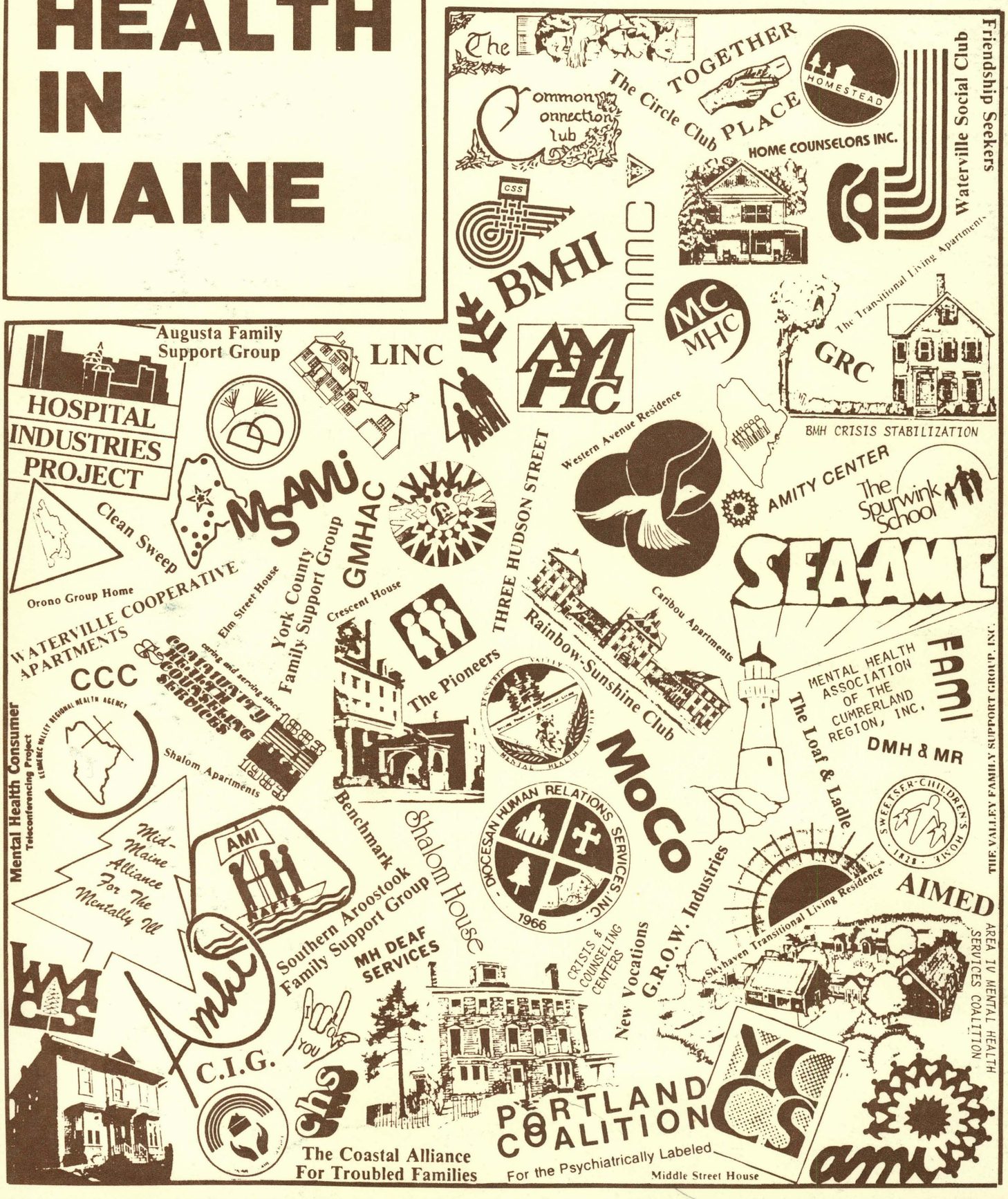
1986

Mental Health in Maine 1985-1986

Maine Department of Mental Health and Mental Retardation

MENTAL HEALTH IN MAINE

1985 - 1986



MENTAL HEALTH IN MAINE
1985 - 1986

State of Maine
Department of Mental Health
and Mental Retardation

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Dear Fellow Citizens:

Another year has passed in which important strides have been made in the development of needed services for Maine citizens affected by mental illness. We are pleased to be able to let you know about these efforts and accomplishments in this year's Mental Health in Maine 1985-1986 report.

The housing needs of individuals with prolonged mental illness are varied, ranging from highly supervised and structured settings to independent low-cost housing. In recognition of the urgent and specialized needs of mentally disabled individuals, a high priority has been placed by the Department on the development of housing alternatives. This has taken several forms, including local housing planning groups to develop new resources and make use of existing ones for mentally ill persons, the development of specialized group homes for elderly persons and deaf persons with prolonged mental illness, and the establishment of supervised crisis and transitional housing attached to the Bureau of Mental Health Crisis Stabilization Program. Already, we are seeing the impact of these efforts in many areas of the state. In addition, in November of 1985, two of the four Medicaid 1115 Waiver demonstration residential programs completed the last year of their Waiver participation; both programs, one providing an intensively supportive group home and the other a semi-independent apartment program, will be continued with state funds by the Bureau of Mental Health.

National and local attention has increasingly been focused on the identification and needs of a growing number of homeless individuals. With one-third of homeless people estimated to have serious mental health problems, the Department has stressed its participation on and commitment to the work of the Governor's Task Force to Study Homelessness, which has been examining the problem of homelessness in Maine. The final report of this task force has made a number of important recommendations, including increased transitional housing resources for persons with mental illness.

Effective September, 1985, a restructuring of Departmental responsibilities established the new Bureau of Children with Special Needs, formed from the existing Office of Children's Services. The new Bureau assumed responsibility for the Department's services to children, incorporating functions from both the Bureau of Mental Retardation and the Bureau of Mental Health.

In this past year much public attention has also been focused on mental illness and the criminal justice system. After careful consideration by the Judiciary Committee of the Legislature, major changes were made in our law governing the insanity defense and the release of persons found to be not responsible by reason of insanity. We believe these changes will improve what has been sound policy in this area.

Twenty-four hour crisis outreach services have long been identified as a major need throughout the state, and the three Crisis Stabilization Program pilot sites, started in 1985, have been highly effective in working with mentally ill individuals in crisis in York County, Portland, and Kennebec County. These three programs, with their highly skilled staff and residential components, have made an impressive beginning to meeting

these urgent needs.

Although this was a year of much change at the Mental Health Institutes with both Superintendencies, now filled, vacant for some time, programs and services at the Institutes have continued to be enhanced such as in alcohol and drug abuse treatment and in adolescent and family programming. However, we continue to be concerned about the dramatic increase in the census at the Augusta Mental Health Institute. This concern has resulted in our inability to admit patients on a voluntary basis.

A major priority has continued to be placed on the needs of special populations of mentally ill persons: deaf persons, elderly individuals, adults with prolonged mental illness, persons with alcohol and drug abuse problems, and children and adolescents and their families. Greater interagency coordination, increased local planning and coordination, the development of specialized group homes, and greater interdisciplinary coordination and planning have been emphasized. A concerted effort has been made to increase public and professional knowledge and understanding not only about mental illnesses but the unique mental health needs of these special populations as well. An aware and informed citizenry has been important in the progress and gains made thus far.

In addition, the Department's continuing commitment to the importance and involvement of families and consumers remains the highest of priorities. The value of the time and effort shared by these individuals is without measure. Their advocacy has made a critical difference in improving services to Maine's citizens who have mental illness.

Maine is, I believe, remarkable in the progress and commitment it has made in mental health and has grown substantially in its understanding of mental illness. National recognition for this progress has come from a recent report, ranking state programs for seriously mentally ill persons by the Public Citizen Health Research Group in Washington, D.C., in which Maine was ranked fourth in the country for its system of hospital and community care. The report specifically cited the ongoing interest and support of the Governor and the Legislature, the leadership at the state level, and the growing family and consumer movement. This understanding shows not only how much we, as a state, have accomplished but also inescapably points to what we have yet to do and urges continued efforts where needs have not yet been met.

We thank you all for your involvement and commitment and ask that you let us know your suggestions and concerns. We hope you find this report useful and informative.

Sincerely,

Kevin W. Concannon

Kevin W. Concannon
Commissioner

KWC/tlc

TABLE OF CONTENTS

INDEX OF FIGURES AND TABLES

INTRODUCTION

The system of Mental Health Services in Maine is complex and encompasses a range of activities meant to meet a variety of needs, including:

- Promotion of mental health and wellness.
- Prevention of specific mental health problems and aid in coping with stressful life events.
- Intervention when mental health problems emerge, before they become severe or long-term.
- Provision of a variety of counseling and other therapeutic services to persons experiencing mental health problems.
- Rehabilitation of psychiatrically disabled persons.
- Long-term services when needed.

The mental health system must balance the needs of the many Maine people who have mental health problems, the resources available to meet those needs, and the availability of public and private providers of mental health and allied services. The Bureau of Mental Health, as the state mental health authority, acts as an advocate for the prevention of mental illness and the provision of effective treatment and rehabilitation services in settings most appropriate to the needs of clients and patients and their families. The Bureau is responsible for promoting the services to those persons needing intensive inpatient services, including those who, for their safety or the safety of others, require involuntary hospitalization. In addition, the Bureau provides services to the courts and criminal justice system, provides treatment and custody in forensic cases, and provides psychiatric services to the Maine State Prison.

The mental health needs of Maine citizens cannot be fully met with current resources, and these needs often must compete with other important human and health services for attention. A stronger state role in mental health system development has resulted in the prioritization of special populations in need of mental health services, a redefinition of services, and an increased attention to financial management.

PURPOSE OF "MENTAL HEALTH IN MAINE"

Mental Health in Maine 1985-1986 has several purposes:

- Provides an overview of mental health needs across the state;

- Serves as a guide to resources, outlining the mental health services licensed or funded by the Bureau of Mental Health for each service area;

- Serves as an annual report for the Bureau of Mental Health for Fiscal Year 1985, describing basic fiscal, program, client, and patient information; and

- Serves as an outline for the Department's goals, objectives, and activities, reviewing recent activities and the activities to be undertaken in the following months.

Mental Health Needs

MENTAL HEALTH NEEDS

A number of methods of measuring mental health needs exist; each method provides a different perspective. Estimates of the overall prevalence of mental health problems within the population is conducted using the findings of studies of people sampled and surveyed in epidemiological studies; indirect measures of mental health problems in a given area can be determined through social indicators, those factors, such as proverty, known to be linked to increased risk of mental illness; rates under treatment indicate the need being met in an area by showing the number of people receiving mental health services in relation to overall population; citizen participation in open forums provides input on unmet need and other concerns; client-based needs assessment looks at the psycho-social needs of individual clients; special population groups may be examined through task forces, reports, studies, and so forth.

PREVALENCE

Recent studies have found that the overall prevalence of serious mental health problems in the population at large is 20%. In Maine this means that 229,000 persons have mental health problems. The prevalence of specific disorders are: disabling anxieties, 8%; alcohol and drug dependency, 6 to 7%; depression or manic depression, 6%; schizophrenia, 1%; and personality disorders, 1%.

Serious mental health problems may occur less often in children and youth. Approximately 12% of persons in this age group may have serious problems, or approximately 37,056 in the state. Prevalence of serious mental health problems in the elderly is as high as 24%, which means approximately 36,221 persons age 65 or older in Maine have mental health problems.

Chronic mental illness, which combines factors related to diagnoses, duration of illness, and disability relative to various life functions, has a prevalency of .75% to 1.25% in the population at large. In Maine, between 8,593 and 14,322 persons suffer prolonged severe psychiatric disability.

The annual cost of psychiatric disorders in this country exceeds $40 billion.

SOCIAL INDICATORS

A number of social factors have been found to be correlated to an increased incidence of mental illness. These factors include low socio-economic status, unemployment, and lack of interpersonal social support. While specific formulas for determining mental health need by examining social indicators have not been developed, some planners utilize weighted scoring of various social factors to identify service areas where greater need can be anticipated. Examples of social indicators related to mental health problems, such as poverty and unemployment, are shown below. These figures are presented by county, although service area lines do not all conform to county lines (see service are descriptions).

Certain other indicators, labeled vital statistics, are another measure of mental health need -- out of wedlock births, infant mortality, death by suicide and accident, and divorce are all linked, directly or indirectly, to mental health problems.

TABLE 1

PERSONS IN POVERTY*
BY COUNTY - 1980 CENSUS

SERVICE AREA	COUNTY	TOTAL PERSONS 1/	PERCENTAGE OF PERSONS
I	AROOSTOOK	14,280	16.2%
II	PENOBSCOT	16,806	13.0%
	PISCATAQUIS	2,472	14.1%
	HANCOCK	5,882	14.6%
	WASHINGTON	7,360	21.6%
		32,520	
III	KENNEBEC	12,452	11.8%
	SOMERSET	7,200	16.3%
		19,.652	
IV	ANDROSCOGGIN	12,164	12.6%
	FRANKLIN	3,339	12.8%
	OXFORD	6,098	12.7%
		21,601	
V	CUMBERLAND	21,977	10.5%
VI	YORK	13,398	9.8%
VII	LINCOLN	4,248	16.7%
	SAGADAHOC	3,140	11.2%
		7,388	
VIII	WALDO	5,591	20.0%
	KNOX	4,589	14.4%
		10,180	
	STATEWIDE	140,996	13.0%

*POVERTY STATUS according to the U.S. Census varies by family size, age and urban/rural status, the average income for a single person in poverty in 1980 was equal to or less than $3,686 per year, for a family of four $7,412 per year (1983 poverty ceiling for a family of four is $9,900, due to inflation).

1/ Excludes persons living in group quarters.

TABLE 2

UNEMPLOYMENT*
BY COUNTY 1984

SERVICE AREA		COUNTY	NUMBER UNEMPLOYED**	UNEMPLOYMENT RATE***
I	AROOSTOOK	AROOSTOOK	3,920	9.7
II	EASTERN MAINE	PENOBSCOT	3,930	5.6
		PISCATAQUIS	560	6.7
		HANCOCK	1,380	6.0
		WASHINGTON	1,380	8.6
		SUBTOTAL	7,250	
III	KENNEBEC VALLEY	KENNEBEC	3,040	5.9
		SOMERSET	1,910	8.4
		SUBTOTAL	4,950	
IV	TRI-COUNTY	ANDROSCOGGIN	3,570	7.4
		FRANKLIN	1,070	8.0
		OXFORD	1,650	7.9
		SUBTOTAL	6,290	
V	CUMBERLAND	CUMBERLAND	4,430	3.9
VI	YORK	YORK	3,390	4.8
VII	BATH-BRUNSWICK	LINCOLN	750	6.4
		SAGADAHOC	730	5.2
		SUBTOTAL	1,480	
VIII	MID-COAST	WALDO	1,270	10.0
		KNOX	1,030	6.0
		SUBTOTAL	2,300	
			======	====
STATEWIDE		TOTAL	34,000	6.1

* From "Civilian labor Force Estimates By Month and Annual Average 1984", Maine Department of Labor, Bureau of Employment Security, Division of Economic Analysis and Research, February/April, 1985.

** Annual average per month.

*** Percent of Civilian Labor Force.

Birth Factors

Approximately sixteen percent (16.3%), or 2,711, of all births to mothers who were Maine residents were out-of-wedlock in 1984. The percentage of out-of-wedlock births of all births has increased in all but one year since 1960. The percent of illegitimate births ranges from 10.1% to 23.3% of births in Maine Counties.

TABLE 3

OUT-OF-WEDLOCK BIRTHS - BY COUNTY*
CALENDAR YEAR 1984

		ILLEGITIMATE BIRTHS	
SERVICE AREA	COUNTY	NUMBER	PERCENT
I.	AROOSTOOK	205	15.3
II.	PENOBSCOT	365	18.9
	PISCATAQUIS	54	21.3
	HANCOCK	99	15.8
	WASHINGTON	111	23.3
	SUBTOTAL	629	
III.	KENNEBEC	290	19.2
	SOMERSET	150	21.2
	SUBTOTAL	440	
IV.	ANDROSCOGGIN	281	18.3
	FRANKLIN	57	13.9
	OXFORD	114	17.4
	SUBTOTAL	452	
V.	CUMBERLAND	452	13.9
VI	YORK	277	13.2
VII	LINCOLN	56	14.0
	SAGADAHOC	49	10.1
	SUBTOTAL	105	
VII	WALDO	77	18.3
	KNOX	74	14.1
	SUBTOTAL	151	
		=====	=======
STATEWIDE	TOTAL	2,711	16.3

*Maine Vital Statistics 1984. Division of Data & Research, DHS

INFANT MORTALITY

The infant mortality rate in Maine in 1984 decreased to 8.1 per 1,000 live births, with 134 infant deaths statewide. Of the 134 deaths, 79 were neonatal deaths (within the first four weeks of life), with a neonatal death rate per 1,000 live births of 4.8. Infant mortality rates range from 2.4 in Lincoln County to 23.6 in Piscataquis County.

TABLE 4

INFANT DEATHS - BY COUNTY+
CALENDAR YEAR 1984

SERVICE AREA	COUNTY	INFANT NUMBER	DEATH RATE*	NEONATAL NUMBER	DEATH RATE*
I.	AROOSTOOK	12.	8.9	9	6.7
II.	PENOBSCOT	10	5.1	3	1.5
	PISCATAQUIS	6	23.6	5	19.7
	HANCOCK	4	6.4	3	4.8
	WASHINGTON	2	4.2	1	2.1
	SUBTOTAL	22		12	
III.	KENNEBEC	10	6.6	5	3.3
	SOMERSET	7	9.8	1	1.4
	SUBTOTAL	17		6	
IV.	ANDROSCOGGIN	15	9.7	9	5.9
	FRANKLIN	4	9.7	3	7.3
	OXFORD	3	4.5	2	3.1
	SUBTOTAL	22		14	
V.	CUMBERLAND	27	8.2	19	5.8
VI.	YORK	22	10.5	14	4.8
VII.	LINCOLN	1	2.4	0	0.0
	SAGADAHOC	4	8.2	1	2.1
	SUBTOTAL	5		1	
VIII.	WALDO	4	9.5	3	7.1
	KNOX	3	5.7	1	1.9
	SUBTOTAL	7		4	
STATEWIDE	TOTAL	134	8.1	79	4.8

\+ Maine Vital Statistics 1984. Division of Data & Research, DHS
* per 1,000 live births

TABLE 5

SOCIAL INDICATORS

SERVICE AREA		COUNTY	UNEMPLOYMENT	ILLEGITIMATE BIRTHS	INFANT DEATH	PERSONS IN POVERTY
I	AROOSTOOK	AROOSTOOK	X		X	X
II	EASTERN MAINE	PENOBSCOT			X	
		PISCATAQUIS		X		
		HANCOCK				
		WASHINGTON	X	X		X
III	KENNEBEC VALLEY	KENNEBEC		X	X	
		SOMERSET	X	X	X	X
IV	TRI-COUNTY	ANDROSCOGGIN	X	X	X	
		FRANKLIN			X	
		OXFORD	X	X	X	
V	CUMBERLAND	CUMBERLAND				
VI	YORK	YORK				
VII	BATH-BRUNSWICK	LINCOLN				X
		SAGADAHOC			X	
VIII	MID-COAST	WALDO	X	X		X
		KNOX	X	X		

(See map on opposite page for visual representation)

1 Unemployment greater than the statewide rate of 9.5.

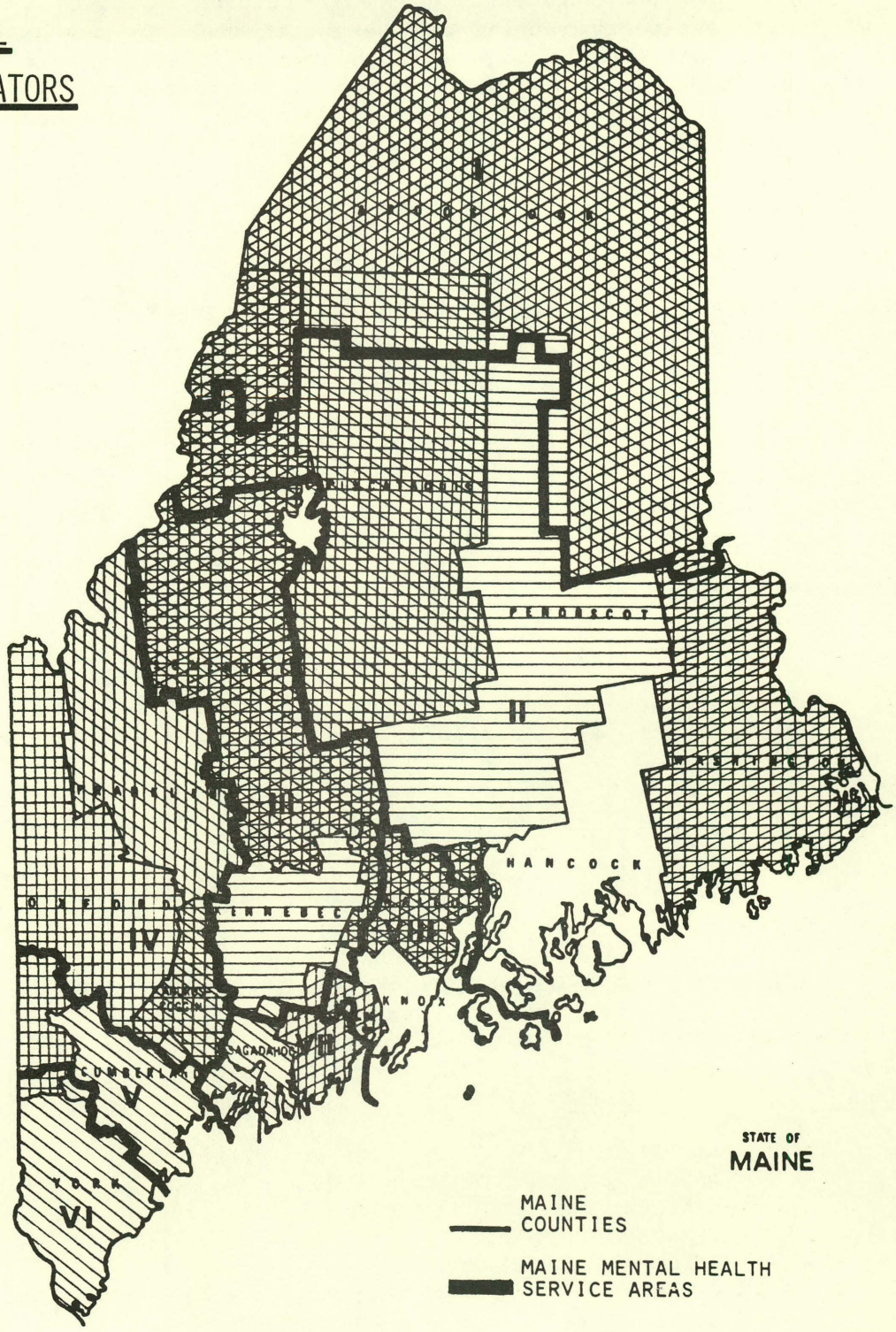
2 Illegitimate births greater than the statewide percent of out of wedlock births to live births of 14.7%.

