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Maine Comprehensive Mental Health Services Plan

Maine Department of Mental Health and Mental Retardation

MAINE COMPREHENSIVE MENTAL HEALTH SERVICES PLAN

MENTAL HEALTH SERVICES FOR ADULTS WITH SEVERE AND PROLONGED MENTAL ILLNESS

Revised Annual Plan and Progress Report
submitted to the
National Institute of Mental Health

Robert W. Glover, Ph.D., Commissioner
Maine Department of Mental Health and Mental Retardation

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MAINE ADULT MENTAL HEALTH SERVICES PLAN - 1991

The Maine Adult Mental Health Services Plan serves a number of different purposes. Both the planning process and the document itself are tools for designing and creating an improved mental health services system based on shared values articulated by the many Maine citizens involved in its ongoing development. It also presents goals and objectives with the specific activities needed to meet the mental health needs of Maine's citizens with severe and prolonged mental illness, as well as progress in meeting those goals and objectives. Finally, the report provides information on mental health services, programs, needs, and funding in Maine.

MISSION AND VALUES

The mental health service system in Maine is complex and encompasses a range of activities designed to meet a variety of needs. This system of services 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 related services. The Department of Mental Health and Mental Retardation, 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 for persons with severe mental disorders in settings most appropriate to their needs and the needs of their families.

The mission of the Maine Department of Mental Health and Mental Retardation has guided, with the advice and involvement of the Maine Mental Health Planning Council as well as other advisory groups and community input, the development of this adult mental health services plan. That mission is to support, empower, and enable individuals and families to enjoy an improved quality of life through effective stewardship of public resources. Certain important operating assumptions, or values, underlie the Department's approach to carrying out its mission:

1. The needs of people as unique individuals will be recognized by department policy and reflected in direct and indirect services.

2. Individuals and their families will be given the highest consideration and involvement in the development of services and department policy.

3. People should live, learn, and work in their communities, and this should be reflected in the system of services developed.

4. There should be opportunities for self-sufficiency through the presence of choices.

5. Services should be flexible and diverse, recognizing the changing needs of individuals and their families.

6. Services chosen by individuals and their families will be provided in a coordinated and collaborative way.

7. These assumptions will be reflected in a management structure which incorporates individual outcomes, collaborative planning at both an individual and system level, communication, accountability, maximization of Federal/State resources, responsiveness to constituent needs, quality assurance at both an individual and system level, privatization of services, and new ideas and concepts.

MODEL FOR MAINE'S MENTAL HEALTH SERVICE SYSTEM

The overriding goal of an effective mental health system is to make services and supports available and accessible to a person while encouraging or maintaining independence and a decent quality of life. While this does not preclude needed periods of inpatient care, it minimizes unnecessary hospitalizations by assuring timely and appropriate interventions and efforts to provide needed basic supports.

It is the premise of this plan that a system of care for people with severe and prolonged mental illness should be developed which promotes their dignity and affirms all the rights accorded by their humanity and citizenship. Consistent with this value, services should be provided in a manner culturally and age appropriate as well as specific to the nature of the community and the needs of the individuals. These services should be provided in the most humane, integrated, and least restrictive manner appropriate to their needs.

On a state and local level, there are values and principles which guide the development of a system of care for persons with severe and prolonged mental illness:

Individualized Services:

Services should be organized to meet the needs of each psychiatrically disabled person, rather than the needs of the system or the needs of service providers. The choices, goals, and needs of local clients should drive the system of services. Self-determination should be valued and promoted, and clients should be enabled to gain as much control as possible over their own lives. Services should be responsive to the unique and changing needs of individuals. Clients should not have to accommodate themselves to programs that are not responsive to their particular needs. While services may be offered to groups of clients, services should remain individualized.

Availability of a Comprehensive Range of Services and Supports:

The development of a system that fulfills a comprehensive range of functions is necessary. These functions or services and supports include four major categories: Integrating Services, Basic Supports, Treatment Services, and Rehabilitation Services. These functions cannot be viewed as separate or isolated elements because they interact in important ways. The development of a local system that emphasizes one of these areas over another will reduce the effectiveness of the system as a whole and reduce the potential for adequate community adjustment for seriously psychiatrically disabled persons.

Flexibility in Service Provision:

The development and delivery of services and supports should be as flexible as possible in order to meet the wide diversity of individual needs of persons in the area. Flexibility includes the need to ensure that the comprehensive range of functions are available and accessible to all clients

in the area rather than targeting one set of functions to only one segment of the disabled population. Flexibility also includes having a wide variety of services, of variable intensity, available at a wide range of times, as well as the ability to deliver the services in a wide range of environments, as necessary, to meet individual needs.

Coordination of Needed Services and Supports:

The functions of a local system are often undertaken by multiple agencies, both public and private. The range of services and supports must be coordinated both on a local systems level and on an individual client basis in order to reduce fragmentation and to improve the efficiency and effectiveness of service delivery. Agencies must work in collaboration to meet the variety of needs that people with psychiatric disabilities have.

Locally Relevant Services:

The development and delivery of a range of services should take into account the particular local environment and the needs of specific cultural and ethnic sub-groups within the group of psychiatrically disabled citizens in the area. Each local system should build on existing resources and be responsive to local needs. The "ideal" system components may look very different from one area to another, as they are tailored to locally relevant needs and resources.

Long-Term Continuity and Commitment to the Target Population:

The local system should strive to meet the needs of psychiatrically disabled persons in a manner that insures both long-term continuity across service settings and continuity as client needs change. The local system must make a commitment to serving severely disabled people collectively and to serving each individual client over the long-term.

Involvement of Primary Consumers and Their Families in Policy and Planning:

The local system should always involve consumers and families in policy development and in the planning of the local system. Primary consumers and families should be involved in policy making, program planning and development, as well as in the development of individual service plans.

There are four discrete functions in a community system for persons with psychiatric disabilities. The interaction of these four functions and their complementary components determines the degree to which psychiatrically disabled men and women can achieve and maintain an adequate quality of life. The relationship of these functions shows that an effective system of services and supports for rehabilitation and treatment is person-centered, is consistent and comprehensive, and provides long-term continuity of care.

These key system functions are

1) Integrating Services
   (which includes community support
   and intensive case management),
2) Basic Support Services,
3) Treatment Services, and
4) Rehabilitation Services.

Each psychiatrically disabled person requires an individually tailored comprehensive program which integrates all four service system functions.

This model, detailed in Maine's Community Systems Workbook, lends itself to a range of organizational structures and program designs.* It provides a conceptual framework for an "ideal" system of services and supports for psychiatrically disabled persons based on specific system principles and functions. It is intended to provide a common language and a tool for the discussion, assessment, and planning of local mental health systems. This report and the goals and objectives summarize, according to the conceptual model, what is and is not in place and what is needed toward the development of the ideal system of services.

* Michael J. DeSisto, Ph.D., Priscilla Ridgway, M.S.W., and George Erikson, M.S. Maine's Community Systems Workbook: Meeting the Needs of Psychiatrically Disabled Persons for Treatment, Support, and Rehabilitation. Bureau of Mental Health, Maine Department of Mental Health and Mental Retardation. Augusta, Maine: 1986.

PRIORITIZED STATEWIDE MENTAL HEALTH SERVICE NEEDS

Strong statewide themes, remarkably similar for children, adolescents, and adults, emerged with the start of the comprehensive local planning process as the identified needs clustered into larger areas. This is reflected in the statewide needs prioritization which follows.

EXTRAORDINARY MEASURES TO RECRUIT AND RETAIN MENTAL HEALTH PROFESSIONALS, INCLUDING EDUCATION/TRAINING ACTIVITIES, IN ORDER TO ALLEVIATE SIGNIFICANT SHORTAGES OF MENTAL HEALTH PROFESSIONALS THROUGHOUT THE STATE, ESPECIALLY THOSE WITH SPECIALIZED EXPERTISE.

Several concerns are reflected in this cluster:

A. By far, the largest issue raised was that of both initial and on-going educational/training opportunities for mental health providers:

- Encouraging Maine residents, including those from minority cultures such as Native American, Southeast Asian, and Deaf, to go into mental health professions was a special focus;
- Making initial education/training available and accessible were felt to be two major necessary initiatives;
- Providing on-going and specialized training was seen as critical to retaining these and other professionals and to individualizing services; and
- Developing cross-training was of special concern: mental illness/substance abuse, mental illness/minority cultures, mental illness/minority cultures/substance abuse, mental illness/deafness/children, mental illness/mental retardation, mental illness/offender.

B. Severe shortages of mental health professionals in both the public and private sectors in various regions of the state also pointed to recruitment and retention problems in relation to the generally low salaries in the mental health system. Low salaries make both initial hiring more difficult and retention and high staff turnover a major problem. It was acknowledged that incentives must be created to not only recruit but retain mental health personnel. Overall shortages were seen as being even more concentrated in mental health fields requiring specialized expertise as in the psychogeriatric and early childhood fields.

A GREATLY EXPANDED AND IMPROVED COMMUNITY SERVICE SYSTEM CAPABLE OF RESPONDING TO SPECIALIZED INDIVIDUAL MENTAL HEALTH NEEDS, INCLUDING PERSONS OF MINORITY CULTURES AND/OR WITH DIAGNOSES SUCH AS DEAFNESS OR SUBSTANCE ABUSE AND THOSE WITH THE MORE SEVERE FORMS OF MENTAL ILLNESS.

This cluster represents primarily three major areas (in priority order):

- Development of new program initiatives, especially for specialized services as noted above. This was seen as a particularly important need by the Minority Cultures Subcommittee.

. Flexible funding for greater individualization of services - services should fit the needs of the individual not the other way around.
. Expansion and improvement of the funding base for existing community mental health programs.

A BROAD, INCREASED RANGE OF RESIDENTIAL ALTERNATIVES INCLUDING LONG-TERM OPTIONS AND THOSE DIRECTED TOWARD SPECIALIZED COMPLEX NEEDS.

This cluster includes a variety of needs:

. Affordable housing in general;
. Psychogeriatric boarding and nursing homes;
. Mental illness/substance abuse group homes;
. Deafness supervised apartments;
. Mental illness/mental retardation residential programs;
. Child & adolescent therapeutic foster and group homes, emergency, crisis, & respite beds; and
. Specialized residential programs for mentally ill offenders with additional special needs.

The importance of linking supportive services to the individual, whenever possible and as much as possible, rather than to a facility, was underscored by several groups.

A STATEWIDE CASE MANAGEMENT SYSTEM COORDINATING AND ASSURING APPROPRIATE INDIVIDUALIZED SERVICE PROVISION FOR THOSE WITH MENTAL ILLNESS.

While it was stressed that case management without services is meaningless, the need to begin developing a statewide system of coordinating individual services in order to assure accessible, appropriate, and timely service provision for each mentally ill individual was identified as one of the major priorities by planning groups and community forums.

GREATLY EXPANDED HOME-BASED/OUTREACH SERVICE PROVISION - SERVICES DELIVERED WHERE THE INDIVIDUAL IS.

Home-based and outreach services were most often cited as major needs by the more vulnerable population groups and also include reaching out with services to sites other than homes such as workplaces, schools, and social centers:

. Mentally ill elderly persons;
. Mentally ill and mentally retarded persons;

. Mentally ill and deaf persons; and
. Children & adolescents with serious emotional disorders, including assessment, therapy, counseling, clinical outreach teams services, esp. for juvenile sex offenders.

PROVISION OF TRANSPORTATION SERVICES FOR THOSE WITHOUT ACCESS TO EXISTING PUBLIC OR PRIVATE TRANSPORTATION.

Transportation was seen as a basic need underpinning service accessibility and utilization. However, it was also perceived as one of the more intractable needs to meet given the size, population, and rural nature of the state. While not hopeful, the exploration of use of existing targeted transportation monies more specifically for persons with mental illness, purchase of demand-response services, and development of greater volunteer transportation was urged.

COORDINATION OF SERVICES AND EFFORTS AMONG AGENCIES/ORGANIZATIONS/SYSTEMS.

The need for statewide system and agency coordination, just as case management, was cited as a pressing need in the development of a coherent and effective delivery of services to the individual. This was seen to affect efficient use of resources, duplication and gaps in services, accessibility, and communication.

DEVELOPMENT OF REGIONAL/LOCAL COMMUNITY INVOLUNTARY IN-PATIENT PSYCHIATRIC CAPACITY.

It is a tenet of the Council and its planning groups that mental health services should be provided as much as possible in local communities thus encouraging the continued integration of the individual in the community. Given the size of Maine, in-patient care at the two mental health health institutes can involve long distances from the individual's home, family, and friends, disrupting lives and support systems. The development of local involuntary psychiatric in-patient units in community hospitals is seen as a needed and feasible alternative, especially in view of the number of very short lengths of stay at the institutes.

EXPANSION OF CRISIS INTERVENTION AND STABILIZATION PROGRAMS THROUGHOUT THE STATE.

Crisis intervention and stabilization programs include 24-hr./day, 7-day/week telephone and outreach service, assessment, and counselling capability; short-term crisis beds; and links to on-going services.

THE DEVELOPMENT OF STATEWIDE COMPREHENSIVE DIAGNOSTIC, SCREENING, AND ASSESSMENT EXPECTATIONS AND PROCEDURES.

The validity of a mental health treatment plan rests on the validity of the assessment process - its comprehensive and specialized knowledge base and its thoroughness. Great variances currently exist, especially in relation to holistic assessments which consider the whole individual including multiple problems (mental illness, substance abuse, offenders, age group, etc.). These point to the need for the establishment of a statewide system of assessment standards.

ADDITIONAL PRIORITIES:

Prevention/Education
Family Support, including training/education
Deafness Accessibility Measures
Vocational Rehabilitation
Day Programming, including center-based services for very young children
Peer Support
Caretaker Education
Holistic Approach to Mental Health
Space/Privacy, space with privacy for counselling, etc.
Advocacy/Lobbying
Information & Referral, statewide system
Management Information Systems
Statutory Changes/Protective

Most importantly, it must be remembered that some community services because of their specificity have been separated into individual rankings (residential, crisis, home-based/outreach, community in-patient capacity, etc.). This means that, taken together, the development of a comprehensive coordinated community-based mental health service system responsive to individual specialized needs is the paramount global goal identified by all the community planning groups for children, adolescents, and adults.

THE MAINE MENTAL HEALTH SYSTEM - 1987-1988

In 1987, the Maine mental health system was divided into eight administrative mental health service areas. This was unlike the other two Departmental units (Mental Retardation & Children with Special Needs) which operate on the basis of six and the Department of Human Services which has five. The Departmental budget for mental health services in the community was approximately 9.9 million dollars less and formed 49.8% of the community agencies' budgets. Over 26,000 persons were served by the community mental health agencies, and all services, except traditional outpatient services have shown substantial increases in funding. Numbers of persons served have remained relatively stable; however, there have been shifts in service priorities to meet the needs of more psychiatrically disabled individuals more adequately and more appropriately.

Case management as a discrete mental health system service did not exist. The federally-funded project in Portland had just recently been awarded by NIMH. The project emphasized services to persons who were homeless and mentally ill by providing a clinical manager for case management services in that area. Case management functions were incorporated in the work of the community agencies' mental health workers, as they are in most direct public service provision.

The fourth crisis intervention program contract, the first one to be provided through contract had just been awarded in the Lewiston/Auburn area, but the program itself was not yet operating.

