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Program Justification Report for the Department of Mental Health and Mental Retardation, 1981

Maine Department of Mental Health and Mental Retardation

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SUNSET REVIEW
1981
DEPARTMENT OF
MENTAL HEALTH &
MENTAL RETARDATION

Maine Department of Mental Health and Mental Retardation



JOSEPH E. BRENNAN
Governor

KEVIN W. CONCANNON
Commissioner

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November 13, 1981

TO: Hon. James McBreairty, Senate Chairman
Hon. Georgette B. Berube, House Chairman
Committee on Audit and Program Review

We are pleased to submit the Program Justification Report for the Department of Mental Health and Mental Retardation.

Members of our Department, and I, are looking forward to working with the Committee and its staff throughout the entire review process. The information provided in this report represents the efforts of numerous individuals who have attempted to show as clearly and concisely as possible the various program responsibilities faced by our Department.

Respectfully submitted,

Kevin W. Concannon
Commissioner

KWC/dlw

INTRODUCTION

The material contained in this Program Justification Report has been compiled in a manner which is straightforward and which, we feel, provides the reader with an easily understood format. The intent is to provide as much program and fiscal information as possible while keeping in mind that the reviewing committee not only needs to appreciate the purpose of a given program, but that it is equally important to show the inter-relationships between various functions. There are nineteen (19) separate reports which describe the Department's varied activities and each of them strives to reflect accurately its individual mission and its correlating relationship with the whole.

In an effort to further stress the importance of clarity, comprehensiveness, and cohesiveness, we have broken the nineteen (19) reports into the following four (4) major groupings:

1. Mental Health and Mental Retardation Administration;
2. Division of Children's Services;
3. Bureau of Mental Health; and
4. Bureau of Mental Retardation.

By doing so, we feel that the quality of the presentation has been enhanced, and the quantity has been held to a level which is both reasonable and sufficient to serve the Committee's purpose.

The fiscal data supplied with each report reflects, in some cases, budget and expenditure amounts which are merely a portion of a larger appropriation (for example, the Bureau of Mental Health Administration and the Bureau of Mental Retardation Administration), or in some cases, where the activity has within it more than one source for its funds (for example, the Augusta Mental Health Institute). For the most part, however, budgets and expenditures for

programs are clearly identified in the Department's budgeting and accounting systems. The section on financial data for each program combines all direct program expenditures and indicates all funding sources by appropriation numbers.

In some instances, the program description and organizational chart of more than one activity attempt to show the unique relationships of various organizational units. An example of this is the Community Support Systems Project which is very involved with the Division of Planning, but which for mental health policies is closely related and affiliated with the Bureau of Mental Health. Some differences among individual reports are apparent due to the nature of the program, size of the program, or the principal author of the program narrative. Format and style, however, should be sufficiently consistent to more than compensate for the idiosyncratic differences.

AGENCY SUMMARY SHEET

(Programs are listed alphabetically by major organizational unit)

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DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

6. Financial Data: (Page 1 of 5)

a. Appropriation account #: 1340.1

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	1,364,843	1,772,295	1,820,471
Balance Forward	14,800	3,483	-0-
Transfers	167,494	(690,231)	(690,231)
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>1,547,137</u>	<u>1,085,547</u>	<u>1,130,240</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	1,214,668	875,795	908,629
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>1,214,668</u>	<u>875,795</u>	<u>908,629</u>
<u>All Other:</u>			
General Fund	322,809	204,459	216,983
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>322,809</u>	<u>204,459</u>	<u>216,983</u>
<u>Capital:</u>			
General Fund	3,798	5,293	4,628
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>3,798</u>	<u>5,293</u>	<u>4,628</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>1,541,275</u>	<u>1,085,547</u>	<u>1,130,240</u>
Undedicated Revenue to G.F.:	-0-	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

6. Financial Data: (Page 2 of 5)

a. Appropriation account #: 1340.3; 3340.3 (Food)

b. Estimated revenue:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	1,898,578	2,033,436	2,236,780
Balance Forward	73,197	3,411	-0-
Transfers	30,000	(986,337)	(1,088,997)
<u>Federal Funds Available:</u>	72,794	7,756	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	2,074,569	1,058,266	1,147,783
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	-0-	-0-	-0-
<u>All Other:</u>			
General Fund	1,998,338	1,058,266	1,147,783
Federal	65,038	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	2,063,376	1,058,266	1,147,783
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	-0-	-0-	-0-
<u>TOTAL FUNDS EXPENDED</u>	<u>1,998,338</u>	<u>1,058,266</u>	<u>1,147,783</u>
Undedicated Revenue to G.F.:	65,038	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

6. Financial Data: (Page 3 of 5)

a. Appropriation account #: 1340.4 (Fuel)

b. Estimated Revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	1,450,344	2,188,908	2,407,799
Balance Forward	20,231	617	
Transfers	848,786	(706,495)	(777,148)
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>2,319,361</u>	<u>1,483,030</u>	<u>1,630,651</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>All Other:</u>			
General Fund	2,317,187	1,483,030	1,630,651
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>2,317,187</u>	<u>1,483,030</u>	<u>1,630,651</u>
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>2,317,187</u>	<u>1,483,030</u>	<u>1,630,651</u>
Undedicated Revenue to G.F.:	-0-	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

6. Financial Data: (Page 4 of 5)

a. Appropriation account #: 1340.5 (Unemployment Compensation)

b. Estimated Revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	250,000	200,000	237,960
Balance Forward	210	-0-	-0-
Transfers	(100,000)	(53,192)	(63,291)
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>150,210</u>	<u>146,808</u>	<u>174,669</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	139,379	146,808	174,669
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>139,379</u>	<u>146,808</u>	<u>174,669</u>
<u>All Other:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>139,379</u>	<u>146,808</u>	<u>174,669</u>
Undedicated Revenue to G.F.:	-0-	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

6. Financial Data: (Page 5 of 5)

a. Appropriation account #: 1340.9 (Capital Improvements)

b. Estimated Revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>			
Balance Forward	711,599	382,404	1,589,230
Transfers	111,460	233,002	(294,850)
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>823,059</u>	<u>615,406</u>	<u>1,294,380</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>All Other:</u>			
General Fund	5,290	5,950	5,950
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>5,290</u>	<u>5,950</u>	<u>5,950</u>
<u>Capital:</u>			
General Fund	435,365	609,456	1,288,430
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>435,365</u>	<u>609,456</u>	<u>1,288,430</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>440,655</u>	<u>615,406</u>	<u>1,294,380</u>
Undedicated Revenue to G.F.:	-0-	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

7. Other Programs:

There are no other programs within or outside of State Government that are the same, similar, or having complementary objectives.

