community Mental Health Program.

Q. When you're referring to the understaffing, how were you going about thinking of - or getting those positions filled. Were you talking with - trying to - in trying to staff your positions,

were you talking to all the unit leaders, finding out what they really needed?

A. I'm not sure I understand your question exactly.

Q. Well, you were talking about the many, many places where we're understaffed, did you talk to the unit leaders and talk about how you might find those positions?

A. How we might find them?

Q. Yeah, or -

A. Well, you can't find them if they're not allocated.

Q. Okay. After they're funded did you -

A. After they're funded, oh, yeah, well, we didn't have a lot of trouble. Mostly they were mental health workers or activity aides or recreational aides and so those filled fairly rapidly. There were only a few critical areas of staffing, LPNs, RNs, psychology, psychiatry, did I miss anybody, OT and COTAs were difficult to fill, but so those - there are some professional areas that were difficult to fill, but most of the positions are fairly easily filled.

Q. Are there any positions now that could be filled where you have money for but are not filled?

A. Yes, I believe there were a number of LPNs, a couple of RNs, I think, two or three RNs, there's a contract physician that is not completely filled and COTAs, I think there were two of those. There may be some others.

Q. So there are some more positions that we could - some more

people that we could bring on line.

A. Yes.

Q. If we could find them.

A. There are some vacancies. In other words, there are some staff vacancies.

Q. Yes.

A. But you will always find staff - a certain number of staff vacancies, yes.

Q. Thank you.

SEN. GAUVREAU - Thank you. Senator Titcomb.

BY SENATOR TITCOMB

Q. Good morning.

A. Good morning.

Q. Listening to your discussion about the response to the rape that took place, I have to question what brought about this lack of procedural appropriateness during the time after this patient was raped. Why do you think that happened? Why do you feel there was so much -

A. I think because the NOD wasn't informed right away is the primary factor. The NOD is pretty experienced and I think would have handled that had it come up sooner.

Q. So you're saying that this particular NOD was not -

A. No, no, I'm just saying I think that the delay was - I think the NOD did not hear about this until 5:30 or - 5:30, I think it was 5:30.

Q. So she was not notified.

A. Yes, and that was the key factor in this whole thing is that had she been notified, I think maybe many of the mistakes that were made would not have been made. It was an inexperienced nurse that probably shouldn't have been working in the first place unsupervised and, not only that, she was not feeling well and I think - so that was poorly handled.

Q. I have some questions -

A. I think indirectly you can look at the availability of substitute staff as an underlying factor, but it was not, in my opinion, a staffing - in that situation it was not related to the fact that the event happened, because there were a number of staff right down the way and so it -

Q. I have a question about the male patient who committed the rape. Now, I've asked this question before and I'm going to ask it again. It was indicated to me that this patient had been involved in March in numerous incidents of sexual assault against individuals. You mentioned yesterday that March was a month of numerous assaults. Can you recall whether this individual was involved, why you specified March was being a month of particular concern.

A. No, I can't, but the way you could get the answer to that question would be to look - and every morning there's a - what we call a morning meeting and it's formally called the Administrative Executive Board. What it is is the people who report to me

generally get together and hear reports from the various unit directors as to what has occurred, what incidents occurred, are there some needs to make some adjustments, and so forth. That report then outlines events that had happened and in turn those are reported to the Commissioner's office. It would be on there if it was reported.

Q. Okay. I have requested that, so I was just curious to see if it got -

A. To answer your question, I do not know the answer to that question.

Q. Now, we've spoken about the team that works together at AMHI and what is correct protocol within the team once the correct procedure for requesting things -

A. That's - that would be a different - there'd be my team and then the Commissioner's team and I would be one person on the Commissioner's team.

Q. Okay. Your team, am I to believe that those are those people that are within the hospital that are actually doing, in one way or another, the hands on work with the patients or the -

A. They're the - the unit directors and the chiefs of the disciplines.

Q. Can you summarize in as few words as possible what you were hearing from these people during the time that these problems were building up. What was the message that you were getting from the people that were in your team concerning the conditions,

what their concerns were, what their frustrations were, were they voicing them to you and, if they were, what did they say?

A. They were saying that we were understaffed and having overtime problems or acuity problems, and so forth and so on.

Q. Were they concerned about the well being of the patients?

A. At various points I think - again, there's an ebb and flow, but at times I think there's more and less feeling of in and out of control and it kind of ebbed and flowed. In other words, things seemed to break down at times.

Q. Now, did you express this concern - and I know you've been asked this before and then Rep. Dellert asked you again if you had done it in the form of a memo. But did you specifically relay these concerns to the Commissioner and let her know that there was concern, that it was ebb and flow, that it was out of control and that there were indeed people on your team that were concerned about the care of patients?

A. I think what you can put your fingers on are the Friday report series, okay, and that you can clearly identify. There are various conversations, verbal conversations about that, that we would talk about what's going on at AMHI. I can't tell you what day I said what.

Q. Okay. I just wanted to -

A. Over a long period of time, but -

Q. A general review.

A. But, you know, the Friday report is more of the formal summary

for the week.

Q. So although you did not give specific numbers, you did express the degree of concern about the situation.

A. I think so, yes.

Q. Why do you feel - and, again, this is going to be just an opinion question, but why do you feel that the Commissioner was reluctant or refused to go beyond your discussions and actually ask for the funding that would be necessary to have the help that would provide the quality degree of care.

A. A couple of opinions, and these are opinions, I think there was a background of trying to not coming up with requests. In other words, I think that there was an emphasis on not putting forth requests, let's say, last spring. In addition to that, I think the thrust of the department and the emphasis is on moving from the institution to the community and emphasizing community as much as possible and to take workload away from the institutions through means. Frankly, we had been talking about this in-patient business, if we could get it going, in southern Maine. It's not something that came up in September. It's something that's been talked about I know since February, because I mentioned it in February that it was on hold, so it must have been being talked about in the fall of '87 as a possibility and I think that had been repeatedly discussed as something we'd like to bring about.

Q. But I feel particularly troubled with - I understand the value of the community programs and I certainly commend that sort

of direction and agree that that would be the long-range goal of trying to alleviate the crowding problem, but are you saying that in spite of the fact that in the interim between our goals and when we get there that the situation at the hospital financially was not being addressed, that there were not requests going in to solve that problem there to keep those people safe and cared for. Is that an accurate assessment?

A. I think the most accurate way of saying it is that requests were not going to be accepted.

Q. By whom?

A. By the Department and I think I talked about that before. I mean, that's what - that we had a meeting to talk about staffing in February. Obviously nothing came of it and it's - you know, you'd have to believe that I sat there and said we didn't need staffing at the meeting specifically called to talk about staffing to believe that I wasn't asking for staff.

Q. When the census is 370, what do the living quarters look like? Patient living quarters.

A. Well, you'll have 370 - and depending on how it's distributed, of course, but you'll have people very crowded -

Q. What could they look like.

A. Crowded and not a lot of space between beds and oftentimes rooms that should have one might have two and rooms that have two might have four or three, rooms that should have four might have seven.

Q. Are people stepping over each other?

A. We try to - we've tried very hard to not have that occur, but there were some instances where beds were jammed up to where the safety office or our other personnel would be concerned about egress and we tried to address those as quickly as we'd identify them.

Q. And my last question, I believe, is who is Victor Perreault?

A. He's the retired hospital services administrator, the hospital - chief of hospital services I believe is the title. That's the person who would have maintenance and the housekeeping and dietary and ancillary departments, plant services.

Q. Is it true that you approached Victor Perreault and asked him to do an assessment of the air conditioning needs and an estimated cost?

A. Oh, yes, it is.

Q. And could you tell me what the results of that study were?

A. Yes.

Q. And when that took place, when your request was issued.

A. Well, it would have been before - it would have been between the patient deaths in August, which would have been August 6th, I believe, and August 25th. The result was the memo that I sent to the Commissioner - the estimate that he came up with at that time was 1.6 million for air conditioning.

Q. Do you feel that with his experience of the plant itself that that estimate could have been used for at least a base figure

for budget request for air conditioning?

A. Well, that was the idea that this was something of significance and needed discussion and review at the cabinet level and that these were estimates and they were estimates, but, yeah, I think so. Now, subsequent to that Victor's replacement had another group come in and it came out 750,000 per building and I talked about that on our September 22nd meeting, so you've got estimates between roughly 1 1/2 to 3 million in terms of air conditioning.

Q. My last question, simply because it's so glaring and it bothers me intensely. Do you feel that it is appropriate that at this point there is still not a budget request in for air conditioning to adequately protect the patients during the heat of the summer.

A. Well, I think we'd all feel better if there were.

Q. The patients more so I think than we.

A. Well, I don't want to underestimate the necessity for doing, you know, a thorough job of looking at - it's a large plant and it's not just going through and saying it's going to cost 3 million, but I think it would be nice to have a budget that we could count on.

Q. Which we don't have now.

A. Right.

Q. Thank you.

SEN. GAUVREAU - The order of questions at this point is Rep. Hepburn, Rep. Clark, Rep. Rolde, Rep. Cathcart, so

Rep. Hepburn is up now.

BY REPRESENTATIVE HEPBURN

Q. Thank you, Senator. I want to look a little bit at the DHS report. Do you have that with you? It might help if you do or maybe we can get a copy for you if you don't.

A. If you've got one that we can operate off the same paper, I think - I was trying to follow along with what I had the other day and I could not.

SEN. GAUVREAU - This is the DHS assessment?

REP. HEPBURN - Yes, that's correct. Basically on Page 8 is what I really wanted to look at in terms of recommendations by the Department and specifically the recommendations to the superintendent and, you know, in kind of a forward looking way here I want to just see, you know, where we are and what's been done and what might be done. A lot of these things seem to be pretty administrative, they would seem to me at least, and perhaps, you know, you could tell me what you think about them or what has been done, what might be done, needed to correct it. And I'd kind of like to just kind of bang right on down the line starting with - in Part B there at the bottom of Page 8 on Question 1, the first - the clinical staff at AMHI should assume immediate responsibility for the pro-active - pro-actively and aggressively addressing the problems of Mr. Blank's inappropriate sexual activity with female staff and patients. Mr. Blank and other patients deserve protection from this dangerous behavior. It's my understanding

that Mr. Blank was moved after the sexual incident to a different ward. Was there a new policy implemented as a result of that incident? What - did anything change? Were there policies that weren't being followed initially? Maybe you can tell us.

A. Yes, the sexual abuse protocol was rewritten by the professional - consultant for professional nursing. The patient was transferred and under the - under Dr. Buck and you heard directly from him the other day. I don't know if you want to hear more about that. He would have done the review of medications.

Q. All right. Well, we won't - no need to dwell on that one I guess. There's a couple of others here that are important. I just want to - unless you have some more you want to say about it.

Question 2, for example, initiate a full review of psychotropic medications, the treatment team look at Mr. Blank's medications. That was done, I assume?

A. I believe so, but -

Q. You're not quite sure.

A. I'm not quite sure. Okay, what was done - now I know what was done. The male patient was moved to the Forensic Unit, written protocol was developed, meetings were held with DHS regarding patient-to-patient abuse reporting which was a problem with them at that time. Training sessions are scheduled with Adult Protective Services staff. Training is planned with the Augusta Police Department on managing legal violations. Human sexuality is being added to the mandatory training and inexperienced nurses

will no longer be assigned. I think that was the practice and that was an exception to the practice and it's something that shouldn't have occurred, but there is a specific protocol or policy that that will not happen.

Q. That inexperienced RNs would not be in charge of an entire ward?

A. Right.

Q. And that speaks to Recommendation 8?

A. Yes. That could in some instances get to be a little easier said than done. If you had, let's say, some sick calls and you were trying to hire overtime to cover a unit that they will, I believe at this point, probably call in maybe unit directors or something to avoid this, but it may not be the easiest thing to abide by depending on the level of sick call or whatever that's being covered at the time.

Q. Okay. Since we're looking at that now, it says the superintendent should examine the current practice of placing any inexperienced RNs in charge of an entire ward, so and so no longer works alone, but the larger issue needs to be examined. Did that happen? Did we look at that?

A. Which number are -

Q. That's recommendation 8 on Page 9.

A. Yes, I think that's the larger issue - that policy to make sure that nurses are properly oriented and have some experience before they're placed in charge of units is the policy that we're

talking about.

Q. And that's - you think that's happening now or -

A. Yes.

Q. Good. Let's look at -

A. There were some -

Q. Yeah.

A. Okay, well, go ahead.

Q. No, I - go ahead.

A. I was just going to say there were some issues about having single sex units, and so forth, I think, that would be fairly difficult to implement at this point.

Q. That would - we'd be looking at Recommendation 4 basically if we're talking about single sex units, to explore the creation of single sex units for patients with a history of inappropriate sexual behavior or activity, excuse me.

A. Right. I think every time you form a different - you know, a separate unit you create a number of problems, especially if it's what we would call a distinct part, as it has staffing implications and the - just the space - you know, the crowding issue would create some real problems in single sex units and so the single sex units tend to be, in the hospital, the Adolescent Unit and the Forensic Unit.

Q. Okay, so that was pretty much -

A. Well, adolescence being male on one side and female on the other, but co-ed together. The rest being -

Q. On the same floor or area.

A. Yes.

Q. But for the most part then Recommendation 4 was rejected. I mean, as something -

A. It is not practical at this point, right.

Q. Okay. Recommendation 3 at the top of Page 9, superintendent initiate an internal review to determine Mr. Blank's repeated documented incidents of sexual activity were never addressed, it says, despite requests from staff. That's pregnant with meaning there. What do you want - what can you say about that. It says they weren't addressed.

A. I can't give you a good answer to that.

Q. Okay. Let's look at Question - Recommendation 4 then, superintendent and staff will explore the - okay, we looked at that, I'm sorry. No. 5 is address the confusion about roles and responsibilities of staff as well as supervisory duties. Do you think there was a confusion in terms of roles or responsibilities of the staff say in the last year?

A. I think Walter Rohm may have - or Rick may have answered that question - this same question about that. I don't think that there is that much confusion about responsibility to staff. I think there were some comments in there about who said who reported to who and I don't think there's any question of who the physician extender reports to. I think maybe the confusion was at a time the NOD is in administrative charge of the facility on that watch,

but - and may have said that everybody reported to her. I think that was one of the confusions, but I don't think that there was any lack of clarity as to who the physician extender reports to.

Q. Well, it seemed that during the sexual incident or the rape that's just been referred to, there was a breakdown at that point and I'm sure that's -

A. Well, the break that - what happened when I got a hold of the situation is that the report was that the protocol had been completed blown, the patient had been bathed, evidence was gone and what do we do now and I said, oh, God, get Tom Ward in, because I - you know, you can argue that he was not the person who should have been doing this because that's not his job. Frankly, I think at the time he was the one person I felt that could straighten it out and admittedly you can say chain of command wise that maybe was - that he - that shouldn't have been thrust on his shoulders. He certainly would have wanted to know about it anyway, but I felt that - and he has done some what you'd call social work for us in some cases, trying to get people into another facility who were inappropriate for our facility and I felt - I viewed that as this is one of those cases where it was going to take some advocacy social work to straighten out and I felt that he was the person for the job and I think did a good job of trying to straighten out was a real mess.

Q. It does seem like it was quite a mess. It seemed that

communications broke down at almost every level in that particular incident. It broke down in terms of reporting the incident to the nurse on duty, it broke down in the fact that the superintendent - the Commissioner didn't find out about the incident until Monday morning when the incident happened Friday night.

A. Yes.

Q. I mean, it was - when did you find out about it? Maybe you've answered that already.

A. I think it was 7:30 or so - I think it was 7:30.

Q. What day was that now?

A. That would have been Saturday morning.

Q. And why didn't you call the Commissioner on that?

A. Basically I didn't feel at that time that this is something that she needed to be bothered about at that - on this weekend and that's - looking back, I probably should have called her.

Q. Yeah, I think that's probably correct. Question - the Recommendation 7, AMHI address the need for improved documentation. Okay, we've had documentation that has been beat around here these last few days like there's no tomorrow, but current form is inadequately completed by staff and, therefore, does not accurately capture necessary information -- the incident report form should be considered. Adult Services and the patient advocate will be making suggestions in the development of this form. Does the patient advocate do that?

A. Yeah, I've looked at it myself and showed a draft to our

professional consultant and then we did eventually weight his - Rick? Is it done?

MR. HANLEY - It is not done yet. We have met once with DHS and we'll be meeting again tomorrow to discuss some of the other incidents as well as the report.

MR. DAUMUELLER - There is - one of the problems in revising the form is the coding of the incidents and trying to track them with - and computerize them which is what we're in midst of and I know coding was something we wanted to be able to follow events over time so that not to have to throw out the old data, so that was, from our point of view, one of the things that we were concerned about. From the advocate's and the DHS point of view, I don't know what they would have suggested, but they haven't suggested anything yet.

Q. The patient advocate hasn't suggested anything?

A. No.

Q. Okay.

A. There was a change in patient advocates, oh, geez, I don't know, a couple of months ago.

Q. We've already looked at Recommendation 8. Recommendation 9, assure that all charts and patients under the guardianship or conservatorship contain fluorescent sticker -- case, name, address, phone number. That's a pretty basic clerical kind of thing. Did that happen, do you know?

A. I know the guardian - the guardianship is in the - on the face

sheet of the chart. I don't know if we're using fluorescent stickers or not.

MR. HANLEY - We are, but we've asked that all the public wards be reviewed to make sure that that's in place and we have requested and received most of the Probate Court orders which will go in the record section of the chart.

Q. So do you think that - based on those recommendations, obviously you've looked at those and seen them. Is this indicative that you need more staff, do you think, all these recommendations, these nine things, is that what that tells us? That the institution needs more staff?

A. Well, I think there's staff and there's organization and if you don't have staff things fall apart because, you know, as I said before, I think good people look bad under bad circumstances. I think they go together and I think if you're under - you can have good people in place and even good policies in place and, by the way, there are a lot of policies in place that maybe people think - don't think there are that are in place. So it's a combination. I think when you're - if you look at - while this incident I think does point out systematic things, I think part of the systematic that's pointed out is that you don't have ward clerks on each unit for upkeep of charts, and so forth, so who's going to do it. It falls to the mental health worker. Now, are they going to take the laundry down the hall or get the laundry cart off the - out of the hallway or are they going to take the patient down to

the clinic or are they going to work with the patient or are they going to, you know, put things in the chart and those are some of the choices that people have to make and that's where some - where you get some breakdowns in systems. You know, I think many of the things that break down are clerical, bookkeeping types of events, but you've got basically a situation where people who shouldn't have to be doing that are doing it, mainly direct care personnel, mental health workers or even nurses in some cases.

Q. All right. Concerning the cutting of staff that we've just been batting around a lot, now, it's been talked about before, but I just want to cover some areas again. The - it came down from the Executive Department, they asked you to cut staff, is that true?

A. No, they said can you take a 4% across-the-board cut.

Q. They asked you if you could.

A. Yes.

Q. Okay. And you said.

A. No.

Q. Okay.

A. And then I also said that - then we worked on some other options in terms of contracting, are there some things that we can contract out that we're currently operating that would save money, were there some savings to be had in terms of combining forensic units and it turns out that none of those options wree really top notch options and eventually the revenue

enhancement came about and that took everybody off the hook, essentially, for having to make cuts.

Q. Okay. So they didn't come back to you after you said no and said you must do -

A. No, no.

Q. So that was a basic kind of probably cabinetwide management tool that said, well, let's cut 4%.

A. Well, yes, I think to fund the priority package I believe is -

Q. Pie shape.

A. It's a $15 million package.

Q. Okay. And so in terms of a cohesive plan to ask for more staff, the only real plan on paper that was submitted to the Commissioner was the one that tracked the - that went along with the September 22nd memo, is that correct?

A. No, that would be the June - the June request.

Q. Okay. There was a written request -

A. Oh, yes.

Q. Okay.

A. That was all in writing.

Q. And how many positions did that request again?

A. That would have been - it started off with 60.

Q. Okay. And that was considered to basically be addressed by the September special session.

A. Yes. And that's what the - the proposal eventually was built on that.

Q. Okay. There just seems to be a lot of confusion or allegations that, you know, there are all these requests for staff and they're always being turned down. I mean, it seems to me that the only time anything appeared on paper and got to the Commissioner's office she got it.

A. The only time anything got to the Commissioner's office on paper we got it after the news media heated up the situation, that's when we got it.

Q. But, you know, I realize there was - in the weekly reports there was - you know there were mentions of, well, we could use more staff and, you know, but we can probably hang on. I mean, if I was Commissioner, I wouldn't look at that as a mandate. I mean, I would look at that, well, you know, he's having a tough time over there, but, you know, I guess it's okay. I haven't got a request for staff. I mean, there's no packet with trends and graphs and predictions of decertification, all this kind of thing. I mean, to the best of my knowledge you didn't put in a formal request for staff or a written request between February and May, is that correct, of last year?

A. As I said yesterday, on January 27th we met as the governing board of Augusta Mental Health Institute. We discussed the need for staffing and a special meeting was set up to discuss that very issue and I did ask for staff, but we didn't go into - we didn't have a special - I didn't have a written request for a number of

staff. What I was asking basically was can we go ahead and can we - in other words, can we open the window. We operate a lot on windows of opportunity, I guess is the way - and is there a window of opportunity that we can go for.

Q. Okay.

A. That's what happened in June. The window of opportunity presented itself.

REP. MANNING - Rep. Clark?

BY REPRESENTATIVE CLARK

Q. A couple points of clarification and then I want to talk about real people that are in this institution. Do I understand correctly that while - that the rape protocol that Rep. Dellert referenced was developed after the August incident?

A. There was a rape protocol that was developed a couple of years beforehand that everybody seems to know what's in it and recall but couldn't find. And then a rape protocol, after nobody could find the protocol, was developed after the rape case.

Q. That would be consistent with Dr. Rohm's comment that there was no protocol then - on Thursday.

A. There was a protocol that was written a couple of years earlier and it was in a memo form.

Q. But nobody knew where it was.

A. And that's true.

Q. So that it wouldn't be in this notebook that Rep. Dellert is referencing.

A. That's right. So you can say that there is no protocol, although everybody swears there is or was one.

Q. And it wasn't followed.

A. And it certainly wasn't followed, right.

Q. Okay. It seems to me that when I read and I listen to - look at the literature on troubled families, a lot of discussion about the no-talk rule. Can you talk a little about the no-talk rule in the Department? Was there a no-talk rule. Let's start there.

A. Okay. Basically the no-talk rule in terms of the department, if you will, would be that members of the department would not independently communicate to the Legislature and if a legislator would call or make an inquiry of me that I would inform the Commissioner of what was said and asked and there was no - it was not said, however, that you would not give information to the Legislature. There was - if they asked a question, you could answer, but you were not to pitch the Legislature independently of the Executive Branch. In other words, you would do whatever - conversing you would -- with the Commissioner and the Associate Commissioner, there would be a departmental position and that position we'd all support. We'd fight about whatever would be within the team.

Q. Did you feel that there was the opportunity within the team to fight bfore you went public?

A. The opportunity is always there to fight. I mean, you just fight, so to say that there was no opportunity, I guess I couldn't

say that. You just have to decide you're going to fight.

Q. Okay. If as a state legislator I had arrived at the front door of AMHI on January 1st, what would have happened? As a legislator, not as a patient.

A. I think we would have taken you through, explained the program, anywhere you wanted to go basically. We did have a very - we do have an open-door policy basically within certain parameters, but - and those have to do with patient rights and respecting their privacy, and so forth. But anytime a legislator or anyone else, for that matter, that would make an inquiry, would be able to go through, talk to people, have their questions answered. I don't think there would be any problem with that.

Q. So if I had arrived on January 1st and said to you, Mr. Daumueller, as superintendent of this institution what do you need to make this run, would you have been allowed to answer that, do you feel?

A. I probably would have said fewer patients or more staff. I think I've never deviated from that. The long-term solution has always been, you know, to come up with what we ideally want in a facility is fewer patients, make a smaller facility, hopefully, or enrich the staffing ratios, but the best way to enrich the staffing ratios, and we would - there again, we're in agreement with the Department, I think, would be to bring down the population. The problem with that is in reality in really working - looking back is not double funding. Double funding is the -

Q. Even if there's double funding, I guess I'd like to talk a little more about that. Let's take a snapshot at any one point in time. We've got 375 patients housed in the hospital, is that correct? How does that break down? Where are they? Are they chronically mentally ill, are they acutely -

A. Seventy are in the nursing home, 70 in the nursing home. Depending on what part - time of the year it would be, we have 70 nursing home, you would have right now roughly 32 or 3 in senior rehab, I suppose.

Q. Tell me what that is.

A. That would be the combination of infirmary and the unit that was newly established, a 20-bed unit, so I think those two together would be about a hundred and -

Q. Is this rehabilitation for physical or mental illness?

A. The concentration there is physical illness and the need for nursing home care, either at the skilled nursing facility level or the intermediate care level.

Q. And how is that different than in the nursing home beds, the 70 nursing home beds?

A. It would be the same only a little higher level of care.

Q. And the rehab is higher or the nursing home is higher?

A. Rehab would be higher, because it combines the old - the medical/surgical/infirmary unit which is like a medical/surgical hospital and a nursing home. So that would be like 103. You have probably 35 or 40 in the alternative living program. You have

depending again probably now somewhere around 21 or 22, I would guess, in the adolescent program, somewhere around there. And then you'd have - on the Admission Unit it's up and down, but probably would average - now it's starting to average between 25 and 28, somewhere in that range, I would imagine. Then you have the Forensic Unit, that's roughly 33 and they stay pretty much around that level. Then you have the four units that were - is young adult program. That's been running about, I think, 48. The older adults - the adult program runs 55 to 60. And so the 48 is about three over what we'd like to see there. The 55 to 60 is about 10 to 15 over what we'd like to see in that unit. Older adult, recently since we made the change and since I left around that time - what's that -

MR. HANLEY - 47

MR. DAUMUELLER - Okay, so it's running - it runs about 47, that's about seven over what we would like to see that unit. And then Stone North Upper is kind of an overflow area that has 12 staff attached to it and that's running about 24 patients.

Q. On those four units, what's the median length of stay? I guess I'm having trouble when all these numbers get floating - thrown around, whether we have a fairly stable population that goes in and out or whether we have a long-term chronic population -

A. You have both. You have some - some of the more chronic and that's one of the problems on the adult program is that some of these people are longer term patients. I think the younger

group has a little higher turnover and the Admission Unit, of course, has the highest turnover of all and so there's a selecting process that goes through is once you get past the Admission Unit your length of stay - the prospect for length of stay being longer is greater, but even there you have people who are going to come in, be in for a while, thirty days or so, and move out and then you have another group that's going to be in for a much longer time and the care needs of that group - you know, the care needs are fairly high.

Q. For the long-term group you're saying are high or for the short term.

A. For some - particularly some on the adult program, there's many very chronic, very difficult patients who - to get them to move you have to do a lot of work with them or provide them, you know, heavily supervised residences.

Q. Okay. So let's go to this older adult unit. You've got 55 or 60 people on it. Is that right?

A. That's the adult unit.

Q. Yeah, okay. Let's talk about that unit. You don't want to even guess on a median length of stay on that unit, huh?

A. I'm guessing about eighty, but -

Q. Eighty days?

A. Yes.

Q. Okay. Tell me what goes on in that unit.

A. Well, you have a large group of people who have an activity

schedule, some off the unit, some on the unit. Many of the patients who have - you have privilege levels, three levels of privilege, people who cannot leave the unit, people who can leave, you know, quite freely and then some in between. Those who can leave freely have much more access to the various hospitalwide programs. We have the canteen, the activity resource center and you'll have activities scheduled for the patients on the unit and opportunities for certain people to go to activities. So activities is a big part of their -

Q. Give me an example, what you mean by activities. What are they doing here?

A. Well, now we have a gym. They might be doing phys ed, they might be doing - in the activity resource center they might be recreating, playing games or, you know, they might be in the library reading or they might be in some structured activities, games, they might be making - doing some kind of crafts or making, you know, pottery. There's a fairly substantial amount of that.

Q. Do those people eat on the unit? Is food brought in?

A. There's a kitchen on the unit,yes.

Q. And so they eat in a communal dining room.

A. Yes, which at 55 and 60 patients is quite crowded.

Q. You didn't talk at all other than recreation about what kind of therapy these people are getting. Who are they seen by?

A. Depending on who it might be, they might be seen by a social worker. They might be seen by their physican or physician extender.

There are psychology - psychologists, they might be seen by a psychologist, either individual or by group. There is limited numbers of groups that - for activities of daily living and other kinds of discussion groups. But the level of active psychiatric treatment that you would maybe expect to see is fairly limited and if you go back in history, one of the reasons AMHI was cited for being a top notch facility is because of the educational and therapeutic programs that were in place at one time, SLT structured learning therapy and a number of things which were very much geared to activities of daily living and helping people learn how to cope with the environment that they would be entering into, how to cope in interpersonal relationships, so to speak. So over time the mental health workers and the staff who were assigned to those programs were pulled back to the units to provide basic care and treatment and so if you find me struggling to come up with a long laundry list of therapy, you know, that any individual patient is going to get on any given day is not a lot there.

Q. If we were going to take those sixty people out of the hospital, what kinds of living - what kinds of situations would we be looking for?

A. Well, the most desirable for the majority of our population, the best judgment - our best judgment are the six to eight, you know, depending how it's structured, group homes which are relatively heavily staffed. In other words, that there's constant and significant supervision and some in-the-home treatment, if you

will, some opportunities for some growth and training right in the facility, yet opportunities for interaction in the community so that people would be well integrated into the community. This is - this may be somewhat traditional and, you know, maybe not as contemporary as some people would like to view things, but this is what I think the majority of our in-house staff would say would be the most - the base - that would be the base line for people who could come out of AMHI. In support of that, in the vocational - people need to have vocational aspects to their life, so that means work or work training and that's extremely important for successful adjustment and people need to have some recreational outlet, so there needs to be some fun in a person's life and you have to be able to get to those things, so there's an element of transportation. So there's, you know, housing, vocational services, recreational services and case management. In other words, people following along with the person in the community to see that they're getting what they need, their needs are being met and that something is actually going on in their lives that's meaningful. And that - and when people see that their lives has some meaning, I think that's their best chance of adjusting.

Q. If you created -

SEN. GAUVREAU - Excuse me, I'm going to have to break in here, because we've received word from the House that the annual House photo is about to be taken and as a courtesy to the House

members of the Committee, I'm afraid we'll have to recess at this time. Since it takes between thirty minutes to one hour to do the photo at the very best, I should ask that the Committee recess.

REP. MANNING - I think what we ought to do is recess until say 12:30.

HEARING ADJOURNED AT 11:00

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on February 2, 1989, in Room 113 of the State Office Building, Augusta, Maine.

Norma Morrisette

I N D E X

REP. MANNING: Neil, you were next.

EXAMINATION OF MR. DAUMUELLER BY REP. ROLDE

Q. Mr. Daumueller, a couple of questions. You said, when you were questioned about the problem of asking for money for staff, and you got the sense back that that wasn't going to go anywhere, that presumably the administration wanted to keep expenses down so that was not an approach that they were going to take and that one of the things they were going to do was - and I'm going to quote your own words - is reduction in census approach, which was the idea of beefing up community services and therefore easing the strain on AMHI. And when that came to the legislature in September, if I remember correctly, out of the $6.5 million that we gave them, something like three million was supposed to go into community services.

A. Yeah, three and a half.

Q. Now that approach does not seem to have worked, because if I understood the chart correctly that we had, the admissions now are the highest that they've ever been, even after all the time between September and February for those projects to go into effect. You also had talked about the proposed 20-bed unit down in southern Maine, and when I questioned you about that yesterday, you were sort of vague as to what had happened with that, and I assume that nothing, essentially, has happened with that. I guess one of my questions was, since this was very critical to AMHI's problems, how much were you brought into either designing what was to be done out in the community or in implementing it? Were you informed of

anything that was going on?

A. I would inquire periodically as to the progress, and the response was that there was some thought that something could come on line as early as the end of last year or the early part of this year, and that looked fairly favorable, and I can't tell you when it stopped looking favorable, I think it may have been November or December, as I understand it, maybe it looks more favorable now. So if I'm saying it's kind of been up in the air and questionable, it has been up in the air and questionable, although it looked real favorable at the time we were expressing that that was part of the budget. So it looked very good at that time, in September, let's say.

Q. And we are talking about the 20-bed unit or -

A. Yes.

Q. Or are you talking about other -

A. Twenty bed - yes, in southern Maine. I was under the distinct impression that that was a very realistic thing to happen at one or two or three facilities.

Q. So where is that now? I mean, do you have any sense?

A. I have a sense, but there are people from the department here -

Q. Who are specifically working on it, but you -

A. I was never involved in that.

Q. You really weren't involved in that -

A. At all, no, but I understand there is some work being done in that very specific area with a specific provider at this time.

Q. Okay. Now I want to ask you a very loaded question.

A. Gee, that will be a switch.

Q. And what I wanted to ask you, and this is your own feeling, do you feel that there has been an attempt to make you a scapegoat for the problems at AMHI?

A. Well, I guess I've said it on the air and in front of God and everybody. I guess it would be hard to say that I didn't feel that way to some extent, and to some extent I feel that way. That's not to say I don't have - you know, I am not saying that I am not part of the problem or I don't have any culpability. I just think that there are a lot of things that play into the problems that are at AMHI and the mental health system as a whole, and one of the big factors is there's a lack of money in both, at the community and at the institutions, and I think that's the bottom line, that there just isn't enough funding to do what people would like to see done. And one of the reasons - I guess the main reason I'm here, in the God's honest truth, I mean, it's not to say that I shouldn't have been fired, that is not it, that's not an issue and never has been for my appearance here. Susan Parker has every right to put anybody she wants to in that position, and one who serves in that position serves at the will of the Commissioner, so that's not even a debate. This is not about getting my job back or anything like that. This is about what's needed to make things right. For whatever reason they were wrong in the past, and for whatever reason led up to it, I think that there's a need for some action and fairly rapid action and fairly significant action. I think the - if you read the stuff that was given to you in the

proposal, the 6.5, it does talk about additional needs and the need - the anticipation that there would be additional requests coming to you, because there are needs out there and the package that you got is a great start and it's the most it has been funded for a long time but it isn't going to do it. It's not enough. It wasn't enough then and it certainly isn't enough now, and in order to make things right and to put together the kind of system that I think you want and the kind of system that I want, which emphasizes community-based care, treating people in the least restrictive setting and having quality institutions and facilities, it's going to take more money. And so we can find people to blame for the failings, but the bottom line is how much are you going to be willing to pay in terms of quality, because I hear you, very concerned about quality, and as you well should be, but that quality does cost money. And yes, there are management issues involved, but there are also resource issues involved, and I think the resource issues, in many respects, create some of the management issues. That's the bottom line, that's why I'm here, and that's what I hope you will focus on and respond to. My sense is that you and many other people in the legislature would be willing to respond to that and possibly one of the struggles at this point is how and what is it that we do now. And if I could focus your attention on what needs to be done, I would say you're going to have to do what I call double-funding, or fund the institutions more heavily maybe than we would like in the overall scheme of things because you don't want to emphasize the institutions, but you need to have good quality institutions, and you need to put money in the

community in order to move people from institutional care into community care. That's a big job and it's going to take some time, and so you - you know, if everybody does the right thing, I think there's going to be a heavy influx of dollars for a period of, let's say, two to five years, until you can get to the point where you can honestly make tradeoffs and say let's move money from the institution to the community, because once you beef up the institutions then you have a whole other set of problems about how do you move institutional resources into the community. There's labor unions that have to be considered and there's people who have jobs and so forth, and you know and I know that that's not an easy issue to tackle but it needs to be addressed in any kind of long-term plan. There needs to be the resources and you've got to build them up in the institutions. At the same time you've got to put money in the community, and over time then I think you can make transfers, but you can't - if you're treating people in the State Hospital for $135 a day on average, you're not going to be able to make that movement from the institution to the community because the institution is underfunded, and so you start taking away from there, you know, you're just going to kill the institution. And if I'm the bearer of sad tidings, I'm sorry, but I think that's the story that needed to be told, that's the reason I came forward to ask to tell it. It wasn't about a lot of other, the side issues that maybe are more noteworthy and catch more press and so forth. I hope I answered your question.

Q. Thank you.

EXAMINATION OF MR. DAUMUELLER BY REP. CATHCART

Q. Mr. Daumueller, are there any widely accepted standards for mental health institutions, such as the patient/staff ratio? What kind of standards when you made those judgments were you basing it on?

A. Well, there are different articles that cite staffing ratios, and there are different things like consent decrees, there was a recent one in Texas, that lay out staff/patient ratios. There's your own Pineland consent decree that gives you some kinds of guidelines as to how you might staff facilities, and I don't think that's a totally outrageous approach to take and it does give you an assurance of quality. That's a real prolem, because the joint commission really doesn't take that on as a cause, Medicare will not take it on as a cause, and it's very difficult for public facilities, state facilities, county facilities, all sorts of public facilities to make the case to legislators or to councilmen or selectmen or whatever as to what the needs really are because it is subjective. So the answer to your question is, there aren't very many good standards, good national standards, to go by. There's some ballpark figures and there is, again, some specific articles that tell you what might be good staffing, and it does depend on admissions. A simple ratio would be how many patients to how many staff, but you have to factor the turn-over and the acuity. If I've given you a longer answer than you wanted, I'm sorry about that, too.

Q. That's okay. Let me ask you this - I'm not just interested in that, but if I as a legislator wanted to know, say, how I would like it to be at AMHI, I mean therapy, occupational things, activities for patients, where would I go for a standard of what a good mental health institution should provide?

A. Well, you could start right at home and go to the professionals who work there. They're by no means lacking in intelligence and insight. I think they could give you some reasonable standards allowed to do so. I can throw out some numbers, I think. In terms of mental health worker types, you'd count your number of patients and just - that's the number of mental health workers I think you ought to have. In terms of physicians, probably rough - medical doctors, I think probably one to a hundred and round off up, so that would be roughly one to four at AMHI. And social work, under normal circumstances it would be roughly one to twenty patients, but then you have to factor in how many admissions that you would want them to take. And then to those figures you have to throw in how much therapy do you want included and make sure that you have the staff either on the units or set up a separate staff to provide those, like college campus courses or therapy groups and so forth. So, I mean, I have a number of ideas as to the staff who work at AMHI who could - I don't think it takes that long to come up with some ballpark recommendations.

Q. I was hoping you would tell me there was one book like this that would tell me exactly.

A. I wish there were. In the nursing home - the nursing home

standards do give you standards, but, quite frankly, those are very low, and when you're dealing with the type of patients with behavioral needs to attend to, those tend not to be very good standards.

Q. Thanks. Everything that I've read and learned since starting to research this situation tells me that there has been, at least the past year, a constant staffing crisis at AMHI. Would you agree with that?

A. Yes. The first time we looked at staffing patterns, it came up that we needed - and this was the first time I ever went through the exercise, and that we probably needed 154, put in a request in for 54 saying that this is - we'd phase into it and we were concentrating on therapy, providing this off-ward therapy and activities, day living, structured learning, therapy, that sort of thing. You know, that went through the mill and got cut back and then trade it off for the spike in admissions for '87, so our focus at that time wasn't doing the therapy and some of the nuances of care became safety and containment and that sort of took over from going back - in a sense we were trying to go back in time to recapture some of what we had lost over the years. So, yeah, there's some staffing needs that have crossed administrations and crossed years and so forth.

Q. In the past few days I've heard a fair amount about the reduction in the number of Medicare beds, and I know that at present if we were to go for recertification, tell me if this is wrong because I want to get this explained a little more, we

would be asking for 30 beds to be recertified. But originally last - a year ago, say, as I understand it, there were 80 Medicare beds at AMHI, and then in the -

A. Yeah, it went from 222 to 202 to 86 to - well, basically 16, and then try and reinstitute 30.

Q. In your Medicare narrative, when you went to that meeting in Boston last April, you stated that you were willing to reduce the number of Medicare beds from 80 to 76 at that time. And then somewhere, I'm not clear right now where in there it went to 30.

A. 86 to 70. There were three units -

Q. Maybe I got that backwards.

A. Yeah, the 30-bed admission unit, the 40-bed older adult program and the 16-bed infirmary, and we were saying at that time that the infirmary was one that has a - that's under a different provider number. And so as a matter of fact, probably to this day it still remains a Medicare unit.

Q. Okay. As I understand it, today we do have 16 Medicare beds.

A. Yes.

Q. When and how is the decision made to go from 70 to 30? Could you just explain that? Who made the decision and what was the reason for that?

A. The reason for it is to try to give us the best sort for certification. The decision is basically a jointly held decision amongst, let's say, myself and the Commissioner, the Associate Commissioner.

Q. And was there a plan - after you decided that then, once we got

recertification for those 30 beds, we'll start trying to work up so we get more Medicare beds back?

A. No. There was a plan to create the senior rehab unit and convert that to a -- licensed SNF ICF unit which would generate revenue and also create a better environment and create a treatment program more conducive to the care and needs of the people we were dealing with. So in that respect, it was almost like getting Medicare on the older adult program, we'd be getting dual licensed nursing home beds on the senior rehab program.

Q. It is confusing.

A. It's hard to make it any -

Q. But in a way, it seems to me, that since we reduced the number of beds to 30 that - we've been throwing around a sum of $41,000 a day that the state is losing in Medicare funding, and isn't it really true that we lost a lot more than that by reducing the amount of beds? That's just where I'm not clear at all.

A. The 41,000, I think, would be Medicare for the older adult population and the admissions unit, and Medicaid for those over 65, and they're roughly equal numbers, 650 apiece, I think. Okay, to get Medicaid funding for people between the ages of - over the age of 65, you have to be in a Medicare bed, okay? So you have to have a Medicare certification. So when Medicare was thrown out for the older adult program, we also lost Medicaid for those 65 and older. Now the same rules don't apply to those zero to 22 that Medicaid will pay for if you're joint commission accredited and have active treatement. So those are the requirements for the

zero to 22 population. So what was the plan? Certify the 30-bed unit for Medicare and convert what used to be the older adult program with Medicare funding, convert that to a more appropriate in terms of care given and get Medicaid funding for a bunch of people who weren't getting any funding and make up the difference that way. So that was a good move, still is, and it makes sense.

Q. That helps a little, but I had one other thing. The JCAHO funding, I think you said yesterday that you thought that if we didn't make some increases in staffing, we would really be in danger of losing that accreditation in October?

A. Joint Commission. Yeah, the difference between Medicare and the Joint Commission in terms of how they view things is one is a governmental agency that's kind of a watchdog of public funds and tends to be, you know, fairly hardnosed. The Joint Commission is a private organization which certainly - you know, accredits people voluntarily, you volunteer to do it, although in reality you pretty much have to do it to get some kinds of funding. They will give you much more rope and much more correction time and handle you in a much more consultative fashion than will the current Medicare surveyors. Medicare is no longer a consultation program, it's strictly enforcement and funding. The Joint Commission does have a consultive role and they see their role as consultive as well as one of enforcing their standards.

Q. But you still are saying that we are in jeopardy of losing that from the Joint Commission next October?

A. Yeah, we expect to receive a number of contingencies, and some of those contingencies will relate to staffing, and nursing staffing is one of those areas that was particularly mentioned in the Exit Conference.

Q. I don't know how much you know about the BMHI situation. I know that they got the letter in December reaccrediting them for three years but there was something like 160 or 170 odd contingencies -

A. 143, I think.

Q. How many, 143? They seem similar to the ones that AMHI would have, a lot of medical record problems and a lot of staffing shortages, so would you say just from knowing that they also probably are in jeopardy unless something -

A. Well, the Joint Commission - the staffing proposal for Bangor in the budget came after the Joint Commission survey, so their request may have reflected more Joint Commission needs and address more of those specific areas. I'm not real familiar with what's going on at Bangor, and the department would be in a much better position to answer that question, but I think that 1.6 was much better aimed in the Bangor situation towards the Joint Commission because they had the survey.

Q. Okay, because their inspection, or whatever it was called, was last July, wasn't it?

A. Yes.

Q. And so they did have a chance to come in --

A. I don't know if they have any additional needs or not.

Q. Just one last question. Of course, you could take the rest of the day on this, but if you can make it brief, anybody in the kind of management position you've held probably would have a vision, you sit back when you have a chance and you think how would I like it to be. Can you tell us just in a couple of minutes what your vision would be, not just for AMHI but for mental health services in the State of Maine?

A. I would like to see Maine have a system of mental health care whereby there was a local or a distributed or regional approach to planning and budgeting and gate keeping. Money would come from a central source and be given to them. I would like to see the budget that goes to AMHI primarily in their hands, so that they would then be in the position of purchasing care from the State Hospital, or not purchasing care from the State Hospital. If they chose to build a group home and house eight people that would reduce their need to provide in-patient care, great, and that would create - by doing that you would create an incentive for someone whose got - I've got a budget and I've got gate keeping responsibility. If I have those two things, then I can make some reasonable choices at the local - at a local or at least a regional level as to what should be done. If I don't have that, if I've got gate keeping only and I don't have the money, then I say, well, send them to the State Hospital, why not, why should I have to break my back keeping people out of the State Hospital when I can just send them to the State Hospital, the patient's gone, what the heck. I'm not saying that that's the attitude, but

I'm just saying, to kind of dramatize the point, that an incentive for finding the most cost-efficient and effective way of providing care lies almost exclusively with the state, which is a very centralized situation right now. It's very difficult from Augusta to try to do mental health planning, budgeting and make gate keeping decisions in that kind of a setting, so that's the first thing, set up a system of care. And, of course, the other thing I'd like to see is that any kind of - the initial care or acute care, if you will, the kind of stuff that comes into our admission unit, as much as possible handled in the locality from which people come. Now, granted, there are some problems with that. Not every general hospital is going to want to get into this business at all. There are a few that will, but where possible, that should happen, and it happens best where the people have the money and the planning and the gate keeping responsibility of working with the general hospital because they've got an incentive to work with them. And so they might put lots of time and energy into developing that contract and having the case management and everything in place for people who are in that kind of an in-patient setting, so as much as possible, local in-patient. And then you get into the need for a large variety of services so that people can live in the community, that means residential options, vocational options, recreational options and transportation options, and, of course, medical followup, you know, medication, medicine, medical followup. So that's - if you read the blue book, there's a lot of all that in there. As I see the role of the State Hospital, it would be less

the acute program that it currently is and more of a secondary and tertiary backup to what's going on in hopefully local or a more regional process. It doesn't make sense for us to have this specialized program because there's only maybe one or two people who would need it, but if you take a whole catchment area, you can have programs which specialize in certain things, you know, like a man - I'm throwing out head injured. I'm not throwing it out because I think head injured people should be in the State Hospital, I think that's probably not where they should be, in fact I'm convinced that's not where they should be, but there are various target groups that might fall out that would be inefficient for a local community provider to fund or try to plan our budget. So basically a smaller role for the State Hospital and over time keep making it as small as you can. Have some kinds of bridging mechanism for the employees and the people who work at state hospitals to move from institutional settings to community settings. I hope I didn't take too much time, but that, in a nutshell, would be what I would like to see, and a very open process of decision-making and planning and so forth as to what the needs are and then you've got a good system, and I think you've got a lot of the pieces of that system right here.

REP. CATHCART: Thank you.

SEN. GAUVREAU: Thank you. The next questioner will be Representative Clark.