Residential services programs numbered about twenty. Neither housing nor homelessness were assigned a State-level point of responsibility. Almost no mental health community providers had any knowledge or expertise in housing development or funding. The Maine State Housing Authority had not yet identified specialized residential service programming as an area integral to any mental health residential proposal they might receive and, as such, required routine consultation.

There were about twelve family support groups throughout the state. The statewide umbrella organization had recently been established and did not have dedicated funding but was funded through request by the Bureau of Mental Health.

Although vocational programs had been supported by the Department for some years, there was no supported employment initiative yet. Community agencies were not accredited by CARF.

Intra-departmental and inter-departmental coordination for special population groups was relatively minimal. For example, services for persons with mental illness and mental retardation were not coordinated between the two Bureaus in the Department and discussion was tenuous; work on mental health services to persons from minority cultures was not a priority; substance abuse as a major issue in mental health had not yet been identified as having serious mental health importance. Community agencies were not yet required to be accessible to deaf persons with mental illness.

The mental health services component for elderly persons was in the very beginning stages - the Geriatric Mental Health Resource Program, for example, was in one four-county service area. Training for staff in nursing and boarding homes was in two.

The quality assurance and data information functions did not exist as discrete Department functions. Human resource development was not yet established as a focus at the Bureau of Mental Health.

ADULT COMMUNITY MENTAL HEALTH SERVICES ALLOCATIONS BY SOURCE FOR STATE FISCAL YEARS 1988-1991

	SFY '88	SFY '89	SF '90	SFY '91
State General Fund	$ 9,180,395	$13,320,144	$17,879,230	$19,204,267
Federal Accounts				
ADMS Block Grant	$ 1,070,336	$ 1,015,437	$ 902,774	960,707
Social Services Block Grant	273,895	273,895	271,395	273,895
Community Services Grant	295,000	519,978	749,015	507,033
Homelessness Block Grant	206,250	133,750	137,500	137,500
Subtotal	$ 1,845,481	$ 1,943,060	$ 2,060,684	$ 1,879,135
Total	$11,163,376	$15,263,204	$19,939,914	$21,083,402

The percentage of Federal dollars of the total community mental health service budget is decreasing as Federal funds either decrease or remain constant while State dollars increase both in percent of the total and absolute amount.

DMHMR Community Mental Health and Mental Retardation
Persons Served: FY'88 through FY'92

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992*
Persons	26,401	27,857	33,786	23,797	23,000

* Projected Number

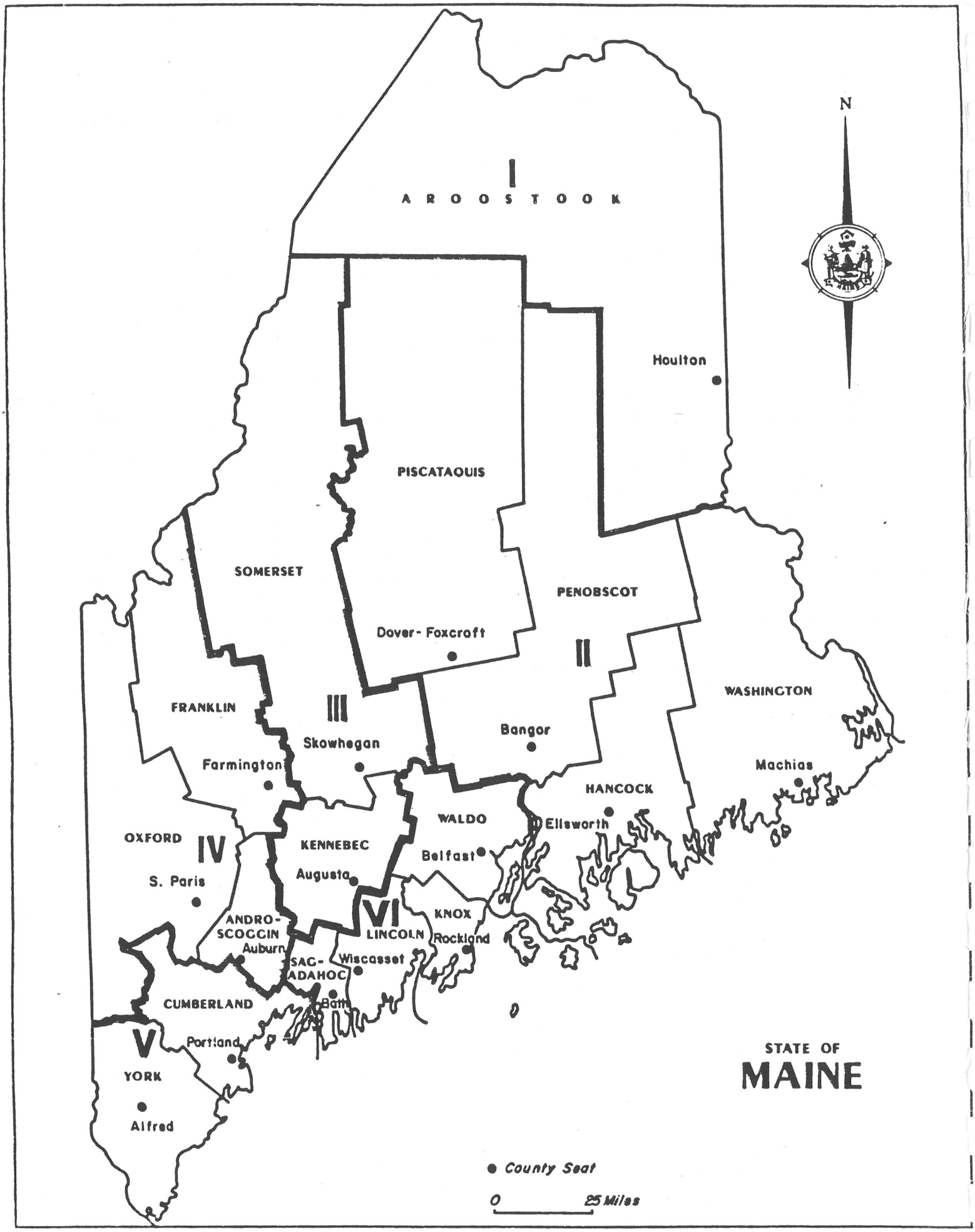
As can be seen, the total number of persons being served is decreasing dramatically. This represents, in large measure, not only better data being collected, including less duplication, but also a strong shift in services to more intensive community support activities. There have, for example, been

major decreases in some community agencies in traditional outpatient services. While the overall figures are decreasing, the number of persons with severe and prolonged mental illness being served is remaining relatively constant, around 5,500 per year.

BMH-FUNDED ADULT COMMUNITY MENTAL HEALTH SERVICES
BY TYPE OF SERVICE* FOR STATE FISCAL YEARS 1988-1991

	SFY '88	SFY '89	SFY '90	SFY '91
Community Residential	$ 1,789,775	$ 2,395,925	$ 2,657,138	$ 2,991,442
Community Support	2,768,891	2,813,113	3,458,162	3,579,196
Consultation/Training/Educ.	218,526	150,283	362,779	503,830
Crisis Intervention	752,905	1,164,009	1,262,675	
Day Treatment/Rehabilitation	874,419	824,882	706,140	718,326**
Emergency	1,168,786	1,211,233	1,679,949	3,405,075***
Human Resource Development		34,747	27,791	67,563
Inpatient	170,139	418,477	1,683,785	1,480,439
Intensive Case Management		1,076,793	1,763,899	1,818,256
Outpatient	1,742,229	1,963,207	2,425,963	2,284,974
Peer/Family Support		200,430	284,164	401,960
Psychosocial Center/Social Club	490,801	327,646	603,647	715,218
Special Populations	607,850	713,910	1,242,368	1,234,552
Vocational		586,349	1,208,543	1,323,252
Other Activities	349,468	808,325		0
Subtotal	$10,933,789	$14,689,329	$19,367,003	$20,524,083
Administration	229,587	573,875	171,726	160,000
TOTAL	$11,163,376	$15,263,204	$19,538,729	$20,684,083

* Service categories have and are being amended, affecting the assignment of funding as reflected above: For example, vocational services, now separate, had been included in Day Treatment, and the Consultation/Training/Education and HRD categories continue to be redefined.
** See emergency.
*** Emergency and crisis intervention combined.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PLAN OBJECTIVES ACHIEVEMENT - SUMMARY

I. ESTABLISHING AND IMPLEMENTING AN ORGANIZED COMMUNITY-BASED SYSTEM OF CARE FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

Overview of Maine's Adult Mental Health System

Maine, with a population of approximately 1,228,000 people, is divided into six mental health service areas which range from 1,600 to 12,000 square miles and from 87,000 to 405,000 people. The six mental health service areas have a variety of mental health agencies and organizations providing services.

Other than two State mental health institutes and three small crisis stabilization programs, the Department of Mental Health and Mental Retardation operates no direct adult mental health service programs itself. Instead, through contracts with seven community mental health centers and over forty other community organizations and agencies, the Department supports a variety of mental health services throughout the state including rehabilitation-oriented day treatment, case management, crisis intervention, vocational, outpatient, inpatient, residential, consultation and education, and other supportive services. Nine of the forty-four general hospitals in the state have psychiatric inpatient units (5-15 beds), and there is one private, for-profit mental health institute in the southern part of the state.

The focus of the Department's mental health institutes and the Bureau of Mental Health is primarily on adults with severe and prolonged mental illness, other persons with special mental health needs (deaf, elderly, minority culture, offender), and those individuals unable to pay for mental health services.

Adult mental health services in Maine 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's Office of Community Support Systems provides crisis stabilization services in the York County, Portland, and Augusta/Waterville areas. These round-the-clock psychiatric crisis programs have integrated respite and transitional housing components.

The two State psychiatric facilities, Augusta and Bangor Mental Health Institutes, have changed considerably in the last twenty or so years with a combined daily census of about 510 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 it presents. Admissions, however, were generally rising, and the Augusta Mental Health Institute restricted admissions to involuntary hospitalizations. Active efforts and major intiatives have been undertaken to prevent unnecessary admissions to the State mental health institutes and the number of

admissions have been decreasing. The institutes also provide intermediate care services to mentally ill elderly persons as well as a variety of forensic services.

The Department of Human Services administers a variety of programs which have a direct impact on persons with mental health problems, including support services, transportation, vocational rehabilitation services, child and adult protective services, boarding homes, and Medicaid funding for community psychiatric units and professional outpatient services. The Department of Educational and Cultural Services provides for a variety of special education, counseling, specialized residential programming, and professional treatment services. In addition, the Department of Corrections makes provisions for some mental health services for both adults and juveniles.

It is important to note that, except for its county courts, sheriffs, and roads, Maine, unlike many states, does not operate on a county system. Its local services and government are based on its 493 townships (490 organized cities, towns, and plantations plus three Native American reservations). However, approximately 47% of the state (with 0.6% of the state population) is unorganized territory with some limited essential services provided by the State. The townships do not systemically support mental health services although town governments may vote to provide funding out of their town budgets for mental health agencies or organizations in their areas.

2) PRIVATE, NOT-FOR-PROFIT AGENCIES/ORGANIZATIONS funded at least in part by the Department of Mental Health & 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 statewide family support groups.

In addition to the Department of Mental Health & Mental Retardation funding, mental health agencies and organizations also receive a variety of other funding - including other state funding, fees charged for services, local public funding, federal monies, and other sources.

> Mental Health Service Area I: Mental health services in this isolated, most northern area are available essentially through the one community mental health center, the Aroostook Mental Health Center, and its programs and three family support groups, one of which runs a small social club for psychiatrically disabled individuals. Voluntary psychiatric inpatient services are available through two community hospitals. This area contains the largest concentration of the state's French- speaking population.
>
> Mental Health Service Area II: The largest in size and containing great isolated regions, this area contains Bangor, one of the state's bigger cities (pop: 33,250), and the Bangor Mental Health Institute which serves both Areas I and II. The area has one comprehensive community mental health center - Community Health & Counseling Services, a family support group, two non-profit agencies which administer two community residential mental health facilities, a

psychiatric crisis hotline program and small crisis intervention program, and a large consumer-run psychosocial center which also operates a vocational program. The area's largest general hospital has become increasingly involved in expanding its inpatient and community psychiatric services and in conjunction with the southern Maine private psychiatric institute is developing a northern for-profit psychiatric facility.

Mental Health Service Area III: The Kennebec Valley area contains Augusta, the Capital of the state; the Augusta Mental Health Institute which serves Areas III - VI; and a variety of very active mental health agencies and organizations in addition to the community mental health center, the Kennebec Valley Mental Health Center. Residential programming has been a significant priority in this area. This variety and activity is, in large part, due to the presence of the Legislature and the Institute in this area. Augusta (pop: 21,100) and Waterville (pop: 16,950) are fairly major urban areas for the state.

Mental Health Service Area IV: Generally known as the Lewiston/Auburn area, this area has a major concentration of French-speaking people and is another large population center for the state (Lewiston, pop: 40,100; Auburn, pop: 22,200). The community mental health center, Tri-County Mental Health Services, and two family support groups, which also run residential programs, have been supplemented by the formation of a coalition which administers a social club, some suppportive residential services, and is actively working to improve and increase mental health services in the area.

Mental Health Service Area V: The Cumberland County area contains Portland (pop: 62,900), fast-growing and the largest city in the state, and is without a primary community mental health center, although the western more rural part of the county has a comprehensive mental health agency, Western Maine Counseling Services. Until the early 80's, the various urban mental health agencies were financially coordinated as members of a limited administrative body which contracted with the State for funding for all its member agencies. This financial relationship has ended and each agency now contracts separately with the State. This area contains the first-organized family support group in the state, which also administers a large consumer psychosocial center and vocational program. The local community hospital in Portland has provided substantial outpatient and medication services. This area is among the better developed in residential mental health programming in the state. It also contains a major consumer-operated support, education, and advocacy organization.

In the York County area, with the exception of a small family support group, a small crisis stabilization program, and the private sector, mental health services are provided almost solely by the community mental health center, York County Counseling Services

(YCCS). A local shelter agency is becoming increasingly active in the development of housing/shelter alternatives for persons/families with mental health problems. This area is one of the state's more densely populated and fastest growing regions and is a major coastal vacation region.

Mental Health Service Area VI: Mental health services in the southern part of this area are provided through the community mental health center, Shoreline Care Systems, Inc. There is also a small and struggling family support group.

The Mid-Coast Mental Health Center and a small family support group in Rockland essentially form the mental health system in the northern part of this area, which has an high number of boarding homes, thus demanding the development of specialized programs to meet the needs of the psychiatrically disabled individuals living in them.

3) PRIVATE PRACTITIONERS AND PRIVATE PROPRIETARY, FOR-PROFIT AGENCIES/ ORGANIZATIONS who may receive payment from Medicaid, client fees, or third-party insurers. The state's only private, for-profit psychiatric inpatient facility, Jackson Brook Institute, is located in South Portland, Cumberland County in Mental Health Service Area V.

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

Objective A: Develop a planning and implementation process for a mental health system which is broadly participatory and includes shared values and standards.

A. Milestone - **By the end of fiscal year 1992, the Maine Department of Mental Health and Mental Retardation will have collaboratively developed a plan for the structure and service provision of the mental health system in Maine which will reflect expressed values.**

B. Progress - During the past three years, overcrowding and issues of patient care at the State institutions have been of major concern for the Department and have received a great deal of attention from the media and the Legislature. This has resulted in the allocation of additional resources to inpatient programs to improve care and reduce overcrowding. Out of this focus, there has been a strong advocacy and priority for community programs -- both as an alternative to overcrowding/hospitalization and as continuity of care from inpatient to community programs -- with both the Department and the Legislature exploring the problems, issues, and alternatives. Although the spotlight of media focus has waned, the resolve of the Department, Legislature, mental health organizations and agencies, and community has not.

