Maine mental health annual review and progress report 1977.

MAINE MENTAL HEALTH ANNUAL REVIEW AND PROGRESS REPORT

1977

STATE OF MAINE

DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

George A. Zitnay, Commissioner

Staff: Charles Acker, Ph.D., Evaluation Coordinator
Marya Faust, M.S.W., Director, Children's Services
Lorraine LeClair, Clerk Stenographer
Frank Schiller, B.A., Planning Associate
Chase Whittenberger, M.A.T., Planning Associate

Department of Mental Health & Corrections

State Office Building *Telephone (207) 289-3161* *Augusta, Maine 04333*

GEORGE A. ZITNAY, Commissioner

July 1, 1977

Governor James B. Longley
State House
Augusta, Maine 04333

Dear Governor Longley:

I am pleased to transmit to you a copy of the 1977 Maine Mental Health Plan Annual Review and Progress Report. This document will be submitted to the Secretary of Health, Education and Welfare in compliance with requirements of the Public Health Services and Community Mental Health Centers Act subsequent to public distribution and a series of four public hearings scheduled for July 11 - 13.

This plan provides documentation of significant achievements of the mental health system in increasing the quality and level of services for children, and in increasing the accountability of mental health provider agencies. It also serves this Department as a mechanism for soliciting comments on public expectations and review criteria for the mental health system.

I appreciate your personal concern and active participation in the resolution of issues related to effective and efficient provision of needed mental health services, and respectfully request your comments and endorsement of the Maine Mental Health Plan Annual Review and Progress Report.

Sincerely,

George A. Zitnay

George A. Zitnay
Commissioner

GAZ/lyl

Department of Mental Health & Corrections

State Office Building *Telephone (207) 289-3161* *Augusta, Maine 04333*

GEORGE A. ZITNAY, Commissioner

June 23, 1977

Allen G. Pease, Director
State Planning Office
184 State Street
Augusta, Maine 04333

Dear Mr. Pease:

I am pleased to transmit to you a copy of the 1977 Maine Mental Health Plan Annual Review and Progress Report for review, comment and endorsement by the State Planning Office. This document was prepared in compliance with the Public Health Service and Community Mental Health Centers Act. This material also descriptively documents significant achievements of the Maine mental health system over the last year and provides the framework through which providers, social institutions and the general public can make their expectations and review criteria known to the Department.

I appreciate the ongoing coordination between this Department and the State Planning Office and look forward to your endorsement of this Annual Review and Progress Report.

Sincerely,

George A. Zitnay

George A. Zitnay
Commissioner

GAZ/lyl

MAINE MENTAL HEALTH ANNUAL REVIEW AND PROGRESS REPORT

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TABLE OF CONTENTS

APPENDICES

TABLE OF CONTENTS

PREFACE

As Maine's officially designated mental health authority, the Department of Mental Health and Corrections has prepared this Annual Review and Progress Report in compliance with requirements of the Public Health Service and Community Mental Health Centers Acts. Beyond meeting these federal mandates, this material descriptively documents significant achievements of Maine's mental health system over the last year, provides an indication of future program development and also provides the framework through which consumers, providers and social institutions can make their expectations and review criteria known to the Department.

Maine's mental health system began in 1840 with the opening of the Augusta Mental Health Institute, then known as the Maine Asylum for the Insane. The state's second state mental health hospital, the Bangor Mental Health Institute, opened in 1901. During the 1950's these institutes developed outpatient clinics or family counseling clinics in several areas of the state. The two institutions have, over the last two decades, been joined by eight community mental health centers which each provide comprehensive programs to all residents of Maine through eight catchment areas.

The 1976 Maine Mental Health Plan was the first overall effort of its kind since 1970. The purposes of the 1976 Plan were to comply with new federal legislation and regulations, and to begin development of an ongoing comprehensive planning process. This Annual Review and Implementation Report follows the same outline as the 1976 Plan and focuses on efforts to more adequately meet the special mental health needs of children and to establish increased accountability for expenditures.

This document reflects major achievements by the Department of Mental Health and Corrections in: 1) implementing several measures to assure quality of services, 2) developing a specific unit responsible for long-range planning, program development and administrative coordination of children's services, 3) improved capacity for long-range mental health planning, 4) implementation of equitable needs assessment and funding allocation procedures, 5) further development of a comprehensive Maine Mental Health Information System (MEMHIS), 6) planning the development of a balanced service system with fixed points of referral. These achievements are more fully described in later sections of this report.

Several problems were also encountered in the preparation of this document and in maintaining progress of the ongoing mental health planning process. After 16 years as Director of the Bureau of Mental Health, Dr. William Schumacher left his position in February, 1977. His position, has been filled by L. Roger LaJeunesse effective June 27, 1977. In addition, Dorothy Doyle, R.N., who was brought on as a mental health planner to develop the 1976 Mental Health Plan left her position in March. This planning position was filled in late April by Frank Schiller. The Department began the process of adding a comprehensive mental health planner to the central office staff in May, and expects to fill this position by the end of July. The state legislature formally created a State Mental Health Advisory Council through L.D. 757 (Appendix A). The Council was approved by the Governor on April 6, 1977, and appointments made on June 10. These changes in staff and advisory council members naturally affected maintenance of planning linkages with the State Health Coordinating Council, the Health Systems Agency, the Council of Community Mental Health Center Directors, and

other public and private elements of the mental health system such as the Maine Psychiatric and Maine Psychological Associations.

Portions of this Annual Report and Implementation Review reflect this transition phase of Department operations. For example, while a funding allocation formula and agreement for provision of community mental health services have been adopted, these are interim measures which will be refined as the Department improves the data base provided by MEMHIS and Council training resources are used to familiarize central office and CMHC staff with development of a balanced service system.

Although federal requirements necessitate development of a comprehensive mental health plan every five years and reports such as this annually, the Department will definitely prepare and submit a full revision of the Maine Mental Health Plan in 1978. Therefore, this document should be viewed as an interim indication of the condition of the Maine mental health system and of the directions the system is taking in meeting the needs of Maine people.

STATE AGENCY

In October 1976, George A. Zitnay was appointed Commissioner of the Department of Mental Health and Corrections. Roger A. LaJuenesse has been appointed, effective in June, Director of the Bureau of Mental Health, replacing D. William Schumacher. Although there are plans to reorganize field service units, the only change in structure is in the addition of two Associate Commissioners in the Augusta Central Office. Charles Meredith, M.D. has been serving as Superintendent of the Augusta Mental Health Institute since January 1977.

STATE ADVISORY COUNCIL

Attached as Appendix A is a copy of the newly legislated statute creating a Mental Health Advisory Council in compliance with PL 94-62 requirements. Also attached is a listing of Council membership. Over the past year the Council has met its statutory obligation in advising the Commissioner both in the selection of a Superintendent for Augusta Mental Health Institute as well as a legislative package for mental health.

ANNUAL REVIEW

One hundred and eighty copies of the Maine Mental Health Plan have been distributed prior to preparation of this Annual Review and Implementation Report. Recipients of the Plan include legislators, human services agencies, mental health provider agencies and interested members of the general public. Two hundred copies of this document will be printed prior to its being submitted to federal officials.

This Annual Review and Implementation Report will be distributed to the Maine Council of Community Mental Health Center Directors, the new Maine Mental Health Advisory Council, and the Maine Psychiatric and Maine Psychological Associations for review and comment. About June 20, 1977 and July 11, 1977, the Department will circulate a news release to major media outlets in the state to inform the general public of the availability of this document from the Department or for review at major public libraries. A series of 5 public hearings have been scheduled to facilitate citizen input. These are scheduled for Aroostook County on July 12, Bangor and Augusta on July 11, Lewiston-Auburn on July 12, and Portland on July 13.

The Department of Mental Health and Corrections has identified Charles Acker, Ph.D., as the primary contact with the Maine Health Systems Agency and Dr. Acker has participated in the development of the mental health portion of the HSA plan as well as goals and objectives contained in this report. Continuing efforts to coordinate with the HSA are planned.

Another vehicle for public exchange and feedback and continuing development of an ongoing comprehensive mental health planning process is the Maine Mental Health Consortium. This organization is currently composed of mental health center directors, representatives of community mental health center advisory boards, the Governor's Advisory Committee on Mental Health, consumers, several central office staff from the Department of Mental Health and Corrections, representatives of the Augusta Mental Health Institute, Bangor Mental Health Institute and the Maine Health Systems Agency. Contribution of this organization to this Annual Review and Progress Report includes participation in development of goals and objectives through a Mental Health Priorities Questionnaire, clarification of the Consortium's role and future development through a Participant Survey, and formulation of specific alcoholism and elderly treatment goals through workshops. Materials reflecting the results of these efforts are included in Appendix B. Generally the Department views the Consortium as a valuable vehicle for coordination, effective utilization of Maine mental health expertise, and as a working partner in long and short-range planning.

Some of the material which was reviewed by members of the DMH&C planning staff in preparation of this Annual Review and Progress Report include annual reports and grant applications from the community mental health system, data from MEMHIS and other components of the mental health information system, and, with their beginning in May, 1977, monthly narrative reports from AMHI and BMHI. Some of the meetings attended preparatory to the writing of this Annual Review include:

1. February 23, 1977, NIMH Regional Office, Maine HSA, Maine Council of Community Mental Health Centers, Mental Health Advisory Council, and, indirectly, Mental Health Consortium representatives. General objectives included:

a. Clarification of the roles of these and other organizations in the preparation and review of the Maine State Mental Health Plan.

b. Review of the three conditions placed on the approval of the present Plan, September 1, 1976.

c. Review of the status of progress towards the July 15, 1977, submission of an approvable Plan for the year September 1, 1977 to August 30, 1978.

d. Exploration of ways to integrate health and mental health planning in the State of Maine.

2. 1/14/76, 1/28/76 and 4/22/76 Stevens I, II and III. Meetings of DMH&C central office and institute staff to discuss and formulate Departmental Goals and Objectives.

3. 11/19/76 Maine Mental Health Consortium. Agenda topics included:

a. Consortium planning committee recommendations on membership.

b. Presentation by Commissioner Zitnay and DMH&C staff Chuck Acker on goals and objectives.

c. Governor's Advisory Committee on Mental Health, status report.

d. Maine Mental Health Institute planning review,

e. Mental Health legislation review and priorities.

f. Corrections plan update and review.

4. 4/22/77 DMH&C institute staff met at AMHI to review mental health institute information systems and use in planning.

5. 4/26/77 DMH&C and Council of Community Mental Health Centers training program staff met to define interrelationships and potential contribution of training system to Departmental goals such as development of a balanced service system.

6. 1/31/77 and 2/10/77 Mental Health Consortium planning committee with DMH&C staff and (on 2/10) DMH&C Commissioner. Agenda items included review of Department's mental health system philosophy, planning needs and schedule, and role of the Consortium.

7. 5/3/77 Meeting with Department of Human Services, Bureau of Resource Development director and staff on Title XX funded mental health aftercare program.

8. 5/18/77 Meeting with DHS Title XX training director and Human Services Development Institute director to review coordination of training and role of DMH&C in interdepartmental manpower training efforts.

9. 4/15, 6/6/77 Meeting with representatives of Human Services and Department of Education to coordinate plans and administration of youth residential treatment centers.

10. 5/5/77 Mental Health Consortium meeting. Agenda topics at this meeting included the Mental Health Priorities Questionnaire results, Maine Mental Health Institute Plans, discussion and survey of members on future roles and activities of the Consortium. Afternoon workshops developed specific elderly services and alcoholism treatment goals and objectives.

The methods to assure public exchange and feedback over the coming year include: continuing participation in the HSA planning process, establishment of stronger linkages with the State Health Coordinating Council, clarification of the role of the Mental Health Consortium, and orientation, assistance and ongoing support for the newly appointed Governor's Mental Health Advisory Council. The expected development of a fully functional MEMHIS statistical data gathering system by late 1977 will be extremely beneficial in future program evaluation and planning.

PERSONNEL ADMINISTRATION

State employees of the Department of Mental Health and Corrections were affected during the last year by the implementation of a Maine merit system which established, through rating and appeal procedures, a basis for determining raises and advancements. Although several problems arose in the implementation of this system, the Department was not affected any differently than other state departments. Also, Frank Mack, Jr., the Department's Chief Personnel Officer was instrumental in the formation of a Personnel Advisory Committee comprised of personnel representatives from each state department. Frank Mack is the chairman of this group, which assesses common problems with the state personnel system, devises solutions, and reports to the Commissioner of Personnel.

This interrelationship of the Department of Mental Health and Corrections with the state personnel system assures compliance with state personnel standards. Also, compliance of state standards with Federal Civil Service mandates is assured through the Personnel Department and also through annual reviews of Departmental personnel policies by the Region I Office, Department of Health, Education and Welfare, Frank Mack performs the function of linking the Department with state and federal personnel systems and therefore acts in an advisory function regarding implications of Departmental reorganization plans.

Assurances

There have been no major changes in the state's mental health system which would affect assurances that are provided in regard to reports, records, conflicts of interest and non-discrimination. Several specific assurances are contained in the revised set of Departmental licensing standards and also in the agreements for provision of services between the Department and CMHC's. (Sample agreement attached as Appendix C.)

Goals and Objectives

The Department of Mental Health and Corrections views goals and objectives as an expression of perceived public priorities for Maine's mental health system. Goals and objectives statements also serve to clarify the roles, responsibilities and relationships of various Departmental units and as an ongoing management technique to monitor areas of progress and needs for improvement.

The 1977-78 Goals and Objectives presented in this Annual Review and Progress Report clearly have a dynamic quality which includes broad participation in their development, ongoing assignment and assumption of responsibility for their implementation, and also ongoing development of additional objectives which lead toward long-term goals.

Previous mental health goals and objectives did not totally reflect these functions. To some extent they were developed in a planning vacuum, focused on processes rather than quantifiable outcome measurements, and were not pursued in an ongoing management process. Nevertheless they did reflect perceived problems with the mental health system and many of the objectives were partially or fully accomplished.

Achievements of the Department of Mental Health and Corrections' planning and evaluation component include the following: Within contraints of personnel changes and continuing reorganization of the Department, the structure, function, and role of the planning unit has been clarified. Presently the planning staff address projects and issues on a team basis. Specific individuals who specialize in mental health, mental retardation and corrections interact daily and jointly share tasks through the leadership of the appropriate planning specialist. Daily meetings with the Associate Commissioner for Programs, and frequent meeting with the Commissioner and Associate Commissioner for Administration assure coordination of efforts, and ongoing monitoring and evaluation of performance. In the last year a specific individual, Marya Faust, was assigned responsibility for children's issues, and her participation in the planning process has assured continuing attention to these issues.

While specification of the Departmental philosophy has not been addressed as a specific issue, improved communication in the planning process has led to consensus on several assumptions, including the overall mission of the Department in increasing the quality of life for the mentally disabled, development of a balanced service system, and increased level of community care.

The Department's mental health statistical information base continued to expand over the last year. Ongoing group meetings of planning, research and evaluation and computer services staff developed a recording system for information requests, identified progress with processing of data received from CMHC's under the MEMHIS format and worked to resolve barriers to full implementation of MEMHIS.

Evaluative data and techniques were used in the Department's analysis of CMHC's capabilities in respect to the Bangor Mental Health Institute phase-down plan, and in analysis of the CMHC's aftercare programs. Evaluative data generated by the mental health information system was also considered in development of alternative allocation formulas for state mental health

funds. To assure continued development of MEMHIS, $62,700 was appropriated to CMHC's for FY 77 for MEMHIS data collection and reporting. In addition, computer hardware time and keypunching costs to the Central Office were about $700 per month. This figure is expected to be fairly stable as computer time increases while costs of keypunching backlogged data decreases.

In the area of Mental Health, several actions reflect the Department's progress towards goals stated in the 1976 Plan. A major change took place in the Department's historical use of a block-grant system of funding CMHC's as agreements for provision of mental health services were developed and applied to FY 1978 allocations to CMHC's. A copy of these agreements is included in Appendix C.

In addition to assuring the provision of a range of services in all areas of the state, the agreements with CMHC's provided the vehicle for several measures which increase the state's capacity for program monitoring and evaluating and begin movement towards accreditation of the CMHC's by the Joint Commission on Accreditation of Hospitals, Council for Psychiatric Facilities. The agreement form also clarified responsibilities of CMHC's to submit an annual report on September 15, 1977, and specified contents of the report.

In the area of children's services, the Department was able to increase its ability to identify children's needs, and inventory available services and resources. Re-activation of the Interdepartmental Coordinating Committee children's services group, comprised of representatives of the Department of Mental Health and Corrections, Human Services and Education, led to greater coordination of children's services and the identification of several needed areas of improvement.

The residential treatment system provides lodging, education and mental health services for youths whose family and behavioral problems are too extreme for normal foster care or day care services and not extreme enough to warrant arrest and custody in juvenile correctional institutions. Funds are partially provided by three state departments and fiscal and management reporting, monitoring and evaluation functions are uncoordinated. Efforts to develop a continuum of services, a consistent screening and referral process, and uniform reporting system have been initiated by the ICC.

The organizational structure of the Department specifies a distinct Departmental unit of children's services equivalent to, and interacting with, mental health, mental retardation and corrections bureaus. The Department's budgeting process for FY 78 includes allocation of a specific portion of the budget for children's services.

Several statutory changes made by the 108th Maine Legislature clarified the Department's responsibility to children. These included provision that the superintendent of the Military and Naval Children's Home no longer must become legal guardian of resident children. The unnecessary detention of large numbers of juveniles in security facilities should be alleviated through mandatory screening, and possible referral and follow-up for all youths arrested or taken into custody by law enforcement personnel.

The Developmental Disabilities Council, the Education Advisory Council and the I.C.C. Children's Services group are several avenues utilized by the Department in coordinating children's services, and establishing respective roles of this Department with Human Services and Education.

The ability of the Department to evaluate the effectiveness of children's mental health programs has been increased through the use of improved contracts with providers of services. Through numerous program site visits the Department has an active function in the ongoing design and modification of service goals and objectives of provider agencies.

The Advocacy unit of the Department was also affected by personnel changes during the year as Susan Young replaced Bob Carlson as Chief Advocate. In addition, the advocacy staff was expanded with the recruitment and hiring of an advocate for the Bangor Mental Health Institute in November, 1976, and an advocate for Pineland in November, 1976. An advocate position for the Maine State Prison is in the process of being approved and filled.

With widespread use of individual treatment plans and progress reports for clients of programs sponsored by the Department, the advocacy office has shifted its emphasis from seeing that these plans exist to qualitative review. The appropriateness, proper development and proper documentation of treatment plans for all individuals are addressed by advocacy staff. Monthly reports from institutes, a procedure begun in early 1977, has provided an additional mechanism for the identification of aspects of the service system which need the attention of the advocacy staff. Periodic site visits by the chief advocate assure sufficient monitoring, evaluation and coordination of Departmental advocacy activities.

The development of the goals and objectives which follow came about through the recognition that there was a need for broad and ongoing participation in the development and review of measurable outcome expectations. The Commissioner, Associate Commissioners, other central office staff and representatives of the institutes met in a series of meetings called Stevens I, II and III to review and reformulate goals and objectives. The Maine Mental Health Consortium membership completed a comprehensive questionnaire on Departmental priorities (Appendix B). The product of these efforts were circulated to Corrections, Mental Retardation and Mental Health Central Office staff and implementation timetables were established through this joint planning process.

STATEMENT OF DEPARTMENT MISSION

The purpose of the Maine Mental Health system, under leadership of the Department of Mental Health and Corrections, shall be to promote the mental health and general well-being of individuals, families and communities of the State of Maine through services to those who are emotionally dependent, emotionally or mentally disabled, or delinquent, and to avert to the extent possible, the development of behavioral problems and emotional problems through prevention and mental health promotion services to the general population.

GOALS AND OBJECTIVES

Goal I

Develop and implement policies, legislation, regulations and performance standards for mental health activities which facilitate the purpose of the Department, the mental health system and its components.

Objectives:	Target Date for Completion
A. To have a $36,539,910 appropriations commitment from the legislature for FY 1978 Department operations.	7/15/77
B. To distribute 70% of available funds through specified contract and purchase of service agreements with CMHC's and other mental health agencies.	7/78
C. To complete an on-site evaluation of at least 3 community mental health centers by 9/77, and complete on-site evaluation of all remaining agency components by 9/78. Within 30 days of each evaluation, a report will be submitted. Within 30 days after receipt of the report, specific goals and objectives will be written to address all recommendations. On the site visits particular attention will be given to program rules, policies, regulations, practices and provision for outcome measurement.	9/77 9/78
D. To establish a central office planning, evaluation, and data processing component;	6/77
1. To determine and monitor data gathering outcome and needs;	8/77, ongoing
2. To have departmental information sub-systems integrated;	1/78
3. To have central component files and input and retrieval programs operational and current.	1/78

	Target Date for Completion
E. To distribute, at least monthly, media releases aimed at improving public awareness of available mental health resources and public support of the mental health system.	7/77, ongoing
F. To design and implement a systematic program, using the mass media, to promote generally accepted principles of behavior development, influences of social environments, and psychological and behavioral factors in physical and emotional health.	6/78

Goal II

To develop an organizational structure which supports and encourages a balanced system of services to all age groups and across all mental and behavior problem categories regardless of diagnosis; to assure continuity of service through coordination across agencies and bureaus at the local service level.

Objectives:

A. To establish departmental regional offices in 3 areas of the State: Northern, Central and Southern.	1/79
B. Develop job descriptions and standards of performance for central office staff, assuring that personnel are adequate to provide the following functions across the areas of mental health, mental retardation and corrections:	9/77

1. Coordination
2. Licensing Standards
3. Comprehensive Planning
4. Information and Evaluation
5. Contract Development and Monitoring
6. Training
7. Children's Services
8. Volunteer Services
9. Public Information
10. Guardianship
11. Legislation

C. To establish, by region, intake systems with fixed department-wide points of referral.	1/79

	Target Date for Completion
D. Each quarter the Associate Commissioner for Programs will review performance of program directors responsible to him in relation to assigned responsibilities and standards.	ongoing
E. To study problems of the juvenile residential treatment, placement and service delivery system; within 45 days after completion of the study, to develop inter-agency goals and objectives to address all accepted recommendations of the study.	9/77
F. To finalize and distribute a plan for provision of a continuum of juvenile services with specific goals and objectives addressing:	1/78
1. Regional establishment/expansion of residential treatment programs,	
2. Regional establishment/expansion of day care programs,	
3. Establishment of procedures for immediate provision of evaluation services to juvenile offenders by CMHC's.	
G. To establish, in each region, a juvenile services division responsible for developing regional goals and objectives, including those which address needs assessment, counseling, pre-trial intervention and alternatives to sentencing.	11/77
H. To provide through specific line items, regional mental health funding for children's programs, commensurate with the proportion of children in the population.	7/77, ongoing
I. To require CMHC's which receive Departmental grant-in-aid funding to include representation of agencies which serve children on their governing boards.	7/77
J. To collaborate with the Bureau of Maine's Elderly to develop a plan of services which will include development in each catchment area:	
1. Outreach Programs	2/78
2. Alternative living arrangements, and	4/78
3. Partial hospitalization services geared for the elderly.	4/78

	Target Date for Completion
K. To collaborate with the Office of Alcohol and Drug Abuse Prevention in developing:	
1. A study of substance abuse prevention needs for each catchment area,	12/77
2. Goals and objectives for each catchment area to include identification of needs, procurement of resources to meet needs, development of standards of treatment, establishment of evaluation formats and integration of program monitoring and data collection.	6/78

Goal III

To establish guidelines and procedures to assure quality of care in all mental health program funded by the department.

Objectives:

A. To develop and make available standards of care applying to diagnosis and treatment, organization and personnel, and the physical plant for all facilities which provide inpatient, residential, day care, aftercare and/or emergency psychiatric counseling.	1/78
B. To require a current written treatment or program plan for each person treated by a mental health agency; the plan specifying, as a minimum, goals of treatment or problems to be treated, methods of treatment, staff person(s) responsible for treatment, and frequency and expected duration of treatment.	7/77
C. To make available a total of 10 person hours a week of Central Office staff time by those persons responsible for program Coordination, Licensing, Evaluation, Training, and Children's Services to assist mental health facilities in meeting standards of care and individual treatment plan requirements.	7/78
D. To require that each facility providing mental health care have a utilization review committee with regular meetings devoted to examination of the type of admissions, length of stay, treatment goals, release criteria and use of professional and ancillary services; to require that minutes of the utilization review committee be kept and be made available at the time of site evaluation.	7/77, ongoing

		Target Date for Completion
E.	To require an annual evaluation plan which includes a component for program outcome evaluation from each facility providing mental health care.	10/77, ongoing
F.	To require the establishment of a peer review evaluation process covering the activities of all staff who provide direct mental health services.	10/77, ongoing
G.	To have family impact statements as a component of all new program proposals.	Ongoing start 7/77

Goal IV

The Department will provide services in the most humane and normal manner and environment appropriate to restore individuals to optimal levels of functioning in the community.

Objectives:

A.	To develop and promulgate a pamphlet which outlines civil and legal rights and responsibilities of individuals receiving mental health treatment.	9/77
B.	To identify and seek adoption of state laws necessary to ensure protection of mental health patient rights.	12/77
C.	To require that each mental health agency licensed by the department have a Human Rights Committee; to promulgate guidelines for such committees and to hold organizational meeting with those agencies which do not have such committees.	Begin 7/77, complete by 7/78
D.	To include provision for protection of client rights in guardianship agreements and periodic monitoring of guardianship agreements.	7/77
E.	To provide opportunity for community comment, complaints and criticism into the planning and administration of the service delivery system.	7/77 Ongoing

Goal V

To provide an array of services for the promotion of attitudes and behavior among all members of the community consistent with good mental health, the prevention of mental illness and early detection of emotional problems.

Objectives:

A.	To develop with the Department of Education	7/79

		Target Date for Completion
	and Cultural Services a curriculum format designed to promote understanding of mental health and factors contributing to the ability to cope successfully and to avoid self-defeating behaviors, such as substance abuse.	
B.	To establish for the Department of Education and Cultural Services, and in cooperation with pupil evaluation teams, a consistent contractual process of consultation, screening, evaluation and referral for all children with probable emotional problems.	1/79
C.	Establishment, with the Department of Education and Cultural Services, a format for the evaluation of diagnostic and screening programs in each school district.	1/78

Goal VI

To establish performance standards as a basis for the allocation of funds to mental health agencies.

Objectives:

A.	To reduce the average number of readmissions to Mental Health Institutes to below 40%.	Ongoing
B.	To increase the "percent of Mental Health Institute admissions with a significant release within one month" to above 85%.	7/77
C.	To require that at least 70% of mental health grant-in-aid expenditures be for direct services. (Direct Services are defined in NIMH Series C#12 and in the MEMHIS master list of codes and definitions).	7/77
D.	To require documentation of savings through energy conservation as a condition of Department approval of future funding.	7/77
E.	To require annual CPA audits of all mental health program expenditures.	Ongoing, 7/78
F.	To determine and establish at least one cost-effectiveness criterion in each major mental health treatment modality to be used in program review and approval.	7/77

Target Date for Completion

Goal VII

To establish a research and training unit within the Department.

Objectives:

A.	To establish a departmental training coordinating committee, one function of which will be to conduct a semi-annual review of training needs.	7/77
B.	To post all training opportunities available to Department staff.	7/77, Ongoing
C.	To establish guidelines for the provision of pre-service and in-service staff training and development.	
	1. For central office staff	8/77
	2. For CMHC staff	9/77
	3. For MR staff	10/77
	4. For Corrections staff	11/77
D.	To provide 3% of mental health funding for research into mental health treatment modalities appropriate for Maine.	7/78
E.	To increase funds available for research and training.	1/78

Pre-Admission Screening

During 1976 the overall policy statement which delineates responsibility of the state mental health institutes to care only for those clients whose needs cannot adequately be met in the community remained basically unchanged. This policy statement is Departmental Policy Number 11 dated February 20, 1974.

No extensive efforts have been made during the year to directly and specifically survey the appropriateness of placement in the state's mental health institutions. Policy Number 11 does, however, clearly charge institute superintendents with the ongoing goal of discharging patients as soon as possible under effective support services. Some indication of the appropriateness of institutionalization is reflected by the AMHI monthly reports which summarize client and staff perceptions of satisfaction with and success of inpatient mental health care. An attempt was made by planning staff to develop linkages with the Department of Human Services foster care program and a survey of the appropriateness of institutionalization which they carried out in one region, but this was found to be too general to be of any use.

Data on admissions to the institutes for 1976 indicate that 84% of admissions to the Augusta Mental Health Institute were referred through the community mental health centers. Courts and correctional facilities were responsible for the referral of 8% under state statutes and policies providing for pre-trial observation and evaluation of competency to stand trial, or in cases where the client had been found innocent by reason of mental disease or defect. This leaves 8% of admissions which AMHI classifies sources to be family, friends, private practitioners and others. The data processing and reporting system at BMHI is not as complex or automated as the AMHI system so it is more difficult to obtain statistics for the referral source of admissions. Of the 611 admissions to BMHI in 1976, 197 entered directly after screening by CMHC's. There were 268 admissions to D-1, the inpatient facility operated jointly by the Bangor Counseling Center (the area CMHC) and BMHI, 11 admissions from superior court referrals, and 297 classed as voluntary admissions. Some of these were referred by CMHC's but an exact count isn't available. Also these total more than 611, so some duplication is obvious.

Beyond the major mental health institutes, the screening system and appropriateness of placement in youth residential treatment centers was addressed by the Department. As a result, the Director of the Children's Services section created in the DMH&C has reviewed and refined the process of admission to residential treatment centers, assuring participation of families, pupil effectiveness teams, school personnel and mental health centers.

The Department of Mental Health and Corrections closed its only state run facility for emotionally disturbed children in 1973 and began providing services through contracts with private residential treatment centers. Since the closing of Children's Psychiatric Hospital, the CMHC's have been actively involved in the screening of children for residential placement. Procedures developed jointly with DECS and DMH&C have been followed which require that the local School Pupil Evaluation Team (PET) recommend the placement and that this is supported by the local CMHC. This joint procedure was enacted to assure that both the child's educational and emotional needs are being assessed and appropriately met.

Once the PET and the local CMHC agree upon a recommendation for placement, the referral is made to Children's Services, DMH&C, for funding approval and, if necessary, a recommendation for a particular residential center. Children's Services notifies the DECS that it concurs with placement and also notifies the residential center to guarantee funding. The local community makes any further necessary arrangements such as an evaluation and visit to the residential center. This procedure is meant to place clinical and treatment decisions at the local level while the role of the central office, DMH&C, is primarily to arrange financial matters.

The CMHC's have each identified a person to coordinate or direct services for children and it is to this person that DMH&C Children's Services makes referrals should there be inquiries from parents or other community agencies. It is planned for this year that these people become more knowledgeable of particular residential treatment center programs and work more closely with them to develop follow-along and discharge plans for youngsters in placement.

Alternatives to Hospitalization: BMHI

The primary means for freeing resources to develop alternatives to hospitalization is the Department's proposal to phase down BMHI. As the attached proposal indicates, the plan would free $350,000 the first year and considerably more each year thereafter. These funds would be utilized to provide community services, and would be allocated on the basis of need and distributed by means of a contract.

The legislature has indicated its unwillingness to implement the Department's proposal on the schedule recommended by the Department (77-78 being the first fiscal year of implementation). Also still at question is the legislature's willingness to accept the concept of phasing down BMHI. Since this is virtually the Department's only alternative for developing internally funds for community alternatives, this process will at best be delayed one fiscal year or more.

The Department still, however, will utilize a funding formula to determine need for existing funding of community services and will implement the contract mechanism for assuming quality and accountability of community services, as described elsewhere. It is anticipated that of these measures will be of significant value in strengthening the delivery of alternative services, if not providing for expansion in the immediate future.

Public mental health hospitals--efforts to improve the quality of care

(App. D)

The attached proposal to phase down the BMHI campus addresses staffing needs as they relate to improving the quality of patient care from several perspectives.