EXAMINATION OF MR. DAUMUELLER BY REP. CLARK

Q. Thank you. When we broke at lunchtime I was asking you to take

us to your older adult ward where you said there were 55 to 60 patients. How many of those patients at any one time would you say would meet the definition or the description that you just gave of active treatment? Maybe I should back up. What would you define active treatment? You used that term when you were responding to Representative Cathcart.

A. Active treatment is a planned, purposeful, coordinated approach to care using an interdisciplinary team and carried out by that team. So you assess the patient, find out what they need, you put the plan together, you implement the plan, assign responsibilities and you carry that out. You write progress notes. Those are all evidence of active treatment and it depends on how strict you want to be with the definition of active treatment. You can make a case for active treatment in many of the cases of those people, but in reality, the kind of treatment that we'd like to provide is not particularly prevalent. Truly individualized care, truly following up on all the things that people plan for the patient, I don't think that that's being delivered in anywhere near the level that the staff and everybody else would like to see.

Q. When you're cited for deficiencies in terms of charting, are they really not citing you as much for the charting itself but for the fact that you have not planned or don't have the personnel to carry out that plan, is that really what that is?

A. The chart is the evidence that the surveyor has that something happens or doesn't happen, so when the chart shows that the assessments

aren't proper or that the treatment planning is not based on the assessment, or the progress notes don't seem to reflect back to the treatment plan, or that progress notes don't reflect very much happening with the patient, all those are indications that the care is not where it should be. And so the question is, is it just charting, the technique of charting is part of it, yes, but, no, it isn't just charting.

Q. So in essence, when we get cited for bad charting, we're really getting cited for the fact that we don't have the people to do the work that the reviewer wanted to see on the chart?

A. That's my opinion, yes.

Q. Thank you. One other question. We've talked a little bit about models here. We talked about the medical model and we talked about the rehab model. Was it your intention as the superintendent that all of your wards would operate on this same model or did they operate on different models?

A. Well, they're all pretty much operating on the medical model. I think in our hearts we'd all like to operate a little more on the rehabilitation model, okay, so there's a lot of us who are conflicted about this. And Medicare and the Joint Commission are all telling us the medical approach, doctor-nurse approach, but the things that I think really help people get through their illness and live successfully in the community are - come out of this rehabilitation model, that in some ways it's from AMHI's past, the structured learning therapy and the good linkage with providers and so forth. So I have definite ambivalence about moving

so much to the medical model, but I think we're forced into it, I don't think we have much choice. I think that's the way the world is. If you want to be a hospital, if you want to have joint commission, if you want to have Medicare, then you are going to have to be a hospital.

Q. Would it be correct for me to say in your opinion that at the current time AMHI would not - does not meet any of the - that none of those models really prevail?

A. I think we run, generally, on the medical model, and there are some -

Q. Except that you've told us that we don't have medical physicians and we don't have enough psychiatrists -

A. Yeah, and that creates some problems.

Q. We don't have enough nurses, so how can we be running on a medical model?

A. Well, you can run on the medical model and still not -

Q. Without the people, huh?

A. Yes.

REP. CLARK: Thank you.

SEN. GAUVREAU: Representative Pederson.

EXAMINATION OF DR. DAUMUELLER BY REP. PEDERSON

Q. Bill, I was interested in your - you must have a team effort then on your level at the hospital, and would you describe what your team would be at that level at the hospital?

A. Four inter-directives, the discipline heads, which would be medicine, that would be the clinical director, the social work,

psychology, activities. The assistant to the superintendent is in that team, as is the chief of hospital services. We also bring in personnel and research evaluation. That's the general team. Those are the people that report to me, basically.

Q. Was it that team that would help you to make decisions on your level then, as far as you would say is the amount of people that you would need in that type of thing?

A. Yes, they are. Unfortunately, one of the fallouts of preparing our package was the amount or lack of involvement in the team, simply because it was fairly tightly held and close to the vest and operating outside of our normal process of development of goals and objections, which run in parallel to that, and whose finish date was after the date of the proposal submission. So in some respects our proposal was outside of our planning effort.

Q. There was an incident that I read of the head of the hospital that involved a lady that had a broken hip and she did not get any medical attention for something like 24 to 48 hours, and I believe that she was also under the psychiatric supervision of Dr. Rohm. Do you happen to recall that incident?

A. No. This could be one where - when you say it didn't get medical attention, was not seen by a physician or didn't get an x-ray?

Q. I was under the impression that she did not - was not seen for medical attention or an x-ray.

A. I would think that the nurse did an assessment, a clinical assessment, and perhaps there were no clinical indications of a

break and then it was discovered. That has happened. I'm not sure which case you're referring to.

Q. I'm not either. I read this and I've been looking and looking to get the particulars on that to verify that. I just thought I would ask you that. I'm still looking, and pershaps I will come up with it.

A. Yeah, that's probably from what the DHS - see, I don't have all the papers relating to the DHS actions, that's not part of my -

Q. And I believe - now, we've talked a lot about accreditation and JCAHO and HCFA, is it possible that they can come in and survey one section of the hospital and actually only be interested in, say, maybe your admitting ward and not really be interested in anything else?

A. Yes. In fact, that's their instruction. They are to look at only the distinct part coming under Medicare and services that would relate to that distinct part.

Q. So, in other words, they would not be surveying the rest of the hospital?

A. Right, unless they did a full survery. Normally, if you have Joint Commission, you have what is called deemed status, and then Medicare will only survey you on two conditions of participation, staffing and medical records. If you get selected for a followup survey or a special survey, they may do the whole Medicare survey, which is very much like a Joint Commission survey. So then they would go through governing body and quality assurance and infection control and all those other things that the Joint Commission go throug

but normally they would just do the ones - just do the two conditions and accept your Joint Commission accreditation as being sufficient.

Q. I'm a little confused. The Joint Commission could also do the same thing?

A. No.

Q. They do the whole hospital?

A. Yes, they do basically everything. Medicare says, yeah, you can do everything but we want to still take a look, for psychiatric hospitals we still want to look at staffing and medical records.

A. Okay. I wasn't sure whether the Joint Commission would come in and say, well, all we're going to, you know, credit you on is your one ward with this inspection.

A. No, in fact that's one of the major differences. They're looking for assurances that there's a single level of care for any given group of patients, so they're looking for equality of care across lines, across units.

Q. Now that you are no longer connected with operation, do you have an opinion on the - if a consent decree was advanced for the mentally ill, do you think that would be helpful? I would assume that that would address not only the hospital but the community.

A. Outside of a suit, outside of like a class action suit and just say we're going to agree to do this and it's like the Pineland decree?

Q. Yeah.

A. Yes. I think if it could be done outside of the antagonism and the horrible upheaval and looking - constantly looking backwards of a court hearing, to come up with some general agreement as to what should be done and put that in some kind of a binding document, yeah, I think that would help.

Q. Okay.

A. And I'm not saying that it has to be a consent decree, I'm just - I think it's horrible that you have to have a consent decree, if that's what someone would call it, but basically an agreement between the state and somebody else that this is what's going to happen, I would think that that would be helpful.

Q. I belong to a family group and one of the concerns from time to time is the emphasis put on one ward of a hospital and reducing the care that has been given other places, and this happens in various ways. I think we see that as an impact on the HCVA accreditation. When you attempt to get a certain ward accredited, you tend to pull staff from other areas and beef it up, and this reduces the care that is ongoing in the other areas. I have some people that were very concerned when they started the forensic unit, that it seemed to reduce the level of care in the rest of the hospital at that particular time. Do you recall that?

A. Yeah, what happened there is that in some respects it did. It was a legislative - you know, that was the will of the legislature to establish that unit, which we carried out and completed it February 19th, I believe. Because of the security of that unit and putting - trying to put a program together, I think we have a fairly decent forensic program, I think maybe one

of our better pieces there. It did perhaps pull - it did pull some people from other areas and enriched that staffing level maybe at the expense of some other areas.

Q. This is kind of like some of the other things, that we're mandated to do certain things and sometimes not given the resources. Was that a situation - was that a comparable situation?

A. Yeah, the funding for that program was - that preceded my coming, so that was in place.

REP. PEDERSON: Okay, thank you very much.

SEN. GAUVREAU: Representative Pendleton.

EXAMINATION OF MR. DAUMUELLER BY REP. PENDLETON

Q. Mr. Daumueller, when you took your job at AMHI, were you presented with a job description? Do you have a written job description or was there a written job description for superintendent of that facility?

A. There was a job description. I don't - yes.

Q. Okay. This morning Representative Dellert and Representative Burke alluded to a policy book and a procedure book. Who is responsible? And you said that there was one - I guess there was one procedure, maybe, that was missing from the book, nobody could find it. Who is responsible to have those two manuals prepared?

A. Ultimately, I am. I think the superintendent is responsible for most everything that goes on in the facility, whether he does the job or sees that it's done or attempts to see that it's done, so the responsibility is there. In terms of who does it, generally the policy manual is kept by the assistant to the

superintendent, although there is Policy Manual A, which is one set, and B, which is another, which is more clinically oriented policies, which is primarily kept up by the professional consultant for nursing.

Q. And previously you were alluding to the Friday reports that all department heads send in on Friday, I guess, to the central office. Were you using this Friday report as a vehicle for requests or recommendations, is that possible?

A. The Friday report is to give an assessment of - it's like the pulse, the weekly pulse of the operation and to reasonably accurately reflect what went on of interest or that I felt should be reported.

Q. So that would not be a vehicle for a definite request for anything, is that what you're saying?

A. No, no. That would be a way of portraying conditions.

Q. Then yesterday you alluded to a December 9th memo, and you said in that memo you made recommendations and requests. You said you had made a request for additional staff, December 9th.

A. No, September 22.

Q. '88. This was the one - the subject was the JCAHO.

A. Okay, all right.

Q. I'm a little confused, because the December 9th memo is not a request for additional staff, it doesn't look like, because it says -

A. No, I don't recall saying that I made a staff request on December 9, I said September 22, I think.

Q. I wrote it down December 9, I put memo, because I was keeping a chronological list here. Perhaps you misspoke?

A. What's in there - what that memo is is the Joint Commission survey impact on our readiness for Medicare. That outlines what - you know, my analysis of what the impact of Joint Commission was on our readiness for Medicare, and it indicates that the Joint Commission had - the survey had some cost implications in it, and I just briefly outlined them at the bottom. Have you got the memo?

Q. Yes.

A. Okay, where it talks about the areas, physical plant, the pipes and emergency power and other life safety issues, staffing, our reduction in patient load, RNs, housekeeping, and then I say that MDs, clerical, QAs not specifically suggested but implied as areas of need. Now I don't call that a staff request.

Q. Okay, so this is not a request and it's not really a recommendation either, it's just a report?

A. That's a report and an alert that there are implications - there are resource implications to the Joint Commission survey.

Q. So in it you said the list is long but not overwhelming when taken one item at a time.

A. Hm-mm.

Q. So I'm just wondering, maybe I would get confused or mixed messages, because if someone said to me, you know, this doesn't look good, we need this, this and this, and then they said but it's not overwhelming, is it possible that maybe the communication wasn't strong enough, is that a possibility? Could some of these

things maybe have occurred because there was not a strong demand on the situation?

A. Well, I guess there's the English language and saying what you think you mean and saying what you mean. I think I've pretty much said what I meant here and the list is long. In other words, I expected to see a list of 150 contingencies or whatever, or something similar to what BMHI got. Most of those things, they're laundry lists and a lot of them can - you know, are administrative items that can be handled fairly readily. At the same time, amongst that list of long laundry lists, most of which taken one at a time can be handled, there are some resource implications, and that's what's at this summary.

Q. Okay. So you weren't really flashing any red lights then. I mean, this doesn't sound like you - you know, you weren't really excited because you said it's not overwhelming, we can do this piece by piece by piece, so you weren't like, yeah!!, we've got to do this or we're dead?

A. Well, I don't know that I would read this that way. I wouldn't read it the same way you're describing it. You wouldn't -

Q. You think this is pretty exciting?

A. What's that?

Q. You think that this is a pretty demanding memo?

A. I'm saying that in reading this memo you would look at it and you would say that there are resource issues that Joint Commission had brought to our attention, and I don't see how you could read it and get any other conclusion.

Q. I'm more excitable than you are.

A. The other thing is, we had a conversation about this memo also. In that conversation I also pointed out that I thought that Joint Commission was in reality more of a problem than Medicare because it applied to the entire facility, and we're trying to gear up the entire facility as a - you know, that's a big, big problem.

Q. So did you tell that to Commissioner Parker and say, look, we've got a big, big problem here, but that's not in writing?

A. Yes, and I was told - well, no, it's not in writing.

Q. It's a conversation.

A. I was there. I can tell you what I said and what was said to me, that - I particularly remember that one well.

Q. Okay.

A. The comments on that comment - my comment was that we simply didn't manage the survey properly and that had we managed the survey properly, this stuff wouldn't have been cited because we would have had a different nurse surveyor or something.

Q. A different nurse -

A. Do you remember the comment about New York?

Q. Yeah.

A. Negotiating their survey with Joint Commission?

Q. Yes.

A. And I didn't know that that was possible, and so maybe I'm stupid.

Q. No.

A. If it is possible, fine, I didn't know that, but that was the conclusion that she arrived at, basically poor management for not setting the survey up better so that we'd pass it.

Q. I see.

A. By arranging for a nurse surveyor of a different - with psychiatric experience.

Q. Background, because this nurse was hospital oriented and you were looking for a psychiatric -

A. Yeah, but then the standards are hospital oriented because they're called a hospital - HAP standard, it's a hospital accreditation program standard. It's a tailored survey that includes the HAP standards, the consolidated standards, which are more psychiatrically oriented and come from a different section JCAH, and the long-term care standards which apply to the nursing home section.

Q. And then again on February 11th you had a meeting and you said you gave a packet of materials and a fact sheet, and at that time you said we're on the edge of disaster.

A. Yes.

Q. But then I thought I heard you say on February 12th you said things had calmed down. Is that true, the very next day everything was just kind of -

A. What I said was we are on the edge of disaster with no reasonable resource response for an influx in patients, which is true, and then I also said for the first two weeks of January things have calmed down but we have every reason to expect from past

experience that they would heat up again. That's not a quote, but that they would again get more - get busier.

Q. Okay. Perhaps I - could I have just put down the wrong date maybe?

A. Okay, let's see - after a fairly extreme January, things seem to have calmed down for the first two weeks in February. From previous years, however, we have every reason to expect substantial increases in admissions and high census due the first quarter.

Q. So that was on February 12th?

A. Yes. And then the next report, after a heavy weekend in terms of admissions, we're back to the 365 census level, acuity consistent with recent past and a bit more crowded than we would like coming into our Medicare survey.

Q. I just - in your job description, did you have the responsibility of overseeing the financial management of AMHI? Is that part of your duties?

A. Financial management, there are a couple of areas where there's significant central office oversight. Finance is one of them, finance and personnel is one of them. To answer your question, yes, but there's an awful lot of central office oversight in the area of finance, personnel, data processing.

Q. But did you have people reporting to you on a regular basis regarding actual versus budgeted expenses, people - you know, because you were overseeing other people? I imagine you must have had like unit -

A. Chief of hospital services, yes.

Q. Okay, and you must have had probably some put in - you know, input from the different units -

A. Yes.

Q. From the, you know, heads of the units.

A. Yeah, when it comes to putting in our budget, yeah, they all sit down - sit down with each department and go over their needs for the year and so forth.

Q. Whole communication type system?

A. Yes, each department was - you sit down with - you know, each department would sit down with the chief of hospital services, go over their budget and, you know, it's a fairly detailed document. I would look at that to some extent but generally deal with the larger document.

Q. And how often were you able to sit down with the different people when you did this planning, when you went over the budget, the actual budget versus the -

A. With the financial people?

Q. Yeah, with your staff people. You know, you would sit down and do this and then you -

A. I don't know, three or four hours or so on a budget, I guess, with the financial people after it's put together, after all the departments have come together and gone over their budgets. I don't know if I'm - I may not be getting the thrust of your question. Is the question do the department heads have anything to do with their budget or have a -

Q. Yes, and how often you - you know, they were able to give their input.

A. On their budget, the budget is a cyclic thing, okay, and the chief of hospital services would meet on a daily basis with his staff, and the chief of hospital services is every day at the table, as is about nine or ten other people.

Q. Then if you were significantly over your budget, or you were under your budget after you meet with your financial people, then I'm understanding you correctly that you would report that to central office, which would be the commissioner, is that right?

A. Well, one of the things about our budget is that we've never had a budget that was in any respects a reality, because from virtually the time it's conceived, you know that it is going to be back in your lap the following year coming up with a request for additional funds. It's one of the frustrating things, that the budget process essentially says tell us what you need and then, well, that's too much, now here's what we're telling you that you're going to need and you put this into your request. I think they call it target budgeting or something, but the department is basically given a target, and so that filters through the ranks, but it's not a zero-base budget or anything where you say this is all our needs and it goes up the thing and it gets pared back up the line. Bascially, it comes back to you and then you resubmit it as a budget that fits the target allocations.

Q. But if you were like really over that budget or under that

budget that already had been planned in your day-to-day operation, like if I was a nurse and I came to you said, geez, we're short this and this and this and it's not budgeted, you would know that?

A. I would know it or I could find it out pretty quickly.

Q. And then that would be reported to central office, if it was significant?

A. Not particularly. You know, that - no, not necessarily. The central office would know about it anyway because they get - they have their allocation sheets and it shows we're over or under. Probably Ron Martel would have a better sense of whether I was over or under a budget more than I would.

REP. PENDLETON: That's all, thank you.

EXAMINATION OF MR. DAUMUELLER BY SEN. GAUVREAU

Q. Mr. Daumueller, we heard some reference from Representative Pendleton to an assessment which apparently was crafted by you in response to a JCAHO evaluation. Is that document - do you have that document? I was looking for it a few moments ago. Apparently you made - that was a memo from you to Commissioner Parker, is that the document to which reference is being made? When did the JCAHO accreditation team come to AMHI last fall?

A. Their Exit Conference was December 2.

Q. And this was dated December 9 in direct response to that assessment, is that correct?

A. Yes.

Q. And is it your position that in the body of this memorandum you communicated to Commissioner Parker the potential for loss of

Medicaid funding?

A. The bottom of Page 2.

Q. Under the summary?

A. Yes, and that's in outline form. I tried to highlight the dollar items.

Q. You say, with this concerted effort our chances are fair but shaky, increasing with time and decreased workload, we're shooting at a moving target. But you say that - within the body of the memo, you make reference to the possibility of a loss of Medicare or a loss of accreditation which would remove our deemed status.

A. I think I said I felt we would get it and -- with many contingencies, and then the thing with Joint Commission, I still don't - I don't think we'll lose Joint Commission. What we'll have are contingencies. The implication - the financial implications are, if we're to meet all the contingencies that are cited, that there will be dollar implications to meet those contingencies. Joint Commission, I think you - if you will, you can string them along or they will go a long ways with you before they finally cut you off in terms of their accreditation, so they will give you some time to correct the deficiencies, unlike Medicare.

Q. Right, I understand that. And I heard the commentary relating to the need to augment RN staffing complements by 40 or 50 to address JCAHO concerns. Were there other focused staff - staffing configurations that -

A. Well, they specifically mentioned housekeeping, and the reason they mentioned housekeeping is the weekend coverage and the

fact that certain nursing personnel were having to augment housekeeping personnel, and so they saw it as taking away from the direct care that those people should be rendering, and so they felt that we should beef up our housekeeping staff and relieve direct service care providers from that task.

Q. And you told us this would be a delayed effect, they would probably come in with an accreditation with contingencies. You were looking at six months or nine months out as far as that occurring?

A. Yeah, about nine months from the time of survey, I think is the schedule. We would probably find out what they said in 90 days to 120 days, three to four months.

Q. So this was the time bomb that was made reference to yesterday and Representative Boutilier indicated that we may have to come back in in a special session, and if, in fact, we have an accreditation with many contingencies?

A. If my judgment is correct, you can call it a time bomb. In other words, there's a problem there that is not addressed.

Q. Now, there's been many questions asked in terms of how you communicated your concerns to the Commissioner. Did you, in fact, personally communicate your concerns regarding potential JCAHO accreditation with contingencies to Commissioner Parker?

A. That was the meeting that I referenced.

Q. Okay, and that was sometime in the month of December, shortly after the survey team came in?

A. Yes.

Q. And was it your impression that she understood the potentiality of a loss or a diminished status of JCAHO accreditation?

A. At that point, it was my impression that she didn't have much credence in what I had to say and that she wasn't buying that and felt that it was just a mismanagement of the survey.

Q. So she - it was her - you felt she didn't take seriously the potential of loss of JCAHO accreditation because she felt the survey wasn't done in an appropriate fashion?

A. She felt it wasn't managed properly, yes.

Q. And you felt personally that she was aiming some of her concerns at you?

A. Clearly, yeah.

Q. Well, how was that meeting resolved? What action did she indicate she would take to determine whether a re-survey should occur or in other ways the accreditation should be reviewed?

A. That wasn't a particularly productive meeting. I don't precisely recall what, if any, outcome there was.

Q. Well, I thought after four days I'd be rather tired at this juncture, but I am surprised. If I understand correctly, that shortly after the JCAHO accreditation team came in, that you, by written correspondence to the Commissioner and then by verbal communication, indicated that there was a likely - a significant possibility that we would either lose JCAHO or more likely we would have JCAHO accreditation but with many contingencies which would have a price tag.

A. Many contingencies, and without resources would not be able to

meet those contingencies, but even if we didn't meet them, we might be able to, you know, play it out longer but -

Q. So I guess the real issue - what action did you understand she would take in response to that report?

A. I didn't think she'd take any action.

Q. Did that surprise you?

A. No.

Q. Did you feel at that time that you had little credibility with Commissioner Parker?

A. I think at that time, yes.

Q. Now you left the department on or about January 11th of this year?

A. Yes.

Q. To your knowledge, had any action been taken to address the concerns in the JCAHO accreditation or a report?

A. No. I do know that staff had met to look at staffing. I've mentioned that right at the beginning. I know that -

Q. But if I understand you correctly, it was your impression that Commissioner Parker thought the problem was more glitch in the way that the survey was conducted than in the actual underlying conditions at AMHI?

A. Yeah, basically mismanagement of the survey, yeah.

Q. I suspect we'll have to take that up with Commissioner Parker. Thank you. Could I ask that this be reproduced for me and other members of the committee may want to have that document. Please make it up for the entire committee. Now aside from the issue of

the RNs, assume for sake of argument that your interpretation of the assessment is accurate and that we are looking at a potential of multiple contingencies as a predicate for JCAHO accreditation. What aside from the RN staffing complement, what other issues must the state address to avoid any such contingencies?

A. There's a very - one of the primary thrusts of JCAHO is the leadership of the medical staff as well as quality assurance throughout, in the medical proper as well as other clinical departments. There have been a number of attempts to devise quality assurance indicators and so forth, and the real problem has been finding someone to go through and dig this stuff out and just to be able to do it, and it's a manpower issue in terms of quality assurance personnel to go through and do qualitative audits in the area of pharmacy, our pharmacy or the pharmacy is not computerized, so there aren't a lot of ways to do good provider profiles and so there's a lot of difficulties in trying to put together a real slick quality assurance program.

Q. Well let me very quickly - we have to report to the legislature on how to so-called fix the problems at AMHI.

A. Yes.

Q. I think that's a quite ambitious task in what we've heard the last week, but I want to, as best as I can, make focused recommendations -

A. Okay.

Q. And so - and maybe it's unfair, and if it is tell me, to put you on the spot now and say what - if it's too copious a task, maybe

we could reduce that to writing at some other point, but I would very much like to know your impression on what actions the state must take to address the gravamen of the JCAHO survey.

A. Okay, one area is just a generic data processing area, and that's a need to maybe upgrade that, and to devise some clinical applications for data processing as opposed to strictly administrative, take some of the load off the direct care workers and try to make their life a little easier. And also, in some respects, produce some records which are not written by hand and impossible to read and have some more things - more of the record come out in the form of typed material. I think that would be nice. The area of quality assurance is going to take some manpower, I think.

Q. I see. So you mentioned those in the memo to Commissioner Parker? I've got - I have them now. Okay, I'm sorry, I didn't find them earlier. So that is a fair summary of what you feel one must do?

A. Yeah.

Q. And do you have an impression as to the numbers of staff which might be involved to address these concerns?

A. The specific ones that relate to Joint Commission, you - I believe we discussed maybe four or so QA people, and that may be four or five or -

Q. Quality assurance?

A. Quality assurance people. Housekeeping, I think 16 housekeepers would get you weekend coverage.

Q. Sixteen, and that's for weekend coverage, primarily?

A. Yeah.

Q. Okay.

A. That would get weekend coverage and backfill some housekeeping areas. Nurses, I think we talked about 50, and there - perhaps somewhere between 30 and 50 but 50 is the number that keeps coming up. But what's really going to impact on the quality of life of the patients is mental health workers, and, of course, that's the big number. That's where I talk about one for one basically. That's where a lot of the cost is.

Q. And that's the number of the 206 or whatever the number that comes up?

A. Yeah.

Q. Two hundred and six mental health workers?

A. No, no, I think it was about 100 mental health workers, and there was housekeeping in there, physicians.

Q. We only have two physicians serving the entire hospital community?

A. For medical problems, yeah.

Q. And based on what your understanding of what JCAHO was, what should we have?

A. Well, I think we should have four.

Q. A total of four or four more?

A. Four total.

Q. So two more?

A. Yeah.

Q. How about psychiatrists?

A. Probably 14 to 17 psychiatrists.

Q. And we currently have six?

A. We currently have ten.

Q. So we need to add another four to seven psychiatrists?

A. Right.

Q. Now were these mentioned in the memo or in some other documents or communicated to Commissioner Parker, the actual numbers of people?

A. The numbers of people, that would be September 22nd, and that's when I gave my off-the-top-of-my-head estimate of need for Joint Commission and quality of care and Medicare and everything else, but with the idea that isn't it great that we're going to reduce the population, so that was the other side of it. It's kind of like let's weigh the balance.

Q. Now we came into session, I thought it was the earlier part of September of last year.

A. September 15, I think.

Q. So were we out of special session by the time that you had that discussion with Commissioner Parker?

A. That was after the special session.

Q. Okay. So did you acquire the knowledge of the need for the additional people contemporaneous to or after the special session, or was that known prior to the special session?

A. Well, I think my estimate of 206 is - roughly conforms to what I had felt for some time.

Q. Well, we had a total package of 128 people, or 130, whatever it is, that dealt with the entire acute care mental health system. Now, was - of those 206 people, were any of those included in the package which went to the legislature in the special session?

A. That would be over and above the special session.

Q. Did you - for my benefit here again, I've been in and out, when did you tell Commissioner Parker, or when did you advise Commissioner Parker of the need for those additional 206 positions in reference to the special session date?

A. That was - for 206, after the special session, and although -

Q. After the special session?

A. Well, I had mentioned it offhand that I felt that the last time I had done such an exercise, I think it came out to about 196, and I had mentioned that.

Q. When did you initially mention the 196?

A. Well, I think I maybe mentioned that a number of times, basically, in conversation relating the high cost of upgrading the facility versus the much better option of reducing the population.

Q. Would it be fair to say that among the several times you've mentioned that to Commissioner Parker, you mentioned it before September of '88?

A. The one mention that I can clearly, unequivocally remember was to Ron Welch, but I -

Q. And have you a time frame for that?

A. It was before the special session, but I don't - well, okay.

Q. I'm just asking if you can recall. That's okay.
In any event, after the special session, you were of the opinion that we needed 206 positions?

A. Two hundred and six positions or reductions in workload.

Q. Or a reduction in census, yeah.

A. To do everything that I thought people wanted and expected of us, and after having the hindsight of the patient deaths and the added scrutiny that was upon us, so after all that had happened, yeah.

Q. Now let me - see if I get this all straight. The 206 positions, are they what you deem we need to meet JCAHO accreditation, or are they what you feel we need to administer appropriate quality of care at the institution?

A. That was to roughly do both. I think if you look at the Joint Commission recommendations, I probably would have had to make some amendments in light of the nursing recommendation and the subsequent followup.

Q. So in any event, as the department was framing its current budget request for this year, by the fall of '88 you had communicated to the department and to the Commissioner that we did need to add on around 200 positions to the department to meet these issues?

A. It was framed to care for 383 patients. To do everything we should do, this is what we should have. It's a better option to reduce the population, and if that's successful, this isn't necessary, okay? So if we drop the population down and primarily, you know, through the -

Q. But it seems that aside from steady prayer, there seems to be little likelihood that we're going to reduce the census at AMHI to levels around 310 or 320, or whatever we deem appropriate.

A. Well, that was becoming more and more apparent as time went on.

Q. And what's most disconcerting is that the numbers at the institution were in the 360s and 370s, and from the chart the Commissioner gave us last week, there seems to be no relief in sight.

A. Not unless there's a rapid development of an in-patient program.

Q. And in your judgment we're not likely to see anything that's going to bring us about a rapid decline in the population in the short term absent that kind of in-patient program?

A. Absent that kind of in-patient - the rapidity of it, it will take some time to develop.

Q. It just seems to me that, having sat here for a better part of four days, the department has seriously underestimated the likely census of AMHI, and along with others, I agree that the long-term plan makes sense, but I just don't think that people are being realistic in terms of the short term.

A. It would be fair to say that there may be some miscalculation in that area, but the design of it and the thrust of it was positive, but the implementation is a problem.

Q. And the other issue that everyone has poked at over the last three or four days has been the whole issue of resource availability, and you've told us that the environment or the climate was such that requests for significant staffing would not be looked on with great favor, is that true?

A. Yes. Well, and it was true in September of '88, also.

Q. You folks have been asked to make a 4% cutback in your - at AMHI, which you resisted.

A. Yes.

Q. But you took it by negative implication that one ought not to ask for a 4% increase in your budget.

A. Yes, and I think it was specifically said that there wasn't any staff going to be allocated for AMHI, that AMHI was not in the picture for additional staffing.

Q. With the benefit of hindsight, do you believe that you could more forcefully have made a case to Commissioner Parker, given all the conditions, that you could have made a more forceful case to Commissioner Parker and department officials for additional staffing to meet these needs you told us about?

A. In hindsight, probably, I think so. I wish I had - you know, I guess if I was going to be fired or, you now, asked to leave, I think of all the things that I feel bad about is that maybe it wouldn't have happened some time ago if that's what the result would have been.

Q. But is it also fair that the environment in which you were working on was not conducive to your making those requests for additional people?

A. Yes.

Q. The fact that you were basically working under a certain finite number of - amount of resources, would that be a fair statement?

A. I think it was more like a ceiling and not being in the area of priority and that just wasn't going to happen. Anything we would do would have to be done within the department's ability to manage its internal resources. I mean, that was the message.

Q. And there was a reluctance - at least from your perspective, was there a reluctance of the department to come before the legislature and make a case for additional positions?

A. Well, the department couldn't do that independently of itself.

Q. It would have to have the Governor's approval?

A. Yeah.

Q. But my question was, were you of the impression that the department could approach the Governor and could come to the legislature and ask for additional positions?

A. It was - that was not my impression.

Q. Now you told us that when you had your discussion in December of '88 with Commissioner Parker, that she gave little weight to your assertions of likely JCAHO accreditation status, jeopardy.

A. Yeah, I think she felt that basically that's just the way nurses are, or that this type of nurse is that way or that, again, we didn't manage properly the survey. It was difficult for me to understand precisely what she meant. She did reference the New York - a conversation with New York, someone from New York that had somehow effectively managed that. Of course, New York has millions of people and quite a few more million dollars to the Joint Commission and perhaps might have more leverage than Maine would, but I had no knowledge that that was possible.

Q. Let me just go back to make sure that I'm clear. I'm jumping around, I'm now going to June of '88. You told us that you had requested 18 positions for the so-called Medicare certification issue which were approved by the department and the Governor. Now,

you also mentioned that you had another piece which was rejected which would deal with so-called quality of care staffing ratios.

A. Overcrowding.

Q. Overcrowding, and I wasn't clear whether you were going - were you recommending 42 or 60 additional positions in that piece?

A. It would total 60.

Q. So 18 plus 42 would be 60.

A. Yeah.

Q. Okay. Now, ultimately, AMHI ended up getting 65 positions in the special session.

A. Yes.

Q. So I guess the question I have is, were those 65 roughly the 60 that you had made reference to in June?

A. Yeah, I mentioned that, the conversation that I had from Wisconsin to Ron Welch, let's frame this as a Joint Commission, we want to do the Joint Commission thing, and I said, well, this is - we want to take your piece and put it together as a Joint Commission piece, you know, basically work from your proposal. And I said, well, my proposal was an overcrowding piece, but if that's what it takes to do it, let's go do it, we need the 65 positions. What you should do is - Rick has my stuff, I left my proposal or my sheets with him, Rick and Vic, work with those guys and come up with some additional support staff which would enhance our Joint Commission chances.

Q. But you're saying now that even with the new positions in place, at least authorized, we're looking at 200 positions, or something in

that order to address long-term issues of JCAHO accreditation?

A. JCAHO, Medicare, and a general overall quality expectation that you have advocates and you have DSH and you have medical oversight, and basically in the context of what has gone before, yes. So it wasn't specifically Joint Commission, it was quality of care, Joint Commission, just where should we be in this - to be a, you know, relatively state of the art, very contemporary program providing active treatment and individualized care.

Q. I want to again shift focus to the future. You mentioned in response to one of the members of the committee earlier in the day that what we ought to do is bite the bullet and basically double-fund services at AMHI, is that correct?

A. Yes.

Q. So what you're talking about is maintain the effort begun last fall for a strong, viable community-based mental health system?

A. Absolutely.

Q. But at the same time you're talking about, at least for the next few years, infusing substantial resources to make sure that we do have good ratios, staff ratios, we do have good care until, hopefully, the long - the benefits of the long-term plan can take effect?

A. To really make it work, I think you've got to upgrade the facility on the short-term, and the community, more than what's been done in this initial package.

Q. And that if we don't do that, short of some fortuitous decline in the census, which seems unlikely, we're likely to have some

major problems with Medicare and Medicaid and JCAHO?

A. You now, obviously if something isn't done, the population is just going to keep going up.

SEN. GAUVREAU: Thank you. Are there other questions of the committee? Representative Manning?

EXAMINATION BY REPRESENTATIVE MANNING

Q. On the JCAHO there was talk about - I guess from what I heard you just talking to Paul about, it was basically Susan questioned the staffing, whether or not we had enough nurses and things like that. She kind of questioned you and said, well, New York renegotiated or did something. That was concerning staffing, right?

A. Yes.

Q. Okay. That would have been the RN staffing. Would that also have included the housekeeping?

A. No, we didn't get much past the RN staff.

Q. You didn't get what?

A. We didn't get much past the RN staffing issue.

Q. Okay. But how could they not talk about the physicial plant? I mean, you're talking about locking fire doors, break away toilets and showers, ALP fire exits, exit lights, other life safety things, automatic emergency power generator. I'm under the assumption then that if the power goes out at - in the area - in the vicinity of AMHI all the power goes or -

A. Well, it's a manual start. They're looking for automatic switch-over. I think that was about $100,000, but there might be an equivalency. Some of these things you might be able to have an

equivalency; in other words, it's like an exemption, but it wasn't clear that that was possible when they left, and I don't know that it is. I think Dick Bisson was going to check on that.

Q. Do you know whether other - if they're asking you to do that, then I'm assuming the 42 or the 44 hospitals that are in the - throughout the state, the general hospitals, they must have the same criteria.

A. Yeah, it's basically the life safety - those are the life safety code issues and building issues.

Q. Yet nothing was put into the budget, Part II Budget at all to address it, nor the emergency budget which is being heard sometime this afternoon?

A. No. You remember, they did come on December 2nd, so I assume my budget meeting on Part II was September 22nd, so much of the Part II work would have been done before the Joint Commission came in. But I don't think there's anything in the budget.

Q. Well, I think I heard distinctly the other day that the only thing that's being proposed at AMHI and Mental Health is the $20 million that translates from the 6.75. So whether or not - you know, if there was ever discussions, I would assume that Commissioner Parker would have told us on Thursday that they were going to try to address some of these JCAH standards. In the past couple days, I've got the feeling that you're the one where the buck stops and that the MDs over there, including the psychiatrists, the assistant superintendent, and nobody - in other words, you ran everything and yet there's no line of responsibility

for anybody else? I mean, all hell broke loose, but yet nobody else is responsible except for you. I don't know if you want to answer that. That's an editorial question, but that's the sense that I got, that everything that went wrong was your fault and nobody else's fault, and therefore we ought not to be looking at the clinical directors or the MDs or the associate commissioners or the commissioners or the Governor's office or anything like that. That's just an editorial. When your weekly memos went to the Commissioner's office, do you know who in the Governor's office was reading those? Do you know if anybody in the Governor's office was reading those?

A. I had heard at one point very early in the game that they were read faithfully. But, there again, I really have no knowledge of that, because they were emphasizing getting them in and getting them in on time and not - not doing them, so it was important for us to do them faithfully.

Q. I'm just curious, because I think you used the word to Representative Pendleton, you know, common English, you read those yesterday. I think a high school educated person would assume that, after listening to some of those, that there was something wrong. Maybe I'm wrong, but it would seem to me those were in plain English, indicating there were a number of increases in the census, the acuity of the people going in there was going up, and it just - I just don't understand where two years ago, 1987, March of 1987, the Governor of this State walked through AMHI. Out of that meeting, the Governor asked Ron Welch, who was then acting

commissioner, and I think probably yourself, to come up with some limited position people to get over the hump during that first four months, five months, six months, or the honeymoon, as we called it back in those days, so that the legislature could deal with it on a long-term basis. Those particular individuals were let off, are no longer in employment as of September.

A. September 26.

Q. Yet, the same type of atmosphere was there one year later.

A. Yes.

Q. And yet nothing in the Commissioner's office put a red flag up, and yet nothing in the Governor's office, if the same type of atmosphere was there the previous year, I mean, I think if memory serves me right, you or somebody else had indicated that they were sleeping in the halls, and I think at that stage of the game -

A. March '87.

Q. Pardon.

A. March '87.

Q. March of '87, the census was going up again in January and February and March of 1988, yet there was no more limited positions put on, again, just to help you over the winter crunch. It seems to me, maybe I'm wrong, but is it traditionally that in the winter months the census tend to go up more than in the summer months?

A. Fall and - usually the first quarter, and maybe more recently it's beyond that.

Q. So yet although the Governor okayed limited positions in 1987 and they went out of effect in September, nothing was done with all these weekly memos.

A. Right.

Q. So what - and I think you indicated the staff was getting frustrated because they could not - they had seen the limited position people the year before, but yet the same crisis, the crisis of which at this stage of the game is called management, but back in those days a crisis was of the - was the dealing with the overcrowding, the same crisis existed in 198 - you know, the first part of 1988 as it had existed in 1987.

A. Right.

Q. The crisis of management that Commissioner Parker talked about really hasn't come on board until probably July or August of 1988, and yet the same limited position people were not put on. So maybe what we need to do is talk to somebody in the Governor's office to find out who in God's name was reading those memos and whether or not they need a course in reading. It seems to me that if in 1987 the Governor of this State put on those positions and in 1988 nothing was put on, somebody either in the Governor's office was letting the ball down or somebody in the Commissioner's office was letting the ball down. I want to get it perfectly clear, did you at any time write a memo asking for money to get recertified with HCFA? We talked about the weekly memos - the weekly notes or whatever those things are called. Those were never -

A. You have to use, as I would - and in courts you'd call it circumstantial evidence - in terms of what I was asking for and talking about after the February 23rd. If you look at those memos, you'd have to wonder what I was talking about, the soft spots in the area of activities and so forth.

Q. Well I'll tell you one thing, if I was the commissioner of this state, or I was somebody in the Governor's office of this state and saw some of those memos, I'd be wondering, especially in the fact that we were still in session until the 28th day of April of last year. So you never really wrote a memo? We don't have a memo that says I need, it's because back in September of 1987 you were asked a question, what would you do with a 4% cut at AMHI.

A. I think there have been discussions subsequent to the first -

Q. But that gave you the first real indication that -

A. Yeah, that this was going to be a tough year for mental health.

Q. This is the same year that when we left here on April 28th, that two months later all of a sudden this state has a $100 million surplus, right?

A. Well, whatever.

Q. Right. To get it perfectly clear and to get it on the record, if we lose JCAH, then the monies that go into the Medicare -

A. Medicaid.

Q. Medicaid, excuse me, Medicaid at AMHI, we will lose that also?

A. For those zero to 21.

Q. For those - again?

A. Zero to 21, so that would be the adolescent unit and the young adult unit and whatever - there's some question about the admission unit, since it's not Medicare, whether any money from Medicaid should go into it, but zero to 22 primarily.

Q. But there's a possibility of losing additional -

A. The nursing home would still receive Medicaid.

Q. So there is the possibility of getting decertified from JCAH sometime in - next fall?

A. There's a possibility. Again, I don't think that will - I think we'll get some -

Q. The problem is -

A. What we're going to do about the contingencies is going to be the problem.

Q. The problem is, we didn't think we were going to lose Medicare either.

A. Yeah.

Q. When we talk about hospitals in the southern Maine area, what will it take that is going to -

A. To really do the job?

Q. To really do the job.

A. I think it would be better to have a roughly 40-bed unit than the 20-bed we're talking about.

Q. What if we had the ability to split that.

A. Oh, that would be great.

Q. In other words, 40 beds in Cumberland and York, where there's

20 in Cumberland and 20 in York.

A. Yeah, there's no problem, it's just finding someone who will do it has been the biggest drawback, and then if you double the number of beds, then there's the financial impact.

Q. If memory serves me right, the monies that were put into the special session budget, which was roughly a half a million dollars, that was for the hospital component of that?

A. Yes, purchasing days of care.

Q. And that was supposed to go on line, I thought, if I heard Susan say the other day, February 1st. Do you know whether or not that's true or not?

A. That's as I understand what was projected in the -

Q. February 1st.

A. Yeah.

Q. And as of today, February 2nd, we still don't have anything on line?

A. Right.

Q. So what we need to do, really, is to take a harder look at the projection that we talked about back in the special session and probably double our money to - because I think at that time we were only talking 20 beds for $500,000, so you need to really take a look at doubling that to get to the 40 beds.

A. And it will be - I think the projection was probably based on - it may have been based on general hospitals, so if you would go with a special hospital, there may be some increases in the price.

Q. So if we go to a special hospital, that we can't get a Medicare

certification or -

A. Medicaid.

Q. Medicaid?

A. Yeah.

Q. Medicaid, then the $500,000 is strictly going to be general fund money, we won't have any matching money then.

A. The bottom line, it will cost you more to go with the special hospital, because you won't - the provider won't have the third-party revenue to offset the costs, so it will be more - it will cost more money, general fund money, yes.

Q. So if, per chance, the department comes back with a proposal that it's going to be a - for instance, a JBI, then we'll need to put more money into that because JBI is not able to get Medicaid?

A. Right. I don't know - I haven't sat and talked with them as to how much they think that it would cost, but there's probably a good chance of that. But, you know, if Jay is around, or someone else might answer that for the department. So the answer to your question is, it will cost more money. No matter how you frame it, it's going to cost more money to do it in a special hospital. Whether they can do it for what's in the budget now, I'm not completely sure, and 40 would be better than 20, because then I think you could, you know, have more assurance that you could take all the admissions and provide all the acute care. Twenty beds might do it, it might be a little snug, 40 would probably lock it up for you.

Q. When the Commissioner was here, she indicated that there is a

consultant or consultants were being talked to concerning the - what needs to be done at AMHI, and you also indicated that there is - the staff has already got together and taken a look at what might be needed over there. Am I right in saying that?

A. Yes.

Q. So between the staff already knowing now what they feel is there, and a consultant coming in, hopefully that would speed the process up so that we would be able to get some type of an emergency piece of legislation back from the department fairly quickly?

A. I would hope so.

Q. I guess to finish up, it's safe to say that when you were hit with surprise, what can you do with a 4% cut at AMHI, that set the stage for the last two years?

A. I think in many respects that's true.

Q. Knowing fully well that we were in a crunch - the budget was put together October of 1987, roughly, the supplemental budget for last year?

A. Roughly, yeah.

Q. Roughly middle of the fall?

A. Yes, we were having budget meetings.

Q. So roughly middle of the fall of 1987, after the limited position people had already gone through the cracks, you were asked, knowing fully well the year before we had a crisis at that time and it wasn't a management crisis, we were - you were asked to cut, try to cut, find a way to cut 4% from an institution such as AMHI, and that's translated in the last two years that an

institution such as AMHI was at one time asked to be cut 4%, when last year this state gave back to the citizens of the state $42 million. That's all I have, Mr. Chairman.

SEN. GAUVREAU: I just have one question in response to what Representative Manning had brought up. When she appeared before us earlier this week, I think for the first time on Tuesday, Commissioner Parker told us that she was contemplating and in fact was in the process of seeking out a consultant to perform an independent critique of the department and of AMHI to assist, and that she would basically defer in fashioning any plan of correction so styled until the management was brought on board. My question to you is, since you were there until January 11, '89, had you had any discussions with Commissioner Parker, or were you aware the department was considering deferring fashioning any plan of correction until the consultant or a consultant was brought on board?

A. I wasn't aware of the consultant.

SEN. GAUVREAU: That was the first I had heard of it, was this week, and so I was somewhat surprised by that revelation.

A. I heard it at the same time you heard it.

SEN. GAUVREAU: Thank you. Representative Burke?

EXAMINATION BY REPRESENTATIVE BURKE

Q. I just have a couple of quick questions, and it's just for my clarification more than anything. When you wrote the December 9th memo about JCAHO, did you use that in a sense as a - were you using the impending JCAHO findings as leverage or were you solely concerned about JCAHO findings in requesting new staff?

A. Was I using the Joint Commission as leverage for more staff?

Q. Right.

A. I would think so, yes.

Q. Okay. So you had been asking for staff and hadn't been getting it, so when you found the leverage of JCAHO you said, this is another reason why I need that staff?

A. Well, yeah, this is another outside group saying - telling us something, and I happened to agree with them, that we were understaffed.

Q. I'm, as I say, just clarifying. And your concern for the standards and the conditions prior to that has - you know, you've been citing the Friday reports and all as an indication for us that you had been concerned well before this December 19th memo, but the December 19th - I'm sorry, December 9th memo is an indication that you were trying to get leverage with the Commissioner or with whomever, the powers that be, that, look, if we don't get this increase in staffing, the conditions are just still going to deteriorate further and JCAHO will not accredit us?

A. Basically, they gave us another set of headaches. The Joint Commission dumped - well, they exposed another set of problems for us.

Q. Okay, thank you. That's all.

A. They uncovered problems, reiterated problems.

SEN. GAUVREAU: Representative Hepburn?

EXAMINATION BY REPRESENTATIVE HEPBURN

Q. Yes. I've been in and out a little today. Have we talked

about the $291,000 shortfall that's being talked about in Appropriations yet today? That was in, I guess, AMHI's All-Other account. What was the deal with that? Can you tell us about it? Martel seemed to be a little bit upset about that today, and I guess they had to add it on to the emergency budget request just at the end.