There are, however, other state agencies that administer programs that are either serving a portion of the same handicapped population or that are operating other state institutions. For example, the Department of Human Services provides social services to a large number of Maine citizens (some of whom are mentally handicapped) and the Department of Educational and Cultural Services provides educational opportunities for many clients also served by the Department of Mental Health and Mental Retardation. The Department of Corrections has as part of its mandate to operate State correctional institutions. In fact, there are individuals who are being served by both departments due to their criminal behavior and mental condition.

While comparisons can be made with other administrative units, the unique services delivered by the Department of Mental Health and Mental Retardation do create obvious differences.

8. Program Effectiveness:

The department provides management and control of services, research, planning and fiscal programs within the bureaus and institutions of the department. It also sets policy and directs procedures to ensure compliance with all laws, codes, regulations and court decisions that concern the operation of its several institutions and the care and treatment provided to its clients.

The effectiveness of the department's central administration can be measured most appropriately by the effectiveness of its various programs and operating divisions. An example of the effectiveness of the central administration is the very dramatic increase in the past few years in the amount of third party revenues generated both within the major institutions and the community agencies that provide services to mentally handicapped persons. During the last fiscal year, approximately eight million dollars was returned to the state's general fund as a result of a concerted effort to help maximize revenues. Also, certifications (Medicaid and Medicare) at both Pineland and Bangor Mental Health Institute will further increase the amount reimbursed during the current year. An expansion of Medicaid reimbursable services in both Mental Health and Mental Retardation community systems has substantially reduced the heavy dependency on state appropriations and has permitted the development of additional community services.

The central administration coordinates the administration of all departmental programs which are described in detail in this report. The administrative

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Program Contact: Kevin W. Concannon, Commissioner

services of Personnel, Affirmative Action, Office of Advocacy, Information and Public Affairs, Financial Services, Division of Planning, Staff Development, Developmental Disabilities Council Coordinator and Division of Children's Services are all essential to ensure the effective coordination for successful implementation of the department's programs for those individuals in need of its services.

9. Future Plans:

The department's central administration will provide direction and support to its various programs, institutions and operating divisions in fulfilling their individual future plans.

Specific future plans formulated for the central administration include the following:

- a. Continue to provide consistent levels of care to mentally ill and mentally retarded individuals statewide;
- b. Refine the long range plan and develop annual corrective action plans to assure compliance with existing fire and safety regulations in the department's facilities;
- c. Develop a comprehensive training program for supervisory personnel, to include such subject areas as: collective bargaining, labor relations, personnel rules and practices, supervisory skills, equal employment laws and communications skills;
- d. Develop program review and evaluation mechanisms in mental health and mental retardation to evaluate internal programs and provide necessary assistance in meeting program objectives;
- e. Develop a comprehensive quality assurance mechanism to efficiently review and evaluate contracting community agencies in all areas pertinent to contract compliance, i.e. quality and quantity of services provided, fiscal responsibility and fair employment practices/personnel administration; and
- f. Develop and strengthen local community support systems to meet the needs of mentally ill and mentally retarded individuals.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

1. Authorizing legislation and other program mandate:

a. Legal citation:

34 M.R.S.A. § 2001 (charges the Bureau of Mental Health with the responsibility for the "promotion and guidance" of community mental health programs)

34 M.R.S.A. § 2051 (authorizes the expansion of mental health services into local communities and promotes efforts to "obtain (a) better understanding for the need for such services...")

b. Other mandates:

Sections 301 and 303 (a) (2) of the Public Health Service Act, 42 USC 241; 42 CFR Part 52 (gives authority to the Public Health Service to fund research and development projects)

2. Public Need:

During the past fifteen years, marked changes have evolved in the treatment of persons with mental illness. Most notable has been increased emphasis placed on the process of "deinstitutionalization", which shifted the primary location of treatment for mental illness from the large state hospitals into the "community". As a result, persons with persistent mental illness who would have previously spent years in the state hospitals now live in and receive treatment "in the community". Community-based treatment has also become the predominant means of serving young adults who now generally have no contact with such hospitals or may have repeated short-term visits.

While this shift in the focus of treatment has numerous positive effects for mentally ill persons, difficulties have arisen in terms of the mental health system's ability to develop and finance the array of services that are necessary to adequately address the special needs of this disabled population.

This difficulty has been documented in numerous federal and state reports which have focused on the plight of the chronically mentally ill.

In 1977 the General Accounting Office (GAO) issued Returning the Mentally Disabled to the Community: Government Needs to do More. This report documented severe and pervasive problems in providing community-based care to severely mentally disabled persons:

- Fragmented and unclear responsibility for the mentally disabled in communities.
- Lack of full and well coordinated support from many state and local agencies administering programs that serve the mentally disabled.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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Contact Person: Robert Weingarten, Director

- Difficulties in financing deinstitutionalization and lack of access to appropriate facilities and services in the communities.
- Inadequate handling of individual transitions to the community, including the need for better discharge planning and follow-up.

The report from the President's Commission on Mental Health elaborates on the problems which chronically mentally ill persons face as an "underserved" population. "The plight of chronically mentally ill persons illustrates the difficulties that exist in developing comprehensive service systems in local communities... These needs cannot be met unless we make basic changes in public policies and programs, particularly in how we plan, coordinate and finance mental health care. There must be much clearer delineation of responsibility and accountability for the care delivered to this population."