The staff section of the proposal (pp 11-17) identifies issues that must be considered in order to assure a smooth transition and adequate retraining for staff who would be transferring to another site and/or function. This section also identifies recruitment problems. The major planning effort was to analyze problems encountered in similar efforts in other states as well as problems that could be anticipated as a result of Maine's particular situation. This effort resulted in a series of recommendations on such matters as minimizing the possible negative effects of staff demoralization on patients assuring that retraining needs are identified accurately, etc.

The improvement of the quality of institutional care was also reflected in the proposed staffing patterns for the Maine Mental Health Institute. These patterns provide 38 staff for 24 patients, a higher ratio than is currently found at either existing institution.

Although the timing of the proposal's implementation will definitely be slowed by the legislature, the substance of the proposal will probably not be altered considerably, particularly with respect to staff and quality institutional care recommendations.

BANGOR MENTAL HEALTH INSTITUTE
BANGOR, MAINE
04401

At the present time Bangor Mental Health Institute is anticipating receipt of appropriations to begin reservations in Pooler Pavilion (Program on Aging) in order to change its inner structure from that of an open ward facility to one comprised of semi-private rooms. These renovations are necessary for the maintenance of JCAH accreditation and licensure as an extended care facility. Loss of licensure will mean a financial loss to the State of Maine of approximately 1.8 to 2 million dollars per year from third party payors.

In addition the Institute has a continuing recruitment program for additional professional staff and have recently contracted for two new psychiatrists.

Our activities department has been busy with various projects which include the construction of an obstacle course for patients. In order to improve the quality service from Activities, we are planning a utilization analysis to better employ our limited resources. Also, the Activity Staff has been strengthened with the addition of three work study students for the summer months.

A Coping Skills Program has been developed and implemented by two individuals in our Patient Education Department. Patient Education has also benefited from the addition of work study students.

The local communities have contributed much to the Institute and patients. We owe the construction of our green dome, fish pond, ice rink, baseball diamond and various activities organized by clubs to the local communities. BMHI has always depended on its volunteers and local community to improve the programs. The Institute has also received a visit from a local junior high school group that brightened up the Franco-American ward with murals on the walls and a volunteer program to provide an individualized birthday cake for each patient has begun.

Some new program developments include a family group therapy program recently initiated and another community apartment program begun by one of our recently hired psychiatrists in order to facilitate a smooth transition for the patients back to home and family.

To ease the adjustment of an admitted patient, we have developed an admission packet which includes essential and helpful information for the patient and guardian.

A series of mini-workshops for support services to improve their understanding of the nature of mental illness has been developed and implemented. Also Staff Development conducts a basic

nursing course which requires all the Mental Health Workers to attend and pass. Other areas of training deal with rehabilitative nursing, Basic Life Support, etc.

A protestant chaplain has been recently hired. Some of the areas he has developed is the organizing of a choir and inviting various religious organizations to entertain the patients.

JS/m

AUGUSTA MENTAL HEALTH INSTITUTE

Augusta, Maine 04330

STATE MENTAL HEALTH PLAN PROGRESS REPORT

The Augusta Mental Health Institute is proceeding both internally and in its interfaces with other mental health services in the communities to improve the quality of care.

Internal planning includes the identification of special need categories of patients such as the adolescents and young adults, the mentally ill/ mentally retarded, patients with special security needs, and patients with speech, hearing, or sight defects, in order to plan appropriate programming to meet their specialized needs. We are pursuing funding through federal grants and possible joint efforts with other agencies charged with special responsibilities for these disability groups.

We are developing systems to insure greater accountability and improved staff skills in the areas of sanitation, safety, and general improvement in the patients' physical environment. We are following a schedule of painting which gives priority to the patient living areas. Modernization of one of our major psychiatric units was completed in December, 1976.

We are aggressively recruiting professional staff to ensure that each patient receives maximum treatment benefit. This recruitment includes specialists in the areas identified above.

We are in the process of expanding our "alternative living" facilities to provide a social milieu conducive to more independent living for the patient with continuing psychiatric disabilities.

The liaison with the Community Mental Health Centers and the utilization of other community resources will be further strengthened when we add to our staff a full time community services coordinator.

Quality and cost control of our services is being strengthened to the point that our general medical services are about to receive delegation for PSRO Review and our psychiatric services are expected to receive delegation within a few months as well. We maintain full JCAH accreditation.

Our Activity Therapy services and our Volunteer Services make maximum utilization of community social and recreational resources.

Our Resident Advocate has recently returned from expanding her educational background and is deeply involved in the development of policies and procedures designed to better clarify and protect patients' rights and responsibilities as well as investigating complaints and monitoring ongoing activities.

The agencies which provide post-discharge services are the 6 Community Mental Health Centers in our service area. Copies of the most recent cooperative agreement with these Centers are attached.

Follow-up Care

Follow-up services are defined as activities which relate to the establishment and maintenance of contact with persons discharged from mental health facilities (institutes, CMHC programs, halfway houses, and other residential program facilities) in order to maintain treatment gains, to assure the availability of additional services when necessary, and to avoid the sometimes deleterious impact of social isolation following discharge.

As presented in the 1976 Comprehensive Mental Health Plan, follow-up aftercare services are provided by each of the eight CMHC's with specific cooperative agreements with the state mental health institutes and varying levels of linkage with other area social service agencies. Five of the eight CMHC's receive partial funding support for their aftercare services through the state's Title XX funding process.

During the last year, the Department of Mental Health and Corrections reviewed the aftercare service system. Particular attention was given to the relationship between mental retardation and mental health aftercare services, the comparative levels of funding for aftercare among catchment areas, the funding mechanisms, methods of need assessment, mechanisms of program monitoring and evaluation, provisions for assurance of service quality, direct vs. indirect program costs, and development of quantifiable outcome objectives.

The mental retardation aftercare program had been funded through Title XX until July 1, 1977. After July 1 aftercare workers will be state employees funded through the Bureau of Mental Retardation in the Department of Mental Health and Corrections. These workers are based in six service centers, one for each MR region. In two areas the staff will work out of CMHC's, a third area's office is in a CMHC funded service center, and in a fourth area MR aftercare workers will be located in a CMHC after arrangements for space are made. Considering the large size of MR (and MH) caseloads, it does not appear that a direct combination of programs would result in any higher quality or more cost effective services. However, during the current year staff supervisors will be required to meet regularly with area MH aftercare staff to assure coordination and non-duplication of services.

Review of the levels of funding for mental health aftercare services showed a lack of consistency in needs assessment methods used in areas with Title XX contracts. Basically numbers of service units and program budgets were based on prior funding, which was related to the amount of funds available for this service when the CMHC developed a Title XX contract. The Title XX reporting (and contract) process used by the Department of Human Services had allowed a wide variety of aftercare objectives to be established with emphasis on quantitative measurement of service units provided but little monitoring of service quality.

As a result of this review, the Department 1) issued guidelines for CMHC use in developing consistent, quantifiable objectives for aftercare services, 2) established a process for monitoring of service quality through contract assurances, 3) promulgated a system of defining direct and indirect costs consistent for all MH programs, 4) with the mental health institutes, surveyed aftercare intake procedures, 5) recommended that Title XX aftercare contracts for FY 78 be initially funded for six

months only, and 6) determined equivalent aftercare budgets for non-Title XX funded CMHC's.

In addition, the Department plans to 1) develop a specific formula for the allocation of Title XX aftercare service funds to be combined with 2) a qualitative evaluation of program outcome and comparative unit costs. Also, 3) a standard intake process will be established which makes full use of institute client information. And 4) problems with the Title XX reporting system will be resolved which currently prevent CMHC's from reporting pre-discharge service units until 60 days after clients have left the institutions.

Agencies responsible for the provision of follow-up services, CMHC's, are found in Appendix E.

The Department has reviewed the availability of halfway house programs in connection with de-institutionalization efforts and the Maine Mental Health Institute Plan and section of this report on de-institutionalization also address the perceived need for halfway house, day treatment type facilities.

Also, the Department has begun to review the historical relationship of Maine's day-treatment programs with Title 19 resources and will at least develop, over the next year, a model set of standards for use by day treatment centers in maintaining or acquiring Title 19 payments.

Manpower

Attached as Appendix D is the Department's plan for the Maine Mental Health Institute which, if approved, outlines the procedures established to protect employees who would be affected if the legislation is admitted. Collective bargaining units have been established recently with the American Federation of State, Municipal and County Employees (AFSMCE) representing the Institutional Services unit and the Maine State Employees Association representing the Administrative Services unit. No contracts have been signed as of this writing, nor have the bargaining agents been determined for three other units affecting the Department.

The 1974 Mental Health Manpower Project stated that for age groups, mental health agencies projected the greatest percent increase in need to children and adolescents, while non-mental health agencies projected the greatest percent increase to elderly and children. This, coupled with the increased interest and efforts to provide services to children and youth has led Children's Services of the Department of Mental Health and Corrections to begin to develop plans to seek training assistance from the NIMH Continuing Education Grant to the Maine Council of Community Mental Health Centers.

It has become evident that residential services for adolescents who are severely disturbed and who may be suicidal or highly aggressive are lacking. These adolescents generally get placed at one of the two state mental health institutes, where no defined adolescent program exists, or at extremely costly out-of-state residential facilities. The Department of Mental Health and Corrections is giving thought to the development of a state operated program and would pursue applying for training assistance from the NIMH grant.

The central issue in the provision of adequate personnel for an adolescent program is not numbers but insuring quality of staff skills. Since there is currently no such program operating in the state, it will be necessary to seek people both in-state and out-of-state to assist in the pre-service training and continuing education for staff of an adolescent program. This training program would also be beneficial to any number of other public or private agencies that, likewise, express the need for increasing their skills for the treatment and programming for adolescents.

STANDARDS OF MAINTENANCE AND OPERATION

Progress in this area has been marked by the following:

1. Formulation of Goals and Objectives having reference to quality control and performance standards. (See Goal VI)

2. Planning for creation of Central Office staff positions and functions relative to standards monitoring. Specifically, Goal II, Objective B calls for the following functions: (2) Licensing standards, (4) Information and Evaluation, and (5) Contract development and monitoring. Persons performing these functions would form a Standards Team responsible for site visits and review of Standards of Maintenance and Operation.

3. Inclusion of performance standards in contractural arrangements being drawn up with community mental health centers.

4. Licensing of Mental Health Agencies:

   New licensing regulations were developed and promulgated by the Department in the spring of 1977. These regulations are shown in Exhibit F. Application for licensure is accomplished through a detailed form reflecting the regulations. These regulations apply to all agencies which provide outpatient mental health services and which are not otherwise licensed as hospitals.

Coordination of Planning

Efforts have been made to be knowledgeable of interfaces and to coordinate planning for services with a number of agencies and groups. These efforts have been particularly extensive for children's services. Agencies and groups involved in the mental health planning process include:

Interdepartmental Coordinating Committee (ICC)

This is comprised of two members each from the Department of Education and Cultural Services, Department of Human Services, and Department of Mental Health and Corrections. This committee continues to be an active group in the planning and resolution of several issues (particularly those related to services for children). One of the most recent tasks has been the preparation of an RFP to study residential treatment services and to suggest alternatives for improvement.

The Community Mental Health Centers (CMHC's)

A meeting has taken place with the Maine Council of CMHC's during which directions for the Department of Mental Health and Corrections was discussed and liaisons for children's services at each of the CMHC's were named. In addition, visits have been made to the CMHC's to be more knowledgeable about current programming, to provide technical assistance for program development, and to share resource information. Directions for the upcoming year include joint meetings with the "children's people" from the CMHC's and the Department of Mental Health and Corrections as well as increasing technical assistance and planning coordination.

Maine Psychiatric and Maine Psychological Associations

A meeting has taken place with the Child Psychiatrists' subgroup to begin to open communication. Suggestions for involvement include a review and comment function, participation on task force projects, and position papers. This group is a source of many skills and knowledge which can be more fully tapped.

Additional linkages with these two associations has occurred through the Mental Health Planning Coalition. This is an informal association of professional providers and management representatives of public and private sector groups whose primary concern has been the Health Systems Agency.

State Advisory Committee on P.L. 94-142

DMH&C Children's Services is represented on this state committee formulated by DECS for the purpose of reviewing special education plans, funding proposals, and legislation. A priority of Children's Services is the close involvement with DECS for collaborative approaches to what are often concerns of mutual responsibility.

Developmental Disabilities Council

Representation on this Council as well as involvement in the subcommittee work has been a benefit for cooperative planning, particularly since there is overlapping responsibility for some client groups, such as children with autism.

Residential Treatment Centers

Regular meetings with Centers' staff individually or as a group have occurred and will be broadened to include occasional meetings with CMHC staff.

Teacher's Committee

Monthly meetings have been held with representatives of educational programs from the CMH&C institutions. The purpose of these has been to examine education purposes and to develop goals and objectives for these programs as well as sharing resources.

University of Maine

There has been involvement with the University of Maine in planning courses for upgrading skills for teachers of children who are severely and profoundly handicapped. There is also on-going collaboration for courses for child development workers particularly to work with severely disturbed children.

The DMH&C also interacts with the University's Human Services Development Institute (HSDI) in the area of staff training. The functions of the Title XX training system organized by HSDI will, on July 1, 1977, be assumed directly by the DHS. Mental Health Centers with Title XX contracts have identified staff training needs and the personnel have benefitted from several training programs. Ray Coniff, newly appointed as director of Probation and Parole, has acted as training liaison between the DMH&C, Title XX training, the Institute and Council of Mental Health Centers training programs.

Adolescent Services Coalition

A number of groups in the Bangor area, with the active assistance of the Counseling Center, have formed a coalition in an attempt to expand and improve adolescent services in that area. Children's Services has participated in this effort and hopes to actively support and expand this effort during the coming year.

Maine Mental Health Consortium

This group has addressed several issues related to mental health planning, including systems for distribution of state funds, Council of Community Mental Health Centers training program, reorganization of the CMH&C (including establishment of regional offices), and the BMHI phase-down plan. The group has also held workshops on elderly and alcoholism services, participated in a Departmental questionnaire on mental health program priorities,

and moved towards further clarification and definition of the Consortium's role in future planning efforts.

The Maine Health Information Center

This group is comprised of representatives of the DMH&C, Maine Blue Cross/Blue Shield, the Maine Medical Association and Maine Hospital Association.

There have been numerous other cooperative approaches, some of very short duration and others that are expected to continue. The DMH&C, and particularly the children's services unit, seeks to continue these efforts and to increase its ability to provide technical assistance, collaborative planning, and resource sharing.

CATCHMENT AREAS

There have been no significant changes in catchment areas in the past year. However, there has been appreciable work done to more precisely define the boundaries of the CMHC catchment areas and to more correctly estimate the populations in each region.

In general, catchment areas are defined by counties or groups of counties, but as can be seen by the map on p. 54 of the State Mental Health Plan (1976), catchment area boundaries do not always correspond with county boundaries. A number of border towns relate to the mental health center of adjacent counties rather than their own counties. Through a series of correspondence and negotiations among mental health center directors, the current political-geographical descriptions of catchment areas have been established. These descriptions were then used to arrive at current (1975) population estimates derived from the latest reports (May, 1977) of the U.S. Bureau of the Census. The catchment area descriptions along with the corresponding populations and resulting (net) populations (as border towns are added or deleted) are shown on the following pages. The table also shows Per Capita Incomes for each county derived from U.S. Census figures.

According to information extracted from the Mental Health Demographic Profile System (2/8/77) the percent of population in poverty (based on the 1970 Census) in each catchment area is as follows:

		Poverty Area
Region I	63.44%	yes
Region II	47.66%	yes
Region III	19.23%	no
Region IV	11.22%	no
Region V	2.21.%	no
Region VI	23.44%	no
Region VII	33.91%	no
Region VIII	55.12%	yes

Accordingly, the catchment areas in Maine which qualify as poverty areas are:

Region I	(Aroostook)
II	(Eastern Maine)
VIII	(Mid-Coast)

POPULATIONS OF MENTAL HEALTH CATCHMENT AREAS

BASED ON U.S. CENSUS ESTIMATES FOR 1975 (issued May 1977)

REGION	COUNTY	BASE POPULATION	TOWNS ADDED	POP. ADDED	TOWNS SUBTRACTED	POPULATION SUBTRACTED	NET POPULATION	PER CAPITA INCOME COUNTY (1974)	PER CAPITA INCOME REGION (1974)
I AROOSTOOK									
	Aroos.	96,044						$ 3,255	
	Pen.		Mt. Chase	238					
			Patten	1,327					
			Staceyville	649					
	Wash.		Danforth	884					
TOTAL		96,044		3,098			99,142		$ 3,255
II EASTERN MAINE									
	Han.	39,145						3,626	
	Pen.	133,671			Mt. Chase	238		3,600	
					Patten	1,327			
					Staceyville	649			
	Pisc.	16,688						3,478	
	Wash.	32,854			Danforth	884		2,958	
	Waldo		Winterport	2,414					
			Frankfort	628					
TOTAL		222,358		3,042		3,098	222,302		3,501

POPULATIONS OF MENTAL HEALTH CATCHMENT AREAS

BASED ON U.S. CENSUS ESTIMATES FOR 1975 (issued May 1977)

REGION	COUNTY	BASE POPULATION	TOWNS ADDED	POP. ADDED	TOWNS SUBTRACTED	POPULATION SUBTRACTED	NET POPULATION	PER CAPITA INCOME COUNTY (1974)	PER CAPITA INCOME REGION (1974)
III KENNEBEC VALLEY									
	Ken.	100,745			Vienna	233		$ 3,942	
	Som.	43,519						3,327	
	Waldo		Burnham	952					
			Freedom	389					
			Unity	1,513					
	Lin.		Somerville	263					
			Whitefield	1,449					
	Saga.		Richmond	2,424					
TOTAL		144,264		6,990		233	151,021		$ 3,756
IV TRI-COUNTY									
	Andros.	94,094						$ 3,627	
	Frank.	24,729						3,339	
	Oxford	45,076			Brownfield	677		3,483	
					Denmark	497			
					Fryeburg	2,549			
					Lovell	673			
					Stoneham	179			
					Stow	133			
					Sweden	136			
	Ken.		Vienna	233					
	Cum.		N. Gloucester	3,071					
			Otisfield	851					
TOTAL		163,899		4,155		4,844	163,210		$ 3,544

POPULATIONS OF MENTAL HEALTH CATCHMENT AREAS

BASED ON U.S. CENSUS ESTIMATES FOR 1975 (issued May 1977)

REGION	COUNTY	BASE POPULATION	TOWNS ADDED	POP. ADDED	TOWNS SUBTRACTED	POPULATION SUBTRACTED	NET POPULATION	PER CAPITA INCOME COUNTY (1974)	PER CAPITA INCOME REGION (1974)
V CUMBERLAND									
	Cum.	202,183			Brunswick	17,338		$ 4,198	
					Freeport	5,411			
					Harpswell	3,144			
					N. Gloucester	3,071			
					Otisfield	851			
					Hiram	836			
					Porter	1,115			
					Baldwin	1,119			
	Oxford		Brownfield	677					
			Denmark	497					
			Fryeburg	2,549					
			Lovell	673					
			Stoneham	179					
			Stow	133					
			Sweden	136					
TOTAL		202,183		4,844		32,885	174,142		$ 4,198
VI YORK									
	York	121,662						$ 3,742	
	Oxford		Hiram	836					
			Porter	1,115					
	Cum.		Baldwin	1,119					
TOTAL		121,662		3,070			124,732		$ 3,742

POPULATIONS OF MENTAL HEALTH CATCHMENT AREAS

BASED ON U.S. CENSUS ESTIMATES FOR 1975 (Issued May 1977)

REGION	COUNTY	BASE POPULATION	TOWNS ADDED	POP. ADDED	TOWNS SUBTRACTED	POPULATION SUBTRACTED	NET POPULATION	PER CAPITA INCOME COUNTY (1974)	PER CAPITA INCOME REGION (1974)
VII BATH-BRUNSWICK									
	Linc.	23,197			Somerville	263		$ 3,766	
					Whitefield	1,449			
					Jefferson	1,341			
					Waldoboro	3,413			
					Monhegan	49			
	Saga.	26,234			Richmond	2,424		3,543	
	Cum.		Brunswick	17,338				(3,914)	
			Freeport	5,411				(4,334)	
			Harpswell	3,144				(3,973)	
TOTAL		49,431		25,893		8,939	66,385		$ 3,777
VIII MIDCOAST									
	Knox	31,925						$ 3,766	
	Waldo	26,187			Winterport	2,414		3,521	
					Frankfort	628			
					Burnham	952			
					Freedom	389			
					Unity	1,513			
	Linc.		Jefferson	1,341					
			Waldoboro	3,413					
			Monhegan	49					
TOTAL		58,112		4,803		5,896	57,019		$ 3,656
MAINE (TOTAL)		1,057,953		55,895		55,895	1,057,953		$ 3,694

INVENTORY, SURVEY, AND PRIORITIES

The Needs Assessment and Resources Survey of the 1976 Plan has not been subjected to revision through any new inventory. There were a number of criticisms of the 1976 needs assessment to the effect that it did not take into account the financial resources available to a given region. An experimental mental health resources survey was undertaken in early 1977. This survey utilized populations, beds, personnel hours, and demographic, social and illness indicators from the 1976 Plan but added in a factor for funding for fiscal year 76-77. New final ranks were then derived. This revised priority schedule did not receive general approval by the Executive Committee of the Mental Health Consortium, two criticisms of it were 1) that the factor weightings were arbitrary, and 2) that the fund allocation factor was duplicative of the available personnel hours factor, but not in any consistent way. (Most funds go into staff, but in at least one case - Area VIII - increased federal funds had been allocated, but staff not yet hired.) This Revised, Experimental Mental Health Resources Survey is included here for discussion and comment only.

TABLE A-1

MENTAL HEALTH RESOURCES SURVEY: AREA I, AROOSTOOK

FACILITY	BEDS Acute Beds	BEDS Long-Term Beds	MENTAL HEALTH PERSONNEL WEEKLY HOURS Out-Pt.	Part. Hosp.	Emergency	Extramural	TOTAL
Aroostook Mental Health Center	10		420	233	146		
C & E						66	
Ed. Svcs.						323	
Aftercare						210	
Bangor Mental Health Institute		*40					
V A Hospital, Togus		33					
TOTAL	10	73	420	233	146	599	1,398

1975 POPULATION: 96,300

Beds per capita	1.04 per 10,000	7.58 per 10,000					1.45 per 100

*BMHI Bed Assignment

Aroostook Co.: 26 Beds + .3 x 48 = 14; 26 + 14 = 40

Eastern Maine: 75 Beds + .7 x 48 = 34; 75 + 34 = 109

Franco Am.:	26	Pop. Aroostook	96,000		
Autistic:	10	East. Me.	223,000	$\frac{96}{319}$ = .3	$\frac{223}{319}$ = .7
Crim. Obs.	12		319,000		
	48				

TABLE A-II

MENTAL HEALTH RESOURCES SURVEY: AREA II: EASTERN MAINE

FACILITY	BEDS Acute Beds	BEDS Long-Term Beds	MENTAL HEALTH PERSONNEL WEEKLY HOURS Out-Pt.	Part. Hosp.	Emergency	Extramural	TOTAL
The Counseling Center							
Bangor	18		863	188			
Testing Service			100		159		
Elderly Services			188				
Children's Services			413				
School Cons.						195	
C & E						188	
Aftercare						488	
Bangor Mental Health Institute		109					
Eastern Maine Medical Center	26						
Community Mental Health Center UMO			20				
V A Hospital, Togus		80					
TOTAL	44	211	1584	188	159	871	2802
1975 POPULATION: 223,400							
per capita rate	1.97 per 10,000	9.44 per 10,000					1.25 per 100

TABLE A-III

MENTAL HEALTH RESOURCES SURVEY: AREA III: KENNEBEC VALLEY

FACILITY	BEDS Acute Beds	BEDS Long-Term Beds	MENTAL HEALTH PERSONNEL WEEKLY HOURS Out-Pt.	Part. Hosp.	Emergency	Extramural	TOTAL
KENNEBEC Valley Mental Health Center, Waterville	14		312	227	54		
C & E						301	
Aftercare						166	
Human Relations Services							
Outreach				20		180	
Aftercare				12		115	
Augusta Mental Health Institute		40					
V A Hospital, Togus		53	302	60			
TOTAL	14	93	614	319	54	762	1749
1975 POPULATION: 144,000							
per capita rate	0.972 per 10,000	6.46 per 10,000					1.21 per 100

TABLE A-IV

MENTAL HEALTH RESOURCES SURVEY: AREA IV: TRI-COUNTY

FACILITY	BEDS Acute Beds	BEDS Long-Term Beds	MENTAL HEALTH PERSONNEL WEEKLY HOURS Out-Pt.	Part. Hosp.	Emergency	Extramural	TOTAL
Tri-County Mental Health Services Lewiston, Maine	21		467	148	200		
C & E Svcs.						231	
Children's Services						510	
Augusta Mental Health Institute		40					
Bureau of Human Relations Svcs.			8				
V A Hospital, Togus		58					
TOTAL	21	98	475	148	200	741	1564
1975 POPULATION: 164,100							
per capita rate	1.28 per 10,000	5.97 per 10,000					0.953 per 100

TABLE A-V

MENTAL HEALTH RESOURCES SURVEY: AREA V: CUMBERLAND

FACILITY	BEDS Acute Beds	BEDS Long-Term Beds	MENTAL HEALTH PERSONNEL WEEKLY HOURS Out-Pt.	Part. Hosp.	Emergency	Extramural	TOTAL
Community Mental Health Center Me. Medical Center, Portland	26		277	305	42		
C & E Svcs.						147	
Rehab. Svcs.						70	
Children's Services					91		
Community Health Svcs. Inc.							
Aftercare						263	
Augusta Mental Health Institute		92					
Community Counseling Center			535				
V A Hospital, Togus		65					
Bureau of Human Relations Svcs.			80				
Rescue Inc.					35		
TOTAL	26	157	892	305	168	480	1845
1975 POPULATION: 175,200							
per capita rate	1.48 per 10,000	8.96 per 10,000					1.05 per 100

TABLE A-VI

MENTAL HEALTH RESOURCES SURVEY: AREA VI: YORK

FACILITY	BEDS Acute Beds	BEDS Long-Term Beds	MENTAL HEALTH PERSONNEL WEEKLY HOURS Out-Pt.	Part. Hosp.	Emergency	Extramural	TOTAL
York County Counseling Services Saco, Me.	12		375	150	38		
Aftercare						315	
Elderly						113	
C & E						113	
Com. Dev.						75	
CREST						(95)	
Augusta Mental Health Institute		40					
V A Hospital, Togus		41					
TOTAL	12	81	375	150	38	616	1179
1975 POPULATION: 121,200							
per capita rate	0.990 per 10,000	6.68 per 10,000					0.973 per 100

TABLE A-VII

MENTAL HEALTH RESOURCES SURVEY: AREA VII: BATH-BRUNSWICK

FACILITY	BEDS Acute Beds	BEDS Long-Term Beds	MENTAL HEALTH PERSONNEL WEEKLY HOURS Out-Pt.	Part. Hosp.	Emergency	Extramural	TOTAL
Bath-Brunswick Mental Health Association	11		320	59	36		
Aftercare						71	
School Consult.						116	
C & E						23	
Rescue Inc.						42	
Augusta Mental Health Institute		27					
V A Hospital, Togus		23					
TOTAL	11	50	320	59	36	252	717
1975 POPULATION: 76,400							
per capita rate	1.44 per 10,000	6.54 per 10,000					0.938 per 100

TABLE A-VIII

MENTAL HEALTH RESOURCES SURVEY: AREA VIII: MID COAST

FACILITY	BEDS Acute Beds	BEDS Long-Term Beds	Out-Pt.	Part. Hosp.	Emergency	Extramural	TOTAL
Mid-Coast Mental Health Center	6		219	62	34		
Aftercare						17	
C & E						83	
Augusta Mental Health Institute		9					
V A Hospital, Togus		19					
TOTAL	6	28	219	62	34	100	415
1975 POPULATION: 58,300							
per capita rate:	1.03 per 10,000	4.80 per 10,000					0.712 per 100

TABLE B

MENTAL HEALTH RESOURCES: RATIOS AND RANKS

	AREA	ACUTE BEDS	RANK	LONG-TERM BEDS	RANK	OUTCARE HOURS	RANK
I	AROOSTOOK	1.04	4	7.58	6	1.45	8
II	EASTERN MAINE	1.97	8	9.44	7	1.25	7
III	KENNEBEC VALLEY	0.97	1	6.46	3	1.21	6
IV	TRI-COUNTY	1.28	5	5.97	2	0.95	3
V	CUMBERLAND	1.48	7	9.96	8	1.05	5
VI	YORK	0.99	2	6.68	5	0.97	4
VII	BATH-BRUNSWICK	1.44	6	6.54	4	0.94	2
VIII	MID-COAST	1.03	3	4.80	1	0.71	1

TABLE C

DEMOGRAPHIC AND SOCIAL AND ILLNESS INDICATORS

SOURCE: EXHIBITS F & G STATE MENTAL HEALTH PLAN, 1976

	AREA	DEMOG. SUM. WTD. RANKS	RANK	SOC. & ILL. SUM. WTD. RANKS	RANK
I	AROOSTOOK	29.0	2	60.5	6
II	EASTERN MAINE	37.0	4	43.5	3
III	KENNEBEC VALLEY	38.5	5	45.0	4
IV	TRI-COUNTY	34.0	3	45.5	5
V	CUMBERLAND	52.5	8	41.0	2
VI	YORK	49.5	7	61.0	7
VII	BATH-BRUNSWICK	47.0	6	64.5	8
VIII	MID-COAST	26.5	1	34.5	1

TABLE D

FEDERAL AND STATE MENTAL HEALTH FUNDING OF CMHC'S

FY 76-77

	AREA	NIMH FUNDS	Bu. M.H. FUNDS	TOTAL GOVT. GRANT-IN-AID	POPULATION	PER CAPITA	RANK
I	AROOSTOOK	362,664	225,787	588,451	96,300	$ 6.11	6
II	EASTERN MAINE	1,012,931	498,554	1,511,485	223,400	6.77	7
III	KENNEBEC VALLEY	431,800	253,330	685,130	144,000	4.76	4
IV	TRI-COUNTY	244,705	569,900	814,605	164,100	4.96	5
V	CUMBERLAND	209,843	218,383	428,226	175,200	2.44	1
VI	YORK	432,857	99,955	532,812	121,200	4.40	3
VII	BATH-BRUNSWICK		282,306	282,306	76,400	3.70	2
VIII	MID-COAST	221,066	236,736	457,802	58,300	7.85	8

TABLE E

COMBINATION OF RANKS FOR SOCIODEMOGRAPHIC INDICATORS,

MENTAL HEALTH RESOURCES AND GOVERNMENTAL FUNDING

		DEMOG.		SOC.&ILL.		AC. BEDS		L-T BEDS		OUTCARE HRS.		FUNDS		Sum.Wtd.	FINAL
	FACTOR WEIGHT	Rk.	Wtd.Rk.	Rk.	Wtd.Rk.	Rk.	Wtd.Rk.	Rk.	Wtd.Rk.	Rk.	Wtd.Rk.	Rk.	Wtd.Rk.	Ranks	RANK
		3		0.5		1		0.5		2		3		10	
	AREA														
I	AROOSTOOK	2	6.0	6	3.0	4	4.0	6	3.0	8	16.0	6	18.0	50.0	7
II	EASTERN MAINE	4	12.0	3	1.5	8	8.0	7	3.5	7	14.0	7	21.0	60.0	8
III	KENNEBEC VALLEY	5	15.0	4	2.0	1	1.0	3	1.5	6	12.0	4	12.0	43.5	4
IV	TRI-COUNTY	3	9.0	5	2.5	5	5.0	2	1.0	3	6.0	5	15.0	38.5	2
V	CUMBERLAND	8	24.0	2	1.0	7	7.0	8	4.0	5	10.0	1	3.0	49.0	6
VI	YORK	7	21.0	7	3.5	2	2.0	5	2.5	4	8.0	3	9.0	46.0	5
VII	BATH-BRUNSWICK	6	18.0	8	4.0	6	6.0	4	2.0	2	4.0	2	6.0	40.0	3
VIII	MID-COAST	1	3.0	1	0.5	3	3.0	1	0.5	1	2.0	8	24.0	33.0	1

Corrected 1/21/77

TABLE OF CMHC SERVICE -

EXTENT OF AVAILABILITY

Table I summarizes the availability of treatment programs within each catchment area. Across the top are generic categories of treatment modalities considered essential in a comprehensive, balanced service system. Down the left hand column are listed the mental health catchment areas, and within each region, four age groups. The presence of a letter at an intersection of a row and column indicates the presence of some type of formal treatment program. Meanings of the letters are explained under "Symbol Definitions" below. There are of course some problems in deciding whether or not to include the services claimed by a given agency as a "formal treatment" program. Generally a program was indicated if a particular organization has been set up to provide the service, or if one or more FTE is designated to service the problem group in question. No attempt was made to identify boarding, nursing and foster home programs.