A. Well, we projected we'd be 758,000 or something like that overexpended when we originally prepared the budget and were allowed to up our budget somewhat, but not to the level - if we put it altogether and you took our first projection, it might be pretty close to what you're seeing now, what we actually projected at the time and what we were allowed to put in the budget.

Q. So it's your feeling that right along the Commissioner's office knew that this was going to be the level of a shortfall, 291, or maybe even up to 700?

A. Yes, we did - we were allowed to put additional funding in, but not to the level that we had requested or projected. I don't have my budget sheets here. This is one that's not easy to respond to. Right now I couldn't tell you exactly what the 291 consisted of. Do you happen to have the -

Q. No, I don't. All I know is that it was in the All Other account, and I don't even know what that means.

A. Well, All Other is contract items, supplies, expenses. Basically, there's personnel and All Other is fringe benefits and contracts and so forth, and the All Other budget, there's a lot more

flexibility or latitude. A lot of - a multitude of sins come out of the All Other budget. It's the one that you have flexibility with.

Q. Overtime, would that go into that account?

A. Overtime would come out of personnel. Workers' comp is usually one of the things that we're over on. I don't know if that - if workers' comp - how that plays into it. I think maybe that's been centralized, the workers' comp problem. I think that was taken out of the individual budget and centralized.

REP. HEPBURN: Okay, thanks.

SEN. GAUVREAU: Is it fair to say the All Other account would not be an appropriate vehicle to augment staffing configurations to comply with JCAHO, Medicaid or Medicare requirements?

A. No, it's when - when you do model lab tests, let's say, on the outside, you send patients to Kennebec Valley Medical Center or purchase a physician, for example, on a contract, that comes out of All Other. Three of our contract positions, those would come out of All Other. So when you said is it fair to say, I misspoke slightly, because there are three of those positions that are All Other, and some of the other things that go on at AMHI go on under a contract. So if you contracted with an independent provider or agency, you can add services to your program without going through personnel funds and have more flexibility.

SEN. GAUVREAU: We had discussed earlier, I believe, in February or March, the Commissioner had authorized, was it another one-half

position, contract position?

A. Right, that would be All Other.

SEN. GAUVREAU: That would come out of All Other?

A. Yes, and the contract - we used to have Owen Buck going down to the Maine State Prision, while we're now paying for that, for corrections, at the rate of, I think it's $700 a day or 750 a day, and so they go once a -

SEN. GAUVREAU: You people are reimbursing the Department of Corrections for Dr. Buck's services?

A. AMHI's budget is paying for the Maine State Prison psychiatrist one day a week, and we're contracting with an agency to provide that service. But it comes out of our All Other budget and the price is going up, so it's putting more of a strain on our budget.

SEN. GAUVREAU: Were there other questions of the committee for Mr. Daumueller? Representative Clark.

REP. CLARK: I need, I think, to have you repeat - this budget piece is new to me. What I'm hearing is that they're currently saying that there's a $291,000 shortfall, is that right, and you're saying that's not a surprise to you?

A. I pretty much figure we go back just about every year. The budgets as constructed, usually you can't live with them. I mean, do I stop sending people to Kennebec Valley? I mean, if people need it, I'm going to say yes, do it, and if it goes over the budget, then fine, get rid of me. No joke intended.

SEN. GAUVREAU: Is it fair to say that it's not an unusual occurrence to have to seek an adjustment in a subsequent financial

year to pay for these services?

A. Every - I mean it's happened every budget that I can remember that we've had a shortfall.

REP. MANNING: It's happened every year since I've been here, and I'm serving my fifth term.

A. If I sound like I'm less than enamored or less than real familiar with your budget, now you know why, because the financial management, it's kind of a joke in a way. You don't have a realistic budget to start from, so it's very difficult to manage one.

SEN. GAUVREAU: Are there other questions of the committee? Representative Dellert.

EXAMINATION BY REP. DELLERT

Q. You were talking about - Mr. Daumueller, about the community activity - community arrangement that you would like to see in regional offices, moving people out. I think I remember you saying earlier that's a very costly thing, it would be far more costly to provide all the services than keeping many of the patients at AMHI because we have to provide so many other --

A. I think however you put it together, a quality system, total system of mental health care that works the way people want it to work is going to cost money, and there are some structural mechanisms that you'd probably have to set up, and I wish that would have been part of the debate at the September session, quite frankly, is to face that very issue, because that was in the Blue Book and nobody seemed to recognize that fact, that the regional office structure was right there. That was part of the -

part of the request was to enhance one section of money and move the state lines that were doing that job into a regional office to provide regional oversight.

Q. You're saying you would give them the money though, so that would be another whole process of managing those monies?

A. Yeah, well there's an argument that, you know, when we're faced with very limited resources you make the argument, do you put it into administration or do you put it into service, and every one of us is going to say yes, let's put it into service, but when you take a step above and say how do we want - do we want a true mental health care system in this state and one that has on-site, you know, regional or some entity of local presence, there is going to be an administrative cost, yes, but there is also, at the same time, some incentives for those people, and at least incentives that can be structured. And you're going to get arguments about that from various quarters, so that's a hot political item, as I think I alluded to, and wasn't really saying it straight out, that there can be - might be a battle that's been waged before and it's one that will have lots of pros and cons and you'll be sitting there saying, oh, my God, what am I going to do with this because of the volume of argument about it.

Q. There was one other thing I wanted to clear up, too. You almost alluded - or maybe you stated that you would prefer to put money elsewhere than to recertify for Medicare. It may be like our ICFs - SNF and ICF beds might be a better -

A. Oh, instead of recertifying the older adult program, what we really in essence are doing is moving those patients to the section attached to the infirmary where those people who are used to dealing with medical problems will, number one, take better care of them, the frail elderly and medically ill will be apart from the more ambulatory patients, so they'll get better treatment. Not only that, if you certify there's a nursing home, then you can get Title 19 for those patients, and so I think - I still think that's a good idea, even in the face of all the problems.

Q. So maybe it would be better - are you saying then not to worry as much about Medicare, certifying for Medicare?

A. Yeah. I think the issue - the public issue at this point is quality of care and obviously reimbursement for care and being fiscally responsible and efficient is important. I'm saying, first, worry about the quality of care, then worry about the fiscal efficiency, and I think that's the important thing, because when we're talking finances, we're talking 30 beds. When we're talking quality of care, you're talking 370 or whatever it is.

REP. DELLERT: Thank you.

SEN. GAUVREAU: I'd like to clarify that just a little bit. Which population specifically did you refer to when you talked about moving that population into -.

A. Stone North Middle, which was the older adult program, was Medicare certified. A number of the patients who were on that unit are now currently housed in what is called the senior rehab

program. What was the 16-bed infirmary and an additional 20 beds adjacent to that 16-bed infirmary now comprise what is called the senior rehab program. That program, the intent is to license that 36 beds as a dual licensed SNF/ICF program, which would then make it eligible for Title 19, assuming that the patients who are there need the services of either the SNF or the ICF level of care, and which those patients do, and thereby bringing in, I think, roughly $600,000 or so.

SEN. GAUVREAU: Of Medicaid monies?

A. Medicaid, yes. I think it was 600,000. The idea was it would basically make up for decertifying on the financial end. It would be a better treatment program and address many of the kinds of issues that you've been reading about in the paper, the medical issues, physical medical -

SEN. GAUVREAU: So you're saying that from a programmatic and a financial point of view, it makes sense to seriously consider pursuing the dual licensing of that population and accessing Medicaid money?

A. Yes.

SEN. GAUVREAU: And that might bring in $600,000 if we did that?

A. Yeah.

SEN. GAUVREAU: Is that an annualized figure?

A. Yes.

SEN. GAUVREAU: Thank you.

MR. MANNING: What would happen if that was certified as Medicare, that unit? Could that unit be certified as Medicare? I'm getting

a strange look from Associate Commissioner Welch, so I'm not quite sure.

MR. DAUMUELLER: No, it's not - it's a different thrust.

REP. MANNING: So it could not be certified as Medicare?

A. No, it's the difference between a nursing home and a hospital.

REP. MANNING: I just wanted to clarify that. But it still is costing us more than if we had those patients as Medicare patients? Medicare patients is 100% federally funded, right?

A. Well, the number - no, you lost about $650,000 in Medicaid and Medicare combined. There were only at any one time four, five, six, seven, maybe nine at one time on that entire unit that were eligible for Medicare, and the rest of them would be the 65 and over who have to - who are eligible for Medicaid, but in order to be eligible for Medicaid they have to reside on a Medicare certified unit.

SEN. GAUVREAU: Representative Dellert?

REP. DELLERT: I was just going to say, I think they've applied for that ICF but it hasn't - the CON is in for it.

A. The letter of intent is, I'm not sure if the application is.

REP. DELLERT: I thought it was.

REP. MANNING: Who certifies -

A. That would be DHS.

Q. Are they ready to go?

REP. DELLERT: It's in, it's in operation.

REP. MANNING: It's in operation?

A. Yes, it's already going - oh, is it ready to go?

REP. DELLERT: Yeah.

REP. MANNING: We are state government.

A. Yes.

REP. MANNING: Why can't one phone pick up - why didn't somebody pick up the phone and say we're ready to go, come over and inspect us?

A. Call bells and curtains are needed.

REP. MANNING: What is?

SEN. GAUVREAU: Cow bells and curtains?

REP. BURKE: Call bells.

MR. DAUMUELLER: It's getting that time of day.

REP. MANNING: So all they need is bells, call bells -

A. Call bells and a few other nuances of startup money which I had requested but it is not in the budget. On the other hand -

REP. MANNING: I would hope that if it's not in the budget, they're still going to find some way in their slush fund to find something.

A. By moving around, I think that's what was going to be happening.

SEN. GAUVREAU: Are there other questions of the committe of Mr. Daumueller?

REP. HEPBURN: One quick last one. In the press it was attributed to you that you were muzzled. All right? I don't know if you used that word or somebody used it or some Senator used it or whoever.

A. I didn't say that.

REP. HEPBURN: Okay but - you didn't say that?

A. No. It's simply a matter of being - I think it's been said

before, it's being a team player and being a loyal trooper, basically, and putting a positive light on what the current position is. I think some of that is very understandable and just simply common managerial, but it - obviously you don't - it is not well taken to speak up, particularly if it would be a legislative - I mean, flapping your gums in the break room is one thing, but talking to a legislative committee or on the public record, it would be severely frowned upon to be highly critical or in opposition to what was being proposed. That's not to say you're muzzled; it's just that you might pay for it if you did.

SEN. GAUVREAU: Any further questions? If not, I want to take this opportunity to thank you, Mr. Daumueller, for your presentations over the last two days, especially where you're not currently in state government, we recognize the sacrifice that you've made to provide information of help to the committee and we are all keenly grateful for your contribution in this area and we certainly will take your comments and you insights into perspective as we fashion recommendations to the full legislature. Once again, we thank you very much, sir.

MR. DAUMUELLER: Thank you.

SEN. GAUVREAU: At this point, my understanding is that the department is currently making its presentation to Appropriations for the supplemental budget, and therefore, because we would very much like to accord Commissioner Parker an opportunity to come back before the committee for clarification or to respond to any

statements made by Mr. Daumueller, I would suggest that we recess to a time uncertain. That time would be fifteen minutes subsequent to the close of the departmental presentation to the Appropriations Committee. And I would also invite the committee to go to Room 228 to hear the presentation of Commissioner Parker and the department. Thank you.

(RECESS)

SEN. GAUVREAU: Please come back to order. First of all, before I forget, I want to commend all the members of the committee for your steadfast attendance during the past days, some of them very trying, and I also want to commend the committee for the caliber of questions, the acuity of thought. I think that you've discharged your responsibilities in an excellent fashion. I'm proud to be on this committee and I'm very proud to have all of you as colleagues on this committee.

REP. MANNING: Just for the public to know that a couple of members are not here because they are on another commission dealing with nursing, one of which is Representative Boutilier, the other one is Representative Dellert, and they're headed for Bangor to have a hearing - commission hearing dealing with nursing. I'm assuming that's sometime tonight, so that's the reason why they're not here. And Representative Cathcart had indicated that she had made plans months ago and that she could not cancel these plans, so that's the reason why she's not here.

SEN. GAUVREAU: At this point, we had, by prior agreement, provided an opportunity for Commissioner Parker to come back again before

the committee to rebut or comment upon any observations or comments proffered by Mr. Daumueller, and we understand that approximately a half an hour ago, or about an hour ago now, the department completed its presentation to the Appropriations Committee that began about 1:00 or 1:30, and I was advised by a representative of the Governor's office that the Commissioner was in a discussion with the Governor and I was later advised that she would not be able to appear before the committee this afternoon. And I understand that Associate Commissioner Ron Martel is present - Ron Welch, excuse me - that Associate Commissioner Ron Welch is present and he may have a more specific reason why Commissioner Parker is unable to be with us here this afternoon.

MR. WELCH: The Commissioner wished she could have been here. We talked about, during the break, the amount of time she would need to prepare a response, especially to the comments that were made today by former superintendent Daumueller, and that the original half hour allotment time probably wouldn't suffice, and because of that, she would rather forfeit the opportunity to make an oral presentation at this point but would be willing to come back if the committee can schedule that in at a later date. And in any case, she would hope to be able to present written comments to the committee for your consideration.

In addition, if the committee wants her back to answer questions that were raised as a result of Superintendent Daumueller's presentation, she would be pleased to do that. It's just that

that's probably not going to be a likely occurrence this afternoon.

SEN. GAUVREAU: Thank you very much, Ron, and I would like to again take the opportunity to once again thank Commissioner Parker for her presentations during the course of the hearings. I think certainly it was a very difficult process for all of us, including Commissioner Parker, and we're grateful for her contributions and participation in the hearings.

REP. MANNING: For the record, I'd like to indicate that Commissioner Parker was here all day yesterday while former Superintendent Daumueller was here, and for unknown reasons left at ten o'clock this morning, when we started roughly at 9:30 this morning, and Appropriations did not go in until one o'clock. So she had the opportunity to be here until roughly one o'clock, when Appropriations did go in. And the emergency budget, for those who don't know, is a budget that is very small. It is a budget that just gets you by this part of the rest of the fiscal year, and I stand by my statement that if you don't know what your emergency budget is two weeks prior to going in front of Appropriations, then you'll never know what that emergency budget is. So if she feels that she had to be away to get studying for that emergency budget, I don't understand it. I asked both Representative Carter and Senator Pearson about that, and they concurred that those are budgets that it should be right off the top of your head and you really don't need to prepare that much for it.

SEN. GAUVREAU: At this point, it's now 4:00 p.m., and the remainder

of our hearing schedule regarding the AMHI situation will be as follows: We plan to come in at nine o'clock on Monday for the purpose of hearing presentations from the Maine Advocacy Services, as well as from the internal advocate for the department, most likely Mr. Richard Estabrook, and we will then - we have invited the Department of Human Services to make a presentation relating to their wards and their concerns regarding treatment for their wards at AMHI, and that will occur on Tuesday. We had also invited Probate Judge Mitchell to attend as well on Tuesday, but now I am advised that he will be out of state for the balance or most of the month of February, so he'll be unavailable. I would expect at that point we'll conclude our hearings and allow members of the committee to join or to catch up with the Maine Development Foundation tour, which will begin on Tuesday, and we will then decide whether we'll begin committee workshops on Thursday or the following week. We're not really sure at this point, but we obviously have to reduce our thoughts and observations to writing and make a full report to the legislature, and at this point that's still fairly fluid.

I believe before we break for today though, that Representative Manning had a request.

REP. MANNING: Yes, and I'd like to ask Jay Harper to come forward and give us again a breakdown on the $8 million for the community side that was not funded in the Governor's Part II Budget.

MR. HARPER: I think I have it, basically.

EXAMINATION OF MR. JAY HARPER BY REP. MANNING

Q. Basically, last Thursday, Jay, the question that I asked was, over and above the 20 million what was requested, and I think the response was that there was 8 million that was asked for in Part II and that it was not granted by the Governor in the community side.

A. That's correct.

Q. And there's been a lot of talk in the last couple of days about community side, and I just want, so the committee has a better understanding now, after four days of questioning, what we need to look at of that Part II budget.

A. I'm pleased to be before the committee and glad to respond to that. The items that were requested by the bureau and the department to the Governor that were not included in the Part II request are as follows: There is a reduction that is taking place, it's a technical reduction, it happens every year between the states and the federal government relative to the block grant allotments provided the state. In fiscal year '90, that would be a little bit less than $74,000; in fiscal year '91 it's a little bit less than $99,000. To go to the fiscal year '90 and '91 residential development that we have started in the special session is $400,000 in fiscal year '90 and $512,000 in fiscal year '91.

Q. What was that again, Jay?

A. 408,000 in -

Q. No, no, what was it for again?

A. Oh, it's for the next round of residential development, which were -

Q. The next round -

A. Which are additional 6-bed group homes and additional independent living environments. There was also new rehabilitation services, peer support and family support. Those type of services were basically some social clubs, which are very important because they provide consumers a place to go and get some basic living skills and social and pre-vocational skills during times when they're not in regular day-structured programs. That was $181,000 in fiscal year '90 and almost $278,000 in fiscal year '91. There was the expansion of treatment services for deaf elderly, including crisis programs. In fiscal year '90, that was $1,609,891, and in fiscal year '91 that was $2,899,661. There was the cost of living increases for all the community agencies so we could at least hold the line and continue the same services we had relative to other inflationary pressures other than service costs. That 629,000 in fiscal year '90, 361,000 in '91, and the establishment of three regional offices for the bureau. As you know, the Bureau of Mental Retardation has six regional offices. It's one of the reasons that they can do about 200 units of development per year. We're lucky if we can do three, and that would be $425,000 in '90 and 437,000 in fiscal year '91. So the total package for the biennium comes to seven thousand, nine hundred fourteen thousand dollars and some change.

Q. Seven million.

A. Sorry, seven million.

Q. If you can do that for 700,000, we'll start tomorrow. Some of that that you indicated is things that - for instance, the cost of living of - I'm assuming those are direct service providers?

A. Yes, they are.

Q. Would that have been in the Part I budget, because if memory serves me right, the monies that we put together last year, the 6.75, part of those monies were for cost of living.

A. $1,140,000 was a base salary increase and not a cost of living. That was provided just for direct care workers in community provider agencies.

Q. I see.

A. In fact, we were trying to differentiate between doing some base salary increases and linking that to a training program to develop career ladders in the long run as opposed to just cost of living increases that should occur on an annual basis.

Q. Okay. You've heard in the last couple of days that the community area is really important and a number of things need to be out there. If the department is in the process of trying to get the hospital base portion of the - the in-patient portion of that money that we gave you, roughly a half a million dollars, one of the important things that we were always told, and I think people like yourself and others told us, that if we do have that hospital base thing going, that you still have to have a very strong community base portion of that so that that person who is in that 10 or 15 day setting in the in-patient, for instance at a general hospital or whatever, that the case manager would have

enough programs for that person when that person leaves there. What will happen if we do have that? I mean, is there enough money in the community base area now, because what I'm afraid of is, if we put money into an in-patient southern Maine facility, that the person will go in and that we'll have the same problems that we are finding out at AMHI, it's the revolving door, because there are no community base alternatives for that person when that person leaves the southern Maine facility.

A. Absolutely correct. All you would do is move the revolving door from Augusta to the new facility. The revolving door is people who come in and out who may need - because of an acute episode or situation, they do need an in-patient place to get through a crisis and restructure their lives and get remedicated or whatever. When they come out, they need all kinds of other supports to keep them out. Unless you provide the supports, they will come back with, in fact we find out, greater and greater frequencies to institutional care. It's very important to break them away from institutional care and to get other supports in the community.

Now we're doing development in the community, and by having the 20-bed capacity or sorts to the south, we will utilize that new community development but we'll fill it up, and then you'll find yourself moving towards the revolving door syndrome again. So you'll have a slight impact and then it will start moving back up again.

Q. If the legislature decided to take and fund Part II requests that were not funded by the Governor, and it was funded in the

Part II which goes into effect in July of 1988, it seems to me that if in September of - excuse me, July of 1989, it seems to me that in September of '88, when we gave you the 6.75, it's taken you at least until February 1 and maybe even later to get part of that community based area going, the money that we gave you.

A. It takes 110 days just for us to contract out if we use a fair RFP procedure.

Q. Wouldn't it be better for us to take a look at some of that community-base money that you've talked about, and it's 8 million over a two-year period -

A. Correct.

Q. And looking at that and funding that in an emergency piece of legislation that would get funded end of the month, you know, first of March, that 110 day lag period is speeded up. Because if we're talking 110 days, you're talking roughly three months, you're talking the summer months when people aren't around, so you're really talking sometime the first of November at the earliest before that community-based area gets going. What I'm wondering is, is it better for us to take a look at portions of that $8 million, put it in an emergency pack, get it out there, get it out there now, so that when the hospital portion gets going, the supplemental portion for the community is there and ready to go?

A. It would sound like it would be better, but there's one very important problem, and that is that the rate at which we're able to expend funds through contract procedures and do it appropriately so

we're not misspending money, and for us we've made the decision to write standards for contracts and put them into the contract language and use an RFP process which had not been done before. There's only so much work we can handle. The Bureau of Mental Health, there's only six professional people working in there. We put three and a half million dollars out on the streets with standards and evaluation mechanisms and training components in the last 110 days. That's three times the development the bureau had ever done before.

Q. Do you need additional staff?

A. If as part of the special package you're discussing would be included the regional office structure so we could bring the additional staff on line immediately to help prepare the RFPs and do the resource development such as MR has done, so you could do it in three differents region besides here, we could certainly do the development that you're speaking of and, in fact, we could even do it in a faster period of time.

Q. Because the way you're talking, if, per chance, we did fund the $8 million, it goes on July 1st, and we could conceivably be talking that really wouldn't get out to the communities until probably the first of January or the first of February of next year.

A. The whole amount, that's probably true. In fact, the $8 million is, in many cases, predicated not on a full 12 months' worth of funding. The annualized cost for this $8 million which you're - my Part II request becomes relatively substantial as the Part I

request rolls forward into outgoing years.

Q. So you're taking into consideration that you're not funding for a full year?

A. We have staggered schedules strictly based upon our ability to deliver the services.

Q. But in the Part - in the second year of the biennium, you would be funding as of November - as of July 1, right?

A. Correct.

Q. So that would be a 12-month budget rather than a five or six or eight month budget?

A. Correct.

Q. So what you would need to do it right would be some additional staff in-house to put monies - how about the quality assurance? That's up and running, I'm assuming.

A. The quality assurance is strictly limited by those same staff numbers. Basically, we're assigning people to have a contract responsibility so they would have an expertise in crisis stabilization. They would work on developing those contracts and they would work with someone who works on the program standards and the quality assurance for that. So we have pairs of people, one person doing QA, one person doing contract and program development.

Q. So what we would need to do then if we wanted to speed some of this stuff up is not - so that it would be done and done right, would be to also supplement some people in the central office?

A. Absolutely. I mean, there's an inherent cost of doing business,

and I think if the effort is to try to insure that you're having the best expenditure of your limited dollars, then one of those costs that should be incurred, I believe, is the cost that guarantees that you plan it properly, develop it properly and assure through licensing or quality assurance that you're getting what you're paying for.

Q. Let me ask you this. If we put somebody - if we put X-amount of people in central office, are they - do we need full-time people who will be working in future years or do we need just somebody to help speed up the process? In other words, do we need to go out and get contract people to help you out to get this thing going faster, or do we have to put full-time people on and there's enough work for those full-time people for the next 18, 20, 30 years?

A. You could do a contract but I think that would be an expensive way to go in the long run. I think there's an inherent structural deficiency in the system in terms of the people we have to do the job we want and to do it right. This request, which is for 12 people, is what is left of an original request that I made for - when I was trying to put together a model system of what I would do in the state, which was 21 people. I could easily keep 12 people fully employed and busy for this year and the next decade.

Q. Okay that was the point I was trying to make, Jay. I just didn't want us to hire somebody and then after six months or so we didn't need them and -

A. No. Let me give you an example of something that we would like

to be able to do that we can't do. We collect a lot of information from our contractors presently, and we are unable to do a very good job of collating it and assessing it and finding out exactly what it's telling us about who we are serving and how we serve them. Every once in a while we take the luxury of stopping everything else we're doing during the day and look at some of those numbers. I have the Mental Health Center that served 1,347 people in a six-month period, and 97 people were my targeted population of seriously mentally ill. Now, that raised to me the question about what's the difference between 97 people and 1,347, was that a good expenditure of resources. I would like to have people that had the ability to say it's a poor expenditure of resources given priorities of need. You need to move money from one place where you have it to a different area of the state or a different type of service. We don't the luxury to do that now. Even efficiencies within our given dollar amount would be gained by having the additional staff that could take the time to do that analysis and redo the program development.

Q. And they would also probably be able - just that alone would probably be able to help out in the revolving door syndrome.

A. Absolutely. And the other side of the story is that by having the people that can take the time to develop programs that are designed from the day start to be Medicaid eligible, we can immediately tap the federal revenue stream that we do not do in complete effectiveness now.

Q. So quite frankly, hiring 12 people like that might be saving

us megabucks - not megabucks but bucks?

A. I would say hiring 12 people like that and given the other part of the package would save you megabucks.

Q. Megabucks, okay. I don't think I have anymore questions. My concern was, we've heard for two days community, community, community, not only by Superintendent Daumueller but I think also by Susan, so I think it's - that's the reason why I wanted you to come on, to explain what was in the Part II budget that wasn't funded by the Governor and for us to have a better idea. If, per chance, you could reduce that to some numbers, writings, and get it back to us, we'd appreciate it.

A. Certainly.

Q. Thank you.

EXAMINATION OF MR. HARPER BY SEN. GAUVREAU

Q. Jay, can you tell me how many people would be served under the proposed Part II request which was not approved?

A. In some areas I'd like to make it clear that what we mean by a definition of service, we've attempted to use to the greatest extent possible national research bases that tell us about services and what they're anticipated effect is. So some of the names and numbers I'll give you are anticipated numbers of people being served, and some of them, however, when you're doing residential development, you know that a bed is a bed and you have one person, so some of them are more solid than some. The way I've done this was a way that in my own mind I was trying to get at going from the fiscal year '89 request in September and

how it looked as you laid out the next two years, the continuum of development that we had proposed at that point in time.

The crisis stabilization program that was funded in September we hope will have an anticipated effect statewide of deflecting 240 admissions per year from both of the institutions. The fiscal year '90-91 effect would add an additional deflected admissions from institutions. The crisis stabilization program, when combined with the intensive case management which was funded in the special session would add an additional 200 admissions being deflected. So statwide it means that you'd have the capacity between crisis programs, which offer you a less intensive temporary place to hold people rather than going to AMHI, which is the only place they have now, with case management of 840 people being deflected from the entire system statewide. Now I don't know how much of that potential we will actually see, but we know that looking at other state statistics, it's certainly doable, other states have done it.

Q. So let me just back you up here a little bit. The number you gave us was 648?

A. It's 840 total when you do the fiscal year '89, '90 and '91 combined crisis stabilization with case management. The case management was funded in the special session, the crisis stabilization was part of the Part II request that was not supported.

Q. That was not. And so I heard you say that - with respect to the crisis stabilization, that one of the Part II requests,

or the component of the Part II request attributable to crisis stabilization funded, that you would have been able to deflect, you project, 480 additional admissions to both BMHI and AMHI?

A. Four hundred.

Q. Four hundred?

A. Yes.

Q. And you've told us - the 840 figure total you gave us, was that assuming you had received the Part II funds?

A. Yes.

Q. So how many now are you projecting will be deflected given the package which was approved in the special session?

A. Two hundred and forty of that 840.

Q. Now do we have any way of breaking down roughly of the - well, let's see. There would be a variance then of around 600 positions, if I understand correctly.

A. That's correct.

Q. So those 600 positions which would have been deflected, those admissions would have been deflected if the entire package were approved. How many of those would be attributable, say, to AMHI as opposed to its sister institution of BMHI?

A. I'm not sure of the exact percentage breakdown, but it's clear the way we've structured the case management and the crisis programs in the plan, that the majority of the impact would be in the southern tier of the state, which is the AMHI catchment area.

Q. So that it would be fair to say at least four to five hundred

admissions would have been deflected from AMHI?

A. I would say 50%, yes, would be a safe number, so of the 840, 400.

Q. And if you know, what's the annualized figure now for admissions at AMHI? Fifteen hundred to twenty five hundred?

REP. ROLDE: Fifteen hundred.

MR. HARPER: And it's important, Senator, to not stop with just this component because there's other parts that have to be in place to provide the supports.

Q. I'm mindful of that, Jay, but that's - if you take four to five hundred people admissions away, you're looking at a one third reduction in your admissions, if I hear you correctly.

A. That's correct.

Q. And so that would obviously have a very significant salutary effect in terms of the overcrowding at AMHI.

A. That is correct.

SEN. GAUVREAU: Thank you. Representative Rolde?

MR. HARPER: Do you want the rest of the package?

SEN. GAUVREAU: Oh, I'm sorry, yes, tell me more.

REP. ROLDE: Is that what got funded or didn't get funded?

REP. MANNING: It did not get funded.

SEN. GAUVREAU: This is the Part II that did not get funded.

MR. HARPER: The residential component that did get funded will have the impact of taking 12 clients presently on AMHI wards out. That would be the long-term chronic clients that would be there and we're providing an alternative bed for them other than

AMHI. In addition, part of the package that was funded would fund 30 additional revolving door clients either to be taken out as they're going through the admissions unit at AMHI or when connected to the crisis and the case management provides them a longer-term option to go than just a short-term crisis stay.

The '90-91 package would include an additional 12 to be taken directly off the wards and an additional 70 revolving door people in more permanent housing. And I think if you remember the presentation we made in September, we talked about going from the existing 130 beds that are in the mental health system, and so you have an idea of what that is, the Bureau of Mental Retardation develops 200 a year. We have 130 in the whole system. It would add another 124 beds over the three-year period, so it's virtually doubling the amount of community beds that we could have the potential of purchasing.

The social club piece would support 70 to 80 people with pre-vocational and basic living skills, and those skills happen to be the key skills that we're finding out in order to keep people out. That's what allows them on their own to work with case managers and interact with the system and keep themselves connected.

The vocational skill program for - which was fully funded in '89 is annualized in our Part I '90-91. There's going to be 150 people per year.

The elderly part of the package, which is a very important

part given the new federal OBRA requirements that we have, in addition to the fact that all the states have an aging population that we're dealing with in the mental insitutions, it would add 7 more coordinators statewide. We're not sure what the impact would be for deferring people from either the geriatric unit at AMHI or BMHI, except that we've told those people that that's their primary job, to see if they can do anything about that.

In-patient services, which is the most fascinating one in its difficulty in this state to try to bring off but also is the most rewarding one if it ever gets off the ground completely, 20 beds would defer 520 admissions from AMHI. The problem is, and I would like - if you don't mind me speaking a little about the problem, we started arranging and setting up contract arrangements to purchase beds as of January 25, a few days ahead of what our schedule was to start doing in-patient stuff in the community. There is only 8 beds a day available in the entire state in the AMHI catchment area that you could buy.

SEN. GAUVREAU: This is in community hospitals aside from specialty hospitals?

A. Yes. If you don't get to that hospital - if you don't get to the right hospital at the right time of the morning with your patient, the bed has a good chance to be gone by the end of the day. We've been checking the hospitals on a weekly basis to see whether that goes up and down.

Q. Well, let me ask you, Jay, is there anything that you would recommend, shall we say, to provide an incentive to hospitals

to develop additional beds for their population? We know it's a hard to manage population, we know there could be problems with the reinbursement formula, but are there things we can do to provide incentives for hospitals to come in and propose bed expansions for this population?

A. I would be pleased to make a bureau recommendation to you. Michigan has the same problems, and they have, I think, a fascinating way of dealing with it. They require through their CON process that their Department of Mental Health have absolute sign off on any and every CON in the state. If you want x-ray equipment and you're in a targeted area where they need in-patient psychiatric beds, you come in and negotiate with the Department of Mental Health.

MR. ROLDE: That's wonderful, that's great, I love that.

REP. MANNING: I'm not sure that the Representative from York could quite buy that, although it would help, probably, in his catchment area.

MR. HARPER: It's very important, as we've had discussions, I think, to understand either the severity of the incentives that you may need if you really want to involve existing players in the game, or realize the fact that you're going to have to go out and build or purchase or renovate your own 20-bed facility to get these 20 beds. That's exactly what we have come to. You have to convince at hospitals the medical staff that they want to take on an in-patient psychiatric unit, and then if you ask them to do involuntaries, they've got to go that extra step, and then

they've got to convince their administrative structure to go to the board of trustees, which has all kinds of other community pressures on them and they may not want to be involved in the psychiatric in-patient game. So if you're not willing to hold their feet to the fire, you have to understand that you play by their game and they tell you whether they want to do the service or they don't want to.

REP. MANNING: Jay, where are the eight beds?

A. Today?

SEN. GAUVREAU: They're changing every day.

MR. HARPER: For the southern part of the state, there is one at Maine Medical Center, zero at Kennebec Valley Medical Center, two at St. Mary's, zero at Maine Medical, three at Southern Maine Medical, two at Regional Memorial, and zero at Pen-Bay. At Regional Memorial, by the way, they have an 11-bed capacity but they can only fill eight, their own choice, because they've not been able to recruit a second psychiatrist and they would lose their JCH accreditation by doing that. There are four beds available in the northern part of the state, but it's a long haul from AMHI to Aroostook County.

The last part of the component for the '90-91 that was not supported was deaf services for people that are mentally ill. And just so you can have an idea of what the impact might be on that, we're estimating that up 200 admissions at AMHI alone are people who come in with some kind of a hearing loss, and it's very important when you're trying to provide services to people

that you're able to take in in a holistic approach not only what all their other needs are, but you could communicate with them over what their problems and their issues are. The money we were asking for was to purchase additional services of people who can do sign and do training programs with doctors and social workers and nurses that interface with people who do have some degree of hearing loss. Not all are completely deaf, but it's a very significant phenomena, it's one that's very often ignored in many states.

SEN. GAUVREAU: So that what you're saying with that population, the deaf AMHI population, is that it's hard for them to maintain community placements because of a -- of resources that - people who in fact are trained in sign who can communicate with them?

A. Absolutely.

Q. And so you would -

A. This state, by the way, is a national leader in deaf mentally ill services. We have a couple of programs that specialize in that. Many states have none whatsoever. We are often called on to provide consultation through our deaf services coordinator.

Q. Now in terms of the deaf services again, will you tell me what was the price tag in FY '90 and '91 for the - the deaf services for the mentally ill.

A. I don't have them broken down by the subcomponents that I just did. They're broken down in either rehab services or treatment service, so it would be part of the treatment service

component, as is the in-patient.

Now the numbers that I gave you, it's important to realize that any one client might be using all of those services. You could have a deaf mentally ill person who uses a crisis program, has a case manager, is living in a residence that we're supporting and periodically needs to use an in-patient bed that we're supporting. The most important, I think, from your perspective of dealing with AMHI is the fact that if you could fill 20 beds every day in another agency, you'd reduce that admissions flow to AMHI by 520.

SEN. GAUVREAU: Representative Rolde.

EXAMINATION BY REP. ROLDE

Q. A number of things. In September we gave you $6.5 million, of which I understand about $3 million was for community services?

A. 3.6.

Q. Okay. And as you say, the key piece was the 20 beds.

A. Hm-mm.

Q. Now I assume that that money has not been spent, is that correct?

A. That is correct.

Q. Okay, so you've got - how much was that?

A. $500,000.

Q. That was 500,000. Has the other money been spent?

A. There's $150,000 for after-care services and underserved areas that just presently the RFP is being developed, and there's

$50,000 for standardized assessment process.

Q. But all the rest of the money has been spent?

A. All of the rest has either been spent or proposals are coming back in in response to RFPs. They only amount to $35,000.

Q. Wait a minute.

A. Not spent is 500 plus 150 plus 50 - 700,000.

Q. 700,000 out of three million?

A. Out of three million, and 35,000 we're just in the process of contracting for now.

Q. But all the rest has been spent?

A. All the rest has been contracted out.

Q. And as far as we can see, it hasn't really had an impact because the admissions are the highest that they've ever been.

A. Correct. The contracts have basically just been concluded in the last three or four weeks, and now -

Q. Three or four weeks?

A. That's right, and now starts the process of those vendors hiring up additional staff and training them to our standards and then going forward with the program.

Q. Now on the 20-bed piece, which seems to have been the most critical, when that was proposed, had nobody talked to any of the hospitals ahead of time to see whether this was a possibility? We talked about CON. Did anybody talk to the hospitals about the Maine Health Care Finance Commission, whether they could actually even do what you are asking them to do, whether they could fit that into their requirements?

REP. MANNING: Representative Rolde, if I could cut in here. Two years ago, in July, Ron - Ron Welch and I met with Jim Castle, and I asked Jim what the philosophy would be and told him to go out and find, you know, places, and said that I, meaning me, would back them at 100%, including over and above the Medicare rate, cutting CON completely out of the picture if we could find some institution that was willing to go and take on a 20-bed or a 30-bed facility, you know, that it wouldn't even be in the CON development account, it would be just go build it. I have not heard back from Jim Castle since then and I don't think - I'm not sure whether the department has heard back. But I gave him my word that that's the way I would look at it, knowing fully well that that would - I mean, we're talking about the state and cutting it down.

REP. ROLDE: Was the department aware of that?

REP. MANNING: The department was there that day. That was in May. It was Ron Welch and myself, and I forget who else was there, waiting - we formed a hospital subcommittee to deal with this very subject, and that was in July, right after we got out in July of 1987. Nothing that I know of has ever occurred back from the Maine Hospital Association.

REP. ROLDE: I've heard from two other people who are not connected with hospitals who said that they could conceivably work in this area or this type of an in-patient thing, and that's Tom Kane from York County Counseling and Jack Rosser from the Spurwink School, and I don't know if they've ever been touched base with

for setting up this kind of a situation. Was it basically the department was just looking for a place that was - that had a facility already and was going to take patients on a one-to-one basis, or were you looking for a specific 20-bed unit or -

MR. HARPER: All the above. We were looking for 20 beds, hook or crook, any way we could get it. We have talked to Tom Kane. In fact, he has investigated two site possibilities for us and we have a meeting with him next Thursday. We've talked of providing medical backup for him from either JBI or Maine Medical. We have talked specifically to Jackson Brook, who has a second floor administrative space unit that was 20 beds. It was modified for administrative purposes and they're willing to unmodify it and put it back into clinical services and allow us to have it. There are some very interesting revenue problems around both of those that need to be addressed.

REP. ROLDE: Through the Maine Health Care Finance Commission?

A. No, through - between the state and Medicaid. If you were to go to Jackson Brook, we would have to pay the full freight. It's a specialized hosptial, they do not apply for and cannot get participation from the federal program. If we run a unit that only has the medical backup provided by a private service but through a mental health center, such as York County Counseling, we can start from the beginning with a program that's a hundred percent Medicaid eligible. The impact on the services would mean we budgeted for the full cost for the 20 beds; if we used the Medicaid approach, we might be able to get more than

20 beds out of it for the same dollar amount in the budget.

Q. But you'd have to be getting a free-standing unit then, or someplace new. It seems to me that would have more capital costs than $500,000.

A. The $500,000 capital cost part could be easily financed through the Maine Housing Authority if we call it a secure residential treatment facility as opposed to an in-patient facility, and that is an approach that New York State has taken. It's not an - it's a very complex problem, it's not an unsolvable enigma. I mean, we looked into it before we made a proposal to the legislature. We understood there was an easy road and there was a hard road, and we chose to try to go the hard road first, which is to make full use and get - and there's a reason in the long-run strategy to try to get community involvement and participation in our solution. That's where the solution will be for the long term, and the sooner we get them involved and participating, the better.

The easy run would have been to just take the $500,000 and go pick a building independently of other support mechanisms and bring them to it. But we allowed ourselves the flexibility of going in either direction but to get 20 beds.

Q. So what's the timetable now? I mean, any light at the end of the tunnel as to when this might go on line?

A. Well, we have - what was very important is that we anticipated not doing the in-patient stuff until this month, and the reason for that was we wanted the crisis stabilization program in place and case management, so that the crisis stabilization program could

act as a triage point for people going through normal hospital emergency rooms, which usually is their way to get to AMHI, and look at those people and say, by the way, we have two other options we can offer you. You can either go to a crisis program or you can go to this other hospital bed. That's now in place for Portland.

Q. Crisis stabilization.

A. Crisis stabilization and their ability to purchase from Jackson Brook and some other hospitals beds on an as-needed basis. We're meeting with Southern Maine Medical to make the same arrangement between our crisis program, Southern Maine Medical's emergency room and York County Counseling for their ability to purchase beds both up north and also across the state line into Portsmouth. It's much easier when you're in Kittery to go across into Portsmouth and get the services than it is to come all the way up to JBI or to AMHI. We're trying to do things that make sense for where families need to go for distances, and also consumers and patients.

Q. Where would you be doing it in Portsmouth?

A. Portsmouth Pavilion. JBI is to get back to us, as is York County Counseling, with budget proposals around the stand-along 20-bed units in about three or four weeks, and at that point we'll know whether we need to go to -- or not or whether or not we need to come back to Representative Manning and ask for a favor here.

REP. MANNING: A waiver.

A. A waiver and a favor, right.

REP. MANNING: For those who don't know, that's a big step for Representative Manning.

SEN. GAUVREAU: Are there any other questions of Jay at this time regarding the package?

EXAMINATION BY REP. CLARK

Q. I'm suddenly getting lost in the time line here. Is this last year's Part II budget or next year's Part II budget?

A. This was last year's special session request in September that funded all these programs.

Q. Right.

A. So the programs we brought up on line between September and just recently was the crisis stabilization programs, which basically just augmented the three that the state presently runs, and all of the case management contracts have been let out and signed now.

Q. Okay. So then all those programs are folded into the Part I budget that we're going to be hearing next month?

A. That's right.

Q. When you talked about Part II budget requests that were denied -

A. They were not supported.

Q. That were not supported, that's this coming cycle?

A. That's correct.

Q. Can you describe for us what happened on that? Where did they get not supported?

A. I jump up and down a lot in front of the Commissioner, as she jumps up and down a lot in front of me to make sure we both are doing the best job we can, and I sold her in terms of our budget package that we wanted, and she fully supported it. What went on from that point forward, I assume, is that at cabinet meetings and working with the executive budget branch, decisions are made about what priorities get supported and don't get supported. The message that comes back to the bureau directors or the superintendents is whether you were or were not supported at that level. It does not mean that anyone is saying the request was an illegitimate request or not a worthy request, it's just whether or not it fit into the priorities, and that's how I perceive it. So after we had done the budget information and we knew that budget meetings took place between all the commissioners and the Executive Branch, they came back to us and said ours was not being supported.

Q. Given what we've talked about in the last week about the situation at AMHI, what kind of predictions - what are we looking at two years down the pike? What's the next crisis coming here? Are we going to be up to -

A. I think that the resolution of the crisis is certainly in the hands of both the Legislature and the Executive together, and that's the only way to solve the crisis.

One of the things that has to be made very clear is what it is that AMHI is. Is it an in-patient psychiatric hospital and

you're going to fund it and run it and have standards for a hospital, or is it providing a lot of other services to the community because there are other agencies that need those in-patient type of services. As long as it can be anything for anybody, which bascially it is now, I think you're just going to be substituting in the long one crisis with another later on. I don't know what it would be, but I would just guess that. Other states have experienced this. We're not unique or new at that, and the way out of it is to say what the hospital does and who it does it to and what the standard is you want it done for and then you fund it, and sometimes that's an expensive standard and some states have chosen just to do custodial care and do not participate or try to get other types of standards, and it's an inexpensive standard.

Q. We've been talking about treatment models, if you will. What's the current literature in the psychiatric community about appropriate treatment models?

A. For in the community? There's an article that just came out in the last month that is a wonderful article. I xeroxed it and sent it to the bureau staff yesterday. What it says is, and it's most important and I think it's very in line with what our approach has been, is that you have to be careful not to follow around the latest buzz words and treatment models, which for right now, for us, it's called psychosocial rehabilitation. Psychosocial rehabilitation assumes that people can go along and be treated in a way that has a rehabilitative component to it,

and many people can that years past were thought that they couldn't. What happens is, they have a tendancy to go too much overboard in that direction, and we need to realize that every patient needs a look at individually and decide whether they can fit into that model or not. Some people do need - I'm not one of the people who believes you can deinstitutionalize everybody. You may not have big institutions, you may have little institutions, but that institutional type of environment, 24-hour very intensive care, will be needed for some human beings, and I think that that's there. There's a danger to go one way or the other. So right now what we're trying to do, and what the literature is finally beginning to say is to strike a balance, and the way you strike that balance is spend a lot more time at the assessment end and looking at people as individuals and try things and do things slowly and incrementally but provide a holistic approach in terms of support services to them if you want success, whatever their success is going to be, not necessarily my success for them. That's where it's at. It's not an easy place to be at, because before the answers were real simple. You medicated them or you locked them up or you let them loose on the street and people thought that was the answer, but I think we've learned a lot from a lot of unfortunate mistakes.

Q. Do we have the techniques to do that kind of assessment?

A. One of the other things that's really interesting about this field is what - is needing to say what you don't know and be honest about that instead of pretending that you have all the

answers. We have - there are assessment processes that are much better now than they were just five years ago, much less ten years ago. We know a lot more about people. There are decisions that will be made that - in the example of the case of the adult at AMHI involved in terms of an alleged sexual assault where you make your very best guess on all the data provided you and you might find out that you're wrong, or you have an unfortunate incident that accompanies that guess.

We think the assessment instruments are pretty good now for people working in the communities and stuff like that, and what's most important is, though, that you have the ethical value structure of all the people working with them to say you stick with the patient, you stick with the client, and when the system fails or they fail or you made the wrong guess, we don't kind of give up and go away, nor do you necessarily regress, but you readdress all the issues again reassessing the line. To me, that's the most exciting thing about the area of psychosocial rehabilitation, is it says you have this cyclical thing that allows you to go on and on and on, learn from mistakes and not just repeating successes as if that's the only model that does work. I'm confident that there are instruments out there that work very well. We're going to find out very shortly. We're about to implement some standardized ones in the next few months.

REP. CLARK: Thank you.

SEN. GAUVREAU: Representative Pederson.

EXAMINATION BY REPRESENTATIVE PEDERSON

Q. The success that you were speaking about, if the proper things were in place, such as the case management and the providers, that the person - a lot of clients would have to have basically 24-hour supervision of some nature, and that might be in an apartment setting, it might be in a home setting, and then they would go to supervised functions, whether it would be social or vocational, and it would be easy to pick up those people whenever they tend to have psychosis or they tend to have a problem, then you could get them to the hospital and treat that, or maybe you could even treat it in the setting that they were if it was such that they could discontinue their routine and be treated because they are not capable of being in that routine. Isn't that basically the things that you're trying to provide with your community -

A. Absolutely. The most expensive single component in terms of what the existing system looks like compared to the one that we're proposing is, it's a very elaborate crisis stabilization program that allows us to find through case managers who may be looking at a client they are working with and say this person is beginning to act in a way where we've seen this pattern before, we know that they're heading towards probably a crisis situation. Or a family member may call and say I have a family member who I can tell is heading towards a crisis, and we can make some very sophisticated choices about intervention. The choice in the past used to be go to the emergency room and go to AMHI. The

choices we want to make are, you may want to go to the emergency room, you may want to have a crisis team come to where you are and help you out there. You may want to have that person dropped off at a crisis stabilization point and we'll take them for two or three days and help them through that period and then reintroduce them to where they are. Or you may want to, in fact, say go to AMHI or an in-patient facility.

