1987

Mental Health in Maine, 1986-1987

Maine Department of Mental Health and Mental Retardation

MENTAL HEALTH IN MAINE

1986-1987

1836 State Capitol Charles Codman

Continuing Maine's tradition of caring for its own

MENTAL HEALTH IN MAINE
1986-1987

State of Maine
Department of Mental Health
and Mental Retardation

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DEPARTMENT OF
MENTAL HEALTH AND MENTAL RETARDATION

Dear Fellow Citizens:

Dramatic changes have been made in the mental health system in Maine in the past seven years. In that short time, Maine has gone from a system primarily composed of the two mental health institutes and the community mental health centers to one with a variety of community-based programs, growing numbers of private practitioners in all the major mental health disciplines, wide and active consumer and family involvement, and greatly improved care and opportunities for psychiatrically disabled people - both in the institutes and the community.

The development of mental health services throughout the state has been extensive:

- Twenty supportive mental health residential programs with two new sites being developed.
- Thirteen vocational programs.
- Six consumer psychosocial centers and several consumer groups.
- Twelve family support groups and the Maine State Alliance for the Mentally Ill.
- Greatly increased educational and training opportunities, including the expansion of the psychosocial rehabilitation model and human resources development activities.
- Increased support and expansion of mental health services to special population groups such as elderly, substance abusing, and deaf individuals with mental health problems.
- Enhanced programming at the mental health institutes for adolescents and families, elderly persons, and for those with substance abuse problems.
- Four crisis intervention programs.
- Establishment of innovative programs in Maine through application for federal funding - human resources development project, case management, mobile mental health assessment teams for elderly persons, community support systems project, mental health elderly services training for nursing/boarding homes, Medicaid waivers for special demonstration psychiatric residential programs, a study of the effect of special rehabilitative programming on the lives of individuals with prolonged mental illness.
- Expansion and increase in Medicaid and third party payment for mental health treatment and programming.

Maine has now established a solid foundation of mental health services - and been commended for it - but is at a pivotal point in the more difficult task of building a cohesive mental health system which is appropriate, responsive, and accessible throughout

the state. Among the work left to be done is the development of a substantially increased number of supportive housing alternatives with a greater variety and a wider dispersal to include the more rural areas, a continued emphasis on specific population groups with special needs such as the expansion of psychogeriatric services, an increased accessibility to mental health services in rural areas, the fuller involvement of the public and private sectors of the community in mental health services, the development of a statewide comprehensive case management system, the expansion of public education and family and provider training on mental health and mental illness, and the development of long-term and home-based services.

The Department is committed to the development of a comprehensive system of treatment, rehabilitation, and support services for psychiatrically disabled adults and their families. It is committed to the planning and coordination of services at the local level with both the public and private sectors, including families and consumers.

Your suggestions and ideas and, above all, your involvement in this effort are important. We hope you will join us in the exciting and difficult work to be done.

Sincerely,

Kevin W. Concannon
Commissioner

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** Cover print courtesy of the Maine State Museum and reproduced from a photograph by Greg Hart.

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INTRODUCTION

The system of mental health services in Maine is complex and encompasses a range of activities meant to meet a variety of needs, such as

- 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, and
- Long-term services when needed.

The mental health system must balance the needs of the many Maine citizens 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 consumers and their families. The Bureau is also responsible for promoting 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 specialized inpatient psychogeriatric services, services to the courts and criminal justice system, treatment and custody in forensic cases, and psychiatric services to the Maine State Prison. The Bureau of Mental Health provides for these services through its two mental health institutes, its Office of Community Support Systems, and its contracts with community mental health centers and many community agencies and organizations.

The mental health needs of Maine citizens cannot be fully met with current resources, and these needs must often compete with other important human and health services for attention. Over the past few years, the Department has placed a strong and continuing emphasis on special populations in need of mental health services, a redefinition of services, an increased attention to financial management, and the increasing involvement of all sectors of the community, both public and private.

PURPOSE OF "MENTAL HEALTH IN MAINE"

Mental Health in Maine 1986-1987 has several purposes:

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

- Serves as a guide to resources, outlining the adult 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, describing basic fiscal, program, and consumer information; and

- Serves as an outline for the Department's goals and objectives, outlining recent activities and current initiatives.

MENTAL HEALTH NEEDS

MENTAL HEALTH NEEDS

Recent studies have found that the overall prevalence of diagnosable mental disorders in the population at large is approximately 18%. In Maine this would mean that 212,000 persons have mental health problems severe enough to need mental health intervention and help. The prevalence of specific disorders are anxiety disorders, 8%; alcohol and drug dependency, 6 to 7%; depression or manic depression, 6%; schizophrenia, 1%; and personality disorders, 1%.

Chronic mental illness, which combines factors related to diagnosis, 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 8,800 and 14,700 persons suffer prolonged severe psychiatric disability.

The annual cost of psychiatric disorders in this country exceeds $40 billion, which in Maine would translate to about $105 million in lost time and productivity and $78 million in treatment costs. In FY'86, 2,117 persons were served in the two mental health institutes and over 27,000 were served in the community through contracts with seven community mental health centers and thirty-seven other community agencies.

MEASURING MENTAL HEALTH NEEDS

A number of methods of measuring mental health needs exist, each method providing a different perspective. Estimates of the overall prevalence of mental health problems within the population are based on the findings of studies of people sampled and surveyed in epidemiological studies. Indirect measures of mental health problems in an 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. Client-based needs assessments look at the needs of individual clients. Citizen participation in open forums and work groups can provide broad input on unmet need and other concerns. Additional needs may be identified and examined through task forces, studies, etc.

Social Indicators

A number of social factors, such as low socio-economic status, unemployment, and lack of social supports, have been found to be correlated to an increased incidence of mental illness. While a specific formula for determining mental health need by examining social indicators has not been developed, some planners employ weighted scoring of social factors to identify service areas where greater need can be anticipated. Examples of such social indicators related to mental health problems are presented in this report by county, although the eight service area boundaries do not all conform exactly to county lines (see service area descriptions).

Certain other indicators, called 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 (the 1985 poverty ceiling for one person is $5,250 and for a family of four is $10,650, due to inflation).

1/ Excludes persons living in group quarters.

TABLE 2

UNEMPLOYMENT*
BY COUNTY 1985

SERVICE AREA		COUNTY	NUMBER UNEMPLOYED**	UNEMPLOYMENT RATE***
I	AROOSTOOK	AROOSTOOK	3,130	8.1
II	EASTERN MAINE	PENOBSCOT	3,610	5.8
		PISCATAQUIS	480	6.3
	HANCOCK	1,230	5.6	
		WASHINGTON	1,120	8.5
		SUBTOTAL	9,570	
III	KENNEBEC VALLEY	KENNEBEC	2,690	5.2
		SOMERSET	1,760	8.0
		SUBTOTAL	4,450	
IV	TRI-COUNTY	ANDROSCOGGIN	3,260	7.0
		FRANKLIN	1,040	8.9
		OXFORD	1,490	6.9
		SUBTOTAL	5,790	
V	CUMBERLAND	CUMBERLAND	3,740	3.2
VI	YORK	YORK	3,090	3.9
VII	BATH/ BRUNSWICK	LINCOLN	640	4.2
		SAGADAHOC	680	5.1
		SUBTOTAL	1,320	
VIII	MID-COAST	WALDO	1,210	9.8
		KNOX	840	5.4
		SUBTOTAL	2,050	
			======	====
STATEWIDE		TOTAL	30,010	5.4

* From "Civilian Labor Force Estimates By Month and Annual Average 1985", Maine Department of Labor, Bureau of Employment Security, Division of Economic Analysis and Research, April, 1986.

** Annual average.

*** Percent of Civilian Labor Force. (Revised)

Birth Factors

Approximately seventeen percent (17.8%), or 3,006, of all births to mothers who were Maine residents were out-of-wedlock in 1985. 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 10.0% to 27.9% of births in Maine Counties.

TABLE 3

OUT-OF-WEDLOCK BIRTHS - BY COUNTY*
CALENDAR YEAR 1985

		ILLEGITIMATE BIRTHS	
SERVICE AREA	COUNTY	NUMBER	PERCENT
I.	AROOSTOOK	185	14.8
II.	PENOBSCOT	360	19.0
	PISCATAQUIS	57	21.7
	HANCOCK	97	15.3
	WASHINGTON	126	27.9
	SUBTOTAL	640	19.8
III.	KENNEBEC	314	19.7
	SOMERSET	155	23.1
	SUBTOTAL	469	20.7
IV.	ANDROSCOGGIN	336	22.7
	FRANKLIN	57	16.0
	OXFORD	138	20.4
	SUBTOTAL	531	21.1
V.	CUMBERLAND	564	16.2
VI	YORK	328	14.5
VII	LINCOLN	59	15.2
	SAGADAHOC	59	10.0
	SUBTOTAL	118	12.0
VII	WALDO	79	17.8
	KNOX	92	19.0
	SUBTOTAL	171	18.4
		=====	=======
STATEWIDE	TOTAL	3,006	17.8

*Maine Vital Statistics 1985. Division of Data & Research, DHS

INFANT MORTALITY

The infant mortality rate in Maine in 1985 increased to 8.9 per 1,000 live births, with 150 infant deaths statewide. Of the 150 deaths, 106 were neonatal deaths (within the first four weeks of life), with a neonatal death rate per 1,000 live births of 6.3. Infant mortality rates range from 0.0 in Lincoln County to 14.0 in Franklin County.

TABLE 4

INFANT DEATHS - BY COUNTY+
CALENDAR YEAR 1985

SERVICE AREA	COUNTY	INFANT NUMBER	DEATH RATE*	NEONATAL NUMBER	DEATH RATE*
I.	AROOSTOOK	7	5.6	3	2.4
II.	PENOBSCOT	24	12.7	16	8.5
	PISCATAQUIS	1	3.8	0	0.0
	HANCOCK	4	8.4	2	3.2
	WASHINGTON	4	8.8	4	8.8
	SUBTOTAL	33	10.2	22	6.8
III.	KENNEBEC	11	6.9	8	5.0
	SOMERSET	5	7.4	4	6.0
	SUBTOTAL	16	7.1	12	5.3
IV.	ANDROSCOGGIN	19	12.8	15	10.1
	FRANKLIN	5	14.0	4	11.2
	OXFORD	8	11.9	6	8.9
	SUBTOTAL	32	12.7	25	9.9
V.	CUMBERLAND	34	9.8	24	6.9
VI.	YORK	18	8.0	12	5.3
VII.	LINCOLN	0	0.0	0	0.0
	SAGADAHOC	5	8.4	5	8.4
	SUBTOTAL	5	5.1	5	5.1
VIII.	WALDO	2	4.5	2	4.5
	KNOX	3	6.2	1	2.1
	SUBTOTAL	5	5.4	3	3.2
STATEWIDE	TOTAL	150	8.9	106	6.3

+ Maine Vital Statistics 1985. 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
II EASTERN MAINE	PENOBSCOT	X	X	X	
	PISCATAQUIS	X	X		
	HANCOCK	X			
	WASHINGTON	X	X		X
III KENNEBEC VALLEY	KENNEBEC		X		
	SOMERSET	X	X		X
IV TRI-COUNTY	ANDROSCOGGIN	X	X	X	
	FRANKLIN	X		X	
	OXFORD	X	X	X	
V CUMBERLAND	CUMBERLAND				X
VI YORK	YORK				
VII BATH-BRUNSWICK	LINCOLN				X
	SAGADAHOC				
VIII MID-COAST	WALDO	X	X		X
	KNOX	X	X		

(See map on opposite page for visual representation)

1 Unemployment equal to or greater than the statewide rate of 5.4.

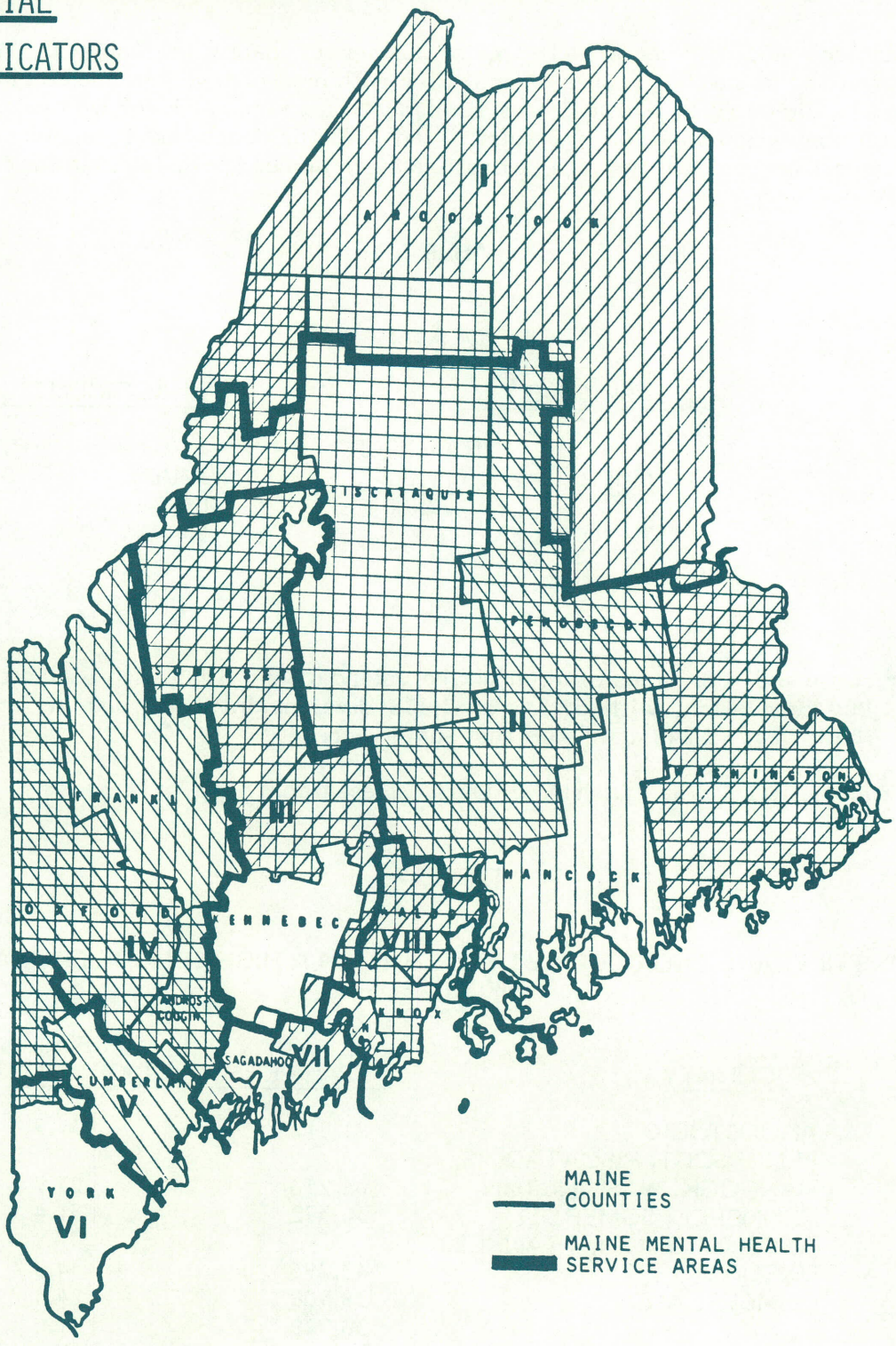
2 Illegitimate births equal to or greater than the statewide percent of out of wedlock births to live births of 17.8%.

3 Higher than infant death rate of 8.9 per 1,000 live births.

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

*Maine Vital Statistics 1985. Division of Data and Research, DHS

SOCIAL INDICATORS



Mortality Factors

Suicides and accidents were major causes of death in Maine in 1985, with accidents ranking as the fifth cause of death for both men and women and suicide ranking ninth overall (suicide ranks as the 7th cause of death for men, 11th for women). The rate per 100,000 population was 14.3 for suicide and 37.0 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 - 1985*

	SUICIDE		ACCIDENT	
	NUMBER	RATE PER 100,000	NUMBER	RATE PER 100,000
MALE	129	22.8	306	54.1
FEMALE	37	6.2	125	20.9

Divorce*

There were 6,070 divorces granted during calendar year 1985 with a divorce rate of 5.0 per 1,000 population, with 57.5% or 3,488 divorces involving one or more minor children. There were 12,248 marriages that same year.

*Maine Vital Statistics 1985. 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 1985 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
DAYS PER 10,000 POPULATION - FY86

SERVICE AREA	HOSPITAL	PATIENT DAYS+		INPATIENT DAYS PER 10,000 POP.
I.	THE AROOSTOOK MEDICAL CENTER	2,968		325.83
II.	EASTERN MAINE MEDICAL CENTER	4,973		210.25
III.	KENNEBEC VALLEY MEDICAL CENTER MID-MAINE MEDICAL CENTER	2,967 6,924	9,891	585.65
IV.	SAINT MARY'S HOSPITAL	5,231		299.07
V.	MAINE MEDICAL CENTER	8,807		445.05
VI.	SOUTHERN MAINE MEDICAL CENTER	2,542		161.19
VII.	REGIONAL MEMORIAL HOSPITAL	2,567		338.79
VIII.	PENOBSCOT BAY MEDICAL CENTER	1,522		243.25

+ Source: Health Care Finance Commission.

TABLE 9

RATE OF ADMISSIONS TO STATE MENTAL HEALTH INSTITUTES OF RESIDENTS OF SERVICE AREAS*
FISCAL YEAR 1986

SERVICE AREA		NUMBER ADMITTED	RATE OF ADMISSION PER 10,000 POPULATION
I.	AROOSTOOK	72	7.90
II.	EASTERN MAINE	228	9.67
III.	KENNEBEC VALLEY	298	17.65
IV.	TRI-COUNTY	188	10.26
V.	CUMBERLAND	321	16.30
VI.	YORK	115	7.29
VII.	BATH-BRUNSWICK	65	8.58
VIII.	MID-COAST	61	9.75

* 82 persons were admitted to these State facilities from a combination of out-of-state, out-of-country, no residence, and other. Nearly 53% of the admissions at AMHI had been admitted there before as had 43% of BMHI admissions at that Institute. Approximately 75% of all admissions have been admitted to a psychiatric facility somewhere before.

TABLE 10

RATE UNDER TREATMENT (PER 10,000 POPULATION)
BMH FUNDED SERVICES* - FY86

SERVICE AREA SUPPORT		OUTPATIENT	COMMUNITY
I.	AROOSTOOK	178.72	105.17
II.	EASTERN MAINE	100.88	25.4
III.	KENNEBEC VALLEY	140.21	82.83
IV.	TRI-COUNTY	108.54	33.63
V.	CUMBERLAND	97.1	42.71
VI.	YORK	93.91	39.51
VII.	BATH-BRUNSWICK	207.07	13.2
VIII.	MID-COAST	233.18	73.84
TOTAL, REGION I & II		122.57	47.63
TOTAL, REGIONS III - VIII		127.54	47.82
TOTAL, STATE		126.15	47.77

* 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 November in eight locations throughout the state: Presque Isle, Bangor, Ellsworth, Rockland, Augusta, Lewiston/Auburn, Portland, and Kennebunk. The forums were held by both the Bureau of Mental Health and the Bureau of Children with Special Needs along with both their advisory groups - the Governor's Mental Health Advisory Council and the Maine Advisory Committee on Children with Special Needs. The forums provided an added and broader opportunity for community discussion of mental health needs, directions, and initiatives. Status papers, describing Departmental special program and population activities and initiatives, were also made available.