Given the Department's limited present capacity to assess the adequacy of programs, no attempt is made here to evaluate a program as to its strength or effectiveness.

It is apparent from the table that there are significant overall deficiencies in inpatient services for children, residential treatment programs (under extended care), transitional living programs, outreach for children and prevention programs on the public education and community action spheres. Special programs for the elderly are also generally lacking.

SYMBOL DEFINITIONS

TREATMENT PROGRAM TARGET SYMBOLS

A = Alcoholism
D = Drug Abuse
J = Community Justice
M = Mental Health
R = Mental Retardation
S = Special
O = Other

SPECIFIC TREATMENT MODALITIES:

EXTENDED CARE

RTC - Residential Treatment Center
BH - Boarding Home
NH - Nursing Home

} These exist in all Catchment Areas

TRANSITIONAL CARE

HWH - Half-way House
GH - Group Home
FH - Foster Home

PARTIAL CARE

PH - Partial Hospitalization
DC - Day Care
TN - Therapeutic Nursery
SW - Sheltered Workshop

OUTPATIENT, NON-SCHEDULED

ES - Emergency Service
CI - Crisis Intervention
WI - Walk In Center

OUTPATIENT - SCHEDULED

MC - Medication Clinic
FC - Family Counseling
VC - Vocational Counseling
C-P - Counseling - Psychotherapy

OUTREACH

AC - After Care
FU - Follow Up
HV - Home Visits

CONSULTATION

CC - Client Centered
SC - Staff Centered
PC - Program Centered

SPECIAL NOTES

A_2 Eastern Maine Medical Center

A_3 Kennebec Valley Comprehensive Alcohol Treatment Program

A_4 Crossroads; 24-Hour Club

A_5 Community Alcoholism Services

A_6 Milestone Foundation

A_7 Midcoast Rehabilitation Center

M_2 Eastern Maine Medical Center and D-1, BMHI

M_3 St. Michael's Center

M_4 AMHI Independent Living Program; Motivation Inc.

M_5 Sweetser Children's Home

M_6 Community School

M_7 Spurwink

M_8 Elan

M_9 Bancroft North

O_1 Summer Camp Program

O_2 Homemaker Services

S_1 Speech and Hearing Program

TABLE I AVAILABILITY OF TREATMENT PROGRAMS BY AREA, MODALITY, AGE AND PROBLEM GROUP

AREA	AGE GROUP	INPATIENT 24-Hour Psychiat	EXTENDED RTC,	TRANSITIONAL HWH, GH FH	PARTIAL CARE PH, DC, TN SW	OUTPATIENT Non-Sched ES, CI, WI	OUTPATIENT - Sched MC,FC,VC,C-P	OUTREACH AC,PC,FU,HV
I AROOSTOOK	Child				O_1			R
	Adoles				O_1			R
	Adult	M A		A	M	M A	M A	M R
	Elder							
II EASTERN MAINE	Child	M_2	R M_3	M	M	M	M	A R O_2
	Adoles	M_2	M_3	M		M	M	R
	Adult	M A_2	M_3 A	A	M	M A	A	M R
	Elder						M	
III KENNEBEC VALLEY	Child				M R		M	R
	Adoles	M		M J	M R	M	M	R
	Adult	M A_3		M_4 J	M R	M	M A	M R
	Elder							
IV TRI-COUNTY	Child				M	M	M	R
	Adoles	M			M	M	M	R
	Adult	M		M	M	M	M A	M R
	Elder							
V CUMBERLAND	Child	M R	M	M	M		M	M R
	Adoles	M R	M	M D	M_5 D	M	M D	M R
	Adult	M A		M A_4	M	M	M A_5	M R
	Elder							
VI YORK	Child		M_5			M	M	
	Adoles		M_5	M		M	M D	
	Adult	M A		A	M	M	M	M A
	Elder							
VII BATH-BRUNSWICK	Child	M				M	M	
	Adoles	M				M D	M D	M
	Adult	M A_6			M	M	M	M A
	Elder							
VIII MID-COAST	Child		M_9					
	Adoles		M_9	M_6				D
	Adult	M A_7			M	M	M A_3	M
	Elder							

TABLE I (cont'd)

AVAILABILITY OF TREATMENT PROGRAMS

BY AREA, MODALITY, AGE AND PROBLEM GROUP

AREA	AGE GROUP	CONSULTATION CC, SC, PC		EDUCATION -CLIENT	EDUCATION -PUBLIC	COMMUNITY ACTION
I AROOSTOOK	Child	M				
	Adoles	M		S_1		
	Adult	M	A			
	Elder					
II EASTERN MAINE	Child	M				
	Adoles	M	J			
	Adult	M			M	
	Elder					
III KENNEBEC VALLEY	Child	M				
	Adoles	M	J			
	Adult	M				
	Elder					
IV TRI-COUNTY	Child	M				
	Adoles	M	J			
	Adult	M				
	Elder					
V CUMBER-LAND	Child	M				
	Adoles	M				
	Adult	M	J		M	
	Elder					
VI YORK	Child	M				
	Adoles	M				
	Adult		J	S_1	M	
	Elder					
VII BATH-BRUNSWICK	Child	M				
	Adoles	M				
	Adult	M				
	Elder					
VIII MID-COAST	Child	M				
	Adoles	M				
	Adult	M				
	Elder					

MENTAL HEALTH ADVISORY COUNCIL

Alan Elkins, M.D.	Portland	(P)
James Lyna	Augusta	(C)
David Shawl	Brunswick	(P)
Arthur Levine	Waterville	(C)
John Ballou, Esq.	Bangor	(C)
Richard Lumb	Saco	(C)
Thomas Kane, DSW	Saco	(P)
Robert Morrell	Brunswick	(C)
Walter Rohm, M.D.	Windsor	(P)
Robert Vickers	Ft. Fairfield	(P)
Louise Mahaney	Bangor	(P)
Amory Houghton	Portland	(C)
J. Gregory Shea	Lewiston	(P)
Arthur Bowie, Jr.	Greene	(C)
Marcel Morin	Lewiston	(C)
Millicent Monks	Portland	(C)
William Barnum, M.D.	Rockland	(P)
Bernedette Bouchard	Caribou	(C)
Sally Haggett	Bath	(C)
Catherine Cutler	Bangor	(c)

APPROVED
APR 6 '77
BY GOVERNOR

CHAPTER
58
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-SEVEN

H. P. 301 — L. D. 357

AN ACT Creating a Mental Health Advisory Council.

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the Federal Department of Health, Education and Welfare requires that the present Maine Interim Mental Health Advisory Council be given formal legislative or executive stature by April 1, 1977; and

Whereas, subsequent action to release or approve the expenditure of federal funds for mental health services in Maine will be jeopardized if such legislative or executive mandate is not effective on or before April 1, 1977; and

Whereas, federal regulations require that the membership of the State Mental Health Advisory Council be representative of both those who understand the need for services and those who are responsible for program implementation, and of the social, economic, linguistic and racial groups residing in the State, as well as its geographic areas; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. 34 MRSA § 2002, first sentence, as repealed and replaced by PL 1975, c. 755, § 9, is amended to read:

The commissioner shall, with the advice of the ~~Committee on Mental Health~~ Mental Health Advisory Council, appoint and set the salary subject to the approval of the Governor ~~and Council~~, for a Director of Mental Health who shall be a person with training and experience in mental health program administration or who has had satisfactory experience in the direction of work of a comparable nature.

Sec. 2. 34 MRSA § 2003 is repealed and the following enacted in its place:

§ 2003. Mental Health Advisory Council; membership; duties

The Governor, with the advice of the Commissioner of Mental Health and Corrections, shall establish a Mental Health Advisory Council and appoint its membership. The membership shall consist of 30 persons, including representatives of consumers of mental health services, including clients and their families, providers of such services; and those who are concerned with the planning, operation, or use of such services and facilities who are representatives of nongovernment organizations or groups; and representatives of agencies of State Government.

A majority, but no more than 60% of the members, shall be neither direct nor indirect providers of mental health services, and no less than 40% shall be direct or indirect services providers. Consumers who are identified as nonprovider members of community mental health center boards may be considered as nonproviders for the purpose of serving on the Mental Health Advisory Council. The nonprovider consumer class of membership shall include, where possible, but not be limited to, persons who have been beneficiaries of the services of a public mental hospital or community mental health center, as well as representatives of patient organizations and patient advocacy groups. The provider class of membership shall include persons from both governmental and nongovernmental mental health service agencies. Both provider and consumer members shall be representative of the social, economic, linguistic and racial groups residing in the State, as well as its geographic areas.

Members shall be appointed for a term of 3 years, except that of the members first appointed, ⅓ shall be appointed for a term of 3 years, ⅓ shall be appointed for a term of 2 years and ⅓ shall be appointed for a term of one year, as designated by the Governor at the time of appointment; except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term. Any vacancy in the council shall not affect its powers, but shall be filled in the same manner by which the original appointment was made. The membership shall elect a chairman.

The duties of the Mental Health Advisory Council shall include, but not necessarily be limited to, acting in an advisory capacity to the commissioner in the development of the state mental health plan and in the appointment of a Director of Mental Health. The council shall meet at least quarterly.

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved.

IN HOUSE OF REPRESENTATIVES,.....1977

Read twice and passed to be enacted.

.....*Speaker*

IN SENATE,.....1977

Read twice and passed to be enacted.

.....*President*

Approved.....1977

.....*Governor*

DEPARTMENT OF MENTAL HEALTH & CORRECTIONS

State Office Building *Telephone (207) 289-3161* *Augusta, Maine 04333*

GEORGE A. ZITNAY, Commissioner

February 1977

Dear Friend:

The Department of Mental Health and Corrections, together with other elements of the Mental Health System, is deeply involved in the process of defining our basic mission and deciding on the best organization and methods for carrying out our purposes. The Department, in conjunction with the Maine Mental Health Consortium, is seeking your input into the process of developing and refining the goals and objectives of the mental health system. This is an essential step in the planning process.

At its meeting in Portland last November, the membership of the Mental Health Consortium agreed to support the circulation of a questionnaire, the results of which will be used to focus our discussion and help us to arrive at a consensus on the goals and objectives for the mental health system.

I would greatly appreciate your taking the time to fill out and return the enclosed questionnaire. We hope to be able to analyze the responses and use the results as a basis for discussion at the next meeting of the Consortium, which is scheduled to take place during the month of March. Your promptness in replying would help very much.

Would you please try to return the questionnaire within a week of the date you receive it? Thank you very much for your part in this important activity.

Sincerely yours,

George A. Zitnay
Commissioner

GAZ/lyl

DEPARTMENT OF MENTAL HEALTH & CORRECTIONS

State Office Building *Telephone (207) 289-3161* *Augusta, Maine 04333*

GEORGE A. ZITNAY, Commissioner

MENTAL HEALTH PRIORITIES QUESTIONNAIRE #1

This questionnaire is being directed to you as one who is interested or involved in Maine's Mental Health System. Please consider yourself as one of a panel of persons whose experiences or expertise can contribute vitally to the planning process. Your responses will be used in the formulation of goals and priorities for mental health programs; the results of this questionnaire will be reflected in the State Mental Health Plan. This is the first of a series of questionnaires and discussions aimed at identifying problems and issues and gaining a consensus on directions for mental health system development. You will receive a feedback of the results of this questionnaire, and later on a more refined set of questions based on these results. The follow-up questionnaire will attempt to more specifically define objectives, responsibilities, and time frames. Meetings of the panel as a group may also be held to help define or resolve certain issues.

The more careful thought you can give this questionnaire, the more helpful it will be. Please try to answer as many items as you can. However, if you feel any question is inappropriate or outside of your ability to answer, it may be omitted. Your comments on the questionnaire itself are welcome.

Your individual responses will be treated in confidence by the planning staff; results will be reported either anonymously or in aggregate form. However, analysis of the results will be aided if you will provide certain identifying information about yourself.

NAME_____

TOWN OF RESIDENCE_____

TOWN WHERE EMPLOYED_____

Check any which apply to you:

- Interested citizen _____
- Recipient of mental health services _____
- Legislator _____
- Other public official _____
- Member, Mental Health Board or Committee _____
- Provider associated with:
  - State or federal government _____
  - State institution _____
  - Community Mental Health Center _____
  - Private agency _____
  - Independent practice _____
- If affiliated with mental health organization, your position or role _____
- Vocational background or training_____

B3

I Below are listed a number of options or alternatives concerning various issues facing the mental health system. For each item, please indicate your degree of agreement or disagreement with the statement by circling the number which most closely corresponds to your feeling on the matter.

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree
A. Movement to community-based services					
1. All mental health services including care of involuntary patients should eventually be supplied by community non-profit or private agencies.	1	2	3	4	5
2. The role of the State in providing institutional care for long-term and involuntary patients should be continued.	1	2	3	4	5
3. The State should provide a greater variety of transitional living services such as half-way houses and semi-independent living.	1	2	3	4	5
4. We should move toward a system in which outpatient services are provided by private practitioners and private clinics, Community Mental Health Centers provide information and referral, inpatient and other services which private practitioners cannot, and State institutions would provide only what CMHC's and private practitioners cannot.	1	2	3	4	5
B. Scope of mental health responsibility					
5. The area of mental health system efforts should be broadened to include all-inclusive prevention and public education programs to minimize emotional problems.	1	2	3	4	5
6. The area of mental health system efforts should be limitted to the remedy and treatment of acute and chronic mental illness.	1	2	3	4	5
C. Funding options for CMHC's					
7. State Grant-In-Aid should be based primarily on catchment area population allowing for any Federal mental health grants the center receives.	1	2	3	4	5
8. State Grant-In-Aid should be based on mental health needs and deficiencies of mental health resources in the catchment area.	1	2	3	4	5
9. There should be a voucher system in which consumers receive "credits" from the government and seek their own providers of choice for mental health services.	1	2	3	4	5

B4

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree
10. The insurance and third-party payor system should be strengthened through legislation.	1	2	3	4	5
11. Support to the CMHC's from the State should come through purchase of service arrangements. In other words, the DMH&C would contract with CMHC's to provide a certain amount of particular kinds of services.	1	2	3	4	5
12. The DMH&C should invest greater effort in identifying and seeking Federal grants to support mental health services.	1	2	3	4	5
13. Mental health system participants should extend greater efforts in the political arena to obtain larger appropriations from the legislature.	1	2	3	4	5
14. Mental health centers and their Boards should make greater efforts toward community fund raising.	1	2	3	4	5
C. Governmental reorganization of social service departments					
15. The present autonomy of DMH&C with its responsibilities for mental health, mental retardation and corrections should be retained.	1	2	3	4	5
16. The Department should be absorbed or integrated into the Department of Human Services.	1	2	3	4	5
17. A new Department of Direct Social Service Delivery incorporating mental health, mental retardation, children's services, elderly's services, protective services and vocational rehabilitation (including alcohol and drug abuse) and related offices should be formed.	1	2	3	4	5
18. A super commission, with powers to integrate human and social service delivery should be formed.	1	2	3	4	5
D. Organization of mental health and corrections service delivery system					
19. The present departmental organization with the three bureaus (MH, MR and Corrections) should be done away with and replaced by a new structure which has a fixed point of referral and provides comprehensive services to individuals without regard to diagnosis or problem category.	1	2	3	4	5

B5

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree
20. The departmental service delivery system should be regionalized so that program decisions are made on a regional basis, and services integrated on a local basis.	1	2	3	4	5
21. The present bureau structure and centralized program decision-making should be retained and strengthened.	1	2	3	4	5
E. Service delivery resource allocation: There should be relatively more <u>mental health resources</u> put into:					
22. Residential treatment services for children;	1	2	3	4	5
23. Child and family outpatient agencies and programs;	1	2	3	4	5
24. School related activities such as diagnosis and screening;	1	2	3	4	5
25. School related activities such as prescriptive learning and psychotherapy in schools;	1	2	3	4	5
26. Recreation-related activity programs (clubs, sports, camps) directed toward children with behavior problems;	1	2	3	4	5
27. Home and family-directed outreach programs with an emphasis on keeping the disturbed child in the home and assisting the family to work with the child;	1	2	3	4	5
28. Pre-school programs such as therapeutic nurseries, day and evening care centers, etc. for children of multiple problem families;	1	2	3	4	5
29. Parent-training programs for parents of children with behavior problems;	1	2	3	4	5
30. Education and public relations programs to elicit more participation by the elderly in mental health services;	1	2	3	4	5
31. Traditional outpatient, day care and inpatient services geared to the elderly, with transportation;	1	2	3	4	5
32. Mental health outreach programs for the elderly;	1	2	3	4	5

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree
33. Integration of mental health with home health and nutrition care for the elderly;	1	2	3	4	5
34. Integration of mental health with transportation programs for the elderly;	1	2	3	4	5
35. Innovative alternatives, e.g., companionship, foster grandparent, self organization and exercize programs, for the elderly;	1	2	3	4	5
36. Training of mental health professionals in dealing with problems of the elderly;	1	2	3	4	5
37. Consultation, information exchange and coordination with Regional Senior Citizens Councils and the Bureau of Maine's Elderly;	1	2	3	4	5
38. Aftercare services (planning, placement, maintenance) for former psychiatric inpatients;	1	2	3	4	5
39. Day care and evening care programs for former psychiatric inpatients;	1	2	3	4	5
40. Mental health services such as assessment and counseling for juvenile offenders;	1	2	3	4	5
41. Community justice programs for pre-trial intervention and sentencing alternatives for offenders;	1	2	3	4	5
42. Residential treatment programs for alcoholics;	1	2	3	4	5
43. Outpatient treatment programs for alcoholics;	1	2	3	4	5
44. Residential treatment programs for drug abusers;	1	2	3	4	5
45. Outpatient treatment programs for drug abusers;	1	2	3	4	5
46. Inpatient treatment programs for the chronically mentally ill;	1	2	3	4	5
47. Inpatient treatment programs for the acutely mentally ill;	1	2	3	4	5
48. Outpatient treatment programs for individuals who are emotionally disturbed or under stress;	1	2	3	4	5

B7

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree
49. Outpatient treatment programs for couples and families with emotional problems and/or are under stress;	1	2	3	4	5
F. Quality assurance, evaluation, and accountability					
50. Emphasis on program effectiveness evaluation should be delayed until other problems of funding, management and mission of mental health agencies have been resolved;	1	2	3	4	5
51. Having an effective quality assurance program should be a condition of licensing for CMHC's;	1	2	3	4	5
52. A system of accountability for the expenditure of public or community funds (being able to tell the public what they're getting for their money) should be a condition of licensure.	1	2	3	4	5
G. Public education					
53. Present methods and efforts to educate the public concerning mental health and how to seek help for problems are adequate.	1	2	3	4	5
54. More use should be made of the media to obtain public support of the mental health system.	1	2	3	4	5
H. Personnel development					
55. Relatively more resources should go into continuing staff education and professional development.	1	2	3	4	5
56. Mental Health institutes and centers have an obligation to try to assist their non-professional employees to achieve professional status, where appropriate, through support of education and training.					

I. Other: List below any issues and/or options which you feel were omitted or not adequately presented above. Rate your own options in terms of agreement/disagreement.

57. _____

_____

(use back of sheet if necessary)

II Target Groups and Treatment Modalities

In the exercises which follow, you are asked to indicate particular groups (first defined by age and then by problems) which you feel require additional attention, and to indicate the form of service or treatment modality which you feel the additional attention should take. Please keep in mind that you are dealing with limitted resources, and that expansion would be possible in only selected target group-modality combinations. Below are brief definitions of the modalities given, followed by an example of the exercise.

DEFINITIONS: Modalities or activities are defined as follows:

1. Inpatient Services: 24-hour psychiatric hospitalization involving nursing service and coverage by psychiatrists and other mental health professionals.

2. Emergency Services: 24-hour telephone service with mental health professionals available for telephone or face-to-face contact on an unscheduled basis.

3. Crisis Intervention: Short-term, limited session counseling or psychotherapy sessions directed toward handling a particular emotional or situational crisis, with planning and referral to continued treatment if appropriate.

4. Outpatient services: The entire range of psychotherapeutic, chemotherapeutic and other therapeutic interventions available on a scheduled basis.

5. Therapeutic Nursery/Child Care Center: A facility for daily (not overnight) care of young children, with personnel trained to guide development and correct behavior problems and possibly to counsel and train parents.

6. Partial Hospital-Psychotherapy Oriented: A day or evening care (not overnight) program providing a daily schedule of several hours of structured supervised therapeutic activities focussing on individual and group psychotherapy and possibly chemotherapy.

7. Partial Hospital-Activity Oriented: A day or evening care (not overnight) program providing a daily schedule of several hours of structured, supervised therapeutic activities focussing on socialization, stimulating and instructional activities. Chemotherapy may be included.

8. Vocational Rehabilitation: A broad range of services provided by trained rehabilitation counselors involving interest and aptitude assessment, counseling, vocational training, referral and job seeking support.

9. Consultation: Provision by mental health professionals of supervision, training, program planning assistance and counseling to other care givers, teachers, administrators, etc.

10. Client Education: Formalized information giving, instruction, or training given to client or client's family or significant others concerning client's problem(s) and how to deal with it (them).

11. Non-hospital Residential Treatment: Board, room, education, counseling, etc. provided according to a boarding school model with some staff in residence.

12. Staffed Half-Way House: Short term residence provided in a family or group living model often following inpatient care, with house-parents or counselors in residence.

13. Boarding Home/Group Home: Semi-permanent board and room, provided according to a boarding house model, usually with proprietor in residence, possibly in a parental role, and the provision of some programs and services.

14. Semi-Independent Living: Long-term residence according to an apartment living model featuring self-care. Counseling and supervision available but staff not in residence.

15. Out-Reach/Home Visits: Services which may include supervision, supportive counseling or companionship are provided in the home by trained visiting staff.

16. Store Front/Walk-In Center: Activities, counseling and other services available on an informal unscheduled basis in non-office or non-institutional-like quarters, usually located near the gathering places of the target group.

17. Indigenous Field Worker: Counseling and other services provided on an informal basis by a professional or paraprofessional person who shares the cultural and personal characteristics of the target group.

18. Leadership Workshop: Workshops for politicians, community leaders and "gatekeepers", business executives, physicians, public administrators, law enforcement officials, etc. on dealing with problems presented by particular target groups.

19. Community Organization: Efforts by trained community organizers to facilitate organization of "powerless" or "high risk: groups for self advocacy, cooperative activity, political action, etc.

20. Other: Any modality, set of activities, or service category omitted or inadequately described above. (Please specify)

EXAMPLE: TARGET GROUPS AND TREATMENT MODALITIES.

Modality or Activity → / Target Group ↓	Inpatient Services	Outpatient Services	Vocational Rehab.	Group Home	Outreach - Home Visits	Storefront - Walk In Centers
Autistic Children	X					
Juvenile Delinquents			X			X
Adult Psychotics						
Elderly Depressed					X	

In the brief EXAMPLE to the left, checkmarks indicate the respondent feels there should be expanded inpatient services for autistic children, juvenile delinquents should have more vocational rehabilitation and walk-in centers, adult psychotics need no additional or expanded modalities over what is already available, and the elderly depressed need more outreach and home visit services.

B11

A1 AGE GROUPS AND TREATMENT MODALITIES

Modality or Activity → / Age Group ↓	1 Inpatient Services	2 Emergency Services	3 Crisis Intervention	4 Outpatient Services	5 Therapeutic Nursery Child Care Center	6 Partial Hospital Psychotherapy Oriented	7 Partial Hospital Activity Oriented	8 Vocational Rehabilitation	9 Consultation	10 Client Education	11 Non-Hospital Residential Treatment	12 Staffed Half-way House	13 Boarding/Group Home	14 Semi-Independent Living	15 Outreach - Home Visits	16 Storefront/Walk-in Center	17 Indigenous Field Worker	18 Leadership Workshop	19 Community Organization	20 Other: _____
Pre-school Children																				
Pre-Adolescent Children																				
Adolescents																				
Young Adults																				
Middle aged Adults																				
Elderly																				

DIRECTIONS: For each age group, check (✓) the box or boxes, if any, under the treatment modality which should be expanded or developed to more adequately serve that age group. Check only those items you feel should receive high priority. Modalities are defined above.

A2. In the spaces below, please list those age group-modality combinations which you have checked on page 10 which should receive the highest order of priority. Place a number in front of each combination to indicate how you would rank the priority (1 = highest priority).

EXAMPLES:	Rank	Age Group		Modality
	(1)	Adolescents	-	Residential Treatment
	(2)	Elderly	-	Outreach-Home Visits
	(4)	Adolescents	-	Walk-in Center
	(3)	Pre-school	-	Child Care Center
	(5)	Preadolescents	-	Other: Advocacy
	etc.			

Please list no more than 10 items.

Rank	Age Group	Modality

B1 DIRECTIONS: On the next page, for each problem group, check (✓) the box or boxes, if any, under the treatment modality which whould be expanded or developed to more adequately serve that problem group. Check only those items you feel should receive high priority. Modalities are defined below.

B1 Problem Groups and Treatment Modalities

Modality or Activity / Problem Group	1 Inpatient Services	2 Emergency Services	3 Crisis Intervention	4 Outpatient Services	5 Therapeutic Nursery/ Child Care Center	6 Partial Hospital Psychotherapy Oriented	7 Partial Hospital Activity Oriented	8 Vocational Rehabilitation	9 Consultation	10 Client Education	11 Non-Hospital Residential Treatment	12 Staffed Half-way House	13 Group Home	14 Semi-Independent Living	15 Outreach-Home Visits	16 Storefront-Walk-in Center	17 Indigenous Field Workers	18 Leadership Workshop	19 Community Organization	Other: _____
Drug Abusers																				
Alcoholics																				
Criminal Justice Offenders																				
Physically Handicapped																				
Abused or Neglected Children																				
Emotionally Disturbed Children																				
Emotionally Disturbed Adults																				
Rape Victims																				
Women Disenfranchised Underemployed Battered wives Etc.																				
Former Psychiatric Patients Brief Hospitalization																				
Former Psychiatric Patients, Long-term Hospitalization																				
Couples in Conflict																				
Families in Conflict																				
Indians, French Speaking, Other Minority Groups																				
Other:																				

B2. In the spaces below, please list those problem group - modality combinations which you have checked on page 12 which should receive the higher order of priority. Place a number in front of each combination to indicate how you would rank the priority (1 = highest priority).

EXAMPLES:	Rank	Problem Group	Modality
	(1)	Families in conflict	Crisis intervention
	(4)	Former Psych. Pts.-long term	Part. Hosp. - Activity Oriented
	(3)	Alcoholics	Group home
	(2)	Emotionally Disturbed Children	Inpatient services

Please limit your list to ten items.

Rank	Problem Group	Modality

III ORGANIZATIONAL PROBLEMS

From the point of view of your particular organization responsibility, check in the first column which organizational problems must be resolved in order for successful programs to be implemented. In the second column rank those items you have checked in order of priority (1 = highest priority)

		(√)	Rank
1.	Staff Reorganization	_____	_____
2.	Staff Recruitment	_____	_____
3.	Upgrading of Staff (Replacement)	_____	_____
4.	Relocation of Displaced Staff	_____	_____
5.	Staff Development (In-Service Training)	_____	_____
6.	Improved Clinical Records Management	_____	_____
7.	Management Information System Development	_____	_____
8.	Evaluation System Development	_____	_____
9.	New Development or Relocation of Satellite Clinics	_____	_____
10.	Identification of New Funding Sources	_____	_____
11.	Upgrading of Governing Body (e.g. Community Board)	_____	_____
12.	Improving Community Relations	_____	_____
13.	Clarification of client selection and treatment philosophies	_____	_____
14.	Other _____	_____	_____
	_____	_____	_____
	_____	_____	_____

IV A. Below is a proposed statement of the purpose of the Department of Mental Health and Corrections. Please indicate the degree to which you approve or disapprove the statement and its sub-parts by circling a number opposite each part of the statement.

PURPOSE OF THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS	Strongly Disapprove	Disapprove	Neutral or Undecided	Approve	Strongly Approve
To promote the mental health and general well-being of individuals, families and communities of the State of Maine through services to those who are emotionally dependent, emotionally or mentally disabled, or delinquent. Services to be provided by the Department include:	1	2	3	4	5
a. Administration and management of both human and physical resources.	1	2	3	4	5
b. Needs assessment and short and long term planning.	1	2	3	4	5
c. Program evaluation, quality assurance programs, standards development and licensing.	1	2	3	4	5
d. Development, coordination and integration of policies and service delivery among bureaus, offices and public and private agencies.	1	2	3	4	5
e. Advocacy for individual client rights and interests.	1	2	3	4	5
f. Institutionalization and placement.	1	2	3	4	5
g. Support of community-based programs.	1	2	3	4	5
h. Support of preventive programs.	1	2	3	4	5
i. Serving as a clearing house for public information and education.	1	2	3	4	5
j. Case finding and need identification.	1	2	3	4	5

B. Below is a set of goals for the Department. Please indicate the degree of importance you would grant each of the goals by placing a number in the space provided. Assign numbers according to the following scale:

0 Should not be a goal
1 Hardly important at all
2 Slightly important
3 Moderately important
4 Quite important
5 Very highly important

a. Process Goals	Importance Rating
1. Develop policies, legislation and regulations which facilitate the purpose of the Department.	
2. Exercise fiscal and managerial responsibility through efficient and effective use of limited financial resources.	
a. Assure an equitable distribution of funds, through a rational and consistent formula for fund allocation.	
b. Move toward contractual and purchase of service arrangements.	
c. Assure complete accountability for the use of all funds.	
3. Develop staffing patterns and personnel necessary to perform the necessary functions.	
4. Protect the rights of clients and provide services in the most humane and normal, least restrictive manner consistent with the purposes of custody, care or treatment.	
5. Develop an organization which provides services to all age groups and across all mental and behavior problem categories regardless of diagnosis or classification.	
a. Development of a fixed point of referral with a department-wide intake system.	
b. Encourage generic service provision through written agreements among local, state and federal agencies to insure inclusion of mentally ill, mentally retarded and offenders among those elligible for services.	
c. Assure continuity of service through coordination across bureaus at the local service level.	
6. Assure quality and cost effectiveness of service delivery programs through monitoring, evaluation and quality assurance programs.	
a. Implement an integrated information, client tracking and monitoring system.	
b. Require evaluation plans of Centers and Institutions to meet Federal and independent commission standards.	