This need for a more comprehensive array of "support services" at the local level and a more effective coordination of services at a systems level is cited by many other groups to study this issue. The Maine Health Systems Plan (July 1981), the State Mental Health Plan (DMH&C, 1980-1985), the Report on the Governor's Task Force, Long-Term Care Dilemmas: Perceptions and Dilemmas and Recommendations (Dec., 1980), the American Psychiatric Association's, The Chronic Mental Patient; Problems, Solutions and Recommendations for a Public Policy (1978), and the National Plan for the Chronically Mentally Ill call for a continuing effort to mobilize effective community resources to support this clientele.

A Summary Description of the Chronically Mentally Ill Population:

Chronically mentally ill persons have emotional or mental problems which are so severe and persistent that they are unable to cope with the ordinary demands of daily living. As a result they probably have had or will have sustained contact with the mental health system and, in general, their illness or disabilities cannot be cured by short term treatment.

The mentally disabled will often have difficulties with basic living skills such as shopping, cooking and budgeting, in finding and keeping a job, and in seeking out and enjoying leisure time activities. Persons with mental illness are extraordinarily vulnerable to stress. They may have temporary episodes of disruptive and anti-social behavior which are harmful to themselves or others. They often make strong demands on others for tolerance of extreme dependency, bizarre behaviors or peculiar interests.

As a result of their disabilities, chronically mentally ill individuals frequently lack enough money to purchase food, clothing and shelter for themselves. Often they will lack the motivation or ability to seek help from human service agencies.

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Program Contact: Robert Weingarten, Director

Despite these limitations, however, severely disabled persons have distinct and personal strengths, interests and competencies which can be enhanced by individual planning for services.

The Community Support Systems Project has estimated that 5,000 citizens of Maine are handicapped by a chronic mental illness. These persons are cared for, treated, rehabilitated and supported by a wide range of service agencies and concerned citizens, rehabilitation programs, transitional therapeutic housing programs, socialization programs, homemaker services and other programs that contribute to a growing community support system for this group of persons.

Though no one individual is the same as the next, studies conducted in Maine indicate that the chronically mentally ill population are predominately 18-44 years of age or over the age of 65; reside in places such as their family homes, apartments, boarding or nursing homes or transitional housing programs; generally have not progressed past the twelfth grade; and live on marginal incomes of less than \$5,000 a year. Residences are found evenly split between rural and urban locations. Sources of income are primarily public funds such as Supplemental Security Income and Social Security Disability Income, food stamps and other subsidy programs and family and personal funds. Needless to say, chronically mentally ill people are a substantially underemployed population, grossly overlooked in the competitive employment sector.

The CSS Project, in its own statewide study of the plight of persons with severe and persistent mental illness, has identified specific gaps in services, problems and needs which mentally ill persons face or are affected by. It is to ameliorate these concerns and issues that the Project has directed its attention during the previous three years. Considerable progress has been made in addressing these concerns about service availability and accessibility for this client population. However, consistency in the quality and distribution of services throughout the state could be enhanced in the following areas:

- a. Identification of and outreach to chronically mentally ill persons in the institution and community;
- b. Supportive services of indefinite duration for individuals in need of ongoing maintenance in the community in the areas of assistance in securing financial, medical and other benefits, and psycho-social rehabilitation services (housing alternatives, employment opportunities, day/social/recreational activities);
- c. Quick response, 24-hour intervention;
- d. Quality medical care;
- e. Back-up assistance to family and community;

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Program Contact: Robert Weingarten, Director

- f. Community involvement in the planning, operation and delivery of community support services and protection of client rights for individuals living in institutions and community settings.

While there is both national, state and local support for meeting the above needs of persons with mental illness, such an undertaking involves many organizations and agencies, is very complex and sometimes cumbersome. The CSS Project has been involved in clarifying agencies' relationships, responsibilities and resources vis-a-vis mentally ill persons in establishing inter-agency agreements.

Although considerable progress can be documented, it continues to be necessary for the Department of Mental Health and Mental Retardation to address the public needs that may result from fragmentation in the array of agencies and helpers whose operations impact on services for persons with mental illness. Departmental initiatives in developing new resources, building a mental health constituency and strengthening advocacy and support continue to be required. There also is the need for improvement in the quality of life of residents in many of our community residential facilities. In this regard, the establishment of more appropriate and more rehabilitative housing alternatives should be listed as among the highest of the department's priorities.

3. Program Objectives:

The objective of the Community Support Systems Project is to promote the development of comprehensive community support systems in local communities which are appropriate to the needs and potentials of adults with serious and persistent emotional difficulties and to improve the quality, appropriateness, level and coordination of existing services, resources and opportunities both on the state and local level.

On a state level, the Project:

- a. Encourages the state and local mental health agencies to give greater priority to the CSS population and to make more appropriate and effective use of the categorical financial and human resources of the mental health system in meeting the needs of the population;
- b. Encourages other health and human service agencies at all levels to give greater priority to this population, to make more effective use of currently available resources, and to generate additional resources where necessary;
- c. Works in cooperation with community mental health centers, state and local providers by providing technical assistance in program planning and public education (conferences, workshops, grant writing, etc.);
- d. Develops recommendations and promotes the development of an effective discharge planning and case management model which incorporates

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community mental health centers, state hospitals, and other local providers; and

- e. Increases the capacity of data systems and understanding of needs/problems faced by CSS target population and sub-populations for use in program development and in ensuring appropriate determinations of resource allocations.