3 Higher than median infant death rate of 7.6 per 1,000 live births.

4 Persons in poverty status greater than 13% statewide average.

*Maine Vital Statistics 1982. Division of Data and Research, DHS

SOCIAL INDICATORS



Mortality Factors

Suicides and accidents were major causes of death in Maine in 1984, with accidents ranking as the fourth cause of death for both men and women and suicide ranking tenth overall (suicide ranks as the 7th cause of death for men, 12th for women). The rate per 100,000 population was 14.7 for suicide and 38.5 for death due to accidents, in the case of both causes of death the rate of death is much higher for males than for females.

TABLE 6

RATE OF DEATH BY SEX - 1984*

	SUICIDE		ACCIDENT	
	NUMBER	RATE PER 100,000	NUMBER	RATE PER 100,000
MALE	132	23.7	296	53.2
FEMALE	37	6.3	145	24.6

Divorce*

There were 5,795 divorces granted during calendar year 1984 with a divorce rate of 5.0 per 1,000 population, with 56.1% or 3,250 divorces involving one or more minor children. With 12,525 marriages that same year, there was, therefore, one divorce for approximately every two marriages (2.2).

*Maine Vital Statistics 1984. Division of Data & Research, DHS

TABLE 7

PERSONS 18 YEARS AND OLDER WITH LESS THAN A HIGH SCHOOL EDUCATION 1980 CENSUS

SERVICE AREA	COUNTY	TOTAL PERSONS	PERCENTAGE OF ALL PERSONS
I	AROOSTOOK	21,812	34.9
II	PENOBSCOT, PISCATAQUIS, HANCOCK, WASHINGTON	46,256	27.7
III	KENNEBEC, SOMERSET	34,372	31.4
IV	ANDROSCOGGIN, FRANKLIN OXFORD	43,295	34.9
V	CUMBERLAND	38,508	24.4
VI	YORK	30,749	31.0
VII	LINCOLN, SAGADAHOC	10,587	27.4
VIII	WALDO, KNOX	13,243	30.18
	STATEWIDE	238,822	

RATES UNDER TREATMENT

Rates under treatment compares the number of persons served in an area, or some measurable unit of service, with the overall population of the area to yield a rate of persons treated, or units delivered, for a set number of persons. Treatment figures below compare persons receiving certain kinds of services and community inpatient days rendered with the 1983 estimated population of the service area. All rates are per 10,000 population. For example, a rate of 94.0 means 94 persons out of every 10,000 persons in the area received the specified treatment. Rates under treatment reflect "met need" and may be greatly influenced by the resources available, or by patterns of health care utilization, and should therefore be evaluated with caution.

TABLE 8

RATE OF COMMUNITY PSYCHIATRIC INPATIENT PATIENT DAYS PER 10,000 POPULATION - FY85*

SERVICE AREA	HOSPITAL	PATIENT** DAYS		RATE OF INPATIENT DAYS PER 10,000 POP.
I.	THE AROOSTOOK MEDICAL CENTER	2,475		267.78
II.	EASTERN MAINE MEDICAL CENTER	5,045		216.01
III.	KENNEBEC VALLEY MEDICAL CENTER	3,588	11,826	712.45
	MID-MAINE MEDICAL CENTER	8,238		
IV.	SAINT MARY'S HOSPITAL	5,967		341.33
V.	MAINE MEDICAL CENTER	9,281		481.10
VI.	SOUTHERN MAINE MEDICAL CENTER	2,995		197.88
VII.	REGIONAL MEMORIAL HOSPITAL	2,922		394.75
VIII.	PENOBSCOT BAY MEDICAL CENTER	1,756		289.26

*The dates of Fiscal Year 85 vary among the facilities.

** Source: Individual facilities.

TABLE 9

RATE OF ADMISSIONS TO STATE MENTAL HEALTH INSTITUTES OF RESIDENTS OF SERVICE AREAS* FISCAL YEAR 1985

SERVICE AREA	NUMBER ADMITTED	RATE OF ADMISSION PER 10,000 POPULATION
I. AROOSTOOK	56	6.06
II. EASTERN MAINE	260	11.13
III. KENNEBEC VALLEY	405	24.40
IV. TRI-COUNTY	202	11.56
V. CUMBERLAND	403	20.89
VI. YORK	116	7.66
VII. BATH-BRUNSWICK	55	7.43
VIII. MID-COAST	64	10.54

*47 persons were admitted to State facilities from a combination of out-of-state, out-of-country, no residence, and other.

TABLE 10

RATE UNDER TREATMENT (PER 10,000 POPULATION) BMH FUNDED SERVICES* - FY85

SERVICE AREA	OUTPATIENT	COMMUNITY SUPPORT
I. AROOSTOOK	187.39	103.54
II. EASTERN MAINE	88.76	24.62
III. KENNEBEC VALLEY	157.24	90.91
IV. TRI-COUNTY	168.29	41.24
V. CUMBERLAND	126.01	68.22
VI. YORK	90.38	40.70
VII. BATH-BRUNSWICK	177.78	36.61
VIII. MID-COAST	254.34	81.71
TOTAL, REGION I & II	116.72	46.99
TOTAL, REGIONS III - VIII	148.95	60.12
TOTAL, STATE	139.79	56.39

* These rates do not reflect services provided by general hospital outpatient clinics or by private providers.

CITIZEN PARTICIPATION

The Bureau of Mental Health places great importance on the involvement of Maine's citizens in the development of its programs and policies for meeting mental health needs throughout the state. The Mental Health Advisory Council, as well as advisory groups for elderly persons and deaf persons who are mentally ill, provide continuing input to the Bureau and Department. Throughout the year, work groups, task forces, and workshops address specific concerns. In addition, community mental health forums are held every year in an effort to encourage broader citizen participation and comment.

COMMUNITY MENTAL HEALTH FORUMS

The community mental health forums for this fiscal year were held in Bangor and Portland in January and provided information on the Department of Mental Health and Mental Retardation's activities and initiatives, with attention directed to efforts for specific special populations. Status papers on these efforts were presented and discussed.

Community members attending the forums expressed several clear needs:

Additional decent, low-cost housing is critically needed throughout the state. No or "poor housing only makes the illness worse."

Education and information on mental health and mental illness need to be considerably increased and made a priority -

- In the school systems, children need to be taught more about mental health and related problems such as substance abuse. At the same time, the teachers should be taught how to teach about these issues and how to teach/work with special needs children. Meeting prevention and early intervention needs was strongly urged.
- Families and service providers need more information on mental health needs and issues in order to educate and advocate more effectively.

SSI/SSDI limitations on allowable income and assets of disabled individuals are too stringent, have a negative effect on vocational development and quality of life, and should, therefore, be reviewed.

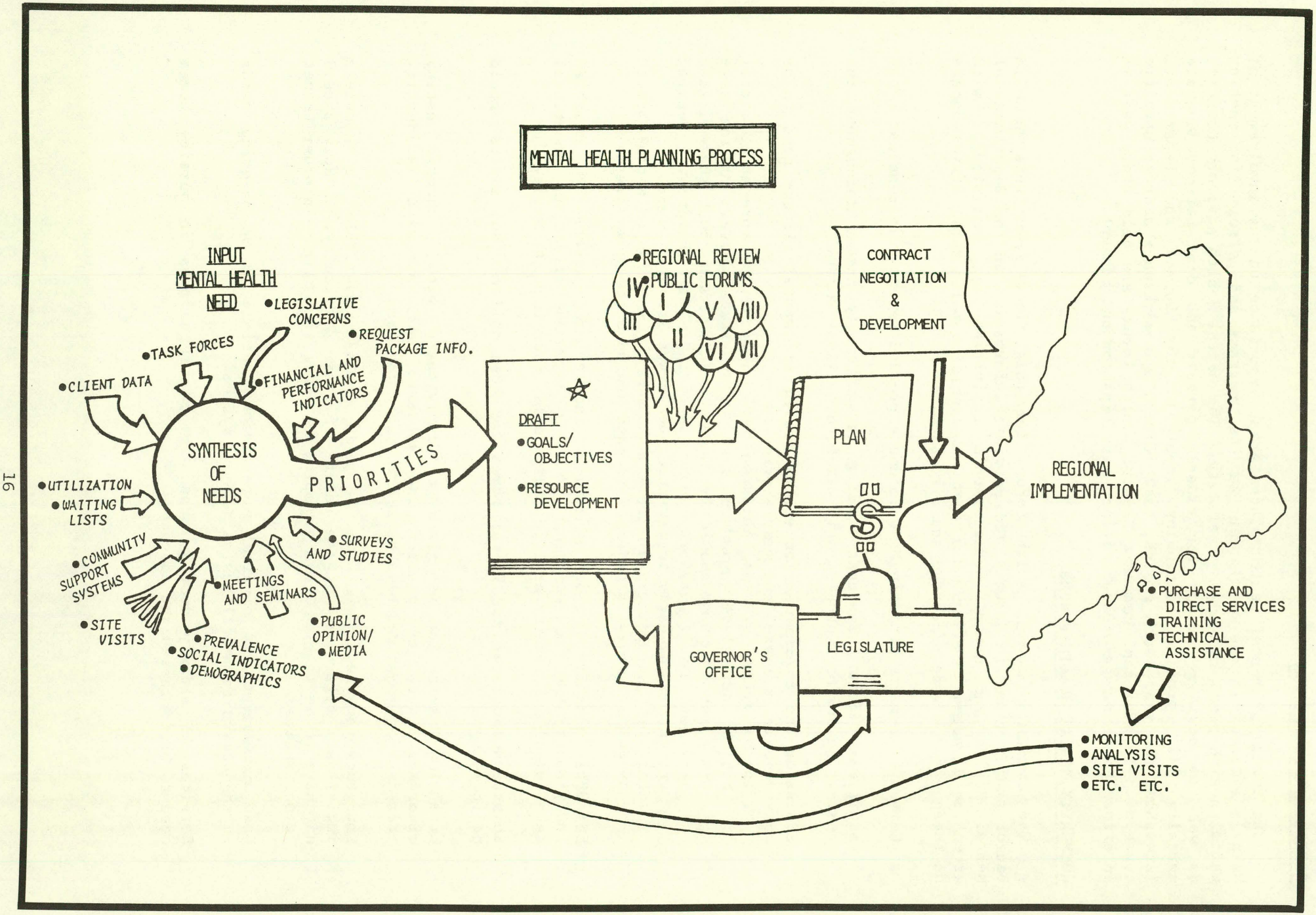
Reimbursement rates for foster homes for both children and adults should be increased.

Attention needs to be given to individuals with **chronic eating disorders**, such as bulemia and anorexia nervosa, with residential treatment programs established specifically for them.

Emergency shelters need to be made readily available to homeless individuals regardless of the nature of their difficulty. People should not have to be labeled - for example, as being alcoholic - in order to get into a shelter.

Case management and clinical supervision continue to be on-going needs in the community mental health service system.

Services to elderly deaf persons with mental illness in nursing homes need to be increased and assessed.


MENTAL HEALTH PLANNING PROCESS
INPUT
MENTAL HEALTH
NEED
•LEGISLATIVE CONCERNS
•TASK FORCES
•REQUEST PACKAGE INFO.
•CLIENT DATA
•FINANCIAL AND PERFORMANCE INDICATORS
SYNTHESIS OF NEEDS
PRIORITIES
•UTILIZATION
•WAITING LISTS
•COMMUNITY SUPPORT SYSTEMS
•SURVEYS AND STUDIES
•MEETINGS AND SEMINARS
•SITE VISITS
•PREVALENCE
•SOCIAL INDICATORS
•DEMOGRAPHICS
•PUBLIC OPINION/
•MEDIA
•REGIONAL REVIEW
•PUBLIC FORUMS
IV
I
V
VIII
III
II
VI
VII
DRAFT
•GOALS/ OBJECTIVES
•RESOURCE DEVELOPMENT
CONTRACT NEGOTIATION & DEVELOPMENT
PLAN
REGIONAL IMPLEMENTATION
GOVERNOR'S OFFICE
LEGISLATURE
•PURCHASE AND DIRECT SERVICES
•TRAINING
•TECHNICAL ASSISTANCE
•MONITORING
•ANALYSIS
•SITE VISITS
•ETC. ETC.

Special Populations

MENTAL HEALTH NEEDS OF PEOPLE WITH SEVERE DISABLING MENTAL ILLNESS

In Maine today there are an estimated 8,000 or more men and women who are experiencing severe disabling mental illness. Each day at least 700 of these require psychiatric hospitalization. More than 3,000 others are receiving mental health services from community agencies. Others receive services from private practitioners and many receive no services at all.

These psychiatrically disabled men and women, when not hospitalized, live in a variety of different settings. 125 to 150 live in specialized community residential programs. Another 1,200 or so live in boarding or nursing homes. Many live with family or friends and many live alone. A small number are occassionally homeless and many more are at risk of being homeless.

People with severe mental illness are often unable to cope with the basic activities of daily living and lack the skills necessary to find and keep a job. This results not only in inadequate income but makes them dependent on others for essential services and assistance. Frequently, the families of these disabled adults are the primary care givers, thus the illness has a tremendous emotional and financial impact not only on the individual but the entire family.

This is especially true for the new generation of young adults up to the age of 40, who have become ill in what is known as the era of deinstitutionalization. Without recourse to long-term hospitalization with the inadequacy of the current system of community care, these young people present serious problems for their families, the service system, and themselves. Their lives are frequently complicated by the use of alcohol and other drugs which are common in this peer group.

These young people, while sharing many of the same service needs as other people with mental illness, have unique needs of their own which require different models of service delivery.

They share a need for psychiatric treatment, for training and assistance in activities of daily living, development of vocational skills, and assistance in identifying and obtaining essential services such as income maintenance, housing, and other support services. Because they often reject traditional services and are unwilling to seek treatment, these young adults often find themselves in crises brought on by their mental illness interacting with their social environment. They require an outreach oriented approach to providing services and a responsive crisis assistance capability that can intervene wherever and when ever needed. Additionally, since the service system is so diverse and complex, they need someone to actively assist them in getting the mental health and supportive services they need, including housing and an adequate income.

The families of people with mental illness are also profoundly affected and have many needs of their own. They need to seek support from one another to learn as much as possible about mental illness and its treatments and to share in the treatment process in a constructive way.

Recent Activities

The Bureau of Mental Health is committed to the development of a comprehensive system of treatment, rehabilitative and support services for psychiatrically disabled adults and their families. This commitment is based on the belief that people with major mental illness have significant potential for productive and fulfilling lives. It is the responsibility of the Bureau of Mental Health to provide leadership in developing a coordinated system of community support services that creates opportunities for people to realize their potential to the greatest degree possible.

Over the last several years this commitment has been translated into a number of significant accomplishments which have improved the services system and focused attention on the needs of people with mental illness and their families.

Program Developments statewide

A range of housing options with 19 separate programs from subsidized independent living to rehabilitative community residences.

Vocational training and employment programs focused on integrated work sites.

Outreach oriented crisis assistance programs with respite and transitional housing.

Maintenance of full accreditation at AMHI and BMHI.

Self-Help and Advocacy activities for families and consumers include:

12 local and one state-wide affiliate of the National Alliance for the Mentally Ill.

Participation in Regional and National consumer conferences, regional and national family conferences.

Several consumer run organizations and clubs.

Development and implementation of model regulations for the rights of persons receiving mental health services.

Activities to promote **public awareness** include:

Establishment of the Office of Community Support Systems to maintain focus on the needs of persons with prolonged mental illness.

Identification, through training and public education of the special needs of young adults with mental illness.

Development of numerous publications and media events which focus on aspects of mental illness, treatment, rehabilitation and related issues.

Current Initiatives

The Bureau of Mental Health will continue the existing directions in program development, self-help and advocacy, and public awareness. Additionally, the current year has seen a new emphasis on local level planning and coordination of services involving both the public and private sector and families, consumers and board members.

This has taken the form of several activities including:

The creation of the Area IV Mental Health Services Coalition to plan for and develop housing, crisis assistance, social club and vocational services in the Tri-County area. This has resulted in funding for a social center and additional housing resources in the Lewiston/Auburn area.

Vocational services planning and coordinating groups in Bangor and Portland which have resulted in a new vocational program in Portland and expanded programs in Bangor.

Local level housing planning groups meeting to develop new resources and to target existing ones to people with psychiatric disabilities.

The Governor's Task Force on Homelessness to look at the causes and solutions to the problems of homelessness.

The Bureau of Mental Health is taking steps to define the community support systems in several ways such as:

Developing service definitions and standards beginning with case management services.

Promoting psychiatric rehabilitation through training of staff in both community and institutional settings.

Provision of technical assistance to family groups, consumer organizations, and community support providers through financial and staff support.

MENTAL HEALTH NEEDS OF DEAF PERSONS

Needs

Maine state law defines a deaf person as one whose hearing is nonfunctional for the purpose of ordinary communication. In other words, hearing is so seriously impaired that information is primarily received through vision. Hearing impairment is the second most prevalent disability in the U.S. with the Maine deaf population estimated at 6,765. Similar to the general population, the deaf community needs to access a wide range of mental health services; however, only recently have programs begun to accommodate services to this population.

Mental health problems can occur with greater prevalence in persons with severe hearing loss, and many studies have demonstrated that communication deficits experienced early in life can seriously impair cognitive and personality development. The incidence of mental health problems in this population is increasing as the current young adult deaf population, many deafened from birth by a rubella epidemic in 1963-1964, matures. Statistics from Maine and national sources indicate an increase in physical as well as mental handicaps within this group.

Inaccessibility of services is the major barrier faced by deaf persons in need of mental health services. Throughout the deaf community American Sign Language remains the primary language, even among those who report little difficulty with spoken English. Service providers who are fluent in sign language and knowledgeable about the characteristics and cultural values unique to the deaf community can provide the most effective services to that population. However, due to the overall scarcity of professionals with these skills and the relative infrequency of deaf clients in sparsely populated areas, other less ideal measures are often necessary. In addition, deafness/mental health problems are often complicated by additional handicaps including deficits in independent living and social skills, learning disabilities, physical handicaps, and existing attitudes and misconceptions about deafness by others.

Shortcomings in service provision to deaf consumers exist in the entire continuum of mental health services despite the considerable gains made in recent years. These shortcomings are not restricted to Maine but rather confront mental health professionals nationwide, necessitating the accommodation of existing services and the development of programming specific to deaf consumers.

Recent Activities

Over the past year a number of measures were implemented to improve mental health services for deaf persons in the following areas: consumer involvement, service coordination, education and outreach, and inpatient and community services. Based on actual records of interpreter services purchased by the Department for mental health service situations, approximately 300 hours of interpreter time were provided in community mental health centers and over 1000 hours of interpreter time provided in state psychiatric hospitals. Based on the past utilization of interpreters in mental health settings, a steady increase in the use of state mental health facilities by the deaf

community can be seen. This growth is an indication that, because services have not traditionally been accessible to this population, the current utilization level will continue to grow as deaf persons become more and more aware of the availability of services and develop greater trust in service providers.

These activities were highlighted by the development of an eight-bed therapeutic residential program for deaf persons with mental illness which opened in April, 1986. Other significant developments have included regional orientations on deafness and mental health, participation by members of the deaf community in all aspects of programming, accommodations at the Augusta Mental Health Institute, presentations to the deaf organizations across the State, and the ongoing participation of the Advisory Committee on Mental Health Services to Deaf Persons. These accomplishments are addressed in detail in the first year-end report on mental health services to deaf persons in Maine, issued in September, 1985 by the Bureau of Mental Health with the direction of the Advisory Committee. Copies of this report have been distributed to agencies in Maine, as well as to agencies in other states at their request.

Current Initiatives

The Coordinator's office, under the direction of the Director of the Bureau of Mental Health and the Advisory Committee on Mental Health Services to Deaf Persons, continues to be the focus of mental health service development for deaf persons. Ongoing activities of the coordinator include advocacy with state and private agencies to assure that the mental health needs of deaf persons are addressed; consultation in specific client situations; development of uniform procedures for accessibility; and education and training for mental health providers, interpreters, and consumers.

New projects for 1986 will continue to focus on service developments in state psychiatric hospitals and at the community level and include the following:

- establishment of an itinerant counselor position, working specifically with deaf persons, that would serve several deaf population centers in Maine;
- establishment of a professional position at the Augusta Mental Health Institute that would work primarily with deaf patients and possess skills in American Sign language and the provision of psychiatric services to deaf persons;
- initiation of hearing screenings in the two state psychiatric hospitals to improve the identification of hearing impaired persons;
- development of further housing options for deaf persons with mental health needs;
- assurance that assessments of deaf clients are administered by professionals trained and experienced in deafness;
- development of training for providers to work with deaf persons in mental health specialty areas;
- development and implementation of an accessibility plan for deaf mental health recipients in conjunction with the Department 504 coordinator;
- assessment of the need for service development for deaf children and deaf substance abusers.

These projects are designed to serve Maine deaf persons in greatest need and to function as a base for future service development. The coordinator will design an on-going system of services for deaf persons with mental health needs and advocate for its implementation through legislation in the next regular legislative session.

MENTAL HEALTH NEEDS OF ELDERLY PERSONS

The elderly population is one of the fastest growing segments of our society. Currently in Maine the elderly comprise 13.1% of the state census, or about 152,000 persons.

For a number of reasons, including the fact that people experience more changes and losses in later years than at any other time in life, the incidence of mental health problems is significantly higher among the elderly than any other age group. But, despite the higher prevalence of mental illness among older people, elderly persons receive less than 4% of all publicly supported mental health services in Maine and across the nation. Values and norms about self-sufficiency as well as a reliance on more traditional non-mental health networks for emotional support keep many elders from clinicians' doors, while misperceptions and even personal fears about growing old keep many clinicians from elders in need. Generally, a combination of stigmas attached to mental illness and stereotypes about aging and mental capacity tend to inhibit public awareness and acceptance of the mental health needs of older persons.

The Bureau of Mental Health stands committed to the principles that comprehensive mental health care for elderly persons must begin with the coordinated efforts of mental health care providers and providers of services to elderly persons and that a knowledge of aging and the skills to work with the elderly must underlie all efforts to develop comprehensive and coordinated programs and services. Within the past year the Bureau has increased its involvement in exploring the range of mental health needs of older people in Maine and has worked toward the development of rational policies and programs designed to meet those needs.

Recent Activities

- In February 1985, the Bureau of Mental Health established the Mental Health Elderly Services Coordination Project and made the following as its primary goals: 1) Planning and development of training and consultation programs on aging and mental health for professionals, elderly persons and their families, and the public; 2) facilitation of increased coordination between aging and mental health networks statewide in the development and implementation of programs and services impacting on the mental well being of elderly persons; and 3) exploration and development of resources and funding for new and expanded programs and services to elderly persons.

- Also, in February 1985, the Joint Advisory Committee on Mental Health Services to Elderly Persons convened to oversee the implementation of the 1984 recommendations of the Task Force on Mental Health Services to Elderly Persons and made as its primary focus housing issues and training and consultation programs for providers of services to the elderly and providers of mental health care in the community, as well as boarding and nursing home personnel.

- The Mental Health Elderly Services Coordination Project has worked closely with the Alcohol and Drug Abuse Planning Committee, Regional Councils on Alcoholism and Drug Abuse, and Area Agencies on Aging in the planning and presentation of several workshops on aging and substance abuse for professionals, elderly persons, and the public throughout the state.

- The Mental Health Elderly Services Coordination Project has been instrumental in the development of four regional aging/mental health coordinating committees in Maine, designed to address the mental health needs of elderly persons using existing local resources, which has contributed significantly to increased communication between elderly services and mental health care providers statewide.