B18
Importance Rating

c. Require on-going evaluation and quality assurance programs in all agencies. _____

d. Apply cost-effectiveness criteria to all competing programs. _____

7. Provide needs assessment and planning which facilitates coordinated and sustained delivery of services. _____

a. Insure that plans including needs assessment components are current for mental health, mental retardation, corrections, children's services. _____

b. Provide staff adequate to support long-range planning and evaluation. _____

8. Research and develop innovative methods of treatment, training and rehabilitation. _____

a. At least one experimental or research program should be going on in each of four areas at one time. _____

9. Provide information and education concerning mental health and the mental health system to the community (general population). _____

10. Identify and develop additional resources for carrying out the purposes of the Department. _____

11. Provide opportunity for community input, complaints and criticism into the planning and administration of the service delivery system. _____

12. Provide for training and professional development of staff at the Departmental and agency levels. _____

b. Outcome Goals

1. Facilitate achievement of maximum potential of Maine people through: _____

a. Improving general quality of life and social environment, shown through measures such as: _____
- Increased assertions of satisfaction by clients
- Increased acceptance of clients into families and primary groups
- Reduction in divorce, and suicide rates in the population served.

b. Reduction and ameloration of mental, emotional and behavioral problems, shown by measures such as: _____
- Improved problem ratings on clients made by clinician, significant other
- Increased rates of employment among former clients
- Increased in-community days among former clients
- Decreased trouble with law among former clients
- Decreased recidivism among former clients
- Decreased social system dependency among former clients.

Importance Rating

c. Enhancement of opportunities for personal growth and development, shown through measures such as: _____

- Increased participation in community activities by clients
- Improved educational levels of clients
- Improved social and vocational skills among clients.

2. Insure maximum dignity and worth of client possible under conditions of treatment, shown through: _____
   - Advocate ratings
   - Client ratings
   - Independent ratings by observers.

List any additional goals or objectives you feel should be considered by the Department.

V (OPTIONAL)

Creating a new system

The next item may require at least some relaxed fantasy if not a flight into grandiosity. Imagine that you are the Commissioner of a new Department of Social Health, backed up by a benificent Governor and a generous Legislature. How would you organize the Mental Health System? What kinds of programs would be developed? What kinds of services would be offered?

DEPARTMENT OF MENTAL HEALTH & CORRECTIONS

State Office Building *Telephone (207) 289-3161* *Augusta, Maine 04333*

GEORGE A. ZITNAY, Commissioner

May 1977

To: Mental Health Consortium Members

From: Charles W. Acker, Ph.D., Evaluation Coordinator

Subject: Interpretive Report of the Mental Health Priorities Questionnaire.

This report represents an interpretation of the results of the recent Mental Health Priorities Questionnaire.

Of 85 questionnaires sent out, 40 were returned. 35 were received in time to be included in the quantitative analysis. Of these respondents, 17 were classified as providers, mainly Directors or Assistant Directors of Mental Health Centers or private mental health agencies; 10 were classified as community representatives, mostly members of Boards of Directors of CMHC's; and 8 were classified as government employees - members of the Department of Mental Health and Corrections and one federal employee. Tabulations of the Questionnaire responses are available in a separate report which may be requested from C. Acker. Generally those results tended to show close agreement between the groups. Specific areas which showed indecision or differences between the groups, and accordingly are regarded as not being generally supported, are listed on page 6. The following goal statements are supported by responses to the Mental Health Priorities Questionnaire. (Those items which received an average rating of 3.5 or higher were regarded as being supported; 3.0 = neutral or undecided; 4.0 = approve or agree; 5.0 = strongly agree

A. Movement to Community Base Services:

The provision of mental health services will be provided through a partnership between State operated facilities and Community Mental Health Centers.

1. The State will continue to supply institutional care for long-term and involuntary patients.

2. The State will be responsible for the development of Transitional living services such as halfway houses and semi-independent living.

3. Outpatient services, acute inpatient care, and other services shall be provided primarily by Community Mental Health Centers and private agencies.

B. Prevention and Public Education:

The scope of responsibility of the mental health system shall be broadened to include public education and prevention programs.

C. Funding of Community Mental Health Centers:

1. The State shall pursue a policy of funding Mental Health Centers through programs of Grant-in-Aid, contracts for service agreements, and identifying and seeking additional federal grants to support mental health services.

2. The mental health system as a whole shall pursue legislation to strengthen the insurance and third party payor support and legislative appropriations for the mental health system.

3. The Community Mental Health Centers and their governing boards shall invest greater efforts in community fund raising.

D. Relatively more mental health resources shall be placed in Services for Children; particularly the following.

1. Residential treatment, day care and outreach programs;

2. School-related activities, particularly diagnosis and screening;

3. Parent training programs for parents of children with behavior problems.

E. Relatively more mental health resources shall be put into Programs for the Elderly; particularly the following:

1. Outreach programs for the elderly and alternative living situations and partial hospital programs.

2. Training of mental health professionals in dealing with problems of the elderly, consultation, information exchange and coordination with Regional Senior Citizens Council and Maine's Bureau of the Elderly.

3. Education and public education programs to elicit more participation by the elderly and mental health services, and the seeking of innovative alternatives for treatment (for example companionship, foster grandparent, self organization and exercise programs for the elderly).

F. Former psychiatric patients shall continue to receive aftercare services and day and evening care programs.

G. Community Justice Programs:

1. The mental health system shall make assessment and counseling available to juvenile offenders.

2. Community Justice Programs for pre-trial intervention and sentencing alternative for offenders shall be available in each catchment area.

H. Substance abuse programs shall be available in each catchment area. These shall include residential and outpatient treatment programs for alcoholics, and residential and treatment programs for drug abusers.

I. Quality Assurance Evaluation and Accountability:

1. A system of accountability for the expenditure of public or community funds shall be a condition of licensure.

2. An effective quality assurance program shall be a condition of licensure.

3. Mental Health agencies shall develop and implement plans for program effectiveness evaluation.

J. Public Education:

1. Greater effort shall be placed in efforts to educate the public concerning mental health and how to seek help for problems.

2. Greater effort shall go into use of the media to obtain public support of the mental health system.

K. Personnel Development:

Mental Health agencies shall invest more resources into staff education and professional development.

L. The purpose of the Department of Mental Health and Corrections shall be to promote the mental health and general well-being of individuals, families and communities of the State of Maine through services to those who are emotionally dependent, emotionally or mentally disabled, or delinquent, and to avert to the extent possible, the development of behavioral problems and emotional problems through prevention and mental health promotion services to the general population. Services to be provided by the Department include:

1. Administration and management of those human and physical resources which are under the control of the Department.

2. Needs assessment and short and long term planning.

3. Program evaluation, quality assurance programs, standards development and licensing.

4. Development, coordination and integration of policies and service delivery among bureaus, offices and public and private agencies.

5. Advocacy for individual client rights and interests.

6. Institutionalization and placement.

7. Support of community-based programs.

8. Support of preventive programs.

9. Serving as a clearing house for public information and education.

M. The goals of the Department shall be both process goals and outcome goals. These goals are described as follows:

1. Process Goals:

a. Develop policies, legislation and regulations which facilitate the purpose of the Department.

b. Exercise fiscal and magerial responsibility through efficient and effective use of limited financial resources.

(1) Assure an equitable distribution of funds, though a rational and consistent formula for fund allocation.

(2) Move toward contractual and purchase of service arrangements.

(3) Assure complete accountability for the use of all funds.

c. Develop staffing patterns and personnel necessary to perform the necessary functions.

d. Protect the rights of clients and provide services in the most humane and normal, least restrictive manner consistent with the purposes of custody, care or treatment.

e. Develop an organization which provides services to all age groups and across all mental and behavior problem categories regardless of diagnosis of classification, and assures continuity of service through coordination across bureaus at the local service level.

(1) Encourage generic service provision through written agreements among local, state and federal agencies to insure inclusion of mentally ill, mentally retarded and offenders among those eligible for services.

(2) Assure continuity of service through coordination across bureaus at the local service level.

f. Assure quality and cost effectiveness of service delivery programs through monitoring, evaluation and quality assurance programs.

(1) Require evaluation plans of Centers and Institutions to meet Federal and independent commission standards.

(2) Require on-going evaluation and quality assurance programs in all agencies.

(3) Apply cost-effectiveness criteria to all competing programs.

g. Provide needs assessment and planning which facilitates coordinated and sustained delivery of services.

(1) Insure that plans including needs assessment components are current for mental health, mental retardation, corrections, children's services.

(2) Provide staff adequate to support long-range planning and evaluation.

h. Research and develop innovative methods of treatment, training and rehabilitation.

i. Provide information and education concerning mental health and the mental health system to the community (general population).

j. Identify and develop additional resources for carrying out the purposes of the Department.

k. Provide opportunity for community input, complaints and criticism into the planning and administration of the service delivery system.

l. Provide for training and professional development of staff at the Departmental and agency levels.

2. Outcome Goals:

a. Facilitate achievement of maximum potential of Maine people through:

(1) Improving general quality of life and social environment, shown through measures such as:

- Increased assertions of satisfaction by clients
- Increased acceptance of clients into families and primary groups
- Reduction in divorce, and suicide rates in the population served.

(2) Reduction and amelioration of mental, emotional and behavioral problems, shown by measures such as:

- Improved problem ratings on clients made by clinician, significant other
- Increased rates of employment among former clients
- Increased in-community days among former clients
- Decreased trouble with law among former clients
- Decreased recidivism among former clients
- Decreased social system dependency among former clients.

(3) Enhancement of opportunities for personal growth and development, shown through measures such as:

- Increased participation in community activities by clients
- Improved educational levels of clients
- Improved social and vocational skills among clients.

b. Insure maximum dignity and worth of clients possible conditions of treatment, shown through:

- Advocate ratings
- Client ratings
- Independent ratings by observers.

NOTE: Controversial Areas

A limited number of items indicate ambivalence, uncertainty or divergence of viewpoints among the respondents. These items have not been included in the above goal statements. The areas showing this lack of support are:

I C. 7 Population based grant-in-aid.

C. 9 Voucher system for mental health services.

C. 17 New department for direct social services delivery.

C. 18 A super commission.

D. 19, 21 Dissolution of mental health, mental retardation and corrections bureaus, replacement by new structure with fixed point of referral and comprehensive services.

D. 20 Regionalization of Department.

F. 15 Program effectiveness evaluation.

H. 56 Support of education and training of non-professional staff.

IV A. j. Case finding and need identification.

IV B. 5 a Fixed point of referral.

IV B. 5 b Generic service provision.

IV B. 6 a Integrated information, client tracking and monitoring systems.

IV B. 8 Research and development.

As these areas tend to have direct implications for the Departmental plans for reorganization, they warrant special attention and discussion. In some cases revision of the concept may be indicated. In other instances, special efforts to explain the concept and educate members of the Mental Health Consortium may be called for.

SERVICE MODALITY PRIORITIES

One set of questions asked respondents to make checkmarks on a gridwork to show which age groups or problem groups should receive more attention through particular treatment modalities. Respondents were also asked to rank order, according to priority, the target group-modality combinations they checked. Responses to this exercise indicated that more attention should be given to development of treatment modalities for age and problem groups as follows:

CHILDREN:

Preschool Children:

Therapeutic nurseries (especially for emotionally disturbed children), outreach, and home visits.

Pre-Adolescent Children:

Inpatient services and residential treatment.

Adolescents:

Inpatient services, crisis intervention and staffed halfway houses.

Abused or Neglected Children, all ages:

Emergency, crisis intervention and outreach services.

Emotionally Disturbed Children, all ages:

Residential treatment, inpatient services, and staffed halfway houses.

ADULTS:

Young Adults:

Vocational rehabilitation (especially for physically handicapped) and staffed halfway houses.

Middle Age Adults:

Semi-independent living (especially for emotionally disturbed adults).

Former Psychiatric Patients, all ages:

Partial hospitalization, staffed halfway houses, group homes.

FAMILIES IN CONFLICT:

Crisis intervention, outpatient services.

ELDERLY:

Outreach, home visits, and group homes.

FINAL RESULTS OF MENTAL HEALTH PRIORITIES QUESTIONNAIRE

I B29 Below are listed a number of options or alternatives concerning various issues facing the mental health system. For each item, please indicate your degree of agreement or disagreement with the statement by circling the number which most closely corresponds to your feeling on the matter. ↓ = SUB-GROUP MEANS { P = PROVIDER GROUP, N = 17; G = GOVERNMENT GROUP, N = 8; C = COMMUNITY GROUP, N = 10; 35

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree	MEAN N = 35
A. Movement to community-based services						
1. All mental health services including care of involuntary patients should eventually be supplied by community non-profit or private agencies.	1 2	2 10	G P↓ C↓ 3 9	4 6	5 8	3.2
2. The role of the State in providing institutional care for long-term and involuntary patients should be continued.	1	2 4	3 4	G C P ↓4↓ 20	5 7	3.9
3. The State should provide a greater variety of transitional living services such as half-way houses and semi-independent living.	1 1	2 3	G↓ 3 4	C 4 10 P↓	5 17	4.1
4. We should move toward a system in which outpatient services are provided by private practitioners and private clinics, Community Mental Health Centers provide information and referral, inpatient and other services which private practitioners cannot, and State institutions would provide only what CMHC's and private practitioners cannot.	1 9	G↓ 2 9	P↓ C↓ 3 2	4 6	5 7	2.8
B. Scope of mental health responsibility						
5. The area of mental health system efforts should be broadened to include all-inclusive prevention and public education programs to minimize emotional problems.	1	2 1	3 2	4 11	P C G ↓↓↓ 5 21	4.5
6. The area of mental health system efforts should be limitted to the remedy and treatment of acute and chronic mental illness.	C C P ↓ ↓↓ 1 20	2 13	3 1	4 1	5	1.5
C. Funding options for CMHC's						
7. State Grant-In-Aid should be based primarily on catchment area population allowing for any Federal mental health grants the center receives.	1 2	2 10	G↓ C P 3↓↓ 10	4 11	5 1	2.9
8. State Grant-In-Aid should be based on mental health needs and deficiencies of mental health resources in the catchment area.	1	2 1	3 4	P ↓4 21 G C↓	5 8	4.1
9. There should be a voucher system in which consumers receive "credits" from the government and seek their own providers of choice for mental health services.	1 6	2 9	C↓ G↓ P 3↓ 14	4 4	5 1	3.1

B30

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree	MEAN
10. The insurance and third-party payor system should be strengthened through legislation.	1	2	3 2	4 G C P ↓ ↓↓ 10	5 22	4.8
11. Support to the CMHC's from the State should come through purchase of service arrangements. In other words, the DMH&C would contract with CMHC's to provide a certain amount of particular kinds of services.	1 3	2	3 5	P G C ↓4↓ 16	5 10	3.9
12. The DMH&C should invest greater effort in identifying and seeking Federal grants to support mental health services.	1	2 2	3 4	P C G ↓4↓ 20	5 8	4.0
13. Mental health system participants should extend greater efforts in the political arena to obtain larger appropriations from the legislature.	1	2 1	3 4	G P C 4↓ ↓ 16	5 13	4.2
14. Mental health centers and their Boards should make greater efforts toward community fund raising.	1 1	2 2	3 3	P G C ↓4 ↓ 19	5 10	4.0
D. Governmental reorganization of social service departments						
15. The present autonomy of DMH&C with its responsibilities for mental health, mental retardation and corrections should be retained.	1	2 2	3 11	P G C ↓ ↓ 4 13	5 9	3.8
16. The Department should be absorbed or integrated into the Department of Human Services.	G C P 1 ↓ ↓ 23	2 8	3 2	4 1	5	1.4
17. A new Department of Direct Social Service Delivery incorporating mental health, mental retardation, children's services, elderly's services, protective services and vocational rehabilitation (including alcohol and drug abuse) and related offices should be formed.	1 2	2 5	P C G ↓3 ↓↓ 19	4 7	5 3	3.1
18. A super commission, with powers to integrate human and social service delivery should be formed.	1 8	G P 2 ↓ 7	C ↓3 17	4 2	5	2.6
D. Organization of mental health and corrections service delivery system						
19. The present departmental organization with the three bureaus (MH, MR and Corrections) should be done away with and replaced by a new structure which has a fixed point of referral and provides comprehensive services to individuals without regard to diagnosis or problem category.	1 1	2 7	C P ↓3 12	4 12	5 3	3.3

B31

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree	MEAN
20. The departmental service delivery system should be regionalized so that program decisions are made on a regional basis, and services integrated on a local basis.	1 / 1	2 / 4	3 C ↓ / 9	3.0 P ↓ 4 / 17	4.3 G ↓ 5 / 7	3.5
21. The present bureau structure and centralized program decision-making should be retained and strengthened.	1 / 5	1.5 G ↓ 2 / 10	2.8 P ↓ 3 / 9	3.8 C ↓ 4 / 16	5 / 1	2.8
E. Service delivery resource allocation: There should be relatively more mental health resources put into:						
22. Residential treatment services for children;	1	2 / 3	3 / 4	3.5 G ↓ 4 / 15	4.3 C P ↓ 5 / 13	4.1
23. Child and family outpatient agencies and programs;	1	2 / 1	3 / 2	C P ↓ 4 / 10	G ↓ 5 / 12	4.3
24. School related activities such as diagnosis and screening;	1	2 / 2	3 / 4	3.5 ↓ P C ↓ 4 / 19	5 / 9	4.0
25. School related activities such as prescriptive learning and psychotherapy in schools;	1 / 1	2 / 4	C P G ↓↓↓ 3 / 8	4 / 14	5 / 7	2.10
26. Recreation-related activity programs (clubs, sports, camps) directed toward children with behavior problems;	1 / 1	2 / 5	P ↓ C ↓ G ↓ 3 / 8	4 / 16	5 / 5	3.5
27. Home and family-directed outreach programs with an emphasis on keeping the disturbed child in the home and assisting the family to work with the child;	1	2 / 1	3 / 3	P C 4 / 19	G ↓ 5 / 12	4.2
28. Pre-school programs such as therapeutic nurseries, day and evening care centers, etc. for children of multiple problem families;	1 / 1	2 / 5	3 / 15	C P G 4↓↓↓	5 / 14	4.2
29. Parent-training programs for parents of children with behavior problems;	1	2	3 / 1	4 / 19	P G C ↓ 5 / 15	4.4
30. Education and public relations programs to elicit more participation by the elderly in mental health services;	1	2	3 / 7	G C ↓ P 4↓ / 20	5 / 8	4.0
31. Traditional outpatient, day care and inpatient services geared to the elderly, with transportation;	1	2 / 2	G ↓ C ↓ 3 / 10	P 4 / 17	5 / 6	2.8
32. Mental health outreach programs for the elderly;	1	2	3 / 6	G C P 4↓ / 19	5 / 10	4.1

B32

		(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree	MEAN
33.	Integration of mental health with home health and nutrition care for the elderly;	1	2 1	3 9	P ↓ GG ↓4 21	5 4	3.8
34.	Integration of mental health with transportation programs for the elderly;	1	2 4	3 8	P ↓ C G ↓4 17	5 6	3.7
35.	Innovative alternatives, e.g., companionship, foster grandparent, self organization and exercize programs, for the elderly;	1	2 2	3 9	C P ↓↓4 13 G ↓	5 11	3.9
36.	Training of mental health professionals in dealing with problems of the elderly;	1	2	3 3	C ↓4 20 G P ↓↓	5 12	3.9
37.	Consultation, information exchange and coordination with Regional Senior Citizens Councils and the Bureau of Maine's Elderly;	1	2	3 4	G C P 4↓ 22	5 8	3.8
38.	Aftercare services (planning, placement, maintenance) for former psychiatric inpatients;	1	2	3 3	G 4 22 P ↓ C ↓	5 16	4.1
39.	Day care and evening care programs for former psychiatric inpatients;	1	2 1	3 3 C ↓	G ↓4 22 P ↓	5 8	3.9
40.	Mental health services such as assessment and counseling for juvenile offenders;	1	2 1	3 3	C 4 17 P G ↓↓	5 13	4.0
41.	Community justice programs for pre-trial intervention and sentencing alternatives for offenders;	1	2 3	3 4	C P ↓4 14 G ↓	5 14	3.9
42.	Residential treatment programs for alcoholics;	1 1	2 3	3 7	P G C ↓↓↓4 13	5 10	3.8
43.	Outpatient treatment programs for alcoholics;	1 1	2 1	3 8	P ↓ G ↓ C 4 16	5 9	3.9
44.	Residential treatment programs for drug abusers;	1 1	2 6	3 11 G ↓ P ↓ C ↓	4 12	5 4	3.6
45.	Outpatient treatment programs for drug abusers;	1	2 3	3 18 G P ↓↓ 3.5	C ↓4 16	5 5	3.7
46.	Inpatient treatment programs for the chronically mentally ill;	1	2 7	3 6 G P ↓	4 12 C ↓ 4.4	5 9	3.7
47.	Inpatient treatment programs for the acutely mentally ill;	1	2 3	3 4 G ↓	4↓ 14 P C ↓	5 13	4.1
48.	Outpatient treatment programs for individuals who are emotionally disturbed or under stress;	1	2	3 2	C G 4.1 P ↓	5 12	4.3

See P

B33

	(1) Strongly Disagree	(2) Disagree	(3) Undecided or Neutral	(4) Agree	(5) Strongly Agree	MEAN
49. Outpatient treatment programs for couples and families with emotional problems and/or are under stress;	1	2	3 4	G C P 4 18	5 12	4.2
F. Quality assurance, evaluation, and accountability						
50. Emphasis on program effectiveness evaluation should be delayed until other problems of funding, management and mission of mental health agencies have been resolved;	1 10	1.6 G 2 13	2.2 P 2.6 C 3 2	4 9	5	1.7
51. Having an effective quality assurance program should be a condition of licensing for CMHC's;	1	2 1	3 4	C P 4 15	G 5 14	4.2
52. A system of accountability for the expenditure of public or community funds (being able to tell the public what they're getting for their money) should be a condition of licensure.	1	2	3 1	C 4 20	P G 5 14	4.4
G. Public education						
53. Present methods and efforts to educate the public concerning mental health and how to seek help for problems are adequate.	1.4 1.5 P G 1 18	2 14	2.3 C 3 2	4	5 1	1.6
54. More use should be made of the media to obtain public support of the mental health system.	1 1	2 1	3 1	C G 4 15	D 5 17	4.3
H. Personnel development						
55. Relatively more resources should go into continuing staff education and professional development.	1	2 2	3 9	C G P 4 17	5 7	3.8
56. Mental Health institutes and centers have an obligation to try to assist their non-professional employees to achieve professional status, where appropriate, through support of education and training.	1	2 3	3 7	P C G 4 15	5 3	3.6

I. Other: List below any issues and/or options which you feel were omitted or not adequately presented above. Rate your own options in terms of agreement/disagreement.

57. _____

_____

(use back of sheet if necessary)

A1 AGE GROUPS AND TREATMENT MODALITIES

Modality / Activity → Age Group ↓	1 Inpatient Services	2 Emergency Services	3 Crisis Intervention	4 Outpatient Services	5 Therapeutic Nursery Child Care Center	6 Partial Hospital Psychotherapy Oriented	7 Partial Hospital Activity Oriented	8 Vocational Rehabilitation	9 Consultation	10 Client Education	11 Non-Hospital Residential Treatment	12 Staffed Half-way House	13 Boarding/Group Home	14 Semi-Independent Living	15 Outreach - Home Visits	16 Storefront/Walk-in Center	17 Indigenous Field Worker	18 Leadership Workshop	19 Community Organization	20 Other: _____
Pre-school Children					1 / 1										4 / 6					
Pre-Adolescent Children	3 / 5										7				18.5					
Adolescents	9 / 3		11.5								16.5 / 4	9 / 8	9 / 18.5			19.5 / 9				
Young Adults							5 / 15.5	14.5	19.5 / 11.5			6.5 / 18.5				11.5				13
Middle aged Adults							15.5		19.5			15.5		15.5 / 11.5						
Elderly						16							18.5 / 10	6.5 / 18.5	2 / 2					

DIRECTIONS: For each age group, check (✓) the box or boxes, if any, under the treatment modality which should be expanded or developed to more adequately serve that age group. Check only those items you feel should receive high priority. Modalities are defined above.

A1 OPEN CHECKING INSTRUCTIONS:

Rank of Frequencies (BLANK: freq. less than 10; range of frequencies - 0-23)

X

Y

A2 RANK-TO-TEN INSTRUCTIONS:

Rank of Average Ranks (BLANK: Average Rank greater than 12,7; range of Avg. Ranks = 5,6 - 15,0)

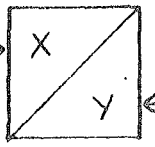
B1 Problem Groups and Treatment Modalities

Problem Group / Modality or Activity	1 Inpatient Services	2 Emergency Services	3 Crisis Intervention	4 Outpatient Services	5 Therapeutic Nursery/ Child Care Center	6 Partial Hospital Psychotherapy Oriented	7 Partial Hospital Activity Oriented	8 Vocational Rehabilitation	9 Consultation	10 Client Education	11 Non-Hospital Residential Treatment	12 Staffed Half-way House	13 Group Home	14 Semi-Independent Living	15 Outreach-Home Visits	16 Storefront-Walk-in Center	17 Indigenous Field Workers	18 Loadership Workshop	19 Community Organization	Other:
Drug Abusers																				
Alcoholics	16											13								
Criminal Justice Offenders			14																	
Physically Handicapped								5 / 22												
Abused or Neglected Children		6	7										18		8.5					
Emotionally Disturbed Children	2 / 1.6	11		11	3 / 3				20	20	9 / 15	5		5	11					
Emotionally Disturbed Adults																				
Rape Victims		1	9 / 20																	
Women Disenfranchised Underemployed Battered wives		13	13																	
Former Psychiatric Patients Brief Hospitalization												13		5						
Former Psychiatric Patients, Long-term Hospitalization						8.5						4								
Couples in Conflict			17	14																
Families in Conflict			9 / 7	13 / 8											14					
Indians, French Speaking, Other Minority Groups																				
Other:																				

B1 OPEN CHECKING INSTRUCTIONS

RANK OF FREQUENCIES

(BLANK: freq. less than 10; range of frequencies 0 - 18).



B2 RANK-TO-TEN INSTRUCTIONS:

RANK OF AVERAGE RANKS

(BLANK: AVERAGE RANK greater than 13.6; range of average ranks: 8.6 - 15.0)

III ORGANIZATIONAL PROBLEMS

From the point of view of your particular organization responsibility, check in the first column which organizational problems must be resolved in order for successful programs to be implemented. In the second column rank those items you have checked in order of priority (1 = highest priority)

		C	G	P
1.	Staff Reorganization	7.8	5.3	8.9
2.	Staff Recruitment	6.5	6.5	8.1
3.	Upgrading of Staff (Replacement)	8.7	5.5	8.7
4.	Relocation of Displaced Staff	9.2	8.0	10.1
5.	Staff Development (In-Service Training)	5.6	5.8	6.4
6.	Improved Clinical Records Management	10.1	7.9	6.1
7.	Management Information System Development	8.9	5.5	5.1
8.	Evaluation System Development	5.8	6.4	4.6
9.	New Development or Relocation of Satellite Clinics	8.0	10.8	10.0
10.	Identification of New Funding Sources	2.9	5.8	3.6
11.	Upgrading of Governing Body (e.g. Community Board)	7.4	9.9	9.0
12.	Improving Community Relations	5.3	9.0	7.4
13.	Clarification of client selection and treatment philosophies	7.8	5.4	10.8
14.	Other _____	9.6	9.1	8.7
	_____	____	____	
	_____	____	____	

IV A. Below is a proposed statement of the purpose of the Department of Mental Health and Corrections. Please indicate the degree to which you approve or disapprove the statement and its sub-parts by circling a number opposite each part of the statement.

PURPOSE OF THE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS	Strongly Disapprove	Disapprove	Neutral or Undecided	Approve	Strongly Approve	MEAN
To promote the mental health and general well-being of individuals, families and communities of the State of Maine through services to those who are emotionally dependent, emotionally or mentally disabled, or delinquent. Services to be provided by the Department include:	1	2	3	4	5	4.2
a. Administration and management of both human and physical resources.	1	2	3	4	5	3.6
b. Needs assessment and short and long term planning.	1	2	3	4	5	4.2
c. Program evaluation, quality assurance programs, standards development and licensing.	1	2	3	4	5	4.5
d. Development, coordination and integration of policies and service delivery among bureaus, offices and public and private agencies.	1	2	3	4	5	4.3
e. Advocacy for individual client rights and interests.	1	2	3	4	5	3.9
f. Institutionalization and placement.	1	2	3	4	5	3.8
g. Support of community-based programs.	1	2	3	4	5	4.5
h. Support of preventive programs.	1	2	3	4	5	4.4
i. Serving as a clearing house for public information and education.	1	2	3	4	5	4.0
j. Case finding and need identification.	1	2	3	4	5	3.4

B. Below is a set of goals for the Department. Please indicate the degree of importance you would grant each of the goals by placing a number in the space provided. Assign numbers according to the following scale:

0 Should not be a goal
1 Hardly important at all
2 Slightly important
3 Moderately important
4 Quite important
5 Very highly important

MEAN	Process Goals	Importance Rating C	C	P
4.5 a.	1. Develop policies, legislation and regulations which facilitate the purpose of the Department.	4.4	4.4	4.4
4.4	2. Exercise fiscal and managerial responsibility through efficient and effective use of limited financial resources.	4.3	4.7	4.4
4.5	a. Assure an equitable distribution of funds, through a rational and consistent formula for fund allocation.	4.4	4.4	4.6
3.9	b. Move toward contractual and purchase of service arrangements.	3.2	4.3	3.9
4.3	c. Assure complete accountability for the use of all funds.	3.9	4.6	4.6
3.7	3. Develop staffing patterns and personnel necessary to perform the necessary functions.	3.8	4.1	3.4
4.4	4. Protect the rights of clients and provide services in the most humane and normal, least restrictive manner consistent with the purposes of custody, care or treatment.	3.7	4.7	4.4
3.6	5. Develop an organization which provides services to all age groups and across all mental and behavior problem categories regardless of diagnosis or classification.	3.3	3.6	4.1
2.8	a. Development of a fixed point of referral with a department-wide intake system.	2.8	4.3	2.2
3.7	b. Encourage generic service provision through written agreements among local, state and federal agencies to insure inclusion of mentally ill, mentally retarded and offenders among those elligible for services.	3.6	4.3	3.5
3.8	c. Assure continuity of service through coordination across bureaus at the local service level.	3.3	4.3	3.8
4.0	6. Assure quality and cost effectiveness of service delivery programs through monitoring, evaluation and quality assurance programs.	3.6	4.4	4.1
3.1	a. Implement an integrated information, client tracking and monitoring system.	3.2	4.1	2.6
4.0	b. Require evaluation plans of Centers and Institutions to meet Federal and independent commission standards.	3.9	4.7	3.9

B39

MEAN		Importance Rating C	G	P
4.0	c. Require on-going evaluation and quality assurance programs in all agencies.	4.1	4.6	3.9
3.8	d. Apply cost-effectiveness criteria to all competing programs.	3.4	4.3	3.8
4.0	7. Provide needs assessment and planning which facilitates coordinated and sustained delivery of services.	4.0	4.7	3.7
4.0	a. Insure that plans including needs assessment components are current for mental health, mental retardation, corrections, children's services.	4.3	4.6	3.6
4.0	b. Provide staff adequate to support long-range planning and evaluation.	3.6	4.6	3.9
3.6	8. Research and develop innovative methods of treatment, training and rehabilitation.	3.2	4.4	3.5
3.1	a. At least one experimental or research program should be going on in each of four areas at one time.	3.4	3.3	2.9
3.6	9. Provide information and education concerning mental health and the mental health system to the community (general population).	3.0	3.4	3.7
4.1	10. Identify and develop additional resources for carrying out the purposes of the Department.	3.3	4.1	4.4
4.2	11. Provide opportunity for community input, complaints and criticism into the planning and administration of the service delivery system.	3.8	3.9	4.4
3.8	12. Provide for training and professional development of staff at the Departmental and agency levels.	3.8	4.1	3.7
b. 4.3	Outcome Goals 1. Facilitate achievement of maximum potential of Maine people through:	4.2	4.8	4.2
4.0	a. Improving general quality of life and social environment, shown through measures such as: - Increased assertions of satisfaction by clients - Increased acceptance of clients into families and primary groups - Reduction in divorce, and suicide rates in the population served.	4.2	4.3	3.8
4.3	b. Reduction and ameloration of mental, emotional and behavioral problems, shown by measures such as: - Improved problem ratings on clients made by clinician, significant other - Increased rates of employment among former clients - Increased in-community days among former clients - Decreased trouble with law among former clients - Decreased recidivism among former clients - Decreased social system dependency among former clients.	3.8	4.7	4.1

B40

MEAN		Importance Rating C	G	P
3.6	c. Enhancement of opportunities for personal growth and development, shown through measures such as: - Increased participation in community activities by clients - Improved educational levels of clients - Improved social and vocational skills among clients.	3.8	3.7	3.6
4.0	2. Insure maximum dignity and worth of client possible under conditions of treatment, shown through: - Advocate ratings - Client ratings - Independent ratings by observers.	3.8	4.4	4.0

List any additional goals or objectives you feel should be considered by the Department.