Q. And the one thing I wanted to say was that along with that is the client quite often without that close supervision could either be drinking coffee and end up being up all night and could not attend whatever function that he normally would like to attend during the day, and he would then also be putting himself right into a psychosis within a short time. There are different things that would upset them. Stress is one of the things that can upset a client very quickly, and without that close supervision - and nobody would know that they were in a problem and then the problem becomes much greater and you have a much longer period of time to get them back to stabilization. Is that your understanding?

A. Absolutely.

SEN. GAUVREAU: Representative Rolde.

EXAMINATION BY REPRESENTATIVE ROLDE

Q. Jay, could you describe a crisis stabilization unit to me? How would that work?

A. Sure. We have -

Q. Is it a place or -

A. Well, if we have a full Part II funding, it will be places

everywhere, for each region in the state, for mostly the urban areas because that's where it makes sense to do it and you have to have transportation to it.

Basically what we're trying to do is design a system that allows in every region, for example in York, you would have 24-hour crisis telephone service for both families, professionals or a person in crisis to call to get not an answering machine and not an answering service but to have people that are there that are licensed practitioners in the field to help work out how to best solve that crisis situation. Tools that are left available to them are to say - when they hear the situation, it might be from a family member, say fine, you keep your family member there with you and we will contact other professionals we have on an on-call basis or we know where they are in the community and we'll send them to you. Or you can say, if you can take that family member and bring them to whatever address it is, and right now we have three sets of crisis residential apartments, one of which is in York, say you drop them off or get them any way you can or we'll come pick them up and bring them there, and they can stay there and they're watched and they're handled by professionals on a 24-hour basis. They're not sent into AMHI to get through the crisis, they're still in their own community. And if the situation doesn't escalate to the point where crisis stabilization is not going to work, you keep them there and they go. We're talking about basically apartments that are available in the community.

Q. So this is somewhere where - let's say somebody was having a psychotic episode. They would go there, they might get medicated and stay for a couple of days and then - is that a possibility?

A. Sure. A very real scenario, I think, is that you have a person that comes out of AMHI, they have medications, they start to feel real good, they're taking their medications and they feel so good they stop taking their medications, and stopping taking the medications perpetuates for them a crisis. They go into a crisis. The case manager knows that that's what the problem is but it's three o'clock in the morning. You take the person and you put them into a crisis apartment. They're being monitored for 24 hours, or whatever it is. At the next available time, you get to a psychiatrist, you have the meds reviewed, you sit down with the client you're working on and put them back on medication and hopefully the crisis is passed.

SEN. GAUVREAU: Are there any further questions at this time of Jay Harper? If not, I understand you will be forwarding to the committee the - a copy of the written -- the Part II request which you have made reference to?

MR. HARPER: Yes, sir.

SEN. GAUVREAU: Thank you very much for taking the time with us this afternoon. We certainly appreciate it.

MR. HARPER: Thank you.

SEN. GAUVREAU: At this point we will then close the hearing for this afternoon, and our calendar, as I said, is to meet next Monday and Tuesday, and with all things going according to track,

we should finally be able to close the hearings sometime on Tuesday and then allow the membership to join the Maine Development Foundation tour. Are there any requests of any members of the committee for other documents or other materials between now and next week so that I can have the staff work on that over weekend?

REP. CLARK: Incident reports?

SEN. GAUVREAU: Incident reports, can you specify?

REP. CLARK: I'd like to include March of '88, and probably August.

SEN. GAUVREAU: Is that confidential?

REP. CLARK: I would like to know repetition, though, even if they're code numbers.

SEN. GAUVREAU: You don't want to identify it, you just want to know what happened?

REP. MANNING: Have you adjourned for the day?

SEN. GAUVREAU: Yes, we have.

REP. MANNING: I have one more quick question. I wanted to speak to Noreen.

SEN. GAUVREAU: Representative Manning has other questions -

REP. MANNING: I have one quick question, Noreen.

EXAMINATION OF NOREEN JEWELL BY REP. MANNING

Q. In the last couple of days people have - the superintendent had indicated that those memos were sent on to the commissioner's office. Were they also sent on to the Governor's office. Do people in the Governor's office read those memos?

A. I really don't know and I'll find out whether or not - what

we get from departments are direct copies of all the memos from all their divisions. I don't know but I can get an answer for you.

Q. Do you have somebody who is a liaison from the Governor's office to -

A. I'm liaison to the department.

Q. How long have you been the liaison?

A. November or December, I guess, for a year now.

Q. November or December of last - in 1988 or 1987?

A. '87.

Q. So do you know whether or not you read those memos?

A. I read what comes out of the department. I don't know - I would have to go back and look at what the commissioner -

Q. Did any of the memos that - the weekly memos that we talked about, do any of those sound familiar to you?

A. I don't know how to - I'd like to take a look at the memos that he sent and the ones that I get and I could answer it. If you're asking whether the commissioner keeps us informed, I have always felt confident -

Q. No, my question is whether or not somebody in the Governor's office reads the weekly memos.

A. I read the commissioner's memos that she sends to the department, and what I would have to find out for you is how much of the information that gets to her actually ends up getting to me. I doubt that I'm reading -

Q. Why would she change anything that -

A. I'm talking about changing, I'm talking about extracting. I

doubt that -

Q. Why would she take anything out?

A. I would not be particularly interested in reading every memo or weekly or monthly report that comes from every division and bureau from all of the departments for which I am liaison. Do you see what I mean?

Q. You're the liaison -

A. No, I rely on the commissioner to keep us informed.

Q. I want to get this straight. You don't think it's appropriate to read every single weekly report that comes out of AMHI, BMHI, Pineland, the Elizabeth Levenson Center and the Children's Hospital, the Children's Center in Bath?

A. I expect to be kept informed on all of that. All I'm saying is, I don't know what the nature of or the size of weekly or monthly or periodic report is that comes from not only all of those but all my other departments and bureaus and divisions.

Q. What other departments are you liaison to?

A. Human Services and Community Services.

Q. So the three departments -

A. And Labor, the Department of Labor.

Q. But there is no other - the Community Service doesn't have institutions and Human Services doesn't have institutions, do they?

A. No, they have Bureau of Social Services, Bureau of Health -

Q. So you feel that it's not important to read the weekly memos of those institutions?

A. Peter, do you mean all of the weekly memos that anybody would

ever give the commissioner?

Q. No. My question is, the weekly memos that go from the superintendents of BMHI, AMHI, Levenson Center and others that was told to us yesterday that they go to the Governor - they go from Daumueller's office to the Commissioner's office and that they also go on to the Governor's office.

A. Right. I read everything that I get from the commissioners and they do keep me updated and informed on all of their bureaus. What I don't know -

Q. Do you know whether she extracts anything?

A. I don't know, Peter. I have never looked - I have never gone in and looked at all of the memos that they get from -

Q. But you do read them?

A. I read everything she gives me.

Q. Okay, thank you.

SEN. GAUVREAU: Thank you, Noreen. I do recall at some point, I'm not sure who requested, maybe it was Brad, there was some request that we reproduce the so-called Friday reports, and I spoke with you about that. My problem is, I don't know what time frame we're looking at.

REP. MANNING: Well, Mark will reproduce them tomorrow.

SEN. GAUVREAU: No, no. I mean at what point in time do we begin the Friday reports?

REP. BURKE: He started giving the chronology in February, or January is when I started writing down my chronology of '88.

SEN. GAUVREAU: So are we looking at '88? Are we looking at Friday

reports in '88?

REP. MANNING: I think we ought to go back to as early as September of '87.

REP. BURKE: Do we need each one or can we take one from each month, because it seems that oftentimes they were repetitious, but, you now, it's fine -

SEN. GAUVREAU: It wasn't my request. I thought it was Brad's. Okay, rather than reproduce thirteen separate compendia on Friday reports, why don't we reproduce one, and then if people want -

REP. MANNING: Why don't we make this - the department - Ron Welch has those, because the department has those weekly memos.

MR. WELCH: Yes.

REP. MANNING: And those are the same weekly - are those the same weekly memos - the same weekly memo that comes from the superintendent's office, does that same weekly memo then go on to the Governor's office?

MR. WELCH: Typically, yes. There will be some exceptions to that. Sometimes the superintendents get a little carried away with detail on issues that aren't really major highlights, and those might be deleted. The important thing is that it's a report to the Commissioner, who then picks what she considers to be the major issues in the report to the Governor.

REP. MANNING: Do you have those copies that go to the Governor?

MR. WELCH: Sure. The weekly highlight reports?

REP. MANNING: Yeah, that go to the Governor?

MR. WELCH: Yes.

REP. MANNING: Okay, could we have a copy of the - I would like to have a copy of the weekly reports from the middle of September of 1987 until January 1 of this year.

SEN. GAUVREAU: Does that sound like a gigantean task or can you achieve that fairly quickly?

REP. MANNING: Let me put it this way, if we could have it done by Monday, that would be all right.

MR. WELCH: One copy?

REP. MANNING: One copy, and then I'd like to have the copies of the same period of time, if he has them, from September of '87 until the first of January of this year. Do you have weekly copies of that, Bill?

MR. DAUMUELLER: Sorry.

REP. MANNING: Do you have weekly copies of - the weekly memo from September of '87, roughly, until - you could give that to our clerk?

MR. DAUMUELLER: They're in.

REP. MANNING: They have them already, okay.

SEN. GAUVREAU: So there are two sets of reports, one is from the superintendent to the commissioner and one is from the commissioner to the Executive Office, is that correct?

REP. MANNING: Yes.

MR. HARPER: What were the dates you wanted?

REP. MANNING: September 1, 1987, until January 1, 1989, and that would be what goes to the Governor's Office, not the commissioner's - not what goes from the superintendent to the

commissioner, what goes to the Governor's Office.

SEN. GAUVREAU: Are there any other requests from the committee for documents or anything else between now and Monday? If not, I think we're ready to adjourn for the day, and once again, thank you very much for your time and your efforts.

HEARING ADJOURNED AT 5:05 p.m.

VII

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute issues held on February 6, 1989, in Room 113 of the State Office Building, Augusta, Maine.

Maralee Kaler

TABLE OF CONTENTS

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9:20 A.M.

SENATOR GAUVREAU - We'll now open up the Monday morning of the session of the Human Resources Committee. Welcome. This is the fifth day of hearings of the Human Resources Committee dealing with the conditions at the Augusta Mental Health Institute. And, today we had calendared for presentation the following individuals: Richard Estabrook, who is the Chief Advocate within the Department of Mental Health and Retardation. We then invited the Maine Advocacy Services, Laura Petrovello will make a presentation. And, we had asked this afternoon for the Department of Human Services to make a presentation; the Department having authored a survey of some 45 wards who were in the custody, or in its control; and the survey, of course, which has garnered some publicity, dealt with certain complaints dealing with conditions at AMHI.

At this point we are now ready to begin the hearings for today and I would invite Richard Estabrook to come forward to make a presentation to the Committee at this time. Good morning.
MR. ESTABROOK - Good morning. My name is Richard Estabrook and I'm the Chief Advocate of the Department of Mental Health and Mental Retardation. What I was thinking I would do this morning, if it's okay with you, is to introduce myself and tell who we are and what we are and then make a couple of points that I think are important from the perspective of the Office of Advocacy and then open it up for questions and answer any and all questions that come my way. If that's okay.

SENATOR GAUVREAU - That's certainly fine.

MR. ESTABROOK - The Office of Advocacy is a State department. We are civil service employees. I, myself, supervise the patient advocates at AMHI and BMHI. We have one patient advocate in each institution. Ed Simms, who is presently the patient advocate at AMHI. He has been there only a couple of months actually. And, Dick Roloffs is the patient advocate at BMHI. He's been at BMHI actually longer than I've been Chief Advocate. He's been there about five years. I've been Chief Advocate about 3½ to four years. Our primary duties are to represent the interests of patients within the hospital and to advocate for them from their perspective and for compliance with all laws, policies, procedures, regulations, so that they are getting a fair shake under those laws, policies, procedures and regulations. And, we also - our second really major duty is to investigate allegations of abuse, exploitation and neglect within the institutions. And, we also try to function as spokes-people for the patients in general. We try to undersand their problems from their perspective and communicate that perspective.

I also supervise the patient advocate - resident advocate at Pineland and then I supervise patient advocates within the mental retardation community.

The first - the point I'd like to make is that I glean from questions that you've been asking and from what I've been reading in the press that you - particularly this Committee

but I think the Legislature as a whole - is understanding that the problems in the institutes, particularly at AMHI, at inextricably linked to problems that exist in the community and that I think it's a really important first step towards solving any problems that exist at AMHI in understanding that those problems are linked to the community. That any problem at AMHI can be defined as a problem in the community. They're one and the same. It's all one system. That overcrowding at AMHI that presently exists I think is in large - largley results from the lack of resources in the community, and since there are no resources in the community, then people end up having to come to AMHI. And, in that you understand that by allocating resources to the community and putting programs in the community trying to fix holes in the system that exist in the community you will thereby fix at least some of the problem at AMHI. I think that's a really crucial important first step toward fixing the problems at AMHI. And, I'm really glad to hear some of the comments that I've heard from people on this Committee and from people in the Legislature indicating that they understand that. I compliment you on that. You know, it's not as easy to understand that as you might think. So, the same principle, by the way, holds true at Pineland. But, that's another day.

The second principal point I'd like to make is these hearings have in large measure focused upon JCHO and the possible loss of accreditation of JCHO by AMHI and, of course, the loss of

accreditation by Medicare at AMHI. And, those are very important issues. I don't mean to denegrate that. They're certainly extremely important. But, having said that I would say that from our perpsective within the Office of Advocacy and I think from the perspective of other patient advocacy groups and from the perspective of parent groups and patient groups that those tests of whether or not the hospital is delivering quality care are not the tests that we would use. That's a long way of saying that even though you may put resources into AMHI and obtain JCHO accreditation and attain Medicare accreditation we will not necessarily be happy with that. That what we are concerned with is the - we believe that the - I'm speaking for the Office of Advocacy and I think also for this larger coalition of people who are interested, what we believe is the only really valid test of how well the hospital is doing is the actual measure of the delivery of services to individual patients within the hospital. We want to see individualized treatment plans and have some sense as we go over individual cases of patients that patients are moving along toward stated goals within the hospital - stated goals to eventually try to get them out of the hospital and back into the community - reintegrated into the community.

Right now at AMHI there is a pervasive sense as you look at patients' lives within the institution. A pervasive sense of lost time. That nothing much is happening. That you have -

you're there, you're stuck there. One of the things that we try to do is to get a sense for what patients' lives are like, what their typical days are like. What do you do in the morning, what time do you get up, what do you do after that, where do you go, what time do you eat lunch, what did you do in the afternoon, who did you socialize with - that kind of thing. And, as we do that questioning over many cases, what we find - and this is a generalization - you end up with about three to five hours a week of meaningful kind of treatment that is given to patients and I think that's just not acceptable to us. What we want to see is something more, particularly on an individualized basis. I'm certainly not asking for time-filler type of activity like basket weaving or making lariats or things like that - the things that were done in mental hospitals twenty years ago. What I'm asking is that we have sufficient resources to be able to deliver to people meaningful treatment options - individualized treatment options so that we can sit down with a real treatment plan and say what are your goals under this treatment plan? Where are you going? What are the time lines that we're looking for to be able to meet those goals. I think that's really crucial and I think that until we have that kind of thing there are problems at AMHI are gonna continue to surface.

The last thing I'd like to say is we - I have an AMHI one key and my advocate at AMHI has an AMHI one key and Dick Roloffs has a BMHI key and you're all welcome at any time to give us a call. We really encourage you to give us a call and we're happy

to take you through and explain what we see if you care to come. And, don't feel as though you have to give us a lot of warning either. We feel that it's best to come through without any - without much warning. In fact, that's one of the reasons why I think that JCHO and Medicare certification are not that great a test of what is happening at AMHI or at BMHI because the hospitals have a chance to prepare. They have a chance to cram for the exam as it were. And, I think to some degree they do things that intentionally create misrepresentations as to the quality of care that is done there. I've never actually been able to prove that. If I could I'm sure I would have gone to the press or gone to you. But, I hear rumors to that a lot and I do think that it happens. To some degree it's normal and natural human behavior to want to do well on exams, so I factor that in. But, I'd now like to open it up for questions and I'd be glad to answer any question that you have.

EXAMINATION BY SENATOR GAUVREAU

Q. Thank you for your comments, Mr. Estabrook. The Committee has obviously spent a good deal of time over the last week and a half entertaining complaints and concerns dealing with the care primarily at AMHI; and, although in fact we have devoted a good deal of time toward the accreditation issues and possible loss of federal funding, there seems to be a real broad concern with the whole generic issue of quality of care at the institutions. But, we see now - we have heard a great deal of praise

regarding the long-term plan at AMHI to augment community based resources, to reduce the census and even critics of AMHI seem to be buying into that long-range plan. Where the concerns are being focused at this point is the so-called interim solution. There seems to be a great deal of concern relating to the quality of life at that institution at present. And, we have heard primarily concerns dealing with staffing, dealing with availability of medical psychiatric care, dealing with shall we say questionable decisions regarding placement of certain patients in the population. And, I think we'd appreciate some direction from you in terms of whether you feel the complaints which we have heard if you're aware of them are they accurate? Are they understated? Are they overstated? Or, are there concerns of which you are aware which have not yet been expressed to the Committee dealing with conditions at AMHI?

A. In terms of specific cases I can't think of any case that has not been already expressed to this Committee in one way or another. I think that the problems at AMHI and BMHI, but let's focus on AMHI, almost uniformly - almost 100% can be traced back down to overcrowding and understaffing. Obviously, it's a complex problem which you no doubt gleaned in the last several weeks.

There is at AMHI I think in talking to - especially the mid level type of manager - people who have been there for many years, there is now at AMHI a feeling that the treaters

at AMHI cannot, because of overcrowding and understaffing, cannot individualize care; cannot really go and take individualized people - individual people, individual patients and move them along. That there's a great deal of frustration among the treaters at AMHI. And I mean that as a whole. That means mental health workers, that means social workers, that means psychiatrists, and that means psychologists. It's just almost impossible, given the present staffing ratios, to individualize patients' problems and then try to address those problems on an individual basis so as to deal with them and get the people at a higher level - I guess that's a crude way of putting it - so that they could be moved out. If you - I oftentimes have an opportunity as I'm sitting and watching - sitting and going over records, something like that, and I have an opportunity to watch the quality of the staff interaction with patients and what I see is a lot of crisis control going on, a lot of dealing with what I would say are fairly petty concerns of patients - can I get a soda, could you take me outside today, when am I gonna get to see the social worker - things like that. It's almost a constant litany of patients coming to the office and wanting information like that; and the time of the direct care staff people is taken up answering those kinds of questions, dealing with those kinds of things, and they can't sit down and do individualized programming. That's - and I think people are really frustrated with that. People at AMHI. And, when you look at the staff ratios, you

have, say, on Stone North Middle now - Stone South Upper - excuse me. It's supposedly an acute care ward. It used to be staffed at about - it used to have upwards of 60 patients on it. Three and a half years ago when I started - almost four years ago when I started it had about maybe 40 patients on it and I think - what I was always told was that it should have 35 people on it. And, now, it's got about 50 people on it as of today. There seems to have been a move in the last month or so to move people off of that ward. But, the way that's been done is to get people out on CS status - convalescent status - and people were moved out into the community. Traditionally, I have not gone to check those people who have moved out. I haven't gone and checked their files. But, traditionally what has happened is the people go out and they come back in. Statistically, I could predict that maybe 50, 60, 70% of the people will be back in and it contributes to the revolving door patient problem. You've heard statistics - I think ex-Superintendent Daumueller referred to the increase in the number of admissions over the years - over the last several years. And I think that part of that is this revolving door population of people. Since the wards are overcrowded, the pressure is on the people at AMHI to move people out. So they move them out probably knowing that they're not gonna be able to stay out and then they come back in in a month or in a few weeks or maybe two months or maybe six months, but they're back in and the census is back up again. One of the things

that we've always suspected happens is that prior to these inspections coming a lot of people get moved out on CS status. The inspectors come through and then the people come back in slowly, so your census problem is not solved over the long term. But you managed to look good for the census - for the inspection. That's something that's very difficult to prove because the people say I'm in good faith trying to move these people out, don't you as the advocate want them to be in the least restrictive alternative and I have to say well yes, that's nice. I want you to do that. So, it's hard for me to prove that there's any illicit motive in doing that, but there seems to be a pattern that we've picked up and I think that happens.

One of the things that patients that have been through AMHI or other mental health hospitals often say - almost uniformly say - I try to go to various patients since they've been out of the hospital and ask them what was useful to you? Why are you out here succeeding and why are you - you know - what's happened to you that you're not back at AMHI or you're not still involved in the system in one way or another as an inpatient. And, they say that one of the factors that's been really important in moving them out of the hospital is they say it takes one person who really cares just about them and they're there to visit, to be with them, to stick with them through their mental health crisis and what I would like to do is enable our system to provide that. I don't think we

do that now. Whether it's a treater, whether it's a friend - I don't know. I don't think that people in the hospital have that very often. If they do have it they tend to get out and I would like to see it systematically done. One person who - one way of saying it is they irrationally care about the person. No matter what happens they're still there and they're still caring about the person. I'd like to see that factored in as part of the system because we know from - at least from case histories of people who have been in AMHI - it helps people and helps them stay out. I'm certainly in favor of any allocation of resources to community programs because I think that's the way to solve the problem at AMHI - long term. Short term, I think Superintendent - ex-Superintendent Daumueller said well, you have to spend money in both places at the outset and I think that's true. That the situation is bad enough at AMHI now that the staff/patient ratios have to be improved. Even with, say, only 50 people on a ward instead of 60, if you look at mental health workers and what they're doing, it still works out to - after you subtract one person for kind of handling the office and the phones and one person for handling medication, then you might have two people left over to handle - taking people to the clinic, taking people outside who don't have privileges to go outside, and just general interaction and there's no way that two or even three people can interact with 50 people on a ward - 50 patients on a ward. They cannot give that kind of individualized attention

and they can't give that quality of interaction that we're looking for.

Q. Let me ask you a question dealing with the very beginning of care at the hospital - the admission unit - because Mr. Daumueller did touch upon that and made some recommendations. Then I'm gonna ask you questions dealing with the whole area of discharge planning which we haven't discussed in great detail but I'd like to get your views on that.

Regarding the admissions unit, Mr. Daumueller suggested specifically that the unit be divided in half. He felt that there was fragmented care now. He said that basically someone goes into admissions for a period of a week or two or whatever it is. There is one treatment team assigned to take history, craft an impression and do stabilization. Then the patient is transferred to another unit at the institution and a whole new treatment team comes on board. He felt that that was rather a disjointed approach and he was recommending that one team be assigned throughout the course of stay at the hospital to a particular patient and he would do that by dividing up the admissions unit. Are you aware of that suggestion and what is your impression of that recommendation?

A. I'm aware of the suggestion. It's not a bad idea. I'm not wholeheartedly in favor of it. I think that it's not the kind of - it's the kind of suggestion that I might be wary of in that it's tried and then people think well, the problem is fixed. That's not gonna fix the problems at AMHI. I think that

I could see - I see some merit in it. And, I assume that what he's talking about is direct admission to a particular ward based upon, say, where you have come from geographically and your age. That makes some amount of sense to me. I believe - and this is my own belief, okay - I believe that to some degree wards at AMHI ought to be divided according to the illness that you have, okay. Essentially what I would recommend is that people who have been diagnosed as having borderline personality disorder have a ward to which they go to that is separate from other wards. The reason for that is - and I think that Superintendent - ex-Superintendent Daumueller referred to this - it's diagnosis for which the traditional way of treating people at AMHI, i.e., through medication, medication doesn't work. So, you're not really talking about medication. And, my reading on the subject which is fairly shallow I must admit is that people who have borderline personality disorders need to have a highly structured unit and what we - what I've seen and what we see in the Office of Advocacy is that people with that diagnosis often are extremely intelligent, extremely verbal, very, very articulate about asserting their rights and very, very good at playing off one staff person versus another. They're masters at it. We try to avoid that. We try - to the degree possible, we try to make sure that their rights are implemented and yet we don't allow us to be played off against everybody else. And, I think that for that particular diagnosis I think it would be a very wise thing to do to have just one unit

to which those people are admitted directly where staff are specially trained to be highly aware of the playing off factor. Other than that I think it would be a workable option and that direct admission to, say, a ward that is especially tied into a discharge system that is geographic so that if you have - they used to do this at AMHI - a ward for like York and Cumberland counties. I think it's useful to have an age - some age discrimination as well. Let me retract that. Some winnowing out according to age, let me put it that way.

REPRESENTATIVE BURKE - Placement based on age.

A. Yes. Ideally, what I would like to see in the long run is - why have people go to AMHI to do that? Why not have beds in the York/Cumberland area and it's so much easier, then, to maintain the family contacts, maintain the community contacts and work together as a unit with discharge planners, with people who are already in the community mental health system to take the person out of the inpatient setting and put him into an outpatient setting with supports. And, to me, that is - that's where we ought to be heading. I think it's - that's not an easy place to get to, but I think that's where we ought to be heading long term. Because it's extremely disruptive of a person's life to get a free ride from the deputy sheriff with blue papers up to AMHI, and if we could avoid that - even if we - I think there's a place for involuntary inpatient services in a mental health system. I've thought about that even. I do think there's

a place for it. Let's try to make it as least disruptive as possible. And, I think that what we would find is that the actual time spent involuntarily in the inpatient unit would be substantially decreased if we had some way of doing involuntary inpatient units statewide. In fact, I think when you really get down to it, Aroostook County now has such a system. But for the fact that there's no actual court commitment to the Fort Fairfield Hospital, that's the only thing that's missing. Generally what happens is people are given the option, well, we can blue paper you down to BMHI or you can stay up here in Fort Fairfield and stay in our inpatient unit, quote, unquote, voluntarily. And, almost everybody - most people choose to stay voluntarily. I think that system - I don't like the idea that you voluntarily choose to stay under threat of blue papers. I have some rights problems with that. But, other than that, the system up there seems to work well. The inpatient unit up there in Fort Fairfield is ever so much more calm, more individualized treatment than what you get at BMHI or at AMHI. I - it's - I've been to treatment team meetings up there and it's like - it floors me the difference in the quality of what people are saying at the treatment team meeting, how they're really fighting to try to keep the person out of the hospital, out of BMHI, saying maybe we can do this and that'll help this person out. It's very individualized. A lot of effort by mental health worker-type people say well, maybe if I try a little bit harder I can - I can take this person outside every day and we can go

to the store and see how it goes. Interaction with the community, things like that. I think that's what people need in the mental health system. That's what patients need. That kind of interaction. From what I've seen of the system up at Fort Fairfield, and I don't think they were just putting on the dog 'cause I was there. It looked good to me. And, I think that that's an excellent model up there in Aroostook County for the rest of the State.

BY SENATOR GAUVREAU

Q. Let me ask you a question about the other side of the coin dealing with discharge planning. There have been concerns raised traditionally with the level of discharge planning from Augusta in particular; and the concerns being that people are discharged, are told to engage in certain medication protocol, and maybe some contacts with community based agencies; but, everything breaks down, the patient doesn't take the meds, doesn't have the referrals and in a month or two or three the patient is back at AMHI. Have you seen any improvement in that area, or is that an area we still should be very much concerned with at AMHI?

A. I have not seen any improvement in that area. That's very much an area of concern. I think that if you talk to the people who are social workers at AMHI whose job it is to do the discharge planning, they're extremely frustrated because there's so little in the community to recommend. The services aren't there so the people get perfunctory discharge planning. Well, here's

the phone number for the community mental health center. When you get out go give them a call. I'll set up the first appointment for you but after that it's your responsibility to go to subsequent appointments. I hear - and this is kind of a traditional enmity between the mental health - the community mental health centers and the institution that even nationally has been going on since the late 40s. So, I think that Maine does not have that in too bad of an extent but there's definitely that feeling that the institution believes that the mental health centers really only deal with the worried well and mental health centers think gee, I can't believe the levels of medication that this guy came to me with from AMHI. The first thing - and you hear a lot of the first thing that the psychiatrist at the mental health center does is lower the degree of medication that's given to the patient coming form AMHI. There's not good communication. It's not a systematic - it's not one system. That's the key to it right there - it's just not one system. There are - you have one state-run system and one system that gets some state money but it's not a high level of state control and they don't mesh very well. Unfortunately, I think the patients are caught in the middle.

Q. But last year we - this was very definitely a point of concern for the Department and was a factor in their case management model which they recommended and we agreed it was a good plan.

A. Yeah. Yeah.

Q. Now I recognize it's just up and running and the contracts haven't actually been finalized yet. Do you think the case management proposal package which we adopted last fall is a reasonable package? Do you think that it will address materially the concerns you just raised?

A. Well, yes with a caveat. I think it's an excellent idea to have case management and it's definitely necessary for the Department to have people out in the community watching over what is happening to people who have been discharged from AMHI and others who eventually could go into AMHI. I think that's excellent. My understanding of the case management model is it's - there's not a great deal of actual case management. Now, that's my understanding and I might have the wrong understanding; but my understanding is that there'll be regional offices as there are now and there may be three people or so in each regional office to check on four or five - to check on the way that people are being served in the community. That's an excellent first step. I think it's really necessary. Drawing upon - I'm fortunate in that I get to see both sides of the Department. Since I work in mental retardation and mental health both, I do a lot of work in both. And of course, the mental retardation side of the Department has CSCs, has case managers who actually go out and do things like make doctors appointments for people and follow up on them, do home visits, do site visits, do a lot of that interaction with people and get to know the treaters in the area, get to know the treaters and their attitudes

towards that particular person who is on their caseload. And, as I understand the system as presently proposed, you're not gonna have a caseworker there. I realize and undoubtedly you realize too that just in Region 5 in the Bureau of Retardation there are probably 20+ caseworkers. And, I don't think that the Appropriations Committee envisions having a hundred or 150 caseworkers for mental health. That's what I would like to see. I think it's necessary in the long term. That's what I would say. Let's try to go for that long term. But, you know, even I have to say okay, let's try to work things step by step sometimes.

Q. So what you're saying is that what we've done by approving 15 or 20 - whatever it is - case managers is a good start but your ultimate goal would be to have a broader dispersal of those case managers throughout the state, not just in regional offices.

A. Yeah, and that's based upon the principle that what I believe people need out of a system is that personal interaction. I think without personal interaction that they - people get lost in the system, they - I don't know. It's hard to explain exactly why it works, but it works. If you have the personal interaction, the person is much, much more apt to be successful in the community or even at AMHI than without it. And, based upon the principle that we need that personal interaction, therefore we need people to provide the personal interaction, those are the case workers. Long range we should be looking at that.

Q. One final question. Many members of the Legislature and

this Committee, I think, were pleased with the mental health package that was passed last fall. They came away with a sense that we had made a meaningful step in addressing the problems of mental health in our society. And, now these hearings raised all these questions once again. Many people are beginning to wonder whether we've done enough. My question to you is were you surprised by the concerns which were raised in the fall and into the winter this year as far as AMHI and do you think that basically this was bound to emerge at some point and that even with the reforms of last year, as good as they are, these problems would still come to the fore?

A. I have the idea - first of all, I thought that the emergency legislation was very good. Okay. Especially in the fact that it didn't concentrate on AMHI. That a portion of it went for the community and I thought great, people are understanding that. And, of course I didn't think it was enough in that I think when you really get down to it there are twelve or so intensive outpatient beds and then some more support for other beds that amounts to about 30 people who would be able to get support out of AMHI. And, when you look at the census of AMHI it would be 360 - 380 - well, obviously it's not enough; but it was an excellent first step. I had the idea, and in the last couple - especially in the last month, I've thought now where did I get the idea that that was just the first step. It was very strongly in my head that that was just a first step and I was surprised when it came down and the Department kind of

saying well, gee, we thought that would solve some of the - that would solve the problems at AMHI and get it certification, etc., etc. I was really surprised by that. I had it in my head, and I don't know - I tried to think of exactly where I got it - all I can think of is it was at the overcrowding hearings; but that that was - that everybody understood that that was the first step and that there were more to come and that people understood there had to be additional major resources allocated to the mental health system above and beyond that. I'm certainly very happy with that first step.

Q. Well now, last Thursday Jay Harper came in front of the Committee at the end of the day and outlined for us - gave us a summary in terms of those portions of the part 2 requests which were not included in the Governor's budget. In fact, they were fairly ambitious - around eight milion dollars - to significantly augment community resources. Was that the kind of thing you were expecting to come forth?

A. Yes it definitely was. Yeah. In fact, I thought eight million was a little low, but you know, I have my perspective. I'd be very happy with something like that. Again, you kind of run into the problem of how much is enough. When do we know. And, my answer to that is we will know when we can do - when we can go into AMHI and we can see - when we can look at the individual lives of people at AMHI and see what is being delivered to them and by the same token what is being delivered to people out of the community. Okay. So, we will know it's enough when we're not

getting large spikes in the admissions, lots of revolving door kind of patients coming in and out. That's when we'll know. For right now I'd be very happy with whatever comes. The system obviously needs something, okay. And, the eight million dollars would be an excellent start. Whether it's enough, I tend to say no, but, shoot, let's give it a try and see what happens.

Q. Let me ask you this. We know we obviously have limited funds in our budget.

A. Yeah.

Q. Yet, we also know that people will look to this Committee to make specific recommendations. If I had eight million dollars - additional dollars to allocate in mental health - a wish list here - would you think that the most appropriate expenditure of those funds would be along the lines of the rejected part 2 request of the Department?

A. Yes. In the communities. Yes. Definitely. Yeah. I guess when I really get down to it, I hate to be put on and say don't spend money at AMHI 'cause I know - I can't really say that in good conscience because the problems in there are so bad. But, I have to try to look at it from your perspective, too, and given the fact that you have scarce resources I'd rather spend the money in a long-term plan in the community that eventually will make things better for people at AMHI that are relatively - than at AMHI. I say that with great sadness. I'd like to see money spent on both.

Q. We appreciate your dilemma. It's the one that we share as well. Let's see, why don't I go clockwise starting with Representative Clark and go around the circle.

EXAMINATION BY REPRESENTATIVE CLARK

Q. Thank you. I've got questions in three areas basically. The sort of the final statement that you made in terms of your initial remarks you talked about yelling louder so people would hear you sort of. Do you feel that you have appropriate places to take your concerns about what's happening at AMHI in a timely manner? Or, do you feel like the Human Resources Committee got their act together last week and you thought, my God, what's taken you the last eight weeks?

A. That's a really good question. I guess in thinking about it I don't see - I think AMHI is in a state of crisis, but I don't think AMHI is substantially different from what it was say two years ago. I think that the problems at AMHI are larger than the Superintendent or larger than the Commissioner. And, I - my role is to communicate with the Commissioner and with the Superintendent and tell them what I think the problems are. And, I think we did that. If anything I think I have been remiss in not coming to this Committee sooner and saying, gees, you know you have a real problem here. I'd have to say that I think I'm at fault in not coming to you guys. So, I hope that's something that we can rectify in the future.

Q. When did you feel as if you were yelling loudly to the Commissioner or to the Superintendent? Is this a two-year

sort of scream or is this - were there some events over the last year that upped your anxiety?

A. Well, no, my anxiety level has been pretty high along these levels for the last couple of years. We started being worried about overcrowding back in early '86, I guess, and we arranged to have - we did a grievance under the proper procedures and had Commissioner Concannon come over. And, I think as a result of that, at least from what I understand, he tells me there were some interim staff that were hired and things like that. I didn't see a lot of - I didn't see improvement in terms - again, in terms of the tests that I use which is the day-to-day life of the individual AMHI patient, I didn't see improvement. And, what I've tried to do is keep the drumbeat going, okay, and saying look, there are - there have been and there continue to be lots of problems in the mental health system. To the degree that - I mean, it's hard even to know when you sit down and first look at it where to begin to solve the problems. I would say that.

Q. Was this sort of feeling like you were beating your head against the wall so you didn't quite - I mean, you commented about the fact that you perhaps should have let us know sooner what was going on. Was that short of the sense that -

A. Yes, yeah. I was frustrated. I think the advocates both - we've now had three advocates at AMHI. It's the burnout position in my office and they were really frustrated.

Q. I notice that you sat on this panel to investigate the deaths and there's a letter dated December 19th to the Commissioner from Ron Welch. Were you comfortable with this report?
A. Yes I was. I thought that was a fair investigation.
Q. It came to my attention this morning, and I haven't had a chance to go through it piece by piece, that there is an earlier report that is not dated that seems to me to be considerably more complete; but I haven't had a chance to really look at that. Did you have a feeling that this is a whitewash?
A. No I didn't. I'm not sure what the documents you have are. One was prepared for public consumption. In other words, for the press because it referred to patient names and also under the personnel laws you can't go and publicize personnel action against various state employees until it's completely finished. And since I guess there was the possibility of personnel action being taken that those names could not be released. My understanding is that the one version, kind of an internal version, had names, had patient names and had employee names and it was deemed not right to release those to the press. I would agree with that. If that's what you're talking about then I bought into that. You have to follow the personnel laws and you can't release those names. And, I think also, all the press has gotten ahold of the names of the patients who were investigated, I still thought that it was not fair or right to release names of people - for the state to release names of people to the press. If it were my relative I wouldn't want to read about

it in the paper about his or her medical problems.

Q. I'd be happy to have you look at the two copies that I'm hanging on to when we're finished.

A. I was a little frustrated in that I had a sense of where - how to explain this - the lawyers will understand. Medical causation, okay, that - it was hard to prove like why did somebody die. It's - when you really get down to it it's very hard to explain. The autopsy doesn't really show - you know, why do they die? Was it heat related? Was it not heat related? It was hard. I wanted to come out with clear answers saying okay, this is heat related and therefore we should do this or that. I was frustrated in that the medical experts who were part of the panel were, to their credit, careful. They'd say I can't say that. I can't tell you definitely if this was the cause or that was the cause. Personally, I was frustrated with that. That was the only thing I was frustrated with. I felt that the - I thought that the inquiry was fair and I thought that we had an opportunity to ask broad ranging questions. One of the things - there were five people that died. We only investigated three that were colorably heat related and I think maybe that there were questions about medical care about those other two and we did not look into those. That I have questions about, but for the investigations done there I am happy with it.

Q. The third sort of set of questions goes back to the information that we received from Mr. Harper on Thursday. Were you

still here?

A. Unfortunately, I caught the end of it. I didn't - I tried to read in the paper what he said and I didn't get a good idea of what he said.

Q. My question was he was giving us an estimate of perhaps 600 admissions that could be avoided if we put this eight million dollars in the community. My question to you was, and you may not have enough information to know whether that was a realistic number.

A. Off the top of my head I'd say yeah, definitely that's realistic. My understanding is that right now - right now that if you had not even great resources in the community but just some resources in the community, at least 50 to 100 people at AMHI could be successfully placed in the community. And if you have some good resources out there it sounds to me like what he's aiming at - I'd say 600 is not unrealistic at all. In fact, it may even be real conservative.

Q. Thank you.

SENATOR GAUVREAU - Thank you, Representative Clark. Are there other questions? Representative Burke?

EXAMINATION BY REPRESENTATIVE BURKE

Q. I understand that there's somewhat of a need to pinpoint that there are both long-term and short-term solutions to the problems within the mental health system; and I understand that the development of the community services falls into both

categories. Obviously, if we had community services right now that 100 people could easily be moved to community services support. What I'm looking for now, though, is a clearer understanding in the sense of what your role is or was throughout the crisis at AMHI. Basically, you're the Chief Advocate. You have one other advocate working with you at AMHI, is that correct?

A. Yes. Full time, yes.

Q. For all of the patients there?

A. Yes.

Q. So, is there any physical way that you could see all the patients that you need to see?

A. Oh, no. No. It's - like I say, the advocacy position at AMHI in my office is the burnout position. You just - I've been over there, I've covered over there. The phone rings and rings and you go out on the wards and - it's very common for us to go out on the wards and you think that - you know, you get a phone call. I'm so and so and I'm on Stone South Upper and I would like to talk to you about a particular problem I'm having. So you go - good, you know, that'll be a half an hour or 45 minutes and I'll get this other person on the list later on. You go out and you talk to the person on the ward and boom, you're surrounded by two or three other people who also have problems who just happen not to call. So, you try to deal with that. It's like -

Q. So in essence it's crisis management even for the advocate

staff.

A. Yeah. Yeah.

Q. Okay.

A. I think that what the advocate does is - the really beneficial thing that the advocate does besides getting in and working with individual patients, to a large degree - we do it - but it's to get to know the people and the programs that are available and actually get out onto the wards and really get a sense for what the place is like. I think that the individual advocate has an even better sense than I do of what it's like on the wards because they're there so much. I happen to make it over there, fortunately. My office is a mile away and I make it over there a fair amount.

Q. So, the office of the advocate itself appears to need to be expanded. That's one short term -

A. I would be most grateful.

Q. Now, to whom, then, do the advocates report? To you?

A. Yes. And, under the statute we report to the Commissioner.

Q. Directly to the Commissioner, bypassing the Superintendent?

A. Yes. We are not under the Superintendent, so the Superintendent cannot - here's how I read the statute, okay. The statute says that the Chief Advocate shall report to the Commissioner. And when it's 'shall report to the Commissioner' I read that to mean she can't necessarily tell me what to do or what to investigate or anything like that. I report to her. That's it. Okay. And, we - our obligation is to represent

the interests of patients, period. And, now, when we do an investigation of an allegation of abuse, exploitation or neglect, traditionally that was always sent to the Commissioner, at least under Concannon. Now whether he read them or not I'm not really sure. I think he did. And, that was delegated to Ron Welch under Susan Parker. I would communicate with the Commissioner upon occasion, have conferences and things like that. So -

Q. So, were there any regular times set up that you had communication with the Commissioner?

A. No. Not like - well, not like the senior management team meets once a week or something like that. No. She would ask me to meet with her once every couple of months or so and I would.

Q. Okay. And, during those meetings did you bring up your concerns about what was going on at AMHI?

A. Yeah. Yeah. I mean, it's - again trying to think about that and think about my whole role in this, I think what I'm mostly concerned about is life on the wards and the bad condition of life on the wards. And, the trick I guess is to communicate that to her in such a way as to try to get her to do something about it but knowing really it's - in my mind it's beyond just her, okay. She needs reosurces. Any Commissioner would. And, I think that was what I was trying to communicate to her. I never pulled any punches with her or anything. I let her know what I thought the conditions on the wards were.

Q. Okay. Did you let her know what the conditions on the wards were in writing?

A. Yeah.

Q. Or, were those written reports always siphoned through an Associate Commissioner?

A. Well, actually, she had asked for a kind of a report from our perspective as to the status of the Department. So - that was in the summer, in July, and we got together and I wrote the report. It was getting information from other - all the other - all the advocates had an opportunity to give me information and I wrote that in. And, -

Q. So you always feel as though she knew what the problems were, not only from - well, basically from the advocate standpoint that you always felt that you were keeping the Commissioner fully apprised of the dire situation on the wards at AMHI.

A. Well, yeah, I'd like to think that. I think so. There's - again, it comes back to my perception that almost every problem there can be traced to overcrowding and understaffing; and I never let up on that. That was the constant theme. She's an intelligent woman and I can't - after awhile it's belaboring the obvious to state it yet another time.

Q. Right. And, your feeling that the problem was beyond her in the sense that it has a lot to do with allocations and things like that, did you get the sense that the Commissioner was going elsewhere with requests for allocations and that they were not being accepted?

A. No. I thought that - I had the perception that with the Overcrowding Commission, and I had an idea of where that was

gonna go. I knew some of the information that was getting in front of the Overcrowding Commission. And, I knew that in the fall of last year that the people within the Department wanted to allocate substantial resources, were gonna be requesting an allocation for substantial resources. The exact number I did not know. They don't tell me that. But, they were going to be requesting substantial resources for the community to try to alleviate some of the problems at AMHI and I was in favor of that. And, I thought that - I thought good, we're finally gonna get some movement on the overcrowding/understaffing issue because of that. So, I was optimistic back in - despite the deaths I was optimistic long range in September/October 'cause I thought - even November - 'cause I thought that it wasn't until the Governor's budget was printed and then oops, there's not a whole lot in there. I was hopeful that we would get a lot of money to address this problem.

Q. So you felt - in a sense, then, you felt with the budgetary process the Commissioner was in fact bringing the concerns again through the budgetary process that you had to the Executive Branch.

A. That was my sense.

Q. So then you were very surprised when the budget from the Executive Branch did not reflect the increased spending that you felt needed to be done.

A. Well, I guess disappointed was more what my real thought was. I guess I've learned not to be surprised in this job. You know,

if it can go wrong it will go wrong. But, I was disappointed, yeah, and I really had expectations that something would be done. And, like I say, one of the advantages of being an internal advocate is you pick up stuff in the office. You know, stuff I probably shouldn't know I know anyway because I - people tell me. And, I really had expectations because of that that we would be getting substantial money.

Q. Okay. Thank you.

SENATOR GAUVREAU - Other questions? Representative Pederson?

EXAMINATION BY REPRESENTATIVE PEDERSON

Q. Good morning, Richard.

A. Hi.

Q. Now, one of the first questions I'd like to ask you would be are all the incidents of the physical harm to patients and all complaints of signs of physical injury reported to the advocate?

A. No. They're supposed to be, as far as I know, under AMHI policy like patient to patient altercations and things like that. They're supposed to be reported and they're not.

Q. Now, do you have a list or do you keep track of how many incidents are reported to you?

A. Per se, no. What we do, though, is we keep track of the investigations that we do so that - like if there - I mean, what had happened in the past under - what had happened in the past was the patient to patient incident reports would come in and then we would file those, okay. And, some of them

we would look over and maybe try to interact on and others we would triage out and not interact on. We would try to keep those - what happened was - over the last couple years basically is those stopped coming to our office. And, Tom Ward, who was the advocate at the time, would - there's supposed to be - under AMHI policy they're supposed to come to the advocate and he would go to Superintendent Daumueller and say get me those reports. I want those reports. I want to keep track of those reports. They don't come in. Now, whether that's AMHI staff keeping information from the advocate or whether it's just incompetence I don't know. Whether it's willful or not I don't know. They don't come to the advocate.

Q. Another question was what was your role as far as some of the really big problems such as that you investigated with the panel. Did you play a role in some of those incidents before your investigation?

A. Oh yes.

Q. But, -

A. The burn victim case, which people - I hope I can just refer to it as the burn victim case and leave it at that. But, basically because of - I was covering at the time. I did the investigation myself, so I knew a whole lot about - I went and did the record review and I asked the questions and tried to get preliminary medical information about whether or not that was - whether or not medically that was done well by AMHI.

And, so that's the one I know the most about. The other two cases Tom Ward did when he was advocate at AMHI and, of course, I had his reports. I had any additional information that came to us, which was substantial, but additional information that came to us during the investigation of those two deaths.

Q. Now, how do you handle those types of complaints? What would be your response? And, what would be your, say, outcome that you would feel that you have done something or whatever needed to be done?