Several major mandates and initiatives are driving the mental health system forward, and planning for it is occurring in a crowded arena:

- SYSTEMS ASSESSMENT COMMISSION - The Systems Assessment Commission was established in 1989 by the Legislature to examine and make recommendations on the role of the State mental health institute in the mental health service delivery system. The Commission has examined other state systems, spoken to individuals throughout Maine and the country, explored the literature, etc. While the Commission was small and was not representative of the mental health community -- for example, it had no consumers or family members -- it made extensive efforts to solicit input throughout the community. Its final report has been issued and made several recommendations, the core of which relate to community participation and the regionalization of Maine's mental health system. Although it is no longer in existence, the former members of this Commission put forward proposed legislation, implementing its recommendations, in the last legislative session. These have been held over and will be considered when the legislature reconvenes.

- VISIONS CONFERENCE - In an effort to build concensus and bring various sectors of Maine's mental health system together, the Commissioner of the Department of Mental Health and Mental Retardation has been holding a series of "Visions" meetings since the fall of 1990. The conferees have included about thirty people from all over the state representing a variety of mental health interests (including consumers, family members and the Planning Council, Systems Assessment Commission, and Commission on Mental Health Chairs). They have explored and debated the mental health mission, population, values and principles, structure, planning, roles, etc., and a vision for Maine's mental health system has emerged which incorporates a regional structure. At this point, this vision appears to be based on the establishment of independent non-profit, non-provider, regional administrative planning and financing entities. The next meeting of the Visions conferees is scheduled for October 11, 1991 to review draft legislation for regionalization.

- MAINE COMMISSION ON MENTAL HEALTH - The Commission in its beginning stages has focussed on monitoring and evaluating the care provided at the Augusta and Bangor Mental Health Institutes, providing consultation to the Legislature and Department toward improving treatment systems. It has begun expanding its focus to include community services and the issues related to the implementation of the consent decree. The agenda of the upcoming November 6, 1991 meeting of the Commission is directed to the evaluation of its priorities and the formation of its direction for the coming year.

- MAINE MENTAL HEALTH PLANNING COUNCIL - The Maine Mental Health Planning Council has struggled in the last two years to identify its role in this quickly changing atmosphere. It decided early this year that until some of the fundamental systemic issues were resolved, the Council's role as a total entity would be tenuous and that it would dissolve after having made recommendations regarding a new Council and having seen the 1991 P.L. 99-660 plan to fruition. (See Requirement #12)

- CONSENT DECREE - A class action law suit filed against the Department of Mental Health and Mental Retardation and the Department of Human Services was settled August 2, 1990. This settlement agreement has, in effect, limned the philosophical context for Maine's mental health system with, in many areas, specific implementation guidelines. The Consent Decree, issued by the Maine Superior Court, has an "open" class of those persons who on or after January 1, 1988 were patients at the Augusta Mental Health Institute. The Decree provides for the downsizing of AMHI from the current 300 to 70 non-forensic persons by August, 1995 (see Decree Timetable in Appendices). The Adolescent Unit is to be closed by September, 1992. The Decree emphasizes individual choice and participation and the development of a comprehensive mental health system based on client need. It requires that community support services be developed in housing, residential support services, crisis intervention & resolution, vocational/training opportunities, treatment options, family support, recreational/social opportunities, and transportation. The implementation plan for meeting the obligations of the Decree was first due in January 1991 and is currently in its third draft.

  The Implementation Plan and its planning/development process should be an integral part of any mental health planning done and not done in isolation. At this time, it has been woven into other planning streams based on individuals involved with its development who may also be involved in other planning efforts/processes. This has been unavoidable, yet also a matter of happenstance. There is, of course, a Consent Decree Implementation Advisory Committee (see Part B), some of whom are also involved with the P.L. 99-660 planning process.

  While the Decree is generally viewed as a mechanism to drive the mental health system forward, there has also been the parallel concern that services and funding might focus on class members alone. This fear continues to grow as the economic climate worsens and Maine has found itself with a growing State deficit. This is of concern to anyone not a class member or anyone serving a non-class member, and doubly so to the northern part of the state, which is not in the Augusta Mental Health Institute's catchment area. The experience of other states has shown that this is not an unreasonable fear.

  However, the Executive and Legislative branches have during these budget crises made a considerable effort to continue the development of a statewide community system of mental health services, and this has been evidenced in the decisions made regarding budget and staff cuts and adjustments.

  The philosophical base underlying the Consent Decree, the Systems Assessment Commission recommendations, and the Visions concensus, as well as the work of the comprehensive community mental health planning process and the Maine Commission, are essentially and substantially in accord and incorporate and complement one another.

- SPECIAL COMMISSION ON GOVERNMENTAL RESTRUCTURING - On May 15, 1991, the Governor approved legislation establishing an independent, 22-member Special Commission on Governmental Restructuring:

> The Commission shall develop and present to the Governor and the Legislature by December 15, 1991 a final plan to maximize citizen participation in public policy making, to use public resources more effectively and to consolidate and restructure State Government in such a way that effeciency is assured and cost savings result.
>
> . . . to obtain this objective by consolidating, restructuring and streamlining existing advisory groups that provide advice and input to government. . .[The Plan must include] a special focus on those programs and services of government related to the provision of human services.

The potential implications of the work of this group for the provision of services in Maine are enormous. Its recommendations may deeply affect not only structure and coordination but may in fact, in some instances, change the underlying philosophy and orientation to services and special populations themselves.

It is generally assumed that a major recommendation will be to bring together all child and family services, as well as AFDC, into a single new Department of Child and Family Services. With less certainty, it is thought that there might also be recommended a large department bringing together adult services and funding (Bureaus of Mental Retardation, Mental Health, Substance Abuse, Public/ Community Health, and Elder & Adult Services, as well as administrative units for Medicaid, etc.). There is also discussion of splitting vocational rehabilitation services between the Department of Labor and the proposed Bureau of Public/Community Health.

Such recommendations would affect the two major service departments, Human Services and Mental Health & Mental Retardation, the most. They would bring together State service systems with differing regional structures, as well as differing relationships between central and regional offices (except for mental health where there are no regional offices): Human Services has six service regions (primarily affecting child & family services) and Mental Health and Mental Retardation has five. It also raises issues and questions regarding the timing, implications, and impact of the restructuring on the work and recommendations of the other groups.

- BUDGET PROCESS - 1988-Annually: The Department presented a preliminary plan for system development to a Special Session of the Legislature in September, 1988. Significant new initiatives resulted from this preliminary ("Blue Book") plan which was based on the extensive work of the Mental Health Advisory Council (precursor of the current Maine Mental Health Planning Council), its Plan Development Committee, and the 1200

people who participated in the planning process. In June 1989, at the end of the Regular Session of the Legislature, additional new resources were allocated. These initiatives included intensive case management, expanded and enhanced crisis stabilization, inpatient diversion, housing support, vocational support, family support, staff retention and other Human Resource Development (HRD) activities, geriatric mental health services, services for persons with the dual diagnosis of mental illness and substance abuse, aftercare services for persons in nursing and boarding homes in Aroostook county and public education. In addition, significant funds have been allocated to the two State mental health institutes for staff increases, facility upgrading, staff training, and salary increases for the institute superintendents, physicians, and physician extenders.

The last legislative sessions have focussed on the State's deepening fiscal crisis and the necessity to reduce spending (raising taxes) to effect a balanced budget as required by law. Projections have consistently failed to predict the severity of the deficit, and repeated budget rethinking and restructuring have been necessary. With the commitment of the Governor, Legislature, and Commissioner, mental health services have fared well in comparison to other sectors of the government and services. Its budget, in some respects, has in fact increased.

- STANDARDS - 1989-1991: An extensive standards development process, a collaborative effort between the Maine Commission on Mental Health and the Department, is also underway. The standards development process began in late summer of 1989, and a Steering Committee, composed of ten members, was formed in September to oversee and drive the whole process forward. Seven work groups covering different service areas were convened in March 1990: inpatient, outpatient, residential, case management, home-based services, crisis & emergency, and medication management. An eighth group has been formed on rehabilitation/ vocational services. The representation on these workgroups is statewide and broad. The work groups have from six to fifteen members with approximately seventy people involved to date.

  The work groups have developed several drafts of standards in their respective areas. Not surprisingly, the effort is proving to be a lengthy, time-consuming process. It is anticipated that final drafts for general public review will be ready in 1991. Significantly, the standards will provide for indicators for both quality assurance and licensing functions. The implementation date set is September 1, 1992.

  Implementation of the standards, a complex process involving both State quality assurance and licensing mechanisms, will take into account costs, funding, frequency of review (annual review), phase-in times, grandfathering, etc. The Commission has recommended that these standards apply to all agencies providing mental health services, not limiting them to those receiving State funding. The Commission and the Steering Committee are also considering the development of administrative standards (funding, licensing, etc.) as well as the development of overall guidance standards. Development of a similar standards process for children's services is under discussion.

C. Barriers - The currently worsening fiscal situation in Maine and the presence of many planning processes, described above, will require an especially determined focus of those involved with mental health services to assure that the essential aspects of a quality mental health system are not lost but are carried forward -- not an easy task even with the resolve of all involved.

D. Outcome/Expectation - Since 1988, there has been a dramatic and general shift in positive public and private interest in Maine's mental health system and its improvement and expansion. This has been clearly true not only of the general community, but towns, service agencies, the Legislature, the Governor, and certainly the media. This evolution, or readiness, influenced not only developing initiatives but also the climate for the settlement and implementation of the Consent Decree.

II. SPECIFYING QUANTITATIVE TARGETS TO BE ACHIEVED IN THE IMPLEMENTATION OF SUCH SYSTEM, INCLUDING NUMBERS OF INDIVIDUALS WITH SERIOUS MENTAL ILLNESS RESIDING IN THE AREAS TO BE SERVED UNDER SUCH SYSTEM.

Recent national studies have found that the overall prevalence of diagnosable mental disorders in the adult population at large is approximately 19%. In Maine this would mean that 174,596 persons have mental health problems severe enough to need mental health intervention and help. Estimates of the number of adults in Maine with severe and prolonged mental illness vary from a low of 8,000 (judgment based on direct experience and the general number of persons being served in the institutes and the community support programs) to between 23,892 to 42,271 (based on National Institute of Mental Health Epidemiologic Catchment Area Study estimates taking into account diagnosis, duration, and varying degrees of disability). The prevalence of specific disorders are anxiety disorders, 8%; alcohol and drug dependency, 6-7%; depression and manic depression, 6%; schizophrenia, 1%; and personality disorders, 1%.

Using the NIMH ECA study and also taking into account variations in race, sex, age, and marital status in Maine, the following estimates occur:

. Total 18+ yrs. population in Maine	918,926
. Any disorder excluding phobias and cognitive impairment group	107.414
. Affective disorder: Depression or mania (bipolar) group	33,789
. Schizophrenia or schizophreniform disorder group	8,797
. Substance Abuse or dependence: alcohol or drugs group	70,969
. Use of any mental health service (ECA profile) group	89, 406

It should be kept in mind that these estimated numbers of individuals are duplicated among categories. Nor does the "Any disorder" category include all mental disorders except those excluded; this category is restricted to a limited field of mental disorders.

Prior to the intiation of P.L. 99-660, there were no systematic needs assessment studies or field surveys to confirm any of these estimates of prevalency within the general population for Maine.

Through the institutional reporting system and the community agency' contractual quarterly and annual reports, some aggregate information is known about people served. There were 1,123 (unduplicated) persons served in the two State mental health institutes in FY '91, and approximately 24,000 people were served through Bureau of Mental Health contracts with seven community mental health centers and over forty other community organizations and agencies. Under 600 persons are in a State mental health institution on any given day, and approximately 5,500 persons received community support services during the fiscal year.

The Intensive Case Management programs serve approximately 550-650 persons. The number of people who may be eligible for case management services, either intensive or community support, and who are known to the system because they were in some sort of BMH-funded community-based program, is close to 4,000. Over 350 have been served in the vocational programs. The Community Linkage Assessment and Stabilization Service (C.L.A.S.S.), between February 1989 and September 1991, has diverted 3,485 individuals from the Augusta Mental Health Institute (AMHI) to either local psychiatric inpatient units or community-based crisis units.

Objective A: Identify individuals with severe and prolonged mental illness receiving DMHMR-funded mental health services in order to determine individual and regional system needs.

A. Milestone - **By the end of Fiscal Year 1991, develop and implement a survey of persons with serious mental illness who are receiving mental health services, including a determination of client needs.**

B. Progress - MAINE ADULT MENTAL HEALTH CLIENT CENSUS

- 1989-1991: As a result of Departmental and Legislative emphasis on client-driven systems, the Department designed and carried out the Maine Adult Mental Health Client Census to be used for systems and budget planning and formulation. This "snapshot" study, ultimately surveying 5,241 individuals (unduplicated) during the week of March 19, 1990, looked at three major population groups:

  1) All those carried on the books at the two State mental health institutes,
  2) Those, aged 18 years and older, who were active clients of any of the eight comprehensive community mental health agencies and were part of the Bureau of Mental Health's defined priority population, and

3) Those, aged 18 years and older, who were active clients of any of the twenty-three other community agencies and were part of the Bureau of Mental Health's defined priority population.

Extensive training was conducted throughout the state to train the direct care workers completing the census forms. A report was issued this summer analyzing the collected data. The survey did not cover those individuals known but not active with the mental health system or those who have not used public mental health services. Projecting the "snapshot" figures into a comprehensive estimate yielded a statewide figure of 9,913 persons requiring any of the range of mental health community support services for persons with severe mental illness.

The client survey indicated the following:

. Nearly 60% were females, 40% male with this disparity increasing with advancing age, as in the general population.

. 98.6% of the clients surveyed were white.

. Slightly over half (55.1%) were between 25 and 44 years old.

. 64% had a primary diagnosis of schizophrenia (26%) or major affective disorder (28%).

. Functional levels (seven point scale, RAFLS,1988) showed (1) 8% as dangerous, (2) 6.6% as dysfunctional, (3) 11% as lacking activities of daily living/personal care, (4) 14% as lacking community living skills, (5) 35% needing role support, (6) 28% needing training or support/training to cope with extreme stress, and (7) 4% as system independent.