Strong statewide themes emerged in the needs identified by community members attending these public meetings:

- **A substantially increased range of long-term, low-cost supportive housing alternatives for persons with mental illness.** Not only a greater number is needed but also a greater variety and wider dispersal to more rural areas. Should include subsidized independent living units, therapeutic psychiatric boarding homes, supportive/structured settings, and crisis and transitional residences. It was stressed by those attending that appropriate housing is critical to the functioning of psychiatrically disabled persons in the community and that needed resources, such as staff time, are being expended in coping with the ramifications of an inadequate residential system.

- **Expanded psychogeriatric services.** Especially home-based services wherever elderly persons might live, as well as increased supportive residential programs and more support for families caring for elderly persons. Establishment of good linkages and closer coordination of efforts between mental health agencies and area agencies on aging.

  Continued emphasis on other special population groups as well, such as individuals with both substance abuse and mental health problems, persons involved with the criminal justice system (including sexual offenders) and deaf individuals with mental health problems (with continued involvement of the deaf community in planning, increased attention to the development of a community center, and on-going coordination with the adult education system).

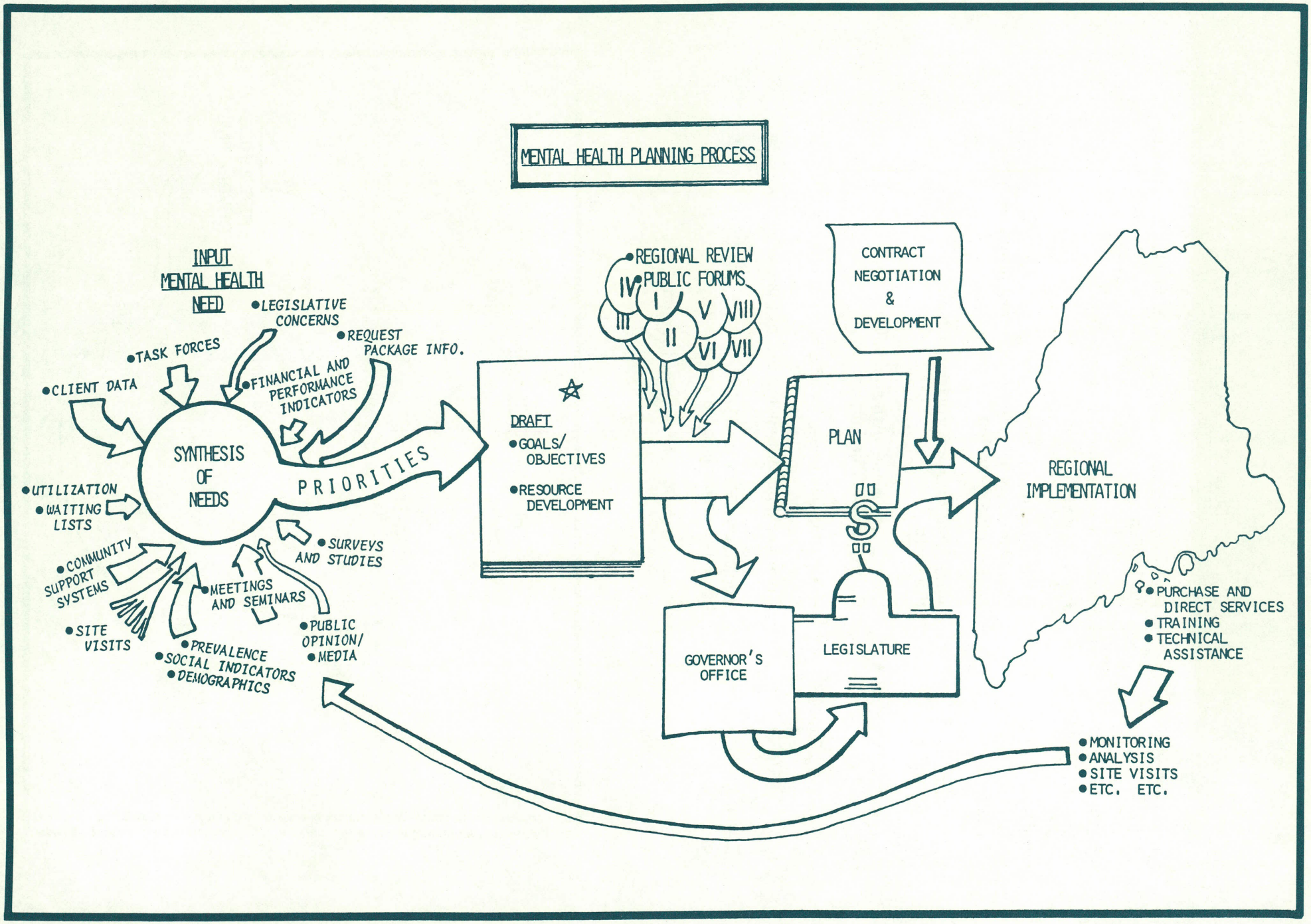
- Development of a statewide comprehensive case management system and expanded coordination of services among agencies and organizations to prevent individuals falling through the cracks and a lack of continuity.

- Increased accessibility to mental health services in rural areas. Distances and sparsity of residents present serious difficulties re: transportation, travel time, availability of mental health professionals, administrative costs, and salary levels. Partial solutions might include use of existing facilities such as schools and health clinics, greater mental health education of the general public and allied service providers, and creation of incentives to mental health professionals to locate in more rural areas.

- Expansion of public education and family and provider training on mental health and mental illness. On-going educational opportunities available throughout the state should be a concerted and focused Bureau of Mental Health effort. The needed expansion of mental health (and allied fields) educational opportunities in Maine's university and college systems was also noted.

Other needs were also identified at the forums:

- Increased use and involvement of private practioners in the mental health system of services.
- Much greater emphasis on in-home services.
- Development and expansion of long-term interventions and programming.
- Expansion of vocational programming, especially integrated work sites and supportive employment.
- Continued efforts to improve public transportation throughout Maine.
- Examination of the increasing difficulties for providers in obtaining liability insurance, as well as low salaries and reimbursement rates in the mental health field.
- Expanded provision of supportive services to families and increased respite care opportunities.
- A number of other clear concerns and plaudits were also made about the mental health and allied systems and programs.


MENTAL HEALTH PLANNING PROCESS
INPUT
MENTAL HEALTH
NEED
•LEGISLATIVE CONCERNS
•REQUEST PACKAGE INFO.
•TASK FORCES
•CLIENT DATA
•FINANCIAL AND PERFORMANCE INDICATORS
SYNTHESIS OF NEEDS
PRIORITIES
•UTILIZATION
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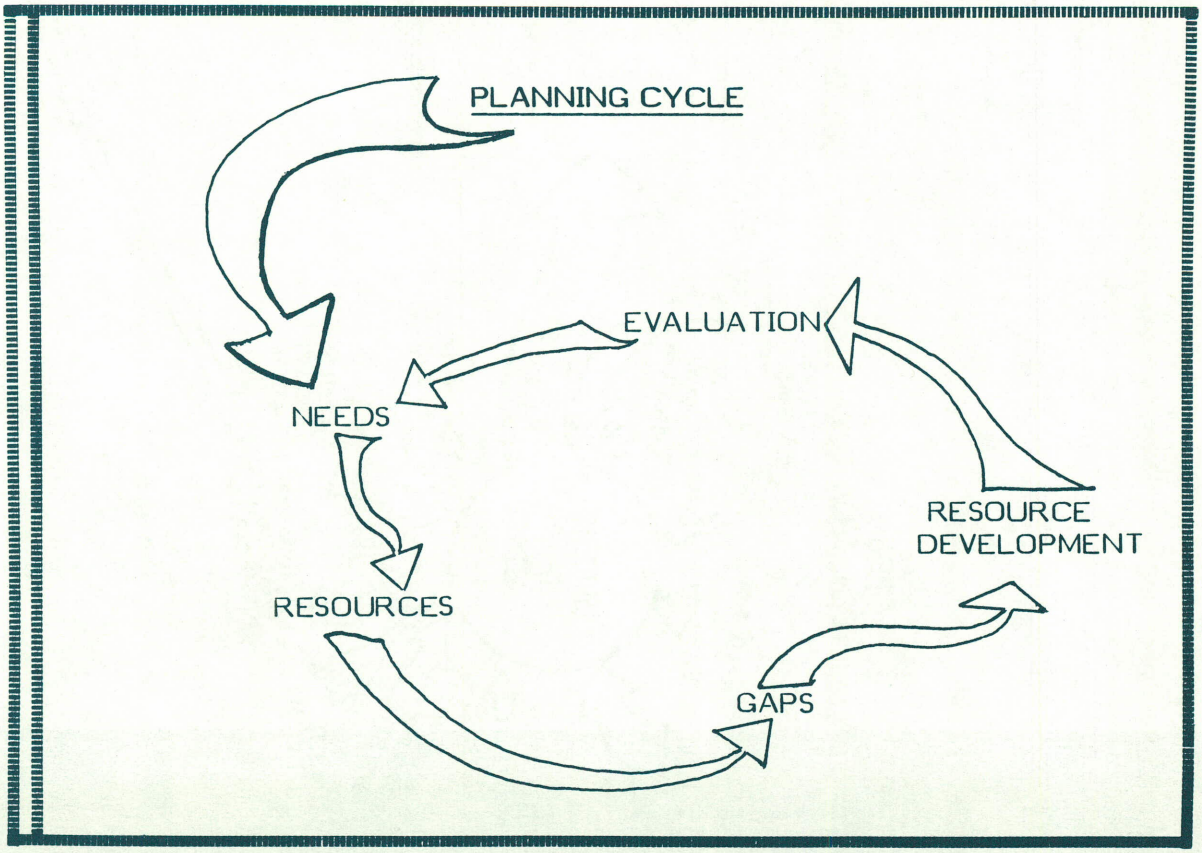
•PURCHASE AND DIRECT SERVICES
•TRAINING
•TECHNICAL ASSISTANCE
•MONITORING
•ANALYSIS
•SITE VISITS
•ETC. ETC.

BUDGET CYCLE

MID-JULY - MID-AUGUST	Preliminary requests/ Initial Bureau budget	Within Targeted Figure
AUGUST - MID-SEPTEMBER	Initial Departmental budget with back-up justification	
MID-SEPTEMBER	Budget to the Governor and Department of Finance & Administration with back-up justification	
OCTOBER - NOVEMBER	Additional back-up justification and discussion	
EARLY DECEMBER	Direct discussion with the Governor and the Bureau of the Budget	
LATE DECEMBER	Preliminary indications of Governor's budget	
JANUARY	Governor's budget submitted to the Legislature	
SPRING	Legislative Hearings with back-up justification and review	
LATE SPRING - EARLY SUMMER	Budget passed for the next Biennium	



SPECIAL INITIATIVES

MENTAL HEALTH NEEDS OF PEOPLE WITH SEVERE DISABLING MENTAL ILLNESS

Over 8,000 men and women in Maine experience 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 - 150 in specialized community residential programs; 1,200 or so in boarding or nursing homes; many with family or friends and many 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.

This is especially true for the growing population of young adults who have become mentally ill. Without long-term hospitalization and 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 further 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 whenever needed. Additionally, since the service system is so diverse and complex, they need someone to actively and individually assist them in getting the mental health and supportive services they need, including housing and an adequate income.

The Bureau of Mental Health is committed to the development of a comprehensive system of treatment, rehabilitation, and support services for psychiatrically disabled adults and their families with an emphasis on local level planning and coordination of services involving both the public and private sectors, including families, consumers, and board members. 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.

Activities and Initiatives

- A variety of housing options with twenty residential programs ranging from subsidized independent living to highly structured rehabilitative community residences, with two new residences being developed.

- An innovative case management demonstration project recently funded and awarded to the Department by the National Institute of Mental Health. The project emphasizes services to persons who are homeless and mentally ill by providing a clinical manager for the planned comprehensive case management services in the Portland area.

- Ongoing efforts to define community support systems such as the development of the Community Support Systems Handbook and the development of service definitions and standards beginning with case management.

- The development of vocational training and employment programs with an emphasis on integrated work sites, ongoing involvement in local planning groups, and coordination of training for staff of the public and private sectors.

- The development of Maine's fourth outreach round-the-clock crisis intervention program with integrated respite and transitional housing. This fourth program will be run by Tri-County Mental Health Services in Lewiston/Auburn with the three other crisis programs, administered by the Office of Community Support Systems, BMH, located in the Portland, Saco/Biddeford, and Augusta/Waterville areas.

- The promotion of psychosocial rehabilitation through training of staff in both community and institutional settings.

- Continuing support of the mutual aid, self-help, and advocacy activities of families and consumers including ongoing technical and financial assistance to the support groups and organizations, increased participation in local and national conferences and other educational opportunities, and the joint funding of a statewide systems advocacy project developed by the Maine State Alliance for the Mentally Ill.

- Recognition of the importance of educational and public awareness activities reflected in such efforts as the social security, case management, and housing workshops, the psychiatric rehabilitation training, the Torrey presentation, psychogeriatric and deafness training, and the increased development of publications and media events.

MENTAL HEALTH NEEDS OF ELDERLY PERSONS

In Maine, the elderly census has tripled since 1900 and is expected to increase 20% by the end of the century. The elderly population is the fastest growing segment of our society with approximately 152,000 people currently in Maine aged 65 and older. While an estimated 18% of the general population suffers from some type of mental health problems, an even greater proportion of the population aged 65 and older, 20-25%, is at risk for mental illness and in need of intervention.

Despite the high prevalence of mental health problems, the elderly receive less publicly supported mental health care than any other age group. For a number of reasons, such as the inability or unwillingness of many older people to seek clinical services, the lack of interest or expertise of many clinicians to treat older people, and the lack of financial resources, the elderly account for less than 7% of all services provided in community mental health agencies, and receive less than 2% of all mental health care delivered by other community-based providers.

Over the past two years, the Department of Mental Health and Mental Retardation has substantially strengthened its commitment to serving Maine's elderly. Representative of that commitment is the establishment of the Elderly Services Coordination Project at the Bureau of Mental Health to assist with the development of programs and policies designed to improve care to Maine's mentally ill elderly and to facilitate the promotion of mental health and well-being among all older people.

Recent Activities

- In 1984, the Bureau of Mental Health jointly established, with the Bureau of Maine's Elderly, a 25-member task force on mental health services to elderly persons for the purposes of exploring the mental health needs of older people and assessing the responsiveness of Maine's human services networks to those needs. The task force's final report and recommendations currently serve as the basis for aging program and policy development at the Bureau of Mental Health.

- In 1985, in response to the work of the task force, a 17-member advisory committee on mental health services to elderly persons was jointly convened by the Bureau of Mental Health and the Bureau of Maine's Elderly to oversee the implementation of the task force's recommendations, and to serve in an information gathering and advocacy capacity in the development of services for mentally ill elderly persons.

- Also in 1985, the Bureau of Mental Health assisted the Bureau of Maine's Elderly in its application to the U.S. Administration on Aging for funding of a major initiative to support caregivers of victims of Alzheimer's Disease. Funds provided by the AOA are currently being used to assist with the development of Alzheimer's Project of Kennebec Valley, a comprehensive residential resource center including a 25-bed boarding and respite care facility, geriatric evaluation unit, and multi-purpose training center.

- Over the past two years, the Bureau of Mental Health has facilitated the development of several regionally-based aging and mental health coordinating committees, comprised of community mental health agencies, area agencies on aging, consumers and advocates, to address the mental health needs of older people using existing local resources and to advise the Bureau of Mental Health as to development of community-based programs and services for elderly persons who are at risk of mental illness.

Current Activities

- In 1986, the Bureau of Mental Health received grant funds from the U.S. Administration on Aging for the development of a Comprehensive psychogeriatric training program for boarding and nursing home personnel. Employing specialized teams of nurses and social workers, training will be delovered on-site in facilities throughout Maine for a period of 17 months.

- The Bureau of Mental Health continues to work with the Citizen's Interest Group of Bangor in the development of its 8-bed mental residential care facility for deinstitutionalized elderly patients.

- In 1986, the State Legislature authorized the allocation funds to the Bureau of Mental Health for the development of the state's first mobile mental health assessment and consultation program serving nursing homes in eastern Maine. Staffed with a psychiatric social worker, geriatric nurse practitioner, and psychologist, the team will conduct client assessments, case consultations, and assist with the development of treatment/care plans and appropriate interventions.

- The Bureau of Mental Health continues to develop a number of training programs designed to increase the knowledge and skills of professional and non-professional caregivers of elderly persons with mental illness, and public education material designed to provide information on mental health and aging and resources for elderly persons, their families and the public.

MENTAL HEALTH NEEDS OF DEAF PERSONS

The Need

In recent years, Maine has become one of a handful of states to undertake a centralized approach towards the development of appropriate services for this special population. The Maine approach has involved the accommodation of existing services and the development of new services specific to the needs of deaf consumers.

Census data in Maine has identified 1 resident in every 350 who is deaf, and national data suggests that this number is twice as great with as many as 20% experiencing a serious mental health problem.

These figures do not take into account parents and siblings of deaf persons who can experience problems related to adjustment of the family to the special needs of deaf members. In addition, the vast majority of deaf parents have children who have normal hearing, a significant number experiencing emotional/behavioral problems and/or involvement with protective services and the correctional system. It has been estimated that deafness related problems account for approximately one third of total mental health needs of deaf persons and their families. This can account for a potential increase of 50% in mental health needs over the general population.

This condition, in light of the communication and cultural barriers that often exist between deaf mental health recipients and hearing providers points to the need for extensive accommodations in mental health services that take into consideration developmental issues related to hearing loss.

Recent Activities

The past year has shown a number of developments in services to deaf persons in addition to the continued activities initiated in previous years. The Advisory Committee on Mental Health Services to Deaf Persons continues to meet on a regular basis providing vital information and suggestions towards creating new service opportunities for deaf consumers. Other ongoing functions include consumer involvement, case consultation, outreach, and inpatient and community services. One indication of the utilization of services is the level of interpreter services provided in community and inpatient settings. Aside from new specialized services, these have increased over those utilized last year with over 1300 hours of interpreter time purchased by the Department for direct services. As outreach activities continue and new service areas become accessible to the deaf population, this growth will continue.

The significant support of the Governor and the Legislature of Maine has resulted in appropriations for the establishment of the statewide deaf services coordinator, and a position was established at the Augusta Mental Health Institute which will work specifically with deaf patients and other staff who work with these patients. The latter position has been staffed and is also responsible for coordinating services with community resources to enhance treatment of deaf patients at AMHI. These initiatives supplement

the eight-bed transitional program that was established in the previous year to serve deaf adults with mental health problems. Other mental health services are purchased by the Department when necessary through contracts with specialists in the field of deafness.

Additional activities involved the initiation of hearing screenings by trained nursing staff for admissions at the Bangor Mental Health Institute and the beginning of implementation of a 504 accessibility plan in the comprehensive community mental health centers that will maximize their potential to appropriately serve deaf persons. All of the activities are described in greater detail in the year-end report, Mental Health Services to Deaf Persons in Maine: 1985-1986.

Current Initiatives

The Coordinator, under the direction of the Bureau Director and with the assistance of the Advisory Committee on Mental Health Services to Deaf Persons, is responsible for the central development of services for deaf persons in Maine. Planning is done in conjunction with a number of state agencies and private providers that focus on treatment in hospitals and at the community level. Ongoing functions of the coordinator include contract managment for the deaf services budget, consultation and advocacy for individual and program needs, outreach to the deaf community to insure consumer participation, and education & training for mental health providers and interpreters.