DEPARTMENT OF MENTAL HEALTH & CORRECTIONS

State Office Building *Telephone (207) 289-3161* *Augusta, Maine 04333*

GEORGE A. ZITNAY, Commissioner

May 27, 1977

To: Members, Mental Health Consortium Planning Committee

From: Chuck Acker, Secretary

Subject: Consortium Survey

Chairman Dick King has recommended that in the absence of pressing business there will be no Planning Committee meeting in June.

Alan Brown has tabulated the results of the Participant Survey, which is enclosed for your review. For each item he has indicated the "mean" or average response. (All scores for a given item are added and the sum divided by the number responding.) The mean is indicated by a number over an arrow. "N" refers to the number of persons responding to the item. "S.D." is the standard deviation which is a measure of how spread out the scores are. (Generally speaking, 2/3 of the responses will fall within one S.D. on either side of the mean. The smaller the S.D., the more the respondents agree with each other and tend to cluster around the mean.) As an example in interpreting the results, there tends to be fairly high consensus on Item 28, "Quarterly", and Item 29, "All Day", with people tending to agree that meetings should be quarterly, all day. In another example, on Item 24, the group tends to just slightly disagree that the primary focus should be on workshops, but the consensus on this (as indicated by the relatively large S.D.) is relatively low.

Written comments are typed out and attached.

Hopefully, we can discuss the significance of these results at the next meeting of the planning Committee.

CWA/lyl
Enc.

MAINE MENTAL HEALTH CONSORTIUM

Participant Survey

In order for the Mental Health Consortium to have maximum impact on the future direction of the mental health service-delivery system, it is of the utmost importance that the membership and other interested parties achieve some degree of consensus on the future directions of the Consortium itself. The purpose of this questionnaire is to allow you to express your interests and opinions as they pertain to a number of issues which, to date, are less than adequately resolved.

MEMBERSHIP

It was decided at one of the previous meetings of this group that membership should be limited to approximately 50--at least until some major organizational issues could be resolved. At the present time, membership consists primarily of representatives from the following groups:

NIMH
Center Directors
Center Board Members
DMH&C Central Office Staff
Governor's Advisory Committee on Mental Health
Maine Health Systems Agency
BMHI/AMHI
Consumers

A number of other groups have requested membership; still others may yet do so. Please indicate below your feelings about expanding the membership by circling the appropriate number.

MEAN RESPONSES

	Strongly Disagree (1)	Disagree (2)	Undecided or Neutral (3)	Agree (4)	Strongly Agree (5)	n	S.D.
1. Consortium membership should be left as is	1	1.7 ↓ 2	3	4	5	26	1.0
2. Membershipshould be open to any and all interested individuals or agencies	1	2	3	3.6 ↓ 4	5	27	1.4
Membership should not be unlimited but should include							
3. Maine Mental Health Planning Coalition	1	2	3	3.9 ↓ 4	5	19	1.0
4. Private MH providers, e.g., childrens' residential treatment centers	1	2	3	3.9 ↓ 4	5	19	1.0

	Strongly Disagree (1)	Disagree (2)	Undecided or Neutral (3)	Agree (4)	Strongly Agree (5)	n	S.D.
5. Maine Nursing Association	1	2	3	3.7 ↓ 4	5	19	1.0
6. Maine Psychiatric Association	1	2	3	(4)	5	19	1.0
7. Maine Psychological Association	1	2	3	4 ↓ 4.1	5	19	1.1
8. Maine Social Workers Association	1	2	3	3.9 ↓ 4	5	19	1.1
9. Legislative Representatives	1	2	3	3.7 ↓ 4	5	19	1.2
10. Unaffiliated private practitioner	1	2	3	3.4 ↓ 4	5	19	1.2
11. Maine Teachers Association	1	2	3	3.4 ↓ 4	5	19	1.2
12. Maine Human Services Council	1	2	3	3.9 ↓ 4	5	19	1.0
13. Togus V.A.	1	2	3	3.7 ↓ 4	5	19	1.0
14. Clergy	1	2	3	3.7 ↓ 4	5	19	1.0

15. Other organizations you feel <u>should</u> be included:

_____

_____

_____

_____

16. Comments: _____

_____

_____

_____

ROLE OF THE CONSORTIUM

To what extent do you feel that the following functions are appropriate for the Consortium?

17. The Consortium should serve primarily as a "sounding-board" for the Mental Health discussion.	1	2	3	3.6 ↓ 4	5	27	1.1
18. The Consortium should actively engage in short, long-range planning	1	2	3	(4)	5	26	1.1

	Strongly Disagree (1)	Disagree (2)	Undecided or Neutral (3)	Agree (4)	Strongly Agree (5)	n	SD
19. The Consortium should serve as a "community educator" in the area of mental health	1	2	3	4 (4.3)	5	27	.7
20. The Consortium should actively lobby for mental health legislation	1	2	3	4 (4.1)	5	27	.8

21. Other (specify): _____

_____

22. Comments: _____

_____

_____

_____

MEETINGS

The primary focus of Consortium meetings should be

23. To provide the Commissioner a forum for sharing information with concerned individuals	1	2	3	(4)	5	24	.9
24. To provide MH workshops and other learning experiences for MH professionals and paraprofessionals	1	2	3 (2.8)	4	5	25	1.8
25. To develop plans for the future of Maine's MH service-delivery system	1	2	3	4 (4.1)	5	25	1.1
26. To work in separate "task forces" to carry out planning developed by the Department and the Consortium Planning Committee	1	2	3	4 (3.7)	5	24	1.0

27. Other (specify): _____

_____

Meetings should be held

28. Monthly	1	2 (2.4)	3	4	5	11	1.4
Quarterly	1	2	3	4 (4.4)	5	23	.6
Semi-annually	1	2	3 (2.9)	4	5	15	1.6
Annually	1 (1.4)	2	3	4	5	10	.7

	Strongly Disagree (1)	Disagree (2)	Undecided or Neutral (3)	Agree (4)	Strongly Agree (5)		
Meetings should be planned to extend over a period of							
29. Half a day	1	(2)	3	4	5	15	1.1
All day	1	2	3	4	5 (4.5)	23	.6
Two days	1	2 (2.8)	3	4	5	16	1.3
I would like to see the next meeting of the Consortium held in							
30. Portland	1	2	3 (3.7)	4	5	14	1.0
Lewiston	1	2	3 (3.6)	4	5	11	1.0
Augusta	1	2	3	4 (3.9)	5	18	1.0
Bangor	1	2	3 (3.3)	4	5	13	.9

Other (specify): _____

COMMITTEES

Currently, there are two standing committees of the Consortium; the Executive Committee (Center Directors, 1 Area Board Director, Institute Superintendents, Maine Council of CMHCs, and Central Office staff) and the Planning Committee (representatives of centers, Institutes, Council and Central Office). Although both groups have met regularly and kept busy, there is some feeling that neither has entirely lived up to its potential--largely because the groups' respective roles have never been adequately defined. Your opinions on how to optimize these two groups would be appreciated.

I believe that the planning Committee should direct <u>most</u> of its energy toward							
31. Planning and arranging the meetings of the large group	1	2	3	4 (3.5)	5	27	1.0
32. Developing the State Mental Health Plan with input from the Department and the Centers	1	2	3 (2.8)	4	5	21	1.3
33. Reviewing the State Plan, after it has been developed by the Department	1	2	3 (3.3)	4	5	23	1.3
34. Working in concert with Department staff to do long and short-range MH planning	1	2	3	4 (3.9)	5	22	1.2

35. Other (specify): _____

I believe the primary role of the Executive Committee should be							
36. To keep the Commissioner informed of the concerns of the Centers and Institutes	1	2	3	4 (3.9)	5	25	1.3

	Strongly Disagree (1)	Disagree (2)	Undecided or Neutral (3)	Agree (4)	Strongly Agree (5)		
37. To carry out activities/tasks proposed by the Planning Committee and approved by the Consortium as a whole	1	2	3	4 4.1 ↓	5	25	.9
38. To set priorities for the Planning Committee and/or the full Consortium	1	2	3 3.4 ↓	4	5	25	1.4

39. Other (specify): _____

40. I am a member of the Consortium _____ An observer _____

41. Name: _____ (optional)

Affiliation: _____ (optional)

HAB:ret

15. Other organizations you feel should be included:

If you are opening it up--go the whole way.

Consumers of mental health services. Health Systems Agency.

State and regional alcohol and drug facilities.

Maine Medical Association, Maine Osteopathic, Statewide Health Coordinating Council.

VNA's or coordinated Home Health Care Agencies, Elderly and Senior Citizens Groups, Representation from Regional Alcohol and Drug Abuse Councils.

The private, half-way houses, treatment centers, schools, private practicioners, hospitals, etc.

Maine Hospital Association, Nursing Home Association, Maine Medical Association, Representatives of State Insurance Commission, Bar Association, Press Association. A broad base helps open up understanding.

Office of Alcohol and Drug Abuse Prevention.

16. Comments:

Difficult until Consortium is more clearly defined.

I'm uncomfortable with a statement to the effect of "any and all agencies should be admitted," but I do strongly feel that a much broader representation is needed.

Anyone should be allowed membership. I represent the private sector--but feel very much a part of the mental health system of this state and am deeply committed to providing mental health services. I feel I have something to contribute to the Consortium as well as learn from it.

It seems to me that Maine needs a broad based mental health association, which includes just plain interested citizens. Perhaps the present coalition could be a nucleus and continuing part of such an association.

Consider having an "open membership drive"--publicly announced and recruitment limited to a 3-week period once a year.

Would like to raise issue of participation by D.D. groups in Consortium.

21. Other:

Should facilitate planning, e.g., Dr. Acker's questionnaire. To serve as a multi-faceted resource to Commissioner, Dept. of Mental Health & Corrections.

It should be more than a "sounding board" for discussion. On a consensus basis it should be able to set directions and broad policy.

The Consortium should establish and work toward as a goal the development of a statewide mental health association of volunteer lay citizens, affiliated with the National Assn. of Mental Health.

Legislation, funding.

The Consortium should deal with a plan for Mental Health, Disability Development Service, prepayment mechanism.

Deal with broader health issues.

22. Comments:

Must include new information for professionals to keep them committed to giving up a day!

27. Other:

Input mechanisms to systems by variety of people! Planning done by smaller unit of Mental Health Professionals and Department.

To serve as a forum for feedback (sounding board) to Commissioner. To serve on a limited, ad hoc basis as vehicle for development of mental health plans.

All of the above plus general education re: mental health to anyone who will listen.

Debate various issues, arrive at consensus.

Open forum for communications.

30. Other:

No preference.

Rockland.

Rotating schedule of any of these.

Squaw Mountain Inn, Greenville.

Rotating schedule (whichever is next).

Should move to allow broader participation.

35. Other:

Working in concert with Department, HSA and the Center to develop a State Mental Health Plan as part of an overall health systems plan.

Follow direction of larger group.

To be spokesperson for the system. Perhaps there should be regional groups which meet monthly leading to larger Consortium meetings 4 times per year.

39. Other:

Act for the Consortium between meetings of the Consortium.

To suggest priorities.

To deal with and seek resolve to system (Mental Health) problems.

DEPARTMENT OF MENTAL HEALTH & CORRECTIONS

State Office Building *Telephone (207) 289-3161* *Augusta, Maine 04333*

GEORGE A. ZITNAY, Commissioner

June 13, 1977

Dear

Enclosed is an Agreement for Purchase of Community Mental Health Services which we have discussed on several occasions. This agreement should allow us to fulfill requirements of L.D. 757 in the allocation of Title II funds and contribute to the Department's credibility in documenting its operations.

This agreement, for a 6 month period, is intended for interim use pending completion of the consultant study of our contract system.

In order to meet our Title II obligations and disburse FY 78 funds without unnecessary delays, please review, sign and return the enclosed agreement by Thursday, June 16th. We will duplicate a fully executed copy for your records. Thank you.

Sincerely yours,

George A. Zitnay
Commissioner

GAZ/lyl

MAINE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

AGREEMENT TO PURCHASE COMMUNITY MENTAL HEALTH SERVICES

THIS AGREEMENT, is made this _____ day of _____, 1977, by and between the State of Maine, Department of Mental Health and Corrections, hereinafter called "Department", and _____,

located at _____, _____, Maine _____,

telephone number _____ Employer Identification Number _____, hereinafter called "Provider", for the period from July 1, 1977 - December 31, 1977.

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and furnished by the Department, the Provider hereby agrees with the Department to furnish all qualified personnel, facilities and materials, and, in consultation with the Department, perform the services described in Rider A. The following Riders are hereby incorporated into this agreement by reference:

Rider A - Specification of Work to be Performed
Rider B - Method of Payment and Other Provisions
Addendum 1 - Licensing Regulations.

IN WITNESS WHEREOF, the Department and Provider, by their duly authorized representatives, have executed this agreement as of the day and year first above written.

DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

BY: _____

_____
(Typed Name and Title)

and

_____
(Provider Name)

BY: _____
(Authorized Signature)

_____
(Typed Name and Title)

Dollar Amount = $_____

RIDER A

Specifications of Services to be Provided

Program Description:

Providers agree to deliver or to assure the availability in their catchment area all services mandated by P.L. 94-63, in a manner consistent with definitions and goals of service presented in P.L. 94-63 and subsequent guidelines for Section 201 published by NIMH, to include:

- Inpatient Services
- Outpatient Services
- Partial Hospitalization
- 24-Hour Emergency Services
- Consultation and Education Services
- Services to Courts, Law Enforcement Agencies, and other components of the Criminal Justice System
- Special Services to Children
- Special Services to the Elderly
- Transitional or Half-Way House Programs
- Aftercare for former Psychiatric Inpatients
- Alcohol Abuse Treatment
- Drug Abuse Treatment

Childrens' Services shall be the responsibility of a formally designated, specialized unit within the Providers' organizational structure.

Goals of Services:

Goals of services shall conform to the Department's mission to improve the quality of life of the mentally disabled through a balanced service system.

Providers agree to develop an implementation plan leading to an accreditation survey and accreditation by the Accreditation Council for Psychiatric Facilities, Joint Commission on Accreditation of Hospitals. This plan shall include provisions for an initial self-survey. The plan shall be submitted to the Department by December 31, 1977, as part of an annual report. The plan shall also include program performance goals based on crisis stabilization, sustenance and growth.

Goals of Providers under this agreement shall include establishment of procedures for immediate provision of evaluation services to juvenile offenders referred to the Provider as established by P.L. 94-63.

Providers agree to have in place a quality assurance program which includes provision for utilization and professional standards review. Committees involved in the quality assurance program shall hold regular meetings of which minutes are kept.

Providers agree to implement an evaluation plan as required by P.L. 94-63, consistent with guidelines published by NIMH, and which shall include a component for treatment effectiveness evaluation. The plan shall specify

at least one cost-effectiveness criterion for each treatment modality.

Also, Providers agree to conform to provisions of 34 M.R.S.A. §2052-A and subsequent Departmental regulations in obtaining a license as a mental health facility as specified in Addendum 1 to this agreement.

Providers understand that they are required to provide the Department with monthly Maine Mental Health Information System (MEMHIS) Statistical Reports as required by the Department unless otherwise agreed upon by the Department in writing. The Provider will submit this information on all clients in de-identified form for all service categories to the Computer Services Unit, Department of Mental Health and Corrections, Augusta, where it should be received on or prior to the 15th day of each month.

Cost of Services:

Providers agree to submit to the Department by December 31, 1977, an annual report which encompasses:

1. An index of services.

2. Annual income and sources of funds by service.

3. Annual expenses by service and by category (e.g. personnel).

4. Activity report, including locations, personnel, and clients served for each major activity and a summary of all service areas.

5. Fee schedules, policies and funds generated.

6. A narrative report for each service area, suitable for updating the State Mental Health Plan. This report shall include a description of improvements and modifications in the functional areas of: services (in addition to what may be included above), administration, citizen participation, research and evaluation, and staff development. Include provisions made to measure and conserve energy.

RIDER B

1. Payments

The Department agrees to provide a total of $_____ to the Provider in two installments on or about the following dates in the following amounts:

$_____ July 15, 1977

$_____ October 15, 1977

This payment schedule is subject to the Provider's compliance with all items set forth in this contract and subject to the availability of funds.

Specific modifications regarding funding may be arranged by mutual agreement of parties to this contract.

2. Contract Administrator

All progress reports, correspondence, and related submissions from the Provider shall be submitted to:

L. Roger LaJeunesse
Director, Bureau of Mental Health
Department of Mental Health and Corrections
Room 411, State Office Building
Augusta, Maine 04333
Tel. 289-3167

who is designated as the Contract Administrator on behalf of the Department for this agreement, except where specified otherwise in this agreement.

3. Independent Capacity

The parties hereto agree that the Provider, and any agents and employees of the Provider, in the performance of this agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

4. Liability

The Provider shall keep in force a liability insurance policy issued by a company licensed to do business in this state which includes the area to be covered by this agreement and licensed by the State Insurance Department with adequate liability coverage to protect itself and the Department from injury or damage suits arising from any accident to any person occurring at the facility. Prior to or upon execution of this agreement, the Provider shall furnish the Department with written or xeroxed verification of the existence of such liability insurance policy.

5. Department's Representative

The Contract Administrator shall be the Department's representative during the period of this agreement. He has authority to stop the work if necessary to insure its proper execution. He shall certify to the Department when payments under the agreement are due and the amounts to be paid. He shall make decisions on all claims of the Provider, subject to the approval of the Commissioner of the Department.

RIDER B (cont'd)

6. Changes in the Work

The Department may order changes in the work, the contract sum being adjusted accordingly. All such orders and adjustments shall be in writing. Claims by the Provider for extra cost must be made in writing and signed by the Contract Administrator before executing the work involved.

7. Subcontracts

Unless provided for in this agreement, no agreement shall be made by the Provider with any other party for furnishing any of the work or services herein contracted for without the consent, guidance and approval of the Contract Administrator. Any subcontract hereunder entered into subsequent to the execution of the contract must be annotated "approved" by the Contract Administrator before it is reimbursable hereunder. This provision will not be taken as requiring the approval of contracts of employment between the Provider and his employees assigned for services thereunder.

8. Subletting, Assignment or Transfer

The Provider shall not sublet, sell, transfer, assign, or otherwise dispose of this agreement or any portion thereof, or of his right, title or interest therein, without written request to and written consent of the Contract Administrator, except to a bank. No subcontracts or transfer of agreement shall in any case release the Provider of his liability under this agreement.

9. Equal Employment Opportunity

During the performance of this agreement, the Provider agrees as follows:

a. The Provider will not discriminate against any employee or applicant for employment relating to this agreement because of race, color, religious creed, sex, national origin, ancestry, age or physical handicap, unless related to a bonafide occupational qualification. The Provider will take affirmative action to insure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age or national origin. Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Provider agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

b. The Provider will, in all solicitations or advertising for employees placed by or on behalf of the Provider relating to this agreement, state that all qualified applicants will receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age, or physical handicap.

c. The Provider will send to each labor union or representative of the workers with which he has a collective or bargaining agreement, or other contract or understanding, whereby he is furnished with labor for the performance of this contract, a notice, to be provided by the contracting agency, advising the said labor union or workers' representative of the Provider's commitment under this section and

shall post copies of the notice in conspicuous places available to employees and to applicants for employment.

d. The Provider will cause the foregoing provisions to be inserted in any subcontracts for any work covered by this agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials. The Provider, or any sub-contractor holding a contract directly under the Provider, shall, to the maximum feasible, list all suitable employment openings with the Maine Employment Security Commission. This provision shall not apply to employment openings which the Provider, or any sub-contractor holding a contract under the Provider, proposes to fill from within its own organization. Listing of such openings with the Employment Service Division of the Maine Employment Security Commission shall involve only the normal obligations which attach to such listings.

10. Warranty

The Provider warrants that it has not employed or written any company or person, other than a bonafide employee working solely for the Provider to solicit or secure this agreement, and that it has not paid, or agreed to pay any company or person, other than a bonafide employee working solely for the Provider, any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this agreement. For breach of violation of this warranty, the Department shall have the right to annul this agreement without liability or, in its discretion to deduct from the contract price or consideration, or otherwise recover the full amount of such fee, commission, percentage, brokerage fee, gifts, or contingent fee.

11. Analysis/Audit

The Provider understands and agrees that a formal analysis of the services provided under this agreement and/or a program audit may at any time during the contract period, or 3 years after termination, be performed by the Department.

12. Access to Records

The Provider shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to cost incurred under this agreement and to make such materials available at their offices at all reasonable times during the period of this agreement and for three years from the date of the expiration of this agreement, for inspection by the Department or any authorized representative of the State of Maine and copies thereof shall be furnished, if requested.

13. Termination

The performance of work under the agreement may be terminated by the Department in whole, or, from time to time, in part whenever for any reason the Contract Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Provider of a Notice of Termination specifying the extent to which performance of the work under the agreement is terminated and the date on which such termination becomes effective. The agreement shall be

equitably adjusted to compensate for such termination and the agreement modified accordingly. In any event, this agreement shall terminate on December 31, 1977.

14. Governmental Requirements

The Provider warrants and represents that all governmental ordinances, laws and regulations shall be complied with.

15. State Held Harmless

The Provider agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, subcontractors, materialmen, laborers and any other person, firm or corporation furnishing or supplying work, services, materials or supplies in connection with the performance of this agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Provider or in the performance of this agreement and against any liability, including costs and expenses, for violation of proprietary rights, copyrights, or rights of privacy, arising out of publication, translation, reproduction, delivery, performance, use or disposition of any data furnished under this agreement or based on any libelous or other unlawful matter contained in such data.

PROPOSAL TO CONSOLIDATE

AUGUSTA MENTAL HEALTH INSTITUTE

AND

BANGOR MENTAL HEALTH INSTITUTE

Department of Mental Health and Corrections
Room 411, State Office Building
Augusta, Maine 04333
Commissioner George A. Zitnay
May 10, 1977

OVERVIEW

HOW CAN THE MENTALLY ILL IN MAINE BEST BE HELPED?

The terms "institutional" and "community based" are often used as though they are opposites, the first bad and the second good. The term "institutional" can evoke these images: depersonalization, isolation, custodial care, and largeness. Any of these conditions can, however, be present in facilities located within the community. So-called "community alternatives" can be institutional if they depersonalize people and provide little more than custodial care. Conversely, state hospital services can be individualized and provide specialized treatment.

The Department of Mental Health and Corrections recognizes that institutional services and community services are not opposites, are both in need of improvement, and are both necessary for treatment of the mentally ill. In addition, the State hospital services and those in the community should be viewed as part of the same continuum of services for the mentally ill, these services should be mutually interdependent and part of a balanced system which is based on a continuing analysis of needs. Whenever one type of service is under utilized or over utilized, resources need to be shifted into another indicated type of service. The balanced system must be dynamic, constantly seeking to rebalance itself according to need.

Certain approaches need to be taken to accomplish a balanced integration of these services. Defined and shared responsibility for the patient and joint hospital and community planning are necessary, as well as having contracts specifying services with evaluation and monitoring mechanisms built in. State hospital services must, at the same time that improvement is occuring in the community, redefine themselves, improve individualized treatment and specialty of programs, as well as eliminating isolationism.

The Department believes that the guiding goals for mental health services should be as follows:

1. The Department of Mental Health and Corrections must strive toward a balanced system of service delivery which is responsive to the needs of people and which makes appropriate use of resources.

2. Services should be provided in the most appropriate and least restrictive environment. People should participate in treatment in their community if possible, and should not be discharged from a state institution until appropriate community services are available.

3. The capacity of the local community to treat, to tolerate, and to understand mental illness needs to be improved. This can be accomplished, in part, by providing sufficient resources for alternatives to hospitalization and community education and training programs.

4. The responsiveness of mental health services to citizens must be enhanced. Increased consumer participation, through the Mental Health Advisory Council for example, as well as changes in the referral process and access to services are some mechanisms that we are addressing.

5. The Department of Mental Health and Corrections feels that it must play a major role in determining the best management of its resources. Where appropriate, the Department of Mental Health and Corrections must make recommendations to the Legislature for public policy decisions regarding the use of resources.

6. Avoiding as much as possible the isolating effects and stigma often attached to treatment for mental illness.

Given then, the assumption by the Department of Mental Health and Corrections that both institutional and community service are necessary and that both are in need of improvement the question becomes -- How can a balanced system be accomplished? The number of patients in the two state hospitals, AMHI and BMHI, has fallen dramatically over the past decade:

	1966	1976	
AMHI	1604	341	79% decline
BMHI	1151	317	73% decline
Total	2755	658	

In addition, 75% of the Department's mental health financial resources are being spent on the two existing state institutions. These issues bring into question the need to sustain two major state institutions, both of which once contained several thousand people and now comprise only 600 to 700 people. Additionally, the current financial commitment is counter to a full range of treatment alternatives as well as counter to responsible utilization of resources.

An array of alternatives has been examined, including:

1. Continued operation of both istitutes with all services presently provided to continue. This was ruled out because of the reduced population in the two institutes, the high overhead cost of operating two large plants when the capacity of one could take care of the population now served by both, and, primarily, because it would do little or nothing to improve either institutional or community services for the mentally ill since resources are limited.

2. Transfer of all the patients now at BMHI to AMHI. This was rejected because it would be isolating for those people particularly from Aroostook County, it would require a significant build up of resources at AMHI and then phasing them down as community placements occurred, it would not provide for short term care in the Bangor area, it could have a negative impact on the elderly clients of the geriatrics unit upon transfer, and it would not provide for any real improvement in institutional services. Also, this move would preclude building on collaborative efforts at the University of Maine in Orono and the Eastern Maine Medical Center as well as possibly creating a severe future strain of mental health services. Though patient populations have declined, there is no guarantee that this will continue to happen. If we closed BMHI, any reversal for future need would be difficult if not impossible.

3. Transfer all of patients now at AMHI to BMHI. This was rejected because of the extensive renovations needed for the BMHI plant and because it is further away from the population center of the state. The present catchment area for AMHI covers 70% of the state's population. This, as in #2, would not provide resources for any significant improvement in mental health services.

4. Close BMHI and transfer all patients to AMHI and to community facilities. Again, the closing would make reversability difficult as well as negating the benefits to be derived from the Bangor community. It would also be stressful on family relationships, particularly on short term admissions, because of the increased travel distance.

5. Transfer some patients from BMHI to AMHI and to other community resources, while keeping BMHI open, but in a smaller more specialized capacity. This is the alternative that the Department of Mental Health and Corrections has chosen. Patient care can be improved at BMHI through a Resource Center with a specialty geriatrics unit for the older emotionally disturbed person and through a specialty program for the severely emotional disturbed person with autistic characteristics (withdrawn, non-verbal, generally low developmental skills). In addition, an inpatient unit, which is currently D-1, can be maintained for short term admissions so that people will not have to travel to Augusta. The money that can be saved through reduced overhead costs and through reduced renovation needs can then be reallocated to improve community resources, such as increased inpatient services in the Aroostook County area and transitional living facilities.

Based on alternative #5, patient movement would look approximately like this (patient census changes daily):

Currently: May, 1977

	Population
AMHI	326
BMHI	301
Total	627

As projected:

	To Remain at BMHI
BMHI - 301 Total --	100 geriatrics unit
	12 autistic unit
	20 short-term in patient
	132

This leaves 169 people to be transferred to AMHI or to be discharged to community alternatives. Staffing plans for AMHI provide for 4 psychiatric teams at about 34 patients per team for total provisions for 136 patients. This would mean that the planned drop in population for the institutions would only be 33.

In summary, we intend to accomplish the continuing specialization of institutional programs in tandem with an expansion and improvement in community services to create a balanced service system. The Department of Mental Health and Corrections recommends to the Legislature, through L.D. 1330, a policy of systematic formal reallocation of some public resources from our state hospital system to comprehensive, area based services to be developed or expanded throughout the state. We clearly recognize that community services need to be restructured and that the penalties of failure are as potentially grim as the images of institutional isolation and custodial care.

The following section details the major factors that the Department of Mental Health and Corrections has explored in its preliminary planning for the preparation of L.D. 1330. It is recognized that more in-depth information and planning will need to be pursued if L.D. 1330 is approved.

L.D. 1330 Report - Patients

Following are the primary areas that have been identified in relation to patient issues:

1. Patient profile: Who is treated in institutions and who is treated elsewhere? What types of information need to be obtained re patients?

2. Patient Rights: How can these best be guarded in any changes and what guiding principles should be established? How can patients be involved in the process?

3. Family/significant others: What impact will any change have on families? How can this be assessed? What are the best methods for keeping people informed of any changes? And when? And how?

4. Admissions: Who is admitted to the state institutes and how? Who is admitted to community inpatient units and how? What are the factors contributing to admission?

5. Transfer process: How can this occur as smoothly as possible? What guidelines should be established? Timeframes? How can staff, patients, and families be involved?

6. Catchment areas: What are these for BMHI and AMHI? Does this method of unit assignment continue to be feasible?

7. Impact on Court System: How will any change affect particularly the District Court? Can this result in an undue burden on the Kennebec District Court? What legislation has been, or will be, presented this session that relates to this issue?

8. Community services: What are they? Where? How much do they cost and of what quality? How can appropriate community services be assured for all patients? What needs to be expanded or changed?

9. Patient records: The records kept at BMHI and AMHI are not in the same format or same system. How can they be integrated? What mechanisms need to be established during a transfer process to insure against loss, confusion, and misunderstanding?

10. Discharge process: What criteria should be established? What should be expected of the institutes and of community services? How can discharge be better coordinated with the Utilization Review Committee?

11. Program/Treatment Activities: If a transfer does occur, how can at least equal programming be provided? What types of activities are needed at AMHI? Will any gaps be created if BMHI is restructured?

The preceding issues have been viewed in light of: (a) the best patient treatment possible, (b) relationship to elements that interact with the mental health institutes, (c) recommendations that can be made now, and (d) issues that need further exploration if L.D. 1330 passes. In addition studies done in other states have been examined and incorporated into the planning process where appropriate.

Patient Profile: The need for patient profile information is important in the planning process and should be looked at in detail if L.D. 1330 passes. Some areas of concern include:

a. Degree of family involvement: What are family expectations for treatment and placement? How frequently do they visit and what are constraints for this? What will be the stress of disruption if the family member is transferred to AMHI?

b. Type of commitment: Is this a District or Superior Court commitment or voluntary? This information is needed to assess the impact of any shift on the Court system.

c. Program needs: What is the patient currently receiving? Is the patient involved in some type of specialty programming? This needs to be assessed to assure at least equal programming as a result of any change.

d. Level of personal care: How well is the person able to care for himself? Does this person require staff assistance?

e. Degree of supervision: Does this person need staff time for supervision because of personal care requirements or behavioral characteristics? Is security a factor?

f. Behavioral/psychiatric characteristics: Is psychotic behavior extensive? What is this person apt to do?

g. Relevance of the catchment area: Does this person still have meaningful community ties? It is recognized that even if a person does not have family or visitors, a return to one's community can be beneficial and should not be ruled out on the basis of lack of relationships.

h. Environmental needs: Aids for ambulation or unsteadiness, security, and supervision as well as sleeping and living space should be known.

i. Potential for return to the community: What type of living and program arrangements are most appropriate and within what time frames?