On a regional level, the Project:

- a. Continues the effort toward resource development, interagency collaboration, community education, consumer and citizen advocacy and self-help, regional planning and technical assistance and systems advocacy;
- b. Works with community mental health centers and other local providers by providing technical assistance in initiating the development of model services such as the significant expansion of housing, employment, transportation, crisis assistance services and other opportunities for chronically mentally ill persons;
- c. Assists in the development of consumer and family groups and the mobilization of these groups into a statewide coalition;
- d. Encourages interagency collaborations between mental health service providers and other private health and human service agencies in local communities; and
- e. Provides for continuation of community education endeavors for information dissemination and stigma reduction.

4. Program Operation:

Maine has established the CSS Unit in the Department of Mental Health and Mental Retardation as the principal focal point for initiating, maintaining and coordinating activities related to building a community support system for persons with chronic mental illness.

The Project operates on a statewide and regional basis. All staff maintain an involvement with functions relating to resource development, program development, technical assistance, public education, community organizing and advocacy, research and data collection and generally promoting within state government and in the community-at-large the needs of persons with chronic mental illness. Within these functions, Project staff are assigned specific priorities according to federal grant mandates, generally accepted practices in the field and on-going assessment of needs and problems. The following details the general nature of the operational tasks assigned each staff member:

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Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

<u>TITLE</u>	<u>MAJOR TASKS/FUNCTIONS</u>
Project Director	Overall management of federal grant and Project subcontracts; supervises CSS staff and directs activities toward fulfillment of CSS philosophy and operational principles; participates in state and departmental tasks and planning groups related to this population and maintains Project accountability within the department; initiates and maintains inter-agency collaboration.
Project Secretary	All clerical, typing, filing and office management routines for all Project staff; includes scheduling, purchase requisitions, travel arrangements, etc.
Regional Coordinator	Coordinates regional field activities and provides overall liaison for regional planners; assists Project Director in statewide functions.
Technical Assistance Coordinator	Coordinates the Project's comprehensive technical assistance program; organizes workshops, conferences and other training opportunities; conducts public reporting and information dissemination; provides technical assistance in grant writing to local agencies.
Planning & Research Assistant	Manages data and information activities of the Project; coordinates program evaluation functions, and survey and research activities; assists in managing and accounting for Project expenditures and federal and state reporting functions; assists in program development, workshop scheduling and other technical assistance aspects.
Regional CSS Planners (Eight individuals based in each of the mental health catchment areas)	Develop and improve community programming and coordination for the chronically mentally ill population; mobilize citizen interest and involvement on a local basis; assist in accessing new resources and re-channelling existing resources; provide liaison and support for consumer and family self-help and support groups; participate in state level and systems issues as assigned.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

5. Staffing:

a. General Fund:

1) Positions authorized: None

2) Positions filled September 1, 1981:

a) Full time: None

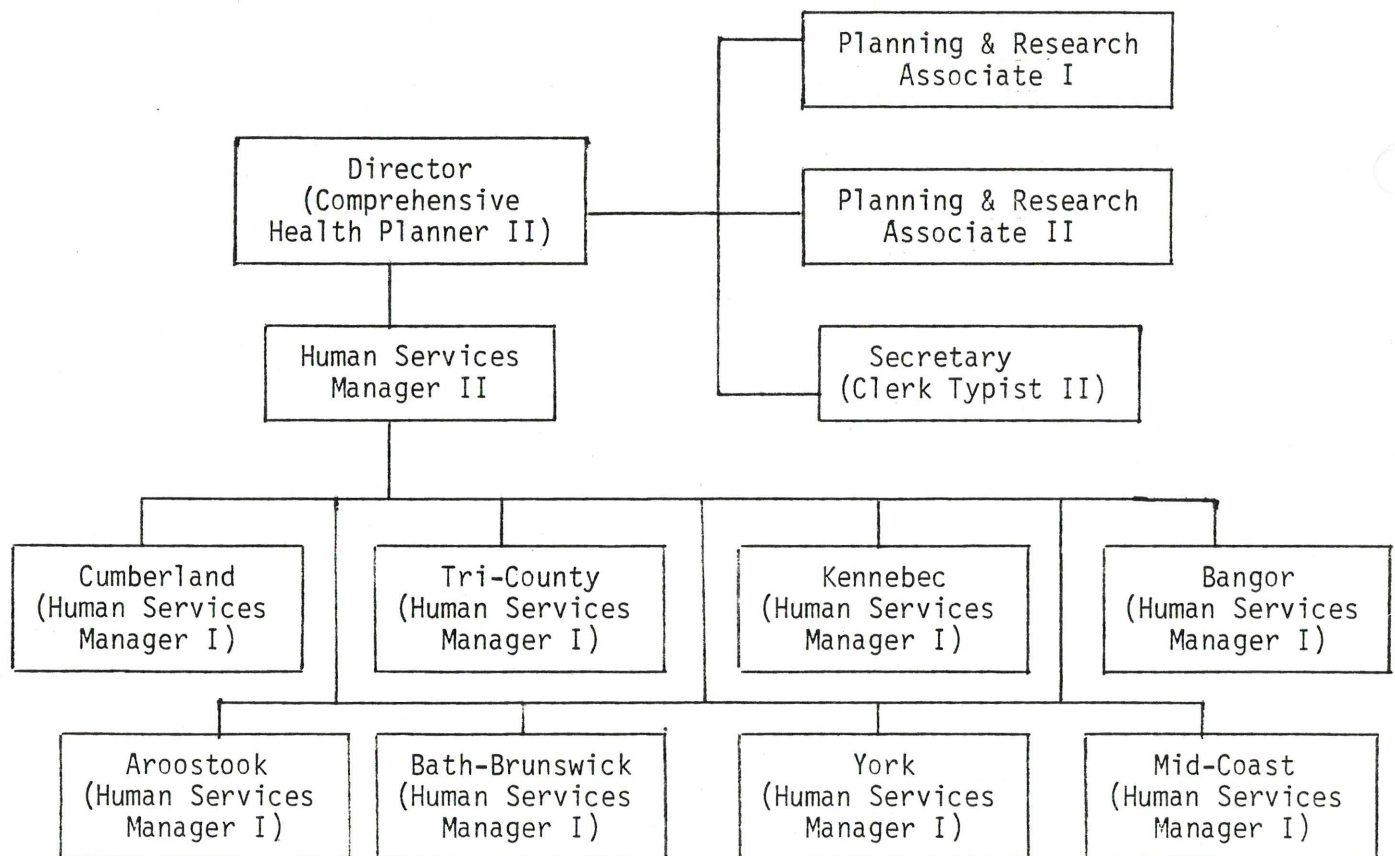
b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: 13