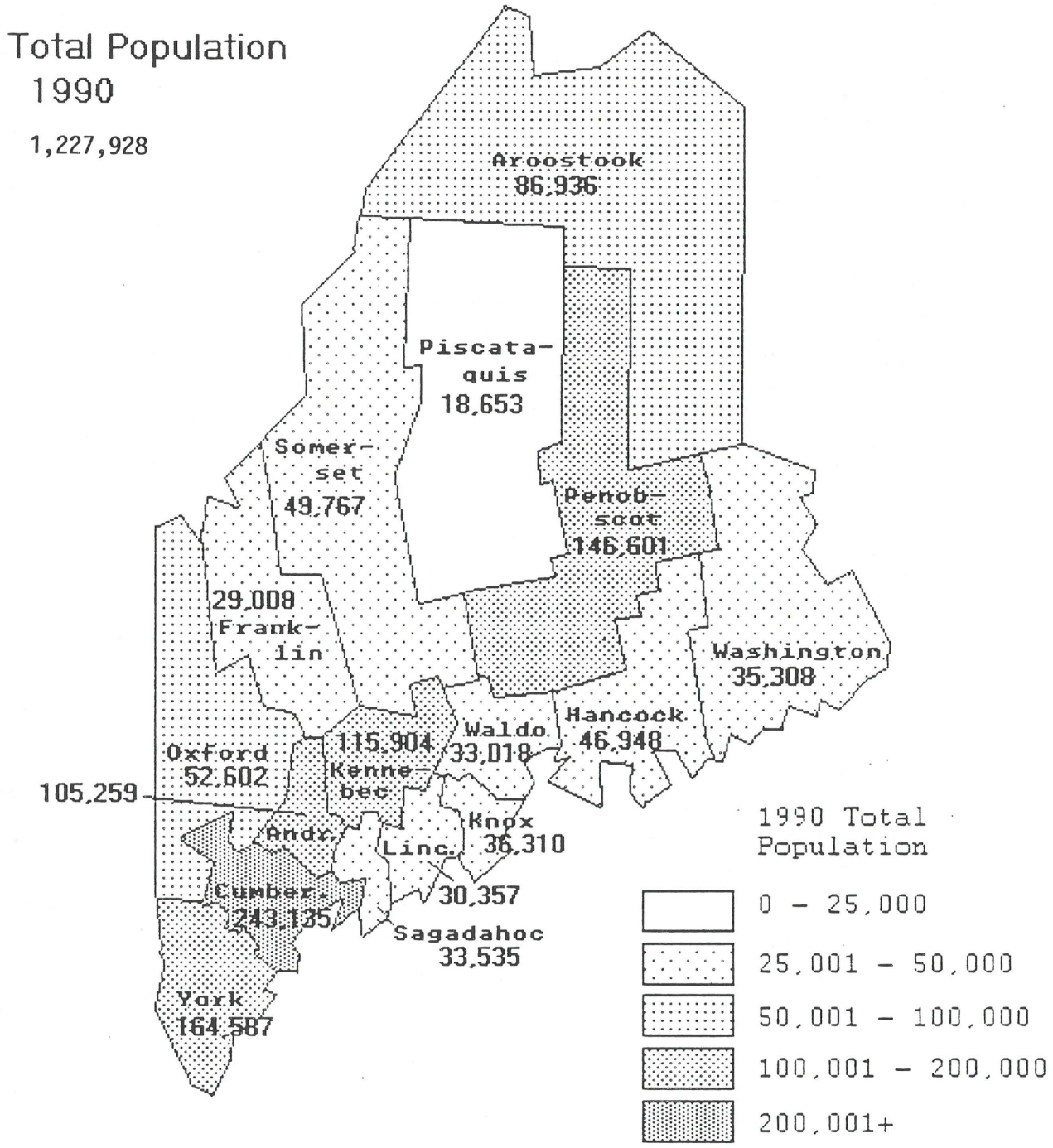
. Substance abuse (12.3%) and personality disorders (11.7%) were the most prevalent secondary diagnoses shown.

. A variety of special services were needed: chronic physical illness, 18%; substance abuse 16.4%; physical handicap, 8.5%; hearing impairment, 2.5%; and other sensory impairment, 2.3%.

. Approximately two-thirds of the clients surveyed have been psychiatrically hospitalized.

. The majority (55.3%) were seen in one of the community mental health centers, 16% in the two State mental health institutes, and 28.4% in one of the 23 other community agencies.

. Service areas II (22%) and V (28%) accounted for half the clients served. (See following map of regional distribution.)



Source: 1990 U.S. Census (Central Maine Morning Sentinel, 1/26-27/91)

C. Barriers - Many difficulties, typical to such enterprises, accompanied the development and implementation of the survey. The most significant were related to the identification of needs and to uniformity of survey completion. For identifying need and its relationship to system development, it was decided to use a seven-point functional scale (RAFLS) and relate functional level to a specific set of service needs. To achieve uniformity across a large number of mental health community support workers and institutional workers completing the form, detailed instructions were developed with a series of training sessions conducted. A test sample was also run. In addition, analysis of the data also proved problemmatic, and it was with outside financial and statistical/computer assistance that the data was ultimately analyzed. Given the level of effort (training of staff, etc.), it was decided, shortly after the completion of the survey itself in 1990, that the survey would not be replicated annually, that both staff time and funds would be better used in working toward the development of a comprehensive ongoing client-based data system.

D. Outcome/Expectation - The report, THE MAINE ADULT MENTAL HEALTH CLIENT CENSUS: A DESCRIPTIVE ANALYSIS, was just issued in August 1991 by the Human Services Development Institute of the University of Southern Maine and has been distributed throughout the mental health system. It has been possible to use the survey to establish some 1990 baseline data on some of the Consent Decree class members and to compare the characteristics of the general census population compared to class members alone. While not necessarily surprising in themselves, the comparisons have implications for the development of service systems:

. Rather than the nearly 20% spread between males and females in the general census, class members were more equally represented (male, 49%; female, 51%).

. Over a third (35%) of the class members were from Kennebec County (where the Augusta Mental Health Institute is located), while 17% of the census lived in Kennebec and Somerset Counties (Region III).

. Class members are apt to receive more substance abuse services than the general census (25.9%:16.4%)

. Class members are three times (36%) more likely to be in state institutions than the general census (12%).

Objective B: Involving community and other agency members, develop a management information system able to provide information on individuals, organizations, services, and human resource development data to increase the responsiveness of the mental health system to individual and local needs.

A. Milestone - By the end of 1992, design -- in a collaborative manner which also recognizes management issues and implications -- and begin implementing a data collection system to identify the services provided to and the unmet needs of individuals receiving BMH-funded mental health services.

B. Progress - The MIS system development has recently taken major steps forward, driven to a great extent by the Consent Decree requirements:

- 1989: The Departmental Information Group was formed and has been meeting to work on organizational strategies in the development of mental health information systems within the Department and participated in informational biennial budget needs as well as the information components of the Consent Decree Implementation Plan.

- 1989-1990: Maine MHSIP grant application was submitted and approved. The Project Director was hired in late FY'90.

- 1991: MHSIP project staff conducted an assessment of BMH staff MIS training needs.

- 1991: The Mental Health Study Group has been established, working closely with the Bingham Consortium for Health Research from the University of Southern Maine, to develop mental health research priorities. Several proposals have been developed related to, for example, substance abuse/mental health services and evaluation of the AMHI consent decree.

- 1991: NIMH and Maine MHSIP sponsored a technical assistance visit to Maine re: information system needs for DMHMR. A wide variety of departmental and community representatives were involved in a variety of meetings and a report including recommendations was developed by the consultants.

- 1991: The Maine Mental Health Information Advisory Committee began meeting monthly to work on the development of an individual client characteristics data base.

- 1991: The MHSIP staff data component was designed, design of the client data component was initiated, and organizational data collection is set to begin early 1992. A series of training sessions on the staff component were conducted statewide in September with implementation due to begin in October.

C. Barriers - Staffing, hardware, and software limitations have posed significant hurdles to the development of an MIS system. Staffing has been an issue not only in terms of inadequate numbers but also in relation to knowledge, experience, and expertise re: MIS systems. The systems both within the Department and the community are all different and have not been designed to work together.

D. Outcomes/Expectation - Great care has been taken to involve both departmental and community representatives in this rather massive effort to involve them in a process and product which will be useful to all. This has been apparent in the first of the MHSIP components to come on line: the staff data component. Apart from its other uses, this will also be particularly helpful in the HRD initiatives underway.

III. DESCRIBING SERVICES, AVAILABLE TREATMENT OPTIONS, AND AVAILABLE RESOURCES (INCLUDING FEDERAL, STATE, AND LOCAL PUBLIC SERVICES AND RESOURCES, AND TO THE EXTENT PRACTICABLE, PRIVATE SERVICES AND RESOURCES) TO BE PROVIDED FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS TO ENABLE THEM TO GAIN ACCESS TO SERVICES, INCLUDING TREATMENT, PREVENTION, AND REHABILITATION SERVICES.

In order to provide accessible services, the more than 40 agencies funded by the Bureau of Mental Health who provide services to persons with severe and prolonged mental illness are located throughout the state. Intensive Case Managers or Community Support Workers provide or arrange for transportation for clients who need it and otherwise provide linkages and advocacy for services. Some services are provided in homes or other locations if that is necessary. Some form of outreach crisis stabilization services are now in place throughout the state. Efforts are made to distribute services appropriately throughout the state; this is true not only demographically but in terms of the characteristics of specific mental health needs (for example, rural vs. urban, etc.).

For some special population groups, this accessibility becomes one of the need for accommodations or specialized services to overcome barriers or meet special needs. For example, language barriers for deaf persons, Native Americans, Franco-Americans, refugees; cultural knowledge and sensitivity; other special or complex needs such as those related to physical health for elderly persons, substance abuse, etc. Progress has been made in these areas. For example, the outreach Geriatric Mental Health Resource Program is now in thirteen of Maine's sixteen counties.

Objective A: To provide transportation services for those without access to existing public or private transportation.

A. Milestone - **By the end of 1992, put in place mental health representation on each regional transportation advisory committee in order to assure the consideration of the needs of persons with mental illness in the regional plans and promote new initiatives.**

B. Progress - Tranportation is seen as a fundamental need underpinning service accessibility and utilization. It is, however, one of the more intractable of accessibility issues. Although mental health funds are not provided discretely for transportation, some small portions are used for this purpose by community agencies. In structured residential programs, vans and their maintenance costs are often part of the program design and costs supported by the Bureau of Mental Health.

- 1991: Contact has been made with the Department of Transportation regarding the inclusion of mental health representatives on the regional advisory committees, as a part of DMHMR approval of Section 18 mass transportation funds, and it has been agreed that DMHMR will identify the mental health representatives who will serve on the advisory committees.

C. Barriers - There are major difficulties to achieving the overall objective and even some to the purpose of this smaller implementation objective. Many service staff feel that there is not much that can be done to make a difference, both in terms of the low level of funding and existing transportation system priorities, requirements, and limitations. On the other hand, some transportation staff point out that, although service sectors want the right of representation, their follow-through is often lacking.

One of the most significant obstacles is the low funding level for public mass transportation, which will present challenges to the mental health representatives in promoting innovative ways of meeting the needs of persons with serious mental illness, especially in the very rural regions. For example, Federal Section 18 mass transportation funds, geared toward non-urban areas, provides $647,809 for rural transportation and $66,302 in rural transit assistance training. Section 9 (urban) funds total $1,175,872 and Section 16 [b][2] (capital equipment for mass tranportation for elderly/handicapped persons) $275,244. State funds are also made available for urban ($167,764) and rural ($172,236) mass transportation as well as intercity transport ($60,000 used for two lines: Milbridge-Bangor and Saco-Biddeford).

D. Outcome/Expectation - The reaction to the prospective representation has been supportive thus far at the State level.

Objective B: To develop a greatly expanded and improved community service system capable of responding to specialized individual mental health needs, including persons of minority cultures and/or with diagnoses such as deafness or substance abuse and those with the more severe forms of mental illness.

A1. Milestone - **By the end of 1992, to create and implement Bureau of Mental Health standard contract language for all contractual agencies regarding accessiblity of services to specific special population groups with severe mental illness.**

B1. Progress - The massive standards development process currently underway, which is soon to be implemented in 1992, accords all persons receiving mental health services equal access, as do the Rights Rules (Rights of Recipients of Mental Health Services) first promulgated in 1984 and again being revised. The Bureau of Mental Health felt that more affirmative action was needed.

- 1990: A general provision was added to BMH contracts regarding accessibility of mental health services to deaf persons - "Provider understands that it is its responsibility to arrange for professional deaf interpretive services to meet the communication needs of clients and clinicians. Consultation with psychologists and psychiatrists specially trained in evaluating and treating deaf persons should take place whenever such knowledge and expertise is not extant within the Provider's staff.

  Provider agrees to maintain and periodically test a telecommunications device for the deaf (TDD) which shall be available and accessible for use by clients and staff. Provider agrees to train appropriate staff in its use and to publish the TDD telephone number on the Provider's stationery, letterhead, business cards, etc., as well as in the local telephone book and the statewide TDD directory."

- 1990: Another general provision was added regarding individuals with physical handicaps which was structured to also include small programs - "Provider agrees to make reasonable accommodations for physically handicapped persons to receive services although not all the Provider's residential facilities may be accessible to persons with physical handicaps. Provider understands that this may require special arrangements within the Provider's programs or with other appropriate community agencies. A non-physically handicapped person living in an accessible unit would be located to another unit within the same facility upon acceptance of an individual requiring accessible accommodations."

- 1991: A major step was taken with the addition of accessibility language to BMH contracts regarding mentally health service provision in relation to substance abuse issues - "No individual may be denied access to services solely on the basis of having a known substance use/abuse disorder in addition to their mental illness. Provider shall develop and maintain a written protocol or policy which describes its service approach to individuals with co-occurring mental illness and substance abuse disorders. In addition, Provider shall ensure that appropriate staff receive training in the inter-relationship of mental illness and substance abuse as well as in the referral and treatment process.

C1. Barriers - Agencies have generally not been actively resistant to the providing accessible services but, with some exceptions, have often perceived them as a burden, especially where funding is limited. The ramifications, as noted below, of these provisions are just beginning to emerge.

D1. Outcome/Expectation - The expectations placed on agencies by such contractual provisions have very practical implications which must be addressed. For example, while placing a TDD in an agency may be relatively simple, keeping staff adept or knowledgable regarding its use may not be as simple given staff turnovers, coverage during absences, sometimes low frequency of calls, etc. This is especially true of maintaining staff skilled in sign language, which is not easy to acquire and must be used in order to maintain proficiency. In addition, Maine still has few (2) clinicians with sign language fluency. Issues related to substance abuse can also pose serious problems.

Residential programs serving persons with the dual disorders of mental illness and substance abuse may not be covered by the same protections or remedies as other populations. This is true, for example, of the Fair Housing Act which excludes actively substance abusing individuals from protection. In the same vein, while residential programs for persons with mental illness are considered as family homes for most zoning purposes in Maine, substance abuse programs are not -- even when abuse of substances on site is prohibited and the program is a mental health one -- and may be classified in another category such as Shelter Care, which can be restricted and limited. In other words, kept out of neighborhoods. Given the prevalence of substance abuse in the mentally ill population group, this has significant implications for program development.

It should be noted that even Medicaid, while paying for a service, will not necessarily pay to make it accessible. Although counseling for someone deaf is reimburseable, the reasonable accommodation of interpreting services to make it possible are not.

A2. Milestone - **By the end of 1992, begin and maintain specific, concrete efforts to expand the availability of specialized services, as appropriate, to special population groups with severe mental illness.**

B2. Progress - Significant progress has been made in the last few years in meeting the unique mental health needs of special populations:

- 1988: State funds were approved in the Legislative Special session for mental health assessments and outpatient treatment for persons 60 years and older living in the community. This Geriatric Mental Health Resource Program, coordinated with the Area Agencies on Aging, is now available in 13 of Maine's 16 counties. This program also provides psychogeriatric public education and in-service training to community agency staff.

- 1988: A mental health case management position was established at the Central Maine Indian Association for the Eastern Maine area for Native Americans living off-reservation.

- 1989: Series of one-day mental health workshops, spread over six months, provided for substance abuse counselors employed by Maine's Native American groups, including the Penobscot, Passamaquoddy, Maliseet, and Micmac tribes, as well as the Central Maine Indian Association.