*Attachment A is a copy of the survey done by Dr. Jacobsohn to find preliminary information, as well as two surveys done by BMHI staff. It is felt that although patient populations may change daily, a point in time survey will provide general fund information sufficient for planning. Please note that these surveys and the patient profile are only intended for generalized program planning needs not to determine or assess individual client needs.

Also, patients have been surveyed by the Department of Human Services re: appropriate placements so that there is a general idea of people who might be appropriate for some type of nursing home or boarding home placement according to the Department of Human Services' regulations and guidelines.

*See material in supplementary package

Patient Rights

It is felt that full access to accurate information on the situation must be provided to all patients and must be provided in a concrete and honest form. If L.D. 1330 passes, the two institutes with the advice of the patient advocates must develop methods for doing so. The patients should participate, to the degree that they are able, in the decision-making process re: transfer to community placement and their preferences must be given meaningful consideration.

The following principles are recommended as the basic guidelines for the transfer process:

a. Patients have the right to be involved in the development and operation of their treatment programs to the maximum extent possible.

b. Patients have the right to be involved in decision-making and to be fully informed of treatment decisions affecting them.

c. Patients have a right to continuity of treatment upon transfer to other facilities. This necessitates early prior identification of patients to be transferred and informational meetings between proposed and current staff.

d. Patients have the right to continuing interest and involvement of their family, community, and other significant persons. Information needs to be shared with sufficient time for discussion.

e. Patients have the right to confidentiality of their records. Provision for security of records upon transfer as well as the problem of reviewing of records by nonessential persons.

f. Involuntary patients have the right to the least restrictive appropriate treatment. There may need to be provision for judicial review for involuntary patients objecting to transfer and for assurance that the individual treatment plan can be fulfilled upon transfer.

g. Voluntary patients retain all civil rights, including the right to leave at any time (34 MRSA Sec. 2290). This can become a problem area for "pseudo" voluntary patients who should not be allowed to leave but for whom no court action has been initiated. Sufficient pre-planning should occur so that these people can be referred to the District Court for its decision.

h. The transfer of patient funds and accounting procedures must be done with utmost care. Patients have a right to have their funds handled responsively.

Family/Significant Others

Information packages must be provided to families re: the process of transfer, how it affects their relative and ways that they can share feedback, questions and preferences. Guardians need to be carefully identified and involved in the move of any of their wards.

Patient profile information can be helpful in assessing the impact of increased travel distance and provisions should be made to assist families with transportation difficulties to the extent possible. Volunteer car-pooling arrangements as well as information about existing public transportation should be reviewed. Additionally, an Open House might be provided at AMHI on one or two days so that families and friends could visit, as well as individual family conferences with key treatment personnel.

Admissions

A timetable for the shifting of admissions from BMHI to AMHI needs to be developed and should be done in close conjunction with referral sources such as the community mental health centers, the courts, the police, and the correctional institutions. The constraints and strengths of community inpatient units must be reviewed with the goal of accepting involuntary as well as voluntary admissions. A short-term inpatient unit will be maintained at BMHI and the inpatient capabilities of the Aroostook Mental Health Center will be expanded to reduce the necessity of admission to AMHI. Contributing factors to admission, such as lack of community services will be assessed for long-term planning needs to develop a balanced service system.

Transfer Process

The following criteria and mechanisms for transfer are recommended:

a. Staff should discuss with patients, on an individual basis, their transfer options and give sufficient opportunity for patient input to have meaningful consideration.

b. Patients should be offered trips to AMHI prior to transfer, as well as to community facilities.

c. Key treatment personnel at AMHI and BMHI should meet to discuss the treatment needs of individual patients.

d. The patient should have the opportunity to meet with key treatment personnel prior to transfer.

e. The number of people looking at patient records should be kept to a minimum to insure confidentiality.

f. The treatment plan established at BMHI should be kept in effect unless key treatment personnel revise it.

g. BMHI staff need instruction on how to respond if the voluntary patient who refuses transfer to AMHI, as well as refusing BMHI discharge.

h. The need for careful, close, and regular communication and planning with the police, courts, and correctional institutions during the transition.

Catchment Areas

BMHI serves the catchment area as defined by The Counseling Center of Bangor and the Aroostook Mental Health Center. AMHI serves the catchment areas as defined by Kennebec Valley Mental Health Center, the Tri-County Mental Health Center, the Maine Medical Center, MHC, York County Community Services, Bath/Brunswick Mental Health Center, and the MId Coast Mental Health Center in the Belfast and Rockland area. AMHI generally assigns people being admitted to the Institute on the basis of geographic catchment area. Thus, the hospital is organized by teams responding to catchment areas. The feasibility and therapeutic value of this method should be reviewed as the need for specialty programs becomes more apparent. It may be appropriate to shift from geographic area to assignment by program need if specialty programs continue to develop.

Impact on Court System:

Some of these issues are addressed in sections on patient rights and transfer process. There has been legislation introduced during this legislative session that could affect this and it needs to be closely monitored. Also, the District Court involvement in involuntary commitment determination needs to be studied for potential bottlenecks created by a transfer of patients. It is estimated that approximately 1/3 of the patients, at any one time, are on involuntary status

Community Services

The following issues must be considered:

a. There is a need for community education regarding the needs of psychiatric patients, particularly for boarding and nursing home staff as well as local physicians.

b. Any transfer or movement of patients must be done carefully so as not to overload the aftercare system.

c. There are two issues to be addressed:

   The pre-existing problems of aftercare and the potential problems posed by implementation of L.D. 1330, such as the increase in the travel time of aftercare workers, the impact on Kennebec Valley Mental Health Center, The Counseling Center, and on Aroostook Mental Health Center. The Department of Mental Health & Corrections is examining ways to equalize statewide the payments for aftercare and to insure that money accompanies any significant increase in the aftercare caseload for a catchment area.

d. The need for a variety of day programs and respite are resources that <u>should</u> precede client placement.

Patient Records

A study committee of BMHI and AMHI personnel, particularly medical records staff, will be established to review record systems and recommend changes for congruence.

Discharge Process

The discharge process must consider the appropriateness and availability of community resources. In addition, for those people being referred to other services or other residential facilities, there must be a written treatment plan and recommendations for future programming. If placed in a boarding or nusing home there must be an assessment of the home's capability to provide treatment. The patient, family, and community services should all be involved in the discharge palnning process.

Program/Treatment Activities

There are problems in gathering data on therapy and other program activities at BMHI since these are not regularly recorded in institute-wide summary form as they are at AMHI. Since the Department intends to provide at least equal programming for anyone transferred from BMHI to AMHI, several methods for obtaining general planning data are suggested:

a. Apply percentage of programming time currently at AMHI to the number of those estimated to be transferred.

b. Compare actual wards at BMHI and AMHI.

c. Have clinicians do hypothetical treatment plans for a typical group of BMHI patients and compare this percentage of programming to AMHI.

It must be noted that these methods are not intended for the designation of individual programs but to gather overview information on the scope of activities that need to be available at AMHI.

STAFF ISSUES

Initial research and planning investigated a broad range of issues and identified the following questions to be explored by the Department and/or addressed in the planning process at a later date.

1. Relocation What can and should be done for employees being dislocated?

2. Retraining What are the retraining needs of the employees, and how can the Department assist in identifying and meeting these needs?

3. Recruitment What role can the Department play in attracting quality professional and direct care staff?

4. Economic Impact How can the Department minimize the economic burden on the area and financial injury to individual employees?

5. Patient Impact How can the Department minimize the chance of patients suffering due to demoralized staff?

6. Legislation Is the transitional language outlined in L.D. 1330 adequate to protect the rights of employees and provide adequate coverage to provide good patient care?

7. Administration What administrative steps are necessary to accomplish a smooth transition in accordance with L.D. 1330 and existing Personnel Rules and Law?

8. Employee Organizations What role should the various employee organizations play to assist in the planning and implementation of the phasedown?

In general, these questions were considered in light of identifying a. appropriate authority and responsibility, b. necessary administrative steps or action, and c. adequate resources to accomplish the necessary steps. The Department researched the various issues, contacted as many concerned agencies as possible and reported to the subgroup. Although time constraints made this process informal at times, the issues outlined above were addressed and the following information and/or recommendations are offered.

1. Relocation Research into the closing and/or phase-down of state hospitals in other states indicated that:

   a. Assistance in relocating was a key factor in making the transition a smooth one for employees.

   b. The agency with authority for the hospital generally restricted relocation assistance to employees who transferred within the agency.

   c. Relocation assistance generally consisted of informational rather than financial resources. (i.e. contact with job opportunities, real estate brokers, etc. rather than cash moving allowances)

   d. The possibility of having to relocate was a key source of anxiety for staff regardless of the level.

Research into existing policies and precedents on this issue in Maine indicated:

a. No information exists at present which would allow an in-depth assessment of BMHI employee relocation needs (i.e. size of family, occupation of spouse, homeowner or not, etc.)

b. Department of Finance and Administration policies permit the assumption of relocation expenses only under restricted circumstances.

c. Precedent in closing other departmental institutions (SS/WCC at Hallowell and WCC at Skowhegan) did not permit assumption of moving expenses or special travel allowance, except as provided within existing policy and practice.

d. Practice in state government as a whole has generally been to restrict moving expenses reimbursement to individuals in high administrative positions "with unique qualifications that would substantially benefit the state."

e. Approximately 200 employment opportunities would be available at Augusta to BMHI employees. Assuming that the Department could find 200 BMHI employees willing to relocate, additional costs could be anticipated as follows

- at $500 - $1,000 per employee (estimated, based on research with moving companies in the area) an additional maximum of $100,00 - $200,000 would be needed in the first year.
- at 13¢ per mile, travel allowance (for those unable to relocate before their job at Augusta might begin) for a period of 2 weeks to 1 month require an additional maximum of $39,000 - $78,000 in the first year.

f. Concern was felt that if a relocation package included reimbursement as indicated in e., precedent would be established for any state positions to be transferred in the future and that grievances might be filed from positions transferred in the past.

g. Relocation cost reimbursement in any case should be a matter of administrative policy rather than statute.

h. The following information should be made available to all BMHI employees who might consider transfer:

- Schools: number, location, registration procedures. This could be put together by the school system and distributed by the Department
- Churches: number, location, denominations.
- Housing: kinds available, etc.
- Shopping
- Recreation
- Banks
- Transportation access

The Augusta Chamber of Commerce has put together a fairly comprehensive package that includes much of this information.

i. BMHI employees should also have detailed information on the following to assist them in making decisions about transferring or relocating: (see #7 Administration for more detail)

- re-employment opportunities within the Department of MH&C, with the MMHI, and in state government in general.
- benefits as a state employee (retirement, lay-off rights, etc.)
- unemployment benefits
- job opportunities outside of state government

j. Special attention should be paid to handling unusual or rare cases wherein the employee might suffer unduly. (i.e. a person who could retire with full benefits if his or her particular lay-off notice were deferred a few weeks or months, a couple needing to transfer together, etc.)

2. Retraining Research into closing hospitals in other states indicated that retraining was generally only considered within the jurisdiction of the agency closing the hospital. (i.e. opportunities for training within the mental health agency)

Research into this issue in Maine indicated the following:

a. There is little or no information in existence which details the retraining needs of BMHI employees as related to the phasedown

b. AMHI employees should also be considered for retraining opportunities made available.

c. BMHI staff proposals for training (particularly of paraprofessionals) have not been funded in the recent past, and there is a considerable amount of anxiety that re-training needs connected with the phasedown would be neither identified nor met.

d. Retraining should be incorporated in the budget, particularly in that the units opening in Augusta would provide limited opportunity for on-the-job training/retraining.

3. Recruitment: Discussions in this area concerned methods of attracting quality professional and paraprofessional staff to the MMHI. Problems identified were as follows:

a. lack of flexibility in the Personnel Law and Rules (i.e. it is impossible to add extra benefits, etc.)

b. limited cultural, educational and other attractions in the Augusta area.

It was felt that these issues were not within the purvue of the Department of Mental Health and Corrections, and that it was unlikely that change could be effected. It was felt that recruitment of quality staff could best be achieved by making MMHI a better place to work - i.e. building innovative programs, etc.

Literature on the closing of hospitals in other states did not address this issue.

4. Economic Impact Research on hospital closing in other states indicated:

   a. Hospitals being phased out or closed were often a major employer in the area

   b. While groups of citizens and businessmen would frequently lobby on the basis of a detrimental economic impact, in fact such area-wide impact tended to be short-term and insignificant.

   c. Converting the hospital to another use tended to lessen economic impact on the area as well as individuals

   d. Phasing down the hospital over a period of time (12-24 months) tended also to reduce detrimental impact.

   e. The heaviest economic or financial burden tended to be at the individual level on the mental health paraprofessional with few transferrable skills.

   f. Several states recommended special planning groups to deal with this issue.

Research on this issue in Maine indicates:

   a. BMHI is one of the major employers in the Bangor Area.

   b. There are a variety of public and private groups in the Bangor area which could be utilized to assist in the planning of the phase-down so as to minimize the financial hardship on individuals, groups, and businesses. (see #7 Administration for detail)

   c. BMHI currently employs 476 persons. The proposed Resource Center would employ 172 persons, and employment opportunities at the Augusta Campus of the MMHI would number approximately 208, leaving approximately 96 persons to assist in obtaining re-employment over the phasedown period (approximately 1 year). Attrition at BMHI is now running about 26% on an annual basis, so about 123 persons could be expected to leave over the phasedown period. Since this is greater than the 96 surplus noted above, it is anticipated that established procedures and phased planning can accomodate the majority of problems.

   d. Special care should be taken to involve all necessary and/or affected groups in the early stages of planning (once the L.D. has passed)

   e. The phasedown should happen over a period of time

5. Patient Impact Research into the effects of staff morale on patients in situations where hospitals were being phased down or closed indicated:

   a. Patient care does suffer when staff become demoralized, depressed etc.
   b. Staff can go through a pattern of initial anxiety, then denial, then depression which lowers morale and affects employee's attitudes toward's their jobs, but this can be alleviated to a great degree by good planning and communication on the part of the administration.

Research into the implications here in Maine indicate:

a. Staff anxiety at BMHI is at a high level, largely due to a combination of several factors
   - several changes in departmental leadership, creating uncertainty
   - lengthy discussion in the public media of the various alternative plans - over a period of two or three years
   - inconsistent information on the entire issue over a period of time

b. The need to have consistent and accurate information at all staff levels throughout the entire process cannot be overemphasized. (see #7, Administration for more detail)

6. Legislation Research into how other states dealt with the personnel issue indicated much inconsistency. Some of the larger states were able to guarantee all displaced employees a job opportunity. Others delayed phasedown until such time as other major programs were being opened, thus virtually assuring jobs.

Policy, practice, and preceding legislation in Maine indicate the following when taken in conjunction with L.D. 1330:

a. The commissioner of Mental Health and Correction must designate staff to provide patient care at the Bangor campus during the transitional period (about 10-1-77 to a maximum of 6-30-78)

b. Special preference is allowed BMHI employees in applying for positions at MMHI. This should be amended to include all Departmental positions, to make the provision comparable with past law (i.e. preference allowed employees laid off from SS/WCC).

c. Existing Personnel Law and Rules are sufficient to guarantee fair treatment and location of staff insofaras possible, provided certain administrative steps are taken (see #7 Administration, for more detail)

d. Maine is not in a position to guarantee state jobs to all who might be displaced.

e. The BMHI Campus, after the effective date of the Act, becomes a sub-set of MMHI under one superintendent (the superintendent of AMHI)

7. Administration As indicated above, proper administration of the phasedown process was key, in many states, to a smooth transition for employees Particularly:

a. Establishment of on-going channels of communication about transfer schedules

b. Determination of employee needs in the areas of relocation, retraining, and job preference

c. Monitoring of state personnel hiring procedures to assure adequate protection of special preferences

d. The establishment of a special group to coordinate staff transfers and lay-offs with patient and resource transfers

e. The establishment of a procedure to identify unusual problems for individuals displaced

f. The removal of top officials or administrators with vested interests from the phase-down process

g. Involvement of community economic development organizations

h. Involvement of employee organizations in the process of planning implementation procedures

The above information leads to the recommendation of several administrative procedures for Maine, taken in conjunction with the requirements of L.D. 1330

a. Administer a detailed staff survey to all BMHI employees to determine their needs. The Subgroup designed a survey but it was decided not to administer it until after the bill was passed.

b. Survey AMHI staff to determine their training needs and to assist in developing an operational policy for hiring onto the new units. This survey needs to be designed

c. Compile seniority lists for BMHI employees for all classes and individuals

d. After gubernational permission is obtained to provide programs on the BMHI Campus, establish positions to operate the programs

e. Before the effective date of the Act (about 10-1-77), the Commissioner must designate staff to operate transitional programs at the BMHI Campus. This must be done in coordination with d. above.

f. As soon as possible after the bill is passed and programs are finalized, employees should be given the information on relocation, re-employment opportunities, and employee benefits. This should happen in small groups with representatives from the Departments of Personnel, Mental Health and Corrections, Employee Relations, and Retirement.

g. Provide Career Counseling through Manpower Affairs on an on-going basis throughout the transition process (i.e. an office established on the Bangor Campus)

h. Build retraining programs based on needs identified in the survey and coordinated with departmental needs

i. Establish a group to build transfer and/or lay-off schedules based on patient and resources transfer. This group should consist of business, program, and personnel staff.

j. Provide BMHI employees on-going access to and assistance in applying for state positions. This should be done by an on-site personnel technician.

k. Employee organization officials should be informed in all stages of the planning process.

l. Establish a group consisting of representatives of the Economic Planning and Analysis Division of the SPO, Manpower Affairs, Eastern Maine Development District, and other development groups to plan means of assisting the Bangor area in absorbing any economic impact. Primary responsibility for this planning should be outside of the Department of Mental Health and Corrections.

8. Employee Organizations Research into the role of employee organizations in other states indicated two basic types of involvement:

a. Total involvement in the planning process, as active participants

b. Involvement in the planning process as review agents, or reactive participants

Since Maine's institutions are represented by a variety of organizations, and since the recent stages of planning were simultaneous with collective bargaining elections, the subgroup felt that the employee organization should be included in the review process for the current plan. At such time as the bill is passed and the phasedown implementation begins, the appropriate employee organizations will be involved in the details of planning.

Material on the phasedown and/or closing of hospitals across the country and in Canada and available on file in the Central Office of the Department of Mental Health and Corrections.

RESOURCES

The area of "resources" includes all those considerations related to the need and utilization of facilities and the funds required for the mental health system, if there is to be a change to one Maine Mental Health Institute. The issues addressed fall within three broad categories: (1) program, (2) identification of facility and financial needs to realize the program plan, (3) development of community services.

As has been described in the overview, after careful consideration of alternatives for consolidation of programs in the two institutions, the Department is recommending that the programs for patient care on the Bangor campus become more specialized in their treatment of the elderly mentally ill and the seriously emotionally disturbed young adult and that psychiatric patients presently in BMHI programs be transferred to AMHI and to other community resources as appropriate. In addition, it is proposed that the current D-1 unit, an inpatient unit for acute and emergency psychiatric care maintained by the Bangor Counseling Center in a joint-venture relationship with BMHI, remain in its present facility for the first year of the transition process.

A full description of the Resource Center and a more detailed discussion of the mental health programs at the Resource Center are presented in another section of this plan.

The largest task for the establishment of resource needs and priorities was the identification of facility and financial needs to realize the program plan. The issues considered are:

a. Renovation costs for program changes:

    1. Costs for AMHI to receive psychiatric teams,
    2. Costs for alternative utilization of the Bangor campus.

B. Personnel, support service and all other costs for proposed programs,

C. Transitional fund requirements:

    1. Unemployment
    2. Training/retraining of staff employed in other Departmental positions
    3. Costs for double teaming during the transfer of patients
    4. Costs for actual movement of patients.

Decisions concerning these issues are reflected in the budget, which is presented in a budget section. The most effort was spent in exploring all possible alternatives for placement of patients and programs within the Bangor building complex. After careful consideration of these alternatives, it was decided that the Pooler Pavilion provided the best patient environment for an on-going program in gerontology and autism, and was also the most realistic alternative from the financial standpoint.

Further attention was given to the consequences of vacating the main building on maintaining the D-1 unit, which currently depends on the programs in K building for back-up staffing. It was determined that D-1 would be able to provide inpatient services for both voluntary and involuntary patients during the first year of transition if the psychiatric teams in the K building were the last to be phased out. During this year the Counseling Center is to seek alternatives for its inpatient unit. (Complete documentation of task force subgroup

discussions and of reports generated from research are available in the secondary materials packet.)

The time-sequence process for the utilization of resources is presented on a chart at the end of this section and needs no further elaboration.

Community services was the third major area of concern in the resources area. What community facilities or services would be immediately needed in the Aroostook and Bangor areas in order to offset the impact of moving psychiatric patients to Augusta? Proposals from both the Aroostook Mental Health Center and the Counseling Center were reviewed. It is recommended on the basis of determination of most immediate and prioritized need that the Aroostook Mental Health Center receive up to $300,000 for the establishment of a structured living rehabilitation program in the County. It is also recommended that the Counseling Center receive $50,000 (in addition to the support to D-1 in the joint venture) for the development of a half-way house in the Bangor area.

The allocation of these funds to the counseling centers will be carried out through special service contract mechanisms which the Department is currently developing, and which will allow the Department close monitoring and evaluation capabilities.

Resource Center

Introduction

As an alternative to the complete closing down of the Bangor Mental Health Institute, the Department of Mental Health and Corrections is proposing to reorient the Bangor campus toward the establishment of an active community service center, allowing for maximum utilization of the current facility.

This plan is primarily concerned with the mental health component of this Resource Center. The Department of Mental Health and Corrections is proposing two other components to be part of this resource center: a corrections component including the existing pre-release center which is on the grounds of BMHI, and a mental retardation component which can include the Levinson Center and a regional mental retardation office. A Regional Government Center is also being planned which will include offices of several state agencies and functions. Community agencies will be invited to utilize the facility to provide for day care and day services in educational and vocational areas.

The following section describes the programs which the Department of Mental Health and Corrections is proposing for the provision of mental health services within the resource center setting.

One of the important aspects of moving from an organizational structure with two institutions developing their own independent, and often duplicative, programs to one institution with a resource center on a satelite campus is that the various programs in the unified organizational framework can compliment and support each other. Especially important is the ability of the combined campuses to share costly specialized staff. The Resource Center concept promotes the concept of better utilization of staff across programs and between campuses and the ability to share staff with other components in the total resource center complex. This capability is an important part of the development of the programs that are described.

Psychogerontology Program

The psychogerontology program envisioned at the Bangor Resource Center would provide services to meet the treatment needs of the elderly mentally ill and would serve the entire State of Maine with respect to public psychiatric inpatient programs serving this type of population.

This program would provide a variety of direct services to patients; would have the capability of providing both medical and psychiatric treatment programs for each patient who could benefit from such programs; and would have the capability of evaluation for placements of patients when they would be ready to leave these programs and for follow-up in aftercare services.

The Jacobsohn Survey of patients in the Program on Aging at BMHI (January 1977) indicated that approximately 100 of the 150 patients show a need for a specialized unit which would address itself directly and more intensively to the psychiatric problems that presently exist with this population. There is a further emphasis throughout the entire mental health system on the complex problems of the aging, resulting from a realization on the national as well as the state level that our knowledge and resources for this important and growing segment of our population are seriously inadequate.

The establishment of this psychogerontology unit would begin to meet the needs of these clients. As the program develops and current clients are rehabilitated to a point where they can function in the community, the decrease in population will allow a change in the mixture of the staff to a degree that specialists in gerontology can become part of the treatment team. As the evolution of the unit continues, a Center for Gerontology with complete treatment, research, training, and outreach capabilities can be established. It is envisioned that the complete program addressing neurologic and organic problems of the aged -- developed during a period of up to five years -- would consist of several elements:

1. a diagnostic unit,
2. a behavioral therapy inpatient unit,
3. a day care capability to provide added services for residents of the Bangor area,
4. a transitional living or group home living facility or facilities,
5. an outreach aftercare component,
6. a teaching-education-training-research and evaluation capacity,
7. a capacity for providing respite care for short-term placement of persons who are being cared for by their families.

The staff of the Bangor Mental Health Institute has developed an initial proposal that outlines a program to meet the treatment needs of the elderly mentally ill. This proposal emphasizes that once fully established, the program could be used not only as a resource within the mental health institute and the extended mental health system (e.g., for community mental health centers), but could become an important resource to elderly individuals being cared for in a variety of other settings, such as nursing homes, boarding homes, and other locations throughout the state.

At the point of full development, the Center for Gerontology would not only concentrate its efforts on difficult clients within the program, but would have extensive research and evaluation capabilities, and could offer inservice training for those working in the social, psychiatric, and medical areas of geriatric treatment as well as those involved in direct service delivery.

Program Plan -- First Year

The Psychogerontology Program would be located in the Pooler Pavilion, where the current BMHI Program on Aging (geriatric population) is located. This building, after renovation to create smaller more private living units for its residents, would have approximately 8 ward areas with 14 beds per ward, for a total of 112 available beds. It is planned that 7 of these ward areas would be set aside for the geriatric population with the remaining ward area being used for the autistic program. It is envisoned that there will be an average daily attendance in the psychogerontology program of approximately 100 patients.

Since the Department of Mental Health and Corrections has to live within its established budget and still meet the needs of its population, a long-term program must be contemplated. Therefore, development of this unit during the first year will focus on certain new programs which are seen as having highest priority for meeting the needs of the existing population, with the full design of the program being realized in the following years.

The nature and full treatment requirements of the population to remain in the Resource Center Psychogerontology Program cannot be established until after a patient survey (which is outlined elsewhere in this plan) and the determination of ability to place patients in alternative care environments. However, current knowledge of the existing population suggests that at least one-half of the average daily attendance of patients will require more direct psychiatric program plans and more intensive psychiatric and psycho-social treatment approaches and assistance. Another part of the population indicates the potential need for a special diagnostic unit designed to evaluate patients who have not only presenting psychiatric symptomatology but also have physical problems which call for alternative treatment program plans. The ability to develop an optimally functioning Center for Gerontology will be dependant on close working relationships with the psychiatric, health and educational communities of the Bangor area. The program could be further enhanced by the capability of sharing staff within the Maine Mental Health Institute, i.e., certain specialized staff serving programs on the Augusta campus also being involved in this program at the Resource Center.

Autistic Program

The so-called autistic population is probably the least understood and most neglected group of multiply disturbed persons in our society. Specialists cannot even agree on a definition and description of the characteristics of this population. Currently, autistic people are, for the most part, either excluded or denied services or placed in inappropriate programs.

For purposes of this proposal, the population for this program is described as the most seriously emotionally disturbed(withdrawn, non-verbal, generally low developmental skills)young adults -- age 21 and over. The existing program on autism at BMHI -- with 11 residents -- is designed to treat individuals whose behavioral disorder has been present since before the second or third year of life and who have remained institutionalized and essentially untreated. Many are properly diagnosed autistic or childhood schizophrenic, even though their average age is about 23.

This Resource Center program will serve up to 12 clients and be relocated in Pooler Pavillion. It will provide an important link in the Department's attempt to develop more comprehensive services for this group of individuals on a statewide basis, lending support to the already existing units at the Maine Medical Center in Portland and at Pineland Center, and to a proposed unit in Augusta (proposal submitted to the Federal government for funding by Augusta Mental Health Institute). It is felt that the potential to draw from the shared staff within the Maine Mental Health Institute and the larger Resource Center--specifically from staff in the Mental Retardation component--will significantly enrich the autistic program, and allow it to develop further in the area of outreach as well as direct treatment. This program is viewed as needing the most intensive research, treatment and outreach knowledge available in order to bring these young adults to the point where they can be returned to and maintained in their families and communities, rather than permanently institutionalized.

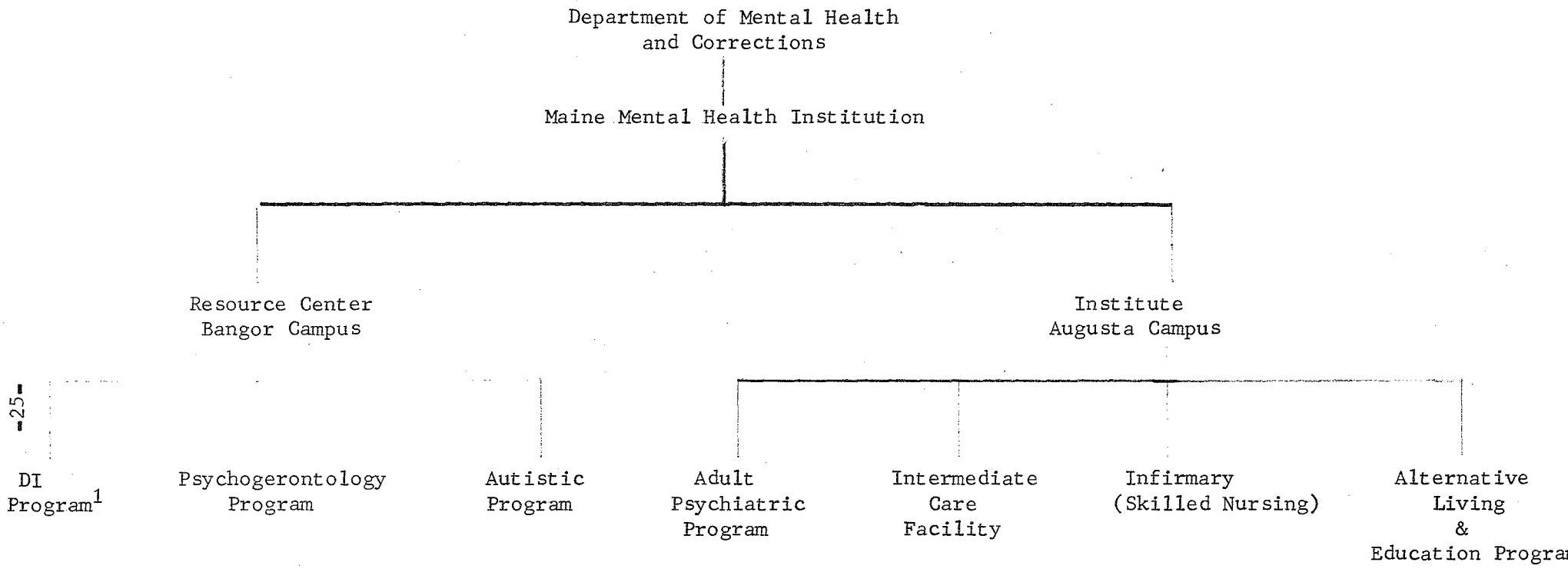
D-1

D-1 is an inpatient unit of the Counseling Center for both voluntary and involuntary acute and emergency psychiatric patients. It has been operated at Bangor Mental Health Institute as part of a joint venture. Currently the Counseling Center provides all the staff for this unit, and BMHI provides support functions such as the building, utilities, laboratory, pharmacy, etc. BMHI has also provided support backup staff on occasions when the D-1 staff needed emergency assistance in dealing with especially difficult patients.

During the first year after the establishment of a Maine Mental Health Institute, the Department proposes that the joint venture be continued. D-1 will continue to serve both voluntary and involuntary patients, and will continue to receive support services during the transition period from the current population at BMHI to the Resource Center programs. Back-up staffing will be available from the K building programs, which will be the last to be phased out.

The Department will work with the Counseling Center during this period in planning for the establishment of alternative facility resources for this inpatient unit.