2) Other positions: None

c. Organization:



DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Comprehensive Health Planner II		1	
Clerk Typist II		1	
Human Services Manager II		1 (vacant)	
Planning & Research Associate II		1	
Planning & Research Associate I		1	
Human Services Manager I		1	
Human Services Manager I		1	
Human Services Manager I		1	
Human Services Manager I		1	
Human Services Manager I		1	
*Human Services Manager I		1	
*Human Services Manager I		1	
*Human Services Manager I		1	

*These three positions were officially approved on September 20, 1981. The budget information and total staff count represent the total complement of staff.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

6. Financial Data:

a. Appropriation account #: 3340.2014; 3340.2020

b. Estimated Revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	-0-	-0-	-0-
<u>Federal Funds Available:</u>	183,609	305,300	300,000
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>183,609</u>	<u>305,300</u>	<u>300,000</u>

	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	-0-	-0-	75,000
Federal	143,971	237,465	150,000
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>143,971</u>	<u>237,465</u>	<u>225,000</u>
<u>All Other:</u>			
General Fund	-0-	-0-	25,000
Federal	37,755	67,835	50,000
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>37,755</u>	<u>67,835</u>	<u>75,000</u>

<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	1,883	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>1,883</u>	<u>-0-</u>	<u>-0-</u>

<u>TOTAL FUNDS EXPENDED</u>	<u>183,609</u>	<u>305,300</u>	<u>300,000</u>
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Undedicated Revenue to G.F.:	-0-	-0-	-0-
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DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

7. Other Programs:

One of the methods used by the Community Support Systems Project to further develop and enhance the opportunities available to chronically mentally ill persons is the facilitation of linkages with other agencies that may have similar or complementary objectives.

The following are examples of specific agencies with which the Community Support Systems Project has worked closely because of their mandated responsibilities to provide services to the chronically mentally ill population:

Maine State Housing Authority: Through its 202 Program, HUD is specifically mandated to set aside monies for housing units for chronically mentally ill persons. The Maine State Housing Authority has worked cooperatively with the CSS Project in developing eight (8) housing units, as well as in providing technical assistance and co-sponsoring forums on housing issues.

Bureau of Medical Services, Department of Human Services: The Bureau of Medical Services has the responsibility of allocating funds available under Medicaid and Medicare. Since these are benefits that can be accessed by persons with mental illness, the CSS Project has worked consistently to advocate on the client's behalf with the Bureau of Medical Services.

Social Services Development, Department of Human Services: The Bureau of Social Services is mandated to administer Title XX funds in Maine. Since Title XX is one of the primary funding sources for community services to the chronically mentally ill population, the CSS Project works with the Bureau of Resource Development in both planning and advisory capacities to assure appropriate Title XX allocations.

Community Mental Health Centers: Community mental health centers are responsible for providing mental health services on an outpatient basis to mentally ill individuals within the community. In order to work more closely on a daily basis with the centers in planning, policy and resource development efforts for its clients, the CSS Project has located a regional planner in each community mental health center.

Other: The Bureau of Maine's Elderly, the Department of Mental Health and Mental Retardation's Office of Advocacy, the Department of Human Services Division of Hospital Licensing, and the Governor's Task Force on Long Term Care each maintain distinct responsibilities and concerns regarding residential alternatives for chronically mentally ill persons. In its planning and advocacy role for this population, the CSS Project works with each of these agencies to maximize the quality of care available to mentally ill persons.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

8. Program Effectiveness:

During the three years the Community Support Systems Project has been in existence it has been very effective in addressing its program objectives to promote quality services for mentally ill persons. For example, because mentally ill persons are only one of many client groups eligible for a multitude of entitlement programs provided by numerous agencies, the Project has responded to the need for a cross-cutting approach to coordinating the delivery of these services to assure that persons in need receive the services to which they are entitled and that these services are effective. Through cooperative agreements and activities, increased utilization of existing services has been realized for this population. (This has also resulted in numerous organizations responding to their mandates as they pertain to chronically mentally ill persons). The Project has also intensified efforts at local CSS component development with emphasis on such areas as employment, alternative housing, transportation, psychosocial centers and the development of local natural support and advocacy groups.

Examples of CSSP accomplishments are:

- a. Participated in efforts that resulted in the expansion of Title XIX Medicaid to cover community support services including: 1) extension of the "medically needy" category to include chronically mentally ill persons; 2) extending reimbursement to services delivered beyond the "clinic setting"; and 3) extending reimbursement to qualified community support workers. The Project provided staff for interagency committees and funds for consultant services. This has resulted in over \$500,000 of additional service monies for chronically mentally ill persons.
- b. Developed and implemented the First Annual CMHC/CSSP Statistical Survey of chronically mentally ill persons throughout the eight catchment areas of Maine. For the first time, the Department has a client profile on all chronically mentally ill persons served by the CMHC's.
- c. Sponsored the Community Support Players' performance of "From Patient to Person?" (23 performances for over 935 people). Public education efforts include the promotion of three CSS related films already seen by an estimated 400 people since October 1980. CSSP staff have appeared on numerous radio and television shows and have been featured in many newspaper articles providing information to the general public about issues of concern to chronically mentally ill persons.
- d. Successfully advocated for the award of HUD funding for (three (3) in 1979 and one (1) in 1980) alternative housing proposals, resulting in 35 additional units of housing:
 - Community Health and Counseling Services, Bangor
8-unit group home
 - Aroostook Mental Health Center, Fort Fairfield
10-unit supervised apartments

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

- Motivational Services, Inc., Augusta
7-unit group home
- Shalom House, Portland
10-unit supervised apartments

The Project helped to draft the State's Letter of Intent, provided extensive technical assistance to applicants and potential applicants, located consultant fees, and participated in the funding and selection process. The Project has also worked closely with the Maine State Housing Authority to develop housing alternatives through the Section 8 program which is required to serve mentally ill persons as part of its mandate to serve disabled people. As a primary housing related activity, the Project has been involved in mobilizing four community groups to utilize these resources.