- The Mental Health Elderly Services Coordination Project has initiated or collaborated on several federal grant applications for programs to promote the mental well being of elderly persons in Maine, including 1) two applications to the National Institute of Mental Health with the Program on Aging at Bangor Mental Health Institute and the Human Services Development Institute at USM for research on family caregivers of victims of Alzheimer's Disease, and mental health outreach programs for the elderly; 2) an application to the National Institute of Mental Health as part of the Bureau of Mental Health's proposed comprehensive mental health planning project; and 3) an application to the Department of Health and Human Services for mobile psychogeriatric training teams in boarding and nursing homes statewide.

Current Initiatives

- The Bureau of Mental Health continues to work with the Bureau of Maine's Elderly in the development of a twenty-bed boarding and respite care facility and resource center for victims of Alzheimer's Disease.

- The Mental Health Elderly Services Coordination Project is currently involved with the Division of Residential Care, DHS, Citizen's Interest Group of Bangor, and the Program on Aging, BMHI in the development of a six-bed boarding home for chronically mentally ill elderly persons in the Bangor area.

- The Bureau of Mental Health is in the process of establishing contracts with three Area Agencies on Aging to develop consultation and training programs for family caregivers of elderly persons.

- In the spring of 1986 the Mental Health Elderly Services Coordination Project will present a training workshop series on the mental health needs of elderly persons for providers of mental health care and direct services to elderly persons.

- The Mental Health Elderly Services Coordination Project is currently developing a public information campaign on the promotion of mental health through activity and involvement for older people, which will include Public Service Announcements and literature.

- The Mental Health Elderly Services Coordination Project continues to pursue increased coordinated planning of programs and services for elderly persons throughout Maine on both regional and state levels.

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MENTAL HEALTH NEEDS OF PERSONS WITH SUBSTANCE ABUSE PROBLEMS

National data approximately indicates that 5% of the overall population are alcoholics and another 10% to 15% have significant alcohol abuse problems. This translates into 250,000 Maine citizens with serious drinking problems. Studies show this level of alcohol abuse holds true for mentally ill and mentally retarded persons and is even higher among children and adolescents who are emotionally disturbed. For example, Maine findings indicates that 60% of admissions to the state mental health institutes have significant substance abuse problems.

Recent Activities

Funds, available from the Premium Law, give the Department of Mental Health and Mental Retardation the continuing opportunity to deal more effectively with the problem of alcohol abuse among persons who are mentally retarded or mentally ill. With a modest ~~$250,000~~ 600,000 annual allocation, the Department has undertaken a comprehensive systems approach which includes elements of prevention, education, research, and treatment.

These initiatives include:

-- The Fetal Alcohol Effects Developmental Disabilities Project makes Maine one of only four states nationally to conduct programs aimed at educating families and physicians statewide in order to prevent developmental disability and fetal alcohol syndrome(FAS). Additionally, hundreds of articles, pamphlets, brochures, bumper stickers, and T.V. spots have been distributed. A major physician training program ~~is planned~~ was accomplished in 1986 and is currently being expanded.

-- The Homebased Family Intervention project, a family substance abuse short-term intervention treatment program, was designed to keep families together during crisis rather than having family members referred to the more traditional and expensive foster care, criminal justice, or residential treatment center systems. Because of the projects' successes, ~~a second team has been~~ two additional were added for ~~1986~~. FY 1987

-- A system has been developed for mentally retarded alcohol abusing clients which has resulted in a published guide to the identification, treatment, and aftercare of this dual-diagnosed population, making Maine the first State in the nation to undertake such a program. Eight(8) agencies have been trained in this model and now make up a statewide network. Specially trained case managers and/or developmental tutors ~~will be the next activity to occur in 1986~~. are being developed as well as a long term highly specialized 3 bed residential facility.

-- The Department continues to provide comprehensive training packages for the diagnosis, treatment, and case management of mentally ill alcohol abusing clients. To date, over 200 community-based clinicians have received this training. The Department will ~~expand~~ continue this training effort to service agencies serving adolescents for ~~FY86-~~87.

-- Mentally ill alcohol abusing clients, who currently account for over half of our state psychiatric hospital admissions, receive dual diagnosis services and treatment at both state psychiatric institutions. Once these clients are discharged to the community, appropriate aftercare is being made available through extensive community training efforts and contractual agreements, particularly in the southern part of the state. These systems, once evaluated, will be replicated to the northern part of the state.

-- The Androscoggin County Jail project, which assists alcohol abusing offenders and links together the mental health, correctional, and judicial systems in the Tri-County area has been so successful that it is being used as the model for ~~possible~~ replication ~~statewide.~~ to two other counties, Oxford and Franklin during FY87.

The Department has worked to assure the cooperation and coordination of the systems and agencies involved in these projects. The Department contracts for these projects through existing alcohol treatment, education, and prevention oriented agencies and requires project advisory committees made up of representation from various sectors of the community such as consumers, clergy, providers, courts, etc. The projects are carefully monitored and routinely evaluated, and comprehensive statistical information is gathered on all projects to determine the success of each program and to develop profiles of the clients served. These efforts ensure that the projects are accountable and responsive to local needs.

Current Initiatives

As a result of the Department's project monitoring, successful components and/or activities are methodologically integrated into ongoing Departmental programs. Examples of this include the merger of the regional FAS pilot project into a comprehensive statewide developmental disabilities prevention program. Similarly, the state psychiatric institutions have been actively persuing avenues to routinize, through institutional resources, dual-diagnosis care. Finally, the outpatient/referral component of the Mental Retardation Alcohol project is being assimilated into ongoing regional Bureau of Mental Retardation services in order to provide more expeditious care.

The long-term direction of this Department is to continue the ongoing capacity building of our existing prevention and intervention systems, as well as to increase our knowledge through the development of special demonstration projects directed to elderly persons with poly-chemical addiction, and to increase home and community base care availability.

The Department's effort to provide a coordinated and cooperative system of substance abuse services is based on the principle that such services and support must be provided in a way that respects the dignity and rights of the clients and their families and builds upon the existing capacities and resources of the Department.

NEEDS OF CHILDREN, ADOLESCENTS, AND THEIR FAMILIES

Many Maine children and youths experience handicapping mental disability, emotional disturbance, serious social malajustment, or neglect or abuse. Ten to twelve percent of the 93,000 Maine children under 5 years of age, or 9,300 to 11,000 children, are either handicapped or at risk of becoming handicapped. Special education programs have found that, of the 212,223 school age children in our State in 1984, 27,069 or 12.7% are handicapped. Of this group of handicapped students, 4,894 are mentally retarded and 4,124 seriously emotionally or behaviorally disturbed or mentally ill. Another group with mental health needs, which may overlap other categories, are those Maine children who suffer neglect or physical and/or sexual abuse. In 1982 and 1983 there were nearly 9,000 new verified cases of child abuse, of which over 1,500 cases involved sexual abuse. Reports of sexual abuse increased 215% from 1982-1983. Abuse and neglect, and more specifically sexual abuse, often result in severe psychological problems.

Both nationally and in Maine, greater attention is now being focused on the needs of emotionally handicapped and abused children and youth. The Department of Mental Health and Mental Retardation is increasing its emphasis on the development of comprehensive service delivery systems, responsive to the needs of such children and youths and their families, that are tailored to the needs of each community and area. In addition, national attention is now being paid to early intervention services for young children who experience handicapping conditions or developmental delays, or who are at risk of developing such conditions. Maine has been very involved in examining and promoting preventive and early intervention services, based on studies which have shown that such services are more effective and more economical in the developmental process of children than are later remediation, treatment, or crisis-oriented services. It is now currently accepted that most handicapping conditions and their impact on the child and his or her family have much in common and require a more unified programmatic and administrative approach within the Department, in close coordination with other state and local agencies working to meet these needs.

Recent Activities

Until September 1985 Maine served its mentally retarded, mentally ill, behaviorally disturbed, and developmentally delayed or disabled children through three administrative units within the Department of Mental Health and Mental Retardation: The Office of Children's Services, the Bureau of Mental Health, and the Bureau of Mental Retardation. Effective September 1985:

*** The new Bureau of Children With Special Needs is responsible to plan, oversee, and deliver departmental services to developmentally delayed or at risk 0-5 year old children and to emotionally disturbed/developmentally delayed 6-20 year olds and their families. Legislation creating the Bureau gives priority to early intervention and programs designed to prevent the removal of children from their homes and communities, or, if removal is necessary, to expedite their return.

In the past year the Department of Mental Health & Mental Retardation has received four major federal grants to improve the service system for children and adolescents and their families in Maine.

Maine Child and Adolescent Services Systems Project (CASSP) is a joint initiative of the Department of Mental Health and Mental Retardation and the National Institute of Mental Health to improve services for children and adolescents who have severe emotional or behavioral disabilities. Maine has two comprehensive pilot case coordination sites in York County and Southern Penobscot County.

The second grant, from the Federal Office of Special Education and Rehabilitative Services, will demonstrate Preventive Intervention and Support for at risk or handicapped 0-3 year olds and their families in two sites.

A third federal grant, through the Office of Developmental Disabilities, seeks to serve autistic school age children and their families through the provision of home and school based training and support in two pilot areas.

The Department has also received a three year grant from the Office of Human Development Services to develop a statewide system of respite care that will provide coordination, referrals, and parent/provider training.

The Bureau has given special attention to developing home-based intervention programs to prevent out-of-home placements. As of November 1985, nine such programs were operational (Presque Isle, Machias, Bangor, Rockland, Brunswick, Skowhegan, Lewiston, Saco, and Portland).

Current Initiatives

*** The Bureau of Children with Special Needs will continue collaboration with the Interdepartmental Coordinating Committee for Preschool Handicapped Children to strengthen Maine's statewide network of preschool coordination programs.

*** The Bureau will collaborate with the Interdepartmental Coordinating Committee to improve the coordination of services for severely emotionally disturbed children and adolescents. Priority areas for 1986 include (a) a coordinated network of sexual abuse treatment services, (b) secure treatment services, (c) preadolescent services, and (d) out-of-home placement funding and related issues.

*** The Bureau will give special attention to improved services to meet needs in the following areas: identification of high risk groups and preventive intervention; behavior stabilization/secure treatment services; emergency services; therapeutic foster care and therapeutic group homes; therapeutic day services, sexual abuse treatment, and increased inpatient resources, as well as services for the mentally ill offender.

*** The Department will continue implementation of the Child and Adolescent Service System Project at state level and in York and Southern Penobscot pilot regions to improve coordination of planning and case coordination for multi-problem children and their families.

*** The Department will continue implementation of its Preventive Intervention projects and Respite Care grant.

MENTAL HEALTH SERVICES FOR PEOPLE WITH MENTAL RETARDATION

Need

A major focus of Bureau of Mental Retardation planning and development is the provision of mental health services to a significant sector of the MR population who suffer from mental illness and associated disabilities. Research points to an up to three times greater occurrence of mental illness in individuals with developmental delays than in individuals with "normal" intellectual development. There is substantial evidence to support the theory that, with limited processing and coping abilities, mentally retarded individuals are susceptible to the whole range of mental and emotional disorders. According to the Management Information System data, extrapolated to the present, there are 764 (21%) BMR clients who have exhibited mental health difficulties to some degree. This number represents a dramatic increase (73%) in the identification of this dual diagnosis population.

Mental health and behavioral problems are responsible for the bulk of crisis situations which may lead to emergency institutional admissions. The provision of mental health services to mentally retarded persons has been inconsistent throughout the state, being in large part dependent upon case by case arrangements between individual regions and local mental health centers. Of equal significance are the complex treatment issues that mentally retarded mentally ill individuals present to practititioners. Traditional psychotherapy has not been an effective treatment mode for the majority of mentally retarded clients who have been in need of mental health services. In that the provision of effective treatment for mentally retarded mentally ill persons is at a pioneer stage of development, ongoing training in current approaches and methodology is critical.

Recent Activities

The opening of the Behavior Stabilization Unit at Pineland Center in 1983 has been the Bureau's most concerted effort to provide behavioral, psychological and psychiatric services to mentally retarded, behaviorally disordered persons. The conception of a BSU grew out of an Intradepartmental Committee (BMR, BMH, Pineland, AMHI, BMHI) looking at the needs of this special, but contentious, population which was not being adequately served. The goal of successful community placement has been realized in a number of cases. Access to appropriate, community-based mental health services, however, continues to be a major deficit. Mental health services are generally contracted on an individual basis according to the need specified in the Individual Program Plan.

The Bureau of Mental Retardation has undertaken an active role in developing specific and comprehensive community placements for a number of mentally retarded clients residing at AMHI and BMHI. Current development projects 7 AMHI placements by February, 1986 and 5 BMHI placements within the first six months of 1986.

Current Initiatives

The Department of Mental Health and Mental Retardation submitted an application for a federal grant to fund a Comprehensive Mental Health Planning Project. A major emphasis of the Project was planning for Mentally Retarded persons who are mentally ill. Three major goals were established.

I. To improve the capacity of the state to effectively plan for mentally retarded mentally ill individuals by basing its efforts on a thorough and accurate data and needs assessment foundation.

II. To enhance or initiate Intra- and Interdepartmental planning for mentally retarded mentally ill persons.

III. To improve accessibility of community based mental health services for mentally retarded mentally ill individuals.

The overriding goal of this planning process was to address the mental health needs of mentally retarded persons, on a proactive basis, thereby diminishing the frequency and severity of crisis and emergency situations which frequently result in institutional admissions.

Secondly, the Department will sponsor and promote training sessions and workshops where experts in this area will impart current research, findings, and approaches to professionals who work with this particularly intractable population. Recognizing that effective mental health treatment for mentally retarded individuals is, in itself, an emerging clinical field the result of training will be an increased ability to provide appropriate mental health services for mentally retarded individuals.

HOMELESSNESS AND MENTAL ILLNESS

INTRODUCTION

The problem of homelessness[1] has been receiving increasing attention in communities across the country. Reports from cities in all regions, as well as Maine, have documented the increasing numbers of people who wander the streets and sleep under bridges[2], as well as the increasing numbers that have sought shelter from both public and voluntary agencies.

There is also consensus that the homelessness population is increasing.

Changing Nature of Homeless Population

The homeless population is heterogeneous and is comprised of many groups including runaway children, immigrants, displaced families, unemployed, battered women, minorities, the elderly. A significant number of individuals with serious drug problems as well as chronic mental illness continue to be identified among the homeless, as well as people who have recently lost their jobs or public assistance, lost their residence, or who have otherwise been unable to find affordable housing. Also, shelters in Maine and across the country are serving younger people, including women and children.

Causes of Homelessness

A number of factors have been at work to contribute to the increase in homelessness:

- increased unemployment
- deinstitutionalization of mentally ill persons and the lack of community-based services for them
- increases in personal and family crises
- cuts in public assistance and disability programs
- decline in low-income housing supply
- alcohol and drug abuse problems.

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1 There is no precise, commonly accepted definition of homelessness. The definition assumed here is "those persons who lack resources and community ties necessary to provide for their own adequate shelter."

2 Estimates range from 250,000 to 3 million nationally on any particular day and between 250 to 350 in Maine.

Homelessness and Mental Health: Deinstitutionalization and Demography.

The increases in homeless mentally ill persons[3] result from a combination of factors, the most important of which are the policy of deinstitutionalization and changes in the nation's demography.

The homeless mentally ill represent individuals, who, twenty-five years ago, would have been admitted to psychiatric hospitals and would have remained there indefinitely. Today, largely due to the policy of deinstitutionalization[4], these individuals are either diverted from inpatient hospital care or enter state hospitals but tend to stay for a short period of time and then are returned to the community.

However, it should not be concluded that deinstitutionalization per se is the cause of homelessness among mentally ill persons. It is also the result in a marked change in demography resulting in a marked increase in the number of young adults in our society who now make up one-third of our population. The result is that the absolute number of young persons at risk of developing schizophrenia and other major mental illnesses has increased dramatically[5].

The interaction of these factors, deinstitutionalization and demography, has resulted in a whole generation of young persons with mental illness who have grown up not in hospitals, but in the community.

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3 A mentally ill individual is a person who has a major mental disorder and has a severe and persistent disability requiring mental health services to alleviate the disability and its consequences.

4 The policy of deinstitutionalization includes

(1) the decline in state psychiatric hospital populations (in Maine, this occurred in the late 1960's and early 1970's, resulting in a decrease from 2600 patients at AMHI and BMHI to the current 630).

(2) due process and policies which divert and discourage admissions.

The average length of stay at AMHI and BMHI admission units is 7 and 15 days, and fifty percent of those admitted (about 1800 last year) leave the hospital after this period.

5 The effect of this trend is reflected in the demography of hospital admissions. Persons between the ages of 18 and 34 make up 52 percent of the admissions. Also, the number of first admissions to any hospital has increased 100 percent in the last five years and now make up 23 percent of all admissions. Also, individuals who have been admitted to another psychiatric facility but never to AMHI now make up 13 percent of all admissions. These groups combined make up 37 percent (470 individuals) of admissions in 1984. These individuals account for the dramatic increase in admissions in the last five years (993 - 1400).

Several other factors, such as exposure to drugs and alcohol, geographic mobility, and a loss of asylum have interacted to produce a significant population of chronically mentally ill individuals who have specialized service needs. Those who lack adequate housing are highly visible to the public, city welfare agencies, the police and hospital emergency rooms.

Studies of Homelessness and Mental Illness

Studies have reported that persons with mental illness generally make up about one-third of the homeless population[6]. However, these studies are complicated by definitional problems and overlap of various sub-groups among the homeless as well as among the mentally ill (i.e. street people, situationally homeless).

Barriers to Care for the Homeless Mentally Ill

It is important for mental health professionals as well as those concerned about mental health services to focus concern on seriously mentally ill persons who are homeless, in which homelessness is either one manifestation of major mental illness and disability or contributes significantly to the mental illness or disability.

We realize that a number of factors such as the lack of affordable housing and proverty may influence whether or not a mentally ill person is homeless. However, it is important for mental health professionals and other interested persons to inquire and focus on the extent to which current mental health services, practices, and methods of service delivery contribute to or influence whether a person with chronic mental illness will become or remain homeless.

- **Current Status of Deinstitutionalization**

  This policy, stressing the avoidance of traditional institutional care and the development of community-based alternatives, has had mixed outcomes. There is consensus that the policy per se was not a bad idea, but there was a failure to plan and consider all the service needs required for mentally ill persons to live successfully in the community that had been provided in a total institution. These services, in addition to mental health treatment,include income, housing, medical services. The result is tht the policy has had mixed outcomes. On the positive side, a large number of

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6 We are gathering information from state psychiatric hospitals, hospital emergency rooms, our crisis programs and community mental health agencies on the number in Maine. We do know that about 20-25 mentally ill people a month seek housing assistance from the City of Portland and that on any given day, there are 15-20 mentally ill individuals in the Bible Speaks Shelter beds in Portland and 5 per week in the Bridge Shelter. We estimate that in any given day there may be as many as 30 homeless mentally ill persons in Portland alone.

individuals are living successfully in the community and a number of excellent programs have been developed.

- **Need for Diversified Programs**

However, on the negative side, what was once a relatively uniform population of long-term patients living in hospitals is now a number of different groups with different histories and different program requirements. These groups include: those released after years and even decades of hospitalization[7]; those who have never been hospitalized[8]; those who remained in hospital; and those who require frequent readmission[9]. The result is that there is a need for diversified programs based on the needs, characteristics and functioning of these various groups.

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7 Along with return to family residences, the boarding home was the major housing program for persons released from Maine's Mental Health Institutes in the early 1970's. Currently, there are over 1000 persons with a history of psychiaric hospitalization residing in boarding homes. These individuals currently occupy about thirty-one percent of all boarding home beds. Mostly maintenance mental health services in the form of community support and medication monitoring are provided to about 400 of these individuals by community mental health agencies.

There were 69 boarding home residents admitted to AMHI in 1984. This is 5 percent of total admissions.

A further breakdown of previous residences of admitted patients is as follows:

Boarding Homes	5 percent
Living Alone	17 percent (235)
Living with Parents	22 percent (311)
Living with Spouse	14 percent (197)
Nursing Homes	1 percent
Half-Way House	1 percent
Foster Home	4 percent

8 See note 5.

9 Curent readmission or recidivism rate is 64 percent.

- **Continuity of Care**

Continuity of care means that as much as possible individuals will be linked to needed services on an on-going basis because mental illness is a life-long condition. This is especially difficult between episodes of hospitalization and subsequent community care. Usually, case managers who follow patients are used to link patients to needed services.

A problem is that the structure of many current programs and reimbursement systems are designed for the "single episode" user of services[10].

Comprehensive Programs and Services

It is now realized that chronically mentally ill individuals require the array of psychiatric, medical, rehabilitative, vocational, and housing services that used to be provided in the psychiatric hospital. However, in the community, the responsibility for these programs is shared among a number of public and private agencies each with different admission criteria and program philosophies. The result is a lack of comprehensiveness and difficulty in accessing needed services. Also, the function of asylum, meaning safety, security and refuge, is generally absent except in an institutional setting.

Non-Specific Responsibility

Clear responsibility for meeting the needs of persons with severe prolonged mental illness has not been clearly delineated. The result is that many resources are directed toward persons with less severe disabilities. Part of this problem is related to the stigma attached to these individuals and the programs and services that care for them. There is no question that deinstitutionalization efforts both in Maine and across the nation have adopted a broader view of their mission than caring for persons with prolonged mental illness.

Homeless mentally ill individuals are particularly affected by these barriers to care.

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10 There have been significant improvements in hospital-community linkages in the past several years, with staff from community agencies participating in discharge planning on site in the hospital in order to coordinate service plans and set up appointments and referral for needed services. However, there is still a problem with tracking individuals who either do not keep appointments or follow-through with planned activities, or who refuse follow-up services. Also, coordination of all services needed by this group is more difficult in the community.

Recommendations

General

- There must be a clear statement that homeless individuals with prolonged mental illness are an unambiguous priority for the mental health services system. This does not mean that every program must direct its efforts toward meeting the needs of this group, but that special efforts are necessary to assure that these individuals have access to needed services.

- The superiority of community care for some individuals has come into question in recent years, and the polarized views that characterized the early period of deinstitutionalization have moderated. We must continue to reinforce the idea that 'institutionalization' may take place in community as well as hospital settings unless programs meet patients' assessed needs. Where care is given is less important than what happens in a particular program, and for many patients, a period of hospitalization may be beneficial as is the case with other chronic illness.

- Because of the variety and diversity of persons with prolonged mental illness and their needs, the mental health system must continue not to settle on one modality or approach toward meeting these needs. It is likely that there is no right way or place to treat these individuals.

- Any attempt to address the problems of homeless mentally ill individuals must begin with the provisions for meeting basic needs such as food, shelter, and clothing. In many cases traditional mental health services have either ignored or delegated this role to others. There is a need for continued advocacy and linkages around these basic needs, as well as training in basic living skills.

Comprehensive Services

- There needs to be continued development of a range of supervised housing programs in the community[11].

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11 Over the past several years, 19 different housing programs for persons with mental illness have been developed in Maine, including group homes, apartments, subsidized apartments, and foster homes. Also, crisis programs which provide supervised respite care have been established in Augusta/Waterville, Portland, and York County. Additionally, the Maine Legislature has appropriated $275,000 to be used to develop supervised apartment programs over this biennium.

Despite these developments, there is still a lack of adequate housing options for persons with prolonged mental illness.