The following projects for 1986 will address change in state hospitals and in community services:

- establishment of a community support position to work with deaf persons who need a variety of services in order to function independently in the community,

- implementation of a 504 accessibility plan for deaf services in each regional community mental health center involving installation of telecommunications equipment and training for designated providers,

- provision of hearing assessments and assistive devices to deaf patients in state psychiatric hospitals,

- increased family support activities for families with deaf members experiencing mental health problems,

- development of a supervised apartment unit for deaf persons transitioning into community living from residential programs,

- sign language assessment of mental health staff providing direct services to deaf consumers, and

- contracted services for psychological assessments and other special services.

These projects are designed to serve Maine deaf citizens in greatest need and function as a base for future service developments. Copies of the year-end report, Mental Health Services to Deaf Persons in Maine, are available on a limited basis by writing: David Lawlor, Bureau of Mental Health, Station #40, Augusta, Maine 04333.

MENTAL ILLNESS AND HOMELESSNESS

Mental illness, a severe disabling mental disorder, is a major factor in up to one-third of persons who are homeless and often a secondary characteristic among others who are homeless. It has been estimated by the Task Force on Homelessness in Maine that 250-350 people in Maine are homeless on any given day.

As is true for all homeless people, a number of factors influence whether or not a mentally ill person is homeless: poverty; scarcity of affordable housing; unemployment; deinstitutionalization and the lack of community-based resources; personal and family crises; decreased public assistance; and alcohol and drug abuse problems.

The increase in the number of homeless persons in Maine with mental illness has been significantly influenced by two major factors:

- The failure to develop adequate community services while decreasing and limiting the number of patients in the state mental health institutes, and

- The increase in the absolute number of young adults at risk of severe mental illness.

The impetus for the 25 year old national and state policy of deinstitutionalization arose in part from the theory that thousands of mentally ill people in mental hospitals throughout the nation could, with the help of the new medications, live independently in the community. However, this movement was flawed by the failure to plan adequately for the community-based services needed to support mentally disabled persons in the community. In addition to psychiatric treatment and basic needs such as food, housing, and clothing, many mentally disabled persons living in the community also required most of the medical, rehabilitative, vocational, and housing services provided in the psychiatric hospital. The result has been mixed. On the positive side, a large number of individuals are living successfully in the community and a substantial number of excellent programs have been developed. However, many mentally ill persons still do not have adequate housing and other critical support services.

There has also been a change in demography resulting in an increase in the number of young adults in our society, now one-third of this country's population. The result is that the number of young persons at risk of developing schizophrenia and other major mental illnesses has increased dramatically. These young adults, who are also more likely to have related substance abuse problems, make up over fifty per cent of the admissions to the state psychiatric hospitals.

Community mental health services need to be further developed to respond to the cyclical nature of mental illness and to make real the independence and humanity that was intended in the move to community-based care. These programs should include the psychiatric, medical, rehabilitative, vocational, and housing services needed to support mentally disabled individuals in the community. However, the urgent need related to homelessness is the continued development of a range of supervised housing programs in the community. A stable and adequate living environment is the essential foundation upon which other support programs must be established. The lack of low-cost decent housing is a pervasive cause of homelessness among mentally ill persons.

Departmental Activities and Initiatives

The Department of Mental Health and Mental Retardation has continued to support the development of adequate supportive housing and other supportive services for Maine citizens who have mental illness.

- Key Bureau staff served on the Executive Task Force on Homelessness in Maine which issued its report in February 1986 and also worked actively on the ensuing Governor's Interdepartmental Cabinet Committee on Homelessness. Included in the mental health recommendations for increased supervised housing, psychiatric, social, and rehabilitative services, and outreach and crisis services were additional short-term and transitional crisis beds, specialized boarding homes, and supported long-term housing; increased vocational programs; six additional consumer psychosocial centers; expanded crisis intervention programs; and enhanced family support services. The Department budget requests for the next biennium reflect this critical need for stable supportive housing.

- The Department's innovative case management demonstration project, recently awarded and funded by the National Institute of Mental Health, will be conducted by a community agency in the Portland area. The project will emphasize services to homeless mentally ill persons.

- In addition, the Department is assisting with new supportive residential programs for mentally ill elderly persons, other adults with mental illness, and persons who are both deaf and mentally ill.

- Housing and Urban Development/Medicaid Section 1115 Waiver participation will end for the remaining two Maine Waiver residential programs in April and May 1987. The first two Waiver residences, whose federal funding ended in November 1985, were continued by the state. The Waiver residences, long-term transitional programs, have provided a range of specialized supportive services and housing to persons with severe and prolonged mental illness in order to prevent their unnecessary hospitalization or assist in their return to the community.

MENTAL HEALTH NEEDS OF PERSONS WITH SUBSTANCE ABUSE PROBLEMS

National data indicates that 5% of the overall population are alcoholics and another 10% to 15% have significant alcohol abuse problems. This translates into approximately 200,000 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 indicate 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 $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 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 was conducted 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, two additional teams were added for FY87.

-- 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 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 continue this training effort to agencies serving adolescents for FY87.

-- 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 in 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 replication 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 and the courts. 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 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 pursuing avenues to include dual-diagnosis treatment among the services they offer. 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 such as the one for elderly persons with poly-chemical addiction, and to increase home and community based 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 and local services and programs.

FAMILY SUPPORT

All families need extra supports in times of stress, and families with psychiatrically disabled members, whether children or adults, experience more stress and require more support. The demands placed on these families by the disabled member often outstrip the families' emotional and financial resources. The ideal family support service system recognizes the role of the family as a social service unit and the family with a disabled member as an extraordinary social service unit because of the unique and increased demands placed on it. Such support systems include several basic supports for families caring for or involved with disabled members both in and out of the home:

- Parent/sibling/extended family support groups - including groups which strive to relieve family isolation and mainstream special families;
- Information/education/training/advocacy - including case management training, behavior, nutrition, parenting, future planning, genetic and family counselling;
- Protection and advocacy - including trusted spokespersons for families who are unable or inexperienced at various forms of advocacy;
- Public awareness services - including support for change in public attitudes and public policy, and specialized media services;
- Planning services - including guardianship, financial planning, medical payment, transitional planning, home remodeling, adaptive equipment;
- Respite care - including home and center-based respite;
- Transportation services - including public transportation, specialized transportation services, and adaptation of family/personal vehicles;
- Homemaker services - including assistance in nutritional requirements, extraordinary cleaning chores, positioning, and medical care.

According to a recent report of the Human Services Research Institute, approximately half of the states in the country have some type of family support system. All families caring for a handicapped member may not require all of these services and needs may change as the family and its situation change. Needs may also cluster at times of crisis or transition. However, if support services are available from the time the disability is first identified, most families should need only incremental support services.

One of the most significant recent movements in the mental health (and other disability) areas in Maine and the rest of the country has been the growing development of family support groups. In addition to helping each other with emotional support and

information, they've become major advocates for their disabled family members, the families themselves, and their special needs. The support groups have had a momentous impact: They've helped shape service systems and their priorities and philosophies. In some cases, they've become service providers. They've talked to clubs, to schools, on television, in newspapers educating the public and working to reduce the stigma of the illness. They have appeared before legislative committees and helped shape laws and funding. Their influence in Maine has been considerable and their spirit and impact continues to grow. Without their hard work and dedication, mental health services in Maine could not have come so far.

Departmental Activities and Initiatives

- The Maine State Alliance for the Mentally Ill has been awarded federal Protection and Advocacy funds through the Advocates for the Developmentally Disabled and additional Departmental funds to develop a significant statewide systems advocacy program. Project goals will include the development of additional family support groups, increased involvement in the mental health planning processing, enhanced informational and educational material, and the identification of community mental health needs and priorities.

- Substance Abuse Services within the Department has been able to offer modest stipends to assist the efforts of family support networking concerned with alcohol and drug abuse problems.

- The Bureau of Mental Health is continuing to assist the twelve mental health family support groups throughout the state and the Maine State Alliance for the Mentally Ill (MSAMI) with annual funding and technical assistance in their mutual aid, self-help efforts. This has also included both financial and technical assistance in the development of public awareness information, advocacy efforts, and mental health service programs such as psychosocial centers, various residential programs, and vocational services.

- A statewide family support services conference in March, 1987 was sponsored by the Bureau of Children with Special Needs, the Maine Respite Project, the Special-needs Parent Information Network, and the Maine Developmental Disabilities Council. The conference brought together national experts on family support systems and Maine programs which demonstrate aspects of such systems.

- Technical Assistance from the Developmental Disabilities Council continues to be provided to the Special-needs Parent Information Network (SPIN) which is a statewide parent training and information resource, established by the Maine Parent Federation with a grant from the Department of Education, Washington, D.C. Now in its third year SPIN provides training for parent and professional groups and responds to information requests through its toll free statewide number.

- The Bureau of Children with Special Needs dispersed funds authorized by the Nelson Act through the preschool coordination program network. The sixteen sites funded provide services which range from a drop-in family center, which welcomes families whose children are not identified as handicapped as well as families with identified special needs, to a training program for parents of children with speech impairments to become therapy facilitators in a geographic area where professional therapists are often unavailable.

- The Respite Care Project, a three-year program funded through the federal Administration on Development Disabilities in late 1985, will establish a state-wide respite care referral system, train new providers, and link families who need respite with care providers. Emphasis is placed on respite care provided in the home and local community. The Project will serve families of children up to twenty years old who experience disabilities.

- Continuing information and education opportunities have continued to be emphasized by the Bureau of Mental Health with workshops, conferences, and skills training frequently offered, such as the well-received presentation on schizophrenia by Dr. E. Fuller Torrey to families from all over the state. The Quarterly Forums jointly sponsored by the Maine State Alliance for the Mentally Ill and the Augusta Mental Health Institute draw families, consumers, and service providers to Saturday morning discussions on mental illness and mental health services. Assistance is also offered to families by the Bureau whenever possible to help offset any costs related to educational/training opportunities.

AVAILABILITY OF QUALITY PROFESSIONAL OUTPATIENT SERVICES

In addition to supporting necessary treatment, rehabilitative, and support services for special service populations, the Department recognizes the need to assure the availability of quality professional outpatient services throughout the State.

Most recent studies suggest that about 18% of the population requires mental health service (Bittker, 1986). While severe and chronic mental illness, which combines factors of diagnosis, duration, and disability, has a prevalence of about 1% in the population at large, such problems as depression, alcohol and drug dependence, and disabling anxieties as well represent treatable disorders in up to 15% of our citizens. The availability of licensed or certified mental health professionals is vital to properly respond to these conditions. It has been well established that prompt quality outpatient care reduces emotional stress, improves job performance, keeps families together, and provides many other personal and social benefits.

The Department has traditionally provided financial support for professional mental health services at community mental health centers and outpatient clinics. This support assures availability and accessibility of these services to persons who are unable to pay the full cost of care, who have no or inadequate insurance, or who are not eligible for Medicaid or other government programs for the very poor. The Department's subsidy for outpatient services makes possible sliding fee scales, fee waivers, and other methods of making services available to low and middle income persons and families.

It has been increasingly recognized that licensed and certified mental health clinicians in private practice provide an important and growing resource to Maine citizens in need of mental health services. At present there are 378 licensed psychologists and psychological examiners in Maine, an increase of from 277 (36.5% increase) five years ago. There are now 957 social workers listed by the Maine Board of Registration of Social Workers compared to 750 five years ago, an increase of 27.6%. A proper needs assessment of the various areas of the State, as well as a proper concern for quality services and for the most efficient use of resources, must take into account these clinicians in private practice.

Recent Activities and Future Directions

The Department has continued its substantial financial support of professional outpatient mental health services at community mental health centers and outpatient clinics. In the current fiscal year, the Bureau of Mental Health provides $1,630,410 for the purchase of outpatient services, and the Bureau of Children With Special Needs provides $948,303. These contract funds will combine with other reimbursements to generate over $6,000,000 in services representing over 100,000 hours of service to Maine citizens.

Beyond the continued provision of funding through contracts, the Department successfully designed and, with the approval and assistance of the Bureau of Medical Services, implemented a new structure of Medicaid reimbursement for mental health services in Maine. This new program has been in operation for one year and has already

had substantial positive effect in that one year. Federal Medicaid funding for mental health services atcommunity mental health centers increased from $968,869 in FY1985 to $2,133,342 in FY1986, a 120% increase. At the same time, federal Medicaid reimbursement for private psychologists increased from $557,080 to $1,017,153, an 82.6% increase. Medicaid reimbursement for social workers in independent practice is not available. In terms of clients served, both the public and private sector have evidenced a greater willingness and capacity to serve Medicaid clients under the new structure. In fiscal 1986, mental health clinics served 6,516 Medicaid eligible clients, an increase of 17.9% over the 5,528 clients served in 1985. At the same time, private psychologists served 3,862 Medicaid eligible clients, an increase of 12.1% over the 3,444 clients served in 1985.

Department staff involved in developing contracts for mental health services and in designing the Medicaid reimbursement system described above have recently received training in other models of financing mental health services; including capitation agreements, health maintenance organizations, preferred provider arrangements, and other types of systems existing in other states. This training will give the Department a broadened perspective in future planning efforts.

In the upcoming year, the Commissioner will convene a task force to improve the coordination of private and public mental health resources and to consider alternative funding mechanisms to assure a balance of available outpatient services in all areas of the State.

RIGHTS OF MENTAL HEALTH CONSUMERS IN MAINE

Significant strides have been made recently in laying the groundwork for a recognition of the rights of Maine citizens who use mental health services, acknowledging their dignity, liberty, and greater personal autonomy. This progress has been a result of leadership from the state government, ex-patient groups, advocates, and concerned family members of persons with mental illness.

Although mental health inpatients in Maine were satutorily guaranteed certain minimal rights as early as 1961, the landmark Wyatt v. Stickney case and federal legislation, setting out specific rights and standards for the treatment of persons with mental illness, spurred several attempts in the late 1970's to create a comprehensive bill of patients' rights. These attempts, however, did not produce a viable bill of rights in Maine. In part, the effort faltered because the base of support from consumer and professional groups was not broad enough.

In 1981, the Maine legislature enacted a bill mandating the Bureau of Mental Health to establish comprehensive rules regarding patients' rights. The Bureau established a task force made up of consumers, services providers, advocates, and family members of patients to help develop these rules. The work of the task force resulted in the "Rights of Recipients of Mental Health Services", enacted in October, 1984. These rules were modeled closely after the federal bill of rights for mental health patients, ultimately enacted in 1986 by Congress as part of the Mental Health Protection and Advocacy bill. The Maine rights rules provided detailed procedures designed to protect rights such as the right to notification about mental health rights, to assistance in the protection of these rights (by a lay or professional advocate), to file a grievance, to informed consent to treatment, to privacy, to freedom from unnecessary seclusion and restraint, and to confidentiality. These rights apply not only to patients in the two state mental health institutes but also to patients/clients of all inpatient psychiatric facilities and all mental health agencies licensed or funded by the Bureau of Mental Health.

Implementation of these rules highlighted problems which still needed to be addressed, and in May 1985, the original task force was reconvened by the Bureau to revise and amend the rules. The most important amendment to the rules, enacted in October 1986, established detailed procedures for a new hearing process to decide disagreements between patients and the treating mental health professional. These hearings are an innovative approach to resolving a difficult problem: how to make real the right to refuse treatment (often psychotropic medication) on behalf of those patients who refuse it but who in the judgment of the treating professional appear to be in need of that treatment and to not understand the issues involved sufficiently to make an informed choice about refusing or accepting that treatment. An independent hearing officer presides over the hearing, attempts to mediate a resolution to the disagreement, and, if mediation fails, decides, according to strict legal standards, whether or not the treatment should be administered involuntarily. Although still in the early stages, this hearing process has worked well and effectively.

State and federal legislation was also passed in 1986 which will significantly enhance advocacy efforts on behalf of Maine citizens with mental illness. In Maine, the legislature enacted "An Act to Enhance the Protection of Mental Health Patients' Rights" on April 4, 1986. This bill created a Mental Health Rights Advisory Board to monitor the implementation of the rules regarding patients' rights and to make recommendations to the Commissioner for improvements in this area. The Board has eleven members, five of whom are persons interested in the delivery of quality mental health services and six of whom are also consumers or family of consumers of mental health services. This Board should be instrumental in advocating for the rights and service needs of mental health consumers, both within the Bureau of Mental Health and with the general public.

In addition, the U.S. Congress passed the "Protection and Advocacy for Mentally Ill Individuals Act of 1986" to provide funding, through existing federally funded protection and advocacy agencies, for advocacy on behalf of mentally ill individuals. In Maine, these federal funds were allocated to the Advocates for the Developmentally Disabled (ADD). ADD has assigned these monies to internal legal services positions and to two contracts: one with a consumer advocacy organization, the Portland Coalition for the Psychiatrically Labeled and the other with a statewide family support/advocacy organization, the Maine State Alliance for the Mentally Ill. The Portland Coalition will be expanding peer advocacy and support efforts statewide with these funds, and MSAMI will be expanding their family support group network and will step up legislative advocacy efforts.

SERVICE SYSTEM SUMMARY

MENTAL HEALTH SERVICES

People who have mental health problems are helped primarily by family, friends, and other persons in their natural environment. When this informal aid fails or is not sufficient, 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 to psychotherapeutic and somatic treatment of acute mental health problems, including rehabilitative 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 of the eight mental health service areas in Maine:

EMERGENCY SERVICES - Twenty-four hour telephone emergency services with professional back-up, screening, 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.

DAY TREATMENT - Rehabilitation-oriented programs to assist in the development of social and living skills for persons with psychiatric disabilities as well as partial hospitalization services.

SUPPORTIVE SERVICES - Community support for persons with psychiatric disabilities including outreach, aftercare, case management, and supportive counseling.

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.

The Bureau of Mental Health provides for these services through its two mental health institutes, its Office of Community Support Services, and its contracts with seven community mental health centers and almost forty other community agencies/organizations.

These mental health services are provided through four major groups:

1) **Public agencies:** In addition to its broad technical assistance, resource development, and coordination responsibilities, the Bureau of Mental Health

Office of Community Support Systems provides crisis intervention services in the York County, Portland, and Augusta/Waterville areas. These highly effective crisis programs have integrated respite and transitional housing.

The two state mental health institutes have changed considerably in the last twenty years or so with a combined daily census of about 650-670 patients, down from 3,400 in 1958. The institutes now have a generally younger and more severely disabled population which has more frequent re-admissions and shorter lengths of stay, and requires intensive intervention and specialized staff to meet the challenges presented by them. Admissions, however, have generally been rising, and because of limitations of space and staff, Augusta Mental Health Institute has had to restrict admissions to involuntary hospitalizations only. The institutes also provide intermediate care services to mentally ill elderly persons and a variety of forensic services. Both institutes have maintained their accreditation by the Joint Commission on Accreditation of Hospitals (JCAH).

Other governmental departments within the state such as the Departments of Human Services, Education and Cultural Services, and Corrections also provide for some circumscribed mental health services for specific population groups they serve.

2) **Private, not-for-profit agencies/organizations** funded at least in part by the Department of Mental Health and Mental Retardation and/or other public funds. This group contains a variety of agencies and organizations providing diverse services and ranging from the comprehensive mental health centers to the family support groups.

3) **Private practitioners and private proprietary, for-profit agencies/organizations** who may receive payment from Medicaid, client fees, and third-party insurers.