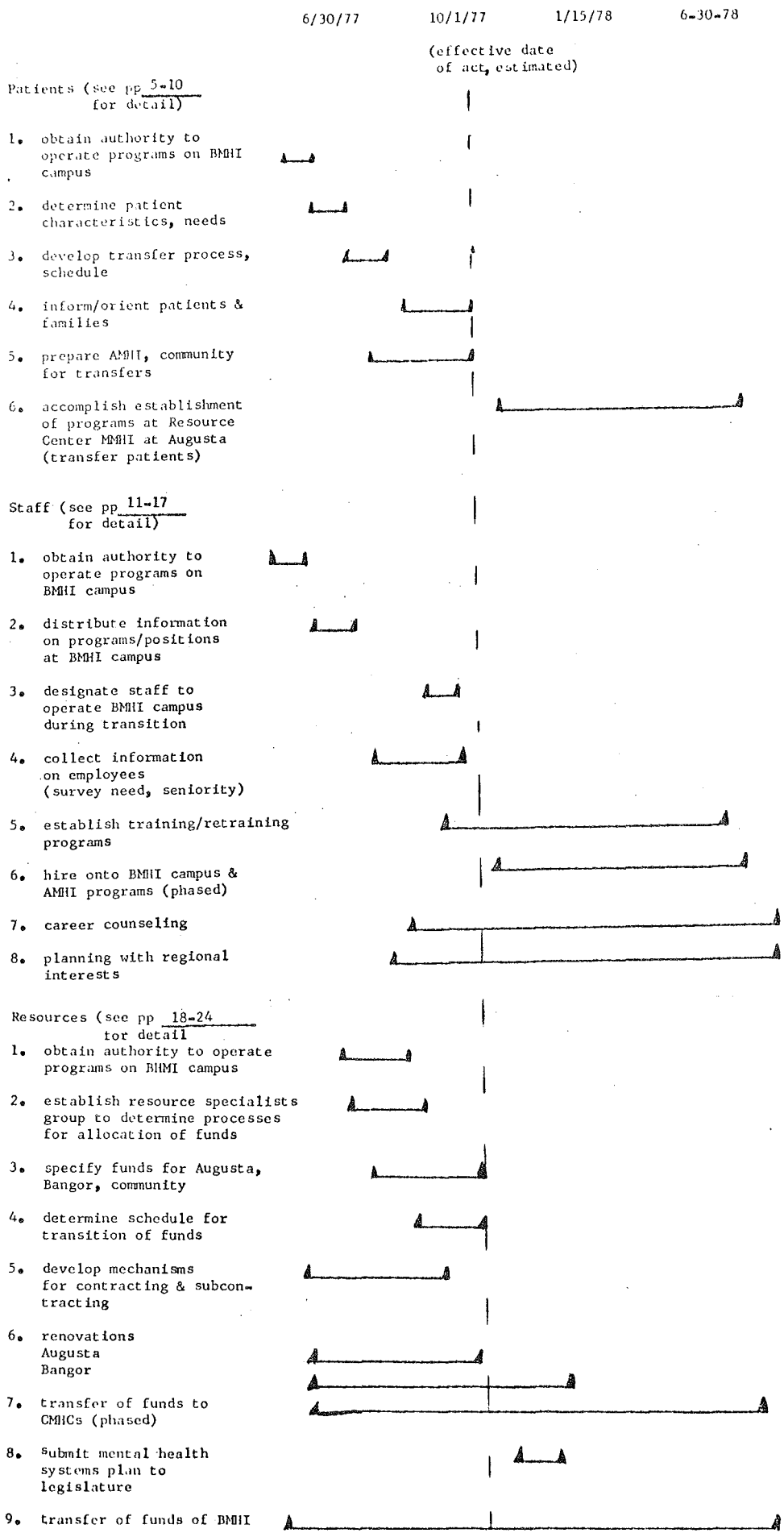
PROGRAM ORGANIZATION CHART



1 An Inpatient psychiatric Unit of The Counseling Center.

2 Half-way houses, sheltered workshop, patient education program.

NOTE: Forensic Program in planning process as are other specialized programs.


6/30/77
10/1/77
(effective date of act, estimated)
1/15/78
6-30-78
Patients (see pp 5-10 for detail)
1. obtain authority to operate programs on BMHI campus
2. determine patient characteristics, needs
3. develop transfer process, schedule
4. inform/orient patients & families
5. prepare AMHI, community for transfers
6. accomplish establishment of programs at Resource Center MMHI at Augusta (transfer patients)
Staff (see pp 11-17 for detail)
1. obtain authority to operate programs on BMHI campus
2. distribute information on programs/positions at BMHI campus
3. designate staff to operate BMHI campus during transition
4. collect information on employees (survey need, seniority)
5. establish training/retraining programs
6. hire onto BMHI campus & AMHI programs (phased)
7. career counseling
8. planning with regional interests
Resources (see pp 18-24 for detail
1. obtain authority to operate programs on BHMI campus
2. establish resource specialists group to determine processes for allocation of funds
3. specify funds for Augusta, Bangor, community
4. determine schedule for transition of funds
5. develop mechanisms for contracting & subcontracting
6. renovations
Augusta
Bangor
7. transfer of funds to CMHCs (phased)
8. Submit mental health systems plan to legislature
9. transfer of funds of BMHI

BUDGET

1. Proposal for Maine Mental Health Institute

The proposed budget to implement the first phase of this plan follows.

Funds available for the development of a Resource Center at the Bangor campus and for the transfer of patients to the Augusta campus represent the amount of funds recommended in the Department's budget document as necessary for the continued operation of the Bangor Mental Health Institute.

As will be noted, the first-year funds for reallocation derived from the establishment of one mental health institute are projected to be $350,000. Up to $300,000 have been designated for the Aroostook Mental Health Center for a community structured living program and increased aftercare capabilities in Aroostook County; $50,000 have been designated for The Counseling Center in Bangor to be applied toward the development of a halfway house. Second year funds for reallocation to community mental health services total over one million dollars. (Budget projections for a five-year period follow the proposed Maine Mental Health Institute budget.)

It should also be noted that funds for staff training and retraining are listed with unemployment benefits, in that the allocations for each area are interrelated, and we will not know specific needs until after a staff survey and futher staff placement planning.

The proposals of staffing patterns for specific programs at the Bangor Resource Center should be viewed as planning documents and are subject to revision. The departmental funds available for these programs, however, remain, for this first year, as designated.

PROPOSAL FOR MAINE MENTAL HEALTH INSTITUTE

(Maintain Pooler Pavilion and Consolidate Psychiatric Clients at Augusta Mental Health Institute - Fiscal Year 1977-78)

Funds Required to Transfer Clients to AMHI - (See Exhibit A)		
Personal Services (208 Positions)	$ 2,159,867	
All Other	330,963	
Capital Improvement	107,000	
Total Funds to AMHI		$ 2,597,830
Funds Required for Resource Center (See Exhibit B)		
Personal Services (172 Positions)	$ 1,659,888	
All Other	688,647	
Capital Equipment	24,383	
Unemployment Benefits & Staff Training	574,518[1]	
Capital Improvements	200,000	
Less: Bond Funds	(107,000)	
Total Resource Center Funds		$ 3,040,436
Resources for Community MH Centers (Bangor & Aroostook)		$ 350,000
TOTAL FIRST YEAR COST		$ 5,988,266
Funds Available (1977 - 78)		
Budget Recommendation - Unallocated		$ 5,570,077
1340.3 - Food		234,520
1340.4 - Fuel		183,669
Total		$ 5,988,266
Second Year Projection		
Cost of Resource Center		$ 2,443,103
Cost of Program to AMHI		2,570,375
Total Second Year Cost		$ 5,013,478
Less: Funds Available (1978 - 79)		
Budget Recommendation	$ 5,713,905	
1340.3 - Food	243,049	
1340.4 - Fuel	192,018	
Total Funds Available		$ 6,148,972
[1]Funds Available for Reallocation to Community Services		$ 1,135,494

[1]An additional $96,000 available in Central Unemployment Fund

EXHIBIT A

AUGUSTA MENTAL HEALTH INSTITUTE

Cost of services required to serve additional psychiatric and nursing home patients.

PERSONAL SERVICES	
154 Four Psychiatric Teams	$ 1,705,169
18 Ancillary and Support Personnel	148,094
36 Nursing Home Unit	306,604
Total Personal Services - 208 Positions	2,159,867
ALL OTHER	330,963
MARQUARDT BUILDING RENOVATIONS	107,000
Total Cost	$ 2,597,830

AUGUSTA MENTAL HEALTH INSTITUTE

Psychiatric Treatment Team Staffing

One Team Capacity: 34 Inpatients, 12 Admissions per Month

1 Psychiatrist IV		$ 36,858
1 Psychologist IV		18,346
1 Master Social Worker		11,440
1 Baccalaureate Social Worker (HSW I)		10,338
1 Recreation Therapist (Recreation & Occupational Therapist Combined)		12,043
2 Registered Nurses III		22,880
1 Registered Nurse II		10,338
1 Registered Nurse I		9,402
1 Mental Health Worker VI		12,043
2 Mental Health Workers V		21,735
2 Mental Health Workers IV		19,718
5 Mental Health Workers I		32,760
7 Mental Health Workers II		51,100
8 Mental Health Workers III		65,896
1 Clerk Typist II		6,344
2 Food Service Workers		11,100
1 Custodial Worker		5,550
Total Salaries - 38 Positions		$ 357,891
Adjustment for Salaries over Step A		17,895
Retirement		44,493
Total Staff Cost Per Team		$ 420,279
Staff Cost for four treatment teams		$ 1,681,116
1 Unit Director	$ 13,915	
1 Clerk Steno III	7,592	
Total	21,507	
Retirement	2,546	24,053
Total Cost for Four Teams		$ 1,705,169

AUGUSTA MENTAL HEALTH INSTITUTE

Nursing Home Team Staffing

2 Nurses III	$ 22,880
1 Nurse II	10,338
1 Nurse I	9,402
2 LPN's	14,768
2 Mental Health Workers III	16,474
4 Mental Health Workers II	29,200
20 Mental Health Workers I	131,040
1 Custodial Worker I	5,550
2 Food Service Workers	11,100
1 Baccalaureate Social Worker (HSW I)	10,338
Total Salaries - 36 Positions	$ 261,090
Adjustment for Salaries over Step A	13,055
Retirement	32,459
Total Staff Cost	$ 306,604

AUGUSTA MENTAL HEALTH INSTITUTE

Ancillary & Support Services

ANCILLARY PERSONNEL	
Clinic	
1 Nurse III	$ 11,440
Laboratory	
1 Lab Technician II	8,590
Medical Records	
1 Clerk Typist II	6,344
Infirmary	
1 Nurse II	10,338
1 Mental Health Worker I	6,552
Admissions, Evaluation & Statistics	
1 Clerk Typist II	6,344
Patient Care Evaluation P.R.S.O.	
1 Medical Secretary	7,904
Patient Rehabilitation	
3 Mental Health Workers I	19,656
SUPPORT PERSONNEL	
1 Plumber	7,300
2 Custodial Workers	11,100
1 Food Service Worker	5,500
1 Account Clerk II	7,300
1 Laundry Worker II	6,344
1 Laundry Worker I	5,616
1 Seamstress	5,782
Total Salaries - 18 Positions	$ 126,110
Adjustment for Salaries over Step A	6,306
Retirement	15,678
Total Staff Cost	$ 148,094

EXHIBIT B

PROJECTED BUDGET - RESOURCE CENTER - BMHI

DESCRIPTION	CODE		
Personal Services (172 Positions)		$ 1,695,588	
Less: Personnel on ELC Payroll		35,700	
Total Personal Services	3000		$ 1,659,888
ALL OTHER			
Professional Service, not by State	4000	$ 94,225	
Professional Service, by State	4100	6,200	
Travel Expenses In State	4200	5,421	
Travel Expenses Out of State	4300	1,444	
Operation State Vehicles	4400	7,500	
Utility Services	4500	87,370	
Rents	4600	8,978	
Repairs	4700	7,000	
Insurance	4800	53,100	
General Operation Expense	4900	7,700	
Office Supplies	5300	5,000	
Clothing	5400	5,600	
Other Supplies	5600	65,250	
Assistance & Relief Grant	5700	2,000	
Pensions	6900	12,500	
Food		135,690	
Fuel		183,669	
Total All Other			$ 688,647
Equipment	7200		24,383
Renovations - Pooler			200,000
Total Operating Expenditures	9999		$ 2,572,918
Unemployment Benefits & Staff Training			574,518[1]
Resources for Community MH Services (Bangor & Aroostook)			350,000
Sub-Total of All Costs			$ 3,497,436
Less: Available Bond Funds			(107,000)
Total First Year Costs			$ 3,390,436

[1] An additional $96,000 available in Central Unemployment Fund.

RESOURCE CENTER

Administration
Base Team

POSITION		
1 Administrator	$ 19,156	
1 Clerk Steno III	9,214	
1 Personnel Technician I	9,859	
Total Position		$ 38,229
SHARED STAFF		
1 Beautician	$ 8,860	
2 Custodial Workers	12,270	
3 Clerk Typists II (Pool)	22,026	
1 Medical Secretary	7,592	
1 Occupational Therapist II	13,250	
1 Physical Therapist II	11,440	
½ X-Ray Technician	4,118	
1 Institutional Teacher	12,584	
1 Music Therapist	12,584	
Total Shared Staff		$ 105,724
Total Salaries - 14½ Positions		$ 143,953
Retirement		17,044
Total Staff Cost		$ 160,997

RESOURCE CENTER

Psychogerentology Unit
112 Beds - 90% Capacity

GERENTOLOGY STAFF		
1 Director	$ 14,458	
1 Clerk Steno II	7,218	
3 Custodial Workers	19,905	
4 Nurses III (team)	45,760	
4 Nurses II	41,348	
10 LPN's	65,900	
4 Mental Health Workers III	31,617	
10 Mental Health Workers II	80,288	
40 Mental Health Workers I	265,466	
1 Psychiatric Social Worker I	10,377	
3 Recreation Aides	23,586	
1 Registered Recreational Therapist	12,043	
1 Physician IV	36,857	
1 Physical Therapist II	11,440	
Total Gerentology Staff		$ 666,263
PSYCHIATRIC STAFF		
1 Psychiatrist IV	$ 36,857	
1 Psychologist III	17,680	
1 Psychiatric Nurse V	14,456	
3 Mental Health Workers VI	36,129	
Total Psychiatric Staff		$ 105,122
OUTREACH STAFF		
1 Nurse III	$ 11,440	
1 Psychiatric Social Worker II	13,915	
Total Outreach Staff		$ 25,355
Total Psychogerentology Staff		$ 796,740
Retirement		94,334
Total Staff Cost - 92 Positions		$ 891,074

RESOURCE CENTER

Support Staff

POSITION	
1 Painter	$ 9,090
1 Plant Engineer	13,250
4 Stationary Firemen	38,188
4 Stationary Engineers	33,780
2 Maintenance Mechanics	16,308
1 Carpenter	8,862
2 Light Equipment Operators	13,770
2 Laborers II	13,770
1 Storekeeper I	7,592
1 Food Service Manager II	12,584
4 Cooks I	30,868
4 Cooks II	35,444
6 Food Service Workers	39,810
3 Custodial Workers I	19,905
1 Laundry Supervisor	7,862
1 Washman	7,093
6 Laundry Workers I	38,940
2 Seamstresses I	13,354
1 Heavy Equipment Operator	7,590
Total	$ 368,060
Retirement	43,578
Total Staff Cost - 47 Positions	$ 411,638

RESOURCE CENTER

Autistic Program
Based on 10 to 12 Clients

POSITION		
1 Director	$ 19,157	
½ Master Social Worker (Outreach, family Coordinator)	5,720	
1 RN IV (Team Supervisor)	14,060	
2 LPN's	18,054	
6 Mental Health Workers II	48,173	
5 Mental Health Workers III	45,488	
1 Speech Therapist	13,915	
1 Recreational Therapist	12,043	
½ Psychiatrist	18,429	
½ Ph.D. Psychologist	12,292	
Total Salaries - 18.5 Positions		$ 207,331
Retirement		24,548
Total Staff Cost		$ 231,879

2. Projected Five Year Budget

The following are budget comparisons showing estimated cost projections for five years of operating the Bangor and Augusta campuses under the Maine Mental Health Institute, first at current census and second with a declining census at Augusta. In both instances, an increasing amount of funds will be available for reallocation: it is the commitment of the Department that these funds should be directly applied toward the development of a balanced system of mental health services in the community setting on a state-wide basis.

Also attached is a projected five year budget of operating AMHI and BMHI as separate institutions, fully accredited. Please note that BMHI will require at least $703,000 in addition to those funds recommended in the budget document to remain accredited.

Maine Mental Health Institute
Projected Five Year Budget
(Based on 120 Census at Bangor Campus & 510 Census at Augusta)

	1977 - 78	1978 - 79	1979 - 80[1]	1980 - 81[1]	1981 - 82[1]
Bangor Resource Center[2]	(172)	(172)	(172)	(172)	(172)
Personal Services	$1,659,888	$1,709,685	$1,846,460	$1,994,177	$2,099,711
All Other	688,647	723,195	766,587	827,914	877,589
Capital	24,383	10,223	11,213	11,886	12,599
Pooler Renov.	200,000[4]	--	--	--	--
Unemployment Benefits & Train.	574,518[6]	--	--	--	--
Total	$3,147,436	$2,443,103	$2,624,260	$2,833,977	$2,989,899
Augusta Campus[3]	(808)	(808)	(808)	(808)	(808)
Personal Services	$8,595,524	$8,853,390	$9,118,992	$9,848,511	$10,636,392
All Other	1,762,499	1,805,712	1,914,055	2,028,898	2,150,632
Capital	44,017	28,401	38,382	40,684	43,125
Renovations	107,000	--	--	--	--
Total	$10,509,040	$10,687,503	$11,071,429	$11,918,093	$12,830,149
Funds Available for Community MH Services	$ 350,000	$1,135,494	$1,192,269[5]	$1,251,882[5]	$1,314,476[5]
al MMHI Budget	$14,006,476	$14,266,100	$14,887,958	$16,003,952	$17,134,524

Funds Available: (LD 118)		1977 - 78	1978 - 79
1350.1	AMHI	$7,392,088	$7,576,375
1350.1	Unallotted	5,570.077	5,713,905
1340.3	Food	450,744	467,136
1340.4	Fuel	486,567	508,684
Total Funds-Budget Document		$13,899,476	$14,266,100

1. Personal Services increased by 8% 1979-1982; All Other & Capital by 6%.
2. $119,457 of costs for Prelease & ELC included in BMHI budget.
3. $360,317 of costs of buildings occupied by other State departments included in AMHI budget.
4. $107,000 available in Bond Funds.
5. Funds for Community Services increased by 5% 1979-82.
6. An additional $96,000 available in Central Unemployment Fund.

Maine Mental Health Institute
Projected Five Year Budget
(Based on 120 Census at Bangor Campus & A Decreasing Census at Augusta)

	1977 - 78	1978 - 79	1979 - 80[1]	1980 - 81[1]	1981 - 82[1]
Bangor Resource Center[2]					
Personal Services	$1,659,888	$1,709,685	$1,846,460	$1,994,177	$2,099,711
All Other	688,647	723,195	766,587	827,914	877,589
Capital	24,383	10,223	11,213	11,886	12,599
Pooler Renov.	200,000[4]	--	--	--	--
Unemployment Benefits & Train.	574,518[5]	--	--	--	--
Total	$3,147,436	$2,443,103	$2,624,260	$2,833,977	$2,989,899
Augusta Campus[3]					
Personal Services	$8,595,524	$8,630,926	$8,623,464	$9,037,611	$9,462,887
All Other	1,762,499	1,770,624	1,837,363	1,905,698	1,975,695
Capital	44,017	28,401	38,382	40,684	43,125
Renovations	107,000	--	--	--	--
Total	$10,509,040	$10,429,951	$10,499,209	$10,983,993	$11,481,707
Census Decline	(510)	(494)	(477)	(460)	(443)
Funds Available for Community MH Services	$ 350,000	$1,393,046	$1,764,489	$2,185,982	$2,662,918
Total MMHI Budget	$14,006,476	$14,266,100	$14,887,958	$16,003,952	$17,134,524

Funds Available: (LD 118)		1977 - 78	1978 - 79
1350.1	AMHI	$7,392,088	$7,576,375
1350.1	Unallotted	5,570,077	5,713,905
1340.3	Food	450,744	467,136
1340.4	Fuel	486,567	508,684
Total Funds-Budget Document		$13,899,476	$14,266,100

1. Personal Services increased by 8% 1979-1982; All Other & Capital by 6%
2. $119,457 of costs for Prelease & ELC included in BMHI budget.
3. $360,317 of costs of buildings occupied by other State departments included in AMHI budget.
4. Funds for Community Services increased by 5% 1979-82.
5. An additional $96,000 available in Central Unemployment Fund.

BANGOR MENTAL HEALTH INSTITUTE

Additional Funds Needed to Maintain Accreditation

If BMHI is to continue operating its psychiatric programs at the existing level, the institution will require $703,014 in addition to the Budget Recommendation in (LD 118). The additional funds are necessary to comply with the J.C.A.H. Deficiency Report and maintain its accreditation.

A comparison of the projected five year budgets for AMHI and BMHI is attached. Please note that the budget for BMHI for the 1977-78 fiscal year includes the $810,014 necessary to maintain accreditation. The Budget Document currently provides funding for 475 positions at a cost of $4,817,790. In order to satisfy the Deficiency Report, another 48 positions at a cost of $449,810 will be needed as well as $360,204 for renovations and environmental improvements. The BMHI has $107,000 in Bond Funds for renovations. The net cost of maintaining accreditation is $703,014:

PERSONNEL	$449,810
ENVIRONMENT	306,508
PATIENT SAFETY	20,950
CONTINGENCY (10% for Inflation & Contingencies)	32,746
	$810,014
Less: Bond Funds Available	107,000
Total Additional Funds Needed	$703,014

BANGOR MENTAL HEALTH INSTITUTE

Additional Funds Needed to Maintain Accreditation

If BMHI is to continue operating its psychiatric programs at the existing level, the institution will require $703,014 in addition to the Budget Recommendation in (LD 118). The additional funds are necessary to comply with the J.C.A.H. Deficiency Report and maintain its accreditation.

A comparison of the projected five year budgets for AMHI and BMHI is attached. Please note that the budget for BMHI for the 1977-78 fiscal year includes the $810,014 necessary to maintain accreditation. The Budget Document currently provides funding for 475 positions at a cost of $4,817,790. In order to satisfy the Deficiency Report, another 48 positions at a cost of $449,810 will be needed as well as $360,204 for renovations and environmental improvements. The BMHI has $107,000 in Bond Funds for renovations. The net cost of maintaining accreditation is $703,014:

PERSONNEL	$449,810
ENVIRONMENT	306,508
PATIENT SAFETY	20,950
CONTINGENCY (10% for Inflation & Contingencies)	32,746
	$810,014
Less: Bond Funds Available	107,000
Total Additional Funds Needed	$703,014

Comparison of AMHI & BMHI
Projected Five Year Departmental Budget
(Based on Current Census-BMHI Accredited)

	1977 - 78	1978 - 79	1979 - 80[1]	1980 - 81[1]	1981 - 82[1]
Bangor Mental Health Institute[2]	(523)	(523)	(523)	(523)	(523)
Personal Services	$5,267,600	$5,425,628	$5,859,678	$6,328,452	$6,834,728
All Other	1,159,543	1,176,421	1,247,006	1,321,827	1,401,136
Capital	10,933	10,223	11,213	11,886	12,599
Renovation & Other Needs	360,204[4]	---	---	---	---
	$6,798,280	$6,612,272	$7,117,897	$7,662,165	$8,248,463
Augusta Mental Health Inst.[3]	(600)	(600)	(600)	(600)	(600)
Personal Services	$6,435,657	$6,625,360	$7,155,389	$7,727,820	$8,346,046
All Other	1,431,536	1,463,367	1,551,169	1,644,239	1,742,893
Capital	44,017	28,401	38,382	40,684	43,125
	$7,911,210	$8,117,128	$8,744,940	$9,412,743	$10,132,064
Total Budget for AMHI & BMHI	$14,709,490	$14,729,400	$15,862,837	$17,074,908	$18,380,527

Funds Available: (LD 118)

1350.1	AMHI	$7,392,088	$7,576,375
1350.1	Unalloted	5,570,077	5,713,905
1340.3	Food	450,744	467,136
1340.4	Fuel	486,567	508,684
Total Funds-Budget Document		$13,899,476	$14,266,100

1. Personal Services increased by 8% 1979-1982; All Other & Capital by 6%.
2. $119,457 of costs for Prelease & ELC included in BMHI budget.
3. $360,317 of costs of buildings occupied by other State departments included in AMHI budget.
4. $107,000 available in Bond Funds.

LIST OF MAINE COMMUNITY MENTAL HEALTH CENTERS

I.	Aroostook Area	Aroostook Mental Health Center Community General Hospital Fort Fairfield, Maine 04742 Robert Vickers, ACSW, Director	472-3511
II.	Eastern Maine Area	The Counseling Center 43 Illinois Avenue Bangor, Maine 04401 James Clark, Director	947-0366
III.	Kennebec Valley Area	Kennebec Valley Mental Health Center North Street Waterville, Maine 04901 Carmen Celenza, M.A., Director	873-2136
IV.	Tri-County Area	Tri-County Mental Health Services 106 Campus Avenue Lewiston, Maine 04240 J. Gregory Shea, Director	783-9141
V.	Cumberland-Portland Area	Maine Medical Mental Health Center 22 Bramhall Street Portland, Maine 04102 Carl Jackson, M.D., Exec. Dir.	871-2355
VI.	York Area	York County Counseling Services, Inc. P.O. Box 617 Saco, Maine 04072 Thomas J. Kane, DSW, Director	282-5976
VII.	Bath-Brunswick Area	Bath-Brunswick Mental Health Center 764 High Street Bath, Maine 04530 Richard A. King, ACSW, Director	443-9793
VIII.	Pen-Bay Area	Mid-Coast Mental Health Clinic 385 Main Street Rockland, Maine 04841 William Barnum, M.D., Director	594-2541

AREA V MENTAL HEALTH BOARD
79 Bramhall Street - Holt Hall
Portland, Maine 04102
Paul Adams 772-6222

LIST OF MAINE MENTAL HEALTH INSTITUTES

Augusta Mental Health Institute
P.O. Box 724
Augusta, Maine 04330
Charles Meredith, M.D., Superintendent 622-3751

Bangor Mental Health Institute
P.O. Box 926
Bangor, Maine 04401
Joseph Saxl, Superintendent 947-6981

Center

ounseling Center
Adult Day Treatment Program
43 Illinois Ave.
Bangor, Maine

Bangor Regional Rehabilitation Center *
P.O. Box 861
Bomarc Road
Bangor, Maine

Multiple Handicap Center of Penobscot Valley
103 Texas Ave.
Bangor, Maine

Abilities and Goodwill, Inc. *
803 Forest Ave.
Portland, Maine

Opportunity Training Center *
Presque Isle, Maine

Mid-Coast Rehabilitation Center **
Owls Head, Maine

Homes Unlimited **
io Street
Bangor, Maine

Serenity House **
Portland, Maine

Shalom House **
Portland, Maine

EMVTI
Hogan Road
Bangor, Maine

Aroostook Mental Health Center
Adult Day Treatment
Fort Fairfield, Maine

Aroostook Mental Health Center **
Alcoholic Rehabilitation Center
Limestone, Maine

Bangor Halfway House **
Cumberland Street
Bangor, Maine

These facilities provide the classical Sheltered Workshop Program.

** These facilities provide a variety of structured living situations with Vocational Rehabilitation and employment an integral part of their program.

COOPERATIVE AGREEMENT BETWEEN
AUGUSTA MENTAL HEALTH INSTITUTE
AND
BATH-BRUNSWICK AREA MENTAL HEALTH CENTER
FOR THE PERIOD JULY 1, 1976 to JUNE 30, 1977

1. Introduction

We, the undersigned representatives of Augusta Mental Health Institute, hereafter referred to as the Institute or AMHI, and the Bath-Brunswick Area Mental Health Center, hereafter referred to as the Center or B-BAMHC, commit these organizations to a cooperative agreement regarding the care, treatment, and rehabilitation of persons mentally ill. The parties to the agreement recognize that "The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization (2) to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible." (Action for Mental Health, 1961.) The purpose of this agreement is to insure the most effective and appropriate treatment to the disturbed person by defining the role and responsibility of each organization, by assuring continuity of treatment, and by assuring the availability of comprehensive services. Both parties recognize that the Center has the primary responsibility for meeting the mental health needs in its service area. The Institute has the responsibility for continuing treatment including extended inpatient care. The Cumberland Unit of the Hospital and the Center should be viewed as a coordinated system within which context gaps in service can be filled and informed decisions can be made and implemented as to what services are needed and how they can best be provided.

II. General Provisions of the Agreement:

A. Channels of communication and lines of authority and responsibility of patient care.

1. a. Authority and responsibility for patient care is vested in the clinical director of whichever facility the patient is currently carried as an active case. Stated in simpler terms: unless the patient is carried as an active patient by the Cumberland Unit-AMHI, authority and responsibility for patient care will rest with the Director of Mental Health Services of B-BAMHC.

b. Patients on short leave and/or convalescent status (C.S.) are considered to be the responsibility of the Center. The Center is to be notified in each instance of release on C.S. If there are court orders or jurisdiction pertaining, such orders, holds, etc. shall remain in effect.

c. It is agreed that when members of the staff of AMHI participate in the care of a patient in the community, that this will be done in the name of and under the director of the B-BAMHC.

2. Communication between AMHI and B-BAMHC occurs on several levels.

a. In matters of broad policy the line connects the Superintendent and Center Director, with the Cumberland Unit Director included for the purpose of information and comment.

b. In implementation, the line connects the Center Director and/or his designate to the Cumberland Unit Director with the AMHI Superintendent included for information and comment.

c. In matters relating to specific patients, communication may occur between any appropriate staff member of both facilities with the Cumberland Unit Director and B-BAMHC Director included for information as appropriate.

3. This policy is to be implemented through regular meetings between the administrative staff of both the B-BAMHC and Cumberland Unit of AMHI. In addition, the Director of Cumberland Unit is invited to attend the meetings of the Board of Directors of B-BAMHC. It is hoped that the Director of Cumberland Unit will attend as frequently as possible. Members of the Cumberland Unit Staff are invited to attend appropriate staff meetings of the B-BAMHC on a regular basis. Members of the aftercare team of B-BAMHC will participate on a regular basis in team meetings at the Cumberland Unit. Meetings between the Center Director and the Superintendent of AMHI will be arranged on an as needed basis.

III. Specific Provisions of the Agreement:

A. The Augusta Mental Health Institute agrees to provide up to $5,000 in medication to the Center for the fiscal year July 1, 1976 through June 30, 1977, said $5,000 to be transferred to AMHI from the Bureau of Mental Health Community Grant-in-Aid Fund. Orders for specific medication will be periodically submitted by the Center directly to AMHI.

B. The Center agrees to provide a comprehensive continued care program for patients discharged or on C.S. from AMHI by ensuring the provision of the following services:

1. Inpatient Service
2. Outpatient Service
3. Partial Hospitalization (Activity therapy and socialization)
4. Emergency intervention service
5. Foster-Boarding and Nursing Home placement and replacement (in cooperation with AMHI staff)
6. Vocational rehabilitation and job placement
7. Psychotropic medication
8. Educational classes for Nursing and Boarding Homes as appropriate and needed.

C. The Center agrees to screen 90% of all referrals to AMHI for its Catchment Area (The Center cannot be held responsible for screening persons committed to AMHI by the court or from residential correctional facilities outside of our catchment area.)

D. The Center agrees to attempt to admit less than 0.5 patients per thousand of the catchment area population during the fiscal year.

E. The Center agrees to attempt to maintain less than one in-patient per thousand in the catchment area population at AMHI at any one time during the fiscal year.

F. The Center agrees to provide accurate information of the continued care provided by B-BAMHC. This information will be provided in the form of a copy of the B-BAMHC aftercare monthly statistical report and shall be submitted by the 15th of the following month or as soon thereafter as is practicable.

G. The Center agrees to provide discharge planning services in order to facilitate the transition and placement of the patient in his community. The Institute agrees not to place patients in the community without the knowledge and approval of the Center's aftercare staff.