A. It's pretty case-specific depending on the fact patterns. Some of the cases are relatively simple, like an individual who was on the staff who was alleged to have, say, struck a patient. Then we go and interview witnesses and involve the union and give notice under the union rules and do an investigation and get the facts surrounding that and try to get a decent idea as to whether or not it happened as alleged. Where it gets more difficult is where you get into the medical issues, such as the burn victim in this case. A lot of judgement calls. And, you get - we get into well, did they do the right thing. Did - would a reasonable doctor, given the same information, have acted in the same way or was it in effect neglect. Was it negligence to have acted toward this patient in a particular - in this particular way - the way they did. We also get into issues like well, to what degree were the person's medical problems caused by a medication - psychotropic medication that

he was on; and should there have been a lesser restrictive alternative that was considered? Should the hospital have done other things other than medication, rather than given the fact that the individual was medically fragile? Those are the - the questions we start asking are those questions, particularly with the medical questions we don't have the expertise necessarily - well, we don't. Not just necessarily. We're not doctors so we can't answer it. And, what we do is we pose the question to the Commissioner and then say we want a panel convened which has this medical expertise so we can get these questions answered. So, that was our role in those cases.

Q. Say in the burn case, were you involved in that any time prior to the - before the patient deceased or was it afterwards?

A. I was only involved afterwards, yeah.

Q. Was the advocate at the hospital involved before the patient deceased?

A. No. Not to my knowledge.

Q. Is that the case in most of the cases is after the fact that you get involved?

A. Yeah, most of the cases are after the fact. We try to do proactive advocacy when we can, but it's hard to do.

Q. Is that a problem then when something's going on that you are never involved 'til after the fact?

A. I can't say never, but often we're not involved until after the fact, yeah.

Q. Now, I understand the Commission on Mental Health, the

Governor's Commission, that they do have clearance to go to the hospitals, to be on the wards, to look at the records and one thing or another; and I think probably that Commission was quite upset when they found out that there was the inner report that you speak of that gave examples of incidents that happened that were - and then they were eliminated to the report that was handed up by Commissioner Parker to the Commission on Mental Health. And, I think that that's why they felt that they had a sanitized copy - that they didn't have the real copy and that they felt that you had - in the other report there was examples and told about some of the history. And also, I think you had some written remarks that was on the report which they didn't have and so it made it look as though they really didn't have a very good example of that report and I think that's the reason that that came out in the news. Do you have anything to add to that?

A. Well, I certainly think that they need to have the, quote, nonsanitized, unquote, version. They're in a position where they're gonna have to get to know the people over there and in order to make really valid kind of recommendations, the best kind of recommendations depend upon if you have a better knowledge based on your recommendations are gonna be better and I think they need to - they're gonna need to get in and see records and certainly they should know the various doctors and personalities involved. Obviously, there are confidentiality

problems in allowing a patient's record to be given to twenty people or so; but I think that can be worked out. I think they ought to get the information.

Q. Now, is there any way that your department could possibly help out the families any more when they see incidents happening to their family members? Many of the family members are some of the first people to come across and feel that there's been a wrong and something's happening. But, they seem to lose out because of the confidentiality. Is there any way that you feel that you could help resolve some of these problems?

A. That's always a tricky question as to giving information to non-guardian family members. Ideally, what we try to do is to work out a compromise to get the patient to release the information or give such information as the patient wants to give out and give that to the family member. I think that works okay. There again, it tends to be - it relies upon well, it's labor intensive for the advocate. You have to get to know individual family members and the patient and it's very hard, I think, for - to do that in all cases. And, that's a regret that I have that we can't be in there more in trying to resolve those kinds of issues 'cause I think in 95% of the cases the actual interest of the family and the patient him or herself coincide. There is certainly lots of room for shared goals.

Q. Thank you very much.

SENATOR GAUVREAU - Representative Dellert?

EXAMINATION BY REPRESENTATIVE DELLERT

Q. Thank you. Good morning.

A. Good morning.

Q. I want to ask some questions, too, on management. Did you work with the Superintendent at all in sharing some of your mutual priorities that you had? Did you discuss any of those with him?

A. Yeah. I think he got sick of me and us telling him that everything was due to overcrowding and understaffing.

Q. Did you ever put that in writing?

A. I never did to him. Now my sense is, although I can't instantly think of any instances of it, my sense is that the advocate at AMHI did, yeah.

Q. Do you have a plan for the advocates? Do you work with them in training them and so forth?

A. Yes.

Q. What is your training? What is your background?

A. My background - I am an attorney by trade. I worked for Pine Tree Legal Assistance up in Presque Isle for about three years in the late 70s and early 80s. When the budget cuts came through for legal services, a bunch of us got together and went into private practice. I moved to Bangor and did a private practice there for about three years. Then three and a half years ago I found myself on the register and surprise of

surprises I ended up getting this job.

Q. When you were on the Commission for Overcrowding did you voice your concerns very loudly?

A. Actually I wasn't on the Commission. I wasn't a member of that Commission.

Q. You were just attending?

A. Well, I attended and Dick Roloff and Tom Ward and I all had a day to testify. And, I thought we spoke. We spoke - we didn't pull any punches there either.

Q. When you met with the Commission did you also put it in writing some of your priorities, some of the things you felt should be done?

A. No I did not.

Q. Do you know about the policies and procedures they have at the hospital - the books that they have?

A. Yes. I can't say I'm intimately familiar with them, but I know about them.

Q. Do you have access to them?

A. Oh, yes.

Q. Do your other advocates know that?

A. Yes. Dick Roloff is particularly adept at manipulating those policies. He's excellent at it, yeah.

Q. Okay, so he follows through on those.

A. Oh yeah. It's not uncommon for us to review policies and get input on proposed policy changes. I mean, yeah.

Q. Who would you report those changes you'd like to see? Would you report those to the Superintendent or to the Commissioner?

A. Usually - like a policy change like that?

Q. Yes.

A. Internal policy change?

Q. Yes.

A. Like at BMHI or AMHI?

Q. Yes.

A. That would usually be done through the Superintendent. Actually - usually what the superintendent does is has a committee who works on - well, at BMHI there's an exercise committee. Okay. The Superintendent delegates people to try to figure out how to get people more exercise at BMHI off the wards and having outside exercise more. So, then, that committee would meet and Dick Roloff would be part of that Committee and they try to come up with a plan and then they communicate that to the Superintendent. Sometimes it's lost and sometimes it's not.

Q. We all feel that the community resources are going to be the best thing that we could possibly have. Have you developed plans and ways of implementing those plans and then given those to the Commissioner or to the Superintendent?

A. No. Not in a word. I probably have a few opinions on that but I haven't. I think it would probably be better done to have somebody who is a mental health planner do that.

Q. And how would you handle - many of the patients who are discharged into the community even though there might be some

resources, if they refuse the social worker and they refuse the medication and refuse to go back to the hospital, what do you do to them?

A. There's not a whole lot that can be done. My first answer is well, have you really, really tried. Have you really tried to make that contact. I think that too often, because people are overburdened, they tend to say they triage out the ones that they can't deal with easily, so those people get lost. Something that gets mentioned every once in awhile is some kind of involuntary outpatient commitment scheme which would require a statutory change and a fair amount of procedure and folderol in order to implement and I think also a fair amount of - a large amount of resources to back it up. It's not a bad idea as long as it works without having to go to court to enforce it; but when you have to go to court to try to enforce it, it's - you might as well not have it; and that's the problem with it.

Q. There are those in the community who have said that even the police cannot help them because unless a person does harm to themselves or to others, there's nothing they can do. And as you say, without going to court - there is a law in Massachusetts called the Rogers Law where they can go to court.

A. For forced medication, yeah; and I think that's - I definitely say try to avoid that here in Maine. It's a very cumbersome system and it takes up a lot of attorney - expensive attorney time and judge time and there must be - there are easier ways

to do it.

Q. Thank you.

SENATOR GAUVREAU - Representative Hepburn?

EXAMINATION BY REPRESENTATIVE HEPBURN

Q. I want to talk about your side of the shop a little bit here. As part of the September package that we passed we had the 65 positions we put in over across the way as well as the community piece which is having a little bit more lag time in terms of getting going. Your office will be - probably have some contact with clients in terms of some of these community based services when they do actually get going, will it not? Did we increase any of your personnel at all?

A. No.

Q. I didn't think we did. That seems like it would be rather difficult to provide advocacy services for. It would seem to me - I'm just trying to get your opinion on that I guess in terms like in intensive case managment part of the pie I guess we put in a half a million dollars there. It's supposed to be effective right about now - maybe it's not quite running yet. But, how are you gonna handle that? Are they gonna call you directly?

A. Well, actually I think what'll happen is they'll probably be directed toward Maine Advocacy Services. We can handle the - we handle the advocacy within the hospital and we try to work with Maine Advocacy Services in all matters; but probably they are going to be the ones who end up doing the advocacy for people in the community. We have in the mental retardation side

advocates - civil service advocates in the community and it works well. I think that - I think the Department is happy that they have those advocates. That we're much more likely to be able to do proactive kind of advocacy in those situations and get to the problems before they become deaths, etc. At this point I'd say - I'd love to have mental health advocates in the community. In truth it's a hole - it's one more hole in the system that we don't have the - there's nothing out there. I can't say nothing, okay, but there's not a whole lot. Statistically you're unlikely to get mental health advocacy in the community. And, it's just one more service that ought to be provided. But, I say don't - I'd have to say don't buy more advocacy at this point; buy services. People need the services more than they need the advocacy for the services.

Q. Thank you.

SENATOR GAUVREAU - Representative Boutilier?

EXAMINATION BY REPRESENTATIVE BOUTILIER

Q. Mr. Estabrook, I just have three questions. You made a statement that was rather curious and that was that AMHI is in crisis but not substantially different from two years ago. Could you just elaborate on that a little bit more? Do you feel it's basically that the staffing issue's been consistent all along and it's just not been addressed? Are there other things that you see have happened? Obviously we have had some changes.

A. Yeah. Even you guys are going to get tied of me saying

overcrowding and understaffing. I think that's been the major problem for the last two years and we noticed it in early '86 that - our - it's almost - I guess it's sad but it's a little laughable, too. We started filing grievances on this back when the ward population was like 44 for a particular ward. Now, it's 50 and we're happy that it's 50 and not 60. That's why I say that I think it's been in crisis since that census started going up in about 19 - late 85 is when I see the demarcation.

Q. You're clearly a patient advocate. You see that as your only and primary role.

A. Yes. Yes.

Q. Do you believe that the loss of Medicare funds or if there in eventuality was loss of Joint Commission for Medicaid that that would be a good sign to raise the flag that there was a diminution of quality care?

A. Oh yes.

Q. What do you think your role is in remedying that situation, if any?

A. Advocate for more resources I think is my role in order to fix that.

Q. Do you think loss of accreditation is a substantial change?

A. It's hard for me to answer that. Definitely it's -

Q. You see what I'm saying - if you admit that accreditation even of just one of those aspects. If we obviously lost all of them it would be a diminution of quality care for patients.

A. Yeah.

Q. But you made the statement that there hasn't been a substantial difference within the past two years.

A. Yeah, namely because that's because the test I use for quality of care isn't JCHO or isn't Medicare certification. I think those are useful -

Q. Expound on that. What do you -

A. What I believe is the only valid test for whether or not an institution or in fact a human services agency is delivering quality care to its clients, its patients, its residents, is whether or not - you have to go and look at the actual day to day life of those patients, clients, residents and see what is actually delivered to them by doing essentially what amounts to a typical day analysis and you find out what they are - what is actually delivered. What's useful to them in helping - in the AMHI situation what is useful to those patients that - or a particular patient - you do many of them but you get a pretty good idea just say doing ten, what is useful to that patient in terms of overcoming mental illness or dealing with mental illness or helping the person get back out into the community to deal with the issues that exist there. That to me is the only valid test. And, I think that I'm not alone in saying that. I think there are a lot of - other advocacy people and patient groups and parent groups would probably say the same thing, although I haven't checked.

Q. So you admit that it's a diminution to lose that accreditation but it's not necessarily a substantial change if these other things you talk about are in place.

A. That's correct.

Q. However, loss of accreditation does take up funds.

A. Yes.

Q. Takes up backlog.

A. Yes.

Q. And if your role as a patient advocate at the end and on the outset is to advocate for greater resources, obviously decertification affects that ability.

A. Yes. I would rather have it certified and getting the funds than not certified and not getting the funds.

Q. I guess I'm trying to reitorate what Representative Pederson said and also Jean Dellert and that is if you view as voicing your concerns for additional resources then you are concerned with decertification. How active has your role been in doing those things? And, do you feel it's been very active?

A. Well, gee, I think it's been active in trying to get other resources. I don't think it's been active in terms of directed toward getting certification. I really have done nothing in that regard. In fact, my interest I think is to if the hospital is recertified, if anything, my role is to make sure - is to try to make sure it's recertified fairly. That no - that inspectors see the hospital as I think it is actually there and not some

Potemkin* Village kind of hospital.

Q. In a yes/no answer, do you feel it's important to gain - to regain recertification whether you're directly involved in that effort or not?

A. I do. I do. Yes.

SENATOR GAUVREAU - Representative Manning.

EXAMINATION BY REPRESENTATIVE MANNING

Q. Earlier you had talked about the separations of I guess diagnosis, county, age group. First of all - a two-part question - do we have enough room over there to do that; and second of all, you gave a lukewarm answer dealing with admissions and the split of admissions asked by Senator Gauvreau. Can you expoun on that lukewarm answer? And, because you kind of went into age, diagnosis and location.

A. Yeah. I think that some kind of split like that architecturally could be done, okay. Unfortunately, at least from my perspective, the wards at AMHI do not lend themselves easily to splitting up. That it's gonna be hard to take areas and segregate out various areas - patient areas at AMHI and split them up into various distinct places where a patient would go with a certain diagnosis or a certain age criteria. I guess that's one of the main reasons long term that I think we ought to just not use AMHI. Long term I'd just say don't use AMHI. Long term I'd say maybe use AMHI for, you know, I could see - I guess -

Q. Let me ask you this question. Would it be better to rebuild or to build a brand new institution and utilize those buildings

*Spelled phonically.

as State office buildings?

A. I think it would be better - I think the best alternative is to do the involuntary inpatient units throughout the state in various areas.

Q. That's admissions, right.

A. Yes.

Q. What about long term?

A. Long term I think it would - you could probably get away with using say 100-bed space over there and still have office space. Even then it would probably be better to rebuild. That's expensive.

Q. So, if we did put the funds into communities and had admissions from Kittery to Fort Kent, as they say, and Calais to Rumford, what would happen is they would be stabilized there and if not and needed additional help then they would be transferred to AMHI for a longer term.

A. Yeah. And I think that that's -

Q. Let me ask you this. If that can't be done because we can't get the cooperation of the community hospitals or community mental health areas aren't willing to get into that, then we go back to the admissions at AMHI. What do you feel then needs to be done to split that off so that the continuity of services is continued? I mean, you talk basically about you really weren't enthusiastic about the splitting off. You said it could work, but what do we need to do to have the

continuity of services continued throughout the whole system if somebody is going to be admitted at AMHI? 'Cause I think if my memory serves me right, last week we talked about a 20-bed involuntary place located in the southern part of the state to deal with Cumberland and York. That still leaves nine counties that would be using AMHI as the involuntary admissions unit. What would we need to make you feel better if we look at splitting them off so that if a psychiatrist was working with Peter Manning today, he would be working with Peter Manning in a month or two after I had been admitted?

A. All within AMHI.

Q. Yeah. You're talking. I know what you want to do and I think ideally a lot of us would like to try to do that. I don't know whether or not there's enough interest in the community. I know there's probably interest in maybe the southern part of the State but I'm not quite sure there's interest in the - of the nine other counties. And, if we utilize AMHI for those nine other counties, what's it going to take to split them off so that a psychiatrist and the team approach or the medical approach, I guess is what Medicare is looking at, that approach goes right with the person all the way through the stay at the hospital. Do we need additional psychiatrists, social workers, RNs?

A. Well, I think in terms of what it would take, then I would say that the model proposed by ex-Superintendent Daumueller

would make sense. That you have people come directly to a particular unit that is probably, with some architectural changes so that it's not really - so that it's not a 60-bed unit but rather a 20-bed unit or a 30-bed unit, then you have a psychiatrist who is responsible for everybody on that unit. I think that that probably could be done by - the wards at AMHI are generally 'L' shaped and I think it would be possible - architecturally it would be possible to say put a wall and a door in a particular place along that 'L' and have a smaller unit and then have another unit somewhere else along the 'L' and then another unit. And, you could really design that however you want it just by making the - you could make them whatever size you wanted by making the - depending on where you want to put the walls.

Q. You feel comfortable with that. He's proposed it. It sounded, to me at least, like some - like a solution not the solution but part of a solution to deal with admissions. You are the advocate over there. Are we getting into something that we're not - it's not gonna - what do we need to make you feel, hey that's not a bad idea. You didn't say that was a good idea. You said well, ah, and then you went into diagnosis and county and age. You're a good politician I might add.

A. Why, thank you. The reason I'm lukewarm on it is that - I mean it's kind of a joke with the Superintendents. You get

in, you study the situation, you reorganize and then you get fired or you resign. I think it sounds to me like another reorganization effort that's not really gonna do a lot of good for people over there. It will do some good. But, in terms of what I really want, which is the more of a regional community based centers, I think that - you get into the question of if you go with a model like that in the long run, does it stimey further reform efforts toward putting people in the community.

Q. Let me ask you this. If we had a pot of gold, if we were the federal government with a 200 billion dollar defecit and we could print money, that idea would not be bad as long as the community-based portion of that was also increased.

A. I'm still lukewarm on it. It's not bad. It's better than what we have now.

Q. The present situation at AMHI I think you indicated 'we're in some type of a crisis over there'.

A. Yes.

Q. We devoted the last six days, five days - I don't know. In the Legislature you lose all track of time. Are we gonna come back this fall or later in this year, any time this year, and have a crisis at BMHI? What's BMHI like? I don't want to sit here and devote all this time to AMHI and then all of a sudden we get the rug pulled out from us from JCAH and BMHI.

A. Well, I, myself, have not sat down and read the JCAHO accreditation of BMHI. I hear from people who have sat down and read it that it reads something like you don't meet 101

standards but we're still gonna give you the certification. It seems like there's gonna have to be a lot of money spent at BMHI in order to get JCAHO accreditation the next time. And, I guess patient life at BMHI is - I guess one of the - it is a little bit amazing to me. You think that one institution would be pretty much the same as another institution in the same state - they're only 80 miles apart. And yet, there are some significant differences. It seems like the record keeping at BMHI is much better. The plans are much better. I think where you still have problems is implementing the plans because of the lack of the resources. But, in that regard it's the same - it's overcrowded but not as severely as AMHI. They've got a sleeper problem they refer to in which people have to sleep off of their home wards. They get their pajamas on and they're taken off to another ward. You know, they sleep in some other ward where there's a vacant bed and they go back in the morning. There are all kinds of problems with that system. They've struggled with it for two-plus years now - three years maybe. Is it a crisis? Not in the same sense that you have people - I don't think you're gonna get people - I don't think you're gonna get the heat-related deaths and deaths like that at BMHI. That's my sense.

Q. Because it's not at the overcrowding position that AMHI is.

A. Yeah and the overall census is smaller, new staff is now - you know, the 67 positions, some of those new staff are now on board. That seems to be being felt up there and for the

better. It's still a place with significant problems, but as far as being in a degree of crisis the way AMHI is now, I don't think it will be. I don't think that there would be headlines and things like that.

Q. Going back to your statement where you indicated that Medicare and JCH does not make you feel that we're getting complete care or the proper care, then if JCAH has indicated that there are 'X' amount of deficiencies, then that still doesn't make you feel that they're getting the proper amount of care. If we got through it we got through it because of the generosity of some survey apparently.

A. That's my perception, yeah.

Q. He must have been eating lobster from the midwest or something. So really, then, there is not a crisis but there's a real serious concern that we ought to be doing additional things also at BMHI to make sure that the level of care is brought back to something that you feel satisfied with.

A. I believe so, yes.

Q. Okay. You touched on something earlier that Everett talked about about families and parents. Because of all this that's going on in the last week, I had a parent call me whose son died over there last year. Until Thursday afternoon the person still didn't know why the son died, which distressed me because when the doctor asked to perform an autopsy, which Dr. Jacobson indicated last week that everything should be performed, any-

thing questionable, that we should have an autopsy and the parents of this individual said yes, perform an autopsy. You're tied up - first of all, should that go that line? I mean, does parents - you deal with patient advocates and I've got enough - I had another parent call me because her daughter is in Pineland and felt very much the same frustration that some of the parents that - or relatives that have people at AMHI and called me on that one. And, they both called the same day and it just struck me that there's things - there's the patient advocate; but where is the family of the - or the parent or something like that advocate? You know, there are people out there who don't know where to turn. For a parent to wait six or eight months to find out that they can call Representative Manning because they're concerned because they haven't heard back why their son died. Should there be an advocate for parents, for relatives, for friends? Just plain things like that. Not only at AMHI and not only at BMHI but even at Pineland where we have quite a few patients in all three locations and parents, they have to turn to a legislator. They've really gotten no answers elsewhere and they know that the legislator at least can probably try to cut through some of the red tape. Should we develop some type of system called 'family advocates' where they can call and find out why this happened or why that's happened or what is going on?

A. It's hard to say no to that, but that's what I would tend to say. Like on the autopsy, it's something that we would handle.

We'd be happy to go in and find out why is there no cause of death known yet. Actually, I've been in on some of those cases. I get the executor of the estate who happens to be a family member who gives me a call and says gees, there was an autopsy on this, why don't we know why she died. I've gotten in on that and tried to find out, tried to get Ryan's office to give me the information, etc.

Q. How -

A. So that kind of thing probably could be handled.

Q. How do parents know that? How do parents - we're dealing with the whole population. Very sophisticated people, very bright people have relatives and friends over there and people who aren't as sophisticated and as intelligent who have friends over there. How do you get around that where - you know, some people just pick up the phone and call Representative Manning and because it happened yesterday they'll pick up the phone and call Representative Manning. But yet there are other people, I'm sure, in my legislative district who let things go - and, this person wasn't in my legislative district. But, I mean there are people in every district who just let things go because they just don't know how to use the system. That's the most frustrating part I think of State government is people just don't know who to call, what to call and if that's the case, how do they have the ability to know that you're the patient advocate and they can pick up the phone and call you and say what's the story.

A. The only answer I can really say to that is try to advertise the service through communications.

Q. Let me ask you this. Would it be proper for the Legislature to ask that any time an involuntary patient arrives at AMHI that the guardian or the relatives are notified about the services of the patient advocate?

A. I think that would be proper, sure.

Q. So that they would know - in a letter - that if you have any concerns about your friends or relatives or anything, a patient advocate is there and do you have an 800 number?

A. No.

Q. Well, we can - but, that's one way of doing it. It concerns me because people just - some people may know that you exist and I think a lot of people who don't. For the first time all of a sudden their relative is in a crisis situation and is at AMHI.

A. Yeah.

Q. The next question - when you communicate with the Commissioner on a nubmer of different things - letters, memos - concerning investigations or anything like that, you had indicated that if it does go outside it has to have the name of the person and all that stuff off. But, we have a Commission on Mental Health. We have an executive director - or will be having and executive director. Should some of that stuff go to them also?

A. Oh yeah. I guess the problem is is that when the law was

written it didn't specifically address the issue of confidentiality; and there's already a law in the books pertianing to confidentiality of information; and technically, the Commission is no different than the general public, so therefore, to release information on particular patients to our own Commission is a criminal violation. Now, I don't think the Legislature intended that to happen, but it did. I think that in order to do its job the Commission has to be able to get in and get patient-specific information from the hospitals. And, I guess along with that goes the responsibility of the Commission to know about confidentiality and respect patients' confidentiality and not leak it.

Q. Well, the people - it seems the people they put on the Board this time around, I think quite a few of them have a lot of information and a lot of knowledge of confidentiality; and that's something I'm glad you told us because that's something we can address. Is there anything else that we should address that you - knowing fully well that this Commission was formed during the special session and there are a lot of times you have to come back - is there anything else that we should add to their agenda or give them permission? When we formed that we formed it so that they weren't under the Department of Mental Health and it was - they were another advocate group out there for both the community and the institutions. I'm just wondering whether or not we've left other things out that we need to address this session so that they can do their job.

A. One of their duties is to come up with standards for care within the hospitals and I guess I would probably talk to the people on the Commission before I would ask them if they wanted this, but to me that would mean - I'd be happier if the actual statute told them to come up, for instance, with patient to staff ratios that are minimum that the hospital has to meet. Things like that. Those are things that exist in the Pineland consent decree and I think that that greatly helps Pineland meet its obligations. And, I - to me when I read that law saying that they're going to come up with standards, I expect them to come up with things like patient to staff ratios; but I'm not sure that they read it that way. And, if you thought it would be useful - you as legislators thought it would be useful to have them come up with that, I'd maybe amend the law to tell them to come up with it. You look at all the evidence and you think about our situation here in Maine and you tell us what goals for patient to staff ratio we should have at our mental institutions. I think that's a very reasonable or legitimate thing for the Commission to do.

Q. If there's anything else please let us know because I think during this period of time we're gonna have growing pains and we'd like to get them off on a good start. Just for my curiosity, you indicated that - going back to my previous question about parent advocates and all this stuff - how many people over there, roughly, are under the State, are State wards compared to people who have relatives over there who

they would refer back - any questions that would be referred back to relatives?

A. I think approximately 50 people are under State guardianship out of 360 or so.

Q. There's quite a few over there, then, who do go back to - anything else would go back to the family.

A. I'm sorry. You mean DHS is guardian for about 50. I don't have a good figure off the top of my head as for how many people are under guardianship - under family guardianship. Just take this for what it is which is nothing more than a guess, and I'd say about a hundred.

Q. Okay. Last week we had heard - now that I have you in front of us - that in the fall of 1987 Pineland was in the process - or five hours away from losing Medicare. What's the situation down there and I mean, if we're five hours away from losing Medicare, are we - let me put it this way. This Committee's got other things to do and I just don't want to have a situation blow up in our face again on Medicare or other things. So, I'm just curious.

A. There's a world of difference between Pineland and AMHI. I've got to be careful when I - after I've been at AMHI for awhile and doing advocacy over at AMHI and I go down to Pineland. I've got to be careful about being too soft, too easy, because I think there's such a world of difference. You know, you go to a treatment team meeting and staff people are in there

saying you know, we don't have to put this person in seclusion. I think we can do something else instead of that. Something less restrictive. And it's just - it's really amazing to me the difference in the two institutions. I'm fairly well pleased with Pineland. It's an institution and it has problems that go with being an institution, but it's not in bad shape. I think that the - I think that if anything it's the mental retardation community services that are gonna be the next crisis in mental retardation. That - essentially, what I think is is the State has done a good job developing community resources for the mentally retarded people who are not so difficult to place out in the community. That they're moderately hard to place in the community, but that's been done and now it's a situation where you have people who are hard to place in the community and at the same time we pick up the - it's hard to hire people to work at mental retardation community facilities like group homes and things like that because the unemployment rate is low, the rate of pay is low. You make a lot more money delivering pizza than you can working with mentally retarded people. That's a - I think that's a major problem. It's not a crisis at this point. Whether it will be in the future, I don't know.

Q. But, do you know why - I mean, it got to the point where it was just those three slots that was gonna throw us out of compliance?

A. That's my understanding. I mean, I have to say that in my own mind I think HICFA was unfair on that one. That's just my perception. I didn't have a whole lot to do with that.

Q. But you also think that additional resources for the community - should we be looking at what we did in the fall by taking a look at the mental health employee - the workers out of state government. I think we gave them an across the board raise.

A. Yes.

Q. Should we take a look at that in mental retardation also because of the problem of unemployment?

A. Yeah, I think so. I think that's the root of the problem right there.

Q. If something isn't addressed then there'll be less and less people going into that.

A. Yes. And more and more turnover. And what happens is you train somebody, you get them up to speed. There's a lot of judgement that is necessary in dealing with mentally retarded people. Then they go off and get another job and you have to retrain somebody.

Q. Revolving door of employees.

A. Yes. Yes.

Q. Thank you.

SENATOR GAUVREAU - Senator Titcomb?

EXAMINATION BY SENATOR TITCOMB

Q. Following a little bit on what Chairman Manning said, I

have a couple of questions. As we uncovered different concerns looking in from an overview and trying to close in a little bit on some of the missing links or the weak links that we might have that are causing the real close on-hand problems in dealing with patients, it's hard for me to accept that simply numbers and overcrowding can be the problem. What I'm seeing is over and over judgement calls that are faulty. I have to question - first of all, I have to question the chain of command when decisions are made - especially those decisions that would endanger a patient's life. And, who are the people that are making these decisions, how qualified are they to make them, at what point do they feel it's appropriate to go to someone above them? Instance after instance I've heard contradictions. One instance, the patient was restrained. The next instance I hear the report that the patient wasn't restrained. Well, if the patient, particularly the burn patient, was restrained who issued that order? Was that person qualified to issue it? Did the actual situation of restraint bring about the patient's death? So, where are the missing links? Beyond the big picture - close up - where are the missing links that are causing the personal problems with these different patients? Was that patient restrained?

A. Yes.

Q. I was told several days ago that absolutely the patient was not restrained or confined. Now I find that the patient was restrained. Who made the decision?

A. The burn victim patient?

Q. Yes.

A. The burn victim patient was unquestionably restrained. I read the record myself. I saw restraint after restraint after restraint after restraint. Five-point, four-point, three-point, two-point restraint, hour after hour. One day it seems to me that sticks in my mind particularly was 23 out of 24 hours that the person was restrained, tied to the bed. Unquestionably, that person was restrained. And, when they weren't - when the person wasn't restrained with physical restraints, they were restrained with chemical restraints - Ativan 2mg., Ativan 2mg. prn, prn. You see that in the last ten to twelve days of his life time after time after time. That case upsets me a lot.

Q. Okay. So there's a doctor who investigated that case who tells me that that patient was not restrained - on record. The patient was not restrained. Where is the missing link? Is it the people that are restraining the patient? Where are the directions coming from? Who knows what the -

A. Well, yeah, who knows.

Q. Yet, that patient was said not to have died from heat.

A. Well, the autopsy was that he died of pneumonia. That's true. He died of pneumonia. But, I think there was a lot - and then you get into well, did the restraints hour after hour contribute to him getting pneumonia? That's where I was frustrated with the medical causation. I couldn't - it was

hard to get a medical expert to say yes it was - you know, this caused this or this caused that.

Q. So bringing it down very, very close to the actual situation, who made the decisions - not by name - but who are the people making the decisions that perhaps are not qualified, are not well trained, haven't been there that long, don't have the continuity? Is this not a root of many of the bigger problems? I would hate to see us add dozens of new people there to work and have just nothing more than dozens of new people making the same mistakes because there's no chain of command and the people that are being put in the position to make deicisons don't know what they're doing.

A. I guess when I think about this I think well, why was the person restrained? Okay. Why did they restrain him? What was the behavior that led to the restraint. Now, a little background. This individual - I did not know him well. I knew of him. I had seen him. My understanding of him is that prior to the summer he was doing pretty well. He was a gentle man. He was not a violent man, okay? He was - he could be troublesome at times like in the way that people can violate other people's personal space and he would come up to a staff person's face and demand something, okay? Something like that. But, in terms of violent, no he wasn't. He wasn't a violent man. Now, why then was he restrained. To me it comes down to overcrowding and understaffing. You have a patient who is

trying to get up, get out of bed. You have continual references to him getting to the floor - trying to get to the floor. Now, in my mind that is he was trying to seek the cool air on the floor. It was so hot in there that he was trying to seek the cool air. And, the staff reacted by saying no, you have to stay in bed and if you don't stay in bed on your own we're gonna restrain you, and they did. Then they got authorization - they asked the doctor for authorization for restraint. All restraints like that have to be authorized by the psychiatrist. The psychiatrists authorize those restraints. I think the psychiatrist should be in there asking questions. Is this restraint really necessary? Why are we restraining him? But, it's kind of done automatically. You need a restraint, restrain him. You get into quality of staff people definitely in that case.

Q. Containment of the problem.

A. Yeah.

Q. Rather than be analyzing the problem and dealing with it appropriately.

A. Yeah.

Q. So in that sense I could see that overcrowding obviously is a problem; but again, I have to question those people who are making the decisions as to whether or not it's appropriate to restrain a patient. Are the mental health workers being adequately trained to make many of the decisions that they're

making? I don't say this as any attack on mental health workers. I would hate to be put in the position to make a decision I wasn't qualified to make.

A. Yeah. I think people can use more training, yeah. I think they're not being adequately trained. I have to say that. And, that's knowing that there are a lot of good mental health workers there whom I respect, but I think that more training would certainly be helpful.

Q. Is there a well understood, well used chain of command on issues that are important?

A. No. For instance, in this burn victim's case, this is an important case. The man - the patient is obviously in a lot of medical difficulty, okay? Psychiatric difficulty or whatever. Somehow - I mean, psychiatrists are medical doctors. Somehow the man was in a lot of difficulty and everybody can agree on that. Yet, the psychiatrist was deferring to the medical doctor and the medical doctor was kind of wishy-washy and deferring back to the psychiatrist. It was not a clear - who's the doctor who's responsible for the care of this patient? That was muddled as muddled can be.

Q. So, it's not just crowding. It's structural problems also. Very clear structural problems.

A. Yeah.

Q. If - one question I've asked almost everyone who's up there and I will also ask you. I'm hearing contradictions that I'd

like to clear up for myself. The sexual abuse situation with the rape.

A. Yes.

Q. Did that person have a significant history of sexual misconduct?

A. Yes. I think so. Now, when you say sexual, I don't think there was actual like getting on a female and trying to achieve penetration; but there were definite - there was a definite history of kind of what I would characterize as minor molestation-types of incidents. Okay. And my understanding is the number is in the 20s or so. I did not go back in that case. I, myself, have not read that patient's record intensely in terms of looking at the numbers of incidents that were recorded in the day-to-day running notes. I did go back and look at the treatment plan for that individual to see what the treatment plan was and I know that in May of 1988 one of the problems identified was this inappropriate sexual touching; and yet there was no - what's the treatment for it? You've identified it in the plan. What's the treatment for it? There was none.

Q. Who will do it.

A. Yeah, that's the question.

Q. Who will actually fulfill that treatment.

A. Now, after - in this case I think there were two victims. Obviously, the woman was the victim; but I think the man was the victim just the same. He's under guardianship. And, there was something identified in his treatment team meeting that

was needed treatment. Yet, he didn't get the treatment all during that summer. And, even after the rape he - I don't necessarily know the correct methodology to treat sexual problems like that. I have an idea. The man's married and his wife is willing to sleep with him, and why not just get a room and call it good. After the rape, okay, and we're saying what are you doing to treat this fellow. He has three or four meetings with a social worker who is not necessarily - who's well meaning, but who's not necessarily trained to do any kind of sexual counseling or anything like that. And then he goes back onto the ward, supposedly with checks, and gets into another incident. Fortunately not as serious, but I guess it raises real questions - it's a good example of the quality of treatment that's delivered.

Q. What would you say is the most common method - if I were to go in the hospital, I would assume that I'd go in, I'd be diagnosed, I'd get a treatment plan and hopefully I could one day expect to get out and to lead a normal life free from, or at least as free as possible, from my affliction. What is the most common method of treatment for patients?

A. This is a slight overgeneralization, but only a slight. The only method of treatment at AMHI is drugs. Okay? That's it. There's not much else there.

Q. So you're saying that other than being a very, very slight overgeneralization, the only method of treatment for patients at AMHI is drugs.

A. Psychotropic - monitored psychotropic medication. You see it a lot in the treatment team records. Continue large ration of psychotropic medications. Quote, unquote. That's it. That's - when you boil it down, that's what the treatment is.

Q. I think that's a very far cry from the public perception of what AMHI as a State mental institute is providing for our mentally ill. I have been running across people that said what do you mean, all that's going on there is delving up whatever medications will supress the present condition. People are under the impression that patients go in there for treatment. Being treated, receiving therapy with an intent of resolving some of their problems. So, basically, that's not happening.

A. Yes. And when we try to test that, we try to figure out how much treatment are they getting we ask ourselves and we try to look into it. And, you do the typical day and you get maybe three to five hours a week would be the average. And you get some people who don't get any. Some get a little bit more.

Q. What's a typical day? You've mentioned typical day a couple of time. What would you describe as a typical day for a patient?

A. You get up at a certain time - usually about 6:30 or so. The staff knocks on your door, gets you out of bed. You go and you eat breakfast. You have exercise time, as it were. It's not much. It's on the ward. Nobody exercises as far as I can tell, or not very many. You have something like a morning meeting with patients - get together. It used to be called

quality circle. You get together and talk with the other patients about ward issues, things like that. You hang around on the ward most of the time. If you have privileges you go off the ward, you go down to the canteen and get a cup of coffee, smoke cigarettes. If it's a nice day you go out on the grounds and walk around, if you have privileges to do that. You eat lunch. You hang around on the ward some more in the afternoon. Maybe in the course of a week there's a - you might go to an AA meeting, or if you're substance abuse you might have a group therapy session for an hour, maybe three hours a week at the most. Sometimes you have actual one on one time with a staff member to talk about problems, but it's once or twice a week at the most. That's my perception of it. That's about it. I don't - you line up to get your medication at the particular when you're supposed to line up and get medication. It's - mostly what you see there is down time. I always am saddened because I get this tremendous sense of wasted time in there. Nothing much is happening in these people's lives. Some people go to GROW workshop. That's nice. Some people go to ARC - the activity resource center. But, you ask the activity resource center how many people are coming this afternoon and they'll say 31 or 35 or something like that. That's seven, eight, nine percent of your population. What are the other guys doing? They have GROW workshop and a few go there, but there's not a whole lot going on.

Q. Just a couple more very brief questions. How frequently have you seen Commissioner Parker on the ward floors?

A. I personally have - I don't think I've seen her - I don't think I personally have seen her at all. She's told me that she goes over there sometimes, but I've never seen her there.

Q. When you send your reports, is it not true that you used to send them directly to Commissioner Concannon and now you send them -

A. To Associate Commissioner Welch, yes.

Q. So, this is via Ron Welch was at whose request?

A. Susan Parker's.

Q. So you no longer have the opportunity to send your reports directly to the Commissioner. They have to go by way of Ron.

A. Yeah. I think I could - I could have sent them to her directly. I could just go ahead and send them to her directly. Since she asked me to send them to Ron, that's who I send them to.

Q. Do you have any sense that the reports that Mr. Estabrook - excuse me - I'm getting too many names here.

A. Tom Ward, the former patient advocate?

Q. Yes. Were those done with the same routine? Those were sent to -

A. Associate Commissioner Welch, yes.

Q. Okay, that's all. Thank you very much.

SENATOR GAUVREAU - Are there other questions? Representative Cathcart.

EXAMINATION BY REPRESENTATIVE CATHCART

Q. You referred to the high burnout and turnover rate of your staff; and also I believe I heard you say that not all incidents, including some patient altercations, even get reported to you, is that right?

A. That's correct.

Q. I'm concerned, then, whether all the patients - every patient or patient's family that requests or needs some advocacy actually gets to speak with an advocate.

A. I would say they probably don't. I'm certain that they don't. There must be - I think if anything we operate on a principle not by choice but the squeaky wheel gets the grease. If you call up the advocate and demand advocacy services you're much more likely to get them than if you don't demand them.

Q. Have you had a meeting or directly talked with the Commissioner about this problem and the need for more advocates?

A. I don't believe so. I talked to Ron Welch about it. Actually, I asked for another advocate at AMHI and BMHI both in the budget, but it didn't make it.

Q. When did you ask for that?

A. In the fall.

Q. Did you - or, do you have some proposal steps that should be taken that you could tell to this Committee to make sure that every patient who perceives the need for advocacy gets some form of advocacy?

A. I think that letting people know on the wards through the staff training - I think just practice and through poster advertising, etc., that there's an advocate available - that's extremely helpful. I think that the problem that we run into is that one person can't handle the job. You get so many requests you can't do it all.

Q. Are there posters up now on the wards informing the patients that they can phone?

A. I don't think so, no.

Q. That would be a really good idea. I also like Representative Manning's idea of the 800 number and somehow informing families that there's somebody; but then as you say, there wouldn't be anybody to help them.

A. That's the real problem. You have to have somebody there to actually do the work and sort out the problems.

Q. How long have you been in this job?

A. Three and a half, almost four years, about three and three quarter years.

Q. On the burnout level, say from one to ten - one you're cool and ten you're fried, where would you say you are?

A. Well, I don't feel burned out at all. I think it's - fortunately I was a legal services attorney before I did this job and I think I went through a certain degree of burnout there and know what the symptoms are, know more or less how to deal with it. I'm happy at this point and I'm not burned out.

Q. Okay. Thanks.

SENATOR GAUVREAU - Are there other questions of the Committee for Mr. Estabrook at this time? If not, do you have any final comments that we have not touched upon directly in the course of our questioning this morning?

A. No. It's much more thorough than I ever expected. I thank you for the opportunity to speak to you.

SENATOR GAUVREAU - At this point, then seeing that it is now nearly quarter of twelve, I should ask that the Committee use this occasion to break and then reconvene at quarter past one this afternoon. This will be for the purpose, of course, of hearing the presentation of the Maine Advocacy Services and, time permitting, we will also hear from the Department of Human Services. If we don't reach that this afternoon we will hear first thing in the morning at nine o'clock from DHS. Thank you very much.

HEARING ADJOURNED AT 11:45 A.M.

VIII

STATE OF MAINE

HUMAN RESOURCES COMMITTEE

Hearing on Augusta Mental Health Institute Issues held on February 6, 1989, in Room 113, State Office Building, Augusta, Maine.

Carmen M. Thibodeau

TABLE OF CONTENT

Augusta, Maine
February 6, 1989
1:30 p.m.

SEN. GAUVREAU - At this point we'll reconvene the Committee hearings. I apologize for the slight delay in getting underway this afternoon. A question has arisen among relatives and families of patients receiving care at AMHI. Basically we've been asked to open up the hearings to allow for these individuals to make presentations to the Committee. The concern that we have is that we know we're under a fairly strict time table to make a report - recommendations to the Legislature and, frankly, it will be difficult and it might even be arbitrary in terms of who we hear and who we do not hear and this is a very painful and sensitive area, because I know the people who are vitally involved with AMHI have a very keen and a very appropriate desire to assist the Committee in its deliberations. And I think that it's difficult to truly accommodate that request in its entirety.

What we will recommend is that we will, so to speak, keep the record, if you will, open until Wednesday of next week and allow for people to communicate to the Committee by means of written correspondence and we will instruct the clerk of the Committee and work with the Legislature in terms of trying to publicize that so that people will have an opportunity to correspond with the Committee and we feel that by - in this mechanism we probably can conserve the Committee's time, but also at least allow some form where members of the - the relatives and the family, people who are currently or in the past have

received care at AMHI, give them an opportunity to communicate their concerns regarding conditions or patient care or whatever or, for that matter, accept their praise as far as items which may be going well at the institution. But we'd like to hear - we recognize the very important contribution these people can give to the Committee, but what should be explained I think at this point is that the Committee, within the next week and a half to two weeks, will begin a very arduous round of hearings on legislation. We expect to receive 80 to 90 bills this year and many of them will be very intricate, complicated. We think that even if we work long days and nights, we'll be in Committee until late May or even early June, so we have to establish certain time frames so the Committee can complete its task in a reasonable fashion. So that is what we will do. We will entertain and keep the record open to receive written comments from members of the families and I wouldn't limit it to families. I think anybody who wants to correspond with the Committee certainly can do so, but we'll take written comments from anyone who is interested in sharing their views or perspectives with the Committee and we will proceed today to receive the presentation of the advocates and then we will go on probably tomorrow to receive the testimony and presentation of the Department of Human Services.

Tomorrow, as you know, we have a joint convention scheduled for the state of the judiciary address by Chief Justice McKusick which is calendared for 11:00 a.m. tomorrow and so Peter and I

will request once again leave of the leadership in both chambers for the Committee to convene at 9:00 a.m. and be excused from attendance at the 10 o'clock session unless there are roll calls in which case, of course, people will be excused to attend to their voting responsibilities. And with a little bit of luck, hopefully we'll be able to finalize the hearings late tomorrow morning.

Rep. Hepburn.

REP. HEPBURN - So are we going to continue having hearings while the Chief Justice is speaking or -

SEN. GAUVREAU - No. What I said is that we would, in fact, come in at 9 o'clock and go until 11: a.m. And, as you know, the Maine Development Foundation is planning its south/central tour which will take part Tuesday to Thursday of this week and some members may be somewhat delayed, I hope they're not, in terms of catching up with the tour. And so if all goes well, hopefully we'll be able to finish the Committee hearings as of 11:00 a.m. tomorrow morning.

With that we will now go on to the next scheduled presenter, that being the Maine Advocacy Services and the Director of that entity is Laura Petovello and I'm very pleased to welcome Laura today for the purpose of making a presentation to the Committee.

MS. PETOVELLO - Thank you very much. My name is Laura Petovello. I'm the Executive Director of Maine Advocacy Services and I thank you very much for this opportunity to speak with all of you.

I have sat through every word said during these hearings and am quite frankly appalled by much of what I've heard. You are not yet getting the whole story of what's going on at AMHI and the extent and nature of the problems and I hope that I and Tom Ward, who will also be testifying for Maine Advocacy Services, will be able to fill in some of that information for you.

The materials that we brought along with us are the correspondence between my agency and the Department of Mental Health and Mental Retardation and the Governor's Office. Not included in there are two letters that we received from the Governor's Office, but if you'd like to see those we'd be very happy to make copies available. I've also included a draft of proposed recommendations that we have been talking about for the last several weeks and this is the first time it's been written up, so I wrote "draft" on there, because I'm sure that we will be fine tuning that, but I will go through the outline of that today, but wanted you to see the much more detailed thinking that we're doing and have included a summary of my testimony.

I've also prepared an outline of information that I think is important for the Committee to hear and would like to cover much of what's in here. I know that the Committee is under some time pressure. I hope that if that's acceptable with the Chair that that's what I'll be able to do. I would also encourage people to ask questions at any time.

What I'd like to cover is who we are and what we do as an

agency; that will be quick. The chronology of our interactions with the department; that will also be quick. Some additional information about the deaths this summer, including a fourth death that has not been discussed at all.

SEN. GAUVREAU - Can everyone hear Laura in the back of the room?

MS. PETOVELLO - Okay, we'll try this. Some additional information about the deaths, including a fourth death that has not been discussed at all. A summary of our findings and a summary of recommendations.

Maine Advocacy Services has been around since 1978. We're a private non-profit corporation that was originally set up under federal legislation to advocate for people with developmental disabilities. Until this November we were known as Advocates for the Disabled and some of you might have been aware of us under that name. We are primarily federally funded, although we also receive some state funding including a small contract from the Department of Mental Health and Mental Retardation and a small appropriation directly from the Legislature.