- 1989: Four-day training and consultation on persons with mental illness and substance abuse problems. Over 300 individuals participated in the training and 4 agencies received consultation by Dr. Bert Pepper and Hilary Ryglewicz.

- 1989: Training program on mental health in jails presented at the Maine Criminal Justice Academy for 21 training officers and related personnel from county jails and correctional facilities.

- 1989: Mental Health and deafness conference held in Ogunquit for 75 mental health clinicians and interpreters.

- 1990: Conference held in Portland on health needs of Cambodian refugees, including mental health component.

- 1990: Mental health and deafness conference held in Portland and attended by 175 mental health professionals and interpreters.

- 1990: Workshop conducted on counseling refugee clients.

- 1990: A highly successful one-day statewide conference was held on "Wabanaki Perspectives on Health: Spiritual Wholeness and Mental Health."

- 1990: BMH contract language amended to require community mental health centers to be accessible to deaf persons. This involves the maintenance of TDD equipment and the development of staff sign language capability.

- 1991: Series of one-day workshops being held for correctional and law enforcement personnel on the issues presented by persons with mental illness and techniques for responding humanely and effectively: 1/91 in Portland for correctional staff; 4/91 in Portland for law enforcement staff; and 5/91 in Washington County for both correctional and law enforcement staff.

- 1991: Survey of the county jails, conducted by the mental health planning committee on persons with mental disorders involved with the criminal justice system, to determine number of individuals in the county jails with mental health needs.

- 1991: Development and establishment of a model psychiatric nursing facility for seventeen elderly persons with mental illness.

- 1991: Approval of a psychiatric group home for elderly persons in the Lewiston/Auburn area with funding through the Maine Mental Health Facilities Bond, McKinney Permanent Housing, and the Bureau of Mental Health.

- 1991: The approval of the Central Maine Indian Association's application for an 8-person residential project through the Maine State Housing Authority. The Bureau of Mental Health is funding a small portion of this program for those residents who might have a mental illness.

- 1991: Approval of funding for Whittier Place, a highly intensive transitional residential program for homeless persons with both mental illness and substance abuse disorders, through the Maine State Housing Authority, HUD McKinney Transitional Housing, and the Bureau of Mental Health.

- 1991: The planning subcommittee on Mental Health Services to Persons with Mental Disorders Involved with the Criminal Justice System conducted and analyzed a "snapshot" survey of all county jail inmates to identify those with serious mental illness.

C. Barriers - The economic downswing poses difficulties for minority populations, especially in Maine where actual numbers may be relatively small, if decisions on priorities are based in part on numbers of people needing particular services. In addition, expertise and knowledge in working with individuals with special needs may be severely limited and complex to obtain. This is true for deaf persons, for refugees, for elderly persons. Maine in most regions has difficult struggles to get minimal numbers of psychiatrists, for example, to work in the public sector, much less those even fewer in speciality areas. In addition, there also continue to be prejudices and lack of knowledge which can stand in the way of adequate and appropriate services. Many times, initiatives in these special population areas are heavily reliant on a specific leader or coordinator; this can be dangerous if that person somehow ends or lessens involvement.

D. Outcome/Expectation - The results of all these efforts have been very positive and have evidenced great growth in a short time. They do, however, point to the need for sustaining initiative efforts and energy beyond the first great push.

IV. DESCRIBING HEALTH AND MENTAL HEALTH SERVICES, REHABILITATION SERVICES, EMPLOYMENT SERVICES, HOUSING SERVICES, EDUCATIONAL SERVICES, MEDICAL AND DENTAL CARE, AND OTHER SUPPORT SERVICES TO BE PROVIDED TO INDIVIDUALS AND CHILDREN WITH SERIOUS EMOTIONAL AND MENTAL DISORDERS WITH FEDERAL, STATE, AND LOCAL PUBLIC AND PRIVATE RESOURCES TO ENABLE SUCH INDIVIDUALS TO FUNCTION OUTSIDE OF INPATIENT OR RESIDENTIAL INSTITUTIONS TO THE MAXIMUM EXTENT OF THEIR CAPABILITIES, INCLUDING SERVICES TO BE PROVIDED UNDER THE EDUCATION OF THE HANDICAPPED ACT.

Objective A: Extraordinary measures to recruit and retain mental health professionals, including education/training activities, in order to alleviate significant shortages of mental health professionals throughout the state, especially those with specialized expertise.

A1. Milestone - **By the end of fiscal year 1992, to identify the staff at community mental health agencies, their education/experience, and needs in order to identify areas of needed training/education, as well as other human resource development issues.**

B1. Progress -

- 1989: Comprehensive survey conducted of 35 contractual community mental health agencies, including the community mental health centers, with a mental health staff of 1,056 individuals. The survey provided information on workloads, education, and training/education characteristics and aspirations of the staff.

- 1991: MHSIP staff data component design completed and reviewed. Statewide series of training conducted in September with implementation set for October.

C1. Barriers - Although information systems are not coordinated, community agencies have a choice of reporting mechanisms. No significant problems have been encountered although there was some initial resistance to including unique identifiers for staff.

D1. Outcome/Expectation - The results of the initial survey, although somewhat useful, were not particularly helpful for planning purposes on an ongoing basis. The current data collection requirement should not have the same problems, since it surveys all staff individually and is updated.

A2. Milestone - **By the end of fiscal year 1991, survey needs and develop mechanisms for recruitment and retention, including salary levels.**

B2. Progress -

- 1988: Survey conducted in public and private sectors to determine salary levels and their role in recruitment and retention of mental health staff.

- 1988: Contracts with community mental health agencies amended to provide for salary increases and other staff retention strategies. A floor of $6.30/hr. was established for adult mental health direct service caregivers; salary increases were limited to staff earning less than $23.07/hr. Within the possible range of staff retention strategies, the largest proportion of agencies chose to raise salaries and fringe benefits. Others included training, recruitment efforts, and other staff retention options.

C2. Barriers - There was some initial resistance and suspicioun encountered.

D2. Outcome/Expectation - Even with the minimums set and the salary increases given, agencies report that the salaries they have been able to offer are not competitive in the broader marketplace.

A3. Milestone - **By the end of fiscal year 1992, design, develop, and begin implementing the various components of a training/educational certification and credentialling process for BMH-funded mental health staff throughout the state.**

B3. Progress -

- 1989: Application submitted for federally funded three-year HRD project which was approved and began in mid-1990. The project, working in conjunction with the post-secondary education system in Maine, has two major goals: 1) the establishment of a statewide psychosocial rehabilitation orientation across the state and across all sectors of the mental health system and 2) the development of curricula and programs for specialized mental health training in, for example, psychogeriatrics, residential services, vocational services, crisis intervention, etc.

- 1990: Design of initial training components were begun by the HRD Project. These include training in supported employment, in substance abuse management, and the development of a curriculum for entry-level mental health technicians.

- 1991: HRD Project courses begun in case management and psychosocial rehabilitation.

- 1991: Statewide BMH certification/credentialling process developed for several areas of mental health workers: case managers, employment specialists, mental health rehabilitation technician series, substance

abuse specialist, residential staff. Course curricula developed; timetables set for completion of training/education; minimum standards set for experience/education requirements for new hires (effective 11/91).

- 1991: Brochure developed with summary of courses and training tracks being offered.

- 1991: Contract agreement negotiations with universities and vocational colleges continuing. Use of the ITV system being emphasized in order to increase course accessibility.

C3. Barriers - Lack of adequate staffing is a problem for an effort as massive as the certification/credentialling process. This is as true for the university and technical colleges as it is for DMHMR. In addition, understandably and not unexpectedly, it has at times been difficult for the higher education system to move at the pace required by the MH system. This follows with the difficulty of introducing and building a competency-based orientation into the coursework offered in the academic settings. Competency-based instruction is considered vital to the success of this effort.

D3. Outcome/Expectation - It's somewhat of a surprise that this complex certification/credentialling process, whose potential for impact on the delivery of quality mental health services in Maine could be extraordinary, is actually occurring and seemingly (in spite of awareness of all the hard work) so quickly.

Objective B: A broad, increased range of residential alternatives including long-term options and those directed toward specialized complex needs.

A. Milestone - **By the end of fiscal year 1992, develop and implement the housing needs identified in the mental health housing bond needs identification.**

B. Progress - Approximately 40% of the 216 beds now available in mental health supportive residential programs have been developed since 1988. This number is being dramatically increased by current initiatives.

- 1988: State funds, from the Legislative Special Session, resulted in group homes being developed in the Portland and Lewiston areas. These opened in late 1989 and early 1990.

- 1989: State-level BMH staff person designated with the responsibility for the development and implementation of its residential program agenda.

- 1989: $7 million housing bond referendum approved by voters in November for mental health housing and community treatment programs.

- 1991: Housing bond funds leveraged into $12 million mental health facility fund for acquisition and rehabilitation of residential program sites.

- 1990-91: Six housing projects for adults with mental illness, jointly funded by BMH and MSHA are currently under development, providing 42 additional beds/units, have begun to be completed:

  1) South Portland, Creative Health Foundation, purchased and rehabilitated a 4-unit apt. building. The program was fully occupied on September 1.
  2) Biddeford, Counseling Services, Inc. has just closed on a 4-unit apt. building. Renovation is expected to take about one month.
  3) Waterville, Kennebec Valley MH Center has purchased a 5-unit apt. building and re-financed a 7-unit building it owned.
  4) Dover-Foxcroft, Penquis MH Association, is purchasing a farmhouse to convert it to 5 independent units.
  5) Bangor, Central Maine Indian Association, is looking for a second site for its 8-bed project.
  6) Sanford, Creative Housing for Maine's People, is closing on a five-efficiency and 6-single room project. It should be operational next year.

- 1991: Legislature approved request for rental assistance program for adults with serious mental illness, which could support 106 units in southern Maine and 36 units in northern, with the following components:

  1) the subsidy itself;
  2) an adminstrative cost component for the agency administering the subsidy;
  3) a rent-up component to allow tenants to connect utilities and pay security deposits;
  4) a furniture loan revolving fund; and
  5) an emergency fund to allow the tenant's apartment to be held temporarily in the event of a hospitalization.

- 1991: Specialized psychiatric community residential/nursing home program developed and opened for seventeen elderly AMHI inpatients.

- 1991: Initial RFP, through the Mental Health Housing Fund, has been conducted for nine residential projects which will result in at least 54 additional community residential places for adults with mental illness. Some of these projects have and will also be applying for federal McKinney Act funds in order to maximize State funds.

  1) Waterville, Motivational Services, a 6-bed facility with an anticipated occupancy date of 4/92.
  2) Auburn, Medical Care Development, an 8-bed psychogeriatric residential program with an occupancy date of 5/92; this project has also been approved for HUD McKinney permanent housing funds.
  3) Hancock County, Medical Care Development, a 6-bed facility with an occupancy of spring 1992.
  4) Houlton, Aroostook MH Center, new construction of 6-bed facility, occupancy summer 1992.

5) Cumberland County, Shalom House, Inc., is looking for a site and may develop in Bridgton through a building owned by Western Maine Counseling Services.
6) Mid-Coast, Mid-Coast Mental Health Center, original site fell through. Plans to apply in the next round of McKinney Supportive Housing applications.
7) Bath-Brunswick, Shoreline Care Systems, proposes to use its current community support building for a residential facility. This is under discussion.
8) York County, Creative Health Foundation, is reconfiguring project site and proposal.
9) Bangor, not awarded, will be re-RFP'd shortly.

- 1991: BMH also working with three community agencies on housing projects which are outside the Bond process.

  1) York, Counseling Services Inc., a 7-bed facility in a building owned by the agency. Approved for HUD McKinney permanent housing funds. Occupancy early 1992.
  2) Portland, Ingraham Volunteers, has assumed ownership of 7-bed HUD McKinney permanent housing facility and has developed residential service programming. Occupancy October 1991.
  3) Portland, Ingraham Volunteers, has been approved for 12-bed residential treatment program for homeless persons with mental illness & substance abuse. Approved for HUD McKinney transitional housing funds. Occupancy late spring/early summer 1992.

- 1991: Development, approval, and implementation of the new Medicaid PNMI option for personal care and rehabilitation services in psychiatric residential programs.

C. Barriers - The inadequacy of available funding for supportive services and operational costs for residential programming has generally been an obstacle in the past few years. It is now, of course, with the State fiscal deficit even more pronounced. This was not as much of an issue when not many agencies were interested in residential development for this population group; however, this situation has changed. The Bond RFP process, for example, elicited many more applications than could be funded (because of lack of support service funding). Expertise in housing development and funding is still fairly limited and, therefore, each development process is more consuming than it might be. This, naturally, will change. There are also sometimes language and orientation differences between housing finance and service entities.

D. Outcome/Expectation - The very high level of interest in residential program development was not fully anticipated but is encouraging, providing a foundation for future efforts. The development of the many projects with the Maine State Housing Authority has produced a working relationship which is becoming more and more effective. The Authority has also now identified a commitment to the development of housing alternatives for special population groups and has been innovative and assertive in exploring options.

Objective C. Emphasize home-based/outreach service provision -- services delivered where the individual is -- in all aspects of services development.

A. Milestone - **By the end of fiscal year 1992, identify outreach and providing services where the client is as a critical characteristic of service delivery.**

B. Progress -

- Home-based geriatric assessment and treatment services are now available in thirteen of Maine's sixteen counties.
- The mental health intensive case management programs area based on an outreach orientation. This is a defined aspect of case management delivery.
- BMH residential program development concentrates on the provision of appropriate services to the individual in the home as needed.
- The provision of effective crisis intervention programs is premised on an outreach capacity, and BMH funded programs are developed with that expectation.

C. Barriers - Outreach is expensive and under or unpaid for travel time. There also seems to be a tendency for service provision to revert to offices if allowed.

D. Outcome/Expectation - The Geriatric Mental Health Resource Program is very highly regarded, and one of the chief components most often cited as critical to it effectiveness is the outreach capacity.

Objective D: Coordination of services and efforts among agencies, organizations, and systems.

A. Milestone - **By the end of Fiscal Year 1992, develop and initiate coordinating mechanisms.**

B. Progress -

- 1990: Vision Conferences, composed of members from agencies and organizations throughout the state, called by Commissioner of the Department of Mental health and Mental Retardation in order to reach concensus on a vision for the mental health system in Maine. Group drafting legislation on reginalization.
- 1991: Systems Assessment Commission report recommends establishment of regional mental health structure with intent to draft legislation to effect this.
- Southern and Northern Tier mental health planning groups called by DMHMR Commissioner.

C. Barriers - Until the Governmental Restructuring recommendations and legislative action on them, as well as action on the proposed regionalization bills, the development of coordination processes is not possible on a long-term basis.

D. Outcome/Expectation - Efforts have generally been positive with a growing concensus on the major needs of the system.

Objective E: Expand crisis intervention and stabilization programs throughout the state.

A. Milestone - By the end of fiscal year 1992, establish additional crisis intervention capacity so that crisis services are available in each mental health service area.

B. Progress -

- 1988-89: Three mobile BMH-operated crisis intervention programs developed in Augusta/Waterville, Portland, and Saco/Biddeford and a fourth program in the Lewiston/Auburn area provided through contract, all with supervised emergency and respite bed capacity.

- 1989: BMH created diversion program to allow acute crisis needs to be met in local hospitals, including Jackson Brook Institute, St. Mary's Hospital, Mid-maine Medical Center, Penobscot Bay Hospital, Brunswick Regional Hospital, Southern Maine Medical Center, Maine Medical Center, Kennebec Valley Medical Center, Portsmouth Pavilion, Bath Memorial Hospital, Eastern Maine Medical Center, and Togus.