- e. Assisted in the development of new local psychosocial programs such as:
 - Together Place (Bangor), a 24-hour social club developed by Maine CSSP, Citizens Interest Group, Community Health and Counseling Services (CMHC), and other state agencies.
 - A social club program implemented by Tri-County Mental Health Services that includes opportunities for in-house volunteer work experience, transitional employment placement, as well as day programs in Tri-County's three rural offices.
- f. Helped draft joint agreements between the Bureaus of Rehabilitation and Mental Health, and Bureau of Resource Development and Mental Health identifying priority service needs of chronically mentally ill persons.
- g. Worked cooperatively with the Maine Council of Community Mental Health Centers and the Governor's Mental Health Manpower Commission to present two three-part training series for operators of nursing, boarding, and foster homes.
- h. Successfully advocated for the recognition of the need of chronically mentally ill persons as a top priority in the State Mental Health Plan, the State Health Plan, the Health Systems Agency Plan and the Area V Mental Health Board (CMHC) Plan.
- i. Assisted in the formation of (and continues to provide) technical and financial assistance to, self-help, mutual support and community advocacy groups:
 - Alliance for the Mentally Ill, Portland
 - Consumer Coalition for Mental Health, Portland
 - Alliance for Troubled Families, Waterville
 - Alliance for Community Mental Health, statewide
 - Rumford Family Support Group
 - Relatives and Friends Together for Support, Lewiston

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Support Systems Project

Program Contact: Robert Weingarten, Director

- j. Successfully advocated for the inclusion of the needs of Maine's chronically mentally ill in regional transportation plans and CSSP review of operations plans before departmental signoff.
- k. Sponsored 14 workshops, conferences or seminars for public education or professional staff training in such areas as "Natural Helping and Self-Help Networks", "The Mental Health Needs of the Elderly", and "The Quality of Life Dimension: Are There Standards?".

9. Future Plans:

For the future, the Department of Mental Health and Mental Retardation will continue to fulfill its commitment to meet the needs of such underserved populations as persons with chronic mental illness. In doing so, the goals, objectives, and methodologies established by the CSS Unit described herein shall be pursued. The most significant encompassing plan for the future calls for continuing the effort to create community support systems in all parts of the state. Effective September 20, 1981 the Maine CSS Project had the benefit of three additional regional planners who will later be assigned to the mental health catchment areas which have previously been covered as a secondary assignment by existing regional staff.

A community support system (CSS) is an organized network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community. While there are many necessary elements in a community support system, the Project shall give priority to the following services:

- a. Supportive and Rehabilitative Employment Opportunities
- b. Supportive and Rehabilitative Housing
- c. Rehabilitative Socialization
- d. Crisis Assistance and Intervention
- e. Case Management and Coordination

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Commission on Mental Health Manpower Development

Program Contact: Peter J. Ezzy, Project Director

1. Authorizing legislation or other program mandate:

a. Legal citation:

None

b. Other mandates:

Executive Order #7 issued by Governor Brennan on March 20, 1979

Public Health Service Act, Section 303, Public Law 78-410, United States Code (creates the National Institute of Mental Health and enables the establishment of training and manpower development programs).

2. Public Need:

Impetus for creating the Governor's Commission came from the National Institute of Mental Health - State Manpower Development's recognition that mental health services and costs were approximately 80% manpower-related and that earlier efforts to increase training for core disciplines, such as: psychiatrists, psychologists, nurses and master level social workers, did not solve problems of manpower recruitment, retention, utilization, distribution and in-service training. The need for such an effort is further supported when one realizes that the percentages of total budgets devoted to personnel costs for Maine's two State mental health institutes (Augusta Mental Health Institute and Bangor Mental Health Institute) were 82% and 81% respectively for FY 80. Maine's eight community mental health centers averaged 78% of total expenditures for personnel costs.

The National Institute of Mental Health awarded small grants to states to provide technical assistance in developing a local capacity for manpower development. It felt very strongly that in a period of limited resources and competing priorities, it was most important that available resources be used in the most cost-effective manner while helping to ensure quality services. In this way, more efficient methods of holding manpower costs down while increasing the availability of more qualified individuals could be addressed in a systems-wide approach.

3. Program Objectives:

The primary purpose of the Governor's Commission on Mental Health Manpower Development is to make recommendations to the Governor which will involve manpower interests and which will address related mental health issues.

Specific objectives of the Commission are:

- a. To become personally knowledgeable about the scope of the mental health manpower system;

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Commission on Mental Health Manpower Development

Program Contact: Peter J. Ezzy, Project Director

- b. To analyze data which will identify trends, needs and problems in mental health manpower and to refine such data for identification of issues;
- c. To prioritize problems in mental health manpower;
- d. To recommend comprehensive manpower policies to be implemented by the mental health system, including public and private institutions, agencies and all others involved in providing mental health services;
- e. To provide liaison with state and federal manpower activities and with various agencies, associations, and universities in the implementation of collaborative action on the recommended policies; and
- f. To prepare and submit reports and comply with other requirements of the National Institute of Mental Health.

4. Program Operation:

The Commission consists of twenty-five members appointed by the Governor for two year periods. Members are selected on the basis of their representing various mental health manpower interests throughout the state. All major professional disciplines as well as individuals from other state and advisory groups are represented.