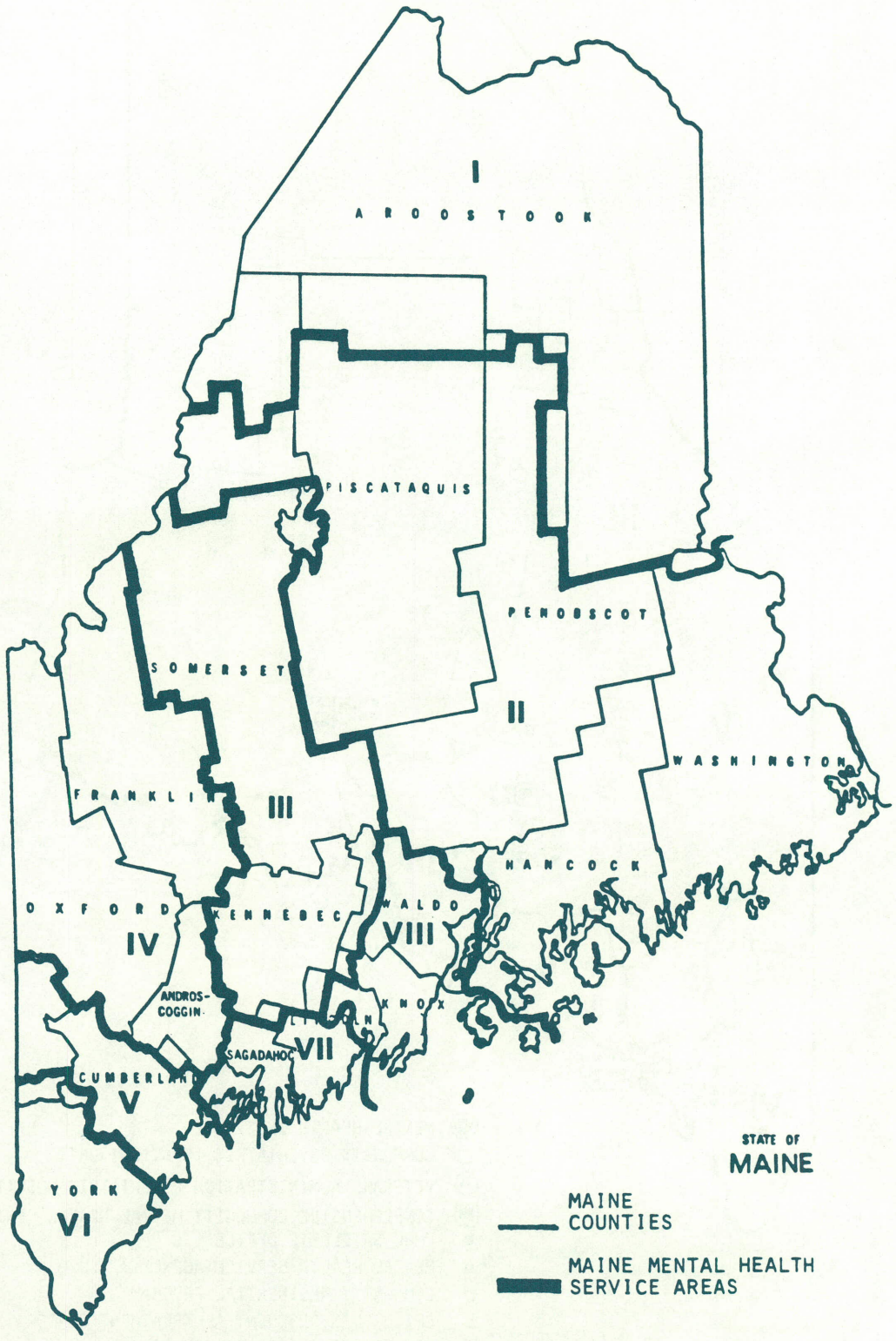
4) **Informal caregivers,** such as family members, friends, peers, and clergy, who receive little or no reimbursement for the mental health services they provide.

PUBLICATIONS

Annual Mental Health Plans
Rights of Recipients of Mental Health Services
Your Rights as a Psychiatric Inpatient in Maine
Mental Health Licensing Review Protocol
Guardianship, Questions & Answers
Report of the Task Force on Mental Health Services to Elderly Persons
Substance Abuse Services for Special Populations
Mental Health Services in Maine Series:
- Vocational Programs in Maine for Individuals with Psychiatric Disabilities
- Alternative Mental Health Residential Programs in Maine
- Mental Health Consumer Organizations and Social Clubs
- Family Self-Help Support Groups in Maine
- Comprehensive Mental Health Agencies in Maine
- State of Maine Mental Health Institutes
- Mental Health for Maine's Elderly

Mental Health Services to Deaf Persons in Maine (annual report)
Aging, Mental Health & Wellness
Service Definitions for the Prevention and Treatment of Mental Health Disorders

MAINE MENTAL HEALTH SERVICE AREAS



MAINE MENTAL HEALTH PROGRAMS

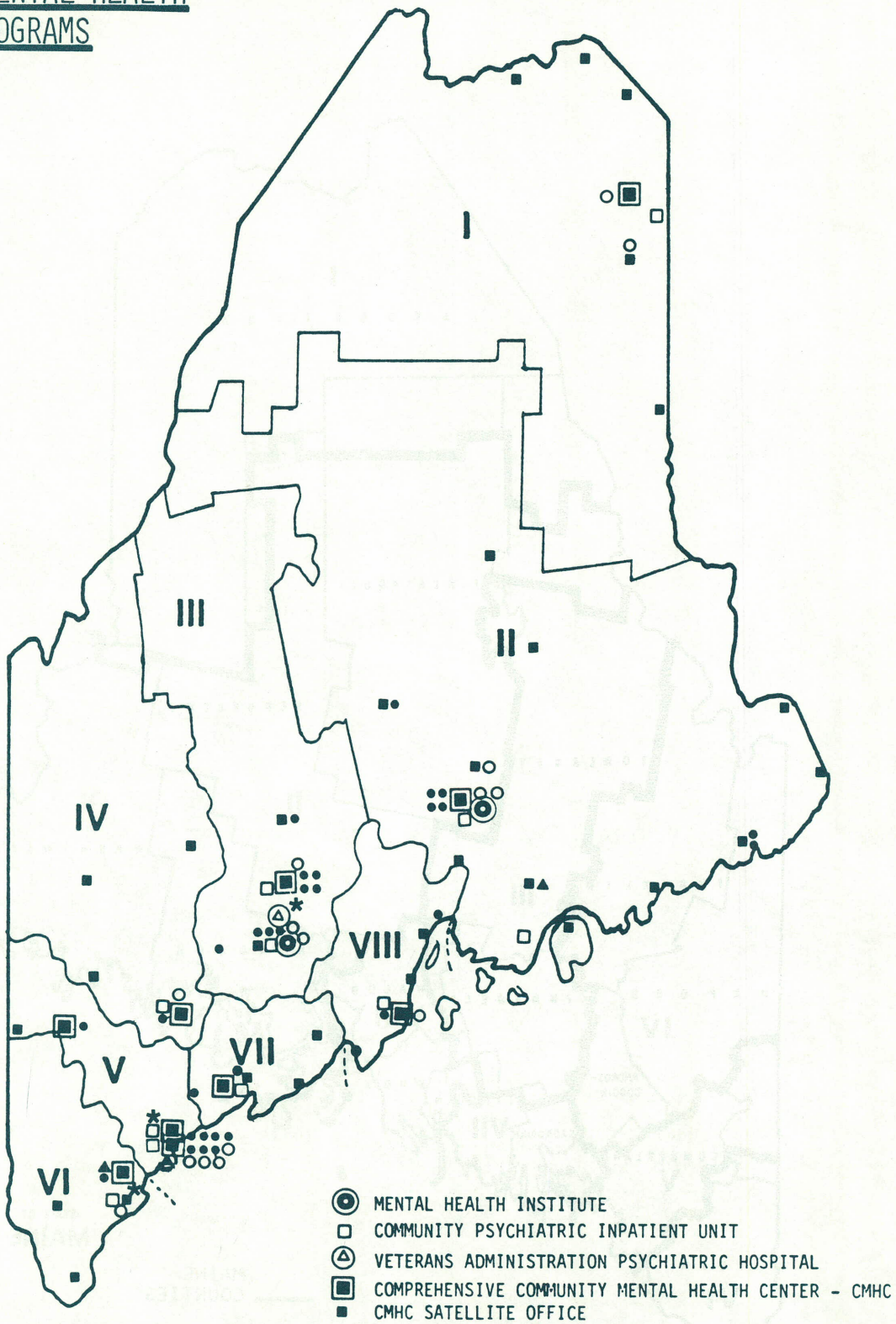


TABLE 11

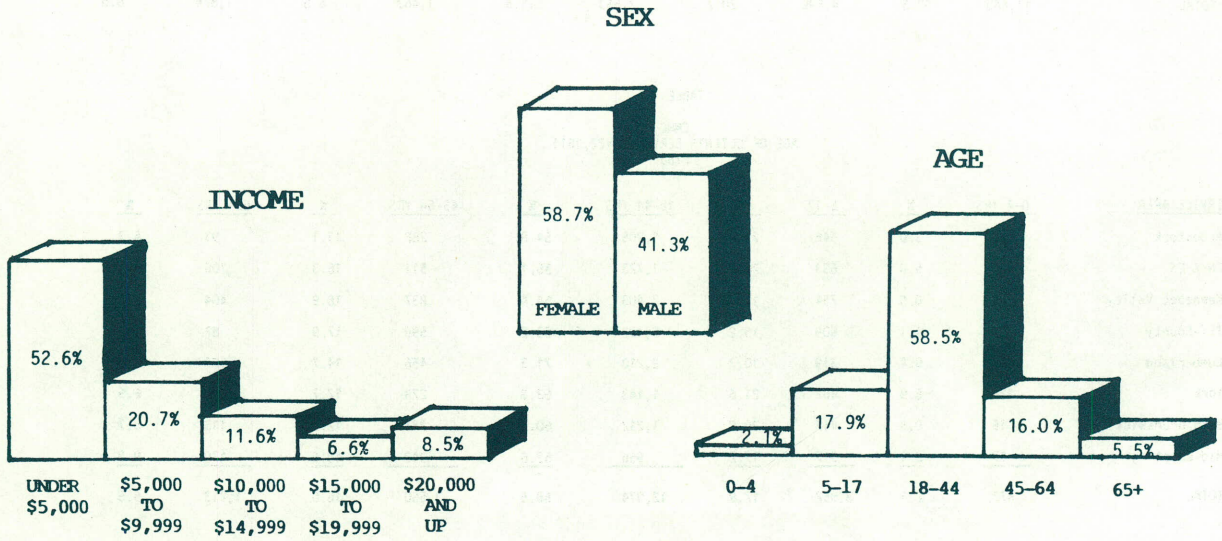
NUMBER OF PEOPLE RECEIVING SERVICE - FY86
MENTAL HEALTH PROGRAMS RECEIVING FUNDING FROM BMH

SERVICE CATEGORY	# OF ADULTS SERVED 1/
Emergency	2,634[1/]
Community Support	5,336
Day Treatment/Rehabilitation	1,090
Psychosocial Clubs	913
Community Residential	372
Outpatient	14,784
Inpatient	678
Crisis Intervention Program	1,111
TOTAL	26,918

1/ Number of People Served represents unduplicated persons within agency service categories. Note that the presentation of People Served in Emergency Services or agency crisis intervention services have insufficient contact with a provider to establish a clinical record. A better measure of utilization is that Emergency Services programs recorded 54,391 contacts in FY86.

FIGURE 4

COMMUNITY MENTAL HEALTH CENTER CLIENT DEMOGRAPHICS
FY86



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 1986.

TABLE 12

CMHC
SEX OF CLIENTS SERVED (N=22,161)
FY86

	SERVICE AREA	FEMALE	% FEMALE	MALE	% MALE
I	Aroostook	1,079	49.1	1,119	50.9
II	CH & CS	1,821	58.2	1,308	41.8
III	Kennebec Valley	2,580	58.4	1,838	41.6
IV	Tri-County	1,999	59.6	1,356	40.4
V	Cumberland	1,960	63.2	1,139	36.8
VI	York	1,309	61.1	834	38.9
VII	Bath/Brunswick	1,198	59.8	804	40.2
VIII	Mid-Coast	1,059	58.3	758	41.7
	TOTAL	13,005	58.7	9,156	41.3

TABLE 13

CMHC
INCOME OF CLIENTS SERVED (N=22,161)
FY86

	SERVICE AREA	UNDER $5,000	%	$5,000-$9,000	%	$10,000-$14,000	%	$15,000-$19,999	%	$20,000-OVER	%
I	Aroostook	858	39.0	617	28.1	311	14.1	171	7.8	241	11.0
II	CH & CS	2,031	64.9	558	17.8	274	8.8	99	3.2	167	5.3
III	Kennebec Valley	2,923	66.2	817	18.5	333	7.5	203	4.6	142	3.2
IV	Tri-County	1,140	33.9	1,003	30.0	568	16.9	324	9.7	320	9.5
V	Cumberland	1,476	47.6	538	17.4	359	11.6	266	8.6	460	14.8
VI	York	1,131	52.8	358	16.7	267	12.4	162	7.6	225	10.5
VII	Bath/Brunswick	887	44.3	406	20.3	289	14.4	172	8.6	248	12.4
VIII	Mid-Coast	1,219	67.1	299	16.4	162	8.9	66	3.7	71	3.9
	TOTAL	11,665	52.6	4,596	20.7	2,563	11.6	1,463	6.6	1,874	8.5

TABLE 14

CMHC
AGE OF CLIENTS SERVED (N=22,161)
FY86

	SERVICE AREA	0-4 YRS	%	5-17	%	18-44 YRS	%	45-64 YRS	%	65+ YRS	%
	Aroostook	66	3.0	546	24.8	1,205	54.8	288	13.1	93	4.3
II	CH & CS	156	5.0	633	20.2	1,723	55.1	511	16.3	106	3.4
III	Kennebec Valley	20	0.5	754	17.1	2,403	54.4	837	18.9	404	9.1
IV	Tri-County	38	1.1	509	15.2	2,122	63.2	599	17.9	87	2.6
V	Cumberland	13	0.4	319	10.3	2,210	71.3	456	14.7	101	3.3
VI	York	126	5.9	462	21.6	1,143	53.3	273	12.7	139	6.5
VII	Bath/Brunswick	16	0.8	417	20.8	1,212	60.5	244	12.2	113	5.7
VIII	Mid-Coast	37	2.1	312	17.2	956	52.6	342	18.8	170	9.3
	TOTAL	472	2.1	3,952	17.9	12,974	58.5	3,550	16.0	1,213	5.5

PUBLIC MENTAL HEALTH EXPENDITURES

The fiscal resources of the mental health system and the public monies which aid mentally ill persons come from a variety of sources and extend 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 through contracts with seven community mental health centers and thirty-seven other community agencies and organizations.

TABLE 15

SUMMARY
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
COMMUNITY SERVICES FUNDING FISCAL YEAR 1986

Bureau of Mental Health General Fund	$ 7,161,035
BMH - Alcohol Drug Abuse and Mental Health Block Grant	763,908
BMH - Social Services Block Grant	291,085
Bureau of Children with Special Needs - General Fund	4,254,730
BCSN - ADAMHS Block Grant	978,291
BCSN - Federal Grants	270,474
TOTAL	$ 13,724,523

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. The 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. The Department of Education and Cultural Services provides for a variety of special education, counselling, specialized residential programming, and professional outpatient treatment services. The Department of Corrections as well makes provisions for mental health services for both adults and juveniles.

TABLE 16

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

SERVICE	ACTUAL EXPENDITURES	UNITS OF SERVICE
COMMUNITY RESIDENTIAL	810,150	33,881
COMMUNITY SUPPORT	2,271,351	87,895
DAY TREATMENT/ REHABILITATION	797,389	48,218
EMERGENCY	972,275	20,931
CRISIS INTER. PROGRAM	207,081	N/A
INPATIENT COMMUNITY	273,786	9,596
OUTPATIENT	1,841,845	76,790
CONSULTATION, EDUCATION & TRAINING	309,111	7,540
PSYCHOSOCIAL CENTER	472,268	65,025
SPECIAL POPULATIONS	74,484	N/A
OTHER ACTIVITIES	193,231	N/A

*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
EXPENDITURES AND INDIVIDUALS SERVED BY SERVICE TYPE*
COMPARISON OF FISCAL YEARS 1986 AND 1987

	FY 86		FY 87	
SERVICE	ACTUAL EXPENDITURES	INDIVIDUALS SERVED	PROJECTED EXPENDITURES	PROJECTED PERSONS SERVED
RESIDEN. TREATMENT	$880,042	123	$ 927,216	120
OTHER RESIDEN. SERV.	187,544	76	214,430	80
HOMEBASED SERVICES	654,116	311+	665,387	360+
DAY TREATMENT	148,467	199	216,825	200
SEXUAL ABUSE	233,817	425	243,170	425
PREVENTION/EARLY INTERVENTION	1,046,826	1,976	1,036,157	2,210
REGIONAL OPERATIONS	1,056,092	988	1,370,660	1,100
OUTPATIENT	846,861		957,145	
CONSULTATION, EDUCA.	260,618	3,870	250,235	4,220
OTHER COMMUN. SERV.	189,112	N/A	353,685	N/A
TOTALS	$5,503,495	7,968	$6,234,910	8,715

+Families

TABLE 18

PATIENT DAYS AND COSTS FISCAL YEAR 1986
STATE MENTAL HEALTH INSTITUTES

	PATIENT DAYS	COSTS
AUGUSTA MENTAL HEALTH INSTITUTE	121,266	$15,731,745*
BANGOR MENTAL HEALTH INSTITUTE	102,298	14,603,642*
TOTAL	223,564	$30,335,387*

* Excludes dedicated revenues totalling $600,467 for sheltered workshop programs which serve, in part, community clients. Figures do include construction and repair costs of $391,899 in FY86.

TABLE 19

FY86 HOSPITAL PSYCHIATRIC+ INPATIENT
DISCHARGES/PATIENT DAYS/AVERAGE LENGTH OF STAY*

SERVICE AREA	HOSPITAL	DISCHARGES	PATIENT DAYS	AVG. L.O.S.
I.	THE AROOSTOOK MEDICAL CENTER	179	2,968	16.6
II.	EASTERN MAINE MEDICAL CENTER	547	4,973	9.1
III.	MID-MAINE MEDICAL CENTER	330	6,924	21.
	KENNEBEC VALLEY MEDICAL CENTER	179	2,967	16.5
IV.	ST. MARY'S GENERAL HOSPITAL	457	5,231	11.4
V.	MAINE MEDICAL CENTER	599	8,807	14.7
	JACKSON BROOK INSTITUTE	338	6,617	19.6
VI.	SOUTHERN MAINE MEDICAL CENTER	219	2,542	11.6
VII.	REGIONAL MEMORIAL HOSPITAL	273	2,567	9.4
VIII.	PENOBSCOT BAY MEDICAL CENTER	137	1,522	11.1
	STATEWIDE, 44 HOSPITALS++	3,954	49,250	12.5

* Source: Health Care Finance Commission.

+ Includes only primary diagnoses of specific mental disorders.

++ Excludes the two state mental health institutes.

TABLE 20

REVENUES AND EXPENDITURES OF BMH FUNDED MENTAL HEALTH SERVICE AGENCIES

REVENUES	FY86	%FY86
Department of MH & MR[1]	$ 8,820,306[2]	44.8
Other State	1,042,561	5.3
Federal	109,842	0.6
Local Public	543,650	2.8
Net Fee For Service	7,676,548	39.0
Other Revenues	1,483,223	7.5
Total Revenue	$19,676,130	100.0%
EXPENSES		
Salary & Wages	$15,213,198	77.8
Non-Personnel Expenses	4,344,872	22.2
Total Expenses	$19,558,070	100.0%

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 FY86 DMHMR does not include Medicaid seed paid by DMHMR of $858,808. This amount is included in Net Fee for Services as part of Medicaid fees.