While there will likely be a continued and increasing need for shelters, it should be recognized that shelters are a stop-gap measure which deal only temporarily with the issue of homelessness. We are already seeing the use of shelters by mentally ill persons as permanent housing.

Adequate housing is the essential foundation on which other programs are developed, and there is no question that the lack of low-cost decent housing is the most pervasive cause of homelessness.

Because of the diversity of needs, there must be caution not to develop one program model or to develop an artificial continuum. The needs of these individuals change from day to day and from person to person.

- In addition to housing, psychiatric and rehabilitative services must be available and must be assertively provided through outreach services when necessary.

The key to providing services to the homeless as well as to all persons with prolonged mental illness is aggressive outreach and drop-in services. This is especially a problem with traditionally trained mental health workers in which it is thought that the patient must accept responsibility for treatment, and if they don't show for appointments, there is no follow-up, and they are dropped from the roles. Outreach and drop-in centers are essential components[12].

- Crisis Services must be available and accessible to both homeless mentally ill individuals and others with prolonged mental illness.

The nature of prolonged mental illness requires that emergency services be available and accessible, and that alternatives to hospitalization be available. Our experience in the crisis programs suggests that homeless mentally ill individuals do not reject such help when in need. We have also found that the availability of these services also increases the ability of families and other care givers to provide on-going support.

- The role of families in the care of this population needs continued emphasis. We must continue to provide support to families in the form of training, information, as well as the assurance of immediate response in crisis situations and the opportunity for respite care.

- There should be an on-going review of legal and administrative procedures in areas such as hospitalization and confidentiality, especially regarding the extent to which they serve as barriers to accessing needed services. This will require that diverse groups work together to make care more accessible to those who are truly unable to care for themselves and who lack capacity to make decisions for themselves, while at the same time not giving up the gains that have been made in the civil rights area to curb abuses in these areas.

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12 Over the past several years, six social clubs or drop-in centers have been established across the State and 13 vocational programs, and more social clubs are needed. Retraining of staff and clear requirements for outreach as part of case management services need to be established. Some one person must be responsible to each chronically mentally ill person in the community.

- State and local agencies must continue to improve coordination at the State and local levels.

- Professionals and paraprofessionals must be trained to provide services to persons with prolonged mental illness.

The reality is that most graduates of professional schools and preservice training in the core disciplines of psychiatry, psychology, nursing, and social work have little training and preparation for this work.

In the area of in-service training for those already working in the field, while there has been some excellent training in rehabilitation, more needs to be done in this area.

- There needs to be more research into the causes and treatment of chronic mental illness.

Service System Summary

MENTAL HEALTH SERVICES

People who have mental health problems are helped most by family, friends, and other persons in their natural environment. When informal aid fails, individuals may seek help from medical, human services, and mental health providers in either the private or public sectors. Services may range from brief outpatient counseling to intensive twenty-four hour hospitalization and from services intended to prevent specific mental problems through early intervention, psychotherapeutic and somatic treatment of acute mental health problems, and includes rehabilitation and supportive services for individuals who are disabled by prolonged mental illness.

The Department of Mental Health and Mental Retardation supports a number of specific services, most of which are available in each service area:

PREVENTION/EARLY INTERVENTION - Focused on 0-5 and young school-aged children, such services include assessment and counseling, therapeutic activities, linkage to needed services, and advocacy.

EMERGENCY SERVICES - Twenty-four hour telephone emergency services with professional back-up, screening, and crisis intervention, and associated programs, such as respite care.

OUTPATIENT SERVICES - Professional diagnostic services, counseling, and psychotherapy to individuals, families, and groups.

INPATIENT SERVICES - Twenty-four hour intensive treatment in community based psychiatric units and in two state facilities which offer specialized acute and rehabilitative treatment services.

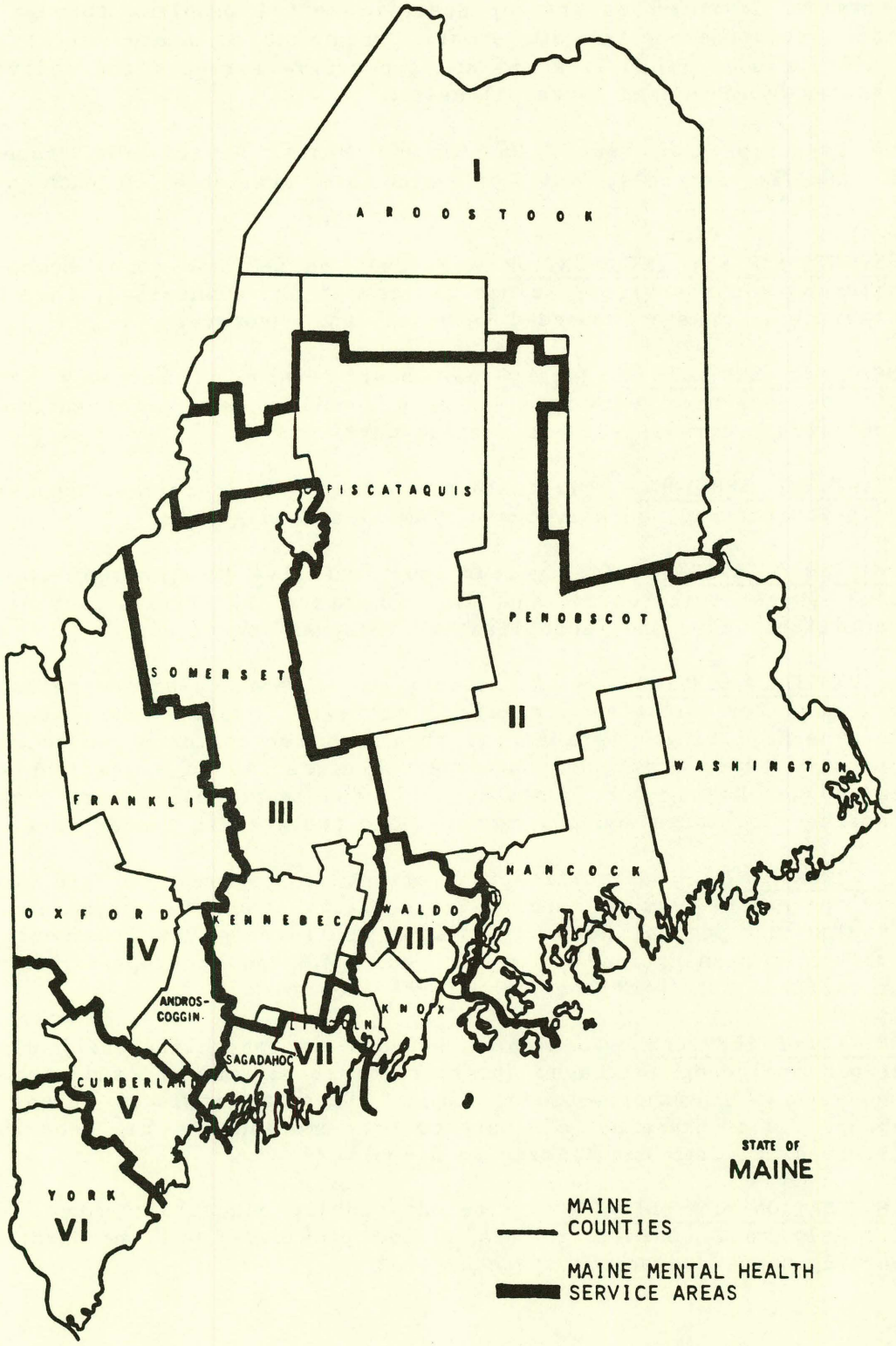
RESIDENTIAL SERVICES - A variety of community-based residential programs for adults including half-way houses and supervised independent living. Residential treatment for children, which entails intensive care, treatment, and special education on a residential and year-round basis for mentally ill and emotionally or character disordered children and adolescents, and therapeutic foster care.

DAY TREATMENT - Rehabilitation oriented programs to aid in the development of social and living skills for the psychiatrically disabled and partial hospitalization. Children's Day Treatment which involves a combination of special education and therapeutic services for children with emotional/behavioral problems.

SUPPORTIVE SERVICES - Community support for psychiatrically disabled persons including outreach, aftercare, case management, and supportive counseling. Community-based Family Support includes counseling, support, and training of parents of emotionally or behaviorally disturbed children and linkage to schools.

CONSULTATION AND EDUCATION - Includes public education; mutual aid or self-help, and consultation to allied providers such as nursing and boarding homes and school systems.

MAINE MENTAL HEALTH SERVICE AREAS



MAINE MENTAL HEALTH PROGRAMS

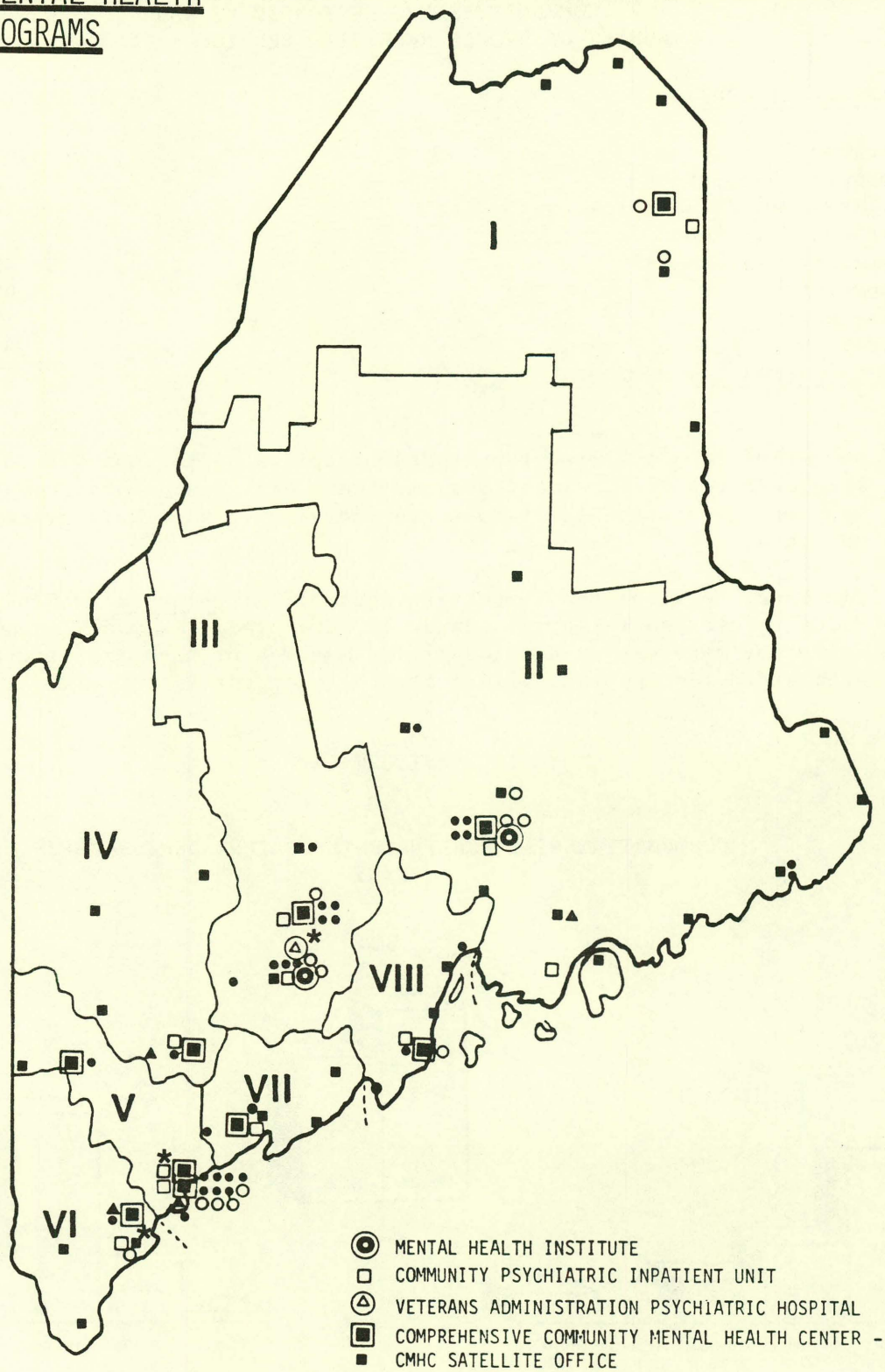


TABLE 11

COMMUNITY SERVICES FUNDED BY BMH
NUMBER OF PEOPLE RECEIVING SERVICE - FY 85

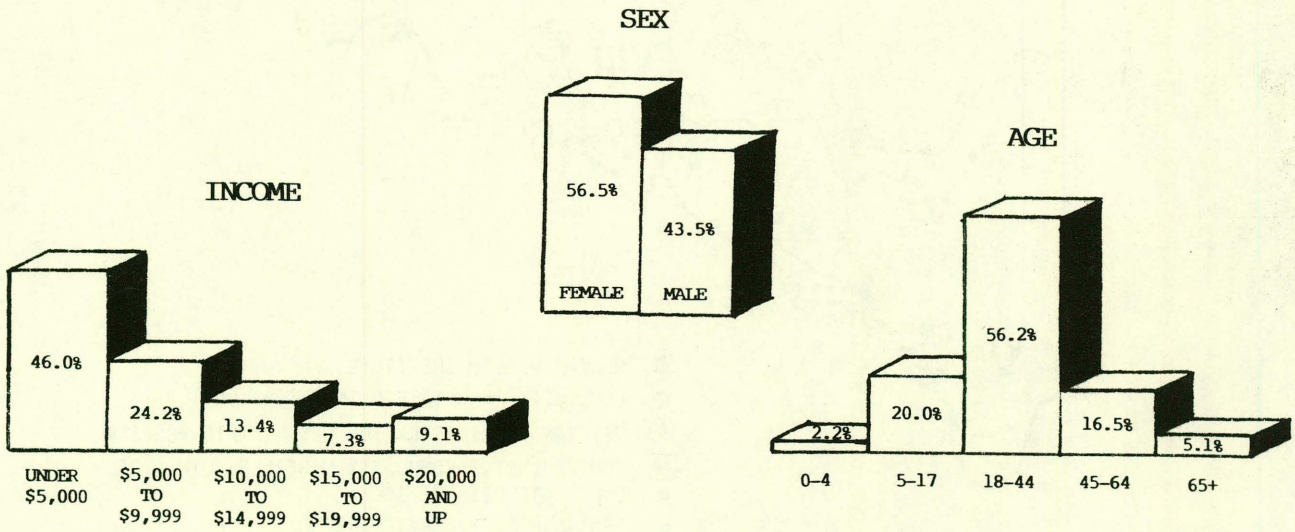
SERVICE CATEGORY	# OF PEOPLE SERVED 1/
Emergency	45,622[2/]
Community Support	6,172
Day Treatment/Rehabilitation	1,163
Psychosocial Clubs	711
Community Residential	229
Outpatient	15,994
Inpatient	829
Crisis Intervention Program	1,536
TOTAL (excluding Emergency)	26,634

1/ Number of People Served represents unduplicated persons within agency service categories, except for Emergency Services. Total People Served may include some duplication where individuals receive service in more than one category.

2/ Emergency Services show appropriate number of contacts in FY85. Unduplicated people served cannot be determined, as many contacts with telephone services do not identify thmselves or have insufficient contact with a provider to establish a clinical record.

FIGURE 4

COMMUNITY MENTAL HEALTH CENTER CLIENT DEMOGRAPHICS
FY85



SUMMARY - CLIENTS SERVED

The Bureau of Mental Health receives periodic reports regarding persons served in programs which it funds. Summary data is presented below, by service area number and percentage, for fiscal year 1985.

TABLE 12

CMHC
SEX OF CLIENTS SERVED (N=24,502)
FY85

SERVICE AREA	FEMALE	% FEMALE	MALE	% MALE
I Aroostook	1,152	48.1	1,243	51.9
II CH & CS	1,509	59.2	1,041	40.8
III Kennebec Valley	2,372	45.2	2,875	54.8
IV Tri-County	2,871	60.3	1,890	39.7
V Cumberland	2,302	62.9	1,360	37.1
VI York	1,251	62.7	744	37.3
VII Bath/Brunswick	1,258	62.9	739	37.1
VIII Mid-Coast	1,137	60.0	758	40.0
TOTAL	13,852	56.5	10,650	43.5

TABLE 13

CMHC
INCOME OF CLIENTS SERVED (N=24,502)
FY85

SERVICE AREA	UNDER $5,000	%	$5,000-$9,999	%	$10,000-$14,999	%	$15,000-$19,999	%	$20,000 OVER	%
I Aroostook	935	39.0	624	26.1	374	15.6	181	7.6	281	11.7
II CH & CS	1,549	60.7	489	19.2	264	10.3	101	4.0	147	5.8
III Kennebec Valley	3,141	59.9	1,077	20.5	539	10.3	271	5.2	219	4.1
IV Tri-County	1,435	30.1	1,621	34.0	806	16.9	428	9.0	471	10.0
V Cumberland	1,515	41.4	807	22.0	509	13.9	366	10.0	465	12.7
VI York	1,042	52.2	343	17.2	243	12.2	157	7.9	210	10.5
VII Bath-Brunswick	637	31.9	519	26.0	300	15.0	212	10.6	329	16.5
VIII Mid-Coast	1,004	53.0	455	24.0	246	13.0	76	4.0	114	6.0
TOTAL	11,258	46.0	5,935	24.2	3,281	13.4	1,792	7.3	2,236	9.1

TABLE 14

CMHC
AGE OF CLIENTS SERVED (N=24,502)
FY85

SERVICE AREA	0-4 YRS	%	5-17	%	18-44 YRS	%	45-64 YRS	%	65+ YRS	%
I Aroostook	69	2.9	547	22.8	1,360	56.8	329	13.7	90	3.8
II CH & CS	131	5.1	630	24.7	1,367	53.6	352	13.8	70	2.8
III Kennebec Valley	165	3.1	1,452	27.7	2,115	40.3	1,186	22.6	329	6.3
IV Tri-County	33	0.7	733	15.4	3,090	64.9	795	16.7	110	2.3
V Cumberland	22	0.6	484	13.2	2,519	68.8	461	12.6	176	4.8
VI York	52	2.6	422	21.2	1,088	54.5	250	12.5	183	9.2
VII Bath-Brunswick	18	0.9	339	16.8	1,232	62.0	284	14.2	124	6.1
VIII Mid-Coast	38	2.0	303	16.0	1,004	53.0	379	20.0	171	9.0
TOTAL	528	2.2	4,910	20.0	13,775	56.2	4,036	16.5	1,253	5.1

PUBLIC MENTAL HEALTH EXPENDITURES

The fiscal resources of the mental health system and public money which aids mentally ill persons come from a variety of sources, extending beyond the funding provided by the Department of Mental Health and Mental Retardation. The Department funds both the Augusta and Bangor Mental Health Institutes and a variety of community mental health services. The implementation of the federal block grant system has significantly added to the funding responsibilities of the Bureau of Mental Health in the last few years.

TABLE 15

SUMMARY
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
COMMUNITY SERVICES FUNDING FISCAL YEAR 1985

Bureau of Mental Health General Fund		$ 7,248,325
BMH - Alcohol Drug Abuse and Mental Health Block Grant		2,322,906
BMH - Social Services Block Grant		285,220
Office of Children's Services		2,208,895
	TOTAL	$12,065,346

In addition to the Department of Mental Health and Mental Retardation funding, mental health agencies also receive a significant amount of other funding - including other state funding, fees charged for services, local public funding, federal monies, and other sources. Support and rehabilitation of mentally ill persons in the community also involves public resources in addition to those which can be provided by community mental health agencies. These include Medicaid funding for private practitioners, human services programs such as food stamps, local welfare benefits, and housing subsidies, as well as Social Security, Medicare, and Supplemental Security income to persons disabled by mental illness.

The Department of Human Services (DHS) administers a variety of programs which have a direct impact on persons with mental health problems including support services, transportation, vocational rehabilitation services, and Medicaid funding for community psychiatric units and professional outpatient services.

In addition, the Department of Education and Cultural Services funds special education programs for behaviorally and emotionally disturbed children and adolescents.

TABLE 16

BUREAU OF MENTAL HEALTH EXPENDITURES AND UNITS OF SERVICE COMPARISONS BY SERVICE TYPE* FISCAL YEAR 1985 AND 1986

	FY 85		FY 86	
SERVICE	ACTUAL EXPENDITURES	ACTUAL UNITS	PROJECTED EXPENDITURES	PROJECTED UNITS
COMMUNITY RESIDENTIAL	589,410	28,284	930,030	29,674
COMMUNITY SUPPORT	2,565,892	91,767	2,376,974	110,743
DAY TREATMENT/ REHABILITATION	1,114,781	42,479	835,241	33,449
EARLY INTERVENTION	62,255		0	
EMERGENCY	682,804		973,526	
CRISIS INTER. PROGRAM	217,373		238,932	
INPATIENT COMMUNITY	271,203	8,382	269,127	9,767
OUTPATIENT	2,709,634	106,600	1,902,118	79,281
CONSULTATION, EDUCATION AND TRAINING	659,787	25,577	309,111	7,359
PSYCHOSOCIAL CENTER	211,919	49,057	320,700	47,500
OTHER ACTIVITIES	630,463		286,148	

*Substantial changes in service expenditures from FY85 to FY86 are primarily related to the transfer of funds and responsibility for services to children to the Bureau of Children with Special Needs. This is shown above mainly in major reductions in Day Treatment, Outpatient, Early intervention, and Consultation and Education for FY86. Corresponding increases will be shown in data of the new Bureau of Children with Special Needs (Office of Children's Services).

TABLE 17

BUREAU OF CHILDREN WITH SPECIAL NEEDS (OFFICE OF CHILDREN'S SERVICES) EXPENDITURES AND INDIVIDUALS SERVED BY SERVICE TYPE* COMPARISON OF FISCAL YEARS 1985 AND 1986

	FY 85		FY 86	
SERVICE	ACTUAL EXPENDITURES	INDIVIDUALS SERVED	PROJECTED EXPENDITURES	PROJECTED PERSONS SERVED
RESIDENTIAL TREATMENT	$916,247	125	$975,266	130
DAY TREATMENT	138,415	115	421,365	320
COMMUNITY SUPPORT	235,383	400	250,050	430
FAMILY INTERVENTION	545.736	475	632,836	535
EARLY INTERVENTION	96,561	100	375,749	360
SEXUAL ABUSE	233,024	375	233,817	375
OUTPATIENT			807.516	33,646+
CONSULTATION, ED., & TRAINING			339,433	8,081+
OTHER ACTIVITIES	43,529		79,266	

*Changes in expenditures from FY85 to FY86 are primarily related to the transfer of funds and responsibility for services to children to the Bureau of Children With Special Needs.

TABLE 18

PATIENT DAYS AND COSTS FISCAL YEAR 1985
MENTAL HEALTH INSTITUTES

	PATIENT DAYS	COSTS
AUGUSTA MENTAL HEALTH INSTITUTE	112,322	$14,779,451*
BANGOR MENTAL HEALTH INSTITUTE	102,642	13,710,979*
TOTAL	214,964	$28,490,430*

* Excludes dedicated revenues totalling $535,954 for sheltered workshop programs which serve, in part, community clients. Figures do include construction and repair costs of $274,930 in FY85.