In 1985 Congress conducted investigations across the nation into conditions and institutions and state hospitals and found a terrible pattern of deaths, abuse, neglect, lack of treatment, all of the things that we've been talking about at AMHI over the last few years. In response to that, in 1986 Congress passed a statute called "The Protection and Advocacy for Mentally Ill Persons Act" which gave the existing P&As, protection and

advocacy agencies, additional funding to advocate for people with a mental illness who live in a facility. Richard said earlier today that when community problems and problems in the community came to his attention, he would refer those to our agency, but I want to make it clear that the federal legislation limits us to advocating for people who are in facilities where they are receiving care or treatment. That's defined very broadly. It can be a public or private hospital, nursing home, boarding home, a shelter for the homeless, but for people who are living independently in the community, we cannot, under that statute, advocate for them, unless they are within ninety days of discharge. So there continues to be - even though we have some money to do advocacy for folks in facilities, there continues to be a very large gap in terms of advocacy in the community.

The priority in the legislation for us is to investigate complaints of abuse and neglect and deaths are defined within the definition of abuse and neglect. The statute gives us access to facilities and records, including access without consent when we have reasonable cause to believe abuse and neglect has occurred or we get a complaint of abuse or neglect or the person is a state ward or is otherwise unable to give valid consent. That's a really important piece of the legislation, because without that we would have had a very difficult time investigating the deaths this summer.

The legislation also gives us the authority to pursue all

administrative and legal remedies on behalf of the people who are covered by the act. We are now receiving $152,000 in federal money for doing this work all over the State of Maine in all sorts of facilities. It went up this year from $125,000. Our program includes part of my time, one-half of an attorney, a full-time program director who is Tom Ward and a full-time advocate as well as support services such as secretarial services.

The first two years of the program we contracted out a significant portion of the mental health work. In November of 1988 we brought almost all of it in-house, so it's only been since November of this past year that the program was fully staffed.

Helen and I - Helen Bailey is the attorney - managing attorney for the - for our agency and is the attorney assigned to the mental health program. Helen and I learned about the two deaths that occurred on August 6 from Tom Ward and the next day Helen brought them up at one of our regularly scheduled meetings. We were sufficiently worried that that day we met with Tom outside of the hospital. It was apparent that there was some sort of problem with the heat. We went to a hardware store and bought thermometers. I remember the earlier testimony that they didn't have thermometers at AMHI - it was not difficult to get them, they were $1.50 apiece - and took them over to AMHI and measured the temperature there. Seclusion and restraint rooms at one o'clock in the afternoon, which is not the hottest time of the day, were over 95°. We toured AMHI and read the records of the two

men who had died earlier in the week. While we were walking through AMHI we were also informed by an employee there that a third man that morning had collapsed apparently from the heat. That was the man who went into a coma and subsequently died. It was apparent to us from the beginning from that first day that the problems at AMHI were much more than the heat.

Problems had to do with either no medical care or inadequate or inappropriate medical care and fundamentally unsafe conditions at the institution, as well as very major confusion on the part of treating physicians between medical symptoms and misdiagnosed psychiatric symptoms.

I called Ron Welch at the Department the next day to inform him briefly of what we had found and to ask what the Department was doing about it and Ron told me that AMHI had an internal investigation procedure and they were waiting to see the results of those investigations.

On August 19th I sent a letter to Commissioner Parker, the Governor, Richard Estabrook and Adult Protective Services and we have a copy of that letter. It's a nine-page letter, it's a long letter, and in there we gave our findings, asked a number of questions that weren't answered by our reading through the record and made some initial recommendations, including as #1 a request for an independent assessment by outside evaluators, a physician, a nurse, psychiatrist, a psychologist, folks who could look at the people who had died, the man who at the time

I believe was still alive, and help us understand what had happened.

I met with Adult Protective Services staff who said that they were sufficiently concerned by what we had found that they were immediately initiating an investigation of their state wards and we worked well with them throughout this. And on August 29th I met with the Commissioner. It's been my only individual face-to-face meeting with the Commissioner throughout this. I don't know whether Commissioner Parker had read the letter at that point. She put her copy on the table and asked me to tell her what was in the letter. So I summarized the findings, summarized the recommendations and at that point the Commissioner turned to me and asked me whether I believed in the importance of data and I said yes, because I do believe in the importance of data. And she said that there was no attempt to cover up anything, but that she needed data before she could make any decisions and when she had that data she would be taking appropriate action.

I tried as much as I could to stress the urgency of the problem. At that point we knew that a third person had died and so there were four people who had either died or were close to death and really pushed hard for an independent investigation as well as some interim steps, staff training, air conditioning units, those kinds of things. The Commissioner would make no commitment to the action that she would take or time lines for action, even

though I specifically asked for time lines.

In September staff worked on the legislation for the Mental Health Commission and I also testified at the Appropriations hearing for the $6.5 million in additional funds. I testified in support of that. At that time I told the Appropriations Committee about the deaths and about our concern regarding medical care and about the need for an independent assessment. I was chastised for stating the problems too strongly and for making statements that only a physician could make and the Committee asked for the Commissioner's response at that point. The Commissioner introduced Dr. Jacobsohn and said that he'd been hired as the medical director and she also said that there had been four deaths in August did not mean that the deaths were related, that they had eighteen to twenty deaths at AMHI every year, which is the same testimony that you've heard.

There was no response to our request for independent medical investigation as time continued. So at the beginning of October I asked the Maine State Alliance for the Mentally Ill and the Portland Coalition for the Psychiatrically Labeled to join us in writing to Governor McKernan to ask for a meeting to press for additional investigation. The Governor wrote back saying that he was indeed very concerned and was working closely with the Commissioner and asked us to work with the Commissioner and about a week and a half later we were all invited to the Commissioner's office to hear about the results of Phase I of

the investigation. Phase I of the investigation was Dr. Jacobsohn's findings that, gee, it had been hot at AMHI during the summer, which is something that everyone knew, and that the doctors there didn't really take into account the effect of psychotropic medications and heat, which is something that was apparent to us the day that we learned of the deaths.

After pressing they said that they were indeed going to have an independent assessment. I asked to be notified of who was going to be appointed to that and also asked to meet briefly, I said a half an hour would be plenty of time, with the panel members to talk about our concerns about medical care and about confusion between medical symptoms and psychiatric symptoms. Never received any response to those requests. We also asked that the other two deaths be investigated and did not receive a response to that request.

We assume as advocates that when we begin to see a pattern of problems that we are seeing the tip of the iceberg, that two or three deaths or two or three particular kind of problems means that there's probably more - a lot more of the same thing in the facility that we're looking at. That's an assumption that I have never found to be false. And so when we received DHS' report in November, that just confirmed our fears that there were indeed institutionwide problems at AMHI. So it was not an isolated problem. When we received the panel investigation, the results of that in December, which confirmed quite strongly the problems

with medical care, our position on that was also confirmed. I really encourage the Committee to not only read the full report of the panel, but to also look at the individual reports by the cardiologist and by the nurse, because those are the two people who most focused on medical care and they've had some very strong things to say about medical care at AMHI in their individual reports.

Never received a response from the Commissioner. Again in January, and I believe you've already seen that letter, wrote to her again saying that we are continuing to see the same problems at AMHI and asking for a response and I have not yet had a response.

In looking at the deaths, the themes that we picked up was, first of all, that there was significant confusion of medical problems with psychiatric diagnoses, or in this case misdiagnoses. Second, there was either no treatment or inadequate treatment or inappropriate medical treatment. Third, there was no behaviorially oriented treatment planning or actual treatment for people and, fourth, the physical environment is just simply unsafe.

For example, I thought about this a lot. I'm going to use the names of the residents here who died. Those names are in the public record at this point and so that we are all clear, because there's been some confusion in the testimony as to who is talking about whom. Four of the deaths that summer, the official cause of death was pneumonia, so it gets confusing.

Mr. Poland died in a coma from heat stroke. He had been admitted to AMHI with a psychiatric diagnosis as well as a history of alcoholism and he was in the adult living program. On August 5th he began complaining of the heat and on August 7th staff began noticing what they called bizarre behavior, picking at strawberries printed on a tablecloth, trying to light the wrong end of a cigarette, stumbling and falling down. On August 10th Mr. Poland was transferred by Dr. Rohm, his treating physician, from the adult living program to a unit in the main hospital for non-compliance with substance abuse treatment, even though there was absolutely no indication in his record, and staff said in his record that they did not believe he had been drinking. He was transferred with no transfer notes, no followup, no nothing. And the next morning, early in the morning, he had a temperature of 106 which rose to 107 when he was transferred to KVMC and he went into an irreversible coma and died several weeks later.

Mr. Bolduc also had a psychiatric diagnosis as well as mild mental retardation. He had been in and out of AMHI a number of times. At his last admission his admission note as well as the treatment team notes said that he was not a danger to himself or others, period, flat out, and that he was at AMHI only because there was no other place for him to go. Nevertheless, he was receiving extremely large doses of both Thorazine and Prolixin, 1200 mg. of Thorazine a day, 200 mg. is the maintenance dose, and 45 to 50 mg. of Prolixin a day, up to 10 mg. of Prolixin is

the maximum recommended dosage. He had poor teeth. Medication over time can damage people's teeth, psychotropic medication. He bolted his food and he had a quite substantial weight gain during the time of his last admission to AMHI, but there was no treatment for that. On August 2nd he had complained of pain and was given Tylenol and on August 6 he said he didn't feel well. There was a note in his record that he felt hot to the touch. He was having some difficulty breathing, although he was walking. And when he went back to his room the staff person he talked to immediately called the doctor. She responded immediately when he said he didn't feel well. When they got to him in his room he was having difficulty breathing. He then vomited and aspirated his vomit. They had a real difficult time getting him out of the hospital because of his size, so even though the rescue unit was called right away, it was some time before he was transferred to KVMC where he was basically dead on arrival from choking to death. Dr. Costellanos was the medical examiner in this case and Dr. Costellanos saw this apparently was death from natural causes, so no autopsy was done, so we do not know what caused Mr. Bolduc to become ill and to die.

Mr. Isaacson, and this is a very, very difficult situation to talk about. Mr. Isaacson is the man who had been burned. He had a diagnosis of organic effective disorder and I never know what those kinds of diagnoses mean. But basically at AMHI even

though there were staff who were very fond of him and cared about him a great deal, he was seen as a behavior problem. His record is replete with notes that he was causing problems for staff. At one point the note in there said, patient had been increasingly pesky and intrusive into other's face. When he would do that, they would put him in seclusion rooms and lock him in the rooms. Sometimes his behavior was called violent, although if being in someone else's face, being in the staff person's face demanding attention is violent, then I don't know what that term means.

Because he had been badly burned, there were notes in the record that he couldn't tolerate the heat and towards the end of his life those notes began to take on a rather desperate quality. I mean, there were nurses and workers there who really recognized that he was in trouble. Air conditioning was prescribed for him towards the end of his life, but it was never provided. I think it would be a very interesting question to ask the Department where they got the air conditioners they put in AMHI after these two deaths. I was at the Department in June and the day that I was there they were delivering crates of air conditioners into the administrative offices of the Department of Mental Health and Mental Retardation. My understanding is - and this is fifth hand information - my understanding is that they were not installed because the wiring in the building could not take the air conditioning units. But in June the Department

was - staff in the Department were hot and they got air conditioners.

Mr. Isaacson was on a laundry list of medications, including Lithium, Darbine (phonetic), Cogentin, Dilantin, Mysolene (phonetic) and Ferrous Gluconate. On July 15th he was locked in a seclusion room pounding on the door and screaming. He was there throughout the night. At 6:00 a.m. he was found with a temperature of 106 and he was transferred to KVMC. He was at KVMC for a week. While he was there they got him medically stablized and they got him off of all of his medications. At the end of the week, he was transferred back to the infirmary at AMHI where he was immediately placed on all of his medications again. And basically from July 23rd on he was placed in one, three, four or five point restraints almost constantly until he died. He was transferred from the infirmary to the unit on July 27th with the notation that his behavior was terrible. The restraint orders continued back on his regular unit. On July 30th there was a note in the record that he was hollering out God help me while he was tied down to his bed. By August 1 he was weak, lethargic and he only responded to deep stimuli and he was transferred back to the infirmary where the restraint orders continued. On August 6th he had a temperature of 106 and he was transferred to KVMC where he died two hours later. The cause of death was pneumonia. The AMHI death review on Mr. Isaacson exonerated the doctors involved and Dr. Jacobsohn was quoted as saying that he "felt the hospital did an excellent job with this patient over the years." That finding was

contradicted by the advisory panel findings.

We obviously became concerned when we received that internal investigation in September and realized that Dr. Jacobsohn was now the medical director for the Department. And we are still concerned that Dr. Jacobsohn as well as the rest of the Department does not recognize or won't admit the problems at AMHI and those problems continue.

For example, one of the deaths that Dr. Jacobsohn chose not to have investigated - and this woman's name has not been released, so I will refer to her as M. M was admitted to AMHI on August 4, 1988, from a general hospital. Her admitting diagnosis was a bipolar disorder. No medical conditions whatsoever were noted on her admission sheet. The admission staff saw her as a behavior problem, so there were some orders for seclusion for her and eight days later she was transferred to Stone North Middle. This is on August 12th. On August 19th there is a note from Dr. Rogers in her record and this note is central to what happened to M, so I'm going to quote it in its entirety which won't take long. "Patient is maddeningly indirect in describing her complaint. Pain in left side. I can say after trying to examine her that she is probably deluded in this particular complaint. I would suggest use of" and at that point the entry completely stops and there is no further entry. Then there is an entry in the record that said the note was completed on 8/26, which was four days after her death and the note goes

on to say, orders for Crineral (phonetic) were written on 8/19 because I feel that she was trying to tell me that she was being bothered by her arthritis. There's an unreadable word, chest we heard only her usual wheezes. The next note was on August 22nd where M appeared for her treatment team meeting that morning. She was observed as having obvious difficulty breathing with cyanosis. She was quoted as saying that she was scared stiff about her medical condition. She was evaluated by Dr. Costellanos, transferred to KVMC where she died that day. The treatment team finished her plan in her absence and said that this patient needs more encouragement and motivation for improvement of mental and physical well being. Her discharge summary by the hospital on August 22nd says that - and remember no illnesses were listed under her admitting summary on - just sixteen days before - bronchial pneumonia, emphysema, asthma, myocardial hypertrophy, hypertension and diabetes. She had an autopsy and the autopsy found that she died from respiratory arrest due to pneumonia and that the entire lobe of her left lung was consolidated. Remember, she had told Dr. Rogers three days before that she had a pain in her left side, but, after all, she was probably deluded in that complaint.

What's not in the record and what was told to us by Tom Ward who was the patient advocate at AMHI at the time is that no one saw her to do a substantive workup until Pat Heavy who is a nurse at AMHI who had been on vacation saw her that morning in the

treatment team meeting. Heavy immediately called Costellanos who told her that he would see M when he had the time and Heavy told him to come and see her right now and that's how she got to be transferred to KVMC at all. When she arrived at KVMC they immediately tried to do a tracheotomy, but she died during the procedure. Dr. Stringer, the treating physician at KVMC told Tom that he never said this kind of thing positively, but in this case he could say that if this patient had received adequate treatment just two days before, she would still be alive. This is one of the cases Dr. Jacobsohn didn't see fit to have reviewed by outside physicians and I don't find that surprising.

SEN. GAUVREAU - Could I just break in here at this point. I might not have heard you correctly, but I want you to correct that, you said that the attending nurse when she noticed the condition of Ms. M, she contacted Dr. Costellanos. Now is Dr. Costellanos a - is he on contract with Kennebec Valley or is he a staff physician at -

A. He's a staff physician, not a psychiatrist, a medical doctor.

SEN. GAUVREAU - I understand. And now, what is the quality of your understanding that the doctor refused at that point to see the patient and indicated when he had time he would see her.

A. My guess is that he was busy.

SEN. GAUVREAU - No, I'm not - I asked what was the quality of your evidence. How did you determine that?

A. I would have to ask Tom how he knew that. I believe that it

was told to him by Pat, but I'm not sure about that either.

SEN. GAUVREAU - So you have no personal knowledge, but you understand this from Tom Ward.

A. Yes.

SEN. GAUVREAU - Okay.

A. That part that was not in the record we learned from Tom.

SEN. GAUVREAU - Okay.

A. These sort of problems continue. I mean, that's a horrifying list and every time I read through that I'm horrified again.

Problems continue. I mean, you've heard about the rape in some detail at this point. In December while reviewing records, Alfred Lund, who's the advocate for the program, came upon a record of a woman whose treating physician and psychiatrist were changing her medications on a day-to-day basis. They were countermanding each other. So she was just being bounced back and forth in terms of the medication that she was receiving. In January the same woman fell. She complained of the pain. It was one and a half days before she was x-rayed and she had a broken hip.

Another woman on the same unit who, because of her illness, tends to be self-abusive was on one-to-one staff/patient supervision, which was discontinued even though she was continuing to hurt herself, it was discontinued to fifteen-minute checks. She now has a detached retina. Both of these happened on the senior rehab unit, which you heard people testify is the unit at

AMHI with the highest level of medical care and supervision.

On Friday, this past Friday, I received a call from a family member who was incensed by what the Commissioner and others from the Department had been saying in the newspapers. The same woman called Sen. Gauvreau, so I can tell you what she said. Her mother has been at AMHI for about two and a half months. They tried to have her admitted to St. Joseph's, but St. Joseph's didn't have any available space. It was the daughter who called me. The daughter said that simple medical problems are not being treated and I quote, the daughter thinks it is pathetic that they don't - that you have to be on their case and scream and yell or they don't do a damn thing. Her mother had been punched by another patient and the family was told that her mother was x-rayed, but this was apparently not true. After a few weeks at AMHI her mother looked so bad that her daughter did not recognize her when she walked in to visit her. And after that happened her daughter began going to AMHI to be there every weekend to both observe what was going on with her mother and to advocate her - advocate for her as well as other family members who have become involved.

This woman told me that weekend activities are a joke. The list of activities for public - the list of activities on the wall are for public consumption only and it is her feeling that - well, this isn't her feeling - when her mother was admitted to AMHI she was told by the treating psychiatrist that her mother

would be receiving other treatment than drugs, but that hasn't happened. And the daughter's feeling is that they see her mother as a chronic patient and there's not any point in doing anything for her other than getting her stabilized and out of the hospital as quickly as possible. The family asked to attend a treatment team meeting and were finally allowed to do so. And while they were there, staff and the family sort of chatted about what was going on and the family kept waiting for something to happen and then the treatment team meeting ended and the family left. And the daughter who has some experience in working in residential facilities understood quite quickly that that just wasn't right. And so the next day she called the treating psychiatrist to ask why no goals were set and he said, oh, we did that after you left. That is not an understaffing problem. Staff were there at the treatment team meeting. The entire family was there and the treating psychiatrist did not see fit to involve the family in treatment at AMHI and assistance in getting this woman out and back home.

Most disturbingly this woman told me that there was a lot of violence on her mother's unit, that she was there one day and she saw a man who had been badly beaten up and she assumed that he was a new admission, but he was not. Her mother had said to her that the fights on the unit are unreal and that her mother fears for her physical safety. This woman's final comment to me was that nobody wants to know about mental illness. If this

were happening in the general hospital, the public would be incensed and would not allow this to continue. And I think that that's probably a very fair assessment of what's happening at AMHI.

Our findings - and this is somewhat condensed, there's a lot more information in the materials that you have. One year after the notice in last February that HCFA would decertify this hospital, AMHI is no closer to better care now than it was then. It continues to be unsafe. There continues to be violence on the wards. There continues to be bad medical care. There continues to be a lack of other treatment. Conditions there are not changing.

Secondly - and no one has wanted to talk about this and this is indeed difficult to talk about, but the problems at AMHI are much, much more than understaffing and overcrowding. There are significant problems with the quality of the staff, particularly the medical staff at AMHI. That's not to say that there aren't really good people who are working very, very hard under terrrible conditions because that's absolutely true. But they have real problems with the quality of their medical staff. Look at Dr. Jacobsohn's actions in all of this. Dr. Rohm, who was the clinical director during the time of all of these deaths, is now not only the clinical director but the acting superintendent. The panel - the advisory panel noted a number of problems such as lack of clear roles and responsibilities, lack of medical

procedures, lack of internal reviews and confusion between medical and psychiatric symptoms that don't have a whole lot to do with understaffing. We really believe that simply putting more money into AMHI without dealing with the attitudinal problems there and without dealing with the quality of some of the key staff is not going to mean much of a change for that hospital, which means that it's not going to be much of a change for the people who live there.

Third, initially we thought that maybe the problem was a lack of policies and procedures and protocols and all those sorts of things and even those are lacking and in some ways they have a lot of paper. The problem isn't just the lack of paper, it's just the lack of direction in telling people what to do. Their paper is not enforced. It's truly just paper policies.

Fourth, the Department at all levels from the Commissioner down is having a very difficult time telling the whole story about what's going on at AMHI and does not seem to understand the problems there. In sitting through these hearings as well as in our own advocacy with the Department, we have many examples of this. I was simply astounded to hear the Commissioner testify on the first day that she worked closely with Maine Advocacy Services. This simply isn't true. We've had a really terrible time trying to get information from the Commissioner's office about what they intended to do to address the problems that we were seeing. The Commissioner testified that there is indeed now

a crisis at AMHI and it's a management crisis. She may be having a crisis because of inaction during the last year, but that crisis was caused by the real crisis, which seems to be unknown to the Department and that's the crisis of lack of treatment, unsafe environment, lack of medical care, poor staff, it goes on and on. And until that crisis is recognized, I don't see how there can be any improvement. You can't address something when you're not even aware of a problem.

In preparing for my testimony today - and I won't go through this, but I made a list - I've taken extensive notes and I made a list of all of the actions that the Commissioner has proposed to address the problems at AMHI and those actions are very weak. Things like giving training to 44 staff and how to write better behavioral objectives and treatment plans. What we've heard is a lot of talk about past planning, current planning and future planning and now the need for an objective outside assessment to tell her what's wrong at AMHI and how to fix it. I don't question the need for some assistance in what to do, but a lot of people for a long time have been pointing out problems at AMHI to the Commissioner's office.

The Commissioner's stand through all of this has been to insist that the residents are safe and that AMHI is improving every day, improving every day is a quote. What we see is that it's taken pressure from the Office of Advocacy, Maine Advocacy Services, the Maine State Alliance of the Mentally Ill,

Portland Coalition for the Psychiatrically Labeled, DHS, HDFA, the advisory panel, the Probate Court, the press and the Legislature to even get this story out and at this point we have no confidence that the Department can deal with the problems at AMHI.

And, finally, I'd like to talk for just a minute about the fifth point that I want to bring to you which is that institutions themselves are just plain wrong. They don't work. They didn't work in the past, they don't work now and they will not work in the future. To say that institutions are wrong and that you don't need them doesn't mean that people with mental illness don't need acute care or at times 24-hour supervision outside of a hospital setting, because that's undoubtedly true. Institutions are characterized by their size and the more people you have gathered in one place, inevitably the more problems you have, that people are expected to stay there for a significant portion of time and that people sleep, spend their days and recreate all in one place and that services are provided all in that place. Those are the essential characteristics of an institution. Problems unique to an institution are that they are a closed system. They are a little world onto themselves and it's really difficult to know what's going on in such a closed system. In addition, people are congregated together from many different parts and placed in an isolated setting which increases how closed that system is.

It's really difficult to know the people that you're caring

for. One of the things that Helen says all the time is that not only do they not know what they're doing, they don't know who they're doing it to. When you have people in and out and you have staff in and out and you have shifts and you have staff turnover, it's really hard to know who it is that you're trying to take care of. It's wrong to make people leave their community and family in order to get support through what is, after all, a health problem and that's what institutions do. They break people's connections to their family and to their community.

It's unrealistic to expect people to learn to cope with problems of life in such an artificial setting. And if you think about that one it makes so much sense that it's undeniable. Places like AMHI provide your food, provide your clothes if you don't have any, structure your days somewhat, basically you sit around there, but structure your days somewhat. Your laundry is done for you. You interact with a small number of people who are paid to be there and then the person is released and expected to go back home and have everything be okay and that's just an unrealistic expectation for anyone, let alone someone who is grapping with a mental illness.

And, finally, staff and residents develop institutional behaviors which would not be tolerated in other settings. Those become the norm in an institution. It's really difficult. In fact, I personally believe that it's impossible to break those

attitudes in an institutional setting. These problems can't be fixed. They're inherent in the model. They've been noted for the last forty years. You see the same problems in every institution in the country, including ones that have been built in the last ten years, so that you have a beautiful physical plant, but you have the same problems in terms of patient care. I've worked in four different states. I've toured more institutions than I care to think about and it's getting boring, ten years after I started this work to be here - to be at this kind of setting once again talking about problems in institutions.

And, finally, everything that happens at AMHI can happen in another setting. I mean, there's nothing that happens there that can't be done in other ways in other places.

The recommendations that we would make to you is, first of all, to completely and totally support the creation of a constellation of community services with the person at the center and the person's needs driving what services that person uses. By constellation we mean that there needs to be lots of different types, because people have different needs at different points in their life. The needs of an eighteen year old who is first diagnosed with a mental illness are different from someone who is thirty-five and wants to have a job. It's really important, also, as community supports are developed that there be consumer and family and advocate involvement in the creation of those plans. Consumer involvement is particulary important. We have

a lot of hope for the Mental Health Commission and have been real encouraged by their interest and actions so far, but there are no consumers on that commission. There's no one on that commission who has experienced the mental health system first hand and that's really too bad.

Secondly, it's absolutely true what you've heard that there needs to be double funding while there is a transition from institutional base services to community base services. We can't forget the 370 people who are at AMHI and so this is a real expensive proposition and there isn't any way around that.

Third, around AMHI specifically treatment planning needs to happen for everyone and what's planned for needs to be actually delivered. There needs to be discharge planning which, as Richard said, is non-existent. There needs to be a treatment orientation that looks at the whole person, not as a person - as a bundle of needs that are determined by the mental illness, but the entire person and that attitude isn't at AMHI right now. And around that there needs to be aggressive and sophisticated staff training for all staff to not only train on concrete things, but to work on people's attitudes, to help staff see people with mental illness as whole people who have a variety of needs and have the same desires as everybody else.

There needs to be a new top administrative structure and we recommend a superintendent, a medical director and a clinical director who is a psychologist or clinical social worker and that

person would be responsible for the treatment of people at AMHI.

In terms of medical care we strongly urge that medical care be contracted out, that doctors be found who will come in and treat people or take people to the hospital and treat them there rather than relying on staff physicians. At this point, the staff physician system at AMHI has so totally failed, we don't believe that it's redeemable.

In addition, there needs to be sufficient nurses to meet JCAHO standards. There needs to be staff training institutionwide on medical needs and there needs to be a complete assessment of the medical treatment needs and pharmacology, the drugs people are receiving, by non-Department, non-AMHI staff within the next six months. That should be done on every person there. We've been asking for that since August. And the model that should be used because we think that it's worked quite well and DHS has done a really good job with this is what DHS has done with the forty-five state wards. They've done a good job and the same teams that were put together to do that should be looking at everybody at AMHI.

In terms of the environment, the unsafe conditions need to be corrected. There's a lot more information than this in the long handout that you have. We suggest resident to staff ratios in there. Seclusion and restraint needs to be looked at or there needs to be staff training to reduce the uses of those. And,

monitoring, and this is always a tough one, because it really is hard to know what's happening. We suggest, at least as a beginning step, that the Department send monthly reports to this Committee, the Mental Health Commission, the Office of Advocacy and us on conditions at AMHI and the steps that they have taken that month to correct the problems. There needs to be increased advocacy resources and I won't go into that now, but I would certainly welcome any questions about that. And perhaps most importantly of all, I hope this isn't presumptuous, it seems to me that one of the problems here is that no one has publicly recognized the problems at AMHI and I hope that if nothing else that this Committee has heard enough to make a statement about the problems at AMHI and to make a strong public statement that it's the public policy of the State of Maine that the State will not tolerate poor care or inaction at any level. I guess what I'm saying there is that it's time for someone to exercise some moral leadership here and that sometimes that's the most important step of all.

Thank you. I know that was a long presentation and I appreciate your indulgence and would be happy to answer any questions you may have.

SEN. GAUVREAU - Thank you for your presentation, Ms. Petovello. Why don't we start questioning counterclockwise now, starting with Rep. Boutilier.

EXAMINATION BY REPRESENTATIVE BOUTILIER

Q. That was a very comprehensive package and I'm glad you brought it today and I wanted to get back to some of the things you mentioned early on and then get to the end of the issues. And I wanted to ask you the same question that I asked Mr. Estabrook. He said that AMHI was in crisis but not substantially different from two years ago. Do you differ from that position?

A. From what I've heard - I've been in the state for eight months so I don't have a personal history going back. From what I've heard, what everyone has said that the Commissioner inherited significant problems. I think that that's real true. I think that the inaction on the part of administrators the last month have made things much worse - over the last year have made things much worse.

Q. Do you believe that the Medicare certification, the loss of that, possible in the future - hypothetically if you lost Joint Commission certification, therefore Medicaid, that that would be a statement to you that quality care had lessened?

A. Yes. I was really struck - I didn't read the HCFA report until after notification of the first two deaths and I was really struck by their statements in there about the three previous deaths. I mean, there have been eight deaths in 19 - unanticipated deaths in 1988 and beyond the paper problems and the understaffing problems, I thought that they did a pretty good job of pointing out that people were in some danger at AMHI. And so to answer your question, yes.

Q. Do you feel that it's absolutely appropriate for any kind of

quality care and changes that recertification would be very instrumental in part of that process?

A. I've been impressed the last couple of years, not only in Maine, but in other states, by HCFA's much stronger stance towards monitoring. Commissioner Parker testified last week that there's been a shift in their approach and that's been a response to Congressional pressure and I think that that's true and that's been real good. So HCFA seems to me to be particularly important to be certified by, because not only is it money, but they also are beginning to look at important things. JCAHO has a reputation of not being an aggressive monitoring body and there is substantial documentation and I believe this personally from personal experience that their certification doesn't mean much in terms of quality of care. It does, however, have big implications for funding and that's real important.

Q. Do you think that they've tried to change in recent months that stance in that they're becoming more aware of that perception and that they're trying to address in terms of becoming a more quality of care oriented certification process?

A. I think that they are now aware - they're under some heat and so they're obviously aware of that. Whether they'll change, I don't know.

Q. What do you feel your role is and if you feel you have a role to play in helping recertify the facility, that's the first part. And do you also feel you have a role - what do you feel your

specific role is in making sure quality of care is provided?
A. Okay. I don't - I haven't thought about the first part of your question and my initial response would be that we do not have a role in certification other than to point out problems that we see, so that the State can address them. But I would need to think about that some more.

In terms of our specific role as an advocacy agent - agency, we are an external agency. We're separate from State Government and the limits on that is that it's harder - it's much harder for us to get information, for example, than an internal agency such as the Office of Advocacy. So part of our role is to have good - a good solid working relationship with internal advocacy agencies, which we do have with the Office of Advocacy, because that helps us to know what's going on.

The second part of that is because we are outside, we have much greater freedom of action than people who are working within a system and so I see a big part of our role as trying to understand as clearly and as well as we can what's happening for people with disabilities and bringing that to the attention of anyone who will listen to us. And then as part of that trying to think as creatively as we can, in part by knowing what's going on in other parts of the country, to make recommendations about how things can change.

The second part of our role - and this is really the bedrock part of the agency - is to do individual representation for

people who fall within our enabling legislation. So beyond putting together reports and doing those kinds of things, we actually represent people one on one.

Q. Do you feel part of that process is similar to what Mr. Estabrook said that his role might be to advocate additional resources?

A. You bet.

Q. In regards to resources, would you agree that the loss of certification obviously makes it harder for him to get additional resources, that we end up taking those monies that maybe would go to beefing up the program to pay what is then a shortfall or to remedy the certification problem?

A. Absolutely, without doubt.

Q. So the purpose of my question obviously about your role is that maybe in the future the advocacy would see those certification issues being something they could be as concerned about as they are the patient issues, although it's been sort of an overview issue. It also affects the ability to get additional resources and that was the purpose of my -

A. Yeah. See, the limit that we have, although we have a lot of assets in a lot of ways, one of our limits is that we don't have any authority to make the Department change anything, so we can bring problems to their attention, but ultimately we can't do anything if they refuse to take action other than to sue them. I mean, that's our ultimate authority.

Q. Let's talk about that, because I thought you were really detailed on a lot of your assessments of some particular cases and I had tried to do some of my own background work on some particular cases and one in particular I tried to question Dr. Rohm on and I never really got satisfied, so I just stopped the questioning. But it concerned an issue and a patient maybe you were familiar with. Are you familiar with the drug Sorental (phonetic)?

A. No.

Q. There was a patient that was listed - it came out of the public sense in the paper, although the patient's name was not listed, who did not die, but was on 600 mg per day of Sorental which was an anti-psychotic drug used primarily for the treatment of alcoholism, and I began to ask Dr. Rohm about that and he refused that that drug was even used for that and I've referenced both the PDR and the nursing '89 books on that issue. Now, I was under the impression in both of those volumes stated that the maximum dosage per day was 300 mg. This individual was at 600, was then documented to have been making sexual comments to staff and other various issues, then later on was off those drugs for a period of four days. Now I'm not aware whether that person - the reason they were off, they had gone to the hospital or not. You mentioned a case where a person was taken off drugs. Be that as it may, four days later they were then put back on the drug at 900 mg. Now, to me it was really a shocking

thing, one to see them at 600, let alone to see them after these other things have been documented, to see them go to 900. They were clearly delusionist, they were disoriented, they were documented to have fallen asleep in the bath - on the toilet, other things. And I was trying to get whether there was a connection between their statements as a female patient to male people on the staff and the connection between that and the dosage of the drugs. Now, I know that that's - I'm inferring a lot there. I never was able to get answers to that. But you had several cases that you were talking about, where there was exorbitant dosages.

A. Yes, all of them.

Q. Of medications and I was trying to lead to the point that there was a pattern of excessive use of medication. Now, could you just - I know you mentioned a lot of statements, but beyond the people who have died, have you seen a clear pattern of excessive medication use?

A. Yes. And I would ask Tom Ward more specifically for that, because I personally haven't looked at that many records, but -

Q. But you do have access to it.

A. We do have access to it and I'm very confident in saying that over-medication is the norm. It's not an exception.

Q. And have you pursued this in the sense of going to - beyond your own realm of advocates and talking amongst yourselves, have you gone to Ron Welch, have you gone to the superintendent,

have you gone through documentation, letters, personal visits, what have you, to the Commissioner and said, I see a pattern of overuse of medication at this facility. Excessive, I mean, 300 to 600 is excessive, 300 to 900 is completely excessive and the levels you mentioned in your cases of people who actually died which then clearly would have been investigated during the times of investigating the death they would have seen was excessive use. Have there been any discussions forthcoming about those statements or have you mentioned it at all?

A. We questioned the level of medication in the first letter, the August 19th letter to Commissioner Parker, and so the Commissioner's office was on notice at that point if they didn't already know. To be real honest, over-medication is so prevalent that it's really difficult to even know where to begin on that issue and that's definitely an issue that we're going to take a look at now that we have staff in the program. But that's everywhere and so that's a hard one to get a handle on.

Q. Has it been used in your opinion, and I know this is an opinion, you're not a medical doctor, been used to alleviate some of the pressures of understaffing because if you over-medicate, people may be a little easier to deal with in some cases.

A. In my opinion, yes.

Q. Do you feel that this enough of a case and you're going to look into it more. Are there some cases where clearly we're talking about unbelievable negligence or are we talking about

something that's used throughout the United States as a way to deal with patients or are we talking about something that maybe is unique to the situation at AMHI and might not occur at BMHI or the other center and that we really have to take a long hard look at the use of medications at that facility.

A. I've worked - as I said, I've worked in four different states. All of them - all of the facilities, including facilities for people with developmental disabilities had significant over-medication issues. There've been studies. It's not unique to AMHI. I mean, it's nationally, one of the features of institutions that in order to control people in what is essentially a chaotic setting, you have to tranquilize them to - I mean, their use is tranquilizers. You have to tranquilize them to a very high level and when you have facilities such as AMHI, which has a real understaffing problem - and I don't mean to minimize that by saying that that's not the only problem. It's hard to get away from the inclination to over-medicate people anyhow to control them in this artificial setting, so it's not unique to AMHI. It's every place. One of the things that you run into as an advocate is this business about, you know, doctors are making clinical judgments and who are we as advocates to be questioning those. I mean, it's really - it's really a difficult problem. It's one of the reasons that I think that institutions don't work. It's hard to get at.

Q. I appreciate your comments at the end about that -- philosophy.

Two more quick questions. One, you mentioned that we needed more nurses to deal with the Joint Committee on Accreditation and I mentioned several times and I felt it's not been addressed in the current budget and that we're going to end up dealing with it at a later time, so it's under your impression that we are going to need a significant boost of nurses to deal with that accreditation and we might lose that as well.

A. I think that there's a real risk. One of the things - Helen is real good at thinking forward and she started to talk among the staff several - well, I don't know how many weeks ago, that the Department wasn't being forthcoming in the extent of the problems in part because they weren't discussing JCAHO accreditation and that it was our understanding that this Committee wanted to know the full extent of the problems and they weren't bringing that up and we were very concerned about that and were really glad when that began to come out because even though the accreditation itself might not mean much for patient care, it has really huge other implications for the facility.

Q. Well, I think the commission has spoken about that on -

A. Absolutely.

Q. It's fairly obvious that the Department has not taken any direct stance to resolve any possible affects of that later on down the road and I think the staffing is the most prominent of all of those issues raised and we might -- with in October or November, but it's clear that right now we know about that.

A. Yes.

Q. And my last question is this. I've talked about certification issues, I've talked about those specific patients, things - some of which you enumerated, and so forth. The last one I want to talk about is management because clearly a good portion of this - the testimony we've heard is talk about management style, the effectiveness of the communication between various branches, and so forth, and you mentioned and I think rather diplomatically you're frustrated with the way information is forwarded and you're frustrated as to the importance of the information. You have provided and your colleagues in the advocacy role and how that's been accepted by the administration. You've mentioned consumer membership on the Mental Health Commission. But other than that, what other things do you think could be done to make the advocacy role more important and more cooperative between all the groups involved and so that we can avoid - if we ever get to the point where we're past crisis stage and we're in a pretty stable thing - position and we want to make sure those types of crises don't happen again, it takes everybody working together, advocates, what have you, what kind of things should we set up to make sure that happens? What kind of changes should we make, if any.

A. That's a really good question and I - and to be real honest I haven't thought about it much. I will say to the Department's credit that we have not had any problems getting access to

information and that's been a real problem in other states and when we ask for something they'll send it to us. And I've been very glad that we haven't had those kinds of problems.

Q. But once you receive that information and you're making evaluations based on the information -

A. We don't get a response back. I don't think that there is a way that we can force a response other than to make the problems and the lack of response as public as we can, although that's not always my -

Q. And that's where you mention maybe sending the reports to us and sending it to other groups and other entities.

A. I also think that the Mental Health Commission is really a key to this, because it's a group of people with a diverse - with diverse backgrounds who are looking specifically at mental health problems and so that if they are getting all of the information and I - they have been very open to us as advocates and to the Office of Advocacy. Tom and I are going Wednesday to meet with one of the subcommittees, the Subcommittee on Institutions, and they're going to invite us to talk with the whole Commission. We've offered to and then they've accepted or at least David Gregory has accepted to send them a monthly report of what we're seeing. And so I have some faith that they will pay attention and we'll be reporting to the Legislature and to the Commissioner's office which will help to open this up. I mean, so on the short term at least, without thinking about this more, we're going to try

to work with the Commission as much as we can, given our limited resources, so that they have the information also.

Q. Make that a vehicle that you want to use.

A. It seems like a logical one to at least try.

Q. Thank you.

A. So we're going to try it.

SEN. GAUVREAU - Are there other questions? Rep. Hepburn.

BY REPRESENTATIVE HEPBURN

Q. Thank you Senator. Laura, when you were going through the case studies of the three deaths, I was kind of semi-following along on the August 19th letter and it seemed like a lot of what you were saying was kind of half way coming out of there. I don't know if you referred to it yourself. Have you got it right there? Do you have that August 19th letter?

A. Yes.

Q. Just something I wanted to look at here as I was thumbing through it, it kind of stood out at me. On page 8, #19 there at the top of the page, those recommendations.

A. Okay.

Q. Question, excuse me, that's Question 19. It says according to Mr. Bolduc's family and AMHI staff, Dr. Costellanos looked down Mr. Bolduc's throat and determined that the cause of death was aspiration of vomit and signed the death certificate. An autopsy was not performed. What's the law on autopsy now? Do you know what it is? I don't know.

A. I read it last August and I might need some help from Helen here to remind me of what it is. I believe that the Medical Examiner - that an autopsy will be done by the Medical Examiner's Office if they're informed that someone did not die of natural causes, that autopsies are not required by law. Dr. Costellanos told the Medical Examiner's Office that Mr. Bolduc had died of natural causes and, therefore, Dr. Ryan decided, based on that information, that an autopsy did not need to be done. We asked Adult Protective Services to check into that and they referred these deaths to the Medical Examiner's Office.

Q. I see. I think this issue did come up earlier when Dr. Jacobsohn was here last week, he mentioned that there was a time when they had - all autopsies were required, I think, when someone died at AMHI. This was several years ago, I guess, and that's no longer the case, I know, but I think -

A. Yes, it's no longer the case.

Q. He expressed a desire to go back in that direction. Do you think that's something that's reasonable or -

A. I think that autopsies should be done when people die in the care of the state, yes.

Q. Okay. Good. A couple of other things though. Did anybody from your group testify before the Commission on Overcrowding that was going on in the fall of '87, do you know? I know you weren't there then probably but -

A. Helen just said that she did not and she would have likely have

been the person. I don't believe that anyone did.

Q. I see.

A. But I can't say absolutely.

Q. No one was invited or just no one was able to get there or it wasn't the proper forum?

A. I couldn't tell you that.

Q. Okay. Have you had a chance to look at that report at all or - the Commission on Overcrowding? There's a lot of stuff you have to look at -

A. I looked at it when it first came out, but I -

Q. Okay. There's some interesting things in there. That's all that - everyone has been talking in the last few days about additional staff for AMHI and the need to reduce census and the relationship that that has to a beefed up community network which we do not yet have. Although the report kind of had two areas in which to go, there was a subcommittee on staffing at AMHI which indicated that understaffing was a problem, but in the summary of the report in general it said that the continuing lack of community resources and the solution to the present problem cannot be to provide additional beds. I guess - how do you read that? Do you think that's the case, we should not - you seem to even advocate the abolition of AMHI. Is that what I heard?

A. That's right. I think it should be phased out.

Q. I see. Okay. I think you are the first person who's actually said that.

A. Well, I've taken some flak for it from various parties, but I really - I've been doing this work for ten years. It will be ten years June 1st and there is nothing in that ten years experience that has led me to believe that institutions can be fixed or made to be safe places where people are actually assisted.

Q. Okay. In terms of the term crisis in management at AMHI has been kicked around a lot in the last few days and you mentioned a number of problem areas that you saw which you did not necessarily categorize as a crisis in management such as medical care I think you mentioned and psychiatric treatment and there was a few others that I didn't write fast enough to get down. But does it not follow though that if there is a crisis in management that oftentimes those other types of care and treatment might suffer as a result of that, record keeping or whatever?

A. Sure. I mean, management flows throughout an organization. The underlying crisis though that's not a management crisis is an attitudinal crisis, how people are perceived, how the residents of AMHI are perceived and unless that changes, you could bring in whomever you want to run the place or have different people in the Department and nothing will change.

Q. Okay. Good.

A. And so to the extent that managers can work on changing that, that's good, but I haven't heard any recognition that there's a real attitudinal problem there.

Q. Okay, thanks. That's all for me.

SEN. GAUVREAU - Rep. Dellert.

BY REPRESENTATIVE DELLERT

Q. Thank you. Thank you, Laura. Were you aware that there was a state mental health plan mandated by the 113th Legislature?

A. Yes, and I looked through that also when it first came out.

Q. Were you or your organization involved in any of those public forums that were held around the state where roughly 1,200 people that came to all those different forums.

A. I don't - the previous executive director might have been involved in that, but he was gone by the time I arrived.

Q. So you wouldn't know.

A. I wouldn't know.

Q. Would you have thought those were good places for airing some of the things that you're advocating? I wondered if any of your thoughts were aired in any of those forums.

A. In terms of phasing out AMHI, I don't know whether people talked about that. I think the public forums are always a good thing as a matter of practice. So I'm not sure that I'm answering your question or not.

Q. Wouldn't you think though that that was a good stance on the part of the - stand on the part of the Department, the Commission Department to do things like that, that that would be a helpful thing to go around the state and getting -

A. Absolutely. I mean, I think that one of the things the

Department is good at - is probably good at is planning. It's just that they don't seem to be taking the next steps.

Q. What are your credentials? Are you a social worker or -

A. I'm a lawyer by training.

Q. Lawyer.

A. I haven't practiced law for a long time and never intend to practice it again and over the last ten years I've done a lot of things, community organization, training, a lot of - I've always worked for protection and advocacy agencies, so the entire ten years has been doing this kind of work, but in different roles.

Q. But not in the medical - you're not -

A. I'm not a medical professional, no.

Q. In your letter of January 13th you were saying that overcrowding is -- the problem, but some of the issues raised by the investigation were not caused by the lack of money or staff. For example, communication among staff daily to establish care roles, transferring of patients, definitely communication between staff, who would handle all of that? Who's really responsible for all those things?

A. Communication is always difficult to have in an organization regardless of the size. You need to have both formal communication mechanisms, regular times that people meet to talk, as well as informal - well, records are part of the formal mechanisms as well as informal talks - and it seems at AMHI that people don't

talk to each other very much about what they're doing and I don't know how to solve that.

Q. Where does that come from though? Where should that come from, all of that? Where should it start?

A. It should come from the expectation that people need to communicate in order to provide appropriate care. I mean, I - if I'm understanding what you're getting at, when people are really busy, it's - you don't have the luxury of sitting around and talking as much as you want. But my organization, even though much smaller, we are all very busy and we work hard at trying to keep each other apprised of what's happening and that's because that expectation is there.

Q. Yeah, but shouldn't it come down through the different levels, starting at the top and coming down so that all communication -

A. Sure, it needs to be both ways. It needs to come from the top down and from the bottom up.

Q. Yes.

A. Absolutely.

Q. And I think that's - I think the Department has faced that and is looking at it and that was the reason for the administrative change, I think. They are at least thinking of how all those communication skills can be put to good use.

A. Hm-mm.

Q. And bring about a better patient attention, and so forth, I just feel that you're right, that we need to look at the people

that - in the whole issue. But if you're thinking of closing out AMHI, many people have stated that community based spots are very, very expensive. We're talking about millions and millions and millions, aren't we? When you talk about breaking down and setting up all these different units all over the State of Maine, which is huge as far as geography is concerned.

A. I don't feel really qualified at this point to talk about this definitely in terms of how much money it would cost. It is undeniably expensive. Running AMHI is extremely expensive.

Q. Yes.

A. It's all expensive. There are, however, ways - and other states are doing this - ways to set up good programs that watch the dollars as well as good programs that don't cost a whole lot of money for what you get. Mr. Daumueller talked about that some when he talked about Wisconsin. They've had - they've developed a very interesting model for how they were going to provide services, including lots and lots of incentives to keep costs down and the incentives to keep costs down also mean that it's better to provide community services for people, because hospitalization is the single most expensive treatment choice.