TABLE 21

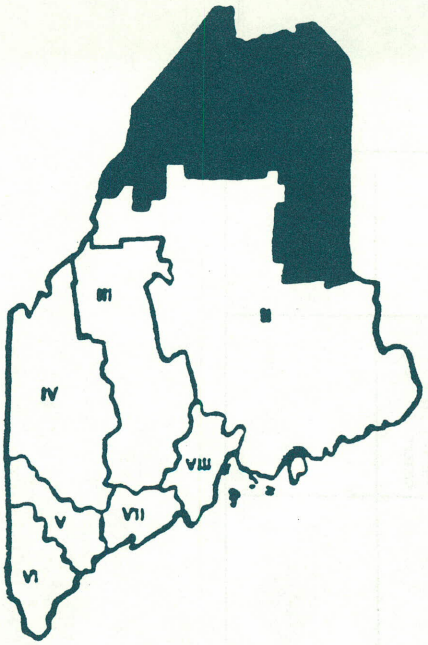
FY86 CMHC REVENUE FOR MENTAL HEALTH PROGRAMS

FY86 CMHC REVENUE FOR MENTAL HEALTH PROGRAMS

REVENUE LINE-ITEM	AMHC	CH&CS	KVMHC	TRI-COUNTY	YORK	BATH-BRUNSWICK	MCMHC	TOTAL	
DMHMR									
BMH Grant[A]	$1,161,852	$1,155,824	$ 855,702	$ 824,691	$ 848,054	$ 494,504	$ 570,757	$ 5,911,384	
BMR		12,268						12,268	
BCSN Grant[A]	43,607	624,076	20,303	286,394	116,435	353,430	150,261	1,594,506	
CSS									
Other DMHMR				36,004				36,004	TOTAL DMHMR = (50.8%)
DMHMR Seed[A]	<75,193>	<182,250>	<169,570>	<92,528>	<83,447>	<45,718>	<74,870>	<723,576>	($7,554,162)
OTHER STATE	214,292	149,537	61,800	164,173	130,750			720,552	
FEDERAL		44,232						44,232	
LOCAL PUBLIC									
Town		42,655		36,141[B]	33,651	33,537	16,873	162,857	
County	32,764		113,020	12,612[B]	45,000			203,396	$366,253 Local Public Total(2.5%)
FEE FOR SERV.[A]	976,227	1,390,304	1,136,228	975,389	693,193	433,982	753,358	6,358,681	$6,358,681 Fee Total[A](42.8%)
Self Pay	122,781	71,586	73,510	118,228	116,096	35,972	28,872	561,045	
Medicare	5,594	16,161	57,548	61,534	3,648	24,464	37,068	206,017	
Medicaid[A]	254,975	742,760	502,276	444,635	294,617	189,275	355,099	2,783,637	Gross Medicaid = 18.7%
Hospitals	107,429		163,556		690		19,557	291,232	
Schools	46,938	191,985	2,540	11,894	68,089		93,565	415,011	
Insurance	80,517	204,030	270,041	115,823	113,040	177,882	188,696	1,150,029	Insurance = 7.7%
Other Fees	357,993	163,782	66,757	223,275	97,013	6,389	30,501	945,710	
OTHER REVENUE	23,705	245,308	129,003	64,408	16,282	48,987	12,410	540,103	
TOTAL REV.	$2,377,254[C]	$3,481,954	$2,146,486	$2,307,284	$1,799,918	$1,318,722	$1,428,789	$14,860,407	

A Since Medicaid Seed paid by the Department is included in BMH, BCSN, and Medicaid lines, an offsetting adjustment has been made and is indicated on DMHMR Seed line.
B Tri-County's Town and County revenues are allocated from a reported total of other revenue.
C In-Kind income not included.

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 1985 estimated population was 91,090.

TABLE 22

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1986
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	$ 93,936	1,869	5,600*
Community Support	339,981	10,844	958
Day Treatment/Rehabilitation	120,448	5,930	125
Community Residential	185,894	5,906	39
Outpatient Services	263,187	7,420	1,628
Consultation, Education & Training	127,786	3,129	-----
Inpatient	30,620	919	89
TOTAL CMHC	$1,161,852	36,017	
The Aroostook Medical Center Hospital Industries Program	7,138	N.A.	1
Valley AMI Social Club	6,000	N.A.	13
TOTAL, REGION I	$1,174,990	36,017	

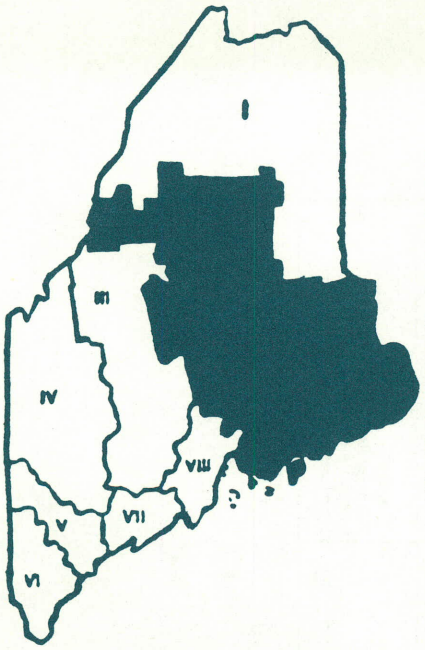
* Emergency Services shows total contacts with Helpline emergency telephone service. Agency reported 49 clients served in after-hours face-to-face services in the year.

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

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 Fort Fairfield in conjunction with AMHC
VALLEY AMI F			Social Club Madawaska			Educational & Support activities for families with mentally ill members	
THE SOUTHERN AROOSTOOK ALLIANCE FOR THE MENTALLY ILL 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 1985 estimated population for the Eastern Maine Service Area was 235,830.

TABLE 23

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1986
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	$ 66,596	1,274	11,557*
Community Support	350,421	8,739	599
Day Treatment/Rehabilitation	161,727	9,614	234
Community Residential	72,498	4,637	76
Outpatient Services	448,542	14,211	2,379
Consultation, Education & Training	56,040	1,307	-----
TOTAL CMHC	$1,155,824	37,179	
Together Place			
Social Club, Vocational Services	51,915	13,785**	260
Charlotte White Center			
Day Treatment/Rehabilitation	49,000	1,448	18
Three Hudson Street			
Community Residential	37,500	2,155	10
TOTAL, REGION II	$1,294,239	54,567	

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

** 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

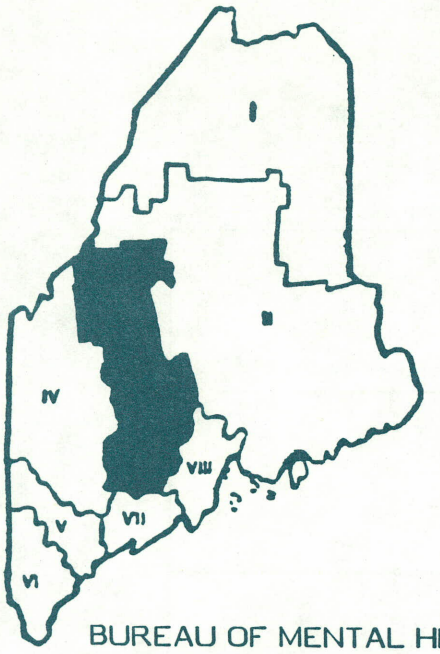
MENTAL HEALTH SERVICE AREA II

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
COMMUNITY HEALTH & COUNSELING SERVICES Bangor Bar Harbor Dover-Foxcroft Ellsworth Machias Linclon Millinocket Calais L,F,O	Workdays: All 8 CHCS Locations	All 8 CHCS Offices BMHI Boarding, Nursing, Foster, Group Homes, locally maintained facilities such as churches & 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	Performs Crisis Intervention for persons referred for admission		BMHI provides Day Program & Sheltered Workshop for BMHI Inpatients	Two on-grounds halfway houses			Services involuntary, voluntary, short & long term, also intermediate care facility, Program on Aging
DOWNEAST ALLIANCE FOR THE MENTALLY ILL L, F				Transitional Living Residences		Ed. & Support activities for families w/ mentally ill members	

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
TOGETHER PLACE, INC. Bangor L			Psychosocial Club Pre-vocational Training				
BLUE HILL MEMORIAL HOSPITAL Blue Hill L	24 Hour emergency services to area residents				Services available at Blue Hill Mem. Hospital., & Island Med. Ctr., Stonington	Support Group for multiple sclerosis	Voluntary short term services available
OPPORTUNITY HOUSING, INC. Bangor O			Day Program for Residential Clients supported work	Residential, Respite Care, and Housing Coordinational	Peer Counseling & Advocacy	Crisis Prevention Institute Instructors	



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 1985 estimated population was 168,890.

TABLE 24

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1986
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	$ 73,795	2,739	5,758*
Community Support	337,687	10,977	1,015
Day Treatment/Rehab	8,815	3,073	119
Outpatient Services	158,205	8,490	2,368
Consultation, Education & Training	104,280	1,770	-----
Inpatient	172,920	6,257	217
TOTAL CMHC	$ 855,702	33,306	
Motivational Services, Inc. (MoCo)			
		1,007 Staff Int	66
LINC Program	157,098	15,204 Soc.Club	115
Clean Sweep Vocational	76,483	N/A	56
Community Residential	206,432	6,765	66
Waterville Social Club	79,791	11,191	115
Crisis and Counseling Services			
Emergency Services	74,450	1,321	396
Kennebec Valley Regional Health			
Community Support	58,000	5,536	384
Kennebec-Somerset Home Aide Services			
Community Support	11,565	7,372	N/A
Emergency Services	152,626		
Mid-Maine Medical Center			
Hospital Industries Program	6,712	N/A	4
TOTAL, REGION III	$1,678,859	81,702	

*Emergency Services figures show total contacts with emergency service.

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

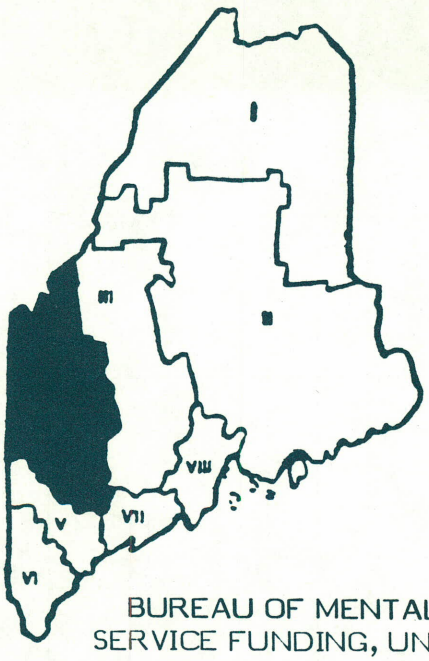
MENTAL HEALTH SERVICE AREA III

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 Monday - Friday Skowhegan L,F	Weekdays: Augusta, Waterville Monday - Friday Skowhegan office After hours/ Weekends/ Holidays Emergency Rooms Kennebec Valley Medical Center Augusta Mid-Maine Medical Ctr. Thayer-Waterville other sites as necessary	Augusta, Waterville & Skowhegan Offices	Day Hospital Program Augusta Waterville Offices		Augusta, Waterville, Skowhegan offices	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 SOMERSET COUNTY L,P	Crisis team available to do in-home crisis intervention throughout Somerset County 24 hrs. a day				Augusta, Skowhegan offices (Crisis only)	Services to groups & agencies by contract and on request	
AUGUSTA MENTAL HEALTH INSTITUTE Serves mental health service areas III, IV, V, VI, VII & VIII		After care workers in Cumberland & Kennebec Counties	AMHI has day programs for inpatients & a sheltered workshop which serves some non-residents		Forensic Evaluation	Psychiatric Grand Rounds are open to public Quarterly education seminars for parents & friends (MSAMI) Placement for many college & university Programs	Services are involuntary & voluntary, short & long term, including nursing home unit & alternative living houses. Adolescent unit is a statewide program
KENNEBEC COUNTY CRISIS INTERVENTION PROGRAM/ BUREAU OF MENTAL HEALTH F	24-hr, 7 day/wk crisis intervention services. Workers are available to respond to people w/ psych. disabilities who are in crisis throughout Kennebec County; short term supp. residential resources available also.			Short-term (7-30 days) supported supervised residences for people in psychiatric crisis in Kennebec County		Consultation & Ed. provided to community groups and agencies upon request	

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
DHRS FAMILY & MARRIAGE COUNSELING SERVICES Waterville L					Individual Family & Marriage Treatment	Training & Consultation to area parishes	
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			Mental health service for physically ill with related mental health issue in agency offices & rural Health Ctrs.	Ed. in Physical/ mental illness & medication assessments	
DHRS HOME CARE SERVICES 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 Home Manchester Readfield Pittston	Case Management services to agency clients living in Augusta community. Community Support for dual - diagnosis Clients (MH substance Abuse)	LINC Social Club Augusta Vocational Program - Augusta Clean Sweep Waterville Social Club	Middle Street House - Augusta Transitional Residence Elm Street House Augusta-Long term Rehabilitation Residence Western Ave. Residence Wtvl. ICF/MR group home for dual diagnosed			
MID-MAINE ALLIANCE FOR THE MENTALLY ILL F				Supported transitional Mental Health program for adults with psych. disabilities		Ed. & Support activities for families with mentally ill members	
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 and 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 1985 of 183,150 persons.

TABLE 25

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1986
SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION IV

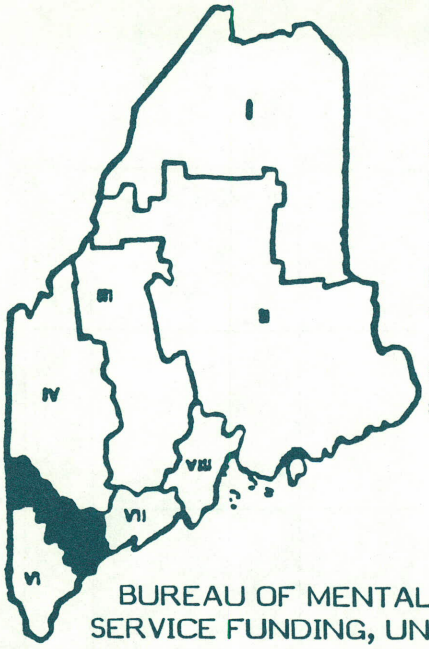
AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Tri-County Mental Health Services			
Emergency Services	$ 115,179	2,540	399
Community Support	255,278	9,560	616
Day/Treatment/Rehab.	159,232	5,844	160
Outpatient Services	280,352	12,919	1,988
Consultation, Education & Training	14,650	996	
TOTAL, CMHC	$ 824,691	31,859	
100 Pine Street (Social Club & Housing Services)	78,600	5,040	82
Franklin Memorial Hospital - Emergency Services	51,000	146	110
TOTAL REGION IV	$ 954,291	37,045	

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

AGENCY	SERVICES AND LOCATIONS						
	EMERGENCY	COMMUNITY SUPPORT	DAY TREATMENT REHABILITATION	COMMUNITY RESIDENTIAL	OUTPATIENT	CONSULTATION, EDUCATION & TRAINING	INPATIENT
TRI-COUNTY MENTAL HEALTH SERVICES (TOMHS) Farmington Lewiston Norway Rumford L,F	Weekdays: All 4 TOMHS locations After hours/ weekends staff available via TOMHS #783-9141 and via agreements with St. Mary's & Franklin Memorial Hospitals	All 4 TOMHS locations In-home treatment of children & families	Day Treatment Lewiston Transitional Employment Program Lewiston South Paris		All 4 TOMHS locations for adults, & children & adolescents and their families	TOMHS staff provide services to area community organizations & groups, training & consultation to schools, other care givers, by contract and on request	Via agreement with St. Mary's (Lewiston) and Franklin Memorial (Farmington)
ST. MARY'S GENERAL HOSPITAL Lewiston	24 hour, 7 day services for psychiatric emergencies provided by TOMHS						Voluntary, short term services are provided in the inpatient unit in Lewiston
RELATIVES AND FRIENDS TOGETHER FOR SUPPORT Auburn F				Boarding Home		Ed. & Support activities for families w/ mentally ill members	
DHRS FAMILY MARRIAGE COUNSELING SERVICES Lewiston L					Individual, family & marriage counseling		
FARMINGTON ALLIANCE FOR THE MENTALLY ILL Farmington F				Respite and Supervised Apt.		Ed. & Support activities for families w/ mentally ill members	
FRANKLIN MEMORIAL HOSPITAL Farmington	Psychiatric emergency services provided via agreement with TOMHS						
ANDROSCOGGIN HOME HEALTH CARE L		Psychiatric nursing					
AREA IV MENTAL HEALTH SERVICES COALITION L,F		Social club		Supervised apartments			



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 1985 estimated population of 196,910.

TABLE 26

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1986
SERVICE FUNDING, UNITS OF SERVICE, AND PEOPLE SERVED - REGION V

AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Emergency Services			
Ingraham Volunteers	$ 46,092.	2,736[1]	29,242*
Western Maine Counseling	17,991.	N/A	N/A
Holy Innocents Crisis Support	113,291.	7,054	197
Community Support			
Community Health	158,858.	11,363	300
Holy Innocents	73,638.	6,315	213
Amity Center Social Club	64,165.	11,674	328
Community Residential			
Shalom House	84,284.	8,915	51
Shalom Apts.	31,022.	N/A	N/A
Ingraham Volunteers - Bridge	19,800.	2,205	125
Outpatient Services			
Community Counseling	13,655.	5,259	1,532
Western Maine Counseling	52,420.	2,897	380
Consultation, Education & Training			
Community Counseling	6,355.	338	N/A
Vocational Services			
Amity Center Pre-Work Activities	20,404.	2,128	123
Maine Medical Center - H.I.P.	8,000.	N/A	5
Other Services			
MH Assoc. of the Cumberland Region	51,113.	N/A	N/A
Maine Medical Ctr. - Psychiatric Services	40,000	N/A	N/A
TOTAL, REGION V	$801,088.	60,884	

*Emergency Services figures under People Served for Ingraham Volunteers show total calls to emergency telephone service.
1/Units of service at Ingraham Volunteers include clinical hours only.