- 1989: Telephone hotline established for Washington, Hancock, Penobscot, and Piscataquis Counties.

- 1990: Crisis intervention programs in Maine expanded to six with the establishment of mobile outreach crisis intervention programs in the Ellsworth and Bath/Brunswick areas,

- 1991: Crisis intervention program developed in the Rockland area.

- 1991: Discussion and planning again initiated re: establishment of crisis program in Bangor area.

C. Barriers - Staffing for the around-the-clock crisis programs continues to be marginal, threatened by illness, vacations; funding is not available for greater numbers. Recruitment can also be difficult due to the required three shift rotations and the complexity and difficulty of the work. In addition, highly skilled staff are needed for crisis intervention. There may also be a tendency for community members and agencies to use the programs for non-crisis situations. In some instances, this reflects inadequate or inaccessible services. In addition, more rural models need to be explored. The developing capacity for community involuntary psychiatric inpatient beds/units in community hospitals should have a significant impact.

D. Outcome/Expectation - The 24-hour per day crisis programs with their emergency/respite bed capacity have proved highly effective, and areas without them have made their needs known.

Objective F: Develop statewide comprehensive diagnostic, screening, and assessment expectations and procedures.

A. Milestone - By the end of 1992, develop and test Individualized Support Plan document and process.

B. Progress -

- 1990: Class action lawsuit settlement agreement signed by DMHMR and plaintiffs. The consent decree calls for thorough assessments and the development and implementation of comprehensive individual support plans for all persons receiving publicly funded mental health services. Their development is underway.

- 1991: Consultants hired to develop ISP and process in conjunction with DMHMR and advisory group. Draft documents completed through a thoughtful, deliberate process.

C. Barriers - The impact of the various approaches and orientations which can be taken to implement client choice in the ISP process has presented challenges in its development as a meaningful document and process.

D.Outcome/Expectation - The ISP is scheduled to be implemented in the near future.

Objective G: Develop and implement integrated individualized vocational opportunities statewide for persons with severe psychiatric disabilities.

A. Milestone - By the end of fiscal year 1992, BMH, in collaboration with BR, will develop a coordinated model design for the provision of individualized vocational opportunities with implementation guidelines.

B. Progress -

- Legislature in Special Session authorizes funds which allow the development of initial supported employment programs.

- 1990: Direct service contracts issued for ten sites by the end of fiscal year 1990.

- 1991: BMH funds services in fifteen sites throughout the state.

- 1991: Vocational data collection instrument developed and implemented. Reporting will be quarterly.

- 1991: Vocational team at AMHI established.

- o 1991: Employment Specialist HRD certificate/credentialling training requirements developed and issued.

- o 1991: Model interagency vocational service delivery system designed in conjunction with the Bureau of Rehabilitation, DHS.

Objective H: Promote the development of family support, peer support, rights, advocacy, education, and socialization opportunities for adults with severe and prolonged mental illness.

A1. Milestone - By the end of fiscal year 1992, establish active family and consumer involvement as a priority and increase focus on consumer-directed and -run efforts.

B1. Progress -

- o 1986: Rights of Recipients rules promulgated in 1986 and revised since. The Rights Rules are once again in revision and should be completed this year. Mental Health Right Advisory Board active in this process.

- o 1989: Bureau of Mental Health establishes a family consultant position to provide formal and informal support, ombudsmanship, and advocacy; issue a family support newsletter; and develop a family support lending library.

- o 1990: Family consultant position transferred to the statedwide Alliance for the Mentally Ill of Maine.

- o 1991: Departmental Office of Consumer Affairs established, and position for Director being developed.

- o 1991: Two-day consumer mental health conference in Maine planned by and for consumers. Conference to be held in November at the Bethel Inn; scholarships and transportation are being made available.

- o 1991: Demonstration projects are to be RFP'd for community social/activities providers, such as the Y's, to develope mainstream alternatives for persons with mental illness. There is $50,000 this year and $100,000 next.

- o 1991: A social club is being developed and will open this year in Rockland, staffed through the Amity Center's vocational program, by Mental Health Services, Inc.

  BMH funding supports a number of social clubs throughout the state. These provide social and recreational rehabilitation. In some of these there are meals provided at a minimum cost. Some also support vocational programs. One consumer-operated peer support/educational/advocacy drop-in center (the Portland Coalition for the Psychiatrically Labeled) and one consumer-directed program (Together Place) exist. The first, in Portland, is funded by the NIMH Community Support Program.

- o 1991: Consumer case management aide training curriculum developed as part of the HRD Project efforts.

- o 1991: Collaborative AMHI/AMI quarterly educational meetings continue to draw attention and attendance.

- o 1991: Consent Decree carries extensive rights requirements. These are being incorporated into the Implementation Plan for mental health services.

- o 1990: Consumer Consultant hired on contractual basis, with component of duties being advocacy.

C1. Barriers - Sensitivity to the rights and needs of individuals must be intrinsic and basic to these activities. There are still many parts of the mental health system which resist some of the new intiatives involving consumer choice and consumer effort and have many questions regarding the impact on treatment.

D1. Outcome/Expectation - The interest in consumer-driven and consumer-run mental health services among consumers of mental health services is high -- this is not unexpected.

V. DESCRIBING FINANCIAL RESOURCES AND STAFFING NECESSARY TO IMPLEMENT THE REQUIREMENTS OF THE PLAN.

Objective: To develop and implement a management information system with the capacity to provide, track, and analyze financial, individual, services, and human resource data to be used in planning the development of mental health services.

A. Milestone - **By the end of FY'92, develop and test an information system, beginning with the staff and individual components.**

B. Progress -

- o 1991: Staff component has been developed and training conducted. Implementation for data collection is effective October 1991.

- o 1991: Work has begun on the individual component design.

C. Barriers - There are difficulties, discussed elsewhere both in this summary and in Part C, relating to the differences in information systems both within the department and the community. Knowledge and skill levels are often inadequate. Staffing levels are also all too frequently inadequate for this purpose. The bulk of information available to the department at this time is in aggregate form and does not lend itself easily to this need.

D. Outcome/Expectation - Thus far, the process has been as would have been expected.

VI. PROVIDING ACTIVITIES (PROGRAMS) TO REDUCE THE RATE OF HOSPITALIZATION OF INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

Objective: To develop the community network of services necessary to preventing or reducing crises which lead to hospitalization.

A. Milestone - By the end of fiscal year 1992, to reduce admission rate to be generally lower than the diversion rate.

B. Progress -

- 1988-91: The Community Linkage Assessment and Stabilization Service (C.L.A.S.S.), or the Diversion Program, was developed through special initiative funding from the Legislature in September, 1988 to purchase inpatient psychiatric services at local hospitals, by facilitating these and other alternative solutions through a closely coordinated network in the Augusta Mental Health Institute catchment area. This network consists of the following components:

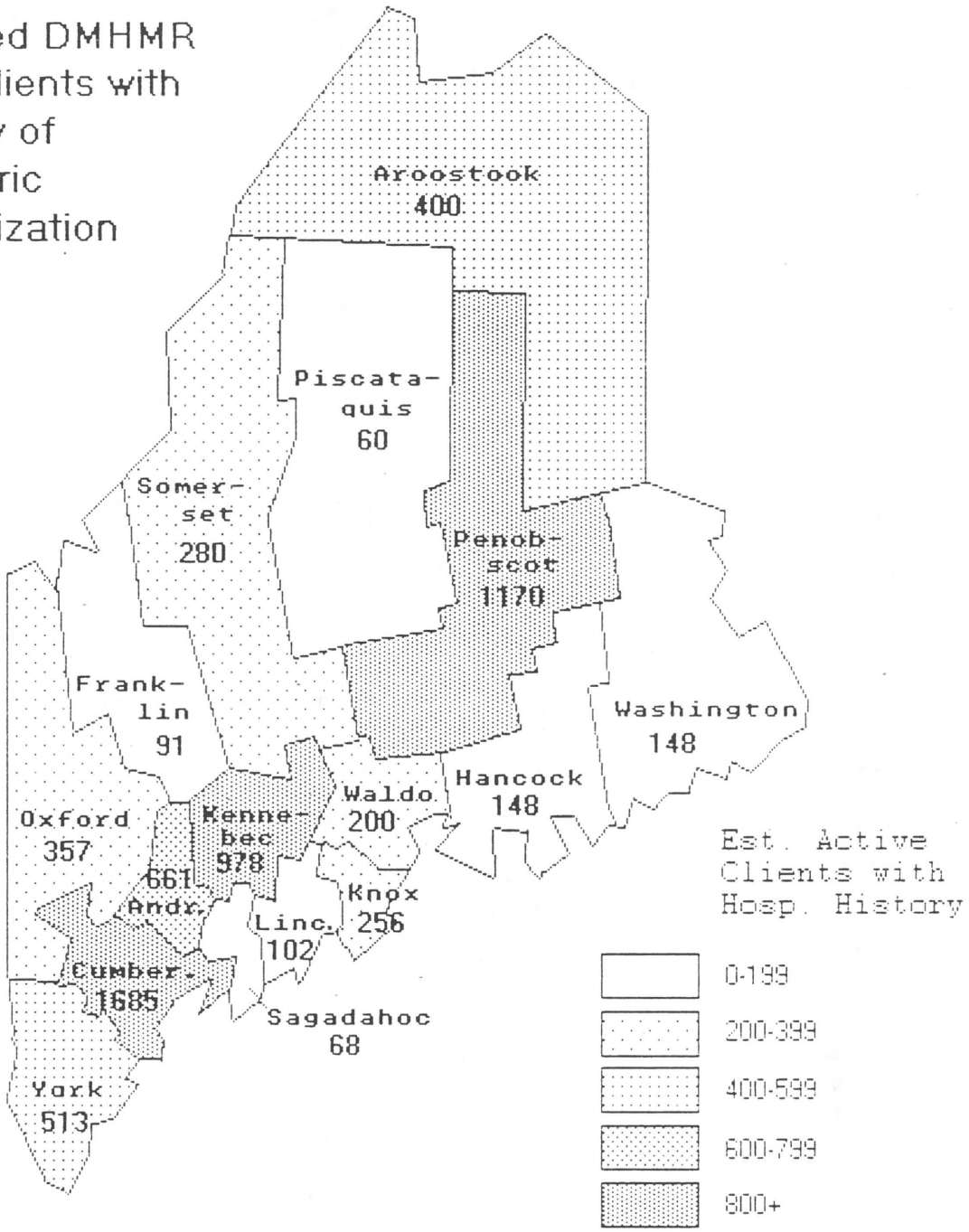
  (a) admission and emergency service physicians and social workers at a variety of community hospitals,
  (b) emergency workers at community mental health agencies,
  (c) crisis stabilization staff in both BMH and community system programs,
  (d) AMHI admission staff and outreach liaisons, and
  (e) community support and case management staff in community agencies.

- 1989-91: From June 1989 to September 1991, 3,485 individuals were diverted from AMHI admission to community psychiatric inpatient programs or, through crisis stabilization in the community, to appropriate community services.

- 1989-91: The daily census at the Augusta Mental Health Institute has gone from 340 in FY'89 to 300 in FY'90 and 285 in FY'91, and admissions have gone from 1,424 to 645 during the same time. Crisis program staff in certain counties have the authority and responsibility to use designated funds to purchase local psychiatric inpatient care. Representatives from all groups meet monthly with BMH and AMHI administrators to review how C.L.A.S.S. is working, to iron out any difficulties, fine tune the process, and anticipate future needs.

- 1991: Considerable effort has and is being made to develop psychiatric involuntary inpatient capacity in community hospitals so that if hospitalization is required, individuals can remain closer to home rather than going to one of the two State institutions. The first of these units will shortly become operational.

Estimated DMHMR Active Clients with a History of Psychiatric Hospitalization



Source: 1990 DMHMR Client Census.

Note: Numbers represent estimations based on frequency of visit information. "Active" means on books during a one week time period.

ANNUAL ADMISSIONS AND AVERAGE DAILY CENSUS
BY FISCAL YEAR
AT THE STATE MENTAL HEALTH INSTITUTES

YEAR	AMHI		BMHI	
	ADMISSIONS	CENSUS	ADMISSIONS	CENSUS
1947	359	1,526		
1948	341	1,557		
1949	368	1,585	345	1,203.6
1950	373	1,646	330	1,153
1951	421	1,694	333	1,119.1
1952	425	1,729	338	1,106.5
1953	416	1,767	358	1,118.1
1954	451	1,800	362	1,142.7
1955	405	1,830	395	1,152.7
1956	481	1,840	427	1,164
1957	423	1,795	410	1,157.5
1958	483	1,797	490	1,168.2
1959	562	1,786	475	1,166.2
1960	551	1,749	513	1,160.8
1961	592	1,747	612	1,161.3
1962	853	1,758	675	1,161
1963	899	1,711	728	1,181.6
1964	989	1,652	747	1,198.8
1965	1,069	1,620	757	1,202.4
1966	1,038	1,558	806	1,174.2
1967	1,177	1,580	792	1,159.9
1968	1,145	1,608	837	1,154.1
1969	1,177	1,615	849	1,168.4
1970	1,207	1,553	903	1,058.4
1971	1,315	1,529	983	931
1972	1,186	1,273	828	712.9
1973	1,101	743	865	536.5
1974	807	520	907	461.2
1975	806	427	853	384.9
1976	878	371	667	309.8
1977	992	338	593	306.9
1978	1,093	315	684	314.2
1979	1,057	299	693	333.6
1980	996	295	723	324.8
1981	933	302	618	318.9
1982	1,115	299	435	301.8
1983	1,242	286	403	303.3
1984	1,405	277	288	290.3
1985	1,347	308	299	281.2
1986	1,129	332	301	280.1
1987	1,203	361	287	277.6
1988	1,477	354	284	274.5
1989	1,420	357	299	275.6
1990	1,093	334	323	270.8

C. Barriers - Staffing positions are not adequate in number. Lack of funding and resources continue to be a problem.

D. Outcome/Expectation - C.L.A.S.S. works well because it brings all the key community service providers together in a formalized, closely coordinated network. This assures that providers are sharing expertise and information in the best interest of persons with severe and prolonged mental illness. However, all aspects of an available, accessible, quality mental health system play a part in reducing the rate of hospitalization. C.L.A.S.S. has exceeded expectations.

VII. PROVIDING CASE MANAGEMENT SERVICES FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS WHO RECEIVE SUBSTANTIAL AMOUNTS OF PUBLIC FUNDS OR SERVICES; THE TERM "INDIVIDUAL WITH SERIOUS MENTAL ILLNESS" TO BE DEFINED UNDER STATE LAWS AND REGULATIONS.

VIII. PROVIDING FOR THE IMPLEMENTATION OF THE CASE MANAGEMENT REQUIREMENTS IN THE PRECEDING PARAGRAPH IN A MANNER WHICH PHASES IN BEGINNING IN FISCAL YEAR 1989 AND PROVIDES FOR THE SUBSTANTIAL COMPLETION OF THE PHASING IN OF THE PROVISION OF SUCH SERVICES BY THE END OF FISCAL YEAR 1992.

Objective A: Development of a statewide case management system coordinating and assuring appropriate individualized service provision for those with a serious mental illness.