TABLE 19

PATIENT DAYS AND DIRECT COSTS - FY85
GENERAL HOSPITAL PSYCHIATRIC INPATIENT UNITS**

SERVICE AREA	HOSPITAL	PATIENT DAYS	DIRECT* COSTS
I.	THE AROOSTOOK MEDICAL CENTER	2,475+	$ 401,000+
II.	EASTERN MAINE MEDICAL CENTER	5,045	342,068
III.	MID-MAINE MEDICAL CENTER	8,238	600,722
	KENNEBEC VALLEY MEDICAL CENTER	3,588	357,348
IV.	ST. MARY'S GENERAL HOSPITAL	5,967+	503,791+
V.	MAINE MEDICAL CENTER	9,281	620,131
VI.	SOUTHERN MAINE MEDICAL CENTER	2,995	323,074
VII.	REGIONAL MEMORIAL HOSPITAL	2,922	218,832
VIII.	PENOBSCOT BAY MEDICAL CENTER	1,756	168,083
	TOTAL	42,267	$3,535,049

** SOURCE: Individual facilities.

* Note that cost figures for community inpatient units are not comparable to Mental Health Institute costs shown above, since available data shows only direct costs of community units. Direct costing excludes allocated costs of utilities, space, ancillary services, hospital administration and other costs which are included in the full cost presentation for the Institutes.

+ Estimated

TABLE 20

COMPARISON OF REVENUES AND EXPENDITURES
BMH FUNDED MENTAL HEALTH SERVICE AGENCIES, FY84-FY86

REVENUES	FY84	% FY84	FY85[2/]	% FY85	FY86[3/]	% FY86
Department of MH & MR[1/]	$ 8,649,273	54.1%	$ 9,326,160	53.1%	$ 9,484,227	48.0%
Other State	581,045	3.6%	939,645	5.3%	1,168,652	5.9%
Federal	92,071	0.6%	239,806	1.4%	223,480	1.1%
Local Public	461,497	2.9%	533,096	3.0%	581,297	2.9%
Net Fee For Service	4,858,417	30.4%	5,416,003	30.8%	6,931,024	35.1%
Other Revenues	1,349,888	8.4%	1,126,776	6.4%	1,384,546	7.0%
Total Revenue	$15,992,191	100.0%	$17,581,486	100.0%	$19,773,226	100.0%
EXPENSES						
Salary & Wages	$12,655,154	78.1%	$13,846,698	78.0%	$15,925,237	80.5%
Non-Personnel Expenses	3,551,850	21.9%	3,895,457	22.0%	3,847,989	19.5%
Total Expenses	$16,207,004	100.0%	$17,742,155	100.0%	$19,773,226	100.0%
Surplus (Deficit)	($ 214,813)		($ 160,669)			

1/ DMHMR funds include state and federal block grant funds administered by any division of the department and provided by grant or contract to community mental health service programs.

2/ FY85 figures are based on agency year-end reports.

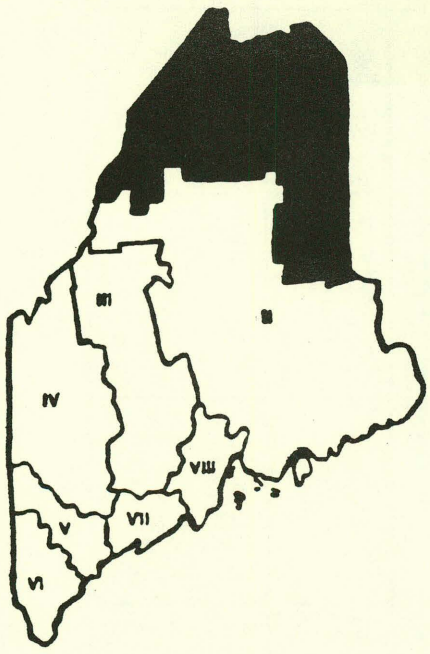
3/ FY86 figures are based on approved contract budgets as of 12/1/85.

TABLE 21

CMHC REVENUE FOR MENTAL HEALTH PROGRAMS FY85

	AROOSTOOK	CH&CS	KENNEBEC	TRI-COUNTY	YORK	BATH-BRUNSWICK	MID-COAST	TOTAL
Dept. of MH & MR								
Bureau of Mental Health	$1,148,673	$1,714,686	$ 905,997	$1,146,038	$ 997,650	$ 753,909	$ 782,620	$ 7,449,573
Bureau of Mental Retard		12,680	20,000					32,680
Bureau of Children with Special Needs		71,495	47,200			134,160		252,855
Community Support Sys.								
Other DMHMR				33,175				33,175
Other State	205,954	159,593	108,810	74,668	92,050	28,362	26,173	695,610
Federal		54,746						54,746
Local Public								
Town	32,762	39,946		38,526	32,875	40,804	18,391	203,304
County			113,111	11,952	45,000			170,063
Fee For Service								
Self Pay	160,954	53,170	39,304	133,576	82,485	97,998	25,798	593,285
Medicare	7,478	13,868	21,833	92,503	9,177	28,829	15,066	188,754
Medicaid	206,929	278,786	229,000	188,007	112,305	45,412	183,081	1,243,520
Hospitals	160,490		167,666		116		15,250	343,522
Schools	53,771	122,407	15,860	33,394	86,462		60,568	372,462
Insurance	65,046	118,326	198,190	106,863	128,803	217,752	120,528	955,508
Other Fees	299,970	131,212	45,512	113,539	46,358	15,014	19,000	670,605
Other Revenues	28,993	204,376	37,381	86,922	12,111	39,622	21,307	430,712
TOTAL REVENUE	$2,371,020	$2,975,291	$1,949,864	$2,059,703	$1,645,392	$1,401,862	$1,287,782	$13,690,914

Service Area Summaries



AREA I
AROOSTOOK

Service Area 1 - the Aroostook Area, encompasses all of Aroostook County plus the towns of Danforth, Stacyville, Patten, and Mt. Chase, and is bounded on the northeast and northwest by Canada. This service area is geographically large, encompassing more than 6,900 square miles, with about half the population concentrated in the larger communities which include Houlton, Presque Isle, Caribou, Fort Fairfield, Limestone, Van Buren, Madawaska, and Fort Kent. The 1983 estimated population was 92,428.

TABLE 22

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1985
SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION I

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Aroostook Mental Health Center			
Emergency Services	$ 113,790	1,792	7,463*
Community Support	421,591	11,710	957
Day Treatment/Rehabilitation	128,438	8,215	200
Community Residential	121,696	5,472	40
Outpatient Services	200,419	11,966	1,732
Consultation, Education & Training	133,748	7,311	-----
Inpatient	28,991	2,219	193
Total, Region I	$1,148,673	48,685	

* Emergency Services shows total contacts with Helpline emergency telephone service. Agency reported 79 clients served in after-hours face-to-face services in the year.

F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

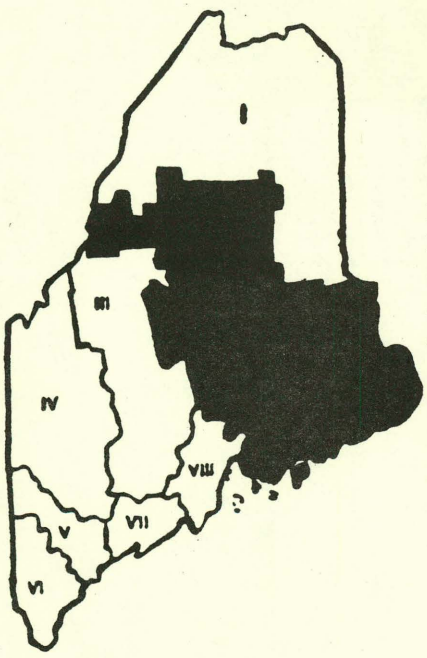
MENTAL HEALTH SERVICES BY SERVICE CATEGORY

MENTAL HEALTH SERVICE AREA I

AROOSTOOK COUNTY

Plus - Danforth, Stacyville, Patten Mt. Chase

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
AROOSTOOK MENTAL HEALTH CENTER Caribou Fort Kent Houlton Madawaska Presque Isle Van Buren L,F	Work Days: All 6 AMHC Offices After Hours/ Weekends: HELPLINE 1-800-432-7805 AMHC offices or other community sites, especially hospital emergency rooms	All 6 AMHC Offices In-home treatment of family and children	Day Treatment All 6 AMHC Offices Psychosocial Vocational Program Caribou	Sky Haven Transitional Residence Presque Isle Supervised Independent Living Apts. Caribou	All 6 AMHC Offices	AMHC staff in all locations provide services to community organizations & groups by contract and by request.	The Aroostook Medical Center - Community Gen'l Division at Ft. Fairfield in conjunction with AMHC
Valley Family Support Group Madawaska F			Social Club Madawaska			Educational & Support activities for Families with Mentally Ill members	
The Southern Aroostook Family Support Group F						Educational & Support activities for Families with Mentally Ill members	



AREA II
EASTERN MAINE

Service Area II - the Eastern Maine Area, encompasses four Maine Counties - Hancock, Penobscot, Piscataquis and Washington except the towns of Danforth, Stacyville, Patten and Mt. Chase, and also includes Winterport and Frankfort. This service area is the largest in the State, more than 12,000 square miles; its boundaries are Aroostook, Somerset, Waldo, and Kennebec counties, Canada and the Atlantic Ocean. Most of the residents of this area live in rural areas, although cities and towns include Bangor, Brewer, Orono, Ellsworth, Bucksport, Dover-Foxcroft and Calais. The 1983 estimated population for the Eastern Maine Service Area was 233,559.

TABLE 23

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1985
SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION II

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Community Health & Counseling Services			
Emergency Services	$ 94,668	1,499	13,957*
Community Support	362,141	8,561	575
Day Treatment/Rehabilitation	410,865	16,102	217
Community Residential	61,064	3,612	57
Outpatient Services	649,869	19,462	2,073
Consultation, Education & Training	136,079	5,088	-----
TOTAL CMHC	$1,714,686	54,324	
Together Place Social Club	45,830	20,341[1/]	211
Charlotte White Center Day Treatment/Rehabilitation	48,000	1,758	27
Three Hudson Street Community Residential	38,000	1,955	11
TOTAL, REGION II	$1,846,516	78,378	

*Emergency Services shows total client-related contacts with Dial Help emergency telephone service.

1/Together Place units of service reflect attendance at psychosocial club program on two session/day mode.

F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

MENTAL HEALTH SERVICES BY SERVICE CATEGORY

MENTAL HEALTH SERVICE AREA II

WASHINGTON, HANCOCK, PENOBSCOT, PISCATAQUIS COUNTIES

Plus - Winterport & Frankfort
Minus- Danforth, Stacyville, Patten, & Mt. Chase

AGENCY	SERVICES AND LOCATIONS						
COMMUNITY HEALTH & COUNSELING SERVICES	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
Bangor Bar Harbor Dover-Foxcroft Ellsworth Machias Lincoln Millinocket Calais L,F,O	Workdays: All 8 CHCS Locations After hours/ Weekends Dial Help: 1-800-432-7810 CHCS offices of hospital Emergency Room	All 8 CHCS Offices BMHI Boarding, Nursing, Foster, Group Homes, locally maintained facilities such as churchs & health centers	Growth Resource Center (Adult) Bangor Big Red/Handi-person Washington County Day Program(Adult) Calais Eastport Machias Milbridge Hancock County Children's Ctr. Ellsworth Children's Garden Bangor	Therapeutic Foster Home Program Child. & Adoles. All 8 CHCS Offices homes, schools Transitional Living Supervised Apartments for Adults Bangor Orono Group Home for Adults	All 8 CHCS Offices Satellite Office in Bucksport	CHCS staff provide services to community organizations, schools & groups by contract and/or request	
Eastern Maine Medical Center Bangor	Emergency Room provides psychiatric emer. services 24 hrs. a day, 7 days a week						Services are voluntary and short term in EMMC at Bangor
Bangor Mental Health Institute Serves Mental Health Service Area I & II F	Performs Crisis Intervention for persons referred for admission		BMHI provides Day Program & Sheltered Workshop for BMHI Inpatients	Two on-grounds halfway houses			Services are involuntary,voluntary, short&long term, including intermediate care facility
DHRS St. Michael's Center, Bangor L,O		In-home treat. of family & children					

F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

CONTINUED...AREA II:

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
Citizens Interest Group Bangor L, F				Transitional Living Residence		Ed. & Support activities for families w/mentally ill members	
Together Place, Inc. Bangor L, F			Psychosocial Club Pre-vocational Training				
Homestead Project, Inc. SW Ellsworth L, O				Residential Treatment for Adolescents			
Blue Hill Memorial Hospital Blue Hill L	24 Hour emergency services to area residents				Services available at Blue Hill Mem. Hosp., & Island Med CTR, Stonington	Support Group for multiple sclerosis	Voluntary short term services available
Child & Youth Board of Washington Cty. Machias F, O					Developmental Svcs to children age 0-5 & their families	Preventive & Preschool Coordination	
United Cerebral Palsy of Northeastern Maine Bangor O, F					Developmental Svcs to children age 0-5 & their families	Preschool Classes	

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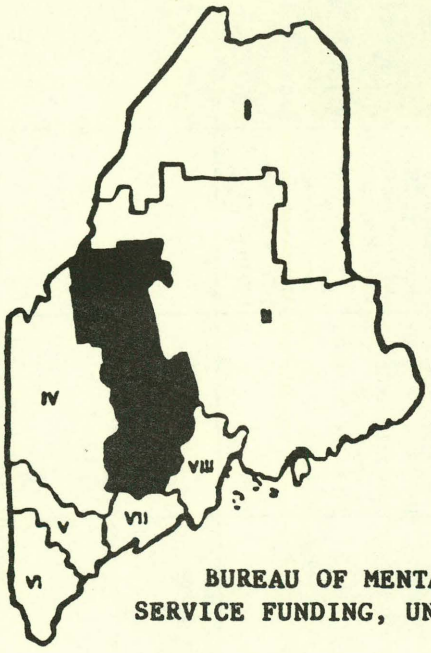
CONTINUED...AREA II:

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
Charlotte White Center Dover-Foxcroft F			Functional living skills, work activities and socialization				
Opportunity Housing Inc. Bangor O			Day Program for Residential Clients	Residential and Respite Care			
Families United of Washington County Machias O		In-home treatment of families & children				Prevention & Education Programs	



AREA III
KENNEBEC VALLEY

Service Area III - the Kennebec Valley Area encompasses Kennebec and Somerset counties as well as the towns of Richmond, Whitefield, Burnham, Unity, Freedom, Palermo and Somerville. This service area covers more than 5,000 square miles, with both urban and rural areas and population concentration in Skowhegan, Fairfield, Waterville, Winslow, Augusta, and Gardiner. The 1983 estimated population was 165,990.

TABLE 24

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1985
SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION III

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Kennebec Valley MH Center			
Emergency Services	$ 101,980	2,334	4,189*
Community Support	327,811	8,704	1,075
Day Treatment/Rehab	37,555	1,816	132
Outpatient Services	208,051	9,857[1]	2,610
Consultation, Education & Training	89,300	1,866	-----
Inpatient	120,300	877	252
TOTAL CMHC	$ 884,997	29,464[1]	
Motivational Services, Inc. (MoCo)			
		962 Staff Int.	65
LINC Program	102,371	14,263 Soc.Club	130
Clean Sweep Vocational	73,967	2,594	67
Community Residential	104,140	5,354	62
Waterville Social Club	46,414	8,774	107
Crisis and Counseling Services			
Emergency Services	60,400	N.A.	438
Kennebec Valley Regional Health			
Community Support	58,000	4,313	205
Kennebec-Somerset Home Aide Services			
Community Support	33,373	10,700	229
Emergency Services	24,937	1,200	N.A.
Mid-Maine Medical Center			
Hospital Industries Program	7,100	N.A.	4
TOTAL, REGION III	$1,395,699	78,124	

*Emergency Services figures show total contacts with emergency service.
[1]KVMHC figures do not include 8,702 units of Child Sexual Abuse services not contracted for by BMH.

F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

MENTAL HEALTH SERVICES BY SERVICE CATEGORY

MENTAL HEALTH SERVICE AREA III

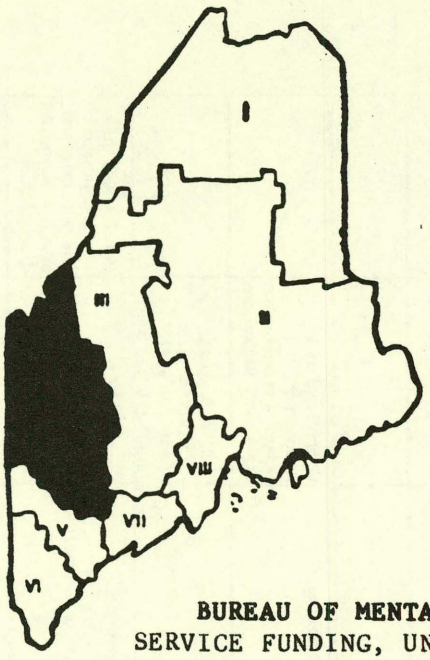
KENNEBEC & SOMERSET COUNTIES
Plus - Richmond, Whitefield, Burnham, Unity, Freedom, Palermo, & Somerville

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
KENNEBEC VALLEY MENTAL HEALTH CENTER Monday - Friday Augusta Waterville Tuesday - Thursday Skowhegan L, F	Weekdays: Augusta, Waterville Tuesday-Thursday Skowhegan office After hours/ Weekends/Holidays Emergency Rooms Kennebec Valley Medical Center Augusta Mid-Maine Medical Center Thayer-Waterville other sites as necessary	Augusta & Waterville Offices	Day Hospital Program Augusta Waterville Offices		Augusta, Waterville, Skowhegan offices 6 rural health center sites on limited basis: Albion Belgrade Lakes Bingham Cooper Mills Madison Richmond	KVMHC staff provide services to community organizations by contract and on request	Mid-Maine Medical Center-Thayer Waterville in conjunction with KVMHC
Kennebec Valley Medical Center - Augusta Division	After hours/ weekends with KVMHC in Emer.room						Services are voluntary & short-term in psychiatric unit
Crisis & Counseling Centers-Augusta Waterville Somerset County L, F	Crisis team available to do in-home crisis intervention throughout Somerset County 24 hrs. day				Augusta, Waterville, Skowhegan offices	Services to groups & agencies by contract and on request	
Augusta Mental Health Institute Serves mental health services areas III, IV, V, VI, VII & VIII F			AMHI has day programs for inpatients & a sheltered workshop which serves some non-residents			Psychiatric Grand Rounds are open to public Quarterly education seminars for parents & friends	Services are involuntary & voluntary, short and long term, including nursing home unit & alternative living houses. Adolescent unit is a statewide program
DHRS Family & Marriage Counseling Services Waterville L					Individual Family & Marriage Treatment		

F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

CONTINUED...AREA III :

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
Kennebec Valley Regional Health Agency Waterville Augusta L, F.		Nurses visit mental health clients in their homes throughout service area. Services available at area office			In-home mental health service for physically ill with related mental health issue		
DHRS Home Care Svcs. Kennebec-Somerset Augusta Waterville Skowhegan L, F		Home aides assist clients in their homes throughout service area					
Motivational Services Inc.(MoCo) Augusta Waterville Skowhegan L, F	MoCo staff available 24 hours to agency clients Family Care Homes Hallowell Readfield	Case Management services to agency clients living in Augusta community	LINC Social Club Augusta Vocational Program-Augusta Clean Sweep Waterville Social Center	Middle Street House-Augusta Transitional Residence SW Elm Street House Augusta-Long term Rehabilitation Residence Western Ave Residence - Wtlv. ICF/MR group home for dual diagnosed			
Winthrop Alternative School Winthrop O			Day Treatment program for adolescents				
Youth & Family Services Skowhegan O, L	Emergency Shelter	In-home treatment of family & children			Counseling	Coordination & Advocacy. School Consultation Community Workshops	
Alliance for Troubled Families Waterville F						Ed. & Support activities for families with mentally ill mbrs.	
Veteran's Administration Center and Hospital Togus	24 hour, 7 day limited crisis intervention to veterans & their families		Day Treatment Program for patients		Outpatient Services for veterans & their families		Brief hospitalization primarily for veterans with service connected disabilities



AREA IV
TRI-COUNTY

Service Area IV - the Tri-County Area covers Androscoggin, Oxford, and Franklin counties, except for the towns of Hiram, Porter, Brownfield, Denmark, Fryeburg, Stoneham, Stow, Lovell, and Sweden, and also includes New Gloucester and Otisfield. This area covers more than 4,000 square miles with population concentrations in Lewiston, Auburn, Lisbon, Farmington-Wilton, Rumford, Norway, and Paris. The Tri-County Service Area had an estimated population in 1983 of 174,814 persons.

TABLE 25

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1985
SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION IV

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Tri-County Mental Health Services			
Emergency Services	$ 91,802	1,853	909*
Community Support	297,166	8,258	721
Day/Treatment/Rehab.	122,397	4,293	148
Outpatient Services	557,743[1/]	18,885	2,942
Consultation, Education & Training	67,572	3,426	
TOTAL, CMHC	$1,136,680	36,755	
Franklin Memorial Hospital	21,948	260	34
TOTAL REGION IV	$1,158,628	37,015	

* Emergency Services reflects emergency contacts, not unduplicated individuals.

1/ Does not include Department of Human Services funding of $9,360 which passes through the BMH contract.

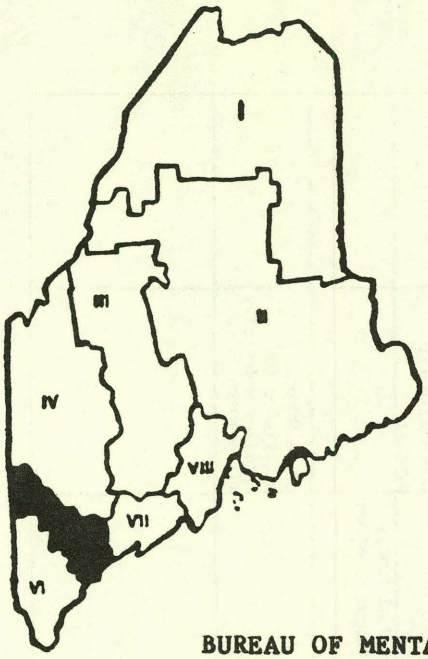
F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

MENTAL HEALTH SERVICES BY SERVICE CATEGORY

MENTAL HEALTH SERVICE AREA IV

FRANKLIN, OXFORD & AND ANDROSCOGGIN COUNTIES
Plus - New Gloucester
Minus- Hiram, Porter, Brownfield, Denmark, & Fryeburg

AGENCY	SERVICES AND LOCATIONS						
TRI-COUNTY MENTAL HEALTH SERVICES	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
Farmington Lewiston Norway Rumford L, F	Weekdays: All 4 TCMHS locations After hours/ weekends staff available via TCMHS #783-9141	All 4 TCMHS locations In-home treatment of children & families	Day Treatment Lewiston Transitional Employment Program Lewiston		All 4 TCMHS locations Depot - Lewiston Specialized services for children & adolescents	C&E specialists & other TCMHS staff provide servies to area community organizations & groups, training & consultation to schools, other care givers, by contract and on request	
St. Mary's General Hospital Lewiston	24 hour, 7 day services for psychiatric emergencies in emergency room						Voluntary, short-term services are provided in the inpatient unit in Lewiston
Regional Educational Treatment Center Auburn O			Day Treatment for Adolescents				
Relatives & Friends Together for Support Auburn F						Ed. & Support activities for families w/mentally ill members	
Alliance for the Mentally & Emotionally Disabled Rumford F						Ed. & Support activities for friends, families w/mentally ill members	
DHRS Family Marriage Counseling Services Lewiston L					Individual family & marriage treatment		
Farmington Alliance for the Mentally Ill Farmington F						Ed. & Support activities for families w/mentally ill members	



AREA V
CUMBERLAND-PORTLAND

Service Area V - The Cumberland-Portland Area includes Cumberland County except for Brunswick, Freeport, Harpswell, New Goucester, Baldwin, and Otisfield, and also includes Stoneham, Stow, Lovell, Sweden, Denmark, Fryeburg, and Brownfield. This service area covers just over 930 square miles, and includes both highly urban and very rural areas. Major population centers are Portland, South Portland, Westbrook, Bridgton, and Fryeburg. Figures showed a 1983 estimated population of 192,914.