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

MENTAL HEALTH SERVICES BY SERVICE CATEGORY

MENTAL HEALTH SERVICE AREA V

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 services	Adult Day Hospital Program at MMC Therapeutic Nursery		Service provided at MMC Specialized services for children at MMC	MMC staff provide services 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 public affairs, community education and planning activities related to mental health in the Cumberland area. Does not provide direct services.						
JACKSON BROOK INSTITUTE S. Portland S W	24 hour, 7 day psychiatric eval. and admission	Sponsors regular support groups: AA meetings Al-Anon Narcotics Anonymous Adult Children of Alcoholics Head-Injured Support Group NEED Support Group					In-patient serv. for adolescents & adults, children & elderly, both voluntary & involuntary diagnosis & short-term treatment. Eating disorders program. Chemical dependency treatment
INGRAHAM VOLUNTEERS, INC. Portland SW, L, F	Dial INFO 24 hour, 7 day telephone crisis intervention by trained, supervised volunteers. Referrals to Maine Medical Center Emergency Room & others. 24 hour, 7 day screening and admission to the Family Crisis Shelter DIAL for the DEAF 24 hour, 7 day vocal relay and emergency services for the deaf.			THE BRIDGE Emergency Shelter for homeless mentally ill		Dial KIDS Peer counseling, information and referral for adolescents.	
CUMBERLAND COUNTY BUREAU OF MENTAL HEALTH CRISIS STABILIZATION PROGRAM	24 hour, 7 day/week, Crisis stabilization workers are available to respond to people with psych. disabilities in crisis. Short-term, supported, supervised residences are available			Short-term (up to 7 days) supported, supervised residences for people in psych. crisis			

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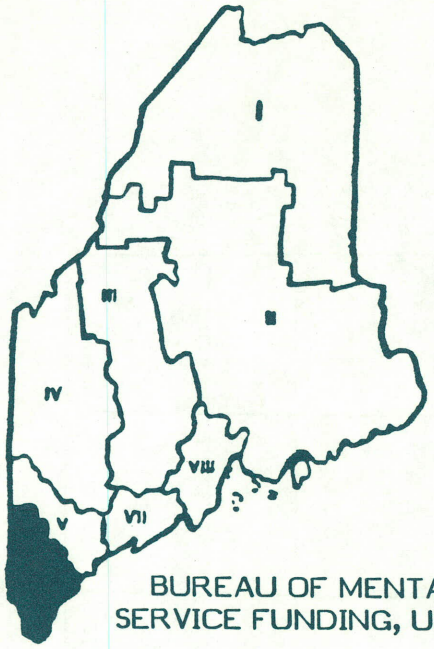
SW = Accepts Statewide Referrals

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	Transitional employment program				
SHALOM HOUSE SW Portland L,F				Trans. Liv. Resid. Shalom Apartments Coop. Apt. Prog.			
COMMUNITY COUNSELING CENTER Portland L,F,O					Serv. provided in Portland, Gorham, Westbrook; Sex Abuse Treatment program	CCC staff provide service to community groups & organizations by contract & on request	
ALLIANCE FOR THE MENTALLY ILL (AMI) Portland F		Psychosocial Club				Ed. & Support activities for families w/ mentally ill members	
WESTERN MAINE COUNSELING SERVICES Bridgton O,L,F	Weekdays: Bridgton Office After hours/ weekends - staff available via tel.	Bridgton Office provides psychiatric services	Adolescent - Child Day Treatment & Alternative School		Individual, family & group therapy provided at Bridgton, Fryeburg, & Raymond Office	WMCH staff provide service to community groups & organizations by contract & on request	
DIOCESAN HUMAN RELATIONS SERVICES HOLY INNOCENTS HOME CARE SERVICE Portland L,F L,F		Comprehensive Case Management Services for Area V CSP clients including housing a assistance; case planning; 24-hour, 7 day crisis intervention; prolixin clinic; in-home assistance; developmental groups; outreach services.					
DHRS FAMILY & MARRIAGE COUNSELING SERVICE Portland L					Individual Marriage & Family Counseling		
CARON STREET DEAF PROGRAM/GOODWILL IND.				Transitional Residential Treatment for deaf adults.			



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 1985 population estimate for this area is 157,700.

TABLE 27

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1986
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	$ 48,176	192	*
Community Support	480,246	11,131	623
Psychosocial Club	92,144	7,124	110
Community Residential	101,983	2,368	5
Outpatient	121,505	9,188	1,481
TOTAL, CMHC	$ 844,054	30,003	
Creative Work Systems			
Vocational Services	10,418	165	9
Goodall Hospital -			
Vocational Services	4,865	N/A	
TOTAL, REGION VI	$ 859,337	30,168	

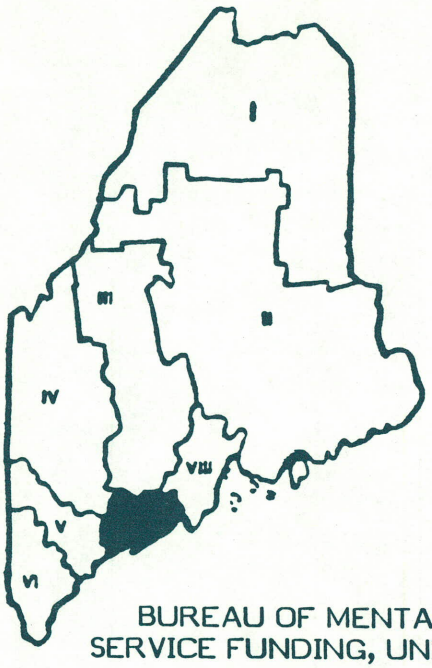
* Agency does not report "people served" in emergency services beyond units of service provided in that category.

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

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 Crisis Hotline	24 hour, 7 day psychiatric emergency services in Emergency Room		Day Treatment Biddeford			Psychiatric Nursing consultations for area nursing homes	Voluntary and short-term services in psychiatric in-patient unit
CREATIVE WORK SYSTEMS F		Worksite intervention	Vocational evaluation work adjustment training Transitional employment & job placement				
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					Individual, marriage & family counseling		
EVENING SUPPORT SERVICES FOR YORK COUNTY/ BUREAU OF MENTAL HEALTH	8 am - midnight M-F, Sat. & Sun. crisis stabilization workers are available to respond to people with psych. disabilities in crisis. Short-term, supported, supervised residences are available also.			Short-term (up to 7 days) supported, supervised residence for people in psych. crisis.			



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 1985 the estimated population of this region was 75,770.

TABLE 28

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1986
SERVICE FUNDING, UNITS OF SERVICES, AND PEOPLE SERVED - REGION VII

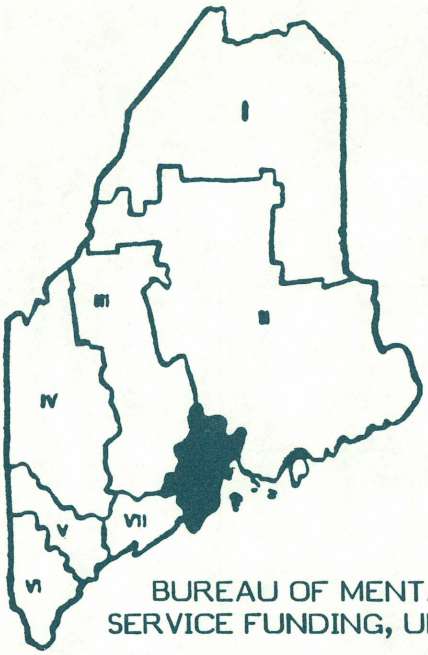
AGENCY/SERVICE	BMH SERVICE FUNDING	UNITS OF SERVICE	PEOPLE SERVED
Bath-Brunswick Mental Health Center			
Emergency Services	$ 38,085	603	26
Community Support	86,447	1,574	100
Day Treatment/Rehab.	117,858	2,291	61
Outpatient Services	219,949	7,797	1,569
Inpatient	32,165	1,313	246
TOTAL, REGION VII	$494,504	13,578	

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

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 Brunswick Damariscotta L,F,O	Workdays: Bath Brunswick Damariscotta Boothbay Harbor After hours/ Weekends: BBMHC staff are available via telephone	Brunswick Damariscotta In-home treatment for children & families	Day Hospital Brunswick Pre-vocational Transitional Employment Program Brunswick		Bath Boothbay Harbor Brunswick Damariscotta Specialized Children's Services Bath Brunswick Boothbay Harbor Damariscotta	BBMHC staff provide services to comm. organizations and groups by contract and on request.	By referral
REGIONAL MEMORIAL HOSPITAL Brunswick	24 hour, 7 day psychiatric emergency service in Emergency Room						Voluntary, short-term in-patient 11-bed unit.
BATH-BRUNSWICK SEA-AMI Bath						Educational & support activities for families with mentally ill members	



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 1985 estimated population of 62,570, with major concentrations of population in Rockland, Belfast, Camden, Thomaston and Rockland.

TABLE 29

BUREAU OF MENTAL HEALTH FUNDED AGENCIES FISCAL YEAR 1986
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	$ 81,085	457	293
Community Support	119,230	4,484	462
Day Treatment/Rehabilitation	47,174	2,521	211
Community Residential	737	930	N/A
Outpatient Services	283,730	8,609	1,459
Inpatient	38,081	1,107	126
TOTAL, REGION VIII	$570,037	18,108	

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

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 voluntary short-term inpatient service in conjunction with MCMHC Rockland
PENOBSCOT BAY MEDICAL CENTER Rockland	24 hour, 7 day psychiatric emergency service in Emergency Room						Voluntary, short-term services at inpatient unit, in conjunction with MCMHC
CENTRAL ALLIANCE FOR THE MENTALLY ILL						Support & Educational activities for families with mentally ill member	

AUGUSTA MENTAL HEALTH INSTITUTE

BACKGROUND

Since 1840 Augusta Mental Health Institute (AMHI) has been providing valuable and needed mental health services to the citizens of Maine. AMHI has responded well to change over the years, and its history of quality is well documented through its continuous JCAH accreditation since 1955 and the receipt of the American Psychiatric Association's Significant Achievement Award as a "Model State Hospital for the 1980's".

AMHI is staffed by the equivalent of approximately 611 full-time state positions augmented by a limited amount of service purchased through contracts. The AMHI annual budget for Fiscal Year 1987 is $16,364,246. The current AMHI program utilizes 30 buildings and 616,132 sq ft of space.

In order to fulfill its mission, thereby providing services of the quality and quantity required and expected in its legislative mandate, the Institute must meet the following program objectives: patient improvement, patient involvement, quality of staff, maintenance of standards, continuity of services, and efficient use of resources.

PROGRAM ORGANIZATION

Each of the functional treatment units is responsible for the total treatment and rehabilitation of its patients. Programatically, AMHI is currently organized into the units described below.

SOUTH PSYCHIATRIC UNIT

Admission Unit

This 30-bed unit is primarily an intensive assessment, diagnostic, and crisis intervention service, offering short-term treatment such as chemotherapy, group therapy, activity therapy, and occupational therapy. Except for forensic patients and adolescents, approximately 50% of AMHI's patients are discharged within 7-9 days. This rapid stabilization and discharge function requires carefully planned aftercare services which are provided by various mental health agencies throughout the state.

Forensic Unit

At present, this is a 33-bed unit divided into an 8-bed high security section and a 25-bed medium security section. The 8-bed section provides short-term intensive diagnostic and treatment services in a secure setting for individuals referred from the courts for observation, care, and treatment and for civil admissions from state and county correctional facilities. Those found Not Guilty by Reason of Insanity (NGRI's) or Incompetent to Stand Trial are generally treated in the medium security

area unless otherwise indicated. The staff of this unit monitors all legal hold patients, regardless of their treatment unit or release status.

Adult Program

This 40-bed program focuses on treatment and social intervention to adult psychiatric patients up to age 45. Most patients in this program are being served in long-term outpatient treatment with periodic hospital level care.

Young Adult Program

A 40-bed short-term intensive psychiatric program designed to meet the needs of patients 18-30 years of age. Many of these patients are best described as being young and chronically mentally ill with the special problems of substance abuse and other social problems.

ADOLESCENT UNIT

This 24-bed unit provides comprehensive diagnostic and treatment services in a residential setting to all those Maine youths, aged 12-17 years, who are mentally ill and whose problems have not or cannot be resolved through less restrictive alternatives in the community.

NORTH PSYCHIATRIC AND REHABILITATION UNIT

Older Adult and Special Treatment Populations Program

This is a 39-bed milieu program for clients who are over 52 years old. The program focuses on remotivation and improvement in basic functional skills and is individualized by additional modalities specific to assessed needs. Services accommodate the needs of persons with head-injuries and hearing-impairment who are part of this program.

Alternative Living Program

The Alternative Living Program consists of six houses or apartments on the grounds of AMHI with a total capacity of 40 patients. Each house provides a small, supportive, homelike group setting which more closely parallels the experiences that patients are likely to encounter in the community. The goal for the individual is to reach the highest level of independent functioning possible, with the ultimate goal being community integration.

Therapeutic Activities

These include a multi-discipline group of action oriented therapies that provide a means for individuals to go from a less to a more functional state. Occupational therapy, recreational therapy, movement/dance therapy and art therapy are among those currently represented at AMHI.

Adult School

An Adult School is provided as a major element in the rehabilitation process, for ongoing assessments of patient needs find many with little formal education and/or very low self-esteem and self-care ability. An adult education program provides skill development, formal academic training, and many leisure-time skill enhancement courses.

G.R.O.W. - Vocational Rehabilitation/Sheltered Employment

This comprehensive workshop program utilizes any funds generated over and above the wages paid to workshop clients to expand rehabilitation Clients with disabilities comparable to those of AMHI patients are referred from the community mental health centers, Bureau of Rehabilitation, Bureau of Mental Retardation, and other mental health related agencies. By extensive utilization of this program, patients who would have remained untreated or whose treatment would have been inappropriate and ineffective have re-entered the world of productive employment in varying degrees of self-sufficiency.

GENERAL MEDICAL AND NURSING HOME

Nursing Home Unit

The patients housed in this 70-bed unit are severely impaired both psychically and behaviorally. Their disabilities are such that they cannot be served in community nursing homes or other alternative settings. A newly established federally funded program, in partnership with the local area agency on aging, will provide psychogeriatric training and consultation services to boarding and nursing homes in the central, southern, and western regions of the state.

Infirmary

The 16-bed infirmary provides a Medicare certified general hospital level of care at less cost than would be incurred by a transfer to a general hospital. Those patients requiring surgery or intensive care are transferred to the Kennebec Valley Medical Center. Psychiatric care to patients in the infirmary continues to be provided by the patient's psychiatric team.

Clinic

The Clinic serves as a medical support service to the psychiatric units, Nursing Home, and Infirmary. It is responsible for medical specialities which are represented on AMHI's consulting medical staff, including physical therapy and dental services. In addition, AMHI is required to maintain well-equipped medical support facilities: an X-ray department, laboratory, and pharmacy.

ANCILLARY AND SUPPORT SERVICES

Chaplains, Volunteers, Staff Development, Library, and a host of other specialized services augment the other treatment services available and add to the overall environment.

ALCOHOLISM PROJECT

AMHI benefits from the Alcohol Premium Fund in the form of services provided through contract with Crisis and Counseling, Inc. This expanded service contract provides staff support to the inpatient programs and to aftercare services. Three fulltime staff are assigned to inpatient units and will provide services to the whole institute population with a strong emphasis on the young adult population.

BANGOR MENTAL HEALTH INSTITUTE

BACKGROUND

Bangor Mental Health Institute (BMHI), known as the Eastern Maine Insane Hospital from 1901 to 1913 and as the Bangor State Hospital until 1973, was established by resolve of the law of the statutes of February 2, 1895, Chapter 18. It was officially opened July 1, 1901.

The Institute received its first accreditation under the Joint Commission of Accreditation of Hospitals (JCAH) in 1976 and continues to be accredited. The Pooler Pavilion is licensed as an Intermediate Care Facility (ICF) by the Maine Department of Human Services. The admitting unit is certified by the National Institute of Mental Health as providing acute psychiatric care.

BMHI is staffed with 556.5 full-time equivalent State positions and provides a small portion of services through state approved contracts. Its annual FY '87 budget is $14,041,388, $12.3 million of which is in personal services.

PROGRAM ORGANIZATION

Bangor Mental Health Institute is now organized into two major in-patient components, the Adult Psychiatric Program and the Program on Aging, and primarily serves the five northern counties of Aroostook, Hancock, Penobscot, Piscataquis, and Washington. Currently there are about 280-300 patients on any given day. Nearly half of this population resides in the Program on Aging, the psychiatric program for elderly individuals.

The Institute focuses its resources on treatment and rehabilitation for mentally ill persons who cannot be treated in the community and for those individuals committed or referred by the criminal justice system. With this specialized function, certain categories of patients are no longer admitted: individuals whose crises are social incompatability or acute medical problems and elderly individuals referred for economic reasons. Major mental illness is the criterion for admission.

PSYCHIATRIC REHABILITATION

Since 1982, the Institute has worked with the Center for Research and Rehabilitation Training at Boston University to develop psychiatric rehabilitation programs at the Institute. As of December, 1986, the Institute has nineteen fully trained practitioners and three trained staff capable of teaching others. Three wards are the site of implementation of this rehabilitation model. Other trained individuals are assigned to a limited number of other wards. The long-term goal is to implement the psychiatric rehabilitation model throughout the Institute's programs whenever there are patients who can benefit from this approach.

ADULT PSYCHIATRIC PROGRAM

Admissions Unit

Admissions is a 17-bed unit admitting all emergencies and most of the acutely mentally ill persons from mental health service areas I and II. It admits roughly 300 people a year, about one-half of whom are discharged directly from the Admissions Unit after an average stay of 11.5 days. Those who are not directly discharged are transferred to other longer-stay units in the hospital.

This unit provides intensive crisis intervention with individuals seeking admission. It averages about 64 people a month who receive sufficient crisis intervention to avert in-patient admission.

Skills Learning Program

These four longer-term units each have 19-25 beds. Two of the units treat patients who have an intermediate length of stay of a few months to a year and a half. Patients are involved in a step program, increasing their level of functioning by a process through which the patient has to earn various privileges.

The other two units are for even longer-stay patients. The staff of one of these units have been trained in Psychiatric Rehabilitation by the Center for Rehabilitation, Research and Training in Mental Health of Boston University. This program not only trains staff to better work with patients, but also trains patients in performing the various functions and skills necessary to reach their maximum level of functioning. BMHI is currently working to expand this program to the rest of the Adult Psychiatric Program and to some of the units in the Program on Aging.

Discharge Unit

This 17-bed unit prepares people for discharge by teaching them the skills they will need to function independently outside the hospital, ensuring their ability to stay in the community. In addition two halfway houses, each with six beds, are both functionally part of the Discharge Unit. Both houses stress maximum independent functioning of the house members, providing staff coverage only from 7-9 A.M. and 3-11 P.M. weekdays and all day weekends. House members do their own grocery shopping, meal preparation, etc. Residents are required to have a minimum of 15-20 hours programmed activity a week outside the house.

Mt. Hope Avenue House

Mt. Hope Avenue House became operational December 16, 1986, and serves as an on-grounds group home for six patients who have mental retardation and have special needs as a result of their severe disabilities.

Forensic Services

This 15-bed unit is for male patients who are being evaluated for competency and/or responsibility for alleged criminal acts, who are incompetent to stand trial, who have been found not guilty by reason of insanity, or who are referred from county jails and state prisons and have become mentally ill and in need of inpatient psychiatric treatment.

PROGRAM ON AGING

The Program on Aging of Bangor Mental Health Institute provides treatment for 130 patients, close to half of the total population of Bangor Mental Health Institute. This program holds a unique position in the health care community due to its ability to provide both acute and chronic care for aging individuals of Central and Northern Maine who are mentally and physically ill and due to its joint accreditation by J.C.A.H. as an acute psychiatric program and the Department of Human Services as an Intermediate Care Facility.

The program population consists of elderly patients with the following needs: a) psychiatric patients needing acute care and treatment; b) psychiatric patients requiring chronic, long-term care and treatment; c) organically impaired patients needing behavioral management throughout the progressive course of illness; d) physically chronically ill patients with significant nursing care needs whose behavioral problems cannot be managed in other settings.

All patients in the Program on Aging have a psychiatric diagnosis, and most also have diagnosed physical conditions requiring nursing services at the intermediate care level. Approximately 60 percent of psychiatric diagnoses are in the functional classification, with the remainder predominantly represented by various dementias such as Alzheimer's Disease. More than half of the population consists of long-term patients with prolonged mental illness who grew old in this, or other, institutions. Admissions are now, as before, about equally divided between persons with long-term mental illness transferred from other units of the hospital and those from community facilities. The Program on Aging's Pre-Admissions Geriatric Screening Team, consisting of a nurse, psychologist, and social worker, screens referrals from community health facilities, boarding homes, and individual families concerning the aging client's appropriateness for admission. Discharges are recommended and pursued in situations where no psychiatric and psychological benefit to the patient can be expected to result from continued care and treatment and where no detriment is predicted from alternative living arrangements.

The Program on Aging is organized into four functional units:

Therapeutic Community Unit

These two units, with a total of 32 beds, are for elderly patients who are primarily ambulatory, self-caring, and verbal but who need assertive treatment to remediate their active psychiatric problems.