A. Milestone - **By the end of fiscal year 1992, establish an intensive case management program in all mental health regions of the state and enhance the case management functions of the community support worker system.**

B. Progress - Integrating services "are those services that bring psychiatrically disabled people into contact with the helping system and provide comprehensive assessment and planning, linkage to other services, resource development, and long-term monitoring and continuity of care." Integrating services coordinate the other service system functions.

Integrating services are currently provided in two ways: (1) Community Support services as a combination of case management, supportive counseling, medication assessment and monitoring, and skill development services; and (2) Intensive Case Management (ICM) as an intensive service that has five major components: connecting, assessing and planning, linking, advocating, and monitoring.

ICM was first provided in Cumberland County, the state's most populous region, by the Holy Innocents social services agency. This program has served as a model for the other ICM programs developed to enhance the range of integrating services in five other population centers of Kennebec, Penobscot, Androscoggin, Knox, and York Counties. Generally, these new programs did not replace the existing Community Support services, but were developed in addition to them. The new programs have been phased in during FY'90, and a total of 560-680 individuals received ICM services by the end of the fiscal year. In addition, there is a small case managment function sited at the Central Maine Indian Association.

A monitoring/evaluation form has been developed to track various elements (e.g. amount of contacts, hospitalizations, changes in housing, job status and social support) on a monthly basis through the reporting of Case Managers on each of the clients they serve.

A three-year NIMH research grant has been awarded to compare case management models at Holy Innocents in Portland. This added 3 new ICM positions in Cumberland County and provides comparative data on the effectiveness of two case management models, as well as the traditional method. An application to NIMH for funding for the development of a client data system has also been funded.

A definition of individuals with severe and prolonged mental illness, the priority population group for the Bureau of Mental Health, is included in its contracts with community mental health agencies. The proposed legislation pending before the legislature provides a new description of the Department and its role and responsibilities as well as describing the population groups it serves. This will be an aspect of any legislation issuing from this effort.

- 1988: The State's first Intensive Case Management Program was started in Portland.

- 1989: Three-year NIMH research grant awarded to DMHMR to compare traditional and rehabilitation case management models being tested at the Portland intensive case management program.

- 1989: Using the Portland case management program as a model, intensive case management programs developed in the Bangor, Augusta/Waterville, Lewiston/Auburn, Saco/Biddeford areas. A case manager position was also established at the Central Maine Indian Association for Native Americans living off reservations.

- 1990: Intensive case management program established in the Rockland area. With the development of this program, there are now case management programs in five of the six mental health service areas.

- 1991: Using monthly reporting date, an outcome assessment analysis was done and a report written reviewing two ICM agencies. Additional analyses of other providers will be done.

- o 1991: The establishment of case management capacity in the Bath/Brunswick area started in July, 1991.

- o 1991: Proposed legislation submitted to legislature containing definition of priority population.

C. Barriers - Medical and dental care is not provided directly through mental health funds. Case managers arrange for clients to receive such care as needed. The case management model is evolving. Expectations of it vary considerably, sometimes causing frustration when the expectation and the program do not match. It seems that, as with crisis services, there is the expectation that it will take care of everything.

D. Outcome/Expectation - Some interesting trends seem to be developing in that a judgment seem to be forming that the linking/brokering model is less desirable. This, it has been expressed, would be especially true for rural areas. The case management research project has not issued preliminary results.

IX. PROVIDING FOR THE ESTABLISHMENT OF AND IMPLEMENTATION OF A PROGRAM OF OUTREACH TO, AND A SERVICE FOR, INDIVIDUALS WITH SERIOUS MENTAL ILLNESS WHO ARE HOMELESS.

Recent surveys of homelessness in Maine estimate that on any given day there are about 350-450 truly homeless persons in Maine, or about 117-150 homeless mentally ill persons (based upon studies which indicate about one-third of homeless persons are mentally ill). In addition, there are a number of mentally ill persons who are at risk of homelessness because of the instability of their housing situation. BMH has identified five major areas of the state containing the greatest numbers of adults who are homeless or at risk of homelessness. These locations center primarily around the larger urban areas in Maine: Bangor, Augusta, Lewiston/Auburn, Portland, and Saco/Biddeford. About half of homeless individuals are located in the Portland area with the others fairly evenly distributed among other areas.

Apart from the regular Section 8 rental subsidies made available to low-income individuals, the network of supportive mental health residential programs and services over the past few years represents a great deal of progress, but, even so, does not begin to meet the need. Through the federal McKinney Act, the Department has applied for and received funds to provide a variety of supportive services for mentally ill persons who are homeless or at risk of homelessness. It has assisted community providers, through technical assistance, matching funds, and other funding for services, to make use of or apply for these funds as well. An NIMH demonstration grant in the Portland area for outreach/case management for the homeless or at risk of homelessness has been refunded, and is in its third and final year.

BMH will continue to work to improve services for the homeless and those at risk of homelessness. This will include efforts to continue to tap federal funding sources, and to increase the availability of housing alternatives as described elsewhere in this plan.

Objective: Identify programs and services which work effectively with homeless individuals with mental illness in order to plan future service development.

A. Milestone - **By the end of fiscal 1992, evaluate the current PATH-funded services to determine their effectiveness and make appropriate adjustments as indicated.**

B. Progress -

- 1988-91: $137,500 in MHSH funds were allocated in State FY '91 to Portland (two projects) and York County for a variety of homelessness services, including case management and outreach. A major shift in service design for the FY'92 PATH formula grant has been implemented: Funding is being spread across a wider variety of agencies to provide part-time outreach, case management, and other supportive services to persons with serious mental illness resident in shelters.

- 1990: Statutory establishment of the Interagency Task Force on Homelessness. DMHMR active member.

- 1989-91: Considerable residential program development as well as establishment of the new rental subsidy program (See Requirement #4).

C. Barriers - The major barrier has been the lack of an individualized MIS system which can identify outcomes and unmet needs. Information provided thus far has been aggregate and/or anecdotal.

D. Outcome/Expectation - The MHSIP data collection system, as it comes on line, will provide individualized information.

XI. CONSULTING WITH REPRESENTATIVES OF EMPLOYEES OF STATE INSTITUTIONS AND PUBLIC AND PRIVATE NURSING HOMES WHO CARE FOR INDIVIDUALS WITH SERIOUS MENTAL ILLNESS.

Objective: Assure the inclusion and active participation of representatives of State institutions and public and private nursing homes who provide services to persons with serious mental Illness.

A. Milestone - **By the end of fiscal year 1992, assure such representation on advisory and planning groups.**

B. Progress -

- o 1991: Maine Commission on Mental Health, the Joint Advisory Committee, Visions, Systems Assessment Commission all have such representation.

C. Barriers - None that have had major impact except for the Maine Commission on Mental Health where State agency representation has clearly not been welcome -- there has all along, however, been a State mental health institute employee on the Commission, an instance where the perception of the individual altered the response.

D. Outcome/Expectation - These idividuals have brought long-term care issues, especially those specifically related to twenty-four hour care and treatment, into planning.

XII. UTILIZING THE STATE MENTAL HEALTH PLANNING COUNCIL, OR ESTABLISHING A NEW COUNCIL TO REVISE, REVIEW, AND MONITOR, AND EVALUATE ALL ASPECTS OF THE DEVELOPMENT AND IMPLEMENTATION OF THE STATE PLAN, WITH A FORMAL TRANSMISSION OF COMMENTS TO THE GOVERNOR AND TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; COUNCIL MUST SERVE AS AN ADVOCATE, INCLUDE CONSUMERS AND FAMILY MEMBERS, AND HAVE NOT MORE THAN 50% OF MEMBERSHIP BE STATE EMPLOYEES AND MENTAL HEALTH PROVIDERS.

Objective A. To develop a coordinated participatory planning process which involves a broad representation of persons involved with mental health services as well as being regionally responsive.

A. Milestone - **By the end of fiscal year 1992, establish a new planning group which meets both Federal and State requirements, whether as a separate entity or a new function for an existing body, with the capacity to meet P.L. 99-660 requirements for both children and adult mental health services.**

B. Progress - The Maine Department of Mental Health and Mental Retardation's mental health planning process is centered in broadly based local participation and incorporates several State and Federal planning requirements:

1. LD 520, introduced and passed by the 112th State Legislature, requires that a biennial comprehensive Bureau of Mental Health State mental health plan be developed. The Bureau of Mental Health (BMH) is responsible for adult mental health services, and its plan for all state mental health services is due to the Legislature by December 15th of every even-numbered year. The Maine Commission on Mental Health is charged with advising the Department in the development of this plan.

2. The Office of Community Support Systems within the Bureau of Mental Health is mandated in State Statute to develop a biennial mental health plan specifically for adults with severe and prolonged mental illness.

3. The Bureau of Children with Special Needs (BCSN) is also required in State Statute to present a biennial plan to the Legislature on January 1st of every odd-numbered year for all children with special needs requiring treatment. This includes children with mental health problems and developmental disabilities. The BCSN Advisory Committee on Children and Adolescents is the advisory group to the Bureau.

4. The federal planning bill, PL 99-660, requires a three-year comprehensive state mental health services plan, first due January 10, 1989, to be submitted to the U.S. Department of Health and Human Services, with annual updates due the end of September. The plan must provide for the development of a coordinated community-based service system for adults with severe and prolonged mental illness as

well as children and adolescents with serious emotional disorders, including case management services and services for homeless mentally ill persons. Planning must be done with the advice and involvement of a properly constituted mental health advisory group, here the Maine Mental Health Planning Council.

5. On August 2, 1990 a settlement agreement was signed by the Departments of Human Services and Mental Health and Mental Retardation and the plaintiffs in a class action suit brought by patients of the Augusta Mental Health Institute. The consent decree carries broad planning requirements for both institute and community mental health services, with the first draft of the implementation plan due January 1991. The population group covered by the decree consists of individuals, both adolescent and adult, who have been AMHI patients at any time as of January, 1988, although no one can be discriminated against soley on the basis of class membership.

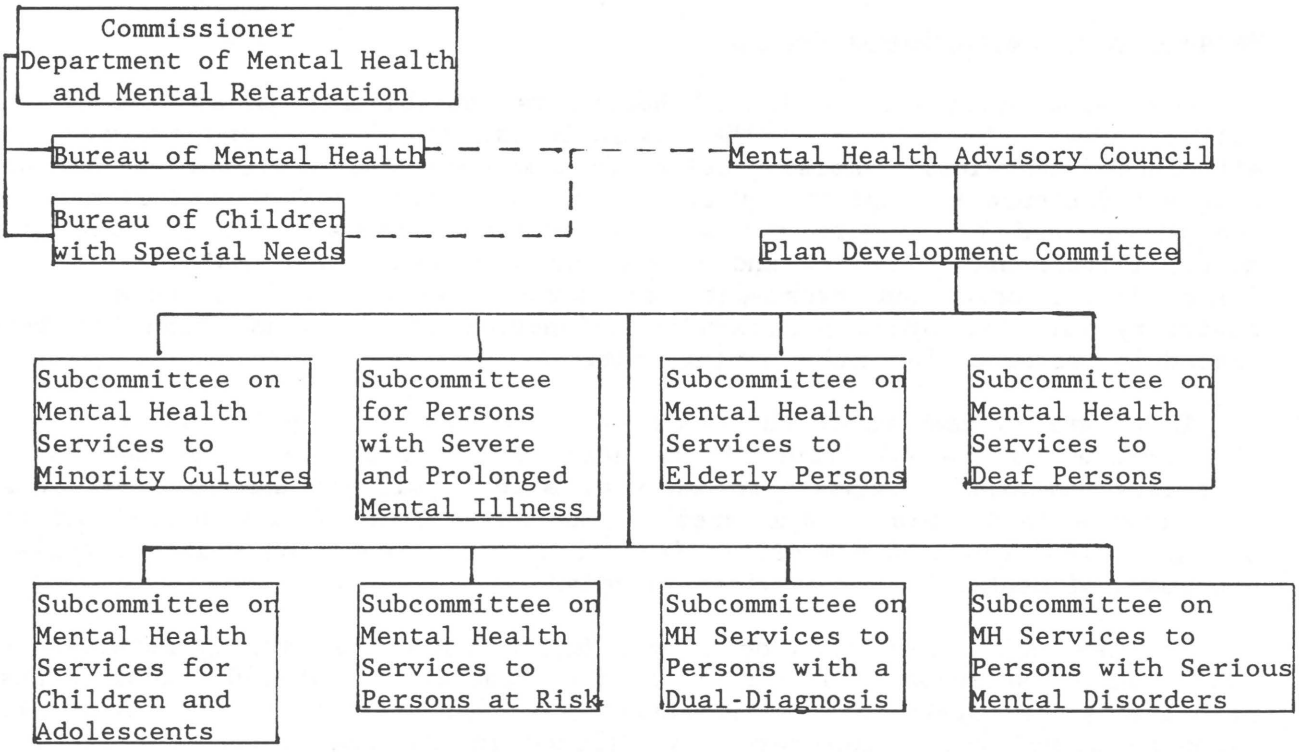
The BMH State mental health report is broadest in scope of the three adult plans, substantially incorporating the other two reports. The Office of Community Support Systems (OCSS) Plan focuses specifically on adults with severe and prolonged mental illness and is incorporated into the BMH State mental health plan, both required to be submitted to the Legislature's standing committee on human resources. The Federal comprehensive state mental health plan focuses on adults with severe and prolonged mental illness (corresponding to the OCSS plan) and children with serious emotional disorders (part of the BCSN plan). However, the mandate of the Consent Decree, although it specific population group is the narrowest of all, may in its effect be the broadest.

MENTAL HEALTH PLANNING STRUCTURE AND PROCESS

Mental Health Advisory Council
Planning - FY 1988

While its roots go back to the 1950's, the original Mental Health Advisory Council was statutorily mandated in 1977 to advise the Department in the development of the annual Bureau of Mental Health State adult mental health plan. Because of this existing function and because it was appropriately representative, the Council was designated by the Governor to serve as the Federal advisory planning body as well. In order to respond to both State and Federal expectations, the Council formed a standing committee, the Plan Development Committee, to organize and implement the Council's planning efforts. The Plan Development Committee formed eight subcommittees focusing on different mental health adult and child population groups. The Chairperson and members of the Plan Development Committee and the Chairs of the subcommittees were Council members, but subcommittee members were not required to be Council members. This structure greatly increased the base of participation in planning efforts.

MENTAL HEALTH ADVISORY COUNCIL PLANNING STRUCTURE



The subcommittees began forming in August, 1987. Meetings were held all over the state with over 1,200 people ultimately involved. Some subcommittees based their process on the formation of distinct regional groups, some on

special populations, while others blended the two configurations. All, however, had regional input and included a wide representation of individuals and organizations. The Plan Development Committee met with the chairs and staff of subcommittees, reviewed drafts, made comments and suggestions in preparation for full Council consideration.

The Department, with the co-sponsorship of the Council, held 10 community mental health forums in 1988 throughout the state to facilitate, broaden, and encourage wide public participation and comment. The comments made at these forums were incorporated directly into the work of the subcommittees and ultimately into the plan. The highest priority service needs identified by all the planning groups, as well as those cited at the community forums, were pulled together by the Council's Plan Development Committee into a list of the ten highest priority mental health service needs statewide (see later in this section).

With legislative and community concern about the August Mental Health Institute increasing, there was a strong desire by some to create an independent State mental health monitoring group. Legislation was introduced to creat an independent, staffed mental health commission which would have monitoring, evaluation, and planning functions. At the same time, the authorization for the Advisory Council was lapsed at the end of June, 1989.