TABLE 26

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1985
BMH FY84 SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION V

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Emergency Services			
Ingraham Volunteers	$ 44,576.	20,926[1]	27,197*
Western Maine Counseling	17,284.	791	N.A.[2]
Holy Innocents Crisis Support	32,655.	1,625	47
Community Support			
Community Health	204,549.	12,889	676
Holy Innocents	103,167.	6,536	212
Amity Center Social Club	60,000.	2,196	231
Amity Center Pre-Work Activities		2,061	197
Community Residential			
Shalom House	81,513.	8,630	51
Shalom Apts.	50,254.		
Outpatient Services			
Community Counseling	16,050.	6,155	1,691
Western Maine Counseling	90,200.	3,642	740
Consultation, Education & Training			
Community Counseling	6,170.	208	---
Western Maine Counseling	6,650.	409	---
Cumberland Consortium(MH Assoc. of the Cumberland Region, Inc.)	40,880.		
TOTAL, REGION V	$753,948.	66,068	

*Emergency Services figures under People Served for Ingraham Volunteers shows total calls to emergency telephone service.
1/Units of service at Ingraham Volunteers includes volunteer hours.
2/Western Maine Counseling Services does not report number of contacts in emergency services. Units of service reflect staff time responding to emergencies.

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MENTAL HEALTH SERVICES BY SERVICE CATEGORY

MENTAL HEALTH SERVICE AREA V

CUMBERLAND COUNTY

Plus - Stoneham, Stow, Lovell, Sweden, Denmark Fryeburg, & Brownfield

Minus- Brunswick, Freeport, Harpswell, New Gloucester, & Baldwin

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
MAINE MEDICAL CENTER COMMUNITY MENTAL HEALTH CENTER Portland	24 hour, 7 day Psychiatric Emergency services at MMC Emergency Room	Provides psychiatric services to Area V CSP clients including medication service	Adult Day Hospital Program at MMC Therapeutic Nursery		Service provided at MMC Specialized services for children at MMC	MMC staff provides service to community organizations & groups by contract and on request	Voluntary, short-term services are provided at MMC inpatient unit
Mental Health Assn. of the Cumberland Region, Inc. Provides no service directly. It is a Volunteer Board & Administrative staff which plans for, coordinates services in Area V L, F							
Jackson Brook Institute S. Portland S.W.	24 hour, 7 day psychiatric eval. and admission						In-patient serv. for adolescents & adults, children & elderly, both voluntary & invol. diagnosis & short-term treatment. Eating disorders program.
Ingraham Volunteers, Inc. Portland SW, L, F	24 hour telephone crisis intervention referral svcs. staffed by volunteers. Referral to family crisis shelter, TTY & referral for Deaf						

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L = Licensed by Bureau of Mental Health
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SW = Accepts Statewide Referrals

CONTINUED...AREA V:

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
Amity Center Portland L, F		Psychosocial Club under auspices of AMI					
Shalom House SW Portland L, F				Trans. Liv. Resid. Shalom Apartments Coop. Apt. Prog.			
Spurwink School SW Portland L, O			Day Treat. for Child. & Adolesc. Falmouth, S. Port. Brunswick	Resid. Treat. for Child. & Adoles. Portland Casco		Family Education	
Community Counseling Center Portland L, F, O					Serv. provided in Portland, Cape Elizabeth, Gorham Westbrook; Sex Abuse Treatment Program	CCC staff provide service to community groups & organizations by contract & on request	
Young Women's Christian Assn., Street Program Portland O						Outreach, info. & referral for adolescents	
Alliance for the Mentally Ill (AMI) Portland F						Ed. & Support activities for families w/mentally ill members	

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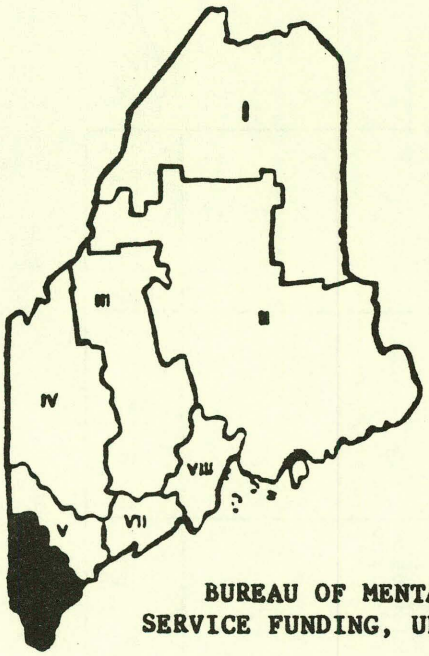
SW = Accepts Statewide Referrals

CONTINUED...AREA V:

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
Western Maine Counseling Services Bridgton O, L, F	Weekdays: Bridgton Office After hours/ Weekends-staff available via tel.	Bridgton Office provides psychiatric service	Adolescent - child Day Treatment & Alternative School		Bridgton Office Fryeburg Office Raymond Office	WMCS staff provide service to community groups & organizations by contract & on request	
Diocesan Human Relations Services Holy Innocents Home Care Service Portland L, F		Home aides provide in-home assistance for CSP clients in Area V. 24-hr., 7 day crisis intervention for CSP clients.					
DHRS Family & Marriage Counseling Service Portland L					Family oriented therapy Individual Marriage & Family Treatment		
Little Brothers Association Portland L, F, O	Emergency Shelter for children & adolescents			Therapeutic, Foster & Group Home for adolescents Semi independent apartments	Home service for families with disturbed children or children at risk		
Community Health Services, Inc. Portland Bridgton L, F		Individual & group counseling & case management services for CSP clients in Area V. In-home counseling & support services					



AREA VI
YORK

Service Area VI - the York Area, includes all of York County plus the towns of Hiram, Porter, and Baldwin. This service area covers over 1,000 square miles with major population centers in Saco, Biddeford, and Sanford. While this area experiences significant growth in population during the summer months, the 1983 population estimate for this area is 151,356.

TABLE 27

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1985
SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION VI

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
York County Counseling Services			
Emergency Services	$ 43,375	164	
Community Support	410,798	11,371	616*
Psychosocial Club	111,919	2,983	108
Community Residential	76,311	2,271	8
Outpatient	236,723	15,285	1,368
Consultation, Education & Training	118,524	4,183	-----
TOTAL, CMHC	$ 997,650	36,257	
Creative Work Systems[1/]			
Assessment	145	1	1
Sheltered Workshop	9,305	155	6
Transitional Employment	1,227	13	14
Direct Employment	3,138	N.A.	N.A.
Goodall Hospital	6,000	N.A.	5
TOTAL, REGION VI	$1,017,465	36,426	

* Agency does not report "people served" in emergency services beyond units of service provided in that category.

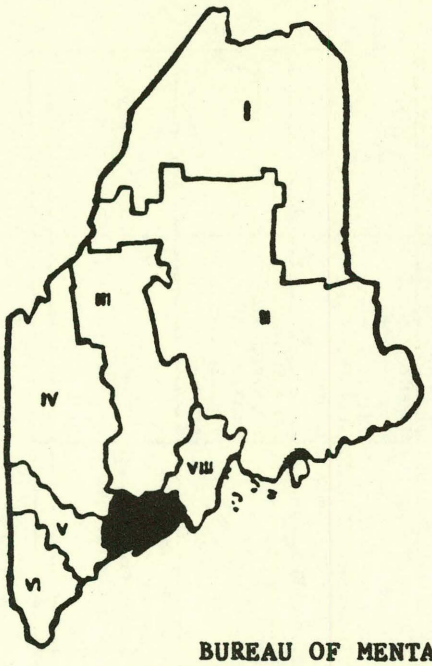
1/ Creative Work Systems has a fee-for-service contract based on "weeks" of Sheltered Employment, Work Adjustment Training, Transitional Employment Services, and other services.

F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

MENTAL HEALTH SERVICES BY SERVICE CATEGORY
MENTAL HEALTH SERVICE AREA VI

YORK COUNTY
Plus - Hiram, Porter, & Baldwin

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
YORK COUNTY COUNSELING SERVICES Biddeford Saco Sanford York L, F	Work Days: Saco Sanford York After hours/ Weekends YCCS staff are available via telephone	Saco, Sanford and York offices and in the client's natural environment	Social Club Saco	Crescent House Biddeford Transitional Residence	Saco, Sanford, York, Kezar Falls Specialized children's services in Saco Sanford York	Specialized C&E staff and all YCCS staff provide services to community organ. and groups by contract and on request	
Southern Maine Medical Center	24 hour, 7 day psychiatric emergency services in Emergency Room		Day Treatment Biddeford				Voluntary and short-term services in psychiatric inpatient unit
Creative Work Systems F			Day Program in Vocational skills including sheltered workshop				
Sweetser-Childrens Home Saco SW L, O		In home treatment for children & families	Day School Treatment for children & adolescents	Residential Treatment for children & adolescents Saco Sanford	Neuropsychology Clinic; compreh. diag./prescript. assessment of child and youth; community followup	Consultation, Ed. & training to schools & other community organizations.	
York Family Support Group Saco F						Ed. & Support activities for families with Mentally Ill members	
Diocesan Human Relations Services Family & Marriage Counseling Service Saco L					Family oriented therapy. Individual, marriage & family treatment		



AREA VII
BATH-BRUNSWICK

Area VII - the Bath-Brunswick Area, encompasses Sagadahoc and Lincoln counties minus Jefferson, Waldoboro, Richmond, Whitefield, and Somerville, and also includes Brunswick, Freeport, and Harpswell. This area covers just over 600 square miles, with population concentrated in Bath, Brunswick, Freeport and Topsham. In 1983 the estimated population of this region was 74,022.

TABLE 28

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1985
SERVICE FUNDING, UNITS OF SERVICES, AND PEOPLE SERVED - REGION VII

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Bath-Brunswick Mental Health Center			
Emergency Services	$ 34,286	709	17*
Community Support	119,620	2,647	271
Day Treatment/Rehab.	145,105	3,442	94
Outpatient Services	373,118	11,548	1,316
Consultation, Educ., Training	15,916	551	N.A.
Inpatient	65,864	2,042	299
TOTAL, REGION VII	$753,909	18,897	

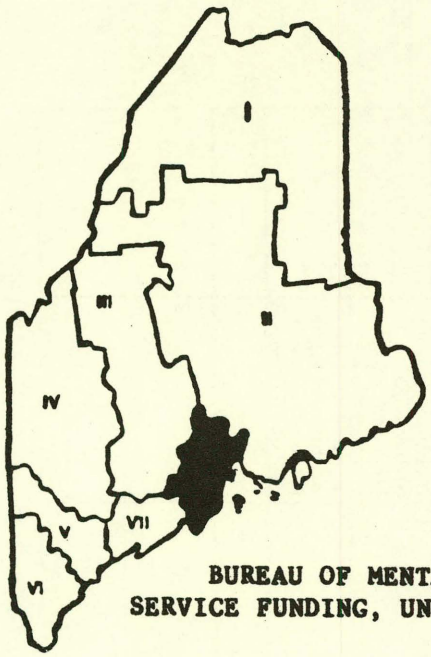
* Persons served reflects weekend and off-hours clients only.

F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

MENTAL HEALTH SERVICES BY SERVICE CATEGORY
MENTAL HEALTH SERVICE AREA VII

SAGADAHOC & LINCOLN COUNTIES
Plus - Brunswick, Freeport & Harpswell
Minus- Jefferson, Waldoboro, Whitefield, & Somerville

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
BATH-BRUNSWICK AREA MENTAL HEALTH CENTER Bath Boothbay Harbor Brunswick Damariscotta L, F, O	Workdays: Bath Brunswick Damariscotta Boothbay Harbor After hours/ Weekends: BBMHC staff are available via telephone and in Regional Memorial Hospital Emergency Room	Brunswick Damariscotta In home treatment for children & families	Day Hospital Brunswick Prevocational Transitional Employment Program Brunswick		Bath Boothbay Harbor Brunswick Damariscotta Full Circle Specialized Children's Svcs. Bath Brunswick Boothbay Harbor Damariscotta	BBMHC staff provide services to comm. organizations and groups by contract and on request.	Regional Mem. Hospital-Bruns. Inpatient Unit operated jointly with BBMHC
Regional Memorial Hospital Brunswick	24 hour, 7 day psychiatric emergency service in Emergency Room						Voluntary, short-term service in inpatient unit in conjunction with BBMHC
Freeport Community Services Freeport O						Coordination & Advocacy for families , children & adolescents	
Bath-Brunswick SEA-AMI Bath F						Educational & support activities for families with mentally ill members	
Dirigo Resources Bath L					Down East Counseling		



AREA VIII
MID-COAST

Service Area VIII - the Mid-Coast Area encompasses Knox and Waldo counties excluding Burnham, Unity, Freedom, Palermo, Winterport and Frankfort, and also includes Jefferson and Waldoboro. This service area covers over 1,000 square miles and had a 1983 estimated population of 60,706, with major concentrations of population in Rockland, Belfast, Camden, Thomaston and Rockland.

TABLE 29

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1985
SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION VIII

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Mid-Coast Mental Health Center			
Emergency Services	$ 58,695	720	300
Community Support	158,278	5,071	496
Day Treatment/Rehabilitation	40,369	1,967	154
Community Residential	6,500	930	N.A.
Outpatient Services	394,089	13,742	1,544
Consultation, Education & Training	85,828	2,743	-----
Inpatient	56,048	1,276	135
TOTAL, REGION VIII	$799,807	26,449	

F = Funded by Bureau of Mental Health
L = Licensed by Bureau of Mental Health
O = Funded by Bureau of Children with Special Needs
SW = Accepts Statewide Referrals

MENTAL HEALTH SERVICES BY SERVICE CATEGORY
MENTAL HEALTH SERVICE AREA VIII

KNOX, WALDO COUNTIES
Plus - Jefferson and Waldoboro
Minus- Whitefield, Richmond, Burnham, Unity, Freedom, Palermo, Winterport, Frankfort

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
MID-COAST MENTAL HEALTH CENTER Belfast Camden Rockland L, F	Workdays: Belfast Rockland After hours/ Weekends MCMHC staff available via telephone & at Pen-Bay Medical Center or Waldo County General Hospital Emergency Room if necessary	Belfast Rockland In homes and boarding homes throughout the service area	Belfast Rockland	Transitional Living Apartment Rockland	Belfast Camden Rockland The Child and Family Center Specialized services to children and families Camden	Specialized C & E staff and all MCMHC staff provide services to community organ. and groups by contract & on request	Penobscot-Bay Medical Center provides Vol. short-term inpatient serv. in conjunction with MCMHC Rockland
Penobscot Bay Medical Center Rockland	24 hour, 7 day Psychiatric emergency service in Emergency Rm.						Voluntary, short-term services at inpatient unit, in conjunction with MCMHC
Home Counselors, Inc Camden/Rockland O		In-home treatment for children and families					
Mid-Coast Children's Services Rockland O			Day Treatment for pre-school children			Prevention & Education activities	

Goals and Objectives

GOAL 1

TO PROMOTE MENTAL HEALTH AND PREVENT MENTAL ILLNESS

OBJECTIVE: TO INCREASE PUBLIC KNOWLEDGE AND AWARENESS REGARDING MENTAL ILLNESS AND SERVICE OPTIONS.

Public education efforts have continued to be emphasized by the Department through the presentation of forums, workshops, the development of public service announcements, booklets and pamphlets, and the provision of volunteer opportunities. Stress has been placed on initiatives for special populations such as elderly persons and deaf individuals with mental illness.

This year the Department will:

- Emphasize information on specific mental illnesses and mental health issues in order to increase public knowledge of mental disorders and to decrease stigma.

- Continue to promote public awareness of the unique mental health needs of special populations such as elderly persons, deaf individuals, persons with severe and prolonged mental illness, and individuals with alcohol and drug abuse problems.

- Maintain and increase its interagency health and mental health education efforts.

- Work closely with the Departments of Educational & Cultural Services and Human Services in implementing the Joint Health Policy Statement signed by the Commissioners of Department of Education and Cultural Services, Department of Human Services, and Mental Health & Mental Retardation.

- Participate as an active member in the Maine School Health Education Coalition in implementing the comprehensive school health curriculum to incorporate components on mental health and positive lifestyles encouraging "wellness".

- Participate and co-sponsor a Maine Wellness Conference aimed at health educators to incorporate components on mental health and wellness.

- Participate as an active quorum member on the Maine School Health Advisory Committee whose purpose is to advise the Departments of Educational & Cultural Services, Human Services, and Mental Health and Mental Retardation on school health issues.

OBJECTIVE: TO INCREASE NATURAL HELPING, SELF-HELP AND MUTUAL AID OPTIONS.

In recognition of the importance of family, consumer, and community participation, the Department has continued to support a variety of efforts and initiatives such as regular family educational forums, consumer teleconferencing, the on-going support/development of twelve family support groups throughout the state, as well as of the state family alliance, the expansion of consumer social clubs for psychiatrically disabled persons, and assistance to groups and individuals to enable them to take advantage of educational opportunities. In addition, this year's Sixth Annual William E. Schumacher, M.D. Distinguished Lecture Series on Mental Health, co-sponsored with the Maine State Alliance for the Mentally Ill, focused on the young adult chronic patient and featured Bert Pepper, M.D., who spoke on bridging the gap between families and mental health providers.

This year the Department will:

- Continue support to family and consumer mutual aid groups and encourage their expansion.

- Facilitate the development of family education training courses, on a regional basis, offered by trained mental health professionals for families with a chronically mentally ill member.

- Encourage the enlisting of deaf volunteers for deaf persons in treatment and establish an information network for families with deaf members needing mental health services.

- Establish contracts with three Area Agencies on Aging to develop family support/training and education programs on caring for elderly relatives.

- Through its Child and Adolescent Service System Project, help facilitate the utilization of natural helpers to meet the needs of severely emotionally disturbed childen and adolescents and promote parent self-help/advocacy efforts.

OBJECTIVE: TO MAINTAIN AND INCREASE MENTAL HEALTH CONSULTATION AND EDUCATION FOR HEALTH AND HUMAN SERVICE AND OTHER ALLIED PROVIDERS.

The Department has been active in its consultation and education efforts with/for related health and mental health providers. It has conducted or co-sponsored orientations, workshops, and conferences including ones on aging, substance abuse, deafness, housing, coping strategies, family support, children and adolescents, etc. It has and continues to assist in determining mental health/educational needs and in planning educational programs. It participates on Task Forces, Boards of Directors, and special committees such as the Community Geriatric Training Committee, Ingraham Volunteers Training Committee, the Maine Executive Task Force to Study Homelessness, and so on.

This year the Department will:

- Increase consultation and education activities, especially in relation to the priority special populations.

- Develop and conduct major psychogeriatric training opportunities for mental health professionals.

- Emphasize interagency and interdisciplinary coordination of existing training/educational resources.

OBJECTIVE: TO INCREASE ACTIVITIES INTENDED TO PREVENT SPECIFIC MENTAL HEALTH PROBLEMS.

The focus on prevention activities has been continued by the Department through several efforts including the cooperative development of the three preventive intervention pilot programs (Norway, Machias, Waterville) for 0-3 year old children and their families, interagency coordination for the early identification of individuals at risk of developing mental health problems such as elderly persons, and the development of the crisis stabilization program.

This year the Department will:

- Develop and implement a plan for comprehensive, statewide, 0-3 year old preventive intervention services.

- Support the development of increased twenty-four hour outreach crisis services throughout the state.

- Increase preventive mental health activities for vulnerable groups.

- Implement a Mental Health & Jails Training Demonstration Project which will address the increasing role of local jails in dealing with former mental health patients or with persons experiencing severe mental health problems while incarcerated.

GOAL II

TO ASSURE QUALITY INDIVIDUALIZED ASSESSMENT AND EARLY IDENTIFICATION OF MENTAL HEALTH PROBLEMS

The early identification of mental health problems, thorough assessment of needs, rapid intervention, and linkage to appropriate services are critical to the promotion of mental health and effective use of resources.

OBJECTIVE: TO INCREASE THE RESOURCES AVAILABLE FOR EARLY INTERVENTION

The Department reorganized this fiscal year with the Legislative creation of the Bureau of Children with Special Needs. The Bureau gives priority to early intervention and home-based programs. As of November 1985, nine home-based intervention programs for children and families were operational (Presque Isle, Machias, Bangor, Rockland, Brunswick, Skowhegan, Lewiston, Saco, and Portland).

This year the Department will:

- Continue model demonstration programming.

- Continue collaboration through the Interdepartmental Coordinating Committee for Preschool Handicapped Children to strengthen Maine's statewide network of preschool coordination programs.

- Develop a specialized series of training programs with Human Resource Development funds including the Nursing Child Assessment Training (NCAST), the Family Focused Intervention Model, and other exemplary programs.

OBJECTIVE: TO INCREASE THE QUALITY OF ASSESSMENTS REGARDING MENTAL HEALTH PROBLEMS FOR SPECIFIC POPULATIONS

During the past year, the Department has stressed improving the assessment of elderly persons, children and their families, deaf persons, substance abusing mentally ill persons, and persons with psychiatric disabilities, as outlined in the target group sections.

This year the Department will:

- Through its pilot projects housed at the state psychiatric institutions, continue to improve and refine its assessment capability to more accurately develop appropriate treatment programs and referral mechanisms for persons with substance abuse and mental illness problems.

- As required by recent statutory changes, establish a state forensic service to perform assessments of competency and criminal responsibility.

- Assure that assessments of deaf persons are conducted by professionals trained and experienced in the special procedures for test administration to this population.

- Utilize Bureau funds to purchase assessments for deaf clients/patients who are not eligible for Medicaid or private insurance reimbursement.

- Improve evaluation of persons who receive both mental health and vocational rehabilitation services.

- Increase psychogeriatric training and knowledge to improve the level of assessments.

GOAL III

TO ASSURE EASILY ACCESSIBLE, ACCEPTABLE MENTAL HEALTH SERVICES

OBJECTIVE: TO IMPROVE ACCESSIBILITY AND ACCEPTABILITY OF SERVICES FOR SPECIAL NEEDS POPULATIONS

During the past year, the Department continued to stress accessibility for special dually-diagnosed populations such as deaf and hearing-impaired persons and substance-abusing individuals. The Department has been actively involved in the development of elderly services multi-disciplinary coordination committees in Saco, Portland, Lewiston, and Bangor with a resulting increased awareness of mental health needs of the elderly and improved communication between the aging and mental health networks. In addition, training for community mental health and substance abuse providers has promoted systems accessibility through increased knowledge. Accessibility has been improved for children and adolescents as well through the Departmental reorganization creating a Bureau of Children with Special Needs thus providing a focus for the development of a continuum of services for children.

This year the Department will

- Improve accessibility of services to elderly persons through coordination with mental health and allied services providers.

- Continue to work with elderly services and mental health services providers, advocates, and consumers in identifying gaps in and barriers to services and addressing those needs using existing regional resources.

- Expand elderly services regional coordination throughout the state.

- Continue to improve services for mentally ill substance abusers at the Augusta and Bangor Mental Health Institutes.

- Establish a medium security unit at the Augusta Mental Health Institute.

- Continue to work with the Bureau of Maine's Elderly (BME) to identify mental health practitioners who are willing to provide in-home mental health care to elders in need, under the BME's Medicaid waiver.

- Implement a service accessibility plan in each of the eight mental health regions to involve establishment of telecommunications devices for deaf persons, training of receptionist for appropriate handling of deaf referrals, and identification of clinical staff to work with deaf clients and receive ongoing training in this area.

- Continue annual presentations to the deaf social organizations in Maine regarding availability of services and input from the deaf community.

- Continue funding interpreters to CMHCs and state psychiatric hospitals.

- Continue to provide information through the Departmental publication, the Report, on mental health services available throughout Maine.

OBJECTIVE: TO IMPROVE TRANSPORTATION TO AND FROM MENTAL HEALTH SERVICES AND INCREASE IN-HOME SERVICES, INCLUDING CRISIS SERVICES.

The Department has continued to stress in-home outreach services, has continued its participation on regional transportation planning committees, increased the availability of home-based children's services, and has worked with the Bureau of Maine's Elderly, DHS for increased and improved mental health care for elderly persons in their homes. Emphasis has, as well, been placed on providing quality crisis services. The three Departmental twenty-four outreach crisis pilot programs have been highly effective in meeting the needs of pesons experiencing a mental health crisis in the Kennebec Valley, Portland, and York County areas.

This year the Department will:

- Advocate for increased in-home mental health services to the elderly.

- Continue to enhance and refine outreach crisis services and home-based services for children and adolescents.

- Maintain its advocacy for improved transportation services.

- Establish a fourth crisis stabilization program in the Lewiston/Auburn area.

- Develop a counselor position, who will have the capacity to provide services in-home, to work specifically with deaf persons .

GOAL IV

TO DEVELOP A CONTINUUM OF MENTAL HEALTH SERVICES WHICH PROVIDE A WIDE VARIETY OF TREATMENT, REHABILITATION, AND SUPPORTIVE OPTIONS AND OPPORTUNITIES INCLUDING LEAST RESTRICTIVE APPROPRIATE ALTERNATIVES

OBJECTIVE: TO MAINTAIN COMPREHENSIVE MENTAL HEALTH SERVICES IN EACH SERVICE AREA TO THE EXTENT THAT RESOURCES ARE AVAILABLE.

The Department has continued its support for the development and maintenance of basic mental health services in the eight mental health service areas of the state, the on-going assessment of changing needs and resources, and the enhancement of coordinated regional planning and development.

OBJECTIVE: TO DEVELOP A CONTINUUM OF SERVICES FOR SERIOUSLY EMOTIONALLY DISTURBED CHILDREN AND ADOLESCENTS.

The Department has increasingly focused its attention on developing coordinated services for severely disturbed children and adolescents and their families throughout Maine. As a part of this effort, the Bureau of Children with Special Needs was created in September 1985 from the Office of Children's Services, drawing responsibility for children's services from the Bureau of Mental Health and the Bureau of Mental Retardation, thus centralizing responsibility within the Department for children's services. A strong emphasis has been maintained on home-based care, prevention and early intervention, quality residential treatment, and active coordination with other agencies and departments in planning, developing, and coordinating services.

This year the Department will:

- Continue implementation of the Child and Adolescent Service System Project--funded by the National Institute of Mental Health--at state level and in York and Southern Penobscot pilot regions to improve coordination of planning and case coordination for multi-problem children.

- Collaborate with the Interdepartmental Committee to define a comprehensive continuum of mental health, educational, residential, and other support services to meet the needs of children, adolescents and their families and to remove barriers to such a continuum.

OBJECTIVE: TO DEVELOP A COMPREHENSIVE CONTINUUM OF SERVICES FOR PERSONS WITH CHRONIC MENTAL ILLNESS.

Persons with severe and prolonged mental illness, who may also have areas of impaired functioning such as in daily living, social, and vocational skills, are a major priority population for the Bureau of Mental Health and the Department.

This on-going commitment to Maine's chronically mentally ill citizens is reflected in the continuing development of a range of housing options, the focus on integrated vocational training and employment, the development of around-the-clock outreach crisis services with attached emergency and transitional housing, support for the continuing development of consumer and family groups, and a redefinition of services.

SUB-OBJECTIVE: IMPROVE HUMAN RESOURCES DEVELOPMENT IN THE AREA OF PSYCHIATRIC REHABILITATION.

During the last few years, the Department has continued to encourage the development of psychosocial rehabilitation assessment and treatment skills through increasing general knowledge in this area, the preparation of trainers, and the involvement of Maine's university and mental health systems in this process.

This year the Department will:

- Continue to expand training linkages in support of psychiatric rehabilitation with the University of Maine - Farmington campus and with the Research & Training Center of Boston University.

- Continue the training activities of Boston University at the Bangor Mental Health Institute in the methods and processes of psychiatric rehabilitation.

- Deliver training in psychiatric rehabilitation by sponsoring/supporting resources at University of Maine - Farmington to provide ongoing technical consultation, sponsor periodic on/off site training, sponsor a two-week Summer Institute in Rehabilitation, June, 1985, and co-sponsor a psychiatric rehabilitation workshop for administrators.

- Sponsor of an Awareness Workshop directed at administrators to address the mission, principles, and practice of psychiatric rehabilitation in conjunction with Boston University and the University of Maine-Farmington.

SUB-OBJECTIVE: INCREASE HOUSING OPTIONS FOR PSYCHIATRICALLY DISABLED PERSONS.

Over the past few years, the Department has maintained efforts to support the development of a range of housing alternatives in Maine from highly structured supervised homes to independent affordable arrangements. There are now 20 programs throughout the state offering a number and variety of options. Two of the four Medicaid Waiver demonstration residential programs completed their Waiver participation in this fiscal year and were funded by the Department. The Department, with the support of the Legislature, provided expanded transitional and emergency housing and supervised, subsidized apartments. A statewide housing conference brought key individuals together to examine local housing needs and to develop local housing planning groups. Efforts have also been underway to establish specialized, structured housing for deaf persons and elderly persons with psychiatric disabilities.

This year the Department will:

- Work closely with local housing planning groups to indentify gaps in housing, target resources to housing development activities, and implement recommendations of the homelessness task force.

- Continue to work with mental health agencies providing community support services to improve support and advocacy for people needing expanded low income housing.

- Continue to work with non-mental health housing and income maintenance agencies to target existing resources to people with psychiatric disabilities attempting to live independently.

- Continue to pursue viable housing options fo elderly persons with mental illnesses and dementias including: a) continued development of a boarding home in the Bangor area for chronically mentally ill elders; b) continued participation in the development of the Bureau of Maine's Elderly residential resource center for victims of Alzheimer's Disease; c) the development of emergency shelter/respite options for elderly persons in crisis.

- Coordinate funding among the Bureau of Mental Health, the Bureau of Rehabilitation and the Division of Residential Care in the establishment of the 8-bed, 24 hour treatment facility for deaf persons with mental health and/or adjustment problems.

- Explore alternate housing options for deaf children with emotional/behavioral problems.

SUB-OBJECTIVE: INCREASE VOCATIONAL OPTIONS.

During the past year, the Department has increased its efforts to expand supported employment opportunities in cooperation with several other state agencies. The Department has worked collaboratively with the Division of Vocational Rehabilitation to establish and expand programs in Aroostook, Penobscot, Washington, Cumberland, and Kennebec counties and has worked with other state and private agencies to develop legislation to increase opportunities for facility-based employment through the State Set-Aside Law. The Department has provided assistance to local planning groups in Cumberland, Androscoggin, and Penobscot counties to strengthen the quality of vocational services in those areas, and the Department has coordinated staff training in vocational rehabilitation through the New England Psychiatric Rehabilitation Training Program.

This year the Department will:

- Establish a work group comprised of providers, family members, and consumers to identify service gaps and to develop a set of principles for the development of programs.

- Continue to work with the Bureau of Rehabilitation toward the development of a cooperative agreement and the establishment of service standards.

- Continue to provide consultation to local groups of vocational providers in Cumberland, Penobscot, and Androscoggin counties and continue to work to enhance and strengthen local planning groups in other areas of the state.

- Continue collaborative efforts with Vocational Rehabilitation to develop and/or strengthen vocational programs across the state including supported employment opportunities.

- Coordinate participation of providers in the New England Psychiatric Rehabilitation Training Program.

SUB-OBJECTIVE: INCREASE SOCIALIZATION AND DAILY LIVING SKILLS TRAINING FOR THE PSYCHIATRICALLY DISABLED.

The Department has continued to assist in the development of socialization programs throughout Maine with social clubs established in the Portland, Augusta, Waterville, Bangor, York, Aroostook, and now Lewiston/Auburn areas.

This year the Department will:

- Continue to enhance and expand social rehabilitation opportunities as resources will permit.

OBJECTIVE: INCREASE SERVICES TO AUTISTIC PATIENTS IN COORDINATION WITH THE BUREAU OF MENTAL RETARDATION.

The Department has launched pilot projects in the Kennebec County and Cumberland County areas with the intention that this new program to serve Maine's special needs autistic children would evolve eventually to include autistic persons in all areas of Maine.

One of the nation's leading experts on autism and other severely handicapping developmental disabilities, Anne M. Donnellan, Ph.D., spoke at a special conference at Bowdoin College sponsored by the Maine Departments of Mental Health and Mental Retardation and Educational and Cultural Services.

OBJECTIVE: TO DEVELOP A CONTINUUM OF SERVICES FOR ELDERLY PERSONS WITH MENTAL HEALTH NEEDS.

The Department, through its Mental Health Elderly Services Coordination Project, has worked with other agencies and programs to present several workshops on aging and substance abuse; has been instrumental in the development of regional mental health/aging coordinating groups; has initiated or collaborated on several federal grant applications; has continued to work with the Bureau of Maine's Elderly in the development of a twenty-bed boarding and respite care facility and resource center for victims of Alzheimer's Disease; has continued to work, along with the Bureau of Maine's Elderly, with the Joint Advisory Committee on Mental Health Services to Elderly Persons; and has continued to provide technical assistance and resource development on mental health and aging.

This year the Department will:

- Increase housing options for psychiatrically disabled elderly persons.
- Pursue day treatment programming options for residents of the Bangor boarding home for chronically mentally ill elders.
- Continue to jointly sponsor the Joint Advisory Committee on Mental Health Services to Elderly Persons in the implementation of the recommendations of the Task Force on Mental Health Services to Elderly Persons.
- Pursue funding for the activities of the Mental Health Elderly Services Coordination Project.
- Pursue increased coordinated planning of programs and services for elderly persons throughout Maine on both regional and state levels.
- Develop a public information campaign on the promotion of mental health through activity and involvement for older people, which will include Public Service Announcements and literature.
- Present a training workshop series on the mental health needs of elderly persons for providers of mental health care and direct services to elderly persons, including a workshop on "Psychogeriatric Issues and Intervention for Mental Health Professionls" with Kenneth Solomon, M.D. with the assistance of Human Resource Development funding.

OBJECTIVE: TO DEVELOP A CONTINUUM OF SERVICES FOR DEAF INDIVIDUALS WITH MENTAL HEALTH NEEDS.

Within the past two years, the Department has made significant strides in increasing and enhancing services for deaf persons with mental health problems in many areas: consumer involvement, service coordination, education and outreach, and community and inpatient services. Use of interpreters in mental

health service situations has increased; orientations and training for the deaf community and mental health professionals have been conducted; individual client case consultations have been provided; a therapeutic residential mental health program for deaf pesons has been developed; and work with the Advisory Committee on Mental Health Services to Deaf Persons has continued.

This year the Department will:

- Continue to increase attention to the mental health needs of deaf pesons as outlined in the special population section.

- Develop further housing options as needed for deaf persons with mental health problems.

- Enhance CMHCs ability to work with deaf clients by establishing a itinerant position to provide clinical consultation to regional staff working with deaf persons.

- Assure quality assessments by trained and experienced professionals.

- Continue consultation and education activities by the Deaf Services Coordinator with mental health providers including the development of a cross-cultural training package and future speciality workshops.

- Assess the need for mental health services of deaf children and deaf substance abusers.

- Continue to assist state psychiatric hospitals to better meet the needs of deaf patients and conduct audiological screenings on a pilot basis.

GOAL V

TO ENHANCE AND PROTECT THE RIGHTS OF PERSONS WHO RECEIVE MENTAL HEALTH SERVICES

OBJECTIVE: TO ASSURE INTEGRATION OF RECIPIENT RIGHTS REGULATIONS IN THE MENTAL HEALTH SYSTEM.

Recent efforts by the Department have been geared toward refining and implementing the policies, training, and monitoring of the mental health recipient rights regulations.

This year the Department will:

- Integrate departmental rights regulations into the regulations for residential child care facilities.

- Examine the need to revise the rights regulations to ensure greater relevancy to the community setting.

- Continue monitoring implementation of rights regulations through internal mechanisms and through licensing reviews.

- Establish, as required by statute, a rights advisory group charged with monitoring and making recommendations concerning implementation of rights regulations.

OBJECTIVE: TO ASSURE PROTECTION OF INCAPACITATED PERSONS.

The Department continues to work with the Department of Human Services, Division of Adult Protective Services (APS) to develop joint agreements and policies and procedures regarding incapacitated patients at A.M.H.I. and B.M.H.I. A variety of training has been conducted and efforts have been made to increase knowledge and awareness of mental health concerns and issues related to rights and incapacity.

This year the Department will:

- Continue collaborative efforts to insure appropriate balancing of the need for protection and for advocacy for incapacitated clients of the department.

- Develop streamlined administrative procedures for obtaining a guardianship/conservatorship.

- Examine and develop protocols for health care decisions of departmental clients involving, for example, living wills and powers of attorney.

OBJECTIVE: TO ASSURE EQUAL SERVICES TO HANDICAPPED PERSONS.

Departmental efforts to assure accessible and available services to handicapped persons have continued. The development of programming for deaf and hearing-impaired persons has continued to be emphasized with the maintenance of the statewide Deaf Services Coordinator position, the increase in interpreter services funding, the inter-program and agency coordination, and the provision of increased consumer, provider and public education, such as the HRD-funded workshop with Dr. John Scanlan and the seminar with Aralyn D. Dennison, CSC, SCIL.

This year the Department will:

- Continue to implement 504 requirements for access for handicapped persons.

- Continue efforts to promote accessibility for deaf consumers, as outlined in the special population section.

GOAL VI

TO ASSURE CONTINUITY OF CARE AND COORDINATION OF MENTAL HEALTH SERVICES WITH OTHER SYSTEMS AND PROVIDERS.

OBJECTIVE: TO INCREASE CONTINUITY OF CARE FOR PERSONS WHO ARE DISCHARGED FROM STATE INPATIENT FACILITIES.

A continued emphasis has been placed by the Department on this population with increasing importance put on the liaison positions between the mental health institutes and community agencies, improved discharge planning and coordination with other agencies and family and consumer participation, and the continuing development of local planning/coordinating groups.

This year the Department will:

- Develop standards and a mechanism for assessing and monitoring community support services and systems at the local level to assure continuity of care to persons discharged from inpatient facilities.

OBJECTIVE: TO DEVELOP THE COORDINATIVE ASPECTS OF THE SERVICE SYSTEM ON A CASE-BY-CASE BASIS FOR SPECIFIC POPULATIONS.

The Department with its emphasis on community support systems has continued to examine case management models and programs, is pursuing its demonstration implementation of case coordination through the Child and Adolescent Service System Project, and has provided educational opportunities on case management such as the HRD-funded seminar on casework management models and mechanisms for enhancing service delivery to multi-problem clients.

This year the Department will:

- Continue implementing case coordination at its two regional CASSP pilot sites in York and Southern Penobscot counties.

- Implement a model case management system for persons with severe disabling mental illness in the Greater Portland area.

OBJECTIVE: MAINTAIN AND EXPAND LINKAGES AND COORDINATION OF THE MENTAL HEALTH SERVICES SYSTEM WITH OTHER SYSTEMS AND PROVIDERS.

Just as the Department has been working toward fully integrated interagency and program linkages and coordination within the mental health system so it has also been actively seeking to coordinate its efforts with other providers and systems. The instances of such coordination are numerous and include working with the Office of Deafness, DHS, Governor Baxter School for the Deaf, Division of Residential Care, and Goodwill Industries in establishing a therapeutic residential program for deaf persons with mental health problems; working with the Bureau of Medical Services on the revision of Medicaid Waiver services; working with the Department of Transportation on regional transportation planning; working with the Bureau of Maine's Elderly, Area Agencies on Aging, Citizens Interest Group, Togus VA on public and professional psychogeriatric training, the development of a structured residential program, thorough assessments of the needs of elderly persons, and the jointly sponsored Joint Advisory Committee on Mental Health Services to Deaf Persons; working with the Bureau of Rehabilitation on vocational and training opportunities for persons disabled by mental illness; working with Adult Protective Services, DHS on protecting the rights of incapacitated persons, and continuing its work on the Interdepartmental Committee with the Departments of Human Services, Corrections, and Educational & Cultural Services to cooperatively plan, fund, coordinate, and monitor services for children and adolescents.

This year significant intersystem efforts will occur:

- Between the Bureau of Children with Special Needs and the Interdepartmental Coordinating Committee to improve the coordination of services for severely emotionally disturbed children and adolescents. Priority areas include (a) a coordinated network of sexual abuse treatment services, (b) secure treatment services, (c) preadolescent services, and (d) out-of-home placement funding and related issues.

- Between the Department of Mental Health and Mental Retardation and the Department of Human Services to enhance the multi-disciplinary approach to child abuse prevention/treatment and to improve understanding of the requirements of confidentiality in this context.

- Between the Bureau of Mental Health and DHS Bureau of Medical Services to improve the availability and appropriate use of Medicaid monies for mental health treatment.

- Between the Bureau of Mental Health, OCSS, and DHS Bureau of Rehabilitation to improve vocational services to persons with chronic mental illness.

- Between the Bureau of Mental Health, community mental health providers, Area Agencies on Aging, and the DHS Bureau of Maine's Elderly to improve the accessibility of mental health services to elderly persons.

- Between the Department of Mental Health and Mental Retardation and the Department of Educational & Cultural Services and the Department of Human Services, per the Joint Health Education Policy Statement, in the development and implementation of a coordinated, comprehensive health education effort geared toward all of Maine's citizens.

- Between the Bureau of Mental Health and broad-based regional coordinating groups which will coordinate and better use existing resources, identify gaps, and develop strategies for enhancing an integrated and coordinated mental health delivery system for elderly persons in their areas.

- Between the Bureau of Mental Health and the Bureau of Health Planning Hospital Cost Containment Commission, review and comment on certificate of need requests for expanded hospital-based psychiatric services.

GOAL VII

TO ASSURE THAT SERVICES AND PROGRAMS ARE FLEXIBLE AND RESPONSIVE TO CLIENT NEEDS AND CHOICES, AND PLANNED SYSTEM CHANGE IS INSTITUTED AS ADVANCES IN KNOWLEDGE OCCUR.

OBJECTIVE: TO IMPROVE MANAGEMENT AND RESPONSIVENESS IN THE PROGRAM AREA

The Department has continued to refine contracting mechanisms and to redefine services for the provision of community mental health contractual services.

This year the Department will:

- Develop and disseminate standards for assessment and monitoring of local community support systems.

- Enhance clinical management and program development skills for Departmental and Community entities involved in the provision of children's mental health services.

- Continue and expand its Human Resource Development mental health in jails initiative.

- Train key staff in new roles, tasks, and skills necessary to the Department's Human Resource Development efforts to build a unified administrative, program and service delivery capability addressing the needs of handicapped and troubled children, youth, and their families.

- Develop Human Resource Development training and education alternatives for mental health providers and administrators, building and expanding on existing and successful linkages with Maine's university system and other educational institutions.

SUB-OBJECTIVE: TO INCREASE ATTENTION TO CLIENT/PATIENT NEEDS DATA.

Substantial progress has been made in recent years toward the development of a comprehensive mental health service system responsive to a variety of special mental health needs; however, efforts to coordinate, consolidate, and refine these initiatives must exist within a comprehensive data base, planning, and resource development process involving all the major service departments. The beginning of this may be seen in the developing management

information system for patient/client data in the institutes and community and in the northern and southern Maine surveys of psychosocial rehabilitation needs.

This year the Department will:

- Continue to promote the further development of an integrated comprehensive management information system.

- Pursue resources for the development and implementation of a statewide comprehensive needs assessment for the mental health needs of elderly persons.

- Assess the number of hearing impaired patients in the State psychiatric hospitals by conducting hearing screenings with admissions.

SUB-OBJECTIVE: TO ASSIST THE BUREAU OF CHILDREN WITH SPECIAL NEEDS IN ASSUMING RESPONSIBILITY FOR COMMUNITY MENTAL HEALTH SERVICES TO CHILDREN, ADOLESCENTS, AND THEIR FAMILIES.

The Maine Legislature established the Bureau of Children with Special Needs within the Department of Mental Health and Mental Retardation effective September 19, 1985. The purpose of the new Bureau is to provide a structural foundation, well coordinated with other state agency efforts and mandates, for the Department to begin to address the problems of handicapped and troubled children under a unified administrative and program structure. Creation of the new Bureau entails the transfer of over $1,600,000 in state and federal funds from the Bureau of Mental Health to continue community mental health services to children under the aegis of the Bureau of Children with Special Needs.

Next year the Bureau of Mental Health will:

- Assist the new Bureau of Children with Special Needs in assuming funding responsibility for community mental health programs for children and adolescents heretofore funded by the Bureau of Mental Health.

- Assist the Bureau of Children with Special Needs in developing and implementing a contract budgeting and monitoring system.

- Share current and historical data to assist the Bureau of Children with Special Needs in addressing its planning, resource development, and management responsibilities.

OBJECTIVE: TO MAINTAIN AND INCREASE PUBLIC INVOLVEMENT IN MENTAL HEALTH POLICY-MAKING.

Public involvement in mental health planning has continued to be a high priority for the Department. It has encouraged participation through a variety of means - task forces, advisory groups, workshops and seminars, regional coordinating/planning efforts, surveys, and public forums - placing great value and importance on such participation.

This year the Department will:

- Continue to encourage public participation, especially consumer and family involvement, on advisory committees, boards of directors, and various work groups.

GOAL VIII

TO IMPROVE MANAGEMENT OF THE MENTAL HEALTH SYSTEM IN THE CLIENT DATA, FISCAL ACCOUNTABILITY, AND REGULATORY AREAS

OBJECTIVE: TO IMPROVE THE COLLECTION AND REPORTING OF CLIENT/PATIENT DATA.

In addition to its usefulness as a tool for management and program planning, data on clients served in Maine's institutions and in the community is necessary to meet the Department's reporting requirements to the federal government. The Department has committed itself to improving data collection to meet the standards of the National Institute of Mental Health Inventory of Mental Health Organizations and federal block grant requirements.

Next year the Bureau of Mental Health will:

- Work with a task force on mental health client data to bring client reporting in the community into compliance with federal standards, as well as to improve its usefulness for state planning purposes.

- Work with the Bureau of Children with Special Needs to implement their data collection requirements in the community mental health system.

- Work with the Department's Division of Planning to produce required state and federal reports.

- Work with the Division of Planning to initiate the Minimal Manpower Data Set.

OBJECTIVE: TO MAINTAIN HIGH STANDARDS OF FISCAL ACCOUNTABILITY.

In the past few years, the Department has improved its ability to monitor the financial aspects of its community service contracts. These efforts have included the development of contract principles concerning revenues and costs, establishment of contract management and audit capacities, upgrading of contract budget and quarterly reporting formats, and implementation of a performance-based contract system.

In the next year the Bureau of Mental Health will:

- Provide ongoing monitoring of community service contracts, with continual communication and follow-up on financial and service problems.

- Follow up on correcting problems identified in Department audits.

- Monitor recently promulgated Medicaid regulations for reimbursement of mental health clinic services.

- Produce financial and service reports for management as well as for state and federal reporting.

- Assist the new Bureau of Children with Special Needs in developing a contract monitoring system appropriate to its needs.

- Review the practicability of revising Bureau cost principles in light of expected single-State audit regulations.

OBJECTIVE: TO IMPROVE MANAGEMENT IN OTHER REGULATORY AREAS INCLUDING MENTAL HEALTH LICENSING

The Department has revised and updated Bureau of Mental Health licensing regulations and procedures.

This year the Department will:

- Consolidate changes in the levels of licensure.

- Examine the feasibility of extending the duration of agency licenses.

- Attempt to integrate licensing site visits with contract monitoring activities.

OBJECTIVE: TO MONITOR RECIPIENT RIGHTS IMPLEMENTATION

The Department has continued its implementation and technical assistance regarding the rights of Maine's citizens who receive mental health services.

This year the Department will:

- Continue monitoring agencies regarding patient's rights implementation.

OBJECTIVE: TO INSURE ACCOUNTABILITY THROUGH IMPROVED QUALITY ASSURANCE RESEARCH AND EVALUATION

The Department is in the process of evaluating its Medicaid 1115 Waiver data for the two sites which have completed their participation in the demonstration program, examining that data with the Quality of Life Assessment.

This year the Department will

- Increase emphasis on agency quality assurance plans and activities.

GOAL IX

TO INCREASE RESOURCES AVAILABLE FOR THE DEVELOPMENT AND MAINTENANCE OF MENTAL HEALTH SERVICES THROUGHOUT THE STATE

For some years the Department has vigorously pursued the development of additional resources for mental health services throughout the state. Notably, Maine, with its informed and committed Governor, Legislature, and consumers and family groups, has continued to support the development of needed and effective mental health services. Even with decreasing federal assistance, Maine has recognized the importance of meeting the mental health needs of its citizens by working toward an effective, coherent mental health system.

On July 1, 1985, new regulations developed by the Bureau of Mental Health and the Bureau of Medical Services of the Maine Department of Human Services went into effect which will greatly increase Medicaid reimbursement for mental health clinic services and allow reimbursement for the first time for day treatment services and for a variety of services to children.

This year the Department will:

- Work with the Department of Human Services to implement improved Medicaid regulations.
- Work with community Medicaid providers to assure compliance with Medicaid requirements.
- Seek additional resources for services to a variety of specific service populations.
- Conduct resource development for elderly services through the Mental Health Elderly Services Coordination Project.

- Develop further options for therapeutic housing for deaf persons with mental health needs.

- Continue to work closely with the Bureau of Rehabilitation to improve the availability, accessibility, and quality of vocational rehabilitation services.

TELEPHONE DIRECTORY:

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
289-4200

Kevin W. Concannon, Commissioner

Ronald S. Welch, Associate Commissioner for Programs
Ronald R. Martel, Associate Commissioner for Administration
Edward Kelleher, Director, Legislation & Community Affairs

Ralph Lowe, Public Information Officer
, Director of Data & Research
Jamie Morrill, Alcohol & Substance Abuse Coordinator
Frank O'Donnell, Coordinator of Human Resources Development
Richard Estabrook, Chief Advocate

Bureau of Mental Health 289-4230

, Director
Michael Hopkins, Field Operations Manager
Frank Ellis, Ph.D., Director of Licensing & Evaluation
Julita Klavins, Planning & Research Associate (289-4238)
Pam Bugosh, Legal Services Consultant
David Lawlor, Mental Health Deaf Services Coordinator (TTY 289-2000)
David Miner, Mental Health Elderly Services Coordinator

Office of Community Support Systems

Susan Wygal, Director 289-4238
Marjorie Hill, MH Program Coordinator, Service Areas I & II (941-4152)
Joan Smyrski, MH Program Coordinator, Service Area III (872-7661)
Brenda Harvey, MH Program Coordinator, Service Area IV & Vocational Liaison (289-4238)
Martin Gouzie, MH Program Coordinator, Service Area V (772-7428)
Craig Phillips, MH Program Coordinator, Service Area VI (282-4250)

Crisis Stabilization Program
Office of Community Support Systems
Bureau of Mental Health

Augusta/Waterville - After hours & weekends - 1-800-322-2222 Ext. 150

Joan Smyrski, MH Program Coordinator
Arlene Cahill, Crisis Worker
Buster McClellan, Crisis Worker
Marilyn Smith, Crisis Worker

Portland - After hours & weekends - 1-800-322-2222 Ext. 122

Martin Gouzie, MH Program Coordinator
Lawrence Spencer, Crisis Worker
Georgianna Chabot, Crisis Worker
Gregory Nevens, Crisis Worker

York County - After hours & weekends - 1-800-322-2222 Ext. 151

Craig Phillips, MH Program Coordinator
Carey Paradis, Crisis Worker
Joann Mazeau, Crisis Worker

Augusta Mental Health Institute 622-3751

William Daumueller, Superintendent
, Assistant to the Superintendent
Victor Perreault, Chief of Special Services
Ulrich Jacobsohn, M.D., FAPA, Clinical Director
Peter Swartz, Director of Volunteer Services
Robert Kingman, Patient Advocate

Bangor Mental Health Institute 941-4000

Charles Meredith, Superintendent
Russell Taylor, Business Services Manager
Roger Wilson, M.D., Clinical Director
Hope Richards, Administrator, Program on Aging
Thelma Andrews, Assistant Volunteer Director
Richard Roelofs, Patient Advocate

Bureau of Children With Special Needs 289-4250

Robert Foster, Director
Sherrin Blaisdell, Resource Development Manager
Edward Hinckley, Field Operations Manager
Veronica Dumont, Child Placement Coordinator

Child and Adolescent Service System Project 289-4251

Rachel Olney, Ph.D., Director
James Harrod, Ph.D., Technical Assistance Coordinator

Interdepartmental Coordinating Committee

Nancy Warburton, Executive Director (289-4259)
Susan Bumpus, Program Assistant (289-4260)

REGION I

AROOSTOOK MENTAL HEALTH CENTER	
Administration	498-6431
Help Line	1-800-432-7805
Skyhaven	764-0759
New Vocations	498-2528
Caribou Apartments	498-3007
In-Patient Unit	
Community General Hospital	768-4731
Caribou Office (clinical)	493-3361
Fort Kent	834-3186
Houlton	532-6523
Madawaska	728-6341
Presque Isle	764-3319
Van Buren	868-5236
VALLEY FAMILY SUPPORT GROUP	728-4610
THE SOUTHERN AROOSTOOK FAMILY SUPPORT GROUP	532-3572
THE VALLEY AMI CENTER	728-4806

REGION II

COMMUNITY HEALTH AND COUNSELING SERVICES	947-0366	
Administration	947-0366	
Dial Help	1-800-432-7810 or 947-6143	
Washington County Day Program	255-8311	
Hancock County Children's Center	667-5357	
Therapeutic Foster Home Program	947-0366	
Transitional Living Apartment	947-0366	
Orono Group Home	866-4212	
Bangor Outpatient	947-0366	
Children's Clinical Services	947-0366	
Big Red Redemption	947-5117	
Handyperson Program	947-0366	
Bar Harbor Office	288-3363	
Dover Foxcroft Office	564-8175	
Ellsworth Office	667-5357	
E. Machias Office	255-8311	
Millinocket Office	723-9739	
Calais Office	454-2928	
Lincoln Office	794-3554	
EASTERN MAINE MEDICAL CENTER	947-3711	
Administration	947-3711	ext. 7090
Emergency Room	947-3711	ext. 8000
Psychiatric Inpatient	947-3711	ext. 8573
BANGOR MENTAL HEALTH INSTITUTE	941-4000	
Administration	941-4036	
Admissions	941-4134	
Halfway Houses	941-4275/6	
DHRS - ST. MICHAEL'S CENTER	947-0507	
CITIZEN'S INTEREST GROUP	941-4152	
THREE HUDSON STREET	947-0202	
TOGETHER PLACE	947-6125	
HOMESTEAD PROJECT	667-2021	
BLUE HILL HOSPITAL	374-2836	
Administration	374-2836	ext. 207
Mental Health Unit	374-2836	ext. 251
CHILD AND YOUTH BOARD OF WASHINGTON COUNTY	255-3426	
UNITED CEREBRAL PALSY OF NORTHEASTERN MAINE	947-6771	
CHARLOTTE WHITE CENTER	564-2464	
OPPORTUNITY HOUSING, INC.	947-2730 or 947-6809	
FAMILIES UNITED OF WASHINGTON CTY.	255-3000	

REGION III

KENNEBEC VALLEY MENTAL HEALTH CENTER	
Administration	873-2136
Day Program - Augusta	622-0442
Inpatient(Mid-Maine Medical Center)	872-4354
Augusta Offices - Hill Hill House	622-0441
Stone Street	622-3138
Skowhegan Office	474-8368
Waterville Office	873-2136
KENNEBEC VALLEY MEDICAL CENTER(Augusta)	626-1000
CRISIS AND COUNSELING CENTERS	
Augusta	623-4511
Waterville	872-2276
Skowhegan	474-2506
AUGUSTA MENTAL HEALTH INSTITUTE	622-3751
BUREAU OF MENTAL HEALTH - CRISIS STABILIZATION PROGRAM - AUGUSTA/WATERVILLE	1-800-322-2274 Ext. 150
WATERVILLE OFFICE	872-7661
KENNEBEC VALLEY REGIONAL HEALTH AGENCY	
Waterville	873-1127
Augusta	622-0765
DHRS FAMILY & MARRIAGE COUNSELING & KENNEBEC SOMERSET HOME AID SERVICES	
Augusta	622-0188
Waterville	873-1146
MOTIVATIONAL SERVICES (MOCO)	
Administration	622-6273
LINC Social Club Members	622-5736
Clean Sweep	622-1522
Middle Street House Office	622-0920
Elm Street House Office	622-2782
Western Avenue Residence Office	872-8195
Waterville Social Center Office	873-1027
Waterville Social Center Members	873-1029
WINTHROP ALTERNATIVE SCHOOL	377-6851
YOUTH AND FAMILY SERVICES	
Skowhegan/Administration	474-8311
Emergency Shelter	453-2997
Counseling Program	474-8311
MID-MAINE ALLIANCE FOR THE MENTALLY ILL	873-3073
(Waterville)	873-3672
VETERANS ADM. CENTER & HOSPITAL	623-8411

REGION IV

TRI- COUNTY MENTAL HEALTH SERVICES	783-9141	
Administration	783-9141	
Emergency	783-9141	
Day Treatment	783-9141	
Transitional Employment	783-9141	
The Depot (Day Center)	783-9141	
Social Learning Center	783-1621	
Farmington Office	778-3556	
Lewiston Office	783-9141	
Norway Office	743-7911	
Rumford Office	364-7981	
ST. MARY'S HOSPITAL	786-2901	
Administration	786-2901	ext. 3107
Emergency Room	786-2901	ext. 2500
Psychiatric Unit	786-2901	ext. 2624
REGIONAL EDUCATIONAL TRAINING CENTER	786-4498	
RELATIVES AND FRIENDS TOGETHER FOR SUPPORT	784-7632	
ALLIANCE FOR THE MENTALLY AND EMOTIONALLY DISABLED	562-8379	
DHRS FAMILY & MARRIAGE COUNSELING	784-0157	
FARMINGTON ALLIANCE FOR THE MENTALLY ILL	778-3429	
AREA IV MENTAL HEALTH SERVICES COALITION (ADVOCACY)	782-2273	
100 PINE STREET (SOCIAL CLUB & SHELTER)	782-2273	

REGION V

MAINE MEDICAL CENTER	871-0111	
Administration	871-0111	ext. 2491
Emergency Room	871-0111	ext. 2381
Adult Day Program MH	871-0111	ext. 2221
Child Psychiatric	871-0111	ext. 2428
Psychiatric Unit	871-0111	ext. 2581
Therapeutic Nursery	773-0361	
MENTAL HEALTH ASSOCIATION OF THE CUMBERLAND REGION, INC.	772-6222	
INGRAHAM VOLUNTEERS, INC.		
Administration	773-4830	
Dial INFO	774-HELP	
Deaf Services	TDD 773-7321	
Dial KIDS	774-TALK	
	TDD 773-1262	
AMITY CENTER	772-1248	
SHALOM HOUSE	874-1080	
SHALOM APARTMENTS	874-1090	
SPURWINK SCHOOL	871-1200	
COMMUNITY COUNSELING CENTER	774-5727	
Cape Elizabeth Office	799-0115	
Falmouth Office	781-3413	
Gorham Office	854-8510	
Westbrook Office	854-8510	
WESTERN MAINE COUNSELING SERVICES	647-5629	
Administration	647-5629	
Adolescent Day Treatment	647-8345	
Western Maine School	647-8345	
Bridgton Office	647-5629	
Fryeburg	647-5629	
Raymond	647-5629	
DHRS FAMILY & MARRIAGE COUNSELING	871-7440	
DHRS HOLY INNOCENTS HOME CARE SERVICE	871-7431	
LITTLE BROTHERS	772-4651	
Administration	772-4651	
Emergency Shelter	773-4701	
Roads Group Home	772-2375	
Community Care	772-4651	
COMMUNITY HEALTH SERVICES, INC.	775-7231	
Portland	775-7231	
Bridgton	1-800-482-0152	
ALLIANCE FOR MENTALLY ILL	774-4357	
YWCA STREET PROGRAM	772-8581	
JACKSON BROOK INSTITUTE	761-2200	

REGION VI

YORK COUNTY COUNSELING SERVICES	282-7504	
Administration	282-7504	
North Street Day Treatment	282-5188	
Common Connection	282-5455	
Crescent House	282-4962	
Saco Office	282-5188	
Sanford Office	324-1550	
York Office	363-2458	
Kezar Falls Office	625-8126	
SOUTHERN MAINE MEDICAL CENTER	283-3663	
Administration	283-3663	ext. 220
Emergency room	283-3663	ext. 100
Psychiatric Unit	283-3663	ext. 460
CREATIVE WORK SYSTEMS	282-4173	
SWEETSER CHILDREN'S HOME	284-5981	
YORK FAMILY SUPPORT GROUP	282-5347	
DHRS FAMILY & MARRIAGE COUNSELING	282-3373	

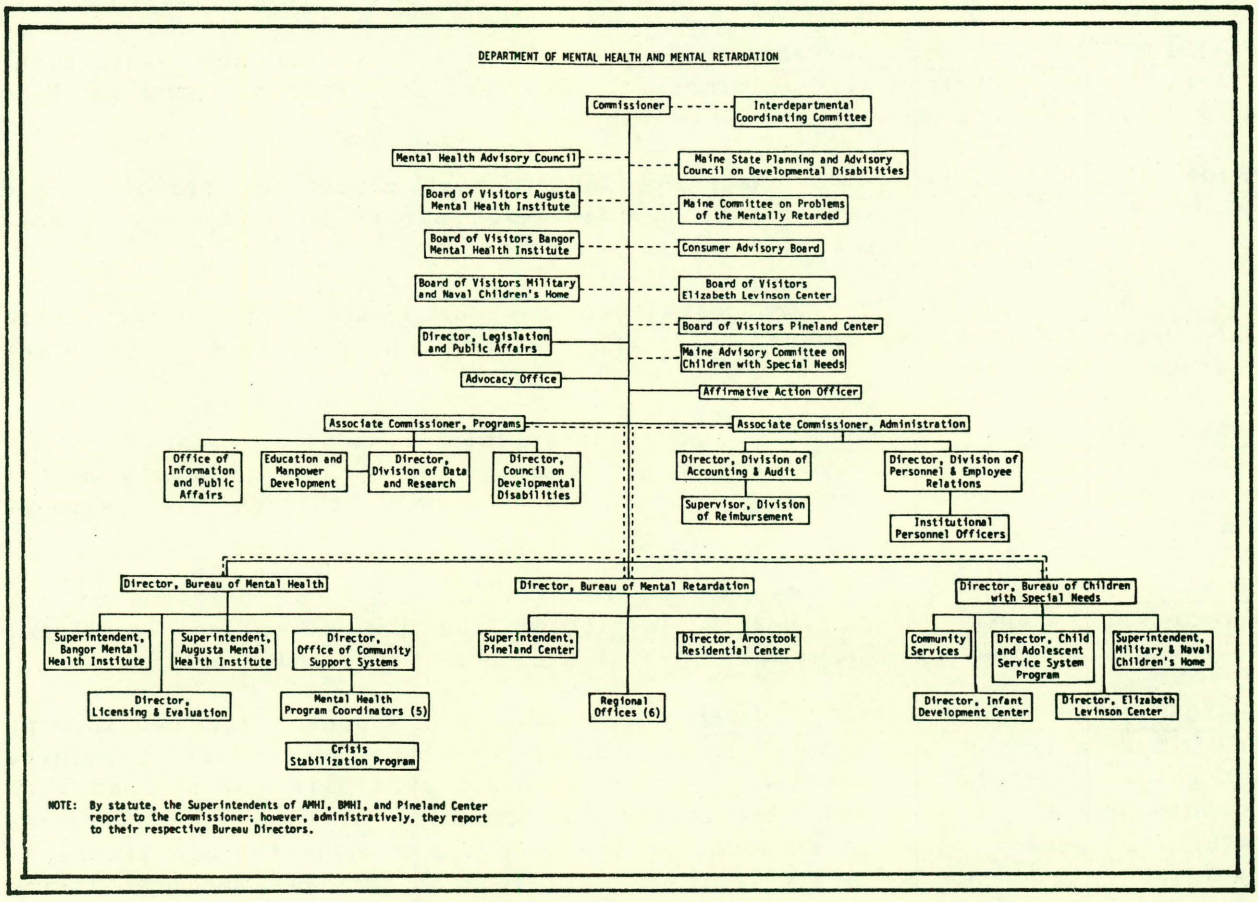
REGION VII

BATH-BRUNSWICK AREA MENTAL HEALTH CENTER	729-4171	
Administration	729-4171	
Emergency Room	729-4171	
Day Hospital	729-1631	
Prevocational Employment Program	729-4171	
Full Circle Program	729-8706	
Merry Meeting Treatment Center	666-5583	
Bath Office	443-3301	
Boothbay Harbor Office	633-5513	
Brunswick Office	729-4171	
Damariscotta Office	563-3902	
REGIONAL MEMORIAL HOSPITAL	729-0181	
Administration	729-0181	Ext. 345
Emergency Room	729-0181	ext. 234
Psychiatric Unit	729-0181	ext. 285
FREEPORT COMMUNITY SERVICES	865-3985	
Information & referral	865-3617	
BATH-BRUNSWICK FAMILY SUPPORT GROUP	443-3576	
DIRIGO RESOURCES	443-1386	

REGION VIII

MID-COAST MENTAL HEALTH SERVICES	594-2544	
Administration	594-2544	
Emergency	594-2541	
Child & Family Center	236-8357	
Camden Office	236-8357	
Belfast Office	338-2295	
Rockland Office	594-2541	
PENOBSCOT BAY MEDICAL CENTER	594-9511	
Administration	594-9511	
Emergency	594-9511	ext. 130 or 140
Psychiatric Unit	594-9511	ext. 246
PROJECTS INC.	596-0047	

APPENDIX 1
DEPARTMENT ADMINISTRATIVE STRUCTURE
TABLE 1



OFFICE OF THE COMMISSIONER: Responsible for the guidance and administration of the Department.

ADVISORY COUNCILS: Statutory bodies established to advise the Department on policy and planning matters: Maine State Planning and Advisory Council on Developmental Disabilities; Governor's Mental Health Advisory Council; the Maine Committee on the Problems of the Retarded; and the Consumer Advisory Board established Wuori et al vs. Concannon et al.; and boards of visitors of State.

DIRECTOR, LEGISLATION & COMMUNITY AFFAIRS: Responsible for coordinating legislation and budget programs. Liaison with hospitals, parents groups, and departmental regional offices.

OFFICE OF ADVOCACY: Responsible for upholding client rights and investigation of client grievances.

ASSOCIATE COMMISSIONER FOR PROGRAMS: Functions as Commissioner in the Commissioner's absence and administers a number of Departmental activities including the Division of Planning and Research, the Office of Public Information, the Bureau of Children with Special Needs, and Human Resource Development.

ASSOCIATE COMMISSIONER FOR ADMINISTRATION: Responsible for budget development and fiscal management; and administers Personnel and Accounting Divisions.

DIVISION OF DATA AND RESEARCH: Responsible for planning and evaluation; research and development; information services and Alcohol premium Fund administration; and Human Resource Development.

HUMAN RESOURCE DEVELOPMENT: Assesses Departmental education, training, and human resources development needs, coordinates programs to meet those needs, and develops planning strategies and policy directions.

PUBLIC INFORMATION OFFICE: Responsible for developing and distributing public information, developing educational experiences and materials, and press liaison.

BUREAU OF MENTAL RETARDATION: Administratively responsible for Pineland Center and Aroostook Residential Center; promotes and guides community mental retardation services which are coordinated statewide through six regional offices.

BUREAU OF MENTAL HEALTH: Responsible for the direction of programs at the Bangor and Augusta Mental Health Institutes and the promotion, guidance, licensing, and funding of community mental health services and programs.

OFFICE OF COMMUNITY SUPPORT SYSTEMS: promotes and supports the development and implementation of comprehensive support systems to ensure community integration and the maintenance of a decent quality of life for persons with chronic mental illness and strengthens the capacity of families and other natural helpers to provide support for mentally ill persons through technical assistance, assessment, monitoring, and evaluaton of services and preparation of reports regarding system needs.

BUREAU OF CHILDREN WITH SPECIAL NEEDS: Assists in the planning, coordination and development of mental health services for children age 0-20 years; works closely with the Bureaus of Mental Health and Mental Retardation to help coordinate services for children who are mentally ill or mentally retarded; contracts for services emphasizing the least restrictive setting appropriate to the child's needs; and is administratively responsible for the Military and Naval Children's Home, the Elizabeth Levinson Center, and the Infant Development Center.

CASSP: The Maine Child and Adolescent Service Systems Project is a federally funded project to assure a comprehensive, coordinated system of services for children and adolescents who have severe emotional or behavioral disabilities and for their families.

INTERDEPARTMENTAL COORDINATING COMMITTEE: Through the Interdepartmental Coordinating Committee the Departments of Mental Health and Mental Retardation, Human Services, Corrections, and Education and Cultural Services coordinate and consolidate management mechanisms in order to assure adequate service delivery.

MENTAL HEALTH ADVISORY COUNCIL

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Report Subcommittee

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