The Commission is staffed (parttime) by a Project Director and a Clerk Stenographer. In addition to the parttime staff, additional administrative and clerical support is provided by other departmental employees as required and appropriate. Various interns are assigned by the University of Maine to work with the Commission under the supervision of professional staff.

By utilizing a variety of planning aids and exercises, the Commission has identified and ranked a number of mental health manpower issues considered to be critical to the provision of quality services at acceptable costs.

Through regular meetings, the Commission will continue to examine issues such as:

- a. Training needs related to primary care physicians offering mental health services and also training needs of mental health workers (direct care) in public institutions and community settings;
- b. Accessibility to mental health services and the inherent manpower implications;
- c. Funding of mental health services and the determining effect upon manpower utilization;

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Commission on Mental Health Manpower Development

Program Contact: Peter J. Ezzy, Project Director

d. Policy determination and planning objectives; impact upon mental health care providers; and

e. Personnel and professional roles.

5. Staffing:

a. General Fund:

1) Positions authorized: None

2) Positions filled Sept. 1, 1981: None

a) Full time: None

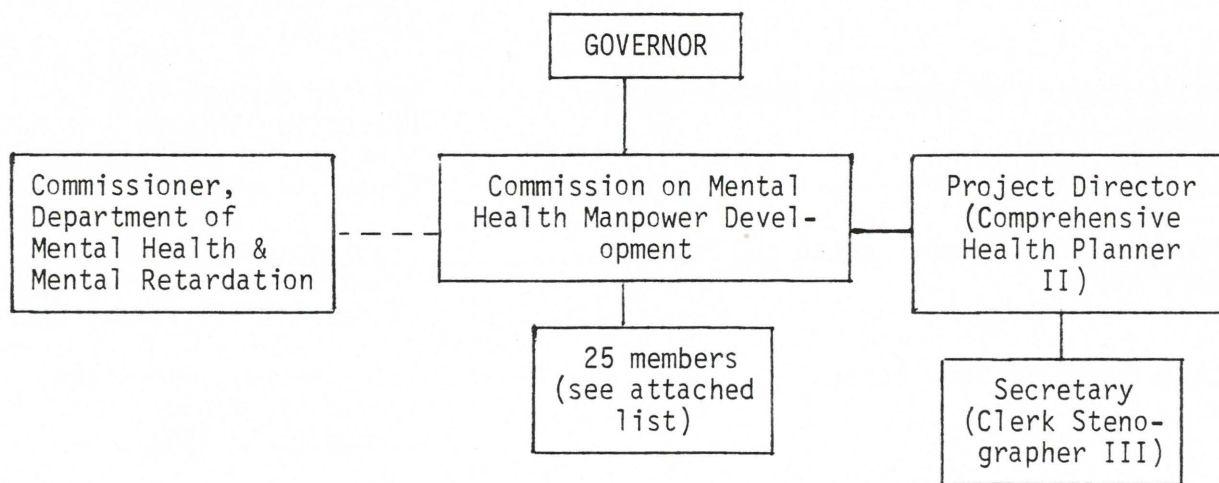
b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: None

b) Other positions: 2

c. Organization:



d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Comprehensive Health Planner II		1	
Clerk Stenographer III		1	

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Commission on Mental Health Manpower Development

Program Contact: Peter J. Ezzy, Project Director

MEMBERS

<u>Representing Agency</u>	<u>Member</u>
1. Maine Mental Health Advisory Council	Robert Morrell Private business executive
2. University of Maine	Harlan A. Philippi, Ph.D. Director, Health Professions Education University of Southern Maine
3. Private Medical Fiscal Procedures	Donald Brann, Director Patient Accounts Central Maine Medical Center, Lewiston
4. State Department of Personnel	Robert W. Maxwell Merit System Administrator State Department of Personnel
5. Maine Council of Community Mental Health Centers	William Barnum, M.D. Executive Director Mid-Coast Mental Health Center, Rockland
6. Deputy Commissioner, Health and Medical Services	Frank McGinty, Deputy Commissioner, Department of Human Services
7. Long Term Care Task Force	Sally Healey, Associate Professor, Bangor Community College
8. Augusta Mental Health Institute	Neil MacLean, Ph.D. Augusta Mental Health Institute
9. Bangor Mental Health Institute	Donald Clark, Mental Health Worker III, Bangor Mental Health Institute
10. Maine Medical Association	Frank W. Kibbe, M.D. Retired Pediatrician
11. Maine Psychiatric Association	George N. McNeil, M.D. Maine Medical Center

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Commission on Mental Health Manpower Development

Program Contact: Peter J. Ezzy, Project Director

MEMBERS (continued)

- | | |
|--|--|
| 12. Maine Association of Social Workers | John M. Slavin, MSW,
ACSW, CSW, Maine Medical
Center |
| 13. Maine Psychological Association | Roger Zimmerman, Ph.D.
Psychologist, private
practice |
| 14. Director, Employment Services Division | Richard Hagan, Director
Employment Services
Division, State Depart-
ment of Labor |
| 15. Maine Nurses Association | Vera Gillis, R.N.
Augusta Mental Health
Institute |
| 16. Mental Health and Mental Retardation | Kevin W. Concannon
Commissioner, Department
of Mental Health and
Mental Retardation |
| 17. Maine Hospital Association | John McCormack, Adminis-
trator, Cary Medical
Center |
| 18. Maine State Employees Association | Diana White, R.N., Augusta
Mental Health Institute |
| 19. Council of American Federation of State,
County and Municipal Employees | Donald J. McCurdy
Pineland Center |
| 20. Maine Osteopathic Association | Charles A. Pernice, D.O.
Osteopath, private practice |
| 21. Board of Health Systems Agency | Richard F. Nellson
Retired business executive |
| 22. Educational and Cultural Services | Harold Raynolds, Jr.,
Commissioner, Department of
Educational & Cultural Services |
| 23. Long Term Care Task Force | Joseph Brannigan, Executive
Director, Shalom House |
| 24. Long Term Care Task Force | Barbara Mayer, Executive
Director, Motivational Services |
| 25. -- | Vacant |