Maine Commission on Mental Health

The Maine Commission of Mental Health was established in statute in the fall of 1988. The purpose of the Commission is "to monitor and evaluate the efficiency and timely implementation of community and institutional reform programs designed to improve opportunities for persons with mental illness in the State, and to promote and monitor advocacy programs for persons with mental illness and to review and assess the development and implementation of standards of care and treatment for persons with mental illness." The statutory biennial State plan advisory function of the Commission has been placed in its Education and Planning Committee.

There are 23 members of the Commission, 12 appointed by the Governor, and 11 appointed by the President of the Maine Senate and Speaker of the House. Statutory membership composition includes Maine residents who have knowledge and provide leadership in the area of mental health. A law passed in the spring of 1989 expanded membership from 21 to 23 by requiring that two primary consumers of mental health services be added.

The new Maine Commission on Mental Health had no membership requirements and when constituted did not meet the Federal PL 99-660 requirements, principally in State agency representation. A new Maine Mental Health Planning Council was, therefore, established in the Summer of 1989 for this purpose. Its members are appointed by the Governor.

Maine Mental Health Planning Council
Planning

The Mental Health Planning Council was formed during the summer of 1989 to become the planning advisory body for federal purposes. Membership in the new Council included primary consumers, family members, community mental health service providers, State agency representatives, and interested community members (educators and advocates). The State agency staff represented agencies responsible for: mental health, education, criminal justice, housing, vocational rehabilitation, social services (two, one each for adults and children), and the State Medicaid program.

The process for developing the September, 1989 revision of the Plan was based on the existing planning process. Two community mental health forums were held that year to discuss the revisions of the Mental Health Services Plan, one in Portland and one in Ellsworth. Notices and goal & objective updates were sent to the 1200 former plan participants, as well as to agency representatives. Those who could not attend the forums were invited to send written comments to the Department. Three primary mechanisms were used to solicit public input: community mental health forums, review by the Maine Commission on Mental Health, and review by the Mental Health Planning Council.

In 1990, the Mental Health Planning Council returned to the orginal planning subcommittees throughout the state asking that they meet again to review the goals and objectives for their currency and progress. The subcommittees were asked to identify accomplishments and problems and barriers to full implementation. Some of the subcommittees had continued their activity throughout the year while some had not, so that the degree to which the groups responded varied greatly. However, the groups responded and continued to meet as they prepared for the biennial State adult mental health plan due December 15, 1990 to the Maine Legislature. Six community mental health forums were held across the state from October 1st through December 10th in Presque Isle, Bangor, Augusta, Bath, Lewiston/Auburn, and Portland.

In 1991, the Council, in a hectic, changing environment, continued its discussions regarding the development of a local long-term, ongoing planning structure and process, as well as its struggle to define its role amid many other planning groups and efforts underway at the same time. Some of these had greater State presence and mandates, making the process much more difficult and complex: the settlement agreement for the law suit filed against the Departments of Human Services and Mental Health and Mental Retardation; the Maine Commission on Mental Health; the legislative Systems Assessment Commission; the Departmental Visions meetings; and the worsening economic climate. In addition, many programs and intitiatives also have their own advisory bodies.

Staffing for the Council and its planning groups continued to be a major difficulty. The Council has been persistent in voicing the need for identified, paid staff, including on a regional basis. The Department had hoped to provide for this through the contractual process but was unable to follow through. The various planning efforts for this progress report have continued to be staffed by either DMHMR personnel or community providers - and in some instances, both -- all of whom have other primary responsibilities.

Community forums were held this year in regard to the Consent Decree, called by the Court Master in conjunction with the Departments of Mental Health & Mental Retardation and Human Services. The purpose was to solicit public input on the first draft of the Implementation Plan by the two departments for the Consent Decree issued by the Maine Superior Court. Ten forums were held from February 11 to March 6, 1991 in Bath, Farmington, Lewiston/Auburn, Sanford, Ellsworth, Rockland, Bangor, Portland, Augusta, and Presque Isle. Written input was also soliticited. All comments, both oral and written, were compiled and analyzed and distributed.

The current Council will meet for the last time on October 29, 1991 to present its commentary on this plan and progress report. It has recommended the formation of a new Planning Council at the point systemic decisions make it viable, whether as a new function for the Maine Commission on Mental Health or as a separate entity. In either event, the Council recommends generally the following:

COMPOSITION: At least 50% of the Council must be composed of non-providers, non-State agency representatives, and must include 1) individuals with severe and prolonged mental illness who receive or have received mental health services; 2) family members of such individuals with severe and prolonged mental illness; 3) representatives of public and private entities concerned with the need, planning, operation, funding, and use of mental health and related services; and 4) State agency representatives for mental health, education, vocational rehabilitation, criminal justice, housing, and social services. The proposed regional planning groups must also be similarly representative.

STRUCTURE: At least 25 members -- and perhaps as many as 60 or more -- on the statewide Council. Council will provide technical assistance to, coordinate with, and assist in developing regional planning groups and processes (whether these are affiliated with regional boards or are free-standing if there are no such structures). Focus groups would be developed as needed.

MEETINGS: The statewide Council will meet quarterly or, as needed, more often. Local planning groups would meet at least monthly. Focus/work groups would meet as needed.

PURPOSE: 1) To bring together a broad and representative constituency concerned with mental health issues; 2) To promote the increased participation of consumers and their families and other constituencies in the local and statewide planning and provision of mental health services; and 3) To communicate a shared vision of mental health services and the principles and values underlying this vision.

FUNCTIONS: 1) To serve as an advocate for seriously mentally ill persons, severely emotionally disturbed children and adolescents, and others with mental illness or emotional problems; 2) To monitor, review, and evaluate, at least annually, the allocation and adequacy of mental health services in the state; and 3) To provide feedback on services being provided statewide, those still needed, the plan to provide them, and the implementation of that plan.

PLANS: Neither the Council nor the regional planning groups would themselves develop the plans. This would be the responsibility of DMHMR and/or the regional authorities, if formed. The Council and regional planning groups would provide input into their formation, identifying needs, and would evaluate the proposed implmentation.

STAFFING: The Council would have its own staff. In addition, the local planning groups, whether affiliated or not, would also have adequate paid staff.

Planning and Advisory Groups to the Department of Mental Health and Mental Retardation on Mental Health Issues

There are a great many advisory groups which work with the Department on mental health issues. Some are in State Statute; others are voluntary and were formed to meet a particular need. A difficulty may be, indeed, that there are in fact so may such groups which, for the most part -- except through occassional in-common members -- do not coordinate their efforts with each other. The following lists groups which participate in some way in the mental health planning process.

1) Maine Mental Health Planning Council - Federally mandated. Full PL 99-660 Council meets monthly. Committees and their subcommittees meet as needed.

2) Joint Advisory Committee on Mental Health Services to Elderly Persons - Voluntary. Meets monthly. Provides the core group for the PL 99-660 Council's subcommittee on elderly mental health issues.

3) Advisory Committee on Mental Health Services to Deaf Persons - Voluntary. Meets quarterly. Provides the core group for the PL 99-660 Council's subcommittee on deafness and mental health issues.

4) BCSN Advisory Committee on Children and Adolescents with Special Needs - Statutory. Meets monthly. Has responsibility for all special needs issues re: youth for the Bureau of Children with Special Needs but forms the core group for the PL 99-660 Council's subcommittee on children's mental health issues and plan.

5) Maine Commission on Mental Health - Statutory. Full Commission meets monthly. Committees meet as needed. Independent State commission, full-time staff. Only one of these groups not to be staffed by DMHMR. Advisory to BMH re: the State biennial adult mental health services plan.

6) Visions Conference - Voluntary. Convened by DMHMR Commissioner to form a shared mental health system vision. Meets monthly. Focusing on regionalization of mental health services. Council Chair is member, as are other Council members, but they participate in other roles.

Consent Decree Advisory Committee - Mandated by consent decree. No relationship to P.L. 99-660. Some members are incidentally part of the local planning process.

There are, in addition, other groups which influence mental health service planning and delivery, such as the statutory Mental Health Rights Advisory Board, the Housing Bond Advisory Board, the HRD Advisory Committee, etc. - as well as several task forces and other work groups, including interdepartmental ones, such as the ongoing Interagency Task Force on Homelessness.

In general, such groups have broad representation including consumers, family members, providers, State agencies, and other interested individuals. Staffing is generally provided by the appropriate State agency which then provides the staff time, administrative support, meeting rooms, etc. and meets members'expenses, such as mileage. The expenses and time for representatives from community agencies are typically assumed by those agencies, although this is not always the case. The effect of increasing budget deficits continues to be of great concern.

INDICATORS OF "SUBSTANTIAL IMPLEMENTATION"

Significant developments in the mental health system of care for adults with serious mental illness have taken place since the initiation of the P.L. 99-660 planning process began in 1987. These changes are provided in detail in "Part C" and in summary form earlier in "Part A".

This effort, involving hundreds of people over the years, has provided an opportunity to examine the existing mental health system in a systematic way and to identify needed services based on this analysis. The services available to Maine citizens today are very different than in 1987:

- **The development of comprehensive standards for mental health services is nearing completion. Specific areas include inpatient, case management, residential, outpatient, home-based services, crisis & emergency, vocational/rehabilitation, and medication managment.**

- **Contractual accessibility provisions requiring accommodtions for persons who are deaf and mentall ill as well as persons with mental illness and substance abuse disorder.**

- **The development of crisis services in nearly all mental health areas of the state:**

  . Three State-operated mobile outreach programs in the Augusta/Waterville, Portland, and Saco/Biddeford areas,
  . One hospital-based program operated by Tri-County Mental Health Services in Lewiston/Auburn,
  . One telephone hotline in Bangor and mobile outreach program in Ellsworth operated by Washington County Associates,
  . One outreach program operated by Shoreline Care Systems throughout its area around Bath/Brunswick, and
  . One crisis program in the Rockland area through Mid-Coast Mental Health Center.

- The development of the statewide HRD mental health certificate/ credentialling process in conjunction with the university and technical college system, using the statewide Interactive Television network and its 84 interactive site (200 viewing sites) as well as the several campuses. All BMH-funded mental health staff will have to comply with the educational requirements by 1995.

- Vocational supported employment services are now in fifteen sites.

- The strengthening of the mental health licensure process, including a requirement regarding the implementation of consumer rights.

- The expansion of the family support network statewide:

  There are over 20 mental health family support groups in Maine: 1) Valley Family Support Group, Madawaska; 2) Southern Aroostook Family Support Group, Houlton; 3) Downeast Alliance for the Mentally Ill, Bangor; 4) Mid-Maine Alliance for the Mentally Ill, Oakland/Waterville; 5) Augusta Family Support Group, Augusta; 6) Machias AMI, Machias; 7) Relatives and Friends Together for Support, Poland/Lewiston/Auburn; 8) The Coastal Alliance for Troubled Families, Rockland; 9) Bath-Brunswick SEA-AMI, Bath; 10) Alliance for the Mentally Ill of Maine, Portland; 11) York County Family Support Group, Saco; 12) the Farmington Alliance for the Mentally Ill; 13) Central Aroostook AMI, Caribou; 14) AMI-CAN, Farmington; 15) Damariscotta AMI, Damariscotta; 16) Calais AMI, Calais; 17) Greater Rumford AMI, Rumford; 18) Northern Penobscot AMI, Lincoln; 19) Peninsula AMI, Blue Hill; 20) Somerset AMI, Skowhegan; and 21) Sunrise County AMI, Harrington -- as well as the Alliance for the Mentally Ill of Maine (statewide umbrella coalition). New groups continue to form throughout the state.

- The development of the Department level consumer affairs office.

- Quite extensive development of structured residential programs, with growing initiatives in more independent living situations and further specialized residential programs for those with dual disorders and/or complex needs, using special housing bond, housing authority, and federal funds.

- The development of a Medicaid option for reimbursement for personal care and rehabilitation services in structured residential settings.

- The development and establishment of seven intensive case managment programs in five of the six mental health servies areas.

- Placement of priority on special population groups such as elderly persons, deaf individuals, and persons with substance abuse disorders who are also mentally ill, as evidenced in the developed of specialized residential programs, educational opportunities, etc.

- Establishment of the Geriatric Mental Health Resource Program in thirteen of Maine's sixteen counties.

- Approval and availability housing bond funds, now leveraged to $12 million from $7 million.

- Through the diversion program and other community services, AMHI admission dropped by about 400 in FY'91 and daily census is down in the low 200's.

- PATH funds used to provide outreach through the case management programs to the shelters.

- Initiation of the mental health MHSIP system with staff and individual components the first to be developed.

- Many participatory planning processes, including the Mental Health Planning Council, the Vision groups, SAC, the Maine Commmission on Mental Health.

- The development and impending establishment of involutary psychiatric inpatient capacity within community hospitals so that, if hospitalization is necessary, individuals may remain close to home rather than going to one of the two State mental health institutes.

- Class action lawsuit settled August 2, 1990 with Implementation Plan in draft at present.

ANTICIPATED PROBLEMS FOR "FULL IMPLEMENTATION"

The most immediate and powerful issues with great potential impact on full implementation by September 1992 are the continuing worsening of Maine's economy and mounting State budget deficits, the Government Restructuring committee's recommendations, and the Consent Decree's Implementation Plan, as well as the other proposed pending legislation including regionalization.

RECONSIDERATION OF PLAN

As these processes resolve, the planning process will be restructured and the plan reorganization, hoped to be done in this round, rethought and reworked. It is highly unlikely, given the circumstances, that either can remain the same.

PART B - OVERSIGHT OF PLAN IMPLEMENTATION

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University of Maine -
Farmington

Roxy Henning
Planner
Dept. of Corrections

Charlene Milliken (N)
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Joyce Saldivar
Director, Adult Services
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Joan Smyrski
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Program Mgr., Hospital Industries
Maine Medical Center

Thomas Kane
Ex. Director
York Co. Counseling Services

William Nye (N)
Governor Baxter School for the Deaf

Betty Scott (N)
Together Place

Cathi-Grace Stephens (N)
Portland

W. Malcolm Wilson (N)
Oakland

*Non-Provider, Non-State Agency Representative

* * * * * * * * *

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Community Counseling Center

Roberta Macke
Eastern Area Agency on Aging

William Julevits, Sr. VP
Maine Hospital Assoc.

Stanley Freeman, Ed.D.
Professor, UMO

Peggy Cope Mascher
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Lori Scott
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Peter Matineau
Caron St., Portland

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Liz Hage
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There are, in addition, other groups which influence mental health service planning and delivery, such as the statutory Mental Health Rights Advisory Board, the Housing Bond Advisory Board, the HRD Advisory Committee, etc. - as well as several task forces and other work groups; including interdepartmental ones, such as the ongoing Interagency Task Force on Homelessness.

In general, such groups have broad representation including consumers, family members, providers, State agencies, and other interested individuals. Persons representing the State institutions and nursing and boarding homes are on the bulk of the advisory groups.

Staffing is generally provided, to the extent possible, by the appropriate State agency which then provides the staff time, administrative support, meeting rooms, etc. and meets members'expenses, such as mileage. The expenses and time for representatives from community agencies are typically assumed by those agencies, although this is not always the case. Few groups in State government are allowed per diems. At one time, it was also possible to provide lunch, etc. for groups with lengthy meetings. It has now, for some time, been made more difficult to justify this expense in the budget process. Staffing and other administrative functions are usually provided by State personnel with other primary respnsibilities.