H. The Center agrees to encourage and implement staff sharing arrangements with AMHI.

I. The Institute will provide treatment for periods anticipated to be of about three to six weeks or more duration or an in-patient basis as dictated by the needs of the individual patients. The Institute will also provide short-term (less than 3 weeks) treatment to patients for whom the inpatient facility of the Center is inappropriate. The Center will provide or arrange for other necessary mental health programs as appropriate.

J. That the Institute and the Center will engage in joint educational efforts whenever feasible.

K. That patient records will when appropriate, and consistent with applicable statutes and policies, be mutually shared with the staff of a participating agency for the welfare of the patient.

L. Periodic evaluation meetings will be held by representatives of both Institute and the Center at the discretion of either party in order to insure continuity and comprehensive patient care.

M. This agreement may be amended at any time upon discussion and mutual agreement by both parties. Such amendments shall be documented and become a part of this agreement.

N. This agreement shall be reviewed at least annually by the chief administrative officer of the Center and the Institute. This agreement may be terminated by either party upon six months written notice to the other, and upon vote of the governing body of the terminating party.

Superintendent, AMHI

Executive Director, B-BAMHC

Director, AMHI, Cumberland Unit

President, Board of Directors
B-BAMHC

9 Aug. 1976

Date

August 16, 1976.

Date

COOPERATIVE AGREEMENT BETWEEN THE AUGUSTA MENTAL HEALTH INSTITUTE AND KENNEBEC VALLEY MENTAL HEALTH CENTER

I. Introduction

We, the undersigned, representatives of the Augusta Mental Health Institute, hereafter referred to as "the Institute" or "AMHI" and the Kennebec Valley Mental Health Center, hereafter referred to as "the Center" or "KVMHC", commit these organizations to a cooperative agreement regarding the care, treatment, and rehabilitation of persons mentally ill. The parties to the agreement recognize that "The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization, (2) to return him to home and community life as soon as possible" (Action For Mental Health 1961). The purpose of this agreement is to insure the most effective and appropriate treatment to the disturbed person by defining the role and the responsibility of each organization, by assuring continuity of treatment, and by assuring the availability of comprehensive services. Both parties recognize that the Center has the primary responsibility for meeting the mental health needs in its service area. The Institute has a responsibility for continuing treatment, including extended inpatient care. Unit III of the Institute, and the Center should be reviewed as a coordinated system within which context gaps in service can be filled and informed decisions can be made and implemented as to what services are needed and how they can best be provided.

II. General provisions of the agreement:

A. The sharing of medical and clinical record information between the Institute and the Center shall be subject to the laws relating to confidentiality.

B. Channels of communication and lines of authority and responsibility of patient care:

1(a) The authority and responsibility for the patient's care is vested in the chief executive officer or his designate(s) of whichever facility the patient is currently carried as an active case. Stated in simpler terms - if the client is an active case of the Ken-Som team, the superintendent, or his designate of AMHI is responsible; if the patient is a resident of the Center's catchment area and not an active case of AMHI, the executive director of the Center or his designate is responsible.

(b) The Center will provide appropriate and available mental health services to all clients (including those discharged or on convalescent status from AMHI in the catchment area) providing necessary fiscal resources, appropriate programs, and sufficient space are available.

(c) AMHI will not discharge patients (Excluding elopements or patients discharging themselves "against medical advice") without the active participation and recommendation of the Center executive director or his designate.

(d) Staff members of AMHI may provide services to clients in Center programs only when such AMHI staff member(s) is accepted for providing service by the Center executive director's designate. Such accepted staff shall be assigned by and clinically responsible to the Center executive director or his designate when functioning in a Center program, or providing treatment to a Center client.

(e) Implementation of the policies of this cooperative agreement is to be facilitated through regular meetings between the administrative staff of both KVMHC and the Ken-Som team of AMHI. Members of the Ken-Som team staff are invited to attend appropriate staff meetings at KVMHC on a regular basis. Members of the aftercare team of KVMHC will participate on a regular basis in team meetings of the Ken-Som team. Meetings between the Center director and superintendent of AMHI will be arranged on an as-needed basis. Additionally, the superintendent or his designate is invited to attend the meeting of the Board of Directors of KVMHC. Similarly, the executive director of KVMHC or his designate is invited to attend the analogous AMHI policy-making body's meetings.

III. Specific provisions of this agreement:

A. The Center agrees to screen 90 percent of all referrals to AMHI from its catchment area, and abide by the Institute's admission policies.

B. AMHI agrees to provide the Center during fiscal year 1976:
(1) $28,000 in medications, said $28,000 to be transferred to AMHI from that portion of the DMH&C Community Grant-in-Aid fund which is designated for the Center. Orders for the prescriptions shall be specifically submitted by the Center directly to AMHI. Preparation charges up to 17 percent for medication prescriptions will be absorbed by the Center.

(2) Other cooperative agreements between the Center and AMHI shall be attached to this agreement as appendices.

C. In order to predict, develop, and prepare comprehensive and coordinated services for the long term inpatient needs of the population at risk in the Center catchment area, the two agencies agree to establish a joint committee whose agendae shall consist of the following:

(1) Review each Center admission to AMHI to establish its relevance and appropriateness given the ideals embodied in the introduction of this cooperative agreement.

(2) Develop written criteria for admissions to AMHI of Center catchment area patients by Center staff and for the maintenance of catchment area inpatients at AMHI.

The chief executive officers of the agencies shall each appoint an appropriate number of people to serve on this committee.

D. The Center and AMHI agree to provide accurate and appropriate information of the continued care provided by each agency giving supportive services. Information shall be completed monthly and submitted by the 15th of the following month or as soon thereafter as practical.

E. The Center will send completed referral forms to AMHI within 48 hours of admission of a Center client by Center staff.

F. The Center and AMHI agree to encourage and implement staff sharing arrangements.

G. The Institute will provide long-term treatment on an inpatient basis as dictated by the needs of the individual patients. The Institute will also provide short-term (less than three weeks) treatment to patients for whom the inpatient facility of the Center is inappropriate or temporarily unavailable.

H. The Institute and the Center will engage in joint educational efforts.

I. In all cases possible, a jointly written and agreeable treatment plan will be prepared by representatives of the two staffs. The service to the client within this treatment plan may include: (1) inpatient services, (2) outpatient services, including psychotropic medications, (3) partial hospitalization services, (4) emergency intervention (24-hour services).

J. Whenever the Center provides such services to a former AMHI patient, AMHI agrees to provide the Center with: (1) a treatment summary that shall include: (a) the patient's mental and physical status upon admission, (b) the type and course of treatment received by the patient during his (her) stay at AMHI, (c) a medical history including data relevant to the use of psychotropic medication, (d) a record of the patient's medication regimen, and his (her) response to it, and (e) recommendations for further treatment.
(2) A consent to treatment form must be signed by each AMHI patient prior to the Center joining in the treatment plan.

K. Periodic evaluation meetings will be held by representatives of both the Institute and the Center at the discretion of either party, in order to insure continuity and comprehensive patient care.

L. This agreement may be amended at any time upon discussion and mutual agreement by both parties. Such amendments shall be documented and become a part of this agreement.

M. This agreement shall be reviewed at least annually by the chief administrative officer of the Center and the Institute.

N. This agreement may be terminated by either party upon six months written notice to the other and upon vote of the governing body of the terminating party.

O. This contract will take effect when signed by the individuals specified below, and will expire on 30 June, 1976.

Richard T. Chamberlin, M.D.
President
Board of Directors
Kennebec Mental Health Association

Roy Ettlinger
Superintendent
Augusta Mental Health Institute

Date: February 25, 1976

E14

COOPERATIVE AGREEMENT

WITH

AUGUSTA MENTAL HEALTH INSTITUTE (hereinafter referred to as AMHI), the MAINE MEDICAL CENTER COMMUNITY MENTAL HEALTH CENTER (hereinafter referred to as CMHC), and COMMUNITY HEALTH SERVICES, INC., MENTAL HEALTH UNIT (hereinafter referred to as CHS, INC.)

AMHI	CMHC	CHS, INC.
Accept referrals to the Institute from CMHC as defined by existing 2-way agreement.	Screen referrals for admission to AMHI utilizing the Institute's admission policy. Call AMHI with referral information on day client transferred from P6 to AMHI with client permission. Send written referral information to AMHI as soon as possible with client permission including (1) Diagnosis (2) Meds (3) Reason for transfer. Call CHS if P6 client transferred is Mental Health Unit client.	Refer to CMHC those clients assessed to need psychiatric care with client permission. Summary of contacts with clients will be sent to AMHI within two weeks of admission or readmission to the Institute.
Send discharge and/or convalescent leave summaries and psycho-socials to CMHC and CHS Mental Health Unit within two weeks after client's discharge or leave. with client's permission.	Receive discharge and/or convalescent leave summaries from AMHI with client permission, within two weeks after discharge or leave.	Receive discharge and/or convalescent leave summaries from AMHI and P6 with client permission, within two weeks after discharge or leave.
Telephone CMHC and CHS when client leaves AMHI who is unready for discharge in AMHI's opinion. Include the following information in the discharge or convalescent leave summary plan of care to CMHC and CHS, Inc. a. Diagnosis b. Medical Care Plan c. Plans made with Mental Health Unit d. Appointment at CMHC - date, time e. Appointment to return to AMHI, if necessary f. Medication - kind, dosage.	Receive telephone information that AMHI client has left Institute who is unready for discharge in AMHI's opinion. Make available to AMHI discharged or on leave patients the following services when medically indicated and when the facility is available: a. Inpatient services b. Outpatient services c. Partial hospitalization services d. Emergency intervention services (24)	Receive telephone information that AMHI client has left Institute who is unready for discharge in AMHI's opinion. Provide the following Mental Health Unit services to discharged or on leave patients from AMHI or CMHC: a. Preparation and placement for community living. 1. Homefinding - Identify suitable approved or licensed residences willing to accept clients; inventory homes regarding socio/recreational, educational, vocational, medical support and physical plan resources. Find new homes.

HI

how often taken, reaction of client to medication. where client will receive further prescriptions.

g. Client behavior and how dealt with in Institute.
h. Client's plans for community living.

CMHC

CHS,INC.

Work with providers to prepare them for clients and ongoing appropriate in-service.

2. Planning for community return - Coordinate with client and facility staff to prepare client for acceptance of an appropriate return to the community; assist client in securing financial support; identify needed community support services; develop a treatment/service plan and evaluation program with facility staff and client.

3. Placement - Work with client and facility staff to determine placement and assure that residence is ready for client; inform relevant agencies of client's arrival in home; carry out actual placement, confirming agreements between client and residence.

b. Community Referrals

1. Intervention and Service Plan - accept appropriate referrals through local mental health and mental retardation service agencies and work with the client and the referring service to develop a treatment/service plan.

c. Community Adjustment and Maintenance

1. Assistance - assist client in initial adjustment to new placement, providing linkage with needed services to facilitate adjustment.

2. Evaluation - Evaluate the client's attainment of the community adjustment goals described in the service/treatment plan. the acceptability of the client by the residence, and the adequacy of services provided by the residence. This evaluation is to be done at a date no later than six months from entry into the Mental Health Unit service, with a report filed in the care record.

3. Maintenance - Provision of social services to clients so that they maintain an effective level of functioning or improve their level of functioning, including the following services:
-working with household members or home managers to assure adequate services to clients.
- provide individual or group counseling to assist in treatment of personnel problems or clients and to assist clients in making decisions consistent with community norms; provide family-group counseling oriented toward coping with family-related problems.
-arranging for a guardian or conservator to be appointed by the court if necessary.
-provide linking and referral services for clients to other service agencies.
-provide resource advocacy aimed at gaining additional resources in residences and in the community for clients.
-assist in enabling clients to participate in planned programs for recreation, socialization. and training.
-assist in providing transportation for clients.
-provide periodic visits with clients and household members in accordance with the treatment/service plan to provide continued assessment of client progress, desires and services, and the use of psychotropic medicine.

d. Treatment/Service Plan Revision -
The Treatment/Service Plan should be reviewed and/or revised no less than once every 90 days. Discharge from the Mental Health Unit will include a written evaluation of the client and the explanation for the discharge filed in the case record.

AMHI	CMHC	CHS, INC.
		e. Evaluation - The Department will provide periodic reports and service evaluations to the Department of Human Services on a statewide basis.
Teams on the Cumberland Unit will discuss discharge planning with clients and Mental Health Unit worker on weekly basis prior to discharge on convalescent leave.		Discuss Mental Health Unit services with clients at AMHI prior to discharge or convalescent leave. This will be done on at least a weekly basis with the Teams on the Cumberland Unit, AMHI.
Teams will discuss Mental Health Unit services available to clients if client is being discharged or to convalescent leave and services have not been discussed by Mental Health Unit worker (i.e. when discharge happens on a weekend and client summary has not included discussion with Mental Health Unit Worker).	Confer on a daily basis with CHS, Inc. regarding discharge planning for those P6 clients needing and desiring Mental Health Unit's services.	Confer daily with CMHC, P6 regarding discharge planning with clients needing and desiring Mental Health Unit services. Will followup those clients who miss MHC appointments if they desire Mental Health Unit services.
Teams will designate a person to telephone Mental Health Unit, CHS when client discharged or on convalescent leave has by nature of his/her stay has missed Mental Health Unit worker.	Send written referrals to CHS, Inc. as soon as possible after discharge of client.	Accept referrals for Mental Health Unit services from CMHC, P6 and AMHI.
Attend regular meetings quarterly as needed with Mental Health Unit Director or a designee and CMHC Director or his designee for the purposes of specific conferences cases, communication problems and general policy information. AMHI, upon referral of client to CMHC, MHC. will give complete name address and telephone number in order that client may be reached.	Attend meetings held quarterly as needed with AMHI designee, CHS designee to discuss specific cases, communication problems, and general policy information. Devise a system for following up on missed mental health clinic appointments. a. will send letter to client who misses appointment b. notify Mental Heal Unit that client has missed appointment if appropriate.	Attend meetings held quarterly as needed with AMHI and CMHC designees to discuss specific cases, communication problems and general policy information.

E19

AMHI	CMHC	CHS, INC.
Provide discharge planning and placement of nursing home clients in cooperation with the Division of Hospital Services. AMHI Nursing Home Aftercare Programs will provide service to clients placed in nursing homes in Catchment Area V. Interaction will occur between the AMHI Nursing Home and Nursing Home operators in Catchment Area V to deal with issues that may arise and provide assistance in dealing with their clients.	The Department of Community Psychiatry will continue to provide CHS, Inc. staff with inservice education as appropriate.	CHS. Inc. will continue to provide in-service education regarding Mental Health Unit services in the community to CMHC and AMHI staff as appropriate.

This agreement shall be ongoing and reviewed by all parties periodically. If termination of this agreement is to be considered, 90 days written notice must be given to each party.

Signed	Date	Witness
Charlie Meredith, Superintendent Augusta Mental Health Institute	4/27/77	Veda Rose RN
Carl Jackson, M.D., Director Community Mental Health Center, Maine Medical Center	5-4-77	
Wilma K. Jordan, RN. MN Executive Director Community Health Services, Inc.	4-24-77	

PENOBSCOT BAY MEDICAL CENTER

GLEN COVE, ROCKLAND, MAINE 04841
EXECUTIVE OFFICE 207-594-9511

February 18, 1977

Chief of Staff
Augusta Mental Health Institute
Augusta, Maine 04330

I, Robert J. Dreher, M.D., Chief of the Medical Staff of Penobscot Bay Medical Center, request that you enter into this Transfer agreement with our physicians to provide care for patients with these specific categories of emergency diseases when transferred upon the request of the patient's physician.

This transfer agreement is developed to meet the requirements of PL 93-154 and our requirements under the EMS program. We expect it to stimulate the standardization of records, information exchange and training as well as to help with the improvement in local care by appropriate feedback to our Hospital.

Chief of the Medical Staff

This is to certify that Maine Medical Center, which has the capability in the signed areas, will provide care for patients in the specific categories signed below when such transfer is requested by the local physician.

Psychiatric: Psychiatric problems sufficiently severe as to threaten the patient's or other person's health or safety

Chief

CHARLES E. MEREDITH, M.D., SUPERINTENDENT
Augusta Mental Health Institute, Augusta, Maine
February 25, 1977

Addendum to the Cooperative Agreement between
Augusta Mental Health Institute
and Tri-County Mental Health Center

The purpose of this addendum is to warrant the continuation of the Cooperative Agreement between the Augusta Mental Health Institute and the Tri-County Mental Health Center signed December 10, 1975, and now in effect.

The provisions of this continuation are:

a.) that a joint letter of endorsement of the agreement from the Executive Director of the Tri-County Mental Health Center and the Unit Director for the Tri-County Team at Augusta Mental Health Institute be forwarded to the President, Board of Directors, Tri-County Mental Health Center and the Superintendent of the Augusta Mental Health Institute on a quarterly basis subsequent to this date.

b.) that any changes in the terms of the Cooperative Agreement be effected in writing over the signature of all parties to the Agreement.

c.) that change or cummulation of changes considered by any one signatory to require a wholly new cooperative statement shall be cause to undertake the process of re-negotiating a new Cooperative Agreement.

SUPERINTENDENT,
AUGUSTA MENTAL HEALTH INSTITUTE

PRESIDENT, BOARD OF DIRECTORS,
TRI-COUNTY MENTAL HEALTH CENTER

UNIT DIRECTOR,
UNIT III

EXECUTIVE DIRECTOR,
TRI-COUNTY MENTAL HEALTH CENTER

DATE

7/27/76
DATE

MEMORANDUM OF UNDERSTANDING

Recognizing the responsibility of the State of Maine to patients discharged into the community and a mutual desire to build a unified and coordinated mental health system, the AMHI enters into an agreement with Tri-County Mental Health Center.

The Augusta Mental Health Institute agrees to employ on the state payroll $42,735 in salaries and retirement benefits and to provide $20,000 in medication for the fiscal year July 1, 1974 through June 30, 1975.

Tri-County Mental Health Center agrees:

1-To provide a comprehensive continued care program for patients discharged from AMHI by ensuring the provision of the following services:

   a. Inpatient services
   b. Outpatient services
   c. Partial hospitalization
   d. Emergency intervention services
   e. Foster-Boarding and Nursing home placement and replacement
   f. Activity therapy and socialization
   g. Vocational rehabilitation and job placement
   h. Psychotropic medication
   i. Training and consultation to foster, boarding and nursing homes which have AMHI former residents

2-To screen 90% of all referrals to AMHI from your catchment area.

3-To admit less than .7 patients per thousand of the catchment area population during the fiscal year.

4-To maintain less than .8 inpatients per thousand in the catchment area population at AMHI at any one time during the fiscal year.

5-To provide accurate information of continued care workload of Tri-County Mental Health Center. The forms will be provided by AMHI and shall be completed monthly and submitted by the 15th of the following month.

6-To provide discharge planning services in order to facilitate the transition and placement of the patient in his community.

7-To provide properly completed forms and at least two months' notice of plans to hire staff under this agreement.

8-To submit to AMHI by September 1, 1974 a continued care program description and clearly defined, time-specific goals and objectives of planned improvements in continued care services for the fiscal year 1974-75.

9-To encourage and implement two-way staff sharing arrangements with AMHI.

Wendell Kincaid, Ph.D./app
Wendell Kincaid, Ph.D., Unit Chief, Tri-County Unit

William E. Davis, ACSW, Director
Tri-Cty. Mental Health Center

Roy A. Etlinger, Superintendent

President of Board

6/17/74
Date

6/24/74
Date

COOPERATIVE AGREEMENT BETWEEN

AUGUSTA STATE HOSPITAL
TRI-COUNTY UNIT

AND

TRI-COUNTY MENTAL HEALTH SERVICES

We, the undersigned representatives of AUGUSTA STATE HOSPITAL, hereafter referred to as the HOSPITAL, and TRI-COUNTY MENTAL HEALTH SERVICES, hereafter referred to as TRI-COUNTY MENTAL HEALTH SERVICES, commit these organizations to a cooperative agreement regarding the care, treatment, and rehabilitation of persons mentally ill over and including the age of 16 years and their families. Tri-County Mental Health Services includes the Franklin and Oxford County Clinics, and this agreement specifically includes these clinics. The parties to the agreement recognize that "The objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible." (Action for Mental Health, 1961) The purpose of this agreement is to insure the most effective and appropriate treatment to the disturbed person by defining the role and responsibility of each organization, by assuring continuity of treatment, and by assuring the availability of comprehensive services. Both parties recognize that Tri-County Mental Health Services has the primary responsibility for meeting the mental health needs in its service area. The Hospital has the responsibility for continuing treatment including extended inpatient care. The Tri-County Unit of the Hospital and Tri-County Mental Health Services should become a co-ordinated system within which context gaps in service can be filled and

and informed decisions can be made implemented as to what services are needed and how they can best be provided.

The provisions of the agreement are as follows:

1. That any person eligible for and requiring services of either organization be referred to the organization best suited to provide such services; provided that adequate space, personnel and equipment are available for such service. The Tri-County Mental Health Services is responsible for the initial evaluation of all applicants to the mental health system. Community resources shall be used as an alternative to state hospitalization, if it is determined to be in the best interest of the client.
2. That no person shall be denied service for reason of race, creed, color, national origin, or age (except that, by statute, admission to the Hospital is restricted to those individuals age 16 and over).
3. That any person eligible for admission to the Hospital will also be eligible for services at the Tri-County Mental Health Services, and that Tri-County Mental Health Services will give priority to formerly hospitalized patients for outpatient services when their progress is such that further treatment can best be given in the community.
4. That Tri-County Mental Health Services will provide 24-hour emergency service including evaluation of prospective admissions to the Hospital and will, whenever possible, schedule these admissions by appointment with the Hospital. For those applicants requiring services other than specialized mental health services, the Center will be responsible for making the appropriate referrals.

5. That the Hospital and Tri-County Mental Health Services will cooperate to facilitate early return and placement of the patient in his community.

6. The Hospital and Tri-County Mental Health Services will encourage and implement staff sharing arrangements between the two organizations.

7. That the Hospital and Tri-County Mental Health Services will engage in joint educational efforts.

8. That patient records will be mutually shared, where appropriate, with the staff of a participating agency for the welfare of the patient.

9. Periodic evaluation meetings will be held by representatives of both the Hospital and Tri-County Mental Health Services at the discretion of either party in order to insure continuity and comprehensive patient care.

10. This agreement becomes effective as of the date of approval.

11. This agreement may be amended at any time upon discussion and mutual agreement by both parties. Such amendments shall be documented and become a part of this agreement.

12. This agreement shall be reviewed at least annually by the chief administrative officer of the Center and the Tri-County Unit. This agreement may be terminated by either party upon six months written notice to the other, and upon vote of the governing body of the terminating party.

Date: Jan 9 1973

Superintendent
AUGUSTA STATE HOSPITAL

President, Board of Directors
TRI-COUNTY MENTAL HEALTH SERVICES

Unit Director, TRI-COUNTY UNIT
AUGUSTA STATE HOSPITAL

Executive Director
TRI-COUNTY MENTAL HEALTH SERVICES

COOPERATIVE AGREEMENT BETWEEN AUGUSTA MENTAL HEALTH INSTITUTE AND YORK COUNTY COUNSELING SERVICES, INC.

I Introduction

We, the undersigned representatives of Augusta Mental Health Institute, hereafter referred to as the Institute or AMHI, and York County Counseling Services, Inc., hereafter referred to as the Center or YCCS, commit these organizations to a cooperative agreement regarding the care, treatment, and rehabilitation of persons mentally ill. The parties to the agreement recognize the "objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization, to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible."

The purpose of this agreement is to insure the most effective and appropriate treatment to the disturbed person by defining the role and responsibility of each organization, by assuring continuity of treatment, and by assuring the availability of comprehensive services. Both parties recognize the mental health Center has the primary responsibility for meeting the mental health needs in its service area. The Institute has the responsibility for continuing treatment including extended inpatient care. The Southwest Coastal Unit of the Hospital and the mental health Center should be viewed as a coordinated system within which context gaps in service can be filled and informed decisions can be made and implemented as to what services are needed and how they can best be provided.

II General Provisions of the Agreement:

A Channels of communication and lines of authority and responsibility of patient care.

1. Authority and responsibility for patient care is vested in the clinical director or his delegate of whichever facility the

patient is currently carried as an active case. Unless the patient is carried as an active patient by the SWCU-AMHI, authority and responsibility for patient care will rest with the Clinical Director of YCCS or his delegate, the Director of the Aftercare program. It has been agreed that when members of the staff of AMHI participate in the care of a patient in the community, that this will be done in the name of and under the direction of the YCCS.

2. Communication between AMHI and YCCS occurs on several levels:

   a) In matters of broad policy the line of communications will be between the Superintendent and Center Director, with the (SWCU) Director included for the purpose of information and comment.

   b) In matters of specific program planning, development and implementation, the chief communication is between the Director of the Aftercare Program and the SWCU Director with the AMHI Superintendent and the Center Director included for information and comment.

   c) In matters relating to specific patients, communication may occur between any appropriate staff member of both facilities with the SWCU Director and YCCS Director included for information as appropriate.

3. This policy is to be implemented through regular monthly meetings between the administrative staff of both the YCCS and SWCU of AMHI. In addition, the Director of SWCU is expected to attend the meetings of the Board of Directors of YCCS as possible.

4. The designated staff of both AMHI and YCCS will participate conjointly in predischarge planning for each patient.

5. Members of the SWCU staff are invited to attend the staff meetings of the Aftercare team on a regular basis. Members of the Aftercare team of YCCS will participate on a regular basis in team meetings at the SWCU. Meetings between the Center Director and the Superintendent of AMHI will be arranged on an as needed basis.

B The AMHI will accept YCCS referral of patients with the limits of laws and statutes.

C York County Counseling Services, Inc., agrees:

1. To provide or insure the provision of a comprehensive continued program for patients discharged from AMHI by ensuring the provision of the following services:

   a) Inpatient services
   b) Outpatient services
   c) Partial hospitalization
   d) Emergency intervention services
   e) Foster-boarding and nursing home placement as a priority function
   f) Activity therapy and socialization
   g) Vocational rehabilitation and job placement when possible
   h) Psychotropic medication

2. To screen 90% of all referrals to AMHI from your catchment area.

3. To admit less than .8 patients per thousand of the catchment area population at AMHI during the fiscal year.

4. To maintain less than .6 patient per thousand in the catchment area population at AMHI at any one time during the fiscal year.

5. To provide accurate information of continued care workload of YCCS. The forms will be provided by AMHI and shall be completed monthly and submitted by the 15th of the following month.

6. To provide discharge planning services in order to facilitate the transition and placement of the patient in his community.

7. To encourage and implement staff sharing arrangements with AMHI.

III Specific Provisions of the Agreement:

A That any person eligible for and requiring services of either organization be referred to the organization best suited to provide such services; provided that adequate space, personnel and equipment are available for such service. The recommendations of appropriate staff of each organization will be accepted by the others as their own.

B That no person shall be denied service for reason of race, creed, color, national origin, or age.

C That the Hospital and the Center will cooperate to facilitate early return and placement of the patient in his community.

D Periodic evaluation meetings will be held by representatives of both the Hospital and the Center at the discretion of either party in order to insure continuity and comprehensive patient care.

E This agreement may be amended at any time upon discussion and mutual agreement by both parties. Such amendments shall be documented and become a part of this agreement.

G This agreement shall be reviewed at least annually by the chief administrative officer of the Center and the Hospital. This agreement may be terminated by either party upon six months written notice to the other, and upon vote of the governing body of the termination party.

Superintendent, AMHI

Executive Director, YCCS

Director, SWCU

President, Board of Directors, YCCS

August 21, 1975
Date

August 20, 1975
Date

DEPARTMENT OF MENTAL HEALTH & CORRECTIONS

State Office Building *Telephone (207) 289-3161* *Augusta, Maine 04333*

GEORGE A. ZITNAY, Commissioner

REGULATIONS FOR LICENSING OF MENTAL HEALTH FACILITIES
(MRSA, T. 34, C. 183, Sec. 2052-A)

A license as a mental health facility as defined in Title 34, section 2052-A will be issued subject to the following requirements:

I. Service(s) and Location(s)

The specific service to be provided and the location at which such service will be provided will explicitly be designated by the applicant for licensing to operate, conduct or maintain a mental health facility. If more than one service is to be provided in a single location, each service must be listed.

II. Health and Safety

The facilities of the applicant agency shall meet acceptable standards for the use made of the facility to insure that the health and safety of the clients and the staff are assured.

The applicant is required to demonstrate that the facility or facilities housing the service have been inspected and approved by the State Fire Marshall's office. Any waiver of the requirements of the Life Safety Code must be approved by a representative of the inspecting agency.

If food services are provided within the facility, the applicant must show that the facilities for the preparation and service of food have been inspected and approved by the Department of Human Services.

The applicant must show that any facility not utilizing a public water system or a public sewerage disposal system has been inspected and approved by the Department of Human Services.

III. Staff

All staff personnel performing professional services which are defined by law as requiring a license or certification shall be so licensed or certified by the appropriate state licensing agency. All professional services shall be provided as controlled by appropriate professional practice acts and in full conformity with existing law.

A roster of all personnel working within each service shall be maintained by the applicant and a record of the credentials of each staff member shall be maintained by the applicant. In the absence of specific credentials of a staff member, a notation of his/her competencies in patient care shall be made which shall include the name of the professional attesting to such competency. Such records shall be available for review at the time of licensing inspection.

IV. Records

A treatment plan of each patient/client shall be maintained at the site where the individual patient/client is served.

The permanent comprehensive case record shall indicate the services provided to each patient/client, including the date and nature of the service provided and by whom the service was provided. The record shall contain a clear definition of the patient's/client's problem, who advised or ordered the service being provided and the goals to be reached by the provision of the service. An active treatment plan shall be included as well as other medical information as needed for treatment/education of the client.

Records and information relative to patients/clients and the services provided to them shall be maintained in a fashion to assure confidentiality in accordance with Chapter 495 of the Public Laws of 1975 effective 1 October 1975.

Patient records shall be available for inspection by the licensing agency to assure compliance with licensing requirements.

V. Professional Responsibility for Services.

Services defined in statutes as professional activities shall be rendered only by professional individuals licensed, certified or registered in accordance with law. Mental health services, not limited by law, which are provided by individuals who are not so licensed, certified or registered, shall be performed only on the specific written prescription of such professionals who shall assume responsibility for the provision, quality and results of such prescribed service. Any such service provided on professional prescription shall be reviewed no less often than once in one hundred twenty (120) days, or after twelve (12) service sessions, whichever is earlier, by the prescribing professional who shall include in the patient/client record, a summary of the results of the review, and a new prescription if the service is to be continued.

The applicant shall provide or make provision for the availability of necessary services for individual clients/patients, including but not limited to: outpatient care, inpatient care, medical service, emergency service, diagnostic evaluation and training.

VI. Peer Review

A system of periodic peer review, review of professional performance by one's colleague of the same profession, acceptable to the Department shall be operational within the facility. The purpose of said review is to insure that care given such patients/clients is necessary, is acceptable in quality and is rendered in the most appropriate setting. The review shall be based on standards established by members of the same profession as those whose activities are being reviewed. Deviations from established standards shall be reviewed by members of the profession of the individual whose work is being reviewed.

Records of such peer review shall be kept and shall be available at the time of licensing inspection. A notation on each reviewed patient/client chart shall be made of each review, but the details of the peer review need not appear in each individual patient's/client's record.

VII. Fees

A schedule of fees for services shall be made available to each client/patient individually, or it shall be posted in the facility for public view.

VIII. Complaints

A procedure for responding to complaints of patients/clients or the public shall be established, including provision of notice of such complaint procedure to each client/patient and to the public. A record of all complaints under the procedure shall be kept and shall be available for review at the time of licensing inspection.

IX. Accreditation by a Nationally Recognized Agency

In the event that the agency has received certification or accreditation of its service or elements of its services by the Joint Commission on Accreditation or Medicare such service or elements of its services may, at the discretion of the Department be considered to have met the requirements of Regulations III to VI inclusive.

A true copy
ATTEST

Date April 29 1977

George A. Zitnay, Commissioner
Department of Mental Health & Corrections