Q. Right.

A. And I was part - I led an evaluation team for a community mental health program in one of the counties in Wisconsin and it was really an interesting experience. It was a very rural part of the state. They weren't doing so well in some things,

but they were doing, very, very, very well at keeping people out of the hospital. It was very rare for one of the folks there to go to the hospital and they said that if their local community hospital would take even one or two people when they were having an acute episode of an illness, they would never need to send anyone to their state hospital. And it was less expensive to hire some staff to provide support than to send folks there a couple of hundred miles away to the state hospital. So there are people really working on that.

Q. Yeah, I think this is what we're looking for is to establish good status wherever we can throughout the state.

A. I was impressed by Jay Harper.

Q. Yes.

A. I mean, I listened to that, too, and was impressed.

Q. Thank you.

SEN. GAUVREAU - Are there other questions? Senator Titcomb.

BY SENATOR TITCOMB

Q. I just have a couple of very quick questions. You mentioned that when you spoke out about your concerns about what was going on, you were chastised.

A. Yes.

Q. For speaking out. May I asked who chastised you?

A. Sen. Pearson.

Q. The other question is concerning the air conditioning which seems to be my fixation over the last few days. You mentioned

that offices had air conditioning and some of the office buildings had them. Do you have - I was quite surprised to find that there was a sudden influx of air conditioners to the wards during that hot spell. What has your perception of what took place with the air conditioners and the fans. Where were they located in the wards? Were they on the floor, were they in the offices?

A. Okay. At the time that we were there in August the medication rooms were air conditioned. The rooms where medications were kept neuroleptic meds. Those were air conditioned and they need to be air conditioned because that medication spoils and then you can poison people basically. Those were air conditioned. We didn't see air conditioning in any other parts of the hospital, although Dr. Jacobsohn testified that there were two other areas that were air conditioned, so there could well be. We just didn't see them. There were fans in the common areas. They're sort of day rooms, you know, with individual sleeping rooms and hallways radiating off those and there were fans in the common areas for the residents. I didn't see, because I looked for the fans in any of the individual sleeping rooms and those were quite warm or fans in any of the seclusion rooms, which are really warm. And they have small windows. They'd open windows, but they have small windows. And one of the things about heat is that in the building the hottest part - the hottest part of the day is not necessarily around noon because of how

buildings attract heat and then radiate it out later, so the hottest time - this is true for our homes, too, if we really think about it. The hottest times are early evening till around one, two in the morning when the building begins to radiate the heat back out in response to the temperature. So my guess is that when people went to bed there at night they were pretty warm. And, in fact, the people who collapsed from excessive heat all collapsed in the early morning hours.

Q. So as far as you know you do not recall that toward the end of the summer after the deaths that there was a sudden influx of air conditioners throughout? I was under the impression that there were quite a number of them and, in fact, Chairman Manning made reference to how surprised he was that they had found air conditioners because I couldn't find one and there were notices that they were out of supply everywhere.

A. I would guess - as I said, I don't know for sure. I would guess that the air conditioners that were installed were the ones that had been purchased for the Department - not AMHI's administration, but the Department of Mental Health and Mental Retardation's administration over in this building in back of us or right above us, but I don't know that for sure. And I also don't believe - Tom would know this for sure, but I don't believe that there were fans in the common areas until after the first two deaths.

Q. Okay. One more question. I was under the impression that

the patient who had been burned and then went on to have such trouble during the heat, that one of the thoughts was that when he was continuously leaving his room and exhibiting this aggressive behavior that, in fact, there were times that he was trying to get into one of the offices where there was a fan. Are you aware of that?

A. Yes. That's what I was told. He was trying to get into a staff area where it was cooler one of those times. He was trying to do a lot of things to cool himself off.

Q. Thank you very much.

SEN. GAUVREAU - Are there other questions of the Committee? Rep. Burke.

BY REPRESENTATIVE BURKE

Q. Thank you for coming and testifying today. Some of your statements have been - I'm sure you realize are really strong. I'm just trying to get a real clear sense. A lot of the qualities of staff concerns that you have you brought to Commissioner Parker?

A. In the last - we asked a number of questions in the first letter about the medical care that was provided, questioning the quality of the medical care, and I'd have to look at the last letter - the January 17th letter. I believe it's in there. There are - well, we were talking about medical care problems from the beginning. It was also in the October letter. So it was from the beginning, there were medical care problems.

Q. Did - I mean, did you also bring them to Superintendent Daumueller when he was there?

A. No. All of our communication has been with the Commissioner's office with copies to the Governor's Office and other agencies.

Q. And that's the correct form - the correct vehicle that you're supposed to follow?

A. We don't have a correct vehicle. It's just that I've found it the best to not go - when you're dealing with urgency to not go up the chain of command, to start at the top.

Q. Okay.

A. And so I made a decision from the beginning that we were not going to talk to ward staff or talk to the superintendent, we were going to go to the top as there was a very urgent situation.

Q. And to summarize - to summarize your dealings with the Commissioner, you would say that she was resistant - how would you characterize it?

A. I wouldn't say that she was resistant. I mean, she would listen and sometimes take notes and then not commit to anything.

Q. Okay. And that was done time after time or -

A. I only met with her face to face once.

Q. Okay.

A. And - I mean, she listened and when I began to make some specific recommendations she wrote those down and I really urged at the time - I really asked as strongly as I could to know what they were going to do and within what time frames and she told

me that she needed more data and that she was busy with the Legislature and she'd get back to me when she could.

Q. You've obviously - you obviously have dealt with a number of agencies throughout the years because that's exactly the way I would handle them, too, when are you going to do it, when shall I check back with you, all those kinds of things. Your concerns about Dr. Jacobsohn and Dr. Rohm, were they ever answered to your satisfaction?

A. I have never - we have never gotten a response from the Department, other than the response in a letter on September 1 where I learned that two physicians had been referred by the Department to the Board of Registry of Medicine and there was a one-page memo from Mr. Daumueller to staff about training around heat and that's the only response - I shouldn't say that. We were also invited to the meeting with your - the Phase I findings, an interesting meeting. Those were the only two times that I've gotten any response. I mean, I've - at this point, when I wrote the letter on January 17th, I called Noreen Jewell in the Governor's Office. Not only have I sent a copy to the Governor, I imagine that Governor McKernan gets huge stacks of mail and I don't have the expectation that he reads all of his mail. So our liaison in the Governor's Office is Noreen Jewell and she's gotten copies also and with the January 17th letter, I called her after that letter was sent out and said we cannot get any response, please help us. And she talked to Commissioner Parker,

because she told me that she did afterwards and I still haven't gotten a response.

Q. And you felt - so, (a), you felt that Commissioner Parker was well apprised of what your concerns were and you were not being responded to and so you also feel that - or do you feel that contacting Ms. Jewell would also necessarily mean that the Governor was also apprised?

A. I assumed that she is talking to him. I mean, the Governor responded with letters to our initial two letters, so I mean, we got a letter back from the Governor as well as one of the times from Noreen. So I assume that he knows, because we got letters from him.

Q. Now, short of closing AMHI, which I know you advocate, I'm not convinced that we can necessarily do without it at this point. I - who knows. But at any rate, would you advocate a complete, even middle management change?

A. Yes.

Q. Okay. Given that a lot of the policies that have gone on have been tolerated, if not encouraged, by even the middle level management.

A. Yes.

Q. How far down the hierarchical scale would you go. Short of closing the hospital, what would the changes be that you would make?

A. That's hard for me to answer because I don't know very much

about how they're organized. I know that that's something that Tom is going to talk about.

Q. Oh, okay.

A. I'm hoping that I'm saying that correctly, because he's spent a lot of time there and we talked about some of his ideas and I'll let him talk about those. In the plan for improving care, I don't remember seeing anything in here about middle level management other than training. Changing the top three positions and taking responsibility for clinical care out of a physician's hands so you can do some things around the medical model. The medical model is not a very effective model.

Q. And just a quick aside question, I was extremely surprised - as a registered nurse I was very, very surprised when Dr. Jacobsohn tried to say - or said that, gee, we in Maine aren't used to 90° heat and, therefore, couldn't be expected to anticipate that there would be problems with patients receiving neuroleptic drugs. Did any of the physicians with whom you consulted express similar surprise at such a statement?

A. I knew that. I mean I knew that and so my reaction is beyond surprise, I was appalled when he sat in the meeting about Phase I and he talked to you about it for about five minutes; he talked to us about it for about twenty minutes about how a physician shouldn't be expected to know and people in Maine and Vacationland USA and went on and on and on and I knew that, that that was a side effect. It's not an uncommon side effect. And, in fact, one

of the things that Helen told me was that at least in the past during the summer at Pineland, psychotropic drugs were discontinued because not only of the threat of heat stroke from the use of them, but they make people very sensitive to light, so you get badly burned. And it's amazing to me that physicians at Pineland who don't deal with neuroleptics nearly as much as physicians at AMHI do knew that and these board certified physicians at AMHI couldn't quite figure that out. I mean, what can you say.

Q. I share your sentiment. At this point I thank you. I may have more questions later, but thank you.

SEN. GAUVREAU - Rep. Clark.

BY REPRESENTATIVE CLARK

Q. Thank you for your presentation. Forgive me if I'm asking a question you've already answered.

A. Sure.

Q. I will listen to the tape, so you don't need to repeat your answer, since I've been out of the room. I am feeling more and more a sense of a concern that there are a whole lot of people who've known about conditions at AMHI for some time and somehow there wasn't a place to take that and that the avenue was to go to the Commissioner and say we're concerned, but there wasn't - there didn't seem to be anything else to do. If you were designing a system so that we didn't all hit the panic button prematurely but we all had a better sense of what was going on in a timely

manner, what would you do? What's missing?

A. Again, I talked some about the Mental Health Commission before and I think that that is a good way to go.

Q. Okay.

A. I also -

Q. Are there other pieces beyond that?

A. I don't think so. I'll think about this. I think that the press in this situation played a really important and valuable role and one of the really wrenching parts of this for us was to try to figure out how much to talk to the press beginning in September and we did that. In the beginning of September we began to talk to the press. That's now our natural inclination, because of privacy issues for people, but because no one was listening, that seemed to be the best route and I - I mean, this is my first contact with the Legislature, so I also didn't know where to come in terms of the Legislature. That's also obviously a valuable place.

Q. Was there discussion about that in your office and have you had that experience in other states?

A. I've had the experience in other states, although not where I was the one responsible for actually doing the talking, so I learned a lot about that. And there - and the press in a lot of ways. I mean, the Maine Times did a good job and Rick Parlin, bless his heart, from the Lewiston Sun, was the one mainstream reporter who was interested in this back in September and a lot of

this is a result of his work and other papers have picked it up. But, I mean, you know, one reporter did a whole lot of good here.

Q. Well, I for one would also like to encourage you, as I did Mr. Estabrook, to use the Legislature more than you have in the past.

A. Yeah, I appreciate that and it has been a real instruction for me to sit through these hearings to see how this works here.

Q. Thank you.

BY SENATOR GAUVREAU

Q. Laura, you raised a couple of very sensitive issues in your comments that haven't been addressed directly before. Perhaps one was your concern dealing with the quality of care now given to patients from a medical standpoint at AMHI and I think the Committee is in somewhat of a bind here because we've heard significant testimony that there is a reluctance among providers to work in institutions and I'm not in any way passing judgment pro or con in terms of the quality of care, but do you have any specific recommendations for this Committee which might put to rest some of the allegations which are now pending regarding the quality of care, not only for the patients who died, but also for other questionable practices.

A. Specific allegations?

Q. How would we address this? We've heard much in terms of testimony and complaints from different people, but how would you recommend the Committee formally respond to these since we don't

have - most of us don't have the medical expertise to really understand exactly whether or not the care was or was not at an appropriate level.

A. I guess I would answer that on a couple of different levels. I think that the advisory panel did a good job. I was also a little frustrated that they couldn't come up with causality statements, but in reading their full report you really didn't - I guess you didn't need that in order to understand that there were serious problems, because they laid out those serious problems in some detail, especially in the examples. And so having a regular - you can either have a regular review body external to AMHI - I mean, I think that their internal reviews are a joke and they're worthless. So you can either have a regular external review panel which is - I'm sort of thinking as I'm talking here, which is probably a real good idea - or convene one on a periodic basis to do investigations as needed. Probably better though to have all of the deaths, including what Dr. Jacobsohn calls the anticipated ones, reviewed by outside physicians who could look at the care and make recommendations. And not only outside physicians, you need to have nurses. Nurses are a key. So I think that that's important, to keep trying to do what you can to open up AMHI.

In terms of recommendations for right now, I share the frustration. This has been the most frustrating advocacy experience I've ever had and that's saying a lot, because at least in other

places where people have died, someone finally says, yes, this is a big problem and we're going to address this and you begin to see action taken. I thought a lot about what I would do if I were in the Commissioner's shoes on this medical care issue because I agree that it's very hard to recruit people to work in institutions and I think that what I would do is go to the medical establishment of this State and say, look, and do this as publicly as possible, look, people with mental illness are citizens of this State, they're the responsibilty of all of us, including you, and it's not sufficient for the medical community in this State to respond to problems by ignoring them and I would challenge them to come up with physicians who would work on a contract basis, give a certain number of hours a week to AMHI, to go there, to provide medical treatment and psychiatric review. No, AMHI - I've said a lot, AMHI is closed and there just is - it comes back to the stigma attached to mental illness and that the leadership needs to say we need help. There are talented people in this State. We need some of your time and we're willing to pay for that. We'll enter into contracts with you. But I think until that challenge goes out there won't be a response. And I have - I'm not totally cynical. I have faith that when you ask people to do a specific job, they will respond. If you ask them to help solve the problems at AMHI, you're not going to get much of a response. If you ask for ten hours of work a month, you might get a significant response.

Q. Were you here when others criticized the availability of physicians to the population at AMHI?

A. Yes.

Q. There are four, I believe, physicians now on staff at AMHI, is that correct? There are four -

A. There were two and two have been added, so there's four and they're looking for six. Yes, there are still two there right now.

Q. Did you have any specific recommendation on what the total number of physicians would be other - they'd be state employees or contract out?

A. You mean in terms of staff/patient ratio?

Q. That's right. In terms of the ratio.

A. Yes, as a matter of fact we do. It's in the - this is staff to patient. It's written in here as patient to staff, one to seventy-five, one physician to seventy-five residents during eight to five on weekdays and one physician in the hospital during all other hours, so that means evenings and weekends. With the clear understanding that if someone gets sick, they'll get transferred to the hospital, which didn't happen this summer.

Q. Now, where did you get that ratio from? Is that common in other jurisdictions? We've heard much about the subjective nature of surveys and standards and it's hard to actually get specific ratios by which legislators can decide what the staffing needs are.

A. I'm going to ask Helen to answer that, because she is the one who had been working on this part specifically. What Helen

said is that she consulted a professional on the staffing ratios, someone here in Maine.

Q. I see. Okay. Some have suggested to this Committee that we give serious consideration to securing the services of a management concern, even taking over the hospital, if you will, for a short time by an independent management concern. That, in fact, seems at first blush to be a rather drastic proposal. From your perspective does that have any merit and, if so, what merit would it have?

A. I think that at this point any action is good and any ideas that the Department has are a step in the right direction. I think that it's probably a good idea that there isn't much indication over there that they have managers who can run the place. So if that's what they need to do on the short term while they're looking for people, then that's what they should do. What I hope doesn't happen is to have consultants come in and evaluate what needs to be done and leave a plan and go home. I mean, there's been lots of planning, I hope that if consultants are being brought in, they're being brought in to actually do the work.

Q. You're saying something which is markedly different than others have said before the Committee. We heard a great deal of commentary regarding improving staffing ratios, access to physicians, downsizing the population, what you seem to be saying is that there's a rather pervasive problem dealing with the way services

are currently structured or delivered at the institution and it's a management problem, not personalize when you want individual or even class of individuals, but rather it's a broad based - that's a fairly significant indictment of the institution.

A. Yes.

Q. And that's what's - so you're saying that's the primary, the primary problem at AMHI as you see it now is the broad - you said we need to really make a major change in terms of the middle level of management.

A. Yes, I think that the underlying - I really do believe that the underlying problem is attitudinal at all levels, not just management and that's one of the features of institutions.

Q. You've admitted to your bias against institutions.

A. Yes.

Q. But most of us recognize the institution will, in fact, survive these hearings hopefully.

A. But short of that, I do believe that there needs to be management changes at all of the levels of management. They need to really look at - I mean, one of the things you do when you come in as a new person, as a new manager, is you spend some time - and it doesn't usually need to be a lot of time, you look at the work that's been done before, you get a sense of what the problems are and that usually doesn't take very much time. You talk to people and figure out who seems to be able to do the job and who can't and you get rid of the people who can't and you

support and encourage the people who can and you bring in, as fast as you can, people who can do the job. I mean, that's so standard in terms of management that it hardly needs to be said and I don't know why they're not doing that. Did that make any sense, by the way?

Q. I think I - let me follow up on that. Some people have suggested during the course of the hearings that ultimate responsibility for the problems at AMHI should repose upon the superintendent, because that person was, in fact, charged with managing the institution and others have suggested, no, that in fact it's a more pervasive concern, that it permeates the entire Department of Mental Health and Retardation and it affects some sort of insensitivity, if you will, to the needs. Do you feel that the primary responsibility should be reposed with any one individual or are you saying that it's a much broader problem than that?

A. I'm not sure whether I understand your question exactly.

Q. Well, there's been a real effort by some in the community to pose the question as Commissioner Parker versus William Daumueller. Frankly, having sat here for five days I think that's somewhat of an irrelevant concern, but I am interested in your perspective in terms of how you view this whole issue.

A. I think that the responsibility for oversight should rest in the Commissioner's office, with oversight of that in the Governor's Office. To say that the superintendent is ultimately

responsible all you're doing there is making what's already a closed system just that much more closed and there is, practically speaking, in addition to that, there is a limit to what a superintendent can do to get what he or she needs in order to run the place effectively, given the political structure that that person is working in. I mean, Mr. Daumueller or anyone else was not - is not in a position to go out and raise funds for AMHI to hire more staff. He has a union contract and those negotiations need to be - involve people other than the superintendent. I mean, I don't know the legalities of this, but it seems to me that a union contract can't be signed by the superintendent. So there are real limitations on that office and unless you're going to make the institution completely free standing with some other oversight body, then the responsibility obviously rests with the Commissioner's office.

Q. Would you agree that basically and unless we meaningfully augment the resources available to the Department and certainly to the acute care hospitals that no matter who is in charge of AMHI, we're not going to see real meaningful progress?

A. I don't think that there's any doubt that the place is understaffed and so you really have to reduce the numbers, which is the direction that this should be moving in, as well as increasing staff. I mean, what everyone has told you about that I believe is true and if a decision were made to phase it out, you'd still need to do that, because people are there now. So I

don't think that anyone - to say that there are additional problems to understaffing doesn't diminish the pressure on the staff in terms of the numbers of residents who are there. That pressure is very real.

Q. Finally, there have been some comments in terms - I think Mr. Daumueller at one point mentioned - even considered the possibility of closing out the current facility of AMHI and dividing it up into two or more units, one, I guess, being primarily southern based and maybe another more located in the central region. What are your feelings as far as the physical plant? Would you recommend to the Legislature that we infuse significant dollars to maintain that facility or would you recommend, notwithstanding your bias against institutions, would you recommend that we consider investing in new physical facilities for acute care hospitals.

A. I'll tell you, I haven't thought about - well, I won't say I haven't thought about this. I would really urge the State not to invest in additional bricks and mortar, to not build new facilities and to the extent necessary fix AMHI physically to diminish its unsafeness while the other things that a number of people have testified to here happen. You know, to box in the pipes, to put in air conditioning, put in window units in some places. You don't need to air condition the whole place necessarily, but put in some window units. Air conditioning in the infirmary and the nursing home definitely, you know, for

people who are high risk during the summer. Make air conditioned areas available to some people, including some sleeping rooms. So there are things that can be done that would not be as expensive as building an entire new facility. Even if you don't believe that institutions can truly be closed, one of the most exciting parts of doing this work is that what we know is possible for people is changing so rapidly that when you invest in bricks and mortar, you lock yourself into facilities that are outmoded the day that they open. I mean, things are - what's possible now for people with mental illness is totally different than what people believe was possible even ten years ago. And so I guess that I would recommend put the money into AMHI, do it as cost efficiently as possible, work on community services, see how that goes and do that rather than build new facilities that, you know, in twenty years someone will be sitting here saying, here are these problems and the place is wearing down and why did they do this twenty years ago.

Q. And Peter will still be here saying I can recall distinctly on February 6 Laura Petovello told us this.

REP. MANNING - And I disagree.

SEN. GAUVREAU - I have no further questions. Are there any other questions of the Committee at this time?

BY REPRESENTATIVE MANNING

Q. I apologize for not being here, but there are about five or six things that I let go all last week that I had to have done

before. Just to go back on something, that building or that complex, just the piping, the air conditioning, the asbestos, all those things that eventually will need to be addressed one way or the other, isn't there a trade-off to do something like that rather than - I mean, the piping, if that is a - what do you call it - an employee's office rather than a hospital, isn't there some trade-off to build something new? I mean, eventually down the road we're going to have to address the piping. I mean, the exposed piping in a mental institution, we don't allow it, I don't think, in Androscoggin County, which my co-chair is having problems with. I mean, that and a number of things, I mean, we - it seems to me we're just looking for trouble if we know it's there, we need to address that. How much money do you have to put into that just to address to have a bad - you know, -- building.

A. I keep coming back to that if the State chooses to build new buildings, we'll be back here in five years telling you about all the problems, the services, the medical care and everything else.

Q. Knowing fully well, though - knowing fully well there's a commitment - there is a commitment to the community.

A. Hm-mm.

Q. If there's a commitment to community and a major commitment to community can we still go ahead and look at it -

A. That's - yeah, that's - you're asking me for a cost benefit?

Q. I know what you're saying, cause you said -

A. I don't know.

Q. The advocates in corrections are the same - have the same philosophy, you know. You know, what you build today is going to be filled by the time you open it.

A. Yes.

Q. And you need -

A. And obsolete.

Q. You need to have other alternatives, but if we committed ourselves to community as well as taking a harder look at that structure over there -

A. Yeah, I don't have the expertise to answer that. That might be a really worthwhile quick study to do, what would be the cost of doing essential repairs as opposed to - maybe not even building another building, but renting or finding an existing building that doesn't have the same problems that AMHI has and renovating that. That's also an option.

Q. Are you familiar with the Medicare laws at all?

A. Oh, a little, not a lot.

Q. It would seem to me that part of that could be funded by the Federal Government through Medicare and Medicaid.

A. I would have to check into that. That's - I've not heard of that, but that doesn't mean that that isn't true.

Q. It seems to me somehow, somewhere down the line somebody told me that there was a possibility if we go and build new buildings

that having funding directly tied to the Federal Government that partial funding could be asked under federal dollars.

A. Maybe it could.

Q. Thank you. Anybody else have any other questions?

BY REPRESENTATIVE DELLERT

Q. One quick one I just want to ask Laura. In Massachusetts they do not take any youngsters, is that correct? That's what I heard anyway.

A. Any youngsters?

Q. Yes.

A. They're not supposed to, but in reality they do.

Q. They do?

A. I worked there for about eight months before I came to work here.

Q. That would be - one other solution might be not to take any young people at AMHI, to take them to other places?

A. I believe that the only young people, and you guys might want to correct me, are in the adolescent unit.

Q. Yeah.

A. And that's what, about twenty people. Occasionally they take people - children there who are quite young who are not supposed to be there. I know Tom has recently been involved in some advocacy around that, getting the ten and eleven year old out of the adolescent unit.

Q. And then another thing that Massachusetts does and maybe it might be possible here is not take - just dimentia cases -

better referred to nursing home or boarding home or -

A. Yeah, I can't see a single good thing about the system in Massachusetts. What they say they do and what actually happens are two different things. They might say that, but who knows. So that might be the policy and, you're right, there are people with disabilities who, even if you believe in big hospitals, certainly should not be at AMHI. They have other sorts of disabilities and they just end up there because there aren't any other options, absolutely.

REP. MANNING - Any other questions?

SEN. TITCOMB - Not that I'm promoting building a new structure, but you talked about a mind set that goes along with a mental health institution. If we are - and hopefully we will be successful in embarking in a new direction in the State of Maine on attitudes about mental health and mental health improvements, can you see merit in the whole idea of getting a fresh start, not only in the direction that we take, but also the attitude that maybe the old established archaic attitudes about mental health might not have a better stand in another place.

A. So you're talking in terms of building another facility?

SEN. TITCOMB - Looking beyond what Rep. Manning said. I mean, is this - I'm sure -

A. I think that you're absolutely right about a new start. The thing that worries me is that I've toured and been involved in sort of an advocacy consulting capacity around new facilities in

other states, brand new spanking beautiful places and although people are not at risk from unsafe environmental conditions the way they are at AMHI, you see the full range of problems just the same and that is really sad to know that a state has sunk millions and millions of dollars into a beautiful place, but all of the problems that you've heard about here still exist. So that's the only reason that, you know, I'm sort of pushing this, because I've had that experience and it really is sad. It's like taking $20 million and throwing it away, which is a lot of money.

Q. Thank you.

SEN. GAUVREAU - Are there any further questions of the Committee? If not, why don't I suggest that we take a break for ten minutes and then we will hear presentations from Tom Ward and Helen Bailey. That will probably conclude the afternoon session for the Committee and we will then plan on seeing Peter Walsh or a DHS representative tomorrow morning at nine until 11:00 a.m. So we'll take a break and come back at twenty minutes of four.

RECESS

SEN. GAUVREAU - Let's get underway here, although it's getting late in the afternoon. Laura had thought she would make a brief and concise statement. She did that, but we asked several questions. We thought that Tom Ward would be the primary presenter this afternoon and, as you may know, Tom has been with the - until recently was with the internal advocate office for several years

and - if I recall correctly, and now he's with the Maine Advocacy Services and he has - because of his longevity of service, he actually can point to more specific case references than Laura who came in in the last six or nine months. So with that I'll recognize Tom Ward.

MR. WARD - Thank you, Senator. My name is Tom Ward. I'm currently the program director for Maine Advocacy Services, protection and advocacy for the mentally ill.

From December, 1986, until last November I was the advocate at AMHI. For five years roughly prior to that I had been directing legal services for a non-profit corporation contracted with the Department of Mental Health and Mental Retardation.

I have to say that I share Laura's frustration and am appalled at the testimony that I've been hearing from the Department since these proceedings began. I think I may be doubly frustrated because the types of answers that were presented here were the same type of answers that I ran into constantly while I was the advocate at AMHI. I have been obviously paying close attention to responses to criticism in the press. My opinion is that the Department of Mental Health is clearly in its damage control phase. I've seen nothing - nothing that even came close to what I would consider honesty and I think that that is the central theme in what the problems are at the Augusta Mental Health Institute and with mental health systems in this State.

When I started at AMHI my primary responsibility was to

implement the patient's rights regulations that were promulgated under statute. Initially and continually there was severe resistance on the part of staff and administration to take these regulations to heart. They saw no purpose for them. They saw them as a means by which patients would somehow gain control of the institution. They failed to recognize that these regulations could enhance the quality of treatment that could be provided to patients and they resisted. They ignored and resisted. Every aspect of what has been found faulty by HCFA and presumably by JCAHO is covered in those regulations. There were deficiencies in treatment planning that continue to this day; deficiencies in discharge planning that continue to this day; seclusion and restraint are abused; medication is abused; psychiatric emergencies are abused. The living environment is horrible. Medical care is incompetently delivered. There are patients who then and who continue to not have access to exercise or to the outdoors.

When I started, the administration was talking about rights in terms of rights and privileges. Most of the rights were swept under the rubric of privileges that would be doled out. For example, it would be a privilege to get off the unit, to get outside or to go to an activity, almost a privilege to have comprehensive discharge planning, a privilege to have comprehensive treatment planning and they blamed this then on lack of resources. And they blamed their overall problems at that time on the rights regulations. If it weren't for these patients' rights, we would

be able to provide treatment.

I think it's important to note that that hospital administration can do nothing other than blame other entities for its problems. In my time there and today I find them almost completely unable or unwilling to accept any responsibility for the care and treatment or the problems that arise therefrom. You've heard Commissioner Parker blame Superintendent Daumueller. You've heard her blame HCFA for somehow conspiring. You've heard her perhaps blame the Legislature, saying that she should - they should have been informed and that she did indeed inform them. That's symptomatic of this entire system. It's frustrating and it makes one extremely angry. But I think what's more heart-breaking is that the patients get blamed.

My first real experience by way of enlightenment on attitude with any sort of intervention advocacy at AMHI was shortly after I started there. There was a female patient who was on the admissions unit and she was close to full-term pregnancy. She was under psychiatric emergency, presumably because she was in danger to self or others. I happened to walk into the constant observation room where she was being kept and the nurse who did not know me because I was very new there continued haranguing this patient as I stood there. The woman was in control; the nurse continued to harangue her about the need to take medication. As the nurse did so, the patient escalated. The patient, in my opinion, was forced out of control by the nurse. The nurse said,

see, you're out of control, either take this medication or walk out of the room and said if you don't take it, I'm coming back with a needle.

I spoke with the doctor who took the psychiatric emergency. Our feeling was it was no longer necessary and filed a complaint. By the time the complaint was formalized, the nurse had denied - absolutely denied that anything like that had occurred, had spoken with several administrators and considered that denial to be completely appropriate and, in effect, they told me I was lying. I found that to be something that would happen time and again throughout my employ there.

The woman did deliver a baby, but in talking to the doctor I found no concern of the effect that medication might have on the fetus. The only time that he seemed to consider it was when I brought it to his attention and he went through something about risk and benefit, that the risk may outweigh the benefits or the benefits may outweigh the risks. But there was nothing in the chart.

Things did not get better from there. When Laura talks about the need for management change, when she talks about the need for middle management change if anything is going to be effective in that institution, I think she's talking about situations like that.

I had numerous run-ins with people who were protecting witnesses during investigations, people who were on the investigation team

internally. The first investigation I did involved two young women who were on the adolescent unit. We had an eyewitness nurse who said that a male staff member had inappropriately taken the clothes off one of them, contrary to procedures. This nurse came to myself and to Kate Corrance (phonetic) who at that time was working with Adult Protective Services doing investigations in institutions. We found this nurse to be very credible. We requested a full investigation. At the investigation the only testimony that had any validity was given by this nurse. The other two members of the team, Vera Gillis and Ruben Cornelius, decided not to give any credibility to this witness. As I walked out of one of the investigation meetings I heard Vera Gillis saying to the person against whom the allegation was made, oh, I know you didn't do it, dear, and this is a quote, read the policy before we interview you on Monday. And somehow a rumor circulated about our witness, the nurse, that she had no credibility because she had Alzheimer's disease. I'll go out on a limb and say that my experience after that would suggest to me that that was started by one of the people on the team.

On that occasion I wrote a minority report demanding disciplinary action. This caused some furor in the hospital. I met with Warren Maxim who is the personnel director at the hospital who gave me the Alzheimer's disease story saying that the nurse - the witness was not credible and even if she were, what this patient had had done to her did not constitute abuse. So, in

effect, what he was saying to me was it was okay, even if it happened, for a male staff member to inappropriate disrobe an adolescent female and that would not constitute abuse.

I made several attempts after that in conjunction with Richard Estabrook to revise the investigation process at AMHI with little success. Peter Walsh - I believe it was Peter Walsh and Kate Corrance (phonetic) met with Daumueller and with Warren Maxim to discuss their concerns about the investigation process. The response on Warren Maxim's part was that they were blowing smoke, that they should not be involved in further investigations. It was very disheartening. That was within the first three or four months of working there. Subsequent investigations went nowhere. And to this day I have absolutely no faith in this process and yet they want to hold out that they police themselves. It's virtually impossible to get someone disciplined and I'm not faulting the unions. They represent their people and they do a good job according to what they're supposed to do. If the hospital is not concerned it's a -- network. They protect their own. These are middle management people protecting their own. This has come up time and again. Seldom, if ever, can you get a full investigation.

We met with Commissioner Parker the one time that she decided to meet with the advocates. We attempted to discuss with her standards of proof in investigations. The issue was raised by Nancy Thomas who's the Pineland advocate. Nancy was saying

that we needed a process that was not only fair to staff, but could enforce and insure that patients were not neglected and abused. Commissioner Parker's response was don't worry about the staff. We know what kind of people end up working in institutions. Now before I - that is a quote from her and I wanted to make very sure before I stated it and I checked with other advocates that were there. I was appalled by that, absolutely appalled. I don't know if she thought she was playing to an audience who would find that appealing. I don't know. It gets kind of hard to talk about. I've been thinking about it for two days. It gets very hard to talk about. It's very difficult to talk about what the lives of patients are there. There are some good staff. There are some good staff there, but they're the people that are holding it together. They don't have a system. They don't have any leadership that will provide them with any sort of support, with any sort of training. I think people outside the institutions do not know how little training, how little support, how little leadership actually exists.

I have debated whether to name names and I've decided that it becomes almost necessary to because I think that the public and this Committee needs to know the quality of service that is being provided. After the investigation that I just mentioned, I had an argument with one of the other team members, Ruben Cornelius, who is head of staff development. And I said to him -

actually I yelled at him and I said, Ruben, you have no idea what goes on in that hospital. And he accused me of being histrionic and said, I don't need to have any idea. I only do staff development. Now I anticipate if you ask him there will be a denial, but I will stand by those statements and I think that that shows up in the quality and the day-to-day care of that institution.

I've seen abuses in seclusion and restraint that go on on a daily basis. Seclusion and restraint under the regulations require that actual treatment be implemented to avoid, whenever possible, having to lock somebody in a room. I have not seen any treatment plan containing a treatment that - any behaviorial treatment that was designed to keep somebody out. They use seclusion and restraint as a first line of treatment. There are reasons for putting people in seclusion and restraint under regulation, for being dangerous to self or others or imminently at danger of disrupting the ward environment. And yet at AMHI if you go and find the statistics, they can put somebody - and they do - at least two or three a month, patients who are put in seclusion and restraint for threathening to be verbally abusive. Now I've asked people what this means. How do you threaten to be verbally abusive? Do you walk up to a staff and stay, hey, if you don't let me off the unit, I'm going to verbally abuse you? Nobody knows what that means. But people get put in seclusion and restraint. It's their statistics, not

mine.

I recall an incident with a woman who had been - and this was in the summer of '87 during very hot days - who had been in seclusion and restraint for seven days running, no attempts to get her out, no attempts to improvise any treatment, no attempts to reassess her. When I saw her she was crying through the door. She wanted a milk shake. Well, it was hot. So I went to the kitchen and I got some milk and I got some Kool-Aid and I opened the door and I went in and I gave it to her and she drank it and I went out and locked the door. I didn't have any authority to let her out of seclusion. Within a half an hour people were up in arms wanting to know why I had interfered with a clinical procedure. Superintendent Daumueller and Assistant Superintendent Hanley were in my office asking about this. They said that I shouldn't open doors for my own safety. Perhaps they were right, but they were more concerned with my opening the door and going in than they were with the question of whether why this woman had been in seclusion for seven days. I asked them about that. They said, oh, yeah, yeah, we didn't think of that. I think those were their exact words. It's frightening.

There's an abuse of commitment procedures. People who the hospital has determined do not have the capacity to stay - to make informed consent decisions are routinely allowed to stay voluntary rather than the hospital having to go through commitment hearings, which is the one chance, minimal though it may be, that

their treatment plans will be reviewed by somebody outside. And I've asked about that. These people are voluntary until they decide to leave. There are cases of patients who have been blue papered, emergency papered, seven, eight times running, rather than being committed. They will put papers on somebody, throw them in SRC because they're out of control. Maybe in that case they need to be there. As soon as they calm down, they'll take the papers off, two days later they're repapering. There's no treatment. It's SRC and medication. And these people are denied a court review. They're voluntary until they want to leave. And somehow AMHI finds nothing wrong with that. There's some in AMHI think that's logical. To my mind it's -- I started sending out letters to those people informing them that if they're voluntary, they're truly able to leave, and unless there was a drastic change in their clinical condition that was documented and that the medical staff could prove that. That caused great concern. And for a while they stopped that practice. That practice is existing again today.

There are patients on the admissions unit who are kept in COR for days on end on a crowded unit who do not get any outside activity. They can be there for up to twenty-five days. They don't get outdoors. They don't get off the unit. Supposedly they're there for observation, but it was my last month of being there that a patient there for observation about ten o'clock one evening was fooling around with some other patient slipped and in

the process of slipping put out her hand and hit the Coke machine with her hand. Her hand was grossly swollen. She was given an ice pack and somebody said they would make a referral to the clinic and have an x-ray done. It was brought to my attention by a mental health worker sixteen hours later that this woman had not received any medical attention. I went to see her, she had a grossly swollen hand. She had already seen a physician's assistant who did some sort of a psychological evaluation but neglected to do anything about the hand, because the patient hadn't complained about it. The patient told me that she didn't complain about it, because she didn't think anybody would listen to her. When I brought it to the attention of the unit directors, I was told, well, we're going to call x-ray. They called x-ray while I was there, x-ray said they couldn't see her for three or four hours, but they had done all they could. I told them to call back and to insure that that woman was taken to x-ray and got medical treatment immediately. And I pointed out to them that if it was them, a member of their family or somebody they knew who had injured their hand, they would be down in the emergency room immediately demanding that they receive proper medical treatment.

In terms of of how they value patients, I think that that says a lot. Fortunately, the woman did not sustain a break and she did receive treatment, but they don't consider that first line and they found nothing unusual about the fact that she waited fourteen hours with ice on her hand. Standard operating procedure

One mental health worker said, well, tell her to stop beating her hand against the wall. I mean, I'm really hardened.

There have been a lot of comments made about the rape that occurred last September. And not surprisingly, you were told some, but you were not told all. You were told among other things that - and I want to stress that the gentleman who's allegedly the rapist, who's allegedly involved in this is as much a victim as the woman. He's a person for whom no treatment was provided. You've heard a doctor - I believe it was Dr. Buck sit here and testify that he gave no indications - his behavior gave absolutely no indication that would lead them to think that he would commit such an act. I have notes here from his chart and I will leave it to you to decide whether these progress notes would lead you to think there's a problem.

Some of the language in it is quite bold, so if you'll indulge me in that. In March there were twenty incidents.

REP. BURKE - March of what year?

A. March, excuse me, March last - March of '88. By way of explanation, this patient would - seemed to cycle. He would become very aggressive. They would fiddle with the medication. He would become very depressed. The chart documents when he was depressed, they thought he was getting better because he wasn't causing a problem for them. At the time that he was - that the alledged rape occurred, he was again beginning to escalate. In fact, there were signs in August that he was again

becoming more active and more aggressive. But in March - and he never received any treatment for this. There are notes in his chart, pulled down his pants exposing himself to female patients. This was on March 14th. No treatment was provided. I questioned whether that is aggressive behavior or something they should have noticed. Certainly they didn't provide him any treatment and by failing to do so robbed him of his own dignity and failed to protect him from himself. This is a gentleman under guardianship. The same day he walked up to a female staff member, look at this, my cock is four and a half inches long. If you want me, you get a big one. This is a very sick gentleman. Later that same day sexually inappropriate and aggressive and this goes on. A couple of days later a male patient had to intervene because he was being sexually aggressive with a female patient. He was seen in female patients' rooms on top of their beds demanding. And it goes on. They fiddled with his medication. Never did this come up in staffing meetings. There's no indication in his treatment conference notes that this was addressed as a problem. When his behavior - as I said, when he became depressed, the notes reflected he was getting better. Dr. Buck made a note in August that he was being physically aggressive with female patients. There was no intervention treatment provided to him. The September incident occurred. Now, that incident itself, I don't think that they told you the whole story either.

It happened on a Friday night. I believe the date was in early September. As you've been told, the woman involved was not seen by a medical person until six or seven hours later. No contact was made with the nurse on duty or if there was one, the physician assistant, Dick Bracket, did not come immediately. He saw her about 6:30 in the morning. His note says, yes, she's been penetrated but she may have done it to herself. This is a 76 year old woman. He gave no followup medical care, none. He left. Dr. Arness who was on duty did not see her. I believe he was notified. The superintendent was called. He told them to call me. I live in Portland. They called me, I said I will be up. I got there - I got called about eight in the morning, I got there a little after eleven. When I walked in there was a new nurse on duty. This is terrible. I walked in and I asked her what she had done. Now this woman is one of the women who is primarily responsible, she's a nurse of some twenty years there, she is primarily responsible for quality assurance at the hospital. I said - she told me what happened and she said to me, well, don't be mad at the staff and she hugged herself. She said, they really care. And I said, have you called the guardian? No. Have you called the police? No. Have you taken her to the hospital or have you contacted them? No. I said, then I suggest you call both guardians, call the police and take her to the hospital. And she said, I have to do that? What are you going to do. I was impressed. I made her

call the guardian. I made her call the police and I drove her to the hospital. She came back from the hospital, a staff member walked her into the dayroom and said, okay, dear, tell us which one of them raped you. It was a dayroom full of patients. The followup medical care that was ordered by the hospital was not provided until the following Monday or Tuesday, I forget which, including preventive antibiotics. I was aghast at this and I was livid over this. These are people who, in an extreme circumstance, cannot decide what to do. How can we reasonably expect them in the day-to-day function of the hospital to know what to do.

The DHS investigation - and you can talk to them about this when they testify - some of the staff present said, well, you know she must have been sexually provocative. Perhaps. But I doubt it.

The deaths - and I can jump - just go from one thing - I could tell you what would constitute horror stories for hours. We were not notified of the deaths. I found out about the death of - I still have a hard time referring to names - the burn victim - from a patient from his unit who had known him for some years who was standing in the hall crying saying, is he dead. And from there we found out about the others.

The hospital - I had a conversation. It was at that time that the Maine Times article was coming out and Richard Estabrook and I were instrumental in bringing that about, because we had gone

to the administration. We'd gone to I think everybody we could think of and the Maine Times was going to do an article and it was -- article and we certainly encouraged and helped them in every way that we could.

I talked to people in the administration about the fact. I made a point of telling them when something was coming down and I went up to them and said, look, these deaths are going to be included in that article and the response was why, don't you think we can take care of that in-house? And my response was absolutely not. I don't see this medical staff making a finding that is going to, in any way, indicate that one of their own people was at fault and if you have an opportunity to look at those internal investigations, you will see that that staff absolutely exonerated itself, including Dr. Jacobsohn. They did nothing wrong. They've never done anything wrong. It's a closed system, as Laura says.

Someone circulated the rumor that the gentleman who died in the coma was drunk and that became the popular belief at AMHI. They considered it run of the mill. These patients not only died, the burn victim had been in Kennebec Valley Medical Center, treated for hepatitis, came back with specific instructions that weren't followed. What they did to him was what they did to him prior to his originally going to Kennebec Valley Medical Center, seclusion, restraint, put him back on full medications against instructions.

The Maine Times article came out and AMHI considered it to be sensationalism. That's not the true story. These people died, but, gee, you know, they would have died anyway. The burn victim because of his condition was considered by many to be better off dead. That wasn't said untimely, but it was said.

And we used to talk about, you know, it's going to take somebody dying before something changes there. I don't know what's going to change. The response of the institution - I think people wax nostalgic for something that maybe never existed about what that institution is. Oh, we remember the good days. What they fail to remember is maybe those good days didn't exist, times have changed, they have to change, they're unwilling to change. They want to get back to something that never was and it's always, we need more staff and they do. If the community would only do what we wanted them to do and there's some truth to that. But I've sat in administrative meetings with the world falling down around them and they talk about transportation. Incidents come and go, hey, what are you going to do about them. Well, it just happened. The patient who lost five teeth, a very fragile patient mixed in with other patients, never got any treatment. He lost five teeth. They failed to protect him from himself. He was a DHS ward and he's part of their study. I think you could ask about him as well.

I talked to - three months after Susan Parker became

commissioner, three or four months, I checked with Richard Estabrook and I called her. I asked her if she would be willing to come over and let me take her on a tour of the institution unannounced early in the morning. She said - she got very icy on the phone when she found out why I'd called and said, I'll get back to you and never did. She didn't tour that institution unannounced until months later. Whether she was too busy, whether she felt she knew, who knows.

Richard and I have spoken with Ron Welch about the deaths as part of the concerted effort to get an outside independent review with Maine Advocacy Services. Without the extreme pressure and I believe without the public pressure, that never would have happened. And yet the response I continually got from the administration is you're not working with the system. If you presented facts to them, if you presented an alternative view, you were a trouble maker, you were not being productive.

AMHI operates like a disfunctional family and the amount of denial existing in that family is incredible. I am concerned that money will be put into AMHI with the existing structure. And, folks, what you're going to see is more money thrown after bad. There is very little leadership. The good people who work there get out. People come in with good ideas. They're not encouraged. People are encouraged to be team players, which is to say don't make any waves, don't ask questions. I admire the people who are working there and trying to do a good

job under some arduous and very difficult circumstances. The burnout rate is very, very high. Nothing that the Department has done to date has made a significant difference. They've been playing the JCAH and Medicare tune for the last year.

When the Medicare inspectors came somebody went out and bought a $130 stuffed plant to dress up the unit. They made sure that some of the more verbal patients were off the unit and they pulled staff from other parts of the hospital to make the coverage look good. In doing so there was an altercation caused by lack of staff on one of the other units while the Medicare surveyors were going through Stone North Middle. Since Medicare they've been focusing primarily on the admissions unit, although three units were decertified. There's no way that they can - they've downsized Medicare over the past several years so that it's impossible for them to even attempt to meet those standards throughout the hospital. When JCAH came they were running around looking for copies of patient's rights. They apparently did a self-assessment on their rights compliance. They never asked me what I thought. They were running around looking for copies of rights to have noticeable on the units. They painted rooms. They discharged people on convalescence status prior to JCAH coming so the actual census would be down. That is something that they do continually, without discharge planning. There is no discharge planning.

And I have to repeat what Helen says, you know, they don't

know what they're doing and they don't know who they're doing it to. I think that's the truest thing that got said today. There's no system, there's no structure, there is no leadership and if this Department and that hospital can stand here in the face of a rape, eight deaths, one decertification, pending a second, lack of accreditation, promises, recommendations and tell you that they know what they're doing, well, you can draw your own conclusions from that.

Units that were designed for thirty people have sixty; units that were designed for thirty-five people have some fifty plus. When they get the census down on one unit by taking some control, they shift patients from other units to that unit to even it out. This summer patients were trying to eat in a dining room designed for thirty people. There were between fifty-five and sixty of them stuck in there. It was very hot. I could stomach it once. They were locked in. There was very little room to move. Some patients would be trying to eat while other patients were vomiting into their trays. There were some fans during that period. This was during the heat phase. There were no air conditioners. They found money very quickly to buy air conditioners for the medication rooms. As soon as the heat came on, they came up with - every medication room had an air conditioner. I think that shows you where their priorities are. That's their treatment.

They have a perfectly viable procedure under the regulations for medicating incapacitated patients over their objections.

They're constantly crying that they can't treat people and yet there are medical staff who ignore the presence of those procedures because they don't want to be bothered. They're saying this patient or that patient needs medication and yet rather than use an administrative hearing, they will let patients languish on on units for months while at the same time they're complaining about census. They don't want to be told. They don't want to suggest that there's a better way of doing things and anybody who tells them or suggests that there is is some sort of a crackpot advocate with an ax to grind.