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Commission on Mental Health Manpower Development

Program Contact: Peter J. Ezzy, Project Director

6. Financial Data:

a. Appropriation account #: 3340.2016

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G. F. Appropriation:</u>	-0-	-0-	-0-
<u>Federal Funds Available:</u>	38,332	25,939	25,939
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>38,332</u>	<u>25,939</u>	<u>25,939</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	-0-	-0-	-0-
Federal	20,280	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>20,280</u>	<u>-0-</u>	<u>-0-</u>
<u>All Other:</u>			
General Fund	-0-	-0-	-0-
Federal	18,052	25,939	25,939
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>18,052</u>	<u>25,939</u>	<u>25,939</u>
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>38,332</u>	<u>25,939</u>	<u>25,939</u>
Undedicated Revenue to G. F.:	-0-	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Commission of Mental Health Manpower Development

Program Contact: Peter J. Ezzy, Project Director

7. Other Programs:

Boarding Home Training Project - In 1978 the Department of Mental Health and Corrections was successful in applying for a grant from the National Institute of Mental Health to develop a training program for boarding home operators in Maine. This grant was a supplement to the Governor's Commission on Mental Health Manpower Development grant approved earlier and enabled the department to develop a training model which would meet the mental health manpower needs of boarding home operators.

Mental Health Advisory Council - The Council was created to assist the Bureau of Mental Health in carrying out its duties. The Council functions as an advisory group to the Bureau in matters involving policies and programs. The Council also advises/assists the Commissioner on the appointment of a Bureau of Mental Health Director and the development of the State Mental Health Plan. The Council does not have a specific manpower focus and does not represent key mental health manpower interests in Maine.

Medical Care Development, Inc. - Medical Care Development, Inc. is a private, non-profit organization involved in a number of health related education and training projects. One project in the area of manpower which is currently funded and active (1981-1982) involved development of a program and incentives to recruit recent medical graduates to rural areas of Maine. The project is oriented towards acute medical care and not mental health care. Close informational ties are kept with Medical Care Development project staff and a number of advisory sessions/meetings have been held between Commission and Medical Care Development staff.

Community Support Systems Project - The Community Support Systems Project assisted in the development of the Boarding Home Training proposal by identifying the boarding homes throughout the state who would receive training. The Director of the Community Support Systems Project is a member of the Advisory Committee of the Boarding Home Project. The project's primary focus, however, is in advocating for, and developing services for, chronically mentally handicapped persons.

8. Program Effectiveness:

Since its inception in 1979, the Commission has met an average of once every two months and has collected and reviewed extensive data on the mental health system as it presently exists in Maine. Numerous technical presentations by mental health specialists and practitioners were made to Commission members during this period of time.

Commission members became personally knowledgeable about various issues influencing the delivery and quality of mental health services in the State by forming task groups and conducting individual, as well as group, research in mental health manpower-related areas. Extensive data was collected during this period by these task groups and staff. In addition, every major mental

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Commission on Mental Health Manpower Development

Program Contact: Peter J. Ezzy, Project Director

health institution and community mental health center in the state was visited by Commission members as well as a number of boarding and nursing homes. The emphasis was placed upon identifying and ranking system-wide issues and problem areas in mental health manpower. In addition to conducting extensive research on its own, the Commission has directed a formal review, by research organizations, of the role of primary care physicians in the delivery of mental health services.

Based upon the work and recommendations of individual task groups, as well as the deliberative review and vote of the Commission as a whole, a series of recommendations were proposed and submitted in annual reports to the Governor. Other reporting (and accountability) requirements of the National Institute of Mental Health were completed by staff members.

9. Future Plans:

The Commission is entering a second phase of activity and new members are being recruited from key mental health manpower interests throughout the state. During the coming months, Commission members and staff will be working towards implementing recommendations made earlier to the Governor. Further research efforts are indicated in the area of interfacing manpower issues between different agencies of the mental health system (for example, between the mental health institutes, community mental health centers and boarding homes).

Also, manpower issues are raised by a shift to block grants and a commission which represents all of the key mental health manpower interests is uniquely suited to make recommendations regarding the recruitment, retention, utilization, distribution and training of critical manpower resources.

Other areas to be pursued by Commission task groups include the following:

- a. Effect of third-party payers upon the utilization of manpower;
- b. The expediency with which psychologists are licensed in Maine; and
- c. The particular manpower needs of mental health clients both in and out of the formal mental health system.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Office of Advocacy

Program Contact: Carroll M. Macgowan, Chief Advocate

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. 1A, Creation of Office of Advocacy

34 M.R.S.A. § 2651 et. seq. Provision of Mental Retardation Services

34 M.R.S.A. § 2141 et. seq. Rights of Mentally Retarded Persons

34 M.R.S.A. § 7, Rules and Regulations and Rights of Patients

34 M.R.S.A. § 2252, Right to Communication and Visitation

22 M.R.S.A. Chapter 166, Rights of Clients in Long Term Care Facilities

18-A M.R.S.A. § 5-301 et. seq. Adult Protective and Supportive Services

b. Other mandates:

Wuori, et. al., vs. Concannon, et. al. No. 75-80 (D. Me., July 14, 1978)

42 U.S.C. § 6001 et. seq., Developmental Disabilities Assistance

20 U.S.C. § 1401 et. seq., Education for All Handicapped Children Act

42 U.S.C. § 1395 et. seq., Social Security Act (including Title XVIII Medicare, Title XIX Medicaid and Title XX Grants for Services)

34 M.R.S.A. generally, Law regarding Department of Mental Health and Corrections

2. Public Need:

The primary public need addressed by the Office of Advocacy is to assist any client of the Department of Mental Health and Mental Retardation in understanding the system from which they receive services. These individuals may be mentally or physically disabled, or housed involuntarily for treatment. The office also assists clients in participating, to the greatest extent possible, in the decision-making process that controls their lives and destinies, