STATE OF MAINE
KENNEBEC, SS.
DOCKET NO. 89-88

SUPERIOR COURT
CIVIL ACTION

PAUL BATES, JOAN CAMERON, Simone Johnson, guardian and next friend of ROBERT JOHNSON, RAYMOND DUTIL, JR., SHIRLEY GIFFORD, MARTHA BRADEEN, MATILDA PERRIN, Betty Chapman, guardian and next friend of TOM CONNORS, Janice Burns, guardian and next friend of WRENDY HAYNES, JOHN BARTON, JOSEPH HORNING and DANA LEONARD,

Plaintiffs

v.

ROBERT GLOVER, in his capacity as Commissioner of the Department of Mental Health and Mental Retardation, LINDA BRESLIN, in her capacity as Superintendent of the Augusta Mental Health Institute, and the MAINE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

and

H. ROLLIN IVES, in his capacity as Commissioner of the Department of Human Services and the MAINE DEPARTMENT OF HUMAN SERVICES

Defendants

SETTLEMENT AGREEMENT

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I. GENERAL JURISDICTIONAL MATTERS

A. Introduction

1. This case was filed by the plaintiffs on February 27, 1989, pursuant to Rules 80C (a) and (i) of the Maine Rules of Civil Procedure, 5 M.R.S.A. § 11001, 34-B M.R.S.A. §§1430, 3003, 3004, 3803 and 3871, 18-A M.R.S.A. § 5-601, Article 1 Sections I and VI-A of the Constitution of the State of Maine, the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

B. Jurisdiction and Venue

2. This Court has jurisdiction to decide this action pursuant to 4 M.R.S.A. § 105, and may grant declaratory relief pursuant to 14 M.R.S.A. §§ 5951 et seq.

3. Venue is proper pursuant to 14 M.R.S.A. § 501.

C. Scope of the Class

4. By order dated June 15, 1989, this Court certified the class in this matter pursuant to Rule 23(b)(2) of the Maine Rules of Civil Procedure as consisting of all persons who, on or after January 1, 1988, were patients at the Augusta Mental Health Institute (henceforth referred to as "AMHI") and all persons who will be admitted to AMHI in the future. The Court also certified a subclass consisting of those persons who are class members and who also have been public wards of the Maine Department of Human Services or who in the future become public wards.

5. In accordance with Rule 23(c)(3), the judgment in this action shall apply to all those persons defined in the foregoing paragraph, subject to the limitation set forth in the Consent Decree.

D. Allegations of the Complaint

6. The fifteen count Complaint alleges that the Defendants have violated Plaintiffs' rights to the following: a reasonable opportunity for physical exercise and recreational activities; adequate sanitation, ventilation and light; protection against physical and psychological abuse; adequate professional medical care and treatment; individualized treatment and service plans; freedom from unnecessary seclusion and restraint; appropriate privacy, humane care and treatment and a humane treatment environment; provision of treatment and related services in the least restrictive appropriate setting; adequate community support services systems and programs following discharge; timely discharge when conditions justifying hospitalization no longer exist; provision of protective services to meet the needs of incapacitated adults; and, for those patients who are public wards, a public guardian who properly and faithfully exercises his duties and responsibilities.

E. Purposes of Settlement

7. The parties to this action agree that the interests of all class members can best be served by entering into this Settlement Agreement (henceforth referred to as "Agreement") rather than by engaging in protracted, expensive litigation.

8. The provisions of this Agreement are a full, fair and appropriate resolution of this case. They address the allegations of the Complaint and provide an appropriate remedy. The Agreement is intended by the parties to assure, inter alia, that conditions at AMHI and services provided to class members in the community will meet constitutional, statutory, and regulatory standards, as applicable.

F. Interpretation of the Agreement

9. In entering into this Agreement, the Defendants do not admit any violation of law. This Agreement shall not be interpreted in any court, administrative or other proceeding as evidence of defendants' liability.

10. The parties agree that the care and treatment of class members implicate rights secured and protected by the Fourteenth Amendment of the United States Constitution, Article 1, Sections I and VI-A of the Maine Constitution, 42 U.S.C. § 1983, 34-B M.R.S.A. § § 1430, 3003, 3004, 3803, and 3871, and State rules entitled "Rights of Recipients of Mental Health Services" and "Rights of Recipients of Mental Health Services Who are Children in Need of Treatment."

11. This Agreement is legally binding and judicially enforceable. This Agreement shall be applicable to and binding upon all the parties; their officers, agents and employees, and their successors; and, to the extent incorporated in contracts as otherwise specified in this Agreement, to agencies which enter into contracts with the defendants for the provision of services to class members.

12. Until the Agreement's termination pursuant to the terms of the Consent Decree, the parties

hereby consent to the court's continuing supervision in this matter, until further order of the Court, and to its authority to interpret the provisions of this Agreement, to review and adopt plans necessary to implementation of its terms, to modify its terms as may be needed to effect its purposes, and to take appropriate actions within its equitable powers to ensure its enforcement and the fulfillment of its terms and purposes.

13. The parties acknowledge that this case is one of first impression for the courts of the State of Maine and that there exists uncertainty and ambiguity as to the questions of law that form the bases of the claims in this action. Acknowledging the foregoing, the parties have elected to enter into this Agreement.

14. The terms of this Agreement shall be interpreted consistent with its overall purposes and principles.

II. DEFINITIONS

l5. As used in this Agreement, the following terms shall have the meanings as set forth below:

Parties

a. **Plaintiffs/Class Members**. "Plaintiffs" or "class members" are all persons who, on or after January 1, 1988, were patients at AMHI and all persons who will be admitted to AMHI in the future, subject to the limitation set forth in the Consent Decree.

b. **Defendants**. "Defendants" are Robert Glover, in his capacity as Commissioner of the Department of Mental Health and Mental Retardation; the Department of Mental Health and Mental Retardation; Linda Breslin, Superintendent of the Augusta Mental Health Institute; H. Rollin Ives, Commissioner of the Maine Department of Human Services; Maine Department of Human Services; and their successors and assigns.

Terms

c. **Abuse**. "Abuse" means the infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain, mental anguish, or death; sexual abuse or exploitation; or the willful deprivation of essential needs.

d. **Designated representative**. "Designated representative" means any person who has been designated in writing by a class member, or by his guardian, to aid the class member in protecting his rights under this Agreement and mental health regulations. Such person shall not be a current patient of or a staff person currently employed in an in-patient facility.

e. Exploitation. "Exploitation" means the illegal or improper use of an individual or his resources for another's profit or advantage.

f. Individualized Support Plan. "Individualized Support Plan" (henceforth referred to as "ISP") means a written document prepared by a team of persons including the class member, which includes an assessment of the class member's strengths and needs, and describes the class member's goals and objectives and the services the class member needs to meet those goals and objectives. The document is described in greater detail in Section VI of this Agreement.

g. **Informed consent**. "Informed consent" means consent given by a person who has capacity to make reasoned decisions. Informed consent is based on an actual understanding of: (i) the nature of the proposed treatment; (ii) the expected benefits of the treatment; (iii) the known risks of a particular treatment, including the common side-effects of a particular medication; (iv) the anticipated duration of the treatment; (v) reasonable alternatives to the proposed treatment, if any; and (vi) the right to give or withhold consent to the proposed treatment. Any consent given must be free from express or implied coercion.

h. Neglect. "Neglect" means an act or omission which threatens a person's health or welfare

by placing the person at risk of physical or mental injury or impairment, deprivation of essential needs or lack of protection from these.

i. **On-call**. "On-call" means accessible by telephone or other electronic means of communication and available to report to the work site within 30 minutes of being called.

j. **Patient advocate**. "Patient advocate" shall mean an employee of the Office of Advocacy of the Department of Mental Health and Mental Retardation appointed pursuant to 34-B M.R.S.A. § 1205 and performing duties at AMHI.

k. **Peer advocate**. "Peer advocate" shall mean a consumer of mental health services trained in peer advocacy and selected by the class member to advocate on his or her behalf.

l. **Physician**. "Physician" means, unless otherwise specified, a medical doctor lawfully entitled to practice medicine.

m. **Physician Extender**. "Physician Extender" means a physician assistant or a professional nurse practitioner performing duties defined in 32 M.R.S.A. § 2102 in accordance with rules promulgated by the Board of Registration in Medicine.

n. **Psychiatrist**. "Psychiatrist" means a physician who either is certified by or is eligible for certification by the American Board of Psychiatry and Neurology or who has successfully completed an approved residency program in psychiatry and upon completion of post-residency requirements will become eligible for examination for such certification.

o. Rehabilitation. "Rehabilitation" means activities designed to prevent or minimize disability while restoring the individual to the optimal level of physical, cognitive and behavioral functioning.

p. Serious Injury. "Serious injury" means a bodily injury which creates a substantial risk of death or which causes serious, permanent disfigurement or loss or substantial impairment of

the function of any bodily member or organ, or which requires extended convalescence necessary for recovery of physical health.

q. Treatment. "Treatment" means any activity meant to prevent, ameliorate, prevent deterioration of, or cure a person's mental health problem or mental illness and shall include behavioral, psychological, medical, social, psychosocial and rehabilitative methods which meet usual and customary standards in the field of mental health treatment.

r. **Weekdays**. "Weekdays" means Mondays, Tuesdays, Wednesdays, Thursdays and Fridays, excluding legal holidays.

III. CLIENTS' RIGHTS

A. Grievances

16. Notwithstanding any other remedies available under law, class members, or guardians acting on their behalf, may bring grievances claiming that the practices, procedures or policies of the defendants or of any agency licensed, funded or contracted by the defendants to provide services elsewhere described in this Agreement, violate the terms of this Agreement or any other applicable law or regulation.

17. By February 1, 1991, defendants shall draft rules for the processing of grievances. Said draft rules shall be submitted to counsel for the plaintiffs and to the master for his approval in accordance with paragraph 293 of this Agreement. Defendants shall thereafter promulgate said rules in accordance with the Maine Administrative Procedure Act, 5 M.R.S.A. §§ 8051 et seq.

18. Said rules shall include provisions for the giving of adequate notice to class members of their right to file grievances, of the process whereby grievances may be filed, and of their right to be assisted throughout the grievance procedure by a representative of their choice. The notice shall list and briefly describe the advocacy services available through the Office of

Advocacy, the protection and advocacy program established pursuant to 42 U.S.C. §§ 10801 et seq., peer advocates, and the Ombudsman program established pursuant to 22 M.R.S.A. § 5112(2).

19. The grievance procedure shall be designed to assure speedy resolution of matters aggrieved. It shall include provision for a hearing, recorded verbatim, before an impartial hearing officer. An expedited procedure shall be available for emergency complaints and for all complaints regarding the development, substantive terms or implementation of ISP's or hospital treatment and discharge plans. Grievances which include allegations of employee misconduct shall be processed, except that no disciplinary action may be taken nor facts found with regard to the alleged misconduct except in accordance with personnel rules and labor contract provisions.

20. Grievances regarding AMHI shall be addressed to the Superintendent, who shall refer them to the appropriate supervisor or director for decision. These decisions may be appealed to the superintendent and finally to the Commissioner of the Department of Mental Health and Mental Retardation. Grievances arising in the community shall be addressed to the agency employee designated to hear grievances. Decisions may be appealed to the Director of the Bureau of Mental Health and finally to the Commissioner of the Department of Mental Health and Mental Retardation. The hearing before an impartial hearing officer shall be convened at either of the two appellate levels. The decision rendered at the commissioner level shall be final agency action subject to judicial review pursuant to the Maine Administrative Procedure Act.

21. Grievances may be brought by or on behalf of individual clients or groups of clients.

B. Complaints

22. By February 2, 1991, defendants shall draft rules for the processing of complaints as described herein. Said draft rules shall be submitted to counsel for the plaintiffs and to the master for his approval in accordance with paragraph 293 of this Agreement. Defendants shall thereafter promulgate said rules in accordance with the Maine Administrative Procedure Act, 5 M.R.S.A. §§ 8051 et seq.

23. The complaint procedure shall be available to any person or agency which is charged with investigating violations of client rights or with delivering or monitoring mental health services. The complaint procedure may be used when:

a. such person or agency knows or has reason to believe that the practices, procedures or policies of defendants or of any agency licensed, funded or contracted by the defendants to provide services elsewhere described in this Agreement, violate the terms of this Agreement or any other applicable law or regulation; and

b. the information was obtained during the general course of the person's or agency's performance of their responsibilities.

24. Complaints which include allegations of employee misconduct shall be processed, but no disciplinary action may be taken nor facts found with regard to the alleged misconduct except in accordance with applicable personnel rules and labor contract provisions.

25. The complaint procedure shall be designed to assure speedy resolution of issues giving rise to complaints. Complaints regarding AMHI shall be addressed to the Superintendent, who shall refer them for decision to the appropriate supervisor or director for decision. The decisions may be appealed to the superintendent and finally the Commissioner of the Department of Mental Health and Mental Retardation. Complaints arising in the community shall be addressed to the agency employee designated to receive complaints and may be

appealed to the Director of the Bureau of Mental Health and finally to the Commissioner of the Department of Mental Health and Mental Retardation. Investigations shall be conducted at each level of the complaint and shall include, as needed, interviews, site visits, or other data collection activities. At the conclusion of each investigation, a written summary of the results of the investigation and a statement of the remedial action to be taken, if any, shall be provided to the complainant.

26. Under no circumstances shall the remedies requested in a grievance be denied nor shall the processing of a grievance be refused because of the availability of the complaint procedure. The complaint procedure is intended to offer additional protection to clients under the circumstances where information of violations of clients' rights is acquired but no client is known or is available who might process a grievance.

D. Reports

27. Defendants shall prepare semi-annual reports of all complaints and of all grievances appealed to the Superintendent of AMHI, the Director of the Bureau of Mental Health and the Commissioner. Said reports shall summarize the issues raised, findings made, and remedial action taken, and shall be submitted to the master, counsel for the plaintiffs, and the Office of Advocacy.

C. Rights Regulations

28. By February 1, 1991, defendants shall draft revisions of the "Rights of Recipients of Mental Health Services" and the "Rights of Recipients Who are Children in Need of Services" as needed to incorporate the rules governing grievances and complaints, required above, and all other terms of this Agreement. The draft revisions shall be submitted to counsel for the plaintiffs and the master for his approval. Defendants shall thereafter adopt said rules in

accordance with the Maine Administrative Procedure Act, 5 M.R.S.A. §§ 8051 et seq.

29. Defendants shall not by rule diminish the rights guaranteed clients under the existing regulations and this Agreement.

30. Defendants shall include in the revised regulations the right of all clients to exercise their rights under said regulations and this Agreement without reprisal, including reprisal in the form of denial of or termination of services.

IV. PRINCIPLES GOVERNING A COMPREHENSIVE MENTAL HEALTH SYSTEM

31. The parties recognize that while the State has invested significant resources in AMHI, improvements in the quality of care to class members can only be achieved by reducing AMHI's census and admissions, reallocating AMHI's resources and increasing community services as alternatives to hospitalization. Defendants shall undertake these efforts as part of an overall effort to establish and maintain a comprehensive mental health system which meets the terms of this Agreement.

32. The following principles shall govern defendants in the development and in the overall and day-to-day administration and maintenance of a comprehensive mental health system to meet class members' needs:

a. Class members are at all times entitled to respect for their individuality and to recognition that their personalities, abilities, needs, and aspirations are not determinable on the basis of a psychiatric label.

b. Class members have individualized needs which may change or vary in intensity over time and according to the individual's circumstances. Needs may span those for housing, financial security, health and dental care, socialization and companionship, spiritual growth, recreation, transportation, education, vocational opportunity and training, emotional support, psychiatric

treatment and crisis intervention and resolution services. Services to meet these needs must be delivered according to flexible models which accommodate changes in individual class members' needs and the variations in the intensity of their needs. The services shall be flexible so that support and supervision may be increased or decreased as the class member's needs change and, to the extent possible, without requiring the class member to move to another setting.

c. Hospitalization physically separates individuals from their families and friends and creates difficulties for these persons in reintegrating into the community upon discharge. Hospitalization at AMHI additionally uproots many individuals from their home communities. All services within the comprehensive mental health system shall be oriented to supporting class members to continue to live in the community and to avoid hospitalization. When class members require psychiatric hospitalization due to medical necessity, services shall be oriented to hospitalizing them in facilities nearest their homes and thereafter discharging them to the community with all necessary supports as soon as is medically possible.

d. Patients have the right to receive treatment in the least restrictive available setting according to the least restrictive means appropriate to their needs.

e. The comprehensive mental health system shall be designed and services shall be delivered based on identified individual needs.

f. Class members have the same rights as do all other citizens of Maine, including the right to live in the community of their choice without constraints upon their independence, except those constraints to which all citizens are subject.

g. Non-class members shall not be deprived of services solely because they are not members of the plaintiff class.

h. Class members have the right to refuse all or some of the services offered, subject to the exceptions noted below. A person's refusal of a particular mode or course of treatment shall not per se be grounds for refusing a class member's access to other services which the person accepts. Only the following services may be imposed against a class member's wishes:

i. involuntary hospitalization pursuant to 34-B M.R.S.A. §§ 3863 et seq.;

ii. forensic services pursuant to 15 M.R.S.A. § 101-B in a residential or hospital setting;

iii. as permitted under applicable law in the case of a person under guardianship, upon the guardian's informed consent and within the limits of the guardian's authority;

iv. in a residential or hospital setting in a psychiatric emergency, pursuant to procedures as set out in this Agreement at Section IX(E), and in the "Rights of Recipients of Mental Health Services"; or

v. in a residential or hospital setting, for individuals who lack capacity to consent to services, pursuant to the administrative hearing provisions of the "Rights of Recipients of Mental Health Services."

V. DEVELOPMENT OF A COMPREHENSIVE MENTAL HEALTH SYSTEM

A. General

33. Defendants, the Commissioner and Department of Mental Health and Mental Retardation, and the Superintendent of AMHI, shall be responsible for the establishment and operation of a comprehensive mental health system in accordance with the terms and schedule as set out in this Agreement.

34. Defendants, the Commissioner and Department of Human Services shall:

a. Participate in the design, recruitment, development, funding and review of programs which are needed for a comprehensive mental health system and which do or will receive

Departmental funding or be subject to Departmental oversight; and

b. Institute appropriate mechanisms to assure that mental health services receive maximum federal financial participation.

B. Development Plan

1. General Plan

35. By January 1, 1991, Defendants shall develop a plan detailing efforts they will undertake in meeting all their obligations under this Agreement. It shall include descriptions of efforts in developing, funding, maintaining, monitoring and evaluating a comprehensive mental health system which meets the terms of this Agreement. Said plan shall be submitted to the court, counsel for the plaintiffs and to the master for his approval in accordance with the procedures set out at paragraph 293 of this Agreement.

36. The plan shall describe each component of the system, its costs and funding sources, timelines for development or implementation, and the means whereby its quality and effectiveness shall be monitored and evaluated on an ongoing basis. For each client service component of the system, the plan shall additionally: describe the models to be used and the capacity of the services both in terms of numbers of individuals to be served and the intensity of services delivered; demonstrate that development plans are based upon class members' actual needs for the planned services, and enclose supporting data.

37. The plan shall verify with supporting data that in meeting class members' identified needs, defendants shall not deprive non-class members of services solely because they are not members of the class.

38. Defendants shall comply with the performance terms and schedule of the plan. The plan may be revised with the master's approval. Defendants must seek revision of the plan as

needed to assure that services are developed based upon class members' actual needs.

39. In the quarterly reports which defendants prepare pursuant to paragraph 280 of this Agreement, defendants shall enclose data demonstrating that the plan for development of a comprehensive mental health system continues to be based upon class members' actual needs as reflected in their Individualized Support Plans.

2. Plan for Reduction of AMHI's Census

40. By August 1, 1995, defendants shall reduce the non-forensic census and licensed capacity at AMHI to 70 persons. No more than 20 of these individuals may be persons requiring intermediate care facility or skilled nursing facility services. Defendants may additionally maintain a forensic unit limited to persons admitted pursuant to Title 15 M.R.S.A. Chapter 5, or who are under sentence to or committed to a State or county correctional facility.

41. Defendants shall meet the reduction of AMHI's population according to the following schedule:

200 by August 1, 1992

150 by August 1, 1993

100 by August 1, 1994

70 by August 1, 1995

42. The plan required by paragraph 35 of this Agreement, shall include specific references to how the comprehensive mental health system will achieve required reduction of AMHI's census and admissions.

43. The plan shall refer to client-specific ISP's and hospital treatment and discharge plans of all class members hospitalized at AMHI as of the date of this Agreement who have diagnoses of mental retardation, other developmental disabilities, traumatic brain injury, dementia

(including Alzheimer's disease or a related disorder) or a primary diagnosis relating to substance abuse or dependence. For each class member, the plan shall describe the community services to be developed or used, and timelines for development and discharge.

44. The plan shall refer to client-specific ISP's and hospital treatment and discharge plans for each individual whose admission to AMHI exceeds 150 days. This portion of the plan shall be updated quarterly to include additional class members whose admission to AMHI may later exceed 150 days. For each class member, the plan shall describe the community services to be developed or used, and shall specify the timelines for development or discharge.

45. To assist the defendants in developing their plan for reduction of AMHI's census, and to assist the ISP and hospital treatment and discharge teams in developing the client specific plans required by paragraphs 43 and 44, defendants shall retain a review panel by October 1, 1990, consisting of two professionals to assess individuals currently hospitalized at AMHI and to develop recommendations to the teams. One of the professionals shall be chosen by defendants, the other by counsel for the plaintiffs. Defendants shall retain additional professionals to perform assessments as needed in individual cases.

46. The recommendations of the panel shall be prepared and submitted to counsel for the plaintiffs, the master and the individual ISP and hospital treatment and discharge teams by March 1, 1991. During each successive quarter, the panel shall be reconvened to conduct assessments of newly-admitted patients and to issue recommendations respecting their discharge and community support service needs, for as long as the master deems it necessary.

47. On the basis of the panel's recommendations, either party may request revision of the schedule for reduction of AMHI's census. Said request shall be submitted to the court, the master and opposing counsel. No revision shall be approved unless the party requesting the

revision can demonstrate its necessity on the basis of the assessment information, and further, that the purposes and principles of this Agreement can be achieved with implementation of the revised terms.

3. Plan for Reduction of AMHI's Admissions

48. The plan required by paragraph 35 of this Agreement shall include descriptions of general efforts which the defendants will undertake to divert the following persons from admission to AMHI, to treatment in appropriate settings: persons who are diagnosed as having mental retardation, other developmental disabilities, traumatic brain injury, dementia (including Alzheimer's Disease or a related disorder), or a primary diagnosis relating to substance abuse or dependence. Efforts shall include training of personnel employed in the AMHI admissions office and in community agencies which routinely refer persons for admission to AMHI. Training shall include, but not be limited to, the following topics: the identification of persons, noted above, who are to be considered for diversion from admission to AMHI; determination of appropriate treatment for said persons; and available treatment programs. Defendants shall rely upon highly qualified professionals to perform this training.

VI. INDIVIDUALIZED SUPPORT PLANS

49. Class members are entitled to receive an Individualized Support Plan as described below, which is coordinated and monitored by a community support worker.

A. Delivery System

50. Defendants, Commissioner and Department of Mental Health and Mental Retardation shall establish, either within the Department or through contracts with private agencies, community support services which, within reason, are accessible geographically to all class members. The plan described in Section V(B) above shall also set forth a schedule, on an annualized basis, for

meeting the needs of class members for community support workers and for ISP's which conform to the requirements of this Agreement. The needs shall be met as quickly as possible. In any event, defendants shall assure that all class members who want an ISP or community support worker shall have them by September 1, 1995.

51. Agencies with which defendants contract shall be required by contract to meet all applicable sections of this Agreement. Such agencies shall be subject to sanctions for non-compliance, including, but not limited to, revocation of the contract.

52. Agencies contracted to provide community support services shall be required to cooperate with defendants in collecting data necessary to the meeting of defendants' obligations under this Agreement. Such agencies shall also be required to maintain current client records which chart progress toward achievement of client goals and which meet applicable requirements of contract, law, regulations and professional standards.

B. Application/Referral for Services.

53. Defendants shall make efforts reasonably calculated to inform class members of their right to receive the services of a community support worker and other individualized support services in accordance with an ISP. Such efforts shall include notice to individual class members whose locations are known and to community and governmental agencies which are known to serve class members. Class members who decline the services of a community support worker or an ISP shall be informed that they may apply for these services at any subsequent time.

54. Class members may apply for the services of a community support worker on their own or with the assistance of a referring agency. With the class member's consent, the referring agency may apply for services on the class member's behalf.

55. A class member who applies for community support services while an inpatient in a psychiatric facility shall be assigned a community support worker within two working days. The community support worker shall be responsible for participating at hospital treatment and discharge planning meetings and for developing an ISP in coordination with the hospital discharge and treatment plan while the class member is in the facility. Upon the class member's discharge, the individual's community support worker shall meet with the class member within four days of discharge, immediately implement the ISP developed during hospitalization and assure that the individual receives the services identified for delivery. Within 30 days of discharge, the plan shall be reviewed and revised. This paragraph shall not be construed so as to prevent the discharge of a patient when a community support worker has not been assigned in conformity with this section.

56. Class members who apply for services and who are not hospitalized at the time of application or referral, shall be assigned a community support worker within three working days of the application. The assigned worker shall meet promptly with the class member and work to meet the his or her needs until such time that the needs are met or an ISP is developed. An ISP shall be developed no later than 30 days from the date of application.

57. Upon application for services, all class members shall be notified of their rights under this Agreement and under the "Rights of Recipients of Mental Health Services" and of their right to name a designated representative or representatives to assist them, to receive notices of meetings and to participate at meetings. Class members shall additionally be given information regarding available advocacy and peer advocacy programs.

C. <u>Individualized Support Plan</u>.

58. An Individualized Support Plan shall be developed and thereafter reviewed and revised no

less frequently than every 90 days. Plans may be reviewed more frequently as necessary to address substantial changes in a class member's life, such as hospitalization. The ISP shall be developed by a team consisting of the class member, the community support worker and other individuals (including hospital personnel when appropriate) among whom the class member has authorized the exchange of information and who are needed to ensure that the class member's needs are adequately assessed and that appropriate recommendations are made.

59. The community support worker shall notify a class member of all ISP meetings and invite and actively encourage the class member to attend. If a class member does not attend an ISP meeting, the community support worker shall relay the class member's views on issues to other members of the team. A class member's guardian, if any, shall also be notified of all ISP meetings and shall be invited to attend. The class member may invite other persons to ISP meetings and the community support worker shall encourage the class member to do so. Notices required by this paragraph shall be given by the community support worker at least ten days in advance of the meeting date, except that when the meeting is being convened to address an emergency, notice reasonable for the circumstances shall be required.

60. The community support worker shall notify persons that if they are unable to attend an ISP meeting they may submit information in writing for consideration at the meeting.

61. ISP's shall be based upon consideration of the class members' housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional, and psychiatric and/or psychological strengths and needs as well as their potential need for crisis intervention and resolution services. For those areas in which formal assessment procedures are available, strengths and needs assessments shall be conducted by appropriately credentialed professionals, with the class member's consent. Assessments shall be obtained through the

community resources services and programs described in Section VII. These assessments shall be updated as frequently as changed circumstances may require, but no less frequently than the standards of the individual professional discipline dictate in order to assure that the information is current and reliable. For class members who are inpatients at a psychiatric facility, the community support worker shall obtain information from the hospital personnel who have current knowledge of the class member's needs.

62. Services to assist the client in meeting identified needs shall be described. Goals shall be written for each service. Short-range objectives shall be stated such that their achievement leads to the attainment of overall goals. Objectives shall be stated in terms which allow objective measurement of progress and which the class member, to the maximum extent possible, both understands and adopts.

63. Services shall be based upon the actual needs of the class member rather than on what services are currently available. If at the time of the meeting, team members know, on the basis of reliable information that the needed services are unavailable, they shall note them as "unmet service needs" on the ISP and develop an interim ISP based upon available services which meet, as nearly as possible, the actual needs of the client. If, after the meeting, and following diligent efforts to locate the identified services, the community support worker determines that the services are unavailable, the worker shall reconvene the ISP team for the purpose of developing an interim ISP as described above. In all cases requiring interim ISPs, the community support worker shall forward a description of the unmet service needs to the Commissioner of the Department of Mental Health and Mental Retardation, and defendants shall use this information to plan for the development of new services in accordance with Section XV of this Agreement.

64. An ISP shall include a description of the manner of delivery of each service to be provided. The manner of delivery shall be one which maximizes the class member's strengths, independence and integration into the community.

65. Within one week of the meeting, the community support worker shall provide the class member with a written copy of the ISP. The worker shall notify the class member, by means the individual shall most likely understand, of the right to file a grievance should he or she disagree with any aspect of the plan or the assessments upon which the plan is based, or later be dissatisfied with the plan's implementation.

66. Following development of an ISP, the community support worker is responsible for both locating the services identified in the plan and for monitoring their delivery to assure that they are delivered in accordance with the terms of the plan.

67. Because class members have different levels of independence at various times, and because the identified service needs could be either routinely available or highly specialized (and more scarce), a community support worker's efforts to achieve location and delivery of services will vary according to circumstances. At times a simple referral of the class member to a known resource and subsequent periodic telephone contact with the class member and/or service provider, may be adequate to assure proper delivery. At other times the community support worker may need to take a more active role. A more active role may include, but not be limited to, recruitment of a currently non-existing resource, assisting in providing transportation, visiting the class member at home, accompanying a class member to appointments, and actively helping class members to resolve problems.

68. When the community support worker does locate the needed services, he or she shall include the names of the providers and their performance expectations in the service plan.

69. When the service is to be delivered by an agency funded or licensed by the State, the community support worker shall execute a written service agreement with the provider. The service agreement shall describe the service to be provided and any applicable terms as included in the ISP and shall include the following provisions:

"The provider hereby agrees to the following: (a) that it will not discontinue or otherwise interrupt services which the provider hereby agrees to deliver to the client and which are elsewhere described in this agreement, without complying with the following terms:

1. The provider shall first obtain prior written approval from the Department of Mental Health and Mental Retardation;

2. If written approval is obtained as specified above, and, as a result, services to the client will be discontinued or otherwise interrupted, the provider shall give thirty days advance written notice to the client, to the client's guardian, if any, and to the client's community support worker. If the client poses a threat of imminent harm to persons employed or served by the provider, the provider shall give notice which is reasonable under the circumstances;

3. The provider shall give such other notice as may be required by law or regulation; and

4. The provider shall assist the client and the client's community support worker in obtaining the services from another provider.

(b). The provider further agrees that it shall cooperate with the Department of Mental Health and Mental Retardation and the Department of Human Services in collecting data necessary to the Departments' meeting their obligations under the Agreement in Bates, et al. v. Glover, et al.

(c). The provider further agrees that it shall maintain current client records which chart

progress toward achievement of goals and which meet applicable requirements of contracts, law, regulations, and professional standards."

70. In addition to the responsibilities described above, the community support worker shall have the following duties: participation at hospital discharge planning meetings; monitoring of services delivered pursuant to the plan in order to assess their continued appropriateness and effectiveness in meeting class members' needs; appraising progress toward and identifying impediments to the achievement of class member goals and objectives; promoting ongoing class member involvement in the review and implementation of their ISP's; attempting to resolve problems with respect to any component of the ISP; participating in the delivery of crisis intervention and resolution services as described in Section VII(D) of this Agreement and providing follow-up services to assure that the crisis is resolved; assisting in the exploration of lesser restrictive alternatives to hospitalization; for other emergencies which may arise, assisting in resolving them by mobilizing resources or by intervening directly; and otherwise providing personalized support to the class member.

71. The ratio of community support workers to clients shall not exceed 1:40. A reasonable effort will be made to have each community support worker serve clients representing a mix of needs. Individual clients who present a multiplicity of needs, who have recently required crisis intervention and resolution services or who have a need for especially intense community support shall, for purposes of computing the above ratio, be counted as 2.5 clients. In regulating the number of clients assigned to community support workers, due regard shall be given to the community support workers' need for training and the demands for record keeping, travel, and the need for communication with other professionals.

72. The ISP is the principal tool through which class member needs are identified. It is,

therefore, a critical element in assuring that the comprehensive mental health system is responsive to class members' actual needs.

73. Not all class members, however, will require or want the active assistance of a community support worker. Defendants shall not require that class members receive the services of a community support worker, in order to gain access to other services and resources described in this Agreement. Defendants shall permit class members to avail themselves of community services and resources independently, with the help of their friends and family, or with various levels of intensity of assistance of a community support worker. Class members shall be encouraged to use the level of supportive assistance appropriate to their circumstances at any particular time.

74. To assure that the needs of class members who do not receive community support worker assistance are considered in the design and delivery of comprehensive mental health services, defendants shall develop a system for the collection of information regarding these individuals which is informal yet reliable. When soliciting the necessary information from class members, defendants shall explain that the information is being collected for the sole purpose of planning services which will meet individually identified needs.

D. AMHI Hospital Treatment and Discharge Plan

75. While class members are admitted to AMHI they shall receive treatment according to a written individualized treatment and discharge plan, which shall be incorporated into the class member's ISP as a discrete sub-part.

76. All AMHI patients shall have a preliminary treatment and discharge plan developed within three working days of admission and a treatment and discharge plan within seven days thereafter. This plan shall be reviewed and revised as frequently as necessary, but in no case

less frequently than within 30 days of development, every 60 days thereafter for the first year, and every 90 days thereafter.

77. The plan shall be developed by an inter-disciplinary team which includes the patient, hospital staff representing the disciplines of social work, psychiatry, psychology, and nursing. Other hospital personnel and other individuals from the community with whom the patient has authorized the exchange of information and who are needed to assure that the patient's needs are adequately assessed and that appropriate recommendations are made shall be included on the team. One of the hospital staff team members shall be designated as the patient's team coordinator.

78. The patient's team coordinator shall have the same responsibilities with respect to the development, coordination and monitoring of the hospital treatment and discharge plan as a community support worker has with respect to an ISP.

79. The hospital treatment and discharge plan shall meet the provisions of paragraphs 61, 64 and 68, with the following modifications:

a. Assessments may be conducted by appropriately credentialed hospital personnel.

b. Complete histories shall be obtained from the patient, community service providers, and to the extent possible, from other individuals in the community as authorized by the patient or guardian. Upon learning that a patient has had a prior psychiatric hospitalization, the team coordinator shall request the patient's consent to the release of the records of that hospitalization to AMHI. If consent is given, the team coordinator shall, within two working days, send for copies of the records. These records shall be reviewed upon arrival and, to the extent of their relevance, shall be considered in the review of the patient's AMHI treatment and discharge plan.

c. Goals which must be met in order for the patient to meet discharge criteria shall be clearly noted. At each review, the team shall assess whether the patient may be safely discharged.

d. Under no circumstances shall a patient's entitlements, as described below at paragraphs 156, 159 and 162 of this Agreement be left unmet after the dates on which defendants are required to comply with the provisions of said paragraphs.

e. To facilitate proper performance of the patient team coordinator's monitoring functions, defendants shall require that hospital chart entries are made and are written in terms of the patient's individualized goals and objectives.

80. For patients who require but are currently without a community support worker, the patient coordinator shall, within 48 hours of identification of the need, make a referral, with the patient's approval, to the appropriate agency for assignment of a community support worker. Once a community support worker has been assigned, or when a community support worker has been previously assigned, the patient team coordinator shall be responsible for assuring that the worker is notified of all future hospital planning meetings, is provided with periodic progress and other necessary reports, and is apprised of the anticipated discharge date. The patient's team coordinator is responsible for assuring that information is exchanged between the AMHI and community planning teams, so that the AMHI treatment and discharge plan and the ISP are compatible**.**

81. For patients who decline the services offered by a community support worker, but who nevertheless will require and accept some post-discharge community services, the patient's team coordinator is responsible for making necessary contacts with community providers, to schedule appointments as necessary, to provide information, and otherwise take steps

necessary to assure that the community services will be available to the patient upon discharge.

82. As soon as possible, but no later than January 1, 1992, all AMHI patients shall have treatment and discharge plans which conform to the terms of this Agreement.

E. Community Hospital Treatment and Discharge Plans

83. Defendants shall require community hospitals to develop hospital treatment and discharge plans in coordination with ISP's for all class members whose admissions are funded by the Department of Mental Health and Mental Retardation. Defendants shall review community hospitals' individualized treatment and service plans, pursuant to the provisions of paragraphs 282 and 283 of this Agreement, for compliance with the requirements of the "Rights of Recipients of Mental Health Services".

VII. COMMUNITY RESOURCES, SERVICES AND PROGRAMS

84. There are many generic resources and services in the community for which class members have a need, but to which their access is limited. Some examples of these resources and services are health and dental care; independent living accommodations; group and individual psychotherapy services; substance abuse counseling; transportation; social organizations; recreational facilities; jobs; and educational institutions. Among the factors limiting class members' access are attitudes of the public toward persons with mental illness; impairments which may be associated with mental illness such as diminished organizational skills, heightened sensitivity to stress, and difficulty with interpersonal relationships; and the side-effects of long-term institutionalization.

85. In ISP's, class members' needs for generic resources and services shall not be ignored, and their access to them shall not be presumed. To the maximum extent possible, defendants shall not use or develop segregated services for any class member, when services otherwise

available to the general public would be adequate to meet the class member's needs, if accessible. Instead, community support workers shall diligently work to meet class members' needs by increasing the accessibility of generic resources and services through efforts in advocacy, education and support.

86. Other class members may require highly specialized services which either currently are unavailable or are insufficiently available within the State of Maine. The specialized needs of these class members shall be considered in their ISP's. These class members may be among the following:

a. Class members identified for diversion from admission to or discharge from AMHI on the basis of their diagnoses of mental retardation, other developmental disabilities, traumatic brain injury, dementia (including Alzheimer's disease or a related disorder) or a primary diagnosis of substance abuse or dependence;

b. Other individuals who have experienced long term institutionalization, who will be discharged to the community and who will require specialized services to assist them in adjusting to community life and avoiding rehospitalization;

c. Other individuals who in the past relied upon hospitalization when lesser restrictive treatment options would have been more appropriate to meet their needs and who may need intensive support in adjusting to a community based service system.

87. In funding, developing, recruiting and supporting housing, residential support and other services to address the needs of the class members described above, defendants shall retain persons qualified and experienced in the design and delivery of the specific specialty services. These persons shall identify pre-existing models or design new models for residential and other support services, and shall advise defendants on staff training and recruitment programs.

A. Hospitalization

88. Defendants shall make reasonable efforts to fund, develop, recruit and support local community acute care psychiatric hospitalization options so that class members who require in-patient psychiatric acute care may receive the necessary hospital services in or reasonably near their home communities. Defendants shall document their efforts pursuant to this sub-section by providing the master, on an annual basis, with minutes and outcomes of meetings with community providers, proposed contracts, recruitment letters, statistics on community hospitalization costs and patient days, and any agreements entered into with community hospitals.

89. Defendants shall assure that class member admissions to community hospitals are effected in accordance with law and shall not fund any community hospitalization which was effected in violation of law or which was not medically necessary.

90. Defendants shall not fund community hospitals for the treatment of patients unless those hospitals can assure continuity of treatment during hospitalization and the full protection of the patients' rights to due process, including the right to a hearing within the time established by statute for patients admitted pursuant to involuntary procedures. Such assurances shall be included as a condition of defendants' contracts or agreements for services and payment. Sanctions for non-compliance with the contracts or agreements, shall include, but not be limited to revocation of the contracts or agreements.

91. Defendants shall take steps necessary to assure that community hospitals provide quality care consistent with the terms of this Agreement.

92. To comply with this sub-section on hospitalization, defendants shall meet the applicable terms and timetables of their plans for development of a comprehensive mental health system

required by Section V of this Agreement.

B. Housing

93. Defendants shall fund, develop, recruit and support a variety of housing options which can accommodate varying levels of supportive assistance to clients, depending upon client need. Some class members will live independently in their own homes, some will require community support worker assistance in their homes, others will require increased levels of supervision in their own homes, and yet others will need to live out of home in more restrictive environments which are fully staff supported.

94. As of the date of this Agreement there are patients at AMHI whose treatment or discharge plans state that they could live in community settings, but for the lack of available appropriate housing. Additional AMHI or other hospitalized class members may later be identified as needing community housing in order to be safely discharged.

95. To comply with this sub-section of the Agreement, defendants shall develop, fund, recruit, or support sufficient housing to meet the ISP identified housing needs of the class members referred to above and of class members who are at imminent risk of hospitalization due to lack of available appropriate housing. Defendants shall develop, fund, recruit and support housing which is designed to address other individual class members' needs in accordance with applicable terms and timetables in their plans required by Section V of this Agreement.

96. For purposes of this sub-section, a home is a residential unit where unrelated persons live together sharing some common space and facilities. It does not include residential arrangements established through the collaborative efforts of the residents. The housing to be developed, recruited, newly funded or supported under this Agreement shall be located where the other community services described in this Agreement are reasonably available. Except for

hospices, shelters and nursing homes, no homes which exceed an eight person capacity may be used or developed. This limitation on the use of large homes shall not apply to class members who choose to live in homes which exceed an eight person capacity, provided the housing is existing and licensed as of the date of this Agreement and the class member makes an informed choice to live in the home after having been advised of the provisions of this paragraph.

C. Residential Support Services

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

98. To comply with this sub-section, defendants shall develop, fund, recruit and support residential support services to meet the ISP identified residential support service needs of all class members who are hospitalized and who require residential support services in order to be safely discharged and of all class members who have been identified as being at imminent risk of hospitalization due to lack of available appropriate residential support services. Defendants shall develop, fund, recruit or support residential support services for other class members in accordance with the terms and timetables of their plans required by Section V of this Agreement.

D. Crisis Intervention and Resolution Services

99. The defendants shall develop crisis intervention and resolution services, either directly or

through contracts with private agencies. In either instance, defendants shall require that the services meet the following standards:

a. Services shall be available 24 hours per day, seven days per week.

b. Services shall be delivered by personnel trained in emergency intervention.

c. The trained intervention personnel shall have available to them at all times, consultation services of a psychologist or a psychiatrist.

d. Services shall include short-term emergency housing for psychiatric crises in a community-based setting supported by trained staff. The crisis intervention and resolution services shall be provided directly by the Department of Mental Health and Mental Retardation or through contracts with private agencies.

e. Crisis intervention and resolution services shall not be operated primarily as screening or transportation services preliminary to an admission to AMHI or other in-patient psychiatric facility. The primary purpose of the services is instead to avoid hospitalization through community-based resolution of crises. Crises cannot always be resolved with one telephone call, by a single visit or through the provision of temporary housing. The persons or agencies providing crisis intervention and resolution services may be required (and must have the capacity) to make multiple contacts with the individuals in crisis. Additionally, crisis intervention and resolution personnel must follow up on the individual's circumstances and work closely with the individual's community support worker after the immediate crisis is resolved.

100. Defendants shall establish sufficient crisis intervention and resolution services to meet clients' needs. Defendants shall, on a quarterly basis, assess the sufficiency of crisis intervention and resolution services. If, during any quarter, less than an average of 90% of all

needs for crisis intervention and resolution services are met, the services shall be deemed insufficient and defendants shall take immediate corrective action. Defendants shall strive to improve the delivery of crisis intervention and resolution services, with the goal of meeting all unmet needs for these services.

E. Vocational Opportunities and Training

101. Defendants shall make reasonable efforts to fund, develop, recruit and support an array of vocational services to meet plaintiffs' needs as identified in their ISP's. These programs may include vocational counseling, employment preparation programs which focus upon the development of work-related skills, supported employment programs, transitional employment programs, competitive employment referral services, and other programs as meet plaintiffs' needs.

102. In fulfilling their obligations under this sub-section, defendants shall work cooperatively with other agencies and departments which operate vocational programs, that clients may realize the benefits of those programs. To comply with this sub-section on vocational opportunities and training, defendants shall meet the applicable terms and timetables of their plans required by Section V of this Agreement.

F. Treatment Options

103. Defendants shall fund, develop, recruit and support an array of treatment services to meet class members' needs as identified in their ISP's. The services shall include, but not be limited to: professional assessments; group and individual psychotherapy; psychopharmacological therapy; occupational therapy; recreation therapy; substance abuse counseling; and sexual and physical abuse counseling.

104. To comply with this sub-section on treatment, defendants shall develop, fund, recruit and

support treatment options to meet the ISP identified treatment needs of all class members who are hospitalized and who require community treatment options in order to be safely discharged and of all class members who have been identified as being at imminent risk of hospitalization due to lack of available appropriate treatment options. Defendants shall develop, fund, recruit and support treatment options for other class members in accordance with terms and timetables of the plan required by Section V of this Agreement.

G. Recreational/Social/Avocational Opportunities

105. Defendants shall assist class members in the development of leisure skills and shall endeavor to improve the quality of class members' leisure time by sponsoring programs which allow class members to utilize, improve, or gain recognition for their avocational talents.

106. To comply with this sub-section on recreational/social/avocational opportunities, defendants shall meet the applicable terms and timetables of their plans required by Section V of this Agreement.

H. Transportation

107. Defendants shall make reasonable efforts to identify and resolve transportation problems which may make services identified in class members' ISP's inaccessible to them. These efforts shall include, but not be limited to: informal arrangements which meet class members' needs and the development of written agreements between the Department of Human Services and agencies charged with providing transportation services for persons entitled to services under Title XIX of the Social Security Act.

108. To comply with this sub-section on transportation, defendants shall meet the applicable terms and timetables of their plans required by Section V of this Agreement.

I. Family Support

109 Defendants shall fund, develop, recruit and support an array of family support services to include:

a. Education on the terms of this Agreement;

b. Education on available services, and on mental illness from the perspectives of professionals, other families, and mental health service recipients;

c. Direct support of family groups through the provision of a facilitator at meetings, if requested;

d. Education on treatment, medications, diagnoses, prognoses, and how to care for persons with mental illness;

e. Group counseling;

f. Psychoeducational programs; and

g. Respite services for families who provide class members with intense supervision and assistance. These services shall be made available on a planned basis and shall be delivered according to models which cause the least disruption to plaintiffs and their families.

110. Defendants shall also require agencies which provide mental health services to include among their services the referral of family members with whom the providers have contact to area family support groups. When referring a family member to a family support group, agencies shall provide information regarding the group and shall additionally offer to call the support group to give the family member's name and the means whereby he or she may be contacted by the support group. Agencies shall periodically reinitiate referrals as appropriate.

111. To comply with this sub-section on family support, defendants shall meet the applicable terms and timetables of their plans required by Section V of this Agreement.

VIII. STANDARDS FOR COMMUNITY PROGRAMS

112. This section applies to agencies which are funded or licensed by the Department of Mental Health and Mental Retardation for the provision of community mental health services. These agencies shall hereafter be referred to as community mental health agencies. This section does not apply to the subdivisions or staff of community mental health agencies which only provide services other than community mental health services.

A. Personnel: Qualifications, Recruitment, Evaluation and Training

1. Qualifications

113. Defendants shall require all agencies providing community mental health services to maintain a manual which contains up-to-date job descriptions for each mental health service position. Job descriptions shall clearly define areas of responsibility, including those required by the terms of this Agreement.

114. Qualifications for each position shall be stated in terms of education and experience. Appropriate licensure, certification or registration shall be required of all persons who are subject to such regulation.

2. Recruitment

115. Defendants, through their resource development system, shall assist agencies which request assistance in recruitment programs. To the extent possible, specific strategies should include the development of clinical affiliation and internship programs; appointment of individual staff persons to act as recruitment liaisons in their professional organizations; and intensive college and university outreach.

116. Defendants shall require community agencies to verify job applicants' licensure, certification or registration credentials and all other qualifications.

3. Evaluation

117. Defendants shall require each agency providing community mental health services to create and implement a performance evaluation protocol for each mental health service position.

4. Training

118. By November 1, 1990, defendants shall provide copies of this Agreement to all community mental health agencies and shall conduct presentations for the agencies' staffs to provide an overview of the Agreement. By February 1, 1991, defendants shall develop a training program on the terms of this Agreement and on the required specific performance obligations which agencies and their employees and contract agents must meet in order to receive future funding or licensing and in order to meet the terms of this Agreement. By July l, 1991, defendants shall deliver said training to the employees and contract agents of all community mental health agencies. Training shall be scheduled so that agencies do not have to suspend the delivery of services at any time. Defendants shall make this training program available to agencies on videotape so that all future new employees and contract agents may receive the training in orientation.

119. By September 1, 1991, all current employees and contract agents shall receive the full complement of training and orientation as required for new employees and contract agents as set out below.

120. All employees of community mental health agencies who perform mental health services as defined in this Agreement, shall receive orientation training which reinforces the principles set out at section IV above. The training shall also reinforce the philosophy that the mental health system is intended to support clients on the basis of their needs, and that agencies and

employees must, therefore, have the flexibility to recognize and respond to highly individualized and varying needs, to listen, and to work in concert with other workers in the community support network and, especially, with the clients themselves.

121. Specific topics in orientation training shall include, but not be limited to, the following: the terms of this Agreement; the legal and human rights of persons with mental illness; perspectives and values of consumers of mental health services; identification of, response to, and reporting of client abuse, neglect, and exploitation; specific job responsibilities of the trainees; individual community support planning process; mental health services system; family support services; the role of AMHI in the mental health system; the responsibilities of various professional and staff positions within the mental health system; the agency mission and philosophy of community support; principles of staff/patient interaction designed to facilitate individuals' health, growth and recovery; and client privacy and confidentiality. Training on the perspectives and values of consumers of mental health services shall be prepared and delivered by such consumers. Defendants shall recruit and assist them as necessary.

122. If applicable to the agency, training shall also be provided in physical intervention techniques.

123. New employees shall not be assigned to duties requiring direct involvement with clients until they have received most of the above training. Employees will not implement physical intervention techniques unless they have received the training in this area.

124. Non-medical staff shall additionally be trained in the basics of: identification of adverse reactions to psychoactive medications; identification of patient illnesses and injury; preliminary medical emergency care and reporting requirements.

125. Para-professional staff shall be trained in the basic principles of each of the therapeutic modalities.

126. Specific training may be waived for any employee whom the agency verifies has recently received the training through prior employment at another community mental health agency.

127. Professional staff shall be required to meet the continuing education requirements necessary to maintain their licenses.

128. Agencies shall provide ongoing training opportunities to all staff emphasizing quality care, including new approaches in the mental health field. Defendants shall take the costs of training requirements into consideration when contracting with community mental health agencies.

129. Contract agents and volunteers shall receive orientation and other training applicable to the specific type of duties they perform, commensurate with the number of hours they provide services.

B. Other Standards

130. By September 1, 1992, defendants shall draft rules establishing operating standards for agencies which the defendants have licensed to provide mental health services. The standards shall be consistent with and designed to assure implementation of the terms and principles of this Agreement. Said rules shall be submitted to counsel for the plaintiffs and to the master for his approval in accordance with paragraph 293 of this Agreement. Defendants shall thereafter promulgate said rules in accordance with the Maine Administrative Procedure Act, 5 M.R.S.A. §§ 8051 et seq.

131. These rules shall include, but not be limited to, operating standards for community mental health agencies in the following areas:

a. Environment;

b. Admission/Acceptance for Services;

c. Discharge/Termination of Services;

d. Individualized support planning;

e. Procedures for the reporting and investigation of allegations of client abuse, neglect and exploitation;

f. Procedures for the reporting and investigation of client injury, disappearance and death;

g. Staff/client ratios where appropriate;

h. Patient records;

i. Systems for assuring quality of individual services;

j. Use of psychoactive medications and reporting systems;

k. Use of seclusion, restraints and protective devices and reporting systems.

132. Rules governing the use of seclusion, mechanical restraints and protective devices shall comply with the terms of Section IX(H) of this Agreement. The physicians who order and the nurses who monitor the implementation of seclusion, restraint and protective devices must be in the employ of or have on-call arrangements with the agency.

IX. STANDARDS GOVERNING AUGUSTA MENTAL HEALTH INSTITUTE

A. General

133. As to this section of the Agreement governing AMHI, unless otherwise specified, "defendants" shall mean the Commissioner and Department of Mental Health and Mental Retardation, and the Superintendent of AMHI.

B. Environment

1. General

134. All patient living and sleeping areas shall be attractively furnished and designed to promote privacy, dignity and comfort. All areas, furniture, and bedding shall be kept clean, odorless, and in good repair. Each patient shall be provided with a secure and readily accessible storage area of adequate size to accommodate his or her personal belongings.

135. Common areas will have space and equipment sufficient to permit patients to comfortably socialize, relax, or engage in leisure time activity. To reduce the chance that patients engaged in activities will intrude upon others not similarly engaged, defendants shall equip the common areas so that intrinsically incompatible activities are not performed in the same areas.

136. Each living unit shall have visiting areas to allow patients to meet with visitors in comfort and privacy. If all designated areas are in use, staff shall make other reasonable arrangements to assure the patient's and visitor's comfort and privacy.

137. Telephones shall be made available to patients in areas where they may engage in conversation privately. A sufficient number shall be installed so that by August 1, 1992, one is available for each seven on-unit staff, and one for each fifteen patients.

2. <u>Health and Safety</u>

138. All patient living and sleeping areas shall meet Maine Department of Human Services Nursing Home and Hospital Licensing Standards, as applicable, as well as the current Life Safety Code. Furniture in sleeping areas will at all times be arranged so that patients may quickly and safely exit in the event of emergency.

139. Defendants shall additionally comply with the following standards:

a. Enclosure of all exposed overhead pipes in patient bedrooms and bathrooms by the date of entry of the Decree in this matter;

b. Safe air quality in all patient living and sleeping areas. Smoking areas shall be well ventilated.

c. Maintenance of temperatures in all patient living and sleeping areas at levels which do not exceed or fall below that considered safe and comfortable for individuals who are taking psychotropic medications, or who are medically frail.

d. Immediate removal or abatement of all asbestos which poses a health threat.

140. If renovations are or become necessary in order for defendants to meet the foregoing environmental standards, they shall submit a plan to the court, the master and counsel for the plaintiffs describing the renovations they will undertake to meet the standards. The plan shall include descriptions of the type of renovation to be undertaken; the name of the contractor or governmental agency which will perform the renovations; the name and title of the AMHI employee directly responsible for oversight of the renovations; dates of performance and completion of specific tasks; itemized costs of the renovations; and the specific areas to be renovated.

141. In planning renovations, defendants shall attempt to minimize overall costs by taking into consideration AMHI's declining census and admissions and consequent changed uses of the facility, and by relocating services where possible.

142. Where adequate renovations to meet the above standards either cannot be achieved by the dates specified in the plan or cannot be achieved without the expenditure of significant resources, defendants shall discontinue use of the affected areas of AMHI for patient living and sleeping use.

C. Admissions

1. General

143. To assure that persons who do not need acute care are not admitted or further institutionalized and that patients requiring further acute care are not precipitously discharged, defendants shall develop standardized admission and discharge criteria which are consistent with law and based upon patient need. These criteria shall be implemented consistently throughout the State mental health system at all times. The criteria shall provide for the identification of persons with mental retardation, other developmental disabilities, traumatic brain injury, dementia (including Alzheimer's Disease or a related disorder), and a primary diagnosis of substance abuse or dependence, and for referral of these persons to other treatment settings.

2. <u>Involuntary Admissions</u>

144. Defendants shall require individuals or facilities initiating emergency involuntary admission to AMHI to transmit to the AMHI admissions office complete records of the evaluation conducted and of any treatment extended at the time of evaluation. With the patient's permission, records of any prior treatment extended shall be transmitted to AMHI at the time of admission.

145. The AMHI admissions office shall, at all times when it is open to admissions, have on duty or on call a physician to assess a person's need for hospital admission and to decide whether or not to admit the person. This physician shall: conduct an assessment which includes a face-to-face interview of the person being proposed for admission; carefully review the documents arriving with the individual which state the basis for proposed admission; review other available historical information; interview individuals familiar with the person, as available; and undertake such further assessment as is professionally required.

146. The defendants shall also require that a community-based support person for each of the

catchment areas served by AMHI be available to consult with the AMHI admissions office. Upon the arrival at AMHI of a person proposed for admission (or sooner, if possible), the AMHI admissions office staff shall immediately contact the appropriate community support or crisis intervention and resolution worker to ascertain that lesser restrictive alternatives to AMHI admission have been fully explored.

147. The defendants shall require that all persons, hospitals, or agencies which routinely initiate emergency applications proposing admission to AMHI are trained as to AMHI's admission criteria and process.

3. Voluntary Admissions

148. Any patient whose admission is characterized as voluntary shall be continuously reviewed so that if the patient withdraws his consent to a voluntary admission, the withdrawal is noted in the record and discharge or involuntary commitment proceedings are initiated. The superintendent shall require that any voluntary patient whose treatment and discharge plan has not been reviewed during any six month period by the Maine District Court or pursuant to this subsection, be examined by two AMHI psychiatrists or psychologists who are not directly involved in the patient's treatment. If either of these examiners determines that the patient objects to hospitalization or does not require further hospitalization, the superintendent shall require that discharge or involuntary commitment proceedings be initiated, whichever is appropriate given the examination findings.

149. If the examiners determine that the patient is appropriately admitted and does not object to hospitalization, the superintendent shall retain a psychiatrist or psychologist who is not in the defendants' employ to examine the patient. If this examiner's findings are consistent with those of the AMHI examiners, no further review shall be required pursuant to this sub-section

for another six months. If the examiner finds that the patient objects to hospitalization or does not require further hospitalization, the superintendent shall require that discharge or involuntary commitment proceedings be initiated, whichever the superintendent finds to be appropriate considering all the evaluations.

4. Information to Patients Upon Admission

150. Upon admission, all patients shall be given information summarizing their rights under this Agreement and the "Rights of Recipients of Mental Health Services." Patients shall also be advised of their right to name a designated representative or representatives to assist them, to receive notices of meetings and to participate at meetings. Patients shall additionally be given information regarding available advocacy and peer advocacy programs.

D. Treatment

151. Treatment at AMHI shall focus upon a patient's strengths, rather than solely addressing symptoms. Patients are at all times entitled to respect for their individuality and to recognition that their personalities, needs and aspirations are not determinable on the basis of a psychiatric label. They shall be treated with dignity; they shall be encouraged and permitted to preserve the basic rhythm of their lives to the maximum extent possible.

152. Treatment shall be delivered according to an individualized treatment and discharge plan.

153. Every patient shall be given a schedule of therapeutic, rehabilitative and recreational activities available at AMHI. The schedule shall be updated monthly or more frequently as necessary. Those activities which would assist the patient in meeting the goals of the treatment and discharge plan and individually scheduled treatment or rehabilitation sessions shall be noted on the schedule. The original schedule shall be developed at the patient's first treatment and discharge planning meeting. Copies of all schedules shall be included in the patient's

record. Defendants will increase program and activity options so that by January 1, 1993, all patients will have services which meet their needs as identified in their hospital treatment and discharge plans. Defendants shall increase leisure activities so that by January 1, 1993, patients will have opportunity to engage in leisure activities for an additional 20 hours per week.

154. In exceptional cases, patients may be offered fewer hours of treatment and rehabilitation than is generally offered other patients, if a physician certifies in writing that such activity would be medically harmful to the patient. For these patients, the amount of treatment and rehabilitation which can be tolerated by such patients shall be noted by the physician and shall be made available**.** Additionally, such patients shall be provided with such treatment and encouragement as is required to expand their tolerance for activity, with the goal that the patient shall receive the minimum treatment and rehabilitation to which all other patients are entitled under this Agreement.

155. Services to be made available to meet patients' needs, and to be considered at the patient's treatment planning meeting include, but are not limited to the following:

Group and individual psychotherapy

Psychopharmacological therapy

Social services

Physical therapy

Occupational therapy

Activities of daily living skills training

Recreational therapy

Vocational/Educational programs

Family support services and education

Substance abuse services

Sexual/physical abuse counseling

Instruction in principles of basic health care,

hygiene and nutrition.

156. Each patient shall be offered individual counseling with a psychiatrist, psychologist, clinical social worker, psychiatric nurse or a psychiatric physician extender for sessions totalling at least one hour per week and with one of these individuals or other appropriately credentialed staff for a minimum of an additional two hours per week.

157. Defendants shall employ the services of an adequate number of nutritionists and dietitions to assure that all patients' nutritional and dietary needs are individually assessed and met. The assessments shall take into consideration and accommodate, if reasonably possible, the patient's wishes.

158. Defendants shall engage independent consultants to assess and recommend treatment programs for patients who are not responsive to the treatment offered at AMHI.

159. All patients are entitled to receive individualized treatment, to have access to activities necessary to the achievement of their individualized treatment goals, to receive visitors, to communicate by telephone and by mail, to exercise daily, to recreate outdoors, and to exercise their religion. At no time shall these entitlements or basic human rights be treated as privileges which the patient must earn by meeting certain standards of behavior.

E. <u>Psychoactive Medication</u>

160. Psychoactive medication may be prescribed only by a physician or physician extender who has examined the patient. The medication may be prescribed only as an integral part of

the patient's individualized treatment plan or in an emergency.

1. Orders as Part of the Treatment Plan.

161. When psychoactive medications are prescribed as part of the patient's individualized treatment plan, the plan must state and the patient must be advised of the specific signs, symptoms or behaviors which the medication is intended to relieve. The patient shall also be advised of alternative therapies and of precautions, contraindications, and potential adverse effects of the psychoactive medication. The method for assessing the patient's response to the medication, including any adverse reactions, shall be stated in objective terms, including, as applicable, behavioral observations, physical assessments and necessary laboratory tests.

162. All orders for psychoactive medications shall be time limited for a period not to exceed thirty days, and for a shorter period for controlled drugs and when clinically indicated.

163. When the order expires, or sooner if clinically indicated or if a treatment planning meeting is scheduled, the physician or physician extender shall examine the patient and review the patient's record entries charting progress or adverse effects. The physician or physician extender shall consider reducing or discontinuing some medications, as clinically appropriate, to assure that the desired therapeutic effects are achieved through the use of minimum dosages and numbers of medications. Before reducing or discontinuing the medications, the physician or physician extender must advise the patient as to the anticipated benefits and any known risks.

164. No physician or physician extender may increase the dosage of specific psychoactive medications, change the types of medications ordered, or add medications in a patient's prescribed psychoactive medication regimen without noting in the patient's chart why, in terms of the patient's responses to the previously prescribed medication, the regimen is being altered.

The physician or physician extender shall also update the patient's chart, as necessary, to describe any changes in the method for assessing the patient's response to the medication. Before entering the order, the physician shall provide the patient with all the information as required by paragraph 161, above.

2. Emergency Orders

165. An emergency exists when the patient exhibits behavior due to mental illness which places him or others at risk of imminent bodily injury. Under such circumstances, the physician or physician extender, upon examining the patient, may declare an emergency and order the administration of psychoactive medication. At no time may a physician or physician extender declare an emergency merely because the patient refuses treatment. The order for emergency medication shall be for a limited period, not to exceed 72 hours. Both the declaration of emergency and order for administration of medication shall be entered as medical orders in the patient's record.

166. The physician's or physician extender's notations shall include the following:

a. A description of the behaviors which he has observed, and which created the emergency;

b. The period, not to exceed 72 hours, during which the medication may be administered;

c. The expected benefits of the order;

d. The specific behaviors or physical responses which staff should monitor and record, and the means they should use.

167. If, after 72 hours, an emergency continues to exist, an order for continued medication may be entered, only upon compliance with the foregoing provisions of this sub-section, and upon authorization of the director of psychiatry or of clinical services and, if the client lacks

capacity, upon initiation of administrative hearing proceedings described in the "Rights of Recipients of Mental Health Services."

3. Monitoring.

168. The superintendent shall appoint an individual or team of individuals who shall be responsible for establishing a data base system for monitoring the use of psychoactive medications at AMHI and for assuring that the required information is entered. The system shall be capable of issuing individual patient medication profiles and periodic statistical data. The reports shall detail the types of medications in use at AMHI, the dosages, duration of use, and concommitant uses, each in conjunction with reported therapeutic and adverse effects. The director of clinical services or psychiatry shall review these reports. In no case shall the prescribing physician be responsible for the review. Following review, the director shall consult on the case with the prescribing or supervising physician and follow-up with examinations as necessary on the following patients:

a. Patients for whom either the beneficial or adverse effects of the medications are not being reported;

b. Patients who are reported as not evidencing any therapeutic effects;

c. Patients who are reported as evidencing significant adverse effects;

d. Patients who are receiving a significant number of medications concomitantly;

e. Patients who are on two or more medications which are known to interact adversely;

f. Patients who are receiving medications in dosages which exceed the manufacturer's recommendations.

F. <u>General Health Care</u>

169. For the purpose of this sub-section, the term "physician" shall be defined as a licensed

medical practitioner specializing in the field of primary care medicine**.**

170. Within 24 hours of admission to AMHI, each patient shall be offered a complete physical examination, including a pregnancy test for women of child-bearing age when appropriate. Patients who refuse physical examinations shall be offered such examinations at later dates. Special attention shall be given to the assessment of medical, nutritional, toxic and neurological conditions which may otherwise explain the patient's behavior. Special attention shall also be given to those conditions which may be adversely affected by the use of psychoactive medication or by any other treatment modality.

171. Medical histories shall be obtained, and, for those patients who are under a physician's care or who are suspected of having or who are found to have physical health problems, medical records from community providers shall be requested at the time of the examination, provided the patient or guardian consents to release of this information.

172. The charts of patients who have specialized medical needs shall be boldly flagged. All persons having responsibility for direct care of these patients shall be trained to recognize signs and symptoms of medical problems as identified in the patient's chart by an appropriate medical professional. They shall additionally be trained to recognize signs and symptoms of adverse drug reactions, including toxic or allergic reactions, to medications administered within the hospital. Training shall include instructions on the appropriate preliminary emergency care which direct care staff shall be required to undertake.

173. No patient shall be denied access to the health care he or she has been receiving in the community solely because he or she is a patient at AMHI. The defendants shall make every effort to ensure that the transportation necessary for the patient to keep appointments is provided. Patients who elect to receive health care services from their community providers

shall be responsible for the cost of that care.

174. Basic medical care shall be available at AMHI seven days per week, 24-hours per day, and shall include the services of at least one physician on duty or on-call at all times. Between the hours of 8:00 a.m. and 4:00 p.m. each weekday, at least one physician will be on duty for every 75 patients. A physician and the treating psychiatrist shall conduct joint weekly reviews on the residential units of each patient at AMHI. Clinic staff shall conduct rounds more frequently as may be necessary to follow-up on the condition of patients receiving clinic services. Each unit shall have an appropriate and private space in which clinic staff may meet with patients.

175. All incidents resulting in physical harm to patients, and all complaints or signs of physical injury, of adverse reactions to medications or of illness shall be immediately reported to a nurse or physician who shall examine the patient and take appropriate action, including complying with the provisions of Section IX(J) of this Agreement. When follow-up care or observation is recommended, the nursing or medical personnel will clearly state in writing their instructions and their expectations of the individuals providing direct care.

176. Defendants shall develop transfer and referral agreements with area hospitals, clinics, and specialists to assure that all emergency, surgical, or specialized medical needs of patients can be met. No patient shall be denied medical care solely by reason of his status as a patient at AMHI. Defendants will offer training to community health care providers and others, as needed to facilitate the effective development and implementation of the agreements.

177. Defendants shall meet medical charting requirements consistent with professional standards.

G. <u>Dental Care</u>

178. Defendants shall contract for dental services as necessary to assure that all patients may receive emergency dental examinations and treatment. All patients who have resided at AMHI for at least six months may additionally receive twice annual examinations, preventive services, emergency restorative services, and periodontal care.

179. No patient shall be denied access to the dental care he or she has been receiving in the community solely because he or she is a patient at AMHI. The defendants shall make every effort to ensure that the transportation necessary for the patient to keep appointments is provided. Patients who elect to receive dental care from their community providers shall be responsible for the cost of that care.

H. <u>Seclusion, Restraint and Protective Devices</u>

1. Seclusion.

180. Seclusion means the placement of a patient alone in an isolation room from which he is denied exit.

181. Seclusion may be employed only when absolutely necessary to protect the patient from causing physical harm to himself or others, or, if the patient is examined by a physician or physician extender prior to implementation of seclusion, to prevent further serious disruption which significantly interferes with other patients' treatment.

182. Seclusion may be used only after less restrictive measures have proven to be inappropriate or ineffective. Seclusion shall be implemented in accordance with the following standards:

a. The decision to place a patient in seclusion shall be made by a physician or physician extender and shall be entered as a medical order in the patient's records. If the physician or physician extender is not immediately available to examine the patient, the patient may

be placed in seclusion following an examination by a nurse if the nurse finds that the patient poses a risk of imminent harm to himself or others. The physician or physician extender shall personally evaluate the patient within 30 minutes after the patient has been placed in seclusion. If the evaluation does not take place within 30 minutes, the reasons for the delay shall be documented in the patient's chart. This provision applies to all patients, including those placed in seclusion during the night. Any patient placed in seclusion shall be kept under constant observation while awaiting an examination by a physician or physician extender.

b. Staff who place patients in seclusion shall have documented training in the proper techniques and in less restrictive alternatives to seclusion.

c. As soon as possible, staff should make reasonable efforts to notify the patient's guardian or designated representative, if any, that the patient has been placed in seclusion, and the reasons therefor.

d. Each order for initiation or extension of seclusion shall state the time of entry of the order. It shall state the number of hours the patient may be secluded, not to exceed ten, and the conditions under which the patient may be sooner released.

e. The need for a patient's continuation in seclusion shall be re-evaluated every 2 hours by a nurse. The nurse shall examine the patient in person, and unless clinically contraindicated, shall conduct the examination outside of the seclusion room. The nurse shall assess the patient to determine whether he or she continues to pose a danger to himself or others or continues to cause serious disruption of other patients' treatment (for cases in which a physician or physician extender has ordered seclusion for this reason). If the nurse finds danger and that the patient continues

to require seclusion, seclusion may be continued if the physician's or physician extender's order has not yet lapsed. Should the patient not need continued seclusion, the nurse shall release the patient even if the time frame of the original order has not yet elapsed.

f. A special progress record/check sheet shall be maintained for each use of seclusion and shall include the following documentation:

i. The indication for use of seclusion, i.e. whether a danger to self, others, or serious disruption of other patients' treatment;

ii. A description of the behaviors which constitute the patient's danger to himself, others, or serious disruption of other patients' treatment;

iii. A description of less restrictive alternatives used or considered, and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration.

g. All orders for the extension of seclusion shall include documentation as for an original order, but shall additionally state whether the patient was examined outside of the seclusion room and, if not, the clinical reasons therefor.

h. Every patient placed in seclusion shall be released, unless clinically contraindicated, at least every two hours to eat, drink, bathe, toilet and to meet any special medical orders.

i. No PRN orders for seclusion may be written and no treatment plan may include its use as a treatment approach;

j. Patients placed in seclusion shall be given maximum observation and in no instance shall they be visually monitored less often than every 15 minutes by staff.

k. A description of the patient's behavior as observed shall be noted on the progress record/check sheet every 15 minutes.

l. The total amount of time which a patient spends in seclusion may not exceed 24 hours unless:

i. The patient is given a medical assessment to include at least vital signs, hydration and nutrition, and assessment and treatment of any injuries;

ii. The patient is examined by the director of psychiatry or clinical services;

iii. The order extending seclusion beyond a total of 24 hours is entered by the director of psychiatry or clinical services following his examination of the patient and consultation with the other examiners; and

iv. The patient's guardian, or designated representative, if any, and if available, has been notified.

m. Records required by the above provisions shall be a part of the patient's permanent record. Copies shall be forwarded to the medical director, the clinical services director and the patient advocate.

n. No patient who is mentally retarded may be secluded except in accordance with this Agreement and applicable regulations promulgated by the Bureau of Mental Retardation (BMR). Seclusion must be implemented by persons fully familiar with and trained in the use of the techniques required by the BMR regulations.

o. Seclusion may be ordered on the basis of a patient's self-report, provided the physician or physician extender otherwise verifies that the patient meets the criteria of paragraph 181 and the decision is otherwise clinically appropriate.

2. Restraint.

183. Restraint is the immobilization of a patient's arms, legs or entire body through the use of an apparatus which is not a protective device as described in sub-section H(3) below.

184. Restraint may be employed only when absolutely necessary to protect the patient from serious physical injury to himself or others and shall impose the least possible restriction consistent with its purpose. Restraint may be used only after less restrictive measures have proven to be inappropriate or ineffective. Restraint shall be implemented in accordance with the following standards:

a. The decision to place a patient in restraint shall be made by a physician or a physician extender and shall be entered as a medical order in the patient's record. If the physician or physician extender is not immediately available to examine the patient, the patient may be placed in restraint following examination by a nurse. A patient placed in restraint shall be examined by a physician or physician extender within 30 minutes. The reasons for any delay in this evaluation shall be fully documented in the patient's chart.

b. Patients placed in restraint shall be kept under constant observation.

c. Staff who place patients in restraint shall have documented training in the proper techniques and in less restrictive alternatives to restraint.

d. As soon as possible, staff should make reasonable efforts to notify the patient's guardian or designated representative, if any, that the patient has been placed in restraint and the reasons therefor.

e. Each order for initiation or extension of restraint shall state the time of entry of the order. It shall state the number of hours the patient may be restrained, not to exceed six, and the conditions under which the patient may be sooner released.

f. The need for a patient's continuation in restraint shall be re-evaluated every two hours by a nurse. The nurse shall examine the patient in person and, unless clinically

contraindicated, shall conduct the examination while the patient is free from restraint. If the nurse finds that the patient continues to pose a danger to himself or others and continues to require restraint, restraint use may be continued if the physician's or physician extender's order has not yet lapsed. Should the patient not need continued restraint, the patient shall be released even if the time frame of the original order has not yet lapsed. The patient shall be examined by a physician or physician extender every six hours.

g. A special progress/check sheet record shall be maintained for each use of restraint and shall include the following documentation:

i. The indication for use of restraint, i.e., whether a danger to self or others;

ii. A description of the behaviors which constitute the patient's danger to himself or others;

iii. A description of less restrictive alternatives used or considered, and a description of why these alternatives proved ineffective or why they were deemed inappropriate upon consideration**.**

h. All orders for the extension of restraint shall include documentation as for an original order, but shall additionally state whether the patient was examined free of restraint, and, if not, the clinical reasons therefor.

i. Every patient placed in restraint shall be frequently monitored and released as necessary to eat, drink, bathe, toilet, and to meet any special medical orders. Patients in restraint shall have each extremity released, sequentially, no less frequently than every fifteen minutes.

j. No P.R.N. orders for restraint may be written and no treatment plan may include its use as a treatment approach.

k. A description of the patient's behavior as observed shall be noted every fifteen minutes on the progress record/check sheet.

l. The total amount of time which a patient spends in restraint may not exceed 24 hours unless:

i. The patient is given a medical assessment to include at least vital signs, hydration and nutrition, and an assessment and treatment of any injuries;

ii. The order extending restraint beyond a total of 24 hours is entered by the director of psychiatry or of clinical services following his examination of the patient and consultation with the other examiners.

iii. The patient's guardian, if any, and if available, has been notified.

m. Records required by the above provisions shall be made a part of the patient's permanent record. Copies shall be forwarded to the medical director, the clinical services director and the patient advocate.

n. No patient who is mentally retarded may be restrained except in accordance with this Agreement and with applicable regulations promulgated by the Bureau of Mental Retardation (BMR) as implemented by persons fully familiar with and trained in the use of the techniques required by the BMR regulations.

3. Protective Devices.

185. Protective devices which are used for medical reasons to ensure a patient's safety and comfort, to provide patient's stability during medical procedures, facilitate medical (non-psychiatric) treatment or safeguard health in the treatment of a health-related problem are exempt from the operation of the foregoing procedures governing the use of restraints. The following procedures for use of protective devices may never be used, however, as a substitute

for those governing restraint or seclusion.

186. Examples of some protective devices are: bed-padding or bolsters to maintain a patient's body alignment; devices for the immobilization of fractures; devices to permit the safe administration of intravenous solutions or to prevent their removal; protective equipment, such as mitts, to prevent the aggravation of a medical condition through scratching, rubbing or digging; helmets to protect the head from falls due to unsteadiness, seizures or self-injurious behavior; geriatric chairs, seat belts, or vest restraints to prevent ambulation when it is medically contraindicated or to permit a patient, who for medical reasons could not do so unassisted, to remain in a seated position.

187. The use of protective devices shall be subject to the following:

a. The decision to use a protective device shall be made by a physician who has examined the patient prior to its use. The decision shall be entered as a medical order in the patient's record.

b. When ordering use of a protective device, the physician shall select the device which interferes with the patient's free movement and ability to interact with his environment to the least degree necessary to achieve the medical purpose for which the device is ordered.

c. Staff who use protective devices shall have documented training in their application.

d. The need for the use of a protective device shall be re-evaluated bi-weekly by a physician who examines the patient. Orders for devices which immobilize patients shall be re-evaluated daily. If the physician determines that continued use of the protective device is clinically indicated, further use may be ordered. The order for extension of use shall be entered as a medical order in the patient's record.

e. Protective devices which hamper a patient's free movement, such as mitts, geriatric

chairs or vest restraints, shall be removed every two hours, so that the patient may be permitted free movement, unless the physician's order indicates that removal would interfere with the patient's health care. The physician shall indicate in his order the level of staff supervision and assistance necessary during the patient's periods of free movement. Where protective devices have been routinely used, the patient's treatment plan will address ways of reducing or eliminating their use.

f. A special progress record/check sheet shall be maintained for each use of protective devices which hamper a patient's free movement. These check sheets shall be used to document the patient's release from the device every two hours and shall include a description of the patient's condition as observed during the period of free movement.

g. Every patient to whom a protective device has been applied shall be frequently monitored and assisted as necessary to meet personal needs and to participate in treatment and activities.

4. Safety Review.

188. The restraint and protective devices used at AMHI and the techniques used for placing individuals into restraint or seclusion shall be examined at least semi-annually by an independent consultant knowledgeable and experienced in the use of seclusion and restraint. No new type of device or technique may be introduced for use without such an examination. The consultant shall examine the devices and techniques to assure that they are safe and humane. Should the consultant find that any device or technique used at AMHI is unsafe or unnecessarily compromises a patient's comfort or dignity, AMHI shall immediately discontinue its use.

5. Reports.

189. Defendants shall prepare monthly reports on the use of seclusion, restraint and protective devices and shall submit copies to the master and counsel for the plaintiffs. These reports shall state the patient's name, age and sex; the reason for the order; the patient's unit; the name of the physician entering the order; the patient's principal diagnosis; whether seclusion, restraint or a protective device was ordered; the type of apparatus or device used, if applicable; and the time and duration of its use. The defendants shall analyze the data in terms of trends relating to rates of admission; census; units of use; physicians entering the orders; patients' diagnoses, age and sex; and other relevant variables.

190. Defendants shall develop and implement training programs, and take such other steps as are necessary to eliminate all inappropriate uses of seclusion, restraint or protective devices, and to reduce the overall use of seclusion and restraint.

191. If, on the basis of the foregoing analyses, defendants determine that any use of seclusion, restraint or protective devices was negligently or abusively ordered or implemented, defendants shall immediately initiate an investigation pursuant to Section IX(I).

I. <u>Patient Abuse, Neglect and Exploitation</u>

192. All staff shall be required to report instances of patient abuse, neglect and exploitation immediately. Reports shall be made to the superintendent with a copy to the patient advocate. The superintendent shall notify the patient's guardian or designated representative and forward all reports to the Bureau of Elder and Adult Services or the Division of Child and Family Services of the Department of Human Services, as appropriate.

193. All reports shall be immediately and thoroughly investigated. Results of investigations shall be in writing and shall be made available to the patient and the patient's guardian or designated representatives.

194. Subject to the State personnel grievance procedures, all AMHI employees shall be:

a. Relieved of duties involving direct patient care during the pendency of an investigation of an allegation of patient abuse, neglect or exploitation, unless the superintendent finds, after diligent review of the available information, that there are no grounds to suggest any probability that the employee poses a risk of harm to patients**;**

b. Terminated from employment upon a finding of sexual abuse of a patient, physical abuse resulting in serious injury to or death of the patient, serious neglect or serious exploitation. Upon a finding of lesser misconduct, the employee shall be subject to imposition of progressive discipline, including suspension and termination.

195. No employee who is terminated from employment as a result of disciplinary action for patient abuse, neglect, or exploitation shall be employed in any capacity, at any time, at any state institution operated by the Department of Mental Health and Mental Retardation.

196. Each employee, before being hired, shall be informed of these provisions and shall be required to sign a statement that he understands the provisions and will abide by them.

197. All allegations and findings of patient abuse, neglect and exploitation shall be collected and analyzed in terms of trends relating to rates of admission, census, units of incidence, job descriptions and prior training of staff involved, and other relevant variables. On the basis of these analyses, defendants shall develop and implement training programs and shall take other steps as are necessary to reduce future incidents.

J. <u>Patient Injury and Death</u>

198. All incidents of serious injury to a patient and all incidents of patient disappearance or death shall be immediately reported to the superintendent with a copy to the patient advocate. The superintendent shall immediately notify the patient's guardian or designated representative,

if any, and shall forward all reports of death, disappearance or serious injury to the commissioner.

199. Upon receipt of these reports, the superintendent shall immediately initiate a review. Reviews of death and serious injury shall be conducted by independent professionals (including non-medical experts when appropriate) who are qualified and experienced in the assessment of the quality of the type of care and treatment which was rendered or should have been rendered in each case. Panels reviewing patient deaths shall not include persons who are employed by the defendants, provided that the defendants may appoint panels consisting of State employees for the purpose of conducting death reviews concurrently with the outside panels.

200. Results of reviews shall be in writing and shall be made available to the master. Specific findings shall be collected and analyzed under the process developed in accordance with sub-section IX(I) above. On the basis of the analyses, defendants shall develop and implement training programs and shall take other steps as are necessary to reduce future incidents of death, disappearance or injury.

201. If it appears, at any time during or following a review initiated pursuant to this sub-section, that a patient's serious injury, disappearance or death resulted from employee abuse or neglect, the superintendent shall initiate proceedings in conformity with sub-section I of this Sectionnt.

K. <u>Staff/Patient Ratios</u>

202. Defendants shall hire and retain staff at AMHI sufficient to carry out the requirements of this Agreement. The overall staff/patient ratio shall be maintained at a minimum of 2:1. Minimum ratios for the staff listed below shall be as follows:

a. General medicine physicians-1:75 during the hours 8:00 a.m. to 4:00 p.m., weekdays, and one physician on duty or on call for the hospital during all other hours;

b. Psychiatrists-1:25 from 8:00 a.m. to 4:00 p.m. weekdays and one on duty or on-call during all other hours;

c. Psychologists-1:25 from 8:00 a.m. to 4:00 p.m. weekdays;

d. Nursing-1:20 from 8:00 a.m. to 4:00 p.m., during the day shift seven days per week, one assigned per unit during all other hours;

e. Social Workers-1:15 from 8:00 a.m. to 4:00 p.m., weekdays;

f. Mental Health Workers-1:6 during the day shift seven days per week and 1:8 all other hours;

g. Recreational/Occupational Therapists/Aides-1:8 overall. Defendants shall schedule working hours on the basis of identified needs of patients, taking into consideration their need for a full range of recreational and community activities or weekdays, evenings, weekends and holidays.

203. The above ratios shall be fully met by September 1, 1992. In planning to meet these staff/patient ratios, defendants may take into consideration reduction in the patient population.

204. For purposes of calculating compliance with the above staffing ratios, only the following employees may be counted: those present and on duty; and those who have completed at least 90% of their orientation training. While performing staff development, quality assurance or similar duties, employees shall not be counted for purposes of calculating compliance with staffing ratios.

L. Personnel: Qualifications, Recruitment, Evaluation and Training

1. Qualifications.

205. Defendants shall maintain a manual which contains up-to-date job descriptions for each

position at AMHI. Job descriptions shall clearly define areas of responsibility, including those required by the terms of this Agreement.

206. Qualifications for each position shall be stated in terms of education and experience. Appropriate licensure, certification or registration shall be required of all persons performing duties at AMHI who, if they performed similar duties in the community, would be subject to such regulation.

207. Defendants shall develop and implement standards for the credentialing of mental health workers.

2. Recruitment.

208. Defendants shall develop a program for recruiting professionals. As needed, this program shall have nationwide application. Specific strategies should include the development of clinical affiliation and internship programs; appointment of individual staff persons to act as recruitment liaisons in their professional organizations; and intensive college and university outreach.

209. Defendants shall annually review salaries for licensed, certified and registered AMHI professionals and recommend salary adjustments as needed to attract and retain qualified professionals.

210. All applicants for positions at AMHI shall be carefully screened. Licensure, certification or registration credentials and all other qualifications shall be verified.

3. Evaluation.

211. Defendants shall establish a task-based competency evaluation protocol for each staff position at AMHI. Supervisors will be responsible for annually evaluating their subordinates on the basis of the protocol. In respect to employees who are found to be deficient in the

performance of their duties, defendants shall pursue all appropriate corrective measures available under law, regulation or contract. Corrective measures include, but are not limited to, required additional training, extension of probation, reassignment to other duties, or, where the deficiencies are serious or the employee has failed to respond to prior corrective measures, termination of employment.

212. In addition to the evaluation process, supervisors shall investigate complaints brought to their attention of deficient performance respecting employees under their supervision.

4. Training.

213. By October 1, 1990, defendants shall provide copies of this Agreement to all AMHI employees and shall conduct presentations to employees for the purpose of providing an overview of the Agreement. By June 1, 1991, defendants shall conduct training on the terms of the Agreement and on the required specific performance obligations each employee must meet to comply with its terms. By September 1, 1991, all current employees shall receive the full complement of training and orientation as required for new employees as set out below.

214. AMHI employees shall receive orientation training of a minimum of 120 hours in the following areas:

a. The terms of this Agreement; patients' legal and human rights; perspectives and values of consumers of mental health services; identification of, response to, and reporting of patient abuse, neglect, and exploitation; fire protection; AMHI's mission and philosophy of care; principles of staff/patient interaction designed to facilitate patients' health, growth and recovery; patient privacy and confidentiality; and specific job responsibilities of the trainees. Training on the perspectives and values of consumers of mental health services shall be prepared and delivered by such consumers.

Defendants shall recruit and assist them as necessary.

b. The treatment and discharge planning process; mental health services system; family support services; AMHI organization and the responsibilities of various departments, professions and staff positions; physical intervention techniques; implementation of seclusion and restraint; specialized patient observation procedures (i.e. close, constant, 1:1 observation, etc.);

c. The basics of: identification of adverse reactions to psychoactive medications; identification of patient illnesses and injury, preliminary emergency medical care and reporting requirements;

d. The basic principles of each of the therapeutic modalities; cardio-pulmonary resuscitation.

Topics required to be included in employee orientation are as outlined in Attachment A.

215. New employees shall not be assigned to duties requiring direct care of patients until they have received 90% of the orientation training. Employees will not implement seclusion, restraint or utilize physical intervention techniques or carry out specialized observation procedures unless they have received the training in these areas.

216. Professional staff shall be required to meet the continuing education requirements necessary to maintain their licenses, registration or certification, and shall be encouraged to participate in interdisciplinary training offered at AMHI. Additionally, all nursing and medical staff shall be required to receive 10 hours of training each year in the psychiatric aspects of their treatment responsibilities and all psychiatrists shall be required to receive at least 10 hours in the non-psychiatric aspects.

217. Defendants shall provide ongoing training opportunities to all staff emphasizing quality

care, including new approaches in the mental health field.

218. The consultants whom defendants have otherwise retained to design individualized programs for patients pursuant to paragraph 158 above, shall be retained to train staff in the delivery of the individualized programs.

219. Defendants shall document the training each employee has received in his or her personnel file.

M. Patient Records

220. Patient records shall be maintained under the supervision of a qualified, credentialed medical records professional.

221. Entries in records shall be legible, dated, signed, and followed by a legible notation of the name of the person making the entry and his or her signature.

222. Information in the records shall be sufficiently detailed and coordinated to assure that persons involved in the patient's care and treatment may readily determine the patient's medical, psychiatric, and social status, as well as the patient's progress in all areas addressed in the treatment plan. In addition to reports, entries and documents which are required by specific provisions of this Agreement, patient records shall include the following information:

a. Patient identification data;

b. Reports of assessments: as completed upon admission, as updated and as completed by consultants;

c. Treatment and discharge plans and treatment schedules;

d. Physicians' orders;

e. Notes of patient progress under the treatment plan;

f. Documents regarding competency, guardianship, admission status and grievance

decisions;

g. Records from other treating sources, documenting history;

h. Check sheets;

i. Reports of all diagnostic tests and procedures; and

j. Discharge summary.

223. This information shall be made available to persons responsible for the patient's care and treatment. The records shall be organized to maximize the delivery of coordinated care and treatment and so that entries by persons of the various disciplines or areas of care and treatment may be readily cross-referenced.

X. STANDARDS GOVERNING TREATMENT OF MINORS

224. Defendants shall immediately undertake such action as is necessary to assure that by September 1, 1992, defendants will discontinue operation of the Adolescent Treatment Unit. Thereafter, defendants will no longer admit any person to AMHI who is less than 18 years old except pursuant to Title 15, chapter 5.

225. From the date of this Agreement until August 1, 1992, defendants may admit individuals to the Adolescent Treatment Unit who are between the ages of 13 and 18 and who meet the criteria for admission under emergency procedures as set out at 34-B M.R.S.A. § 3863. Under no circumstances are individuals under the age of 18 to be treated on the same unit as adults.

226. While the Adolescent Treatment Unit remains in operation, its census shall not exceed 12 patients. It shall meet all the standards of Section IX of this Agreement, including Section K governing "Staff/Patient Ratios," except that ratios for the positions listed below shall be as follows:

Child Psychiatrist: 1:15 during the day shift on weekdays;

Certified Educational Psychologist: 1:12 during the day shift on weekdays;

Nurses (RN, LPN): 1:5 during the day shift on weekdays, at least one on the unit during all other hours;

Mental health workers: 1:3 during the day shift on weekdays and 1:4 during all other hours;

Teachers: 1:12 during the day shift on weekdays;

227. The Adolescent Treatment Unit shall additionally meet the following standards:

a. The Adolescent Treatment Unit must designate a professional to be on duty or on call at all times, to consult with admissions office personnel for the purpose of screening individuals being proposed for admission to the Adolescent Treatment Unit. This individual must be trained and experienced in the treatment and diagnosis of childhood mental illnesses, and must also be familiar with the then current census of the unit as well as general characteristics and treatment needs of the unit's patients. This individual will be responsible for advising the admissions office personnel whether the adolescent being proposed for admission may safely and appropriately be admitted.

b. The Adolescent Treatment Unit shall include an area, separate from the leisure activity area, which is conducive to study and equipped with age appropriate library materials. The unit shall include an activity area with age appropriate equipment. A broad array of activities shall be available to adolescent patients and shall be designed to enhance the patients' social, intellectual, physical, and emotional development.

c. All dental care services, as set out at Section IX(G) of this Agreement shall be available to adolescents regardless of the length of their hospital admission.

d. Psychotropic medications may only be prescribed under the direction of a Board

eligible or certified child psychiatrist.

e. Family therapy shall be offered to the parents and/or custodians of each patient and shall be available for a minimum of one hour per week.

f. The procedures governing seclusion of adult patients shall be followed in the Adolescent Treatment Unit, except as modified below:

i. Seclusion may be employed only when absolutely necessary to protect the patient from causing physical harm to himself or others;

ii. Patients placed in seclusion shall be monitored no less frequently than every five minutes by a designated staff person;

iii. The primary focus of the person doing 1:1 or five minute checks will be to make contact with the patient, to listen to the patient and to assess the patient's ability to establish self control and follow staff direction; and

iv. A description of the patient's behavior as observed will be noted on the progress record/check sheet every five minutes.

g. Defendants are responsible for assuring that all patients on the Adolescent Treatment Unit receive educational services during their hospitalization, regardless of whether the adolescent is restricted to the unit or is permitted to attend school in the community. Within one working day of an adolescent's admission, defendants shall contact the responsible school unit to arrange educational services.

h. Defendants shall designate a staff person or persons on the unit to monitor educational programs to assure that the children are receiving the educational services, in terms of individualization, substance, location and duration, to which they are entitled. The staff person or persons shall be familiar with the provisions of the Education of the

Handicapped Act, 20 U.S.C.S. § 1401-1485; the regulations adopted pursuant to that Act, 34 C.F.R. Part 300; the education regulations adopted pursuant to Section 504 of the Rehabilitation Act of 1973; and Maine law and regulations governing education of exceptional children, 20-A M.R.S.A. §§ 7201 et seq. and Special Education Regulations, Chapter 101.

i. When defendants believe that a patient is not receiving the educational services to which he or she is entitled, they shall notify the adolescent's parent or guardian or surrogate parent appointed by the Department of Educational and Cultural Services, for the purpose of attempting resolution with the responsible school unit. If further remedy available under the foregoing laws and regulations needs to be pursued, defendants shall assist the parent, guardian or surrogate parent in pursuing those remedies and shall refer them to available legal and advocacy assistance.

j. Defendants shall retain consultants or employ individuals qualified to perform neuropsychological evaluations, and educational and developmental assessments, when required for any patient. These consultants or employees shall also be qualified and experienced in making recommendations for individualized educational programs.

k. In developing the adolescent's treatment and discharge plan, defendants shall comply with the provisions of Section VI of this Agreement, but shall additionally consider the child's educational, and other developmental needs, and shall make recommendations for services, both at AMHI and upon discharge, which meet these needs.

228. Professional and direct care staff employed on the Adolescent Treatment Unit shall receive training as required by Section IX(L) of this Agreement, and shall additionally receive training in the following areas:

a. Principles of treatment in accordance with childhood and adolescent and developmental psychology;

b. Principles of treatment of the sexually or physically abused adolescent;

c. Educational rights.

229. Only those employees who have received training in the above areas shall be assigned for duty on the Adolescent Treatment Unit.

230. When it is apparent that a patient in the Adolescent Unit will soon be ready for discharge and no known community resources are available, Defendant Commissioner of Mental Health and Mental Retardation, and, in the case of a child in State custody, the Commissioner of Human Services, shall be notified for the purpose of immediately mobilizing all resources necessary to effect a timely discharge.

231. Defendants shall file monthly reports with the master and counsel for the plaintiffs on any actions taken pursuant to the foregoing paragraph.

232. If, after the date of this Agreement, defendants determine that discontinuation of AMHI services to adolescents will place mentally ill adolescents at serious risk of harm, they may submit a request to the master to allow them to continue operation of the Adolescent Treatment Unit.

233. Any requests for continuation of operation of the Adolescent Treatment Unit shall be submitted with a written report which contains the following:

a. A statement of the need for continuation of AMHI services to adolescents with supporting facts;

b. A description of all steps which defendants have taken since the date of this Agreement to develop or utilize alternative resources for the treatment of adolescents;

c. A description of the adolescents whom the defendants have admitted since the date of this Agreement. Descriptions for each adolescent shall include: age, diagnosis, presenting problems upon admission, custodial status, and crisis intervention and lesser restrictive alternatives explored prior to admission;

d. A description of the treatment services rendered to adolescents admitted to AMHI since the date of this Agreement, the length of their inpatient stays, and a description of the community programs to which they were discharged;

e. A description of the treatment programs which defendants intend to offer in the future, anticipated length of in-patient stays, and the community programs currently available to adolescents upon discharge and those which defendants intend to develop;

f. Summaries of all agreements or established working relationships, between the AMHI Adolescent Treatment Unit and other governmental or community agencies, which are used to effect discharge and community support plans. Where agreements are in writing, defendants shall submit copies to the master;

g. Job descriptions of all staff to be employed on the Adolescent Treatment Unit, with notations as to the positions currently filled;

h. Copies of all AMHI policies and procedures which are or shall be exclusively applicable to the Adolescent Treatment Unit; and

i. A statement of the period of time for which the defendants are requesting continued operation of the Adolescent Treatment Unit.

234. For those adolescents who were admitted to the Adolescent Treatment Unit following the date of this Agreement and who were in the custody of the Department of Human Services during any period of their hospitalization, defendant Commissioner of the Department of

Human Services shall submit a report to the master describing the steps he has taken since the date of this Agreement to develop or utilize alternative resources to meet the needs of children in the custody of the Department of Human Services.

235. Defendants shall supplement the information required by these reports as may be requested by the master. The master shall act upon defendants' request for permission to continue operation of the Adolescent Treatment Unit in conformity with the procedures set out in Section XVII below.

XI. STANDARDS GOVERNING TREATMENT OF NURSING HOME PATIENTS

236. Defendants may treat persons requiring nursing home care at AMHI.

237. By September 1, 1991, these patients must, at all times, be treated on distinct units at AMHI which meet all state and federal regulations governing the operation of nursing homes. By August 1, 1995, the combined licensed capacity of these units shall not exceed 20 persons. Defendants must maintain licenses issued by the Department of Human Services to operate each entity as a nursing unit. Additionally, defendants must maintain proper certification from the Health Care Finance Administration of the United States Department of Health and Human Services pursuant to Title XVIII and Title XIX of the Social Security Act, as applicable. At no time after August 1, 1995 may defendants apply for or operate the nursing home units under a waiver of or grandfather provision in respect to any of the state and federal licensing and certification requirements.

238. By September 1, 1992, no patient may be admitted to a nursing home unit of AMHI unless the patient meets the admission criteria of the institute as well as the admission criteria of the laws and regulations governing operation of nursing homes. By September 1, 1995, no patient may reside in a nursing home unit of AMHI unless the patient meets the admission

criteria of the institute as well as the admission criteria of the laws and regulations governing operation of nursing homes. No patient who may be diverted appropriately to another setting for treatment, as required by Section V(B)(3) of this Agreement, may be admitted to a nursing home unit of AMHI.

239. All sections of this Agreement, including Section IX(K) governing Staff/Patient ratios, shall apply to the nursing home units except that ratios for the position listed below shall be as follows:

Nurses (RN, LPN), 1:10 during the day shift seven days per week; 1:20 during all other hours.

240. In meeting the requirements of Section IX(D) of this Agreement, defendants shall not exempt any nursing home patient from treatment solely by reason of the patient's age. Exemptions must be based upon documented medical conditions and the terms of paragraph 153 must be met.

241. Discharge to lesser restrictive treatment settings, including home-based services, or discharge to nursing homes closer to the patient's home community or the communities of involved friends or family shall be explored actively for all patients. When the treatment and discharge team determines that a patient could be discharged to a lesser restrictive treatment setting, or would benefit from discharge to a nursing home in another community, or when a voluntarily admitted patient requests such a discharge, the patient's team coordinator shall immediately attempt to locate the necessary services or treatment setting. If, after diligent efforts, the patient's team coordinator is unable to locate the necessary resources, the coordinator shall forward a description and location of the unmet service or treatment settings to the commissioner, and defendants shall use this information to plan for the development of new services in accordance with Section XV of this Agreement.

242. Models for the provision of community services to class members who currently reside on nursing home units at AMHI and who will be discharged or diverted from admission shall be described in the plan required by Section V of this Agreement. The models shall include pre-existing nursing homes and other residential settings, as appropriate. Defendants shall provide or fund supplementary psychiatric, psychiatric nursing, and other services to these homes as necessary to meet class members' needs.

243. Staff employed on the nursing home units shall receive the training as required by Section IX(L) of this Agreement, and shall additionally receive training in the following areas:

Feeding techniques;

Care of persons who are bed-ridden or who are frail, including special techniques to lift and transfer patients; position patients in bed; maintain patient privacy; maintain patient hygiene.

Adverse reactions to medications common to geriatric patients;

Principles of nursing and psychiatric treatment and care of geriatric patients;

Recognition of conditions common among geriatric patients which may be mistakenly identified as symptoms of mental illness.

244. Only those employees who have received training in the above areas shall be assigned for duty in the nursing home units.

245. By January 1, 1991, defendants shall retain a nationally recognized consultant, approved by the master and counsel for the plaintiffs, to develop a training program and principles of psychiatric treatment and care of geriatric patients. Said consultant shall be a psychiatrist specializing and experienced in geriatric psychiatry.

246. The consultant whom defendants retain to develop the training program referred to above

shall additionally review the records of all nursing home patients and examine the patients as needed. The consultant shall specifically review treatment programs, laboratory protocols, medical care, the use of psychoactive medications, defendants' reports of evidence of tardive dyskinesia and extra pyramidal symptoms, defendants' use of restraint and protective devices, and any other matters within the consultant's expertise. To assist defendants in complying with the provisions of this Agreement, the consultant shall issue a report which includes his findings and recommendations for the revision of individual treatment programs and medical care and for overall revision of AMHI practices, policies and procedures in the nursing home units. The report shall be submitted to the defendants and the master and counsel for the plaintiffs. Within 90 days thereafter, defendants shall submit a plan to the master in response to the consultant's recommendations. On the basis of the consultant's report, the master and counsel for the parties will identify any patients not previously identified as requiring the development of housing in accordance with Section VII(B) above.

247. By January 1, 1993, defendants shall recruit, employ or contract with a psychiatrist who is specially trained and experienced in psychiatric treatment and care of geriatric patients to serve on an on-going basis as a consulting psychiatrist for the nursing home units. Defendants shall also contract for the services of a neurologist and a physician specializing in geriatric medicine to meet the individual patient neurological consultation and general medical care needs of AMHI patients residing on nursing home units.

248. Should the defendants plan to continue use of the Greenlaw building for the treatment of patients, they shall make necessary structural alterations to assure the following:

a. All patients' bedroom areas shall have walls which extend from floor to ceiling;

b. No patient shall be required to share a bedroom with more than one other patient;

c. All patient bedroom areas shall have access to natural lighting and ventilation;

d. Distinct dining and activity areas shall be maintained.

249. By January 1, 1993, defendants shall submit a plan and schedule to the master and counsel for the plaintiffs for the above structural alterations, or in the alternative, for development of new nursing home units. If new nursing home units are to be developed, defendants shall demonstrate that in selecting locations for the new units, defendants gave specific consideration to the home communities of the patients, or of their friends or families.

XII. STANDARDS GOVERNING TREATMENT OF FORENSIC PATIENTS

250. The terms of this Agreement governing standards at AMHI shall apply to the Forensic Treatment Unit and to persons who become class members by reason of an admission to the Forensic Treatment Unit of AMHI except that the discharge and release of forensic patients from AMHI shall be governed by 15 M.R.S.A., Chapter 5. The terms of this Agreement shall not apply to any class member while he or she is incarcerated in a correctional facility.

251. By January 1, 1992, defendants shall submit a plan to counsel for the plaintiffs and to the master for his approval, outlining treatment of juvenile forensic patients after the Adolescent Treatment Unit is closed. Said plan shall describe measures the defendants will take to treat and protect juvenile forensic patients, giving particular attention to the need for separating juveniles from adults.

XIII. PUBLIC EDUCATION

252. Defendants shall develop, fund and support a variety of public education programs designed to educate the public regarding mental illness, the myths and stigma associated with it, and the rights of consumers of mental health services and their families. Programs shall include those targeted to assist members of individual communities or employees of public

service agencies to interact with persons with mental illness without prejudice and to foster the full integration of persons with mental illness into their home communities. Groups to which the public education programs shall be offered may include, but not be limited to, schools, libraries, area agencies on aging, general assistance offices, shelters, governmental agencies, civic organizations and law enforcement agencies.

XIV. DEPARTMENT OF HUMAN SERVICES PUBLIC WARDS AND ADULT PROTECTIVE SERVICES

253. For purposes of this section, "public wards" refers to wards of the Defendant Department of Human Services.

254. Defendant Department of Human Services shall provide casework services to its class member public wards. Services shall include the active monitoring of all ISP's or hospital treatment and discharge plans and attendance at all planning meetings.

255. When caseworkers are contacted for the giving of necessary consent to decisions, they shall seek the information necessary to the giving of an informed decision which will be in the ward's best interest and which will maximize the ward's independence consistent with the ward's current circumstances. Before authorizing treatment, the Department of Human Services will seek the counsel or opinion of an independent professional when the risks associated with the proposed medical order or procedure are great, or when the proposed medical order or procedure limits the ward's independence and the prognosis for improvement as a result of implementing a proposed medical order or procedure is poor or guarded.

256. Caseworkers shall visit all class member public wards at least twice monthly.

257. By January 1, 1992, active caseloads for caseworkers assigned to class member public wards shall not exceed 25 cases.

258. Caseworkers shall advise class member public wards of their right to name a designated

representative or representatives and the availability of advocacy and peer advocacy assistance.

259. Caseworkers shall additionally advise class member public wards at least annually of their right to petition the Probate Court for termination of guardianship. The advice shall be given both orally and in writing and shall include information on the application and hearing procedure and on the availability of legal assistance.

260. By October 1, 1990, defendants shall provide copies of this Agreement to all DHS adult protective service and guardianship workers and shall conduct presentations to employees for the purpose of providing an overview of the Agreement. By June 1, 1991, defendants shall conduct training on the terms of the Agreement and on the required specific performance obligations each employee must meet to comply with its terms.

261. By September 1, 1991, all Department of Human Services employees who are assigned to work with class members shall receive the full complement of orientation training on the following: the terms of this Agreement; class members' legal and human rights; perspectives and values of consumers of mental health services; identification of, response to, and reporting of abuse, neglect and exploitation; individual treatment and discharge planning process; ISP process; and the mental health services system. All new employees or all workers newly assigned to work with class members shall be required to receive this training and to complete 90% of the training before undertaking to work directly with class members. Training on the perspectives and values of consumers of mental health services shall be conducted by such consumers. Defendant Department of Mental Health and Mental Retardation shall assist them as necessary.

XV. PLANNING, BUDGETING AND RESOURCE DEVELOPMENT

262. The Department of Mental Health and Mental Retardation shall develop a centralized

system for the planning, budgeting and development of resources to meet class members' needs.

263. Class members' needs shall be determined by information obtained from ISP's and hospital treatment and discharge plans. Defendants shall require that all AMHI treatment team coordinators and all community support workers submit reports describing plaintiffs' current unmet service needs and their projected future service needs. Defendants shall additionally collect information from concerned family members and citizens through the use of public forums. The Department of Mental Health and Mental Retardation shall issue semi-annual reports of the information collected and shall forward these reports to the Commissioner of the Department of Human Services and to the master and counsel for the plaintiffs. Defendants shall use this information in the preparation of budget requests and in the planning and development of resources, so that the actual needs of the class members dictate resource development.

264. Persons responsible for administration of the resource planning and development system shall keep apprised of all programs and services available within the State and of their effectiveness in meeting class members' identified needs. This information shall be circulated to AMHI patient team coordinators and to community support workers on a quarterly basis for their use in the ISP planning process.

265. Resources developed shall be based upon current knowledge in the mental health field. All resources shall be designed to maximize clients' strengths and independence and to integrate clients fully into the mainstream of community life.

266. Defendants shall acquire and maintain the capacity to develop necessary resources on a local level. When developing resources, defendants may elect to contract with area agencies or

individuals for development and administration or, defendants themselves may develop the resources and administer them directly or through contracts.

267. Defendants will establish liaisons with professional associations to assist in the recruitment of qualified professionals for positions of employment, training or consultation at AMHI and in the community.

XVI. MISCELLANEOUS

A. Budgets

268. The defendants shall prepare budget requests which are calculated to meet the terms of this Agreement. The defendants shall additionally take all necessary steps and exert good faith efforts to obtain adequate funding from the Legislature. A copy of all portions of the governor's budget applicable to this Agreement shall be sent to the master and counsel for the plaintiffs when the budget is sent to the Legislature, and a copy of the final budget approved by the Legislature shall be sent to the master and counsel for the plaintiffs immediately following approval of the budget. This paragraph shall apply to any supplemental budget requests. The terms of this paragraph shall not be construed so as to limit the rights of the plaintiffs to seek further relief pursuant to paragraph 12 of this Agreement, subject to any defenses that the defendants might have to such relief.

B. Capacity

269. Defendants shall establish and implement a protocol for assuring that all treatment is delivered by means consistent with the determination of a patient's clinical and judicial capacity. The protocol shall require that clinical determinations of incapacity are reviewed every sixty days. Because patients may be requested by different persons to consent to a variety of forms of treatment or procedures, the protocol shall be designed to assure that

determinations as to patients' capacity to consent are cross-referenced and are consistent.

270. Where inconsistent determinations as to a patient's capacity to consent have been made, the clinical services director, or a physician or psychologist whom he appoints and who is not directly treating the patient, shall examine the patient, make a determination as to the patient's capacity to consent, and enter his findings in the patient's record.

271. A class member who is determined to be incapacitated shall be treated in conformity with procedures established under the "Rights of Recipients of Mental Health Services."

C. Defendant's Designees

272. In various provisions of this Agreement, the individual named defendants or specific professionals are required to perform certain tasks. The parties agree that the individual defendants may delegate their required tasks or those of the named professionals to subordinates, but that individual defendants shall have responsibility for assuring that the required tasks have been completed.

D. Attorney's Fees

273. Nothing in this Agreement shall operate so as to bar plaintiffs' counsel from filing motions with the Court seeking approval of the payment of reasonable attorneys' fees and costs incurred in the oversight, enforcement or implementation of this Agreement. Defendants reserve the right to object to any said motions.

XVII. QUALITY ASSURANCE, INTERNAL MONITORING, REPORTING AND IMPLEMENTATION:

274. Defendants shall take all necessary action to insure substantial compliance with each of the provisions of this Agreement by September 1, 1995, and to thereafter maintain compliance.

275. Defendants shall be responsible for assuring the quality of services required by this Agreement and for monitoring and evaluating all mental health services, programs and other

systems required to carry out the terms of this Agreement. In meeting this responsibility, defendants shall:

A. Licensing

276. Defendant Department of Mental Health and Mental Retardation shall develop licensing standards for all agencies and facilities providing mental health services. The standards shall be consistent with the terms of this Agreement, and shall cover all its terms. Standards shall govern both practices and policies and licensing reviews shall be conducted in a manner to assure compliance with both.

B. Contracts

277. Defendant Department of Mental Health and Mental Retardation's contracts with agencies for the provision of mental health services shall require the individuals or agencies to accept referrals of all class members. Once the interdisciplinary team determines that the class member requires specific services, no agency under contract with the defendants may refuse those services except when, in the case of a residential facility, there are no vacancies, and in the case of other services, the extension of services would cause the agency to exceed pre-established staff/client ratios. Services may be terminated against the recommendations of the interdisciplinary team only upon the agency's compliance with the contract terms required by paragraph 69 above, with notice to the client of his right to grieve the decision.

278. All contracts referred to above shall be written in terms of the specific performance expected of the mental health service agency or individual. Such terms shall be consistent with the terms of this Agreement. The Commissioner and Department of Mental Health and Mental Retardation shall be responsible for monitoring compliance with the terms of the contracts by reviewing both policies of the agency and actual practices.

C. Quality Assurance and Internal Monitoring

279. By September 1, 1991, Defendants shall design a comprehensive system of internal monitoring, evaluation and quality assurance for all areas covered by this Agreement. Critical data shall be collected and reported through an electronic data base system. As part of this system, defendants shall perform an annual random statistically significant review of class members residing both at AMHI and in the community to measure defendants' compliance with this Agreement in meeting individual class members' needs and in protecting their rights under this Agreement.

D. Progress Reports

280. Defendants shall prepare quarterly reports on their progress in meeting and thereafter complying with the terms of this Agreement. These reports shall make specific reference to the headings and structure of this Agreement, and will contain a brief description of efforts made and progress achieved. Defendants shall note the areas where compliance has not been achieved, provide a brief explanation of the reasons for their non-compliance, and a description of the efforts they will be undertaking during the forthcoming quarter to come into compliance. For those areas in which defendants claim to have achieved compliance with the terms of this Agreement, they shall attach copies of their most recent internal monitoring, evaluation and quality assurance report. Quarterly progress reports shall be submitted to the master and counsel for the plaintiffs for approval by the master in accordance with the procedures set out in Section XVII below. Defendants shall send copies to oversight bodies, including the Commission on Mental Health, Office of Advocacy, the agency for the protection and advocacy of mentally ill individuals established pursuant to 42 U.S.C. §§ 10801 et seq., the Joint Standing Committee on Human Resources and, if requested, to the Probate Courts.

281. Defendants Commissioner and Department of Human Services shall be responsible for assuring that each class member public ward is provided all the benefits of this Agreement. On a quarterly basis, they shall prepare and issue a report regarding each such ward identifying the treatment plan for that period, the steps taken to comply with the treatment plan, any obstacles identified in achieving the stated goals, and plans for overcoming such obstacles, if any. These reports shall be submitted to the master and counsel for the plaintiffs.

E. Enforcement of Regulations

282. Defendants shall take administrative action necessary to assure that the regulations entitled "Rights of Recipients of Mental Health Services" and "Rights of Recipients of Services who are Children in Need of Treatment", as may be amended, are applied to all facilities providing in-patient psychiatric services and to all agencies or facilities providing in-patient, residential or outpatient mental health services which are licensed, funded or contracted by either the Department of Mental Health and Mental Retardation or the Department of Human Services.

283. Staff from the Department of Mental Health and Mental Retardation's Office of Quality Assurance and Licensing shall participate in DHS licensing surveys of the aforementioned facilities for the purpose of monitoring compliance with the "Rights of Recipients of Mental Health Services," the "Rights of Recipients of Services who are Children in Need of Treatment," and the standards of this Agreement. The Department of Mental Health and Mental Retardation shall prepare reports of its findings. Said reports shall not contain client names or other client-identifying information. These reports shall be submitted to the Commissioner of the Department of Human Services, the Commissioner of the Department of Mental Health and Mental Retardation, the Office of Advocacy, the master and counsel for the

plaintiffs, and the agency for the protection and advocacy for mentally ill individuals designated pursuant to 42 U.S.C. § 10801 et seq.

XVIII. MONITORING AND ENFORCEMENT ROLE OF THE MASTER

284. The parties agree to the appointment of a Master to monitor the implementation of this Agreement. The Master shall serve as an officer of the Court and shall serve solely the Court and the interests of justice. The Master shall serve for a fixed term to be set by the Court in its Order Appointing or Renewing the Appointment of the Master, but in any event, the term of the Master shall terminate no later than the date of the Court's order pursuant to paragraph 13 of the Consent Decree.

285. The Master shall commence his duties as soon as practicable, but no later than 45 days from the date of his appointment.

286. The Master shall not be subject to dismissal except for good cause. Either party may petition the Court for dismissal or replacement of the Master or renewal of the term of appointment of the Master upon thirty days notice to the court and opposing counsel.

287. Upon resignation, disability, termination for cause or expiration of term of the Master, the parties shall consult one another in an effort to reach agreement about the replacement or appointment of the Master.

288. If the parties are unable to reach agreement as to the person to be replaced or appointed to the Master's position, they shall each submit a list of three nominees to the Court, along with supporting curriculum vitae. These lists shall be supplied within 21 days of the date of any order issued by the Court approving the replacement or renewal of the term of the Master. Each party will then have 15 days to comment on the list of candidates nominated by the opposing party. The Court shall thereafter promptly issue an order for the appointment of the

Master from the lists of nominees presented.

289. Defendants shall pay the salary and expenses of the Master and shall pay for necessary clerical and professional support. In addition, the Master shall be reimbursed for reasonable and necessary expenses incurred in the discharge of his duties and responsibilities under this Agreement. Such expenses include, but are not limited to, fees and expenses of expert consultants, travel expenses, transcriptions and photocopy fees, and office and clerical expenses. The compensation and expenses for the Master shall be subject to approval by the Court. Within 45 days of the date of this Agreement, and on each subsequent anniversary, the parties shall submit a proposed annual budget to the Court, including the proposed rate of compensation for the Court's approval. In subsequent years, the parties shall consult with the Master regarding his budgetary needs. As necessary, the Master may submit supplemental amended budget requests to the Court for its approval after the parties have had an opportunity to comment. Unless and until the Master's budget is directly appropriated to the Judicial Department, the defendants shall deposit the amount of the approved budget or supplemental amended budget into an established court-supervised escrow account.

290. The Master shall have only those duties and responsibilities specified herein. In general, the Master has the duty and responsibility to monitor the implementation of all terms of this Agreement, to attempt to resolve disputes arising between the parties and to make recommendations that will facilitate the goals and objectives of this Agreement.

291. The Master shall, in consultation with counsel for all parties, develop a process to evaluate and measure the Defendants' compliance with the terms and principles of this Agreement.

292. It is the duty of the Master to review all reports that the Defendants are required to

prepare by this Agreement. In addition to these reports, the Master may require the Defendants to file reports or respond to written questions relating to any matter covered by this Agreement. All reports submitted to the Master shall be made available to all parties to this action, subject to the right of defendants to seek an order restricting disclosure to counsel of documents defined at 32 M.R.S.A. § 3296 and 24 M.R.S.A. § 2510(3).

293. This Agreement requires the Master's approval of certain plans or reports prior to defendants implementing their terms. This Agreement also requires the Master's approval of certain draft regulations prior to their promulgation under the Maine Administrative Procedure Act. When reviewing such plans, reports or draft regulations, the Master shall solicit responses from counsel for the parties and shall thereafter issue a written opinion approving or disapproving the plan, report or draft regulations within 30 days. Any party aggrieved by the Master's decision may invoke the procedures set out at paragraphs 294 through 297 of this section.

294. Either party may submit any dispute concerning this Agreement to the Master, who shall attempt to informally mediate and resolve the dispute. The Master may make use of such informal dispute resolution processes as he deems necessary, which may include, but are not limited to, informal suggestions or recommendations and compulsory conferences of the parties.

295. If these informal attempts fail to resolve the dispute, either party may submit a written request to the Master for specified relief and for a recommended decision. A copy of this request shall be filed by the petitioner with the Court and served upon opposing counsel. The Master shall issue and file a written recommended decision supported by written findings of fact with the Court within 21 days from the date of receipt of the written request and shall

serve counsel of record with copies of the decision. The recommended decision shall become final and binding upon the parties unless either party files an objection to the recommended decision and a request for hearing on the matter in controversy with the Court within 21 days from the date of the issuance of the decision. The Court shall then promptly convene a conference of counsel in an attempt to expedite the scheduling of the hearing.

296. Although the parties shall be afforded a de novo hearing, the Master's written recommendations and findings may be introduced into evidence by either party and the Master may be called to testify as a witness by either party or by the Court.

297. The parties may, by written agreement made in advance, agree to submit any dispute to the Master for adjudicative resolution. If the parties proceed under this section the Master shall schedule an evidentiary hearing wherein they may submit such evidence and testimony as are permitted by the Maine Rules of Evidence. The Master shall issue his written decision, including findings of fact and conclusions of law within 21 days of the completion of the hearing. The decision of the Master shall become final and binding upon the parties unless either party files an objection to the decision and supporting memorandum of law with the Court within 21 days of the date of the issuance of the Master's decision. The responding party will then have 14 days to prepare an opposing memorandum. The Superior Court shall apply an appellate standard of review when considering any matter submitted for its review under this section.

298. The Master also has the authority to make recommendations sua sponte with regard to implementation of this Agreement if: (1) the Master believes that the Defendants are not in compliance with the Agreement; (2) this judgment is accompanied by written findings of fact which indicate the source for the evidence upon which each finding is based; and (3) the

recommendations are consistent with and can be implemented within the framework of the Agreement. Such recommendations will include, where necessary, timetables for implementation of steps or measures necessary to bring the Defendants into compliance. These recommendations will become final and binding upon the parties unless either party invokes the procedures set out at paragraphs 294 through 297.

299. The Master shall submit a written report to the Court and the parties every six months detailing the progress achieved by the Defendants with implementing the terms of this Agreement. Each report shall include a description of all disputes and interpretive questions which have been addressed and resolved by the Master in the preceding six-month period. The report shall highlight all instances of Defendants' compliance and non-compliance with the Agreement within the six-month period and shall include specific recommendations as to how to facilitate Defendants' full and timely compliance with the provisions, goals and objectives of this Agreement. All recommendations made by the Master shall be supported by specific findings and shall reference the documentary evidence relied upon by the Master in rendering his recommendation. Prior to filing the report, the Master shall submit a proposed draft to the parties for comment. The specific recommendations contained in the report shall become final and binding upon the parties unless either party invokes the procedures set out at paragraphs 294 through 297. The Master shall take appropriate measures to prevent the disclosure of confidential information to the general public. Nothing in this paragraph shall prohibit the Master from submitting additional reports or comments to the Court or the parties at any other time.

300. For the purpose of gathering relevant information and prior to submitting the report required by paragraph 299 above, the Master shall solicit public comment from class members,

relatives of class members and their guardians, client advocacy groups, the Office of Advocacy, community service providers, Defendants' employees or other necessary persons, regarding the progress achieved by the Defendants in implementing this Agreement. The requirements of this section may be satisfied by holding a publicized public meeting, by soliciting written comments, by a combination of the above or by any other methods of gathering input and information that the Master deems necessary and appropriate.

301. Copies of the final report shall be furnished to the counsel for the plaintiffs, chairpersons of appropriate committees of the Legislature, the Office of Advocacy, and the protection and advocacy program established pursuant to 42 U.S.C. §§ 10801 et seq. In addition, a copy shall be supplied to any member of the public who makes a request for the report, provided that reasonable photocopy and mailing fees may be charged to cover the costs of public disbursement of the report.

302. The Master shall have access to all facilities, records, documents, information, programs, residential settings and persons affected by or involved in the implementation of this Agreement. The Master shall have the authority to conduct inquiries and consult with professionals to assist in finding facts relevant to implementation of this Agreement.

XIX. ENFORCEMENT

303. The parties agree that the terms of this Agreement may be specifically enforced directly by the Court upon written motion of the parties, with notice to opposing counsel; provided that, the Court may require the parties to mediate their dispute before the Master pursuant to the provisions of paragraph 294 above prior to proceeding to a hearing on the parties' motion. During any time where a Master is not serving or has not been appointed, the parties shall make reasonable attempts to informally resolve all disputes prior to their application to the

Court.

Consented to by the undersigned:

FOR THE PLAINTIFFS:

Date:_____
Richard M. Goldman

Date:_____
Helen M. Bailey

Date_____
Neville Woodruff

Date:
Peter Darvin

Date:
Robert Marks

Date:
Helen Hershkoff

Date:
John A. Powell

FOR THE DEFENDANTS:

_____Date:
Robert W. Glover

_____Date:
Linda Breslin

_____Date:
Rollin Ives