I think that this Committee - certainly the Legislature, hopefully the Maine Commission can go a long way toward establishing standards of care and towards monitoring their compliance. Whether you can change the administration there or not, I don't know, but certainly they can be held accountable. They have a public trust and by no measure are they living up to it.

I know this has been a little bit rambling when I think - I mean things just keep coming, but I would be glad to entertain any questions from this Committee at this point.

SEN. GAUVREAU - Thank you for your presentation, Mr. Ward. Why don't we start in a clockwise fashion. Rep. Cathcart.

REP. CATHCART - Thank you. Just one question. Is there a quality assurance program in place at AMHI and, if so, why is that failing miserably.

A. AMHI is very strong on paper and very short on substance.

The quality assurance person - there are two primary ones - are reviewing treatment, treatment plans and assuming that somehow the treatment that is being provided is adequate. They check documentation. I think it's most telling that the person who I talked about concerning the rape, who does a lot of work with paper, had no idea what to do with people in assuring the quality. But they talk a lot about, yeah, we're upgrading our quality assurance and when Medicare comes we'll show them.

REP. CATHCART - Thank you.

SEN. GAUVREAU - Rep. Clark?

BY REPRESENTATIVE CLARK

Q. Tom, how long were you - when did you leave AMHI?

A. November last.

Q. Let me ask you the same three questions I asked Mr. Estabrook this morning, please. The first is - and I hear some of this in your voice obviously, but were there places to take your complaints in a timely manner or did you feel like you were kind of hitting your head against the wall?

A. I think I felt like I was hitting my head against the wall.

Q. How would you design a system that would work better? What pieces do we still need? In terms of not letting things go.

A. In terms of advocacy?

Q. Yes.

A. The first thing you need to do, and this is something I've demanded and never gotten, is to insure that advocates get copies

of all incident reports pertaining to patient-to-patient altercations, patient-to-staff altercations and medical problems and deaths. Advocates are not routinely informed of those at this point.

Secondly, I think that it's absurd to expect one advocate for between 350 to 400 patients to be able to adequately do the job. It's virtually impossible. I could give you a list of things I never did as well as what the staff there never did. I make no bones about that.

There needs to be an enforcement mechanism. I think one of the things that can be done is to strengthen the rights regulations, to make sure that grievances are heard by an independent outside hearings officer and to set up a format by which those decisions are binding on the Department. The grievances I have pursued have to be on a case-by-case basis. There is no policy change. I believe that the Commissioner, probably jointly with somebody from the Legislature, needs to listen to what advocates are saying. I would like to see both the Department and the Legislature listen to advocates simultaneously so that there could be no question about what was being said. We need access to medical experts for investigations that come from outside of the hospital. That's clear. The only medical experts I ever had were internal medical experts. Those are some ideas off the top of my head.

Q. Okay. Thank you. Are you aware of a memo that looks like this?

A. Hm-mm.

Q. That just says Last Panel Meeting Notes. I don't have a date on it and then a report that looks like this that says Panel Report?

A. Yes, I have.

Q. Have you had a chance to look at that and see whether that was whitewash or whether things got translated in reasonable ways?

A. I want to say up front that I think that with the information that the panel had, their findings and their work are exemplary. In terms of what the panel presented, I consider it to be up front. I think that the members of that panel worked very hard. As Laura suggested, there are notes from the individual panel members that the Department has that they could make available to you and I would urge you to look at them. In terms of my impression, I think that it was very convenient for Dr. Jacobsohn to limit the investigations to the three deaths that he considered to be heat related. I have seen no written report from him on his findings. There's substantive findings on the other two deaths. As Laura said, Ms. M had sufficient deficiencies - extreme deficiencies in care that were corroborated by a Dr. Stringer at Kennebec Valley when I talked to him. What appalled me about the process - I should add, too, that nobody was given access to the outside medical records from Kennebec Valley, from Mid-Maine Medical Center where the gentleman who

died in a coma died, although those were readily available. My office had them. If they had asked, we would have shared them. They certainly did not seek them, although they complained they did not have sufficient medical information to draw conclusions.

Again, so to sum, in terms of the panel, no, I do not think it was a whitewash. In terms of the Department I think that they wanted to defray criticism by saying, hey, is this a heat related thing and people in Maine, doctors in Maine can't be expected to pursue - you know, to be aware of this phenomenon. It was a medical issue. Their findings were so similar to Medicare's and that was the key issue. That panel found the same thing that Medicare found months later.

Q. Okay. Thank you. My third question has to do with the plan that we heard from Jay Harper on Thursday about community resources?

A. Correct.

Q. Do you have an assessment about whether in fact that would decrease the numbers at AMHI? His estimate, as I recall, was about 600 admissions per year.

A. I believe that it would. There's a real shortage of crisis intervention in the community and I think that that's what he was talking about. If he could do acute care crisis intervention, you would decrease admissions to AMHI which would take off the patient load. I was very impressed with what Jay

was putting forth and as part of an overall package, I certainly support that.

It should be noted, too, that when people are admitted to AMHI it happens at night, that the physician assistants who are the primary people responsible for admissions at night are told that they can let anybody in. They can turn nobody away. There needs to be a psychiatrist on duty. At least one in the evening. There should be at least one twenty-four hours on the evening and night shifts. That people can give you figures that many people who are admitted to AMHI do not have a primary diagnosis of being mentally ill. They could be treated elsewhere. You see a lot of people will come in with alcohol related problems. There's a dearth in the community of facilities to deal with those.

Q. That prompts a fourth question that I've had off and on all day. Do you have a sense of appropriate treatment for dual diagnosed clients? I guess I get particularly concerned when I hear about the heavy use of medication for people who come in with other substance abuse problems.

A. Hm-mm.

Q. Is that a consistent problem?

A. Yes, it is. Substance abuse - there are populations within AMHI for whom no appropriate treatment exist there. Substance abuse is one. They have some people coming in and doing some dual diagnosis. There's certainly not enough of them. I think

there are three people in AMHI trying to do the dual diagnosis. Staff at AMHI need education and how to approach this. They have at least one doctor who is very, very good at this. But on the whole they're not particularly well versed. And I would also add that sexual abuse which has turned up in the histories of many, many patients is misunderstood, not appropriately treated. In the population known as borderline personality disorders sexual abuse is prevalent and these are the people who end up spread eagle in five-point restraints. It's been talked about. There must be a better way to do it. Certainly nobody has come forth with anything substantive to this date, but there are many, many people at AMHI who have a history of having been sexually abused.

Q. Do you have an estimate, a guesstimate at all of the percentage of patients at any one time that are substance abusers as well as mentally ill?

A. No, I don't. I would say that it's very high.

Q. Half maybe, more than half?

A. More than half.

Q. Okay. Am I correct that there's only one AA meeting conducted on the grounds during the course of a week?

A. No, I think there are two or three and they do provide some off-ground transportation to a limited number of people.

Q. Patients are taken off?

A. Some are.

Q. If you behaved appropriately?

A. If you behave appropriately you can go to -

Q. Okay. Thank you very much. I don't tell people like you often that I'm awful glad you're there.

SEN. GAUVREAU - Rep. Burke.

BY REPRESENTATIVE BURKE

Q. First of all, I want to comment on how difficult I know that your testimony must be because the level of frustration that you obviously feel and must have felt then is palpable here and like Marge, I'd like to thank you for having put up with it and then coming forth here and now and hopefully we'll be able to do something.

What I have frequently been trying to establish is, in fact, exactly how much the Commissioner knew, what her response was when told, whether or not you got a sense that your concerns were being conveyed to the Executive Branch and, therefore, what kind of sense - what kind of response we were getting from the Executive Branch. So let me go through that similar line of questioning that I did with Mr. Estabrook this morning. To whom do you report?

A. At AMHI I reported to Richard Estabrook.

Q. Okay. Did you - so you met with Mr. Estabrook how often?

A. Richard had a statewide system to supervise, but I tried to talk with him on the phone two or three times a week and I would - I met with him probably on the average of once a week

if not more. I mean, he was very good about trying to come over to AMHI and be supportive if he couldn't be there full time.

Q. You mentioned a couple of times that you both collaborated on efforts to get things changed at AMHI. Did you appeal to other authorities, Mr. Daumueller, Mr. Welch, Commissioner Parker?

A. Ron Welch and I had a conversation with Richard - Richard and I had a conversation with Ron Welch at the time of the death and I believe I talked - prior to the investigations and I believe I've spoken with him on other occasions. Bill Daumueller and I had many conversations about what problems were, what I perceived the problems to be. At one point there was supposed to be a monthly meeting between himself, Walter Rohm and me to address issues. That happened for a couple of months and got put on the back burner because there were other things that needed tended to on their part. It just kept getting continued. I did - I have to say that on Bill Daumueller's behalf I got a sense of frustration on his part as well. We had conversations - I didn't know what was going on about him and I still don't know the full story anymore than anyone else here does, but we did have conversations where I felt that his ideas were good. The sense of what he wanted to do was good. What I didn't see was anything changing and on the other side of the coin, I didn't feel he spent enough time on the units. He depended too much on people, his administrators, and I think expecting that they would be giving him the true story. And anyone who understands that power

structure history of AMHI knows that under Garrell Mullaney, Garrell had a very, very different style. Bill came in and expected that people would tell him basically the truth. What they weretelling him and what I was observing were two different things and I did pass that information on to him. What he chose to do with it was up to him.

Q. Did you ever - other than the time that you mentioned that you called Commissioner Parker and invited her to come over unannounced and all, did you speak with Commissioner Parker ever about your concerns other than that time?

A. Not at length.

Q. Not at length.

A. I have met with Commissioner Parker on very, very few occasions. She did not choose to meet with advocates for whatever reason. However often she met with Richard I don't know. Certainly more than she met with me or the other advocates. She met with us on that one occasions. She had an agenda. It was to make advocates into raw data collectors for the central office without giving us the materials to do that. And we discussed, as I said, the problem of burden of proof. I spoke with her next on the day that she had the press conference, just after the HCFA decertification. We had a brief meeting because the TV people were going to talk to me as well. And on that occasion there was a five-minute conversation. I told her that I was going to be talking to television people, that I wanted to hear what

she had to say and she smiled at that and I told her that I didn't agree with much of what she had to say and a fleeting look of rage came over her face and I went on. At that point she said she believed she could gain recertification by reallocating existing resources. I met with - I met with her once while she was meeting with the patient's rights advisory board, a group to which the department has given only lip service types of support. They presented her with a list of concerns that to date have not been acted on, including access to the outside. I was present at that meeting and I think just prior to my leaving I had lunch with her at which time nothing of substance was discussed. It was a pleasant lunch. That's been the history of my meeting with Commissioner Parker.

Q. So were you - did you ever get a feeling that she knew about the overcrowding situation at AMHI or -

A. I assume that she did. I mean, it was not only AMHI, I mean this was public knowledge. She sat on the overcrowding commission and she was present at many, if not all, of the meetings. She read the papers. Certainly she was getting information from Bill Daumueller. You know, the fact that she didn't come to me and say, Tom, what do you think we ought to do about this gives me no reason to think that she did not know. I would have given her what information I had had she asked.

Q. And in terms of the lack of quality among the staff, did you have a sense that anyone in the administration staff was aware of

the concerns - of your concerns?

A. Anybody in the immediate AMHI administrative staff?

Q. Well, if it was the middle level management that was in essence the big problem for you -

A. The AMHI management, yes.

Q. Okay, so the AMHI senior administrative staff knew that there was a problem -

A. They knew what my concerns were. Whether they considered those to be factual or not or considered that a real problem I do not know, but I certainly expressed to both Bill Daumueller and Rick Hanley and to Victor Perreault who was for twenty years the chief of hospital services and somebody to whom this Committee may well want to talk, I expressed those concerns to him. They were very aware of it.

Q. So do you feel as though there has ever been an honest administrative response from the executive, the Commissioner on down to alleviate or even attempt to answer the problems at AMHI, whether you look at it from an overcrowding, understaffing or quality aspect.

A. No, I do not. I consider it reactionary damage control in bringing out -- doctors dancing to accreditation tunes and doing the minimal about it necessary.

Q. Do you feel that there's even been an attempt to even meet accreditation standards?

A. Not in any substantive way. I believe that they made enormous

efforts. The staff did what theywere told to do. They made enormous efforts at trying to come up to paper compliance. These are the direct line staff. I believe that they tried. I saw a lot of effort going into that both for JCAH and for Medicare I will say that there are two units that seem to be functioning fairly well that get by on Medicaid, the adolescent unit for all its problems and through, I think, very little help on that part of the administration of the hospital has passed Medicaid. And interestingly enough, they're able to work as a unit and they make efforts to do treatment, something I see nowhere else in the hospital. And Greenlaw, the nursing home, seems to do fairly well.

Throughout the hospital they didn't have the attitude, they didn't have the personnel, they didn't have the resources and I think they thought they could get by with buying $130 stuffed plants, painting walls, washing floors. I mean, it looks pretty, when people come through, it looks real nice. No.

Q. Okay. Thank you.

BY SENATOR GAUVREAU

Q. Mr. Ward, Richard Estabrook testified earlier today that it appeared to him that the primary treatment protocol, if we can refer to it as that, at AMHI was overmedication of patients. Would you concur with that assessment?

A. Pardon?

Q. Would you agree with that assessment?

A. Absolutely.

Q. Has your office - what efforts has your office taken to try to curb that practice and encourage the administration to develop more realistic and more appropriate treatment plans?

A. We've done several things. In terms of specifically medication when I started there psych emergencies were being extended for sixty, seventy days on some patients. Now, that's a very long emergency. These are seventy-two hours emergencies that keep getting repeated. We put a stop to - we were successful in putting a stop to that immediately. We encouraged them to use the administrative hearings procedure under the regulations which they did. It was like pulling teeth. When pressure was put on them to use it, they would use it, when not, not. I did an investigation - I think - I'd have to check, but I think it was about six months prior to Medicare decertification that involved Dr. Beyers. Several of the staff had been complaining about the quality of this care. He had - his situation had changed. He had been in charge of two units. He was then in charge of one. I relied - I had to rely on Dr. Rohm to provide me with the medical expertise. Dr. Rohm failed to find there was any wrongdoing. The staff who had been vocal to Rohm were unwilling to talk to me in terms of an investigation, but one of my recommendations that I made to both Bill Daumueller and to Walter Rohm was that an outside independent team of medical people come in and provide an articulated standard or

standards of medical practice and that this be monitored on a monthly basis. Bill Daumueller seemed to agree with that. Walter Rohm absolutely was opposed. He said we can do it ourselves. So it was prior to, again, Medicare, it was prior to the deaths, it was prior to JCAH. We've had ongoing battles with amounts of medication, constantly being told you can't comment on that, you're not doctors. If it's raised, in a lot of cases the response would be rather than to put up with pressure from advocates to not medicate the person who may need it. Some people are asking for a lower dosage. Some people are asking for assessments. They do not routinely get them. We have asked them to change their documentation so that it directly affected the quality of care being provided and the actual care being provided. Even HCFA has not been successful in getting them to be able to do that. We were exploring possibilities about setting up an experimental treatment program for behavior types, borderline personality disorders that went nowhere. We've raised the question that people don't have enough activities, well, we don't have enough resources. I mean this was an ongoing theme and probably on a daily basis. Something was happening around medication and alternatives to treatment. One of the things that the staff goes through phases of doing is using the courts for assaultive patients as an extension of their therapeutic milieu, that they find that when patients are out of control and maybe threaten the staff or do indeed hit a staff, that it's a good idea to

press charges and take them to court and let them spend some time in jail. Doctors - some doctors agree with this, mental health workers are, in some cases, encouraged to do it and you go through rashes of this. What I usually do is tell them that - is get an attorney for the patient. But they think this is going to work, that this is going to change somebody.

Q. Well, let me - you described your frustration as far as being an advocate for a while on the inside. Can you just take us briefly through how the process should work as an advocate who might want to cross what you deem or view to be inappropriate patient care. Assuming that you get no immediate response from the supervisor or the nurse or the administration, what remedies are available to the patient through your office to vindicate the patient's rights?

A. Okay. There is an internal grievance procedure that I referenced earlier. It's a four-stage procedure which starts at the unit director level, goes to the superintendent to the bureau director to the Commissioner and ultimately to Superior Court on appeal. We have implemented grievances and argued grievances on behalf of patients. That's one avenue that we have available to us. Again, there is no independent hearer of facts and there's no independent finder of facts. Most of them have fallen down at the superintendent's level. I think my winning record is not real high. We have been a little more successful at the bureau level, but, again, not particularly.

And the frustration involved there is that we would have to do the same cases over and over and over and over again. One of the things that works real well in getting them to respond are threats of coersion. They seem - the hospital seems to respond very well to threats and coersion. It's unfortunate. Those are basically the tools that we had available to us. Every once in a while you can throw out, hey, if things don't change, we're going to have a class action suit and that will make them think for a little bit. Primarily though it's the grievance procedure. And those were only areas that did not involve medical decisions.

Q. Now, it would take you on the average a good six months or so to litigate a Superior Court review on an 80(b), wouldn't it? I mean, it would take you long.

A. I'd have to defer to Helen on that one. They don't comply with them afterwards is the problem. It would -

Q. Well, my concern is this, I mean, you say - you claim that you don't have an impartial adjudicatory body.

A. Exactly.

Q. That you, in fact, are appealing actions of those who are administering the program.

A. Exactly.

Q. And what you're complaining about. I can see your source of frustration. Do you know of systems where you have external parties who are totally financially, professionally independent

of the hospital? Is this done in other types of appellate systems?

A. I do know that within - I don't know what's available nationwide. I do know that within the rights regulations themselves for medication hearings DHS hearings officers preside and I believe that that would be a viable - certainly a better alternative to this if they could be also brought in to preside over grievance hearings. And I think in terms of complaints involving abuse investigations, there needs to be a hearing mechanism that does not include people who may be predisposed, who may have connections with people against whom an allegation has been launched. There needs to be independent mechanisms for investigating abuse and neglect.

Q. Now, what - this question's been raised earlier, but what role do relatives and families have in trying to urge - either work with your office or work with the hospital in - assuming there's a conflict or - in terms of what people believe is most appropriate treatment -- how would a parent or a relative pursue that claim?

A. Parents can - I don't have the regs in front of me that in terms of a grievance that arises out of poor treatment. A parent who's a guardian obviously can pursue or a parent could be named as a representative or co-representative. Parents or friends or relatives certainly should be apprised of and be part of - fully a part of treatment team meetings, which is something that does

not occur that often. Those with guardians, I think, may fare a little better, but nothing substantial. I think it's a matter of finding out who the patient wants involved in their treatment process, making sure that that person is notified. In the case of public guardians, mandating that they be notified from the beginning and that they be present at all meetings. You can't do that with private guardians. And insuring that they're notified in a timely manner and that they're given full information, that they have an opportunity if the patient wants to review the chart, that the team is available to answer questions, that the team be held accountable. What goes on now in many of the units is that a family member is brought in. They're overwhelmed. They're given not too much information and they end up agreeing, because they're sitting there with professionals, as it were. They're sitting there with a psychiatrist and they don't know what questions to ask. One of the things - a broad base can be done is training for family members, advocacy types of training for concerned others and family members who want to be a part, how to ask questions, what rights are, what sort of treatment somebody can expect.

Q. Do you find that parents of relatives often contact you or your office for help?

A. Many do. Many did while I was at AMHI certainly.

Q. Internal. And how much time were you able to give to those parents and friends, relatives?

A. Not a lot to be perfectly honest. As much as I could. I mean, I would stay if somebody asked - called me and asked. On many occasions I did stay and meet with teams or set up meetings after normal working hours. Certainly I was not able to provide a full complement of services for family members. A lot of it was over the phone. A lot of it simply didn't get done. When I could I would make referrals to Richard. I would contact what was then Advocates for the Disabled. Helen spent an enormous amount of time in the institution. She was incredible support and - well, actually more than that, I mean, she had a heavy caseload there.

Q. Now, the internal advocate reports - as you say, reports to the Commissioner.

A. The internal advocate is on - on a flow chart is right across from the superintendent, reports to the chief advocate, who reports to the Commissioner. There was ongoing struggle at AMHI to convince the powers that be that I didn't work for them.

Q. It seems that there's a flawed mechanism regarding apprising this Committee and the Legislature of any concerns regarding conditions at AMHI recognizing that there are always two sides to any issue and that we have to be impartial and investigate fairly. But it seems to me that absent this occasional crisis which erupts with dunning regularity, there's no formal mechanism for the advocate to approach the Legislature and keep us apprised.

I mean, we're reliant upon others who - and this is through no sleight upon their credentials at all, but who might not have the same perspective or even have the same interest in disclosing, let's say, you know, unfavorable conditions at AMHI. The idea of the advocate is for a person to be truly independent of that and so to give your perspective. Would you think there'd be value in us allowing or even requiring the advocate - the internal advocate to report on a fairly regular basis to this Committee regarding conditions at AMHI and BMHI.

A. I think there would be. That's an incredibly important step. And I think in so doing that the - somebody from the Department should be mandated to be present while that report is being made. Richard and I had that frustration. We didn't know what access we had to the Legislature and we decided that we needed to approach the Legislature without really knowing how to do it. Last June, not wishing to be partisan, quite honestly I contacted Sen. Gill and Sen. Bustin who both agreed to meet with us that day. We met with both of them and later that day met with Sen. Pray. This was just before the unions had their demonstrations and filed their class action grievance and I believe that it was a combination of those two actions, the unions plus our coming over here, that resulted in the additional positions in September, because prior to that the Department, as far as I know, had no intention of asking for more. I think that there needs to be access, not only for the internal advocate, but for external advocates,

coalitions of consumers, certainly the patient's rights advisory board. And as I recall from last September, a letter was to go out from this Committee for Alice Bliss to address the Committee on problems that they've had with compliance with regulations and the Department's response.

Q. I know it's early in the process, but if you have an opinion, what is the current relationship between the Commission on Mental Health and your organization now, the Maine Advocacy folks.

A. At this point it's very good. Laura and I will be meeting with the Subcommittee on Institutions this Wednesday coming, day after tomorrow. We certainly supported that bill. I have talked with individual members. I've been to both meetings they've had to date and had some conversations with Commission members outside of meetings. We fully intend to continue attending meetings. I've toured with one, the Subcommittee on Institution members, two weeks ago or three weeks ago as they were going through and I plan to do so again. We are certainly available to them and we offer complete support.

Q. Would you believe it appropriate in order to assist you in your role that we allow you broader access to documents and patient records at the institutions?

A. It becomes absolutely essential to have that and the first thing that needs to be accessed voluntarily on the part of the institutions are the incident reports I mentioned earlier. Patient charts we have access to on a case-by-case basis and for

those wards under guardianship. We need access to statistics generated by the institution. We need access to reports that they put out on a monthly basis concerning care and treatment. We need access to reports on deaths. All of those things need to happen.

Q. Now, would any of that violate state and federal statutory or regulatory prohibitions regarding confidentiality of information?

A. To the best of my knowledge, no. If they're general reports certainly providing statistics and numbers, certainly it would not. Patients for whom we have no access to charts, i.e., individuals who are not represented or those who are not state wards, people who do not fall into those categories, it would be a violation of their confidentiality. We would have to have their consent, but I see no reason why reports with names cleaned - purged out of them, but then again that would lead us into abuse, so we'd probably have access to that, too. We're very conscious of not wanting to, as much as we want full information, not wanting to violate or abrogate someone's right to confidentiality. But they produce all sorts of reports that would not be in violation if we had them.

Q. Thank you very much. Are there other questions of the Committee? Rep. Manning.

BY REPRESENTATIVE MANNING

Q. Tom, just to follow up a couple - just recently the question under - Paul talked about federal and state confidentiality

reports. Under the federal law you -- do they give you any leeway on the confidentiality?

A. Absolutely. Helen can correct me if I'm wrong. We have access to the patients I mentioned, those under public guardianship and those who ask us to represent them. We also have access where we suspect - and we have to have good reason to suspect - abuse and neglect is occurring, i.e., these death investigations. In cases of abuse and neglect that did not involve death, we would clearly want to talk to the patient and get their permission before we represented them. And we - the statute which - if we haven't provided you with a copy of it, we certainly can - gives us access to representing patients for whom or who may lack the capacity to give informed consent if we have reason to suspect that abuse or neglect is taking place. It's a broad federal mandate.

Q. Did it get broader with the Weiker -

A. This is the Weiker. This is the Weiker. As far as what we do with the information, we're required to follow the same standards as the institution or agency from whom we receive the information.

Q. Okay. Just - do you have keys?

MS. BAILEY - There is something I would like to add to that - to our access problem. I haven't had opportunity -

SEN. GAUVREAU - For the record, this is Helen Bailey. For the record.

MS. BAILEY - I haven't had the opportunity to read his opinion, but apparently there's an opinion from David Markaza in the mail to me regarding our access, because I had been in contact with the Adult Protective Service regarding representation of wards of the Department of Human Services. Upon our receiving complaints as to their treatment, he has a difference of opinion as to our access to records. I have not yet received his letter. I will have it tomorrow. I don't - I have some impression that it may be something of a stall or an honest difference of opinion as to interpreting whether or not -- existing system or whether or not we need some enabling legislation. I should be able to get that letter hopefully by tomorrow and can share it with you.

Q. Who's David Markaza?

MS. BAILEY - David Markaza is an assistant attorney general with the Department of Human Services and he's specifically representing Adult Protective Services. I spoke with James Tierney on Friday, told him that we had a brewing misunderstanding as to whether or not we were entitled essentially as an existing system without -- enabling legislation. And he said he didn't know that this was brewing. He didn't know anything about it, but would check it out, check into it, but as of tomorrow I might have some information for you. If there is a need for enabling legislation, which I don't believe, that may be something you need to address.

Q. Okay. Thank you. Just out of curiosity, you don't have a key

anymore, do you?

MR. WARD - No, they made a point of taking it away from me when I left. They do give me keys when I go over. I can ask for a key and be given one.

Q. So the only time I can get a key is to go talk to Richard.

A. Well, no, not really.

Q. Richard has a key and can go in night or day.

A. Richard has a key. If I go up to the switchboard and ask for a key, they'll give me one, but the chief of hospital services tracked me down and said he wanted his key back. I gave it to him.

Q. This is kind of a loaded question, but I mean what hasn't been loaded. The chief advocate of the Department reports directly to the Commissioner. What would you say if a piece of legislation that the chief advocate now reports to the Commission of Mental Health? I mean, I set that group up and I can say that, you see, it was my idea and I set it up simply because I thought it should be an advocacy group to advocate not only for the community side, but for the institutional side. Why not then have a chief advocate report to the Commission on Mental Health, which is an advocacy group, which is much more powerful under the statute now than under the old Mental Health and - Mental Health Advisory Council.

A. I haven't really thought about that. I mean, I don't know. I think I see some pitfalls there. I think that the chief advocate

should have total access to that Commission. Perhaps a better solution than that would be legislation that would put the chief advocate on a par with the Commissioner, giving him as much access to the Legislature and other bodies. In effect - and you might want to talk to Richard about this - in effect, creating an Office of Advocacy that was not tied to the Department in terms of lines.

Q. Okay. You talked about earlier families and all, you know, they don't understand what's going on, would this be similar to what they have like in special ed like what they call - I guess they call a pet meeting where the parents would come in and the guardians would come in and they would have somebody available if they wanted to have somebody represent them or do we have to get that far into a system like that.

A. I think you'd need to look in terms of perhaps - and I don't think this is a strict analogy, but more in line with what the IDT process is with BMR. What is needed is for when a patient, a family member or both are involved in treatment planning that those people need to be assured that treatment will be delivered and that there needs to be an accurate needs assessment. Right now one of the problems with treatment planning involving patients, families or anyone else is that the needs are dictated by what resources are available. There is nothing to drive this system so that needs can be found out. The patient's need are deemed not to exist if AMHI can't meet them if they don't have the

resources. They don't even write them down. And there is no enforcement mechanism other than the grievance procedure.

Q. So you advocate for more advocates whether it's in the system over at AMHI or a family type of advocate. I mean, my concern this morning was, you know, there are people who know the system, people who have been involved with the system can get answers a lot quicker than that person who has no way to turn. How do you like that idea of the family advocate type of thing. Would that person deal strictly with the concerns of - I mean, is there enough work to keep one person going maybe either in the system or in each institution, where that person's one main concern is to deal with guardians and family concerns and things like that and getting back to them in a timely fashion. And do we need that over and above the advocates or do we need more advocates over there also?

A. One of the problems you're going to run into if you have that is that many times patients, for whatever reason, do not want their family members deciding what their treatment options are going to be if they're not under guardianship. And you may run into advocates versus advocates. Certainly concerned family members need to have information. They need to know what's going on and they need to know where to go to get information and I think education and support can do a lot in those ways. My suggestion would be to increase - I think you need to increase the number of advocates in the institution anyway.

Q. So that they could share that family responsibility so you're not advocate against advocate, you're -

A. Or not set up a situation where it's family - I'd hate to see any situation where you're exploiting family versus patient and that would be my fear.

Q. You know, my concern is some of these people are just - you know, where is the coat that we bought her last year. You know, we go up and we see her and all of a sudden the coat that we bought her and the boots that we bought her are gone.

A. Okay.

Q. And, you know, where are those. You know things that - if it means just more advocates in giving you responsibility to get back to Mrs. Jones who wants to know about her daughter who's coat is missing, fine and dandy, I just - I'm concerned that there are parents out there and relatives and friends and people who are some type of guardian. There's the guardian and then there's the people who are guardians who don't have - who don't know how to use the system. I mean, that's the worse part of those -- there are people out there who just don't know how to, you know, go about contacting people and they just sit there and just wonder what's going on.

A. I think that the best way to approach that and, hopefully, in those cases you're actually talking in concert with - or family members and patients acting in concert and I think that an increased number of advocates within the institution could

take care of those problems without designating some of them as purely -

Q. Family advocates.

A. Family advocates and I think vitally important in conjunction with that is intensive training support for family members in the community on who to contact, how to self advocate, you know, how to advocate for your family member and where to get information on how to do it on an ongoing basis.

Q. Okay.

SEN. GAUVREAU - Are there other questions? Rep. Pederson.

BY REPRESENTATIVE PEDERSON

Q. Good afternoon, Tom, or good evening. Is it true that the client or the patient has to ask to be advocated for?

A. That's correct. And the way that they're informed is that when they come in on admissions amidst all the other information that they're given or being asked, they're given a cursory review of their rights, saying that they have a right to representation.

Q. Is this - do you see this sometimes as a problem for you? In other words, when a patient has a problem that you cannot run up and advocate for them unless they ask you to?

MS. PETOVELLO - That may be true for the Office of Advocacy. If we receive a complaint or have reasonable cause without even receiving a complaint of abuse or neglect, we can advocate under our federal statute without any request.

MR. WARD - That's correct.

Q. Is that also true of the advocate that's in the hospital?

A. Yes. But unfortunately, what happens is that many patients don't know and many things don't get brought to light. I mean there's no comprehensive system. The way that I found out about things at AMHI was by being on the wards a lot over splitting three shifts.

Q. Did you notice while you were at AMHI that there was at least some problem of retaliation if a patient complained that sometimes they were sort of retaliated against and that when the family also sometimes complained, then they were - felt that they were in a box and they felt that if they did complain too harshly or made too much of an incident, then their family member might be retaliated against in some form?

A. Those concerns were voiced to me fairly often. Family members were concerned about raising their concerns, about raising allegations, about demanding more for fear that people would get less or that if they were discharged and came back and found out - particularly if they were discharged on the outside, found out about something that had happened, they'd be unwilling to bring that back to the hospital for fear of rehospitalization would bring about retaliation. Patients on units were oftentimes afraid of raising concerns because of fear of retaliation and staff who wanted to were often afraid about speaking out because of fear of reprisal from co-workers and superiors.

Q. I was interested in some of the other reports. Do you have - or do you have any idea how many reports of pregnancy occurred at the hospital or do you have -

A. I recall four, but they were not - they were patients who were admitted while pregnant.

Q. Did you also have any occurences or reports of VD?

A. Again, I don't recall any. We did have numerous instances of scabies, lice and crabs. Certainly I did get - and I could never ever substantiate this, because patients' testimony or word is not considered good. Patients were not - many did not feel safe at night with the lack of staff that they were being sexually advanced upon by other patients and you're talking about four patients in a two-patient room or eight in a four-bed dorm. To raise this, one, I was never going to put myself in a situation where it was patient versus patient and, two, to make anything - make a substantive charge against the administration I would have had to have more proof and I just could not get the documentation.

Q. I want to try to clear up another question, I think, that Rep. Clark asked. I think that her question was that was the report of the - that was given out by Ron Welch and this report here.

A. That's correct.

Q. And one of the things that I notice is a difference in that report as to another report that give the cases. The other

report gives an account of what happened in the case, which the report that we were talking about that was given to the Mental Health Commission did not have the cases reported. In other words, they could have blocked out the name of the client they have, give a case which would give you a scenario of what actually this was all about, whereas the report that was given to the Commission gives recommendations for solutions and did not give the background on the case.

A. That's correct. The more detailed report was the report of the panel to the Commissioner. I think it would have been much easier - they could have just as easily have run this through the word processor and deleted the names and provided those to the Commission. They are available.

Q. That's all. I mean, I remember that - talking to some of the people on the Commission. They felt also that they had laundered reports and they were - it was hard for them to understand what they were recommending because they didn't understand how that case developed. Thank you.

SEN. GAUVREAU - Rep. Dellert.

BY REP. DELLERT

Q. Yes, I have a couple of questions. Didn't you attend hearings on overcrowding? The meetings of the committee to study overcrowding at AMHI?

A. I was - I testified at one and attended two others.

Q. Didn't you voice any concerns then?

A. Absolutely. I voiced within the limited time period that I had then. I voiced many of the same concerns that I have now.

Q. Did you read the report when it came out?

A. When, the interim or the final?

Q. Both.

A. I read them both.

Q. I have one other statement I'd like to make, Chairman Gauvreau. I'm a little concerned. I come from the Gardiner - Augusta/Gardiner/ Randolph area and I hesitate to hear people that I know - names being used in a thing where they had no chance for rebuttal. I'm just very, very concerned about that and I would think they would and I would think the union would. I'm just a little concerned about that.

SEN. GAUVREAU - You're speaking about having a chance -

REP. DELLERT - He's referring to names and they have no chance -

SEN. GAUVREAU - Right. He made comments regarding certain levels of care provided by certain individuals.

REP. DELLERT - Right. And I think that's a very dangerous thing to do.

A. Would you like me to respond to that?

REP. DELLERT - I don't care if you do or not. I'm just voicing my concern, that's all. I think they would be very concerned to have their names used like that without a chance for rebuttal.

A. And I - well, and I think I mentioned that if this Commitee decides to call them that I would expect them to deny and refute

completely. I struggled with whether I should name names and I decided to, because what I've heard so far from the Department has been a mindless, nameless, nobody's to blame and if you care to call them, call them. And I mean, I can understand why they may be concerned and I can understand why the union would be concerned, but I have a concern -

REP. DELLERT - I'm concerned myself that I might be used in a case like that.

SEN. GAUVREAU - Rep. Hepburn.

BY REP. HEPBURN

Q. Thank you. Tom, there's been several comments today about the - you know, the feeling of a large number of people at AMHI concerning - maybe the staff has become institutionalized, I don't know, they - maybe a feeling of a callousness has developed or you spoke to them I think that in some levels they are to protect each other rather than necessarily provide the highest level of care. Is that a fair characterization of -

A. I would say that that's absolutely true.

Q. Okay.

A. I would couch that in terms of it is not all staff. I mean, I need to be very clear about that.

Q. No, you made that clear, I think. Let's just say were you king of the system for a day or for a month -

A. I was thinking about applying for the superintendent's job.

Q. Were you? I hear they're looking for one. If you could do

anything and all rules were aside, how many people would you - not to name names, of course.

A. Certainly not.

Q. Just in terms of numbers, what - or is there a certain number at the top that you think maybe ought to be cleaned out or -

A. Hm-mm. Either cleaned out or made accountable.

Q. I see. Ten to fifteen come to mind.

A. Is that right? Okay. Of course, in a lot of - even if that - if that can be done, obviously, you know a lot of the problems, but if that could be done, there's a shortage of psychiatrists. I don't know. What do you think about that. Do you think that's a real shortage? I mean, that's been raised as a problem, you know, in these hearings.

A. There is a shortage of psychiatrists. It becomes a question of whether anybody is willing to put up with poor quality medical care as has been defined by many bodies by this point for the sake of having a psychiatrist. It seems - somebody was quoted in the paper as saying, you know, the psychiatrists - some of them seem to change from one institution to the other and so it's the same church, different pews, from Togus to AMHI to Togus to AMHI. You have a shortage of psychiatrists now. If you cannot hold those psychiatrists - all of them, not just the ones who are trying to do their jobs - to an articulated standard of care that will result in good treatment, then it makes no sense to keep somebody who is not doing that around.

Q. Okay. I see that, but if we got into a situation where we were to let certain people go, for example, and then the argument might be, you know, one that would have to be settled somewhere was that, you know, is no shrink better than the bad shrink, I don't know. Or in terms of RNs, is a bad RN better than no RN if we can't hire a new one. What do you think? I'm just giving you open ended questions. I'd like to hear what you have to say about it. Do you think we can find people out there that will do that?

A. I think - and I've had some conversations with members of the Subcommittee on Institutions that there are recruiting mechanisms that can be employed. Dr. Elkins seemed to agree with me. I would say that no shrink is better than a bad shrink. In terms of meeting accreditation and certification I'm sure it looks better to have a body on board in terms of day to day care. Most of it is provided by social workers, nurses and mental health workers to begin with.

Q. Okay. Thank you.

SEN. GAUVREAU - Are there other questions of the Committee? Sen. Titcomb

SEN. TITCOMB - I just had a thought as Rep. Hepburn was asking you about the lack of quality available staff. Do you perceive that there's a possibility that knowing the conditions and historic conditions and certainly of late more aggravating conditions at AMHI that a person of especially good stature

within the medical field would have a questionable time stepping into that situation.

A. It's possible. There are a couple of - a couple of psychiatrists there, two or three come to mind immediately, of exceptionally good stature who are working there because I believe they like working in that setting. To me it's no different than an attorney who wants to do poverty law. I think you can find them. I think people would step in. You'd probably have to pay them a little more and probably not step in if they're going to have a caseload of one to God knows how many, but they would do it.

SEN. TITCOMB - Perhaps if we improved the conditions and make it apparent that we know that AMHI has not closed that we're going to begin to attract some good quality people.

A. The key needs to be reducing the population. That is a 250-bed hospital. It is not a 343-bed hospital that became a 343-bed hospital as the census went up. That's all that happened. It's designed for 250 and adding more, except in the short term as an interim to stabilize, is not going to be the solution. If you downsize the hospital, you're going to downsize the caseloads and I think that would be more attractive to some practitioners.

SEN. TITCOMB - That was - I just wanted to make sure that that point was made that if the hospital situation is improved, then, in fact, I think we may find people more willing to put their shingle up on the wall.

A. And if it's improved - if people see that it's - if people can have a reasonable hope that it's going to be improved, you may not have to wait until the actual improvements take place.

SEN. TITCOMB - Thank you very much.

SEN, GAUVREAU - Rep. Boutilier.

BY REPRESENTATIVE BOUTILIER

Q. Tom, just two quick things just on what you recently stated. One having to do with the physicians, it was stated that maybe a better way to handle it, I believe, Laura mentioned about contracting the physicians rather than using in-house. Do you have any comment on that? You were making the statement that you thought there were some good ones in-house.

A. Psychiatrists.

Q. Psychiatrists. Do you think that we should maintain that and try to attract just good psychiatrists that want to be in that environment or do you think we'd have a more successful recruitment tool if we contracted rather than had in-house psychiatrists.

A. I don't think that the rent-a-doc approach, as they call it, has worked particularly well. They did that in order to get somebody and they paid substantially more for those people. In terms of psychiatrists, I think it would work well if you could attract some people who'd want to be in-house. In terms of medical care within that facility, I think it would be

appropriate to try to contract out for medical physical treatment.

Q. Okay, but not the psychiatrists then.

A. No, I don't necessarily see that. I mean, again it all gets down to the fact that there's a confusion of roles and if you contracted out for medical doctors, you may find less confusion. You'd have to give them appropriate authority.

Q. The last question, somebody mentioned just at the end that the facility is 250 beds.

A. That's correct.

Q. And that we're up to 360 or so. The question I kept asking over and over and I never really thought I got an appropriate answer, but if we had community services, not a new AMHI, not a new separate 100-bed unit in southern Maine or wherever you want to put it, but just the community based services that we currently have but with slots enough to handle, how many people from the current census, not lessening nor greater - or greater admissions, but the census that we have now, how many of those individuals could be placed in a community based setting?

A. Jay Harper says all of them. I tend to agree with that.

Q. You believe that everyone in the current census could be in a community based setting?

A. Depending on the community based setting appropriate to the needs.

Q. Acute care.

A. Acute care is not a long-term care necessarily. You would

still need nursing homes. You would still need a nursing home and you would still need a forensic unit, but the majority of people in the hospital - the psych unit proper, I would say all, could be gotten out. Now, the question is you couldn't get them out tomorrow even if you have the beds, because they'd have to be transitioned out. They'd have to be worked with to be ready to go out, but they could all be out.

Q. And you think in terms of the cost to do that that the quality of care would far outweigh the additional cost?

A. Absolutely. If the treatment system - if the service system, whatever you want to call it, is designed around the patient and if the money followed the patient into the hospital for acute care needs and back out, a really needs driven system.

Q. We're going to be hearing from Peter Walsh tomorrow, right?

SEN. GAUVREAU - Yes.

REP. BOUTILIER - And it was mentioned earlier - in someone's - other testimony, maybe Laura also said that the DHS, the team approach that they use for their wards was a good approach. Back to Rep. Hepburn saying, if you were in the part where you could say, okay, this is the way I'm going to do it, how quickly could you establish a team to do that for people other than DHS wards? Do you think the resources are there and that it just takes more of a real focus by management and by the Commissioner's office and the -

A. Are you talking about in terms of doing an assessment similar

to DHS'?

Q. Yes.

A. You could probably pull that together in a short period of time. I mean, the resources - if the money were there, the resources are there. What you go out and do is contract with quality people to come in and do psychiatric, psychological, medical and social assessments. People probably are in Augusta who could do that. You could take some of the people who DHS used. They seem to have done a very, very good job. They weren't all internal. DHS contracted for some of those people.

Q. Thank you.

SEN. GAUVREAU - Rep. Manning?

BY REPRESENTATIVE MANNING

Q. Two things. When we talk about moving people out of the community into the community, you know, shutting down the institutions, and all that, the concern I have is if we're having a hard enough time getting psychiatrists at one location, it's going to be that much harder to go throughout the whole state, wouldn't it? I mean, that's - I understand what you're saying, but, I mean, it's almost going to be to the point where unless we stop putting out heart surgeons and start pumping out psychiatrists out of medical schools, we're going to be in real deep trouble if we move a lot of patients throughout the whole state because of the lack of psychiatrists. I mean, I think that's one of the key things, isn't it?

A. But I think there are ways to approach that. The first thing you need to do is stabilize AMHI before you talk about going beyond and getting it down to a reasonable census. There are ways to establish residency programs instate and I think that this Committee would do well to talk to Alan Elkins about that. I think there are probably ways to recruit psychiatrists, but, again, before you start, I don't know what kind of a model, whether you're talking about locally based acute care facilities or -

Q. You see, my only problem is I spent, prior to this year, eight years dealing with corrections and eight years dealing with corrections advocates who have said to me time and time and time again that there were alternatives we ought not to be building in the community itself. I sometimes feel that, yeah, there's an awful lot we need to do in the community, but I also sometimes feel that we need to have an institution also, because I don't see the community with all the answers.

A. I think what needs to be explored is what is our concept of community and to me it's an array of services, a constellation of services I like to call it, and what is our concept of an institution. Clearly we need acute care facilities. The question becomes do we need to centrally locate them so that people are torn out of their homes or do we want to somehow try and provide them in a more central location so those acute care facilities become just part of the constellation of services and -

Q. And - okay, when you say acute, you're talking the admissions type of situation in the long term?

A. Not necesasrily. I'm talking about the kind of things that would get somebody into AMHI today.

Q. But what I'm talking about - what if the long term - in the long term where people are - have fallen through every conceivable - you know, the top of the line, the quarter house, the half house, case management and all that stuff, are there not going to need to be places for somebody to be in a long period of time? With good ongoing construction treatment plans.

A. I don't see the need to have people in institutions for years. I don't know what you mean by a long period of time. My approach would be if you need to put somebody in an acute care or let's say a highly restrictive setting, then at that point you have to reassess the treatment you're providing for that person. They may be there for a few months. There may be that need. I have no way of foretelling. But all of the focus has to be on getting them out of that highly restrictive setting. The one point I'd like to get across is institutions are now seen as ends in themselves. AMHI is seen as a treatment end in itself and if we can get acute care facilities away from that idea, I think we can start opening up other possibilities.

Q. Let me ask you another question. Currently under the chart the superintendent answers to the Commissioner. Maybe I should ask Ron Martel that. Is that true? I mean Ron Welch.

MR. WELCH - That's true, he does.

Q. Okay. What if we had to bridge this gap? The superintendents of the institutions answered to the director of - the bureau - director of health, so that person is in charge of bridging the gap between the hospital and the community also.

MR. WARD - Who would in turn answer to the Commissioner?

Q. Who would in turn answer to the Commissioner.

A. I have never given that idea any thought although it's worth considering.

Q. I mean, that person there would - I mean, right now the Bureau - director is Jay Harper. It seems to me he is more concerned - and this has got nothing against Jay Harper, but his main concern right now is the community. Now, we've got a director and we've got two superintendents, but if we had a director who was as concerned about the institutions as he is the community to have the bridging, would it be better to have something like that.

A. Well, first I have to say I don't know that Jay is not concerned with the institutions.

Q. And I don't say that.

A. I believe that he is and I believe that his community package is geared toward decreasing the census. It may not - my uninformed opinion - obviously I haven't given this previous thought, is that it's worth exploring. I mean, that's the most I can say. It would certainly create an overall picture and bring all

of the needs into scope. But how feasible that would be administratively I don't know. I don't know what the objections would be to that.

Q. Let me ask Ron one quick question from the audience. How does that work under the Bureau of Mental Retardation. Does the superintendent of Pineland answer to the Commissioner?

MR. WELCH - Yes. Although Bureau directors by statute in both cases have responsibility for the programs in the institutions.

REP. MANNING - Okay.

SEN. GAUVREAU - Are there any other questions at this time of Mr. Ward? If not, I want to thank you for your presentation and that of your organization. I think it was very helpful, although clearly your presentation was direct and pointed, I think that it's going to steer some - prompt some very important questioning by this Committee and I think we'll all benefit from that in terms of trying to deal with the very severe problems which currently exist at AMHI. This will bring to a close this portion of the hearing. Tomorrow morning at nine o'clock Peter Walsh from the Department of Human Services will make his long awaited presentation dealing with the forty-five wards in the custody of the Department. And once again, as I said, we'll meet here in this room at nine o'clock until eleven o'clock. You'll be excused from going to your legislative session. At eleven o'clock we'll have the State of the Judiciary address.

HEARING ADJOURNED AT 5:50 P.M.