Adaptive Living Skills Unit

The 32 beds of these two units are for elderly patients who are more chronically mentally and/or organically ill and who need supervision in daily living activities in order to maintain or improve their social-psychological level of functioning.

Resocialization Unit

The two units (33 beds) of this program are geared for patients who have physical and mental illnesses and who need basic socialization and reality orientation to maintain their communication and social skills.

Psychiatric Nursing Home Unit

The two unit, 33-bed nursing home component is primarily for non-ambulatory severely regressed patients who need extensive nursing care to maintain the most healthful quality of life possible.

REHABILITATIVE SERVICES

The programs of Rehabilitative Services span all the components of BMHI and endeavor to provide a comprehensive array of rehabilitative services to all the residents at BMHI. With the exception of workshop services and diversional programming, all rehabilitative services are individualized, goal-oriented, and integrated into each resident's treatment plan.

Physical Therapy Department

The Physical Therapy Department provides both acute treatment and maintenance therapy services, where indicated, to residents throughout the Institute.

Occupational Therapy

The Occupational Therapy Department offers a wide range of traditional O.T. services which include various aspects of activities of daily living evaluation and training, sensory awareness, and remotivation as well as work/activities, work adjustment, and skills training services in its sheltered work program, Benchmark.

Recreation Department

The Recreation Department provides an extensive array of recreational programming, both structured skill-building options as well as diversional activities. These services are available six days a week as well as evenings.

Health Sciences Media Center

The Health Sciences Media Center offers a variety of educational and library services to residents and staff. Such services include evaluation, individual and/or group classes, as well as career guidance and referral services.

Chaplaincy Department

The Chaplaincy Department consists of both Protestant and Catholic clergy who offer pastoral care services to both residents and staff of the Institute. Regular workshops are also offered by the Department.

Volunteer Office

The Volunteer Office provides and coordinates a wide range of volunteer services to programs and individual residents of the Institute.

GOALS AND OBJECTIVES

GOAL I

TO PROMOTE MENTAL HEALTH AND PREVENT MENTAL ILLNESS

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

Public education efforts continue 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. A priority has been placed on initiatives for special populations such as individuals with prolonged severe mental illness as well as elderly persons, substance-abusing persons, and deaf individuals with mental illness.

This year the Department will:

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

- Increasingly 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, individuals with alcohol and drug abuse problems, and persons with serious anxiety disorders and eating disorders.

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

- Continue to 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.

- Continue participation 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.

- Continue to promote mental health and wellness in aging through literature and public service announcements.

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

Recognizing the importance of family, consumer, and community participation, the Department continues to actively support a variety of efforts and initiatives such as regular family educational forums, consumer teleconferencing, the on-going support/development of family support groups throughout the state--as well as of the state family mental health alliance, the expansion of consumer social clubs for psychiatrically disabled persons, and assistance to groups and individuals to enable them to take advantage of both in-state and out-of-state educational opportunities. The September 1986 meeting in Portland with E. Fuller Torrey, M.D. and his discussion of schizoprenia was well attended by both consumers and family support group members from throughout the state and was very enthusiastically received. The 1986 Seventh Annual William E. Schumacher, M.D. Distinguished Lecture Series on Mental Health presented Shervert Frazier, M.D., Director of the National Institute of Mental Health speaking on public responsibility for mental illness.

This year the Department will:

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

- Encourage the growth and involvement of self-help and advisory groups through training for boards and staff of local agencies.

- 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.

- Continue to advocate for the greater involvement of deaf and hearing- impaired consumers and families through the expanded and more appropriate use of interpreter services by the mental health and substance abuse systems.

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

- Encourage peer support and advocacy efforts by consumer groups and organizations such as that conducted by the Portland Coalition for the Psychiatrically Labeled.

- Encourage the development of specific mental disorder-related support groups.

- Promote and develop advocacy and locally-based statewide needs assessment through the jointly funded contract by the Advocates for the Developmentally Disabled and the Bureau of Mental Health with the Maine State Alliance for the Mentally Ill.

- Continue to work with Area Agencies on Aging and community mental health and other related service providers to develop mutual self-help opportunities for caregivers of elderly persons, the bulk of whom are family members.

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 mental health and related health providers. It has conducted or co-sponsored orientations, workshops, and conferences including ones on aging, substance abuse, social security, deafness, housing, case management, and human resource development. 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 Governor's Cabinet Committee on Homelessness, the Community Geriatric Training Committee, and Ingraham Volunteers Training Committee.

This year the Department will:

- Increase consultation and education activities for staff of the Department and other agencies, especially in relation to the priority special populations such as deaf individuals, elderly persons, and other individuals with prolonged mental illness as well as inpatients at the mental health institutes.

- Develop a major statewide consultation training program to operate in boarding and nursing homes caring for elderly residents with mental health problems.

- Promote interagency and interdisciplinary coordination of existing training and educational resources.

- Develop specialized training for mental health staff throughout the state focusing on community mental health and the provision of specific services such as crisis intervention, residential services, case management services, etc.

- Promote the expansion of training and educational opportunities to include mental health disorders such as the anxiety and eating disorders.

- Develop aging and substance abuse training opportunities for professionals through coordinated efforts between the Regional Councils on Alcohol and Drug Abuse and the Area Agencies on Aging.

- Develop training opportunities with the Bureau of Maine's Elderly and the Veteran's Administration for Certified Nurses Aides and other direct care providers in the community and in institutional settings.

- Maintain annual training conducted jointly with the Bureau of Rehabilitation.

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 interagency coordination for the early identification of individuals at risk of developing mental health problems such as elderly persons and the development of a fourth crisis stabilization program in the state, which will be run by Tri-County Mental Health Services.

This year the Department will:

- Continue its emphasis on training, screening, and referral for fetal alcohol effects/syndrome.

- Continue to emphasize the development of increased twenty-four hour outreach crisis services throughout the state.

- Increase preventive mental health activities for vulnerable groups.

- Evaluate, disseminate, and implement the results of the Mental Health & Jails Training Demonstration Project which addresses the increasing role of local jails in dealing with former mental health patients or with persons experiencing severe mental health problems while incarcerated.

- Create training linkages with post-graduate educational initiatives with programs providing 24-hour crisis intervention services.

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 QUALITY OF ASSESSMENTS REGARDING MENTAL HEALTH PROBLEMS FOR SPECIFIC POPULATIONS.

During the past year, the Department has stressed improving the assessment of elderly persons, deaf persons, persons with mental illness who are also having substance abuse problems, and persons with psychiatric disabilities, as outlined in the target group sections. During the past year, as required by statuatory changes, the Department has established a state forensic service to perform assessments of competency and criminal responsibility.

This year the Department will:

- Develop an assessment and certification process in the federally-funded case management pilot program in Portland.

- Through its projects located at the state mental health institutes, continue to develop and refine treatment programs and referral mechanisms for persons with both substance abuse and mental illness problems.

- Develop and implement, through a special demonstration project, a comprehensive functional assessment instrument for elderly persons, living in the community, who have mental health problems.

- Through an expanded dual-diagnosis project, establish a community network of trained mental health/substance abuse providers to appropriately serve dually-diagnosed patients discharged from the state mental health institutes.

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

- Continue 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 throughout the state, using human resource development resources as fully as possible.

GOAL III

TO ASSURE EASILY ACCESSIBLE, ACCEPTABLE MENTAL HEALTH SERVICES.

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

The Department has maintained its emphasis on service accessibility for special dually-diagnosed populations such as deaf and hearing-impaired persons and substance-abusing individuals who also have mental health problems. This year also marked the development of a federally funded mobile psychogeriatric evaluation program. The Department continues its statewide efforts in the development of multi-disciplinary coordination committees for elderly services, especially in Saco, Portland, Lewiston, and Bangor, resulting in an increased awareness of the mental health needs of elderly persons and improved communication between the aging and mental health networks. In addition, continued training and increased knowledge has promoted the greater systems accessibility of community mental health and substance abuse providers.

This year the Department will

- Improve the accessibility of services through the pilot case managment program in the Portland area.

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

- Continue to use Human Resource Development resources as fully as possible to develop and deliver a series of training and educational activities aimed at providers of services to special population groups.

- Continue to improve services for patients with both mental illness and substance abuse problems at the Augusta and Bangor Mental Health Institutes.

- Develop a statewide network of volunteers and providers trained in the issues of poly-chemical use/abuse among elderly persons.

- Continue to work toward improving accessibility of services to elderly persons through active, on-going coordination with community-based aging and mental health service providers.

- Implement a service accessibility plan in each of the eight mental health regions which involves the 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.

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

- Continue Bureau of Mental Health funding of interpreters for community mental health centers and state psychiatric hospitals.

- Continue to provide current detailed information on mental health services throughout the state through the Departmental publication, the Report, as well as through the development of other sources such as booklets, brochures, radio and television, etc.

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

The Department is continuing its emphasis on home-based and outreach services, has maintained its participation on regional transportation planning committees, and has worked extensively for increased and improved mental health care for elderly persons in their homes. Emphasis has, as well, been placed on providing quality outreach crisis services. The three Departmental twenty-four hour outreach crisis programs have been highly effective in meeting the needs of persons experiencing mental health crises. These programs in the Portland and Kennebec and York County areas have been supplemented in this year in the Lewiston/Auburn area by a fourth crisis program, run by Tri-County Mental Health Services, so that all emergency services in Mental Health Service Area IV are now administered by one organization.

This year the Department will:

- Promote increased in-home mental health services for elderly persons.

- Continue its advocacy for improved transportation services.

- Continue to actively promote and develop outreach crisis services and home-based services throughout the state.

- Implement a counselor position, which 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 maintained its strong 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 local planning and development, involving both public and private sectors and including consumers and families.

OBJECTIVE: TO DEVELOP A COMPREHENSIVE CONTINUUM OF SERVICES FOR PERSONS WITH PROLONGED AND DISABLING 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, continue to be a major priority population for the Bureau of Mental Health and the Department.

This on-going commitment to Maine's chronically mentally ill citizens has been 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 continued development of consumer and family groups, the continuing growth in training/educational opportunities for community mental health staff, and the on-going initiatives such as the case management model program.

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

During the last few years, the Department has encouraged the development of psychosocial rehabilitation assessment and treatment skills through increasing general knowledge of psychosocial rehabilitation, the preparation of trainers from all parts of the state through the Research and Training Center of Boston University, 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 ongoing technical consultation, expanding periodic on/off site training, and continuing to sponsor Summer Institutes in Rehabilitation.

- Develop and establish a focal coordination point for psychiatric rehabilitation training in the state.

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

Over the past several years, the Department has actively supported the development of a range of housing alternatives in Maine from highly structured supervised homes to independent affordable arrangements. There are now over twenty specific programs throughout the state offering a variety of options. The last two of the original four Medicaid waiver demonstration residential programs will complete their waiver participation in this fiscal year. The Department, with the support of the Legislature, has continued to provide expanded transitional and emergency housing and supervised, subsidized apartments. Efforts to establish specialized, structured housing for deaf persons with psychiatric disabilities were successful with the April 1986 opening of the Caron Street Transitional Program. In addition, a grant was awarded to a Bangor community agency for a housing coordinator to assist individuals with mental illness to locate housing as well as provide help with related housing costs from a revolving fund. Progress was made in the development of a residential program in the Bangor area for elderly persons with mental health problems with the opening of the program anticipated for late fiscal year 87.

This year the Department will:

- Continue on a local level to indentify gaps in housing, target resources to housing development activities, and implement recommendations of the homelessness task force and the Governor's Cabinet Committee on Homelessness.

- Continue to work with mental health agencies providing community support services to improve support and advocacy for people needing expanded low income housing such as the focus on homeless individuals in the pilot case management program in Portland.

- 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 for elderly persons with mental illnesses and dementias including: a) continued development of the Finson Road boarding home in the Bangor area for elderly persons with prolonged mental illness and b) continued involvement with the Bureau of Maine's Elderly residential resource center for victims of Alzheimer's Disease.

- Assist with the development of increased specialized residences for people with mental illness in the Portland area.

- Utilize Human Resource Development resources to address the training and educational needs of staff implementing the case management homelessness project in Portland.

SUB-OBJECTIVE: INCREASE VOCATIONAL OPTIONS.

During the past year, the Department has worked with the Bureau of Rehabilitation to strengthen vocational programs in Aroostook, Kennebec, and Cumberland counties. The Department, in cooperation with other public and private agencies, has expanded supported employment opportunities in Franklin and Cumberland counties, and similar efforts are underway in Knox county. The Department has been actively involved in the development of program standards for vocational programs and in the development of services for severely emotionally disabled young adults who, because of their age, are no longer able to receive services from the educational system. The Department has continued to provide assistance to local planning/coordinating groups in Cumberland, Androscoggin, and Penobscot counties, and the Department has coordinated staff training in vocational rehabilitation through the New England Psychiatric Rehabilitation Training Program.

This year the Department will:

- Develop and implement a joint rehabilitation training program with the Bureau of Rehabilitation for community support practitioners and vocational rehabilitation counselors.

- Continue to coordinate training efforts.

- Continue to provide consultation to local planning groups.

- Continue to work with facilities to implement program standards.

- Continue efforts with families and other state agencies to enhance vocational opportunities for persons who are psychiatrically disabled - such as through the Maine State Alliance for the Mentally Ill vocational advisory subcommittee.

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 Lewiston/Auburn areas.

This year the Department will:

- Continue to enhance and expand social rehabilitation opportunities as resources will permit.
- Develop standards for socialization programs in conjunction with consumer social clubs.
- Use Human Resource Development resources to support training/educational needs of local groups involved with individuals who have psychiatric illness.

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

The Department, through the Elderly Services Coordination Project, generated funding and resources for the development of services to elderly persons through federal grants. In addition, consultation and education initiatives are currently being developed for clinicians, aging services professionals, and caregivers. The Department continues to work with Regional Aging and Mental Health Coordinating Committees to identify areas of need at the community level and to explore means for addressing the needs. All activities are conducted in conjunction with the Bureau of Maine's Elderly and are overseen by the Joint Advisory Committee on Mental Health Services to Elderly Persons.

This year the Department will:

- Increase housing options for psychiatrically disabled elderly persons.
- Implement its Administration on Aging-funded mobile consultation and training program to operate in boarding and nursing homes statewide.
- Increase the role of Regional Coordination Groups and the Joint Advisory Committee in the planning process for mental health services to elderly persons.
- Implement its National Institute of Mental Health-funded demonstration project for community-based care to elderly persons with serious mental illness.

- Continue working with the Bureau of Maine's Elderly to improve care to elderly persons with mental health problems.

- Implement its legislatively mandated assessment and consultation program for nursing homes in eastern Maine in cooperation with community-based aging and mental health services providers.

- Establish a statewide training program and resultant network of volunteers/agencies with a greater understanding of the problems associated with poly-chemical use/abuse among elderly persons.

- Develop and 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 with resources and assistance from Human Resources Development.

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

Within the last three years, the Department has taken important steps to increase and enhance a variety of services for deaf persons with mental health problems throughout the state: consumer involvement, service coordination, education, and outreach, and community and inpatient services. Use of interpreters in mental health service situations is continuing to increase; 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 persons has been developed and opened in the Portland area in April 1986; and work and consultation 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 initiatives section.

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

- Enhance the ability of community mental health centers to work with deaf clients by establishing a 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, making use of Human Resource Development resources where possible.

- Assess communication skill levels of program staff providing direct services to deaf persons and recommend measures for skill development.

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

- Promote support groups for deaf parents experiencing problems with hearing children.

- Work closely with the Maine Association of the Deaf to develop additional support services for deaf persons experiencing mental health problems.

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 enacted in October 1984 and last amended in October 1986 with the establishment of detailed procedures for a hearing process for disputes between mental health patients and treating professionals. In addition, as required by statute, a broadly-based rights advisory group, charged with monitoring and making recommendations regarding implementation of rights regulations, has been established.

This year the Department will:

- Develop and implement patient rights materials appropriate to the communication needs of deaf persons.

- 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.

- Implement, coordinate, and refine procedures for the hearing process.

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 assure an appropriate balancing of the need for protection and the need for advocacy of incapacitated clients of the department.

- Continue to streamline administrative procedures for obtaining a guardianship and/or conservatorship.

- Develop and adopt protocols for health care decisions regarding the withholding or withdrawal of life-sustaining procedures for 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 has continued to be an on-going priority. The development of programming for deaf and hearing-impaired persons has been emphasized through the continuation of the statewide Deaf Services Coordinator position, the increase in interpreter services funding, inter-program and agency coordination, and the provision of increased consumer, provider, and public education.

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.

An increasing emphasis has been placed by the Department on this population with importance put on the development of comprehensive case management services, 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 growing development of local planning/coordinating groups.

This year the Department will:

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

- Develop quality assurance and monitoring capability and procedures through the focus on this population group by the pilot case management project.

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

With its emphasis on community support systems, the Department is continuing to examine case management models and systems and has awarded a contract for the establishment of a pilot case management program in Portland.

This year the Department will:

- Implement the model case management program 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.

At the same time that the Department has been working toward fully integrating interagency and program linkages and coordination within the mental health system itself,

it has also been actively seeking to coordinate its efforts with other allied providers and systems. Examples of such coordination are numerous and include working with the Office of Deafness and the Division of Residential Care, DHS, Governor Baxter School for the Deaf, and Goodwill Industries in expanding and refining appropriate services for deaf persons with mental health problems; working with the Bureau of Medical Services on the inclusion of Medicaid case management services and administration 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, continuing its work on the Interdepartmental Committee with the Departments of Human Services, Corrections, and Educational & Cultural Services; working with the Maine State Housing Authority and other agencies and groups on both the task force on homelessness and the subsequent Governor's Cabinet Committee on Homelessness; and working with the university and college systems in Maine to expand and increase mental health and allied education and training opportunities.

This year significant intersystem efforts will occur:

- Between the Bureau of Mental Health and DHS Bureau of Medical Services to include Medicaid case management services and 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 severe and prolonged 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 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 and through the Departmental representative on the Maine State Education Committee, 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 various broad-based regional coordinating groups which coordinate and better use existing resources, identify gaps, and develop strategies for enhancing an integrated and coordinated mental health delivery system in their areas for elderly persons, persons with special housing needs, persons with severe and prolonged mental illness, etc.

- 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 a certification, training, and standards process for a range of community support staff.
- Develop and disseminate standards for assessment and monitoring of local community support systems.
- Collect data for the Minimal Manpower Data Set.
- Continue and disseminate its Human Resource Development mental health in jails education and training initiative.
- Develop a computer literacy program for service administration using the Minimal Manpower Data Set.
- Develop Human Resource Development training and education alternatives for mental health providers and administrators, building and expanding on existing and successful linkages with educational institutions and executive leadership in the private sector.
- Continue casework supervision seminars established through the Human Resources Development program.
- Involve administrators of local agencies in quality assurance and JCAH training.

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

Dramatic progress has been made in recent years toward the development of a comprehensive statewide 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. Although there remains a substantial amount left to be done in establishing an adequate data collection and analysis system, the beginning of this process 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.

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

- Continue to monitor 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 Bureau of Children with Special Needs was established by legislative action effective September 15, 1985. This action entailed the transfer of over $1,600,000 in state and federal funds from the Bureau of Mental Health as the new Bureau assumed responsibility for community mental health services to children and their families.

In the past year, the Bureau of Children with Special Needs has developed a contracting and monitoring system for its community services funding in collaboration with the Bureau of Mental Health. This collaboration has assisted the new Bureau in addressing its financial, planning, and management responsibilities.

Next year the Bureau of Mental Health will:

- Continue to work closely with the Bureau of Children with Special Needs on mutual resource development and service issues.

- Share client and financial data to enhance information system development and planning capabilities.

- Work jointly on shared reporting requirements; e.g. federal block grant applications and reports.

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

Public involvement in mental health planning has continued to be one of the highest priorities for the Department. The Department has sought participation through a variety of means - task forces, advisory groups, workshops and seminars, regional coordinating/planning efforts, surveys, and statewide public forums - placing great value and importance on such participation. Recent legislative action directed family/consumer involvement on the Boards of Directors of Bureau of Mental Health-funded agencies.

This year the Department will:

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

- Ensure that all public mental health forums and information efforts are communication-accessible to Maine's deaf citizens.

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 and services provided 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:

- Implement the client reporting system developed last year by a task force of providers and representatives of the Bureau of Mental Health and the Bureau of Children with Special Needs.
- Utilize the client reporting system to establish direct reporting between the Department and the National Institute of Mental Health.
- Assure timely and accurate reports and analyses required by state and federal agencies.
- Work with the Human Resource Development staff to integrate the Minimal Manpower Data Set with other data bases being developed by the Bureau.

OBJECTIVE: TO MAINTAIN HIGH STANDARDS OF FISCAL ACCOUNTABILITY.

The Department has continued to improve 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, increased contract management and audit capacities, refinement of contract budget and quarterly reporting formats, and the 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. This involves the re-establishment of management analyst services in all regions.

- Follow up on correcting problems identified in Department audits.

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

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

- 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:

- Continue to consolidate changes in the levels of licensure.

- Examine and implement further specifications to clarify mental health licensing regulation.

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

OBJECTIVE: TO MONITOR RECIPIENT RIGHTS IMPLEMENTATION.

The Department is continuing its active 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 patients' rights implementation through its licensing authority.

- Work with the newly established Mental Health Rights Advisory Board to ensure the effective implementation of patients' rights in the state mental health institutes.

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

The Department, as a part of its federal reporting requirements, will evaluate the Medicaid 1115 Waiver data for the two sites which have already completed their participation and the two which will complete their involvement in April and May 1987.

This year the Department will

- Increase the Department's 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 greatly increased Medicaid reimbursement for mental health clinic services and allowed reimbursement for the first time for day treatment services and for a variety of services to children. In the first year of implementation (fiscal year ending June 30, 1986), this new structure of Medicaid reimbursement for mental health services at community mental health centers has increased federal Medicaid reimbursement from $968,869 in Fiscal Year '85 to $2,133,342 in FY86, a 120.2% increase.

This year the Department will:

- Continue to work with the State Medicaid agency to explore avenues for further Medicaid reimbursement for mental health services. Specifically, reimbursement for case management services for residential programs will be pursued.

- Seek additional grant resources for services to elderly persons.

- Continue to work closely with the Bureau of Rehabilitation to improve the availability and quality of vocational rehabilitation services to persons with mental illness.

- Work with community Medicaid providers to maintain and expand currently available reimbursements by assuring compliance with program and record-keeping requirements.

- Continue to work closely with the Division of Deafness, Bureau of Rehabilitation to increase service options to deaf persons in Maine.

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

Ralph Lowe, Public Information Officer
Jamie Morrill, Alcohol & Substance Abuse Coordinator
Richard Estabrook, Chief Advocate

BUREAU OF MENTAL HEALTH 289-4230

, Director
Michael Hopkins, Field Operations Manager
Katherine Murray, Management Analyst - Southern Agencies (772-6222)
Chris Cotnoir, Management Analyst - Northern Agencies (289-4230)
Mary Jo Blazek, Director of Licensing & Evaluation
Julita Klavins, Planning & Research Associate
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 289-4238

Susan Wygal, Director 289-4238
Marjorie Hill, MH Program Coordinator, Service Areas I,II,& VIII (941-4152)
Joan Smyrski, MH Program Coordinator, Service Area III (872-7661)
Brenda Harvey, MH Program Coordinator, Service Area IV (795-4536) and
Vocational Liaison (289-4238)
Martin Gouzie, MH Program Coordinator, Service Area V (773-0902)
, MH Program Coordinator, Service Area VI (282-4250)

CRISIS STABILIZATION PROGRAM

AUGUSTA/WATERVILLE - After hours & weekends - 1-800-322-2274 Ext. 150

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

PORTLAND - After hours & weekends - 1-800-322-2274 Ext. 122

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

YORK COUNTY - After hours & weekends - 1-800-322-2274 Ext. 151

, MH Program Coordinator
Anne Daly, Crisis Program Supervisor
Carey Paradis, Crisis Worker

HUMAN RESOURCES DEVELOPMENT 289-4203

Frank O'Donnell, Staff Development Coordinator
Peter Ezzy, Human Resources Development Project Director

AUGUSTA MENTAL HEALTH INSTITUTE 289-7200

William Daumueller, Superintendent
Richard Hanley, Assistant to the Superintendent
Walter Rohm, M.D., Clinical Director
Victor Perreault, Chief of Special Services
Peter Swartz, Director of Volunteer Services
Thomas Ward, Patient Advocate

BANGOR MENTAL HEALTH INSTITUTE 941-4000

Charles Meredith, M.D., Superintendent
Roger Wilson, M.D., Clinical Director
Russell Taylor, Business Services Manager
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
Shirrin 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
Jacquelyn C. Dodge, Penobscot CASSP Coordinator (941-4400)
Kimberly Strom, York CASSP Coordinator (282-7313)
Dale Stephenson, Cumberland CASSP Coordinator (772-3026)

INTERDEPARTMENTAL COORDINATING COMMITTEE

Nancy Warburton, Executive Director (289-4203)
Susan Bumpus, Program Assistant (289-4250)
Roxy Hennings, Program Assistant (289-4203)

REGION I

AROOSTOOK MEDICAL CENTER	
In-Patient Unit	768-4731
AROOSTOOK MENTAL HEALTH CENTER	
Administration	498-6431
Help Line	1-800-432-7805/762-4851
Skyhaven (Transitional Living	764-0759
Residence)	764-0759
New Vocations	498-2528
Caribou Apartments	498-3007
Caribou Office (clinical)	493-3361
Fort Kent	834-3186
Houlton	532-6523
Madawaska	728-6341
Presque Isle	764-3319
Van Buren	868-5236
BUREAU OF MENTAL HEALTH/ DMH&MR	
Marjorie Hill, Mental Health Program Coordinator	941-4152
HOSPITAL INDUSTRIES PROGRAM	768-4000
THE SOUTHERN AROOSTOOK ALLIANCE FOR THE MENTALLY ILL	532-3572
VALLEY FAMILY SUPPORT GROUP	728-4610
THE VALLEY AMI CENTER	728-4806

REGION II

BANGOR MENTAL HEALTH INSTITUTE	941-4000	
Administration	941-4036	
Admissions	941-4134	
Halfway Houses	941-4275/6	
BLUE HILL HOSPITAL	374-2836	
Administration	374-2836	ext. 130
Mental Health Unit	374-2836	ext. 165
BUREAU OF MENTAL HEALTH/ DMH&MR		
Marjorie Hill, Mental Health Program Coordinator	941-4152	
CITIZEN'S INTEREST GROUP	941-4152	
COMMUNITY HEALTH AND COUNSELING SERVICES		
Administration	947-0366	
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	866-4214	
Bangor Outpatient	947-0366	
Children's Clinical Services	947-0366	
Big Red Redemption	947-5117	
Handiperson Program	947-0366	
Bar Harbor Office	288-3363	
Dover Foxcroft Office	564-8175	
Ellsworth Office	667-5357	
Machias Office	255-8311	
Millinocket Office	723-9739	
Calais Office	454-2928	
Lincoln Office	794-3554	
DOWNEAST ALLIANCE FOR THE MENTALLY ILL	**941-4152 (Days)** 989-4604 (Evenings)	
EASTERN MAINE MEDICAL CENTER	947-3711	
Administration	947-3711	ext. 7090
Emergency Room	947-3711	ext. 8000
Psychiatric Inpatient	947-3711	ext. 8573
OPPORTUNITY HOUSING, INC.	947-2739 or 947-6809	
THREE HUDSON STREET	947-0202	
TOGETHER PLACE	941-2897	
Loaf n' Ladle	941-2999	
Check Out Cleaning	941-2897	

REGION III

AUGUSTA ALLIANCE FOR THE MENTALLY ILL	377-2078
AUGUSTA MENTAL HEALTH INSTITUTE	289-7200
BUREAU OF MENTAL HEALTH/DMH&MR	
Joan Smyrski, Mental Health Program Coordinator	872-7661
CRISIS AND COUNSELING CENTERS	
Augusta	623-4511
Skowhegan (Office)	474-2506
(Crisis)	1-800-452-1933
CRISIS STABILIZATION PROGRAM/ BUREAU OF MENTAL HEALTH	
AUGUSTA/WATERVILLE AREA (24-hr. #)	1-800-322-2274 Ext. 150
WATERVILLE OFFICE	872-7661
DHRS FAMILY & MARRIAGE COUNSELING & HOME CARE SERVICES	
Augusta	622-0188
Waterville	873-1146
Skowhegan	474-5231
HOSPITAL INDUSTRIES PROGRAM	873-0621
KENNEBEC VALLEY MEDICAL CENTER (Augusta)	626-1000
KENNEBEC VALLEY MENTAL HEALTH CENTER	
Administration	873-2136
Day Program - Augusta	622-0442
Inpatient (Mid-Maine Medical Center)	872-4354
Augusta Offices	
Stone Street	622-3138
Hill House	622-0442
Skowhegan Office	474-8368
Waterville Office	873-2136
KENNEBEC VALLEY REGIONAL HEALTH AGENCY	
Waterville	873-1127
Augusta	622-0765
122 State Street	622-0126
Hill House	622-0441
MID-MAINE ALLIANCE FOR THE MENTALLY ILL	873-3073
(Waterville)	873-3672

MID-MAINE MEDICAL CENTER	872-1000
MOTIVATIONAL SERVICES (MOCO)	
Administration	622-6273
LINC Office	626-0020
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
VETERANS ADMINISTRATION CENTER & HOSPITAL	623-8411

REGION IV

AREA IV MENTAL HEALTH SERVICES COALITION (Advocacy)	782-2273	
Area Coordinating Council (Transitional Services)	782-2273	
100 Pine Street (Social Club & Supervised Apartments)	782-2273	
ANDROSCOGGIN HOME HEALTH SERVICES		
Psychiatric Nursing	784-9304	
BUREAU OF MENTAL HEALTH/ DMH&MR		
Brenda Harvey, Mental Health Program Coordinator	795-4536	
FARMINGTON ALLIANCE FOR THE MENTALLY ILL	778-3429	
Respite and Supportive Apartment Program	778-3556/778-3429	
FORTY-SEVEN WOOD STREET	784-6996	
FRANKLIN MEMORIAL HOSPITAL		
Emergency Psychiatric Services	778-6031	
RELATIVES AND FRIENDS TOGETHER FOR SUPPORT-AMI	784-7632	
ST. MARY'S HOSPITAL	786-2901	
Administration	786-2901	ext. 3107
Psychiatric Unit	786-2901	ext. 2624
TRI-COUNTY MENTAL HEALTH SERVICES	783-9141	
Administration	783-9141	
Emergency	783-9141	
Day Treatment (Day Center)	783-4667	
Transitional Employment	783-4667	
The Depot	783-4661	
Social Learning Center	783-4672	
Farmington Office	778-3556	
Lewiston Office	783-9141	
Norway Office	743-7911	
Rumford Office	364-7981	

REGION V

ALLIANCE FOR THE MENTALLY ILL	774-4357
AMITY CENTER (Social Club & Transitional Employment Program)	772-1248
BUREAU OF MENTAL HEALTH/DMH&MR	
Martin Gouzie, Mental Health Program Coordinator	773-0902
CARON STREET (Deaf Transitional Program)	797-8046
COMMUNITY COUNSELING CENTER	874-1030
Falmouth Office	781-3413
Gorham Office	839-6436
Westbrook Office	874-1030
CRISIS STABILIZATION PROGRAM/ BUREAU OF MENTAL HEALTH	1-800-322-2274 ext. 122
DHRS HOLY INNOCENTS HOME CARE SERVICE	
Case Management Services	871-7431
INGRAHAM VOLUNTEERS, INC.	
Administration	874-1055
Dial INFO	774-HELP
Deaf Services	TDD 773-7321
	1-800-492-0859
Dial KIDS	774-TALK
BRIDGE Shelter	
Staff	871-7211
Residents	871-1493
JACKSON BROOK INSTITUTE	761-2200
MAINE MEDICAL CENTER	871-0111
Administration	871-2491
Emergency Room	871-2381
Adult Day Program MH	871-2221
Child Psychiatric	871-2428
Psychiatric Unit	871-2581
Therapeutic Nursery	773-0361
Hospital Industries Program	871-2463
MENTAL HEALTH ASSOCIATION OF THE CUMBERLAND REGION, INC.	772-6222
PORTLAND COALITION FOR THE PSYCHIATRICALLY LABELED	772-2208

SHALOM APARTMENTS	874-1090
SHALOM HOUSE	874-1080
WESTERN MAINE COUNSELING SERVICES	
Administration	647-5629
Adolescent Day Treatment	647-8345
Western Maine School	647-8345
Bridgton Office	647-5629
Fryeburg	647-5629
Raymond	647-5629
WORKPLACE LAB PROJECT	
University Industries Program	780-5455

REGION VI

CREATIVE WORK SYSTEMS	282-4173	
CRISIS STABILIZATION PROGRAM/ BUREAU OF MENTAL HEALTH	1-800-322-2274	ext. 151
SOUTHERN MAINE MEDICAL CENTER	283-3663	
Administration	283-3663	ext. 220
Emergency room	283-3663	ext. 100
Psychiatric Unit	283-3663	ext. 460
Crisis Hot Line	282-6136	
	1-800-345-3498	
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	
YORK FAMILY SUPPORT GROUP	282-7789	

REGION VII

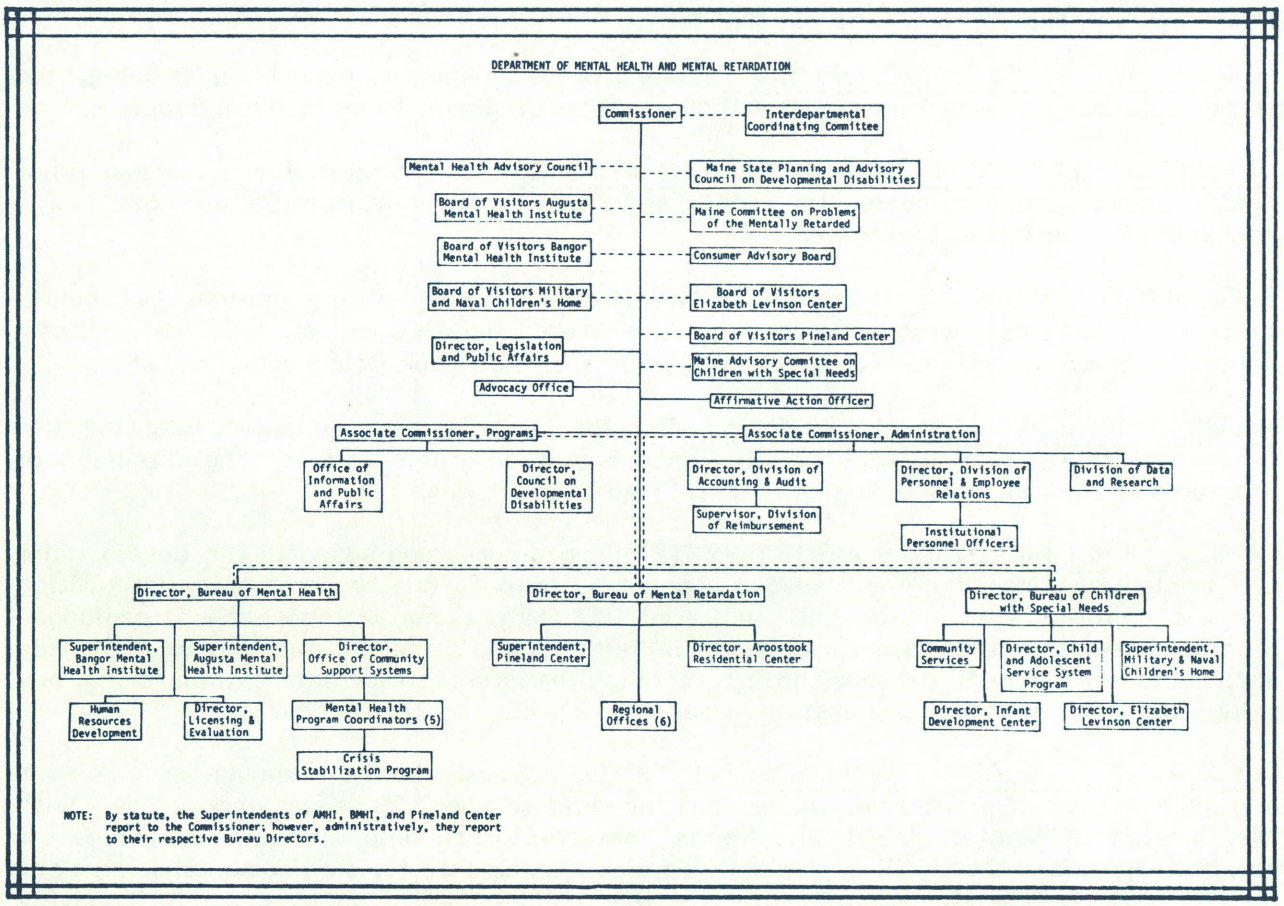
BATH-BRUNSWICK AREA MENTAL HEALTH CENTER		
Administration	729-4171	
Emergency Services	729-4171	
Day Hospital	729-1631	
Full Circle Program	729-8706	
Merry Meeting Treatment Center	666-5583	
Bath Office	443-3301	
Boothbay Harbor Office	633-5513	
Brunswick Office	729-4171	
Damariscotta Office	563-3902	
BATH-BRUNSWICK FAMILY SUPPORT GROUP (SEA-AMI)	443-3576	
DIRIGO RESOURCES	443-1386	
REGIONAL MEMORIAL HOSPITAL		
Administration	729-0181	Ext. 345
Emergency Room	729-0181	ext. 234
Psychiatric Unit	729-0181	ext. 285

REGION VIII

BUREAU OF MENTAL HEALTH/DMH&MR		
Marjorie Hill, Mental Health Program Coordinator	941-4152	
COASTAL ALLIANCE FOR THE MENTALLY ILL	594-9368	
MID-COAST MENTAL HEALTH SERVICES		
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		
Administration	594-9511	
Emergency	594-9511	ext. 130 or 140
Psychiatric Unit	594-9511	ext. 246

APPENDIX 1

DEPARTMENT ADMINISTRATIVE STRUCTURE



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; the Maine Advisory Committee on Children with Special Needs; 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, parent 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 Office of Information and Public Affairs.

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

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

OFFICE OF INFORMATION AND PUBLIC AFFAIRS: Responsible for press and other media liaison and for developing and distributing public information and developing educational experiences and materials.

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

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

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 severe and prolonged mental illness and strengthens the ability 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 IDC 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

Joan Fortin, Chairperson

John Ballou, Esq.
William Barnum, M.D.
Henrietta Benedetto
Shapour Borna, Ph.D.
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Councilmember Marian E. Gowen died this past year and will be greatly missed by all of us. The Council and Department gratefully acknowledge her work and dedication to quality mental health services for all of Maine's citizens.

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* Serves as the joint mental health advisory committee on elderly issues to both the Bureau of Mental Health in the Department of Mental Health and Mental Retardation and the Bureau of Maine's Elderly in the Department of Human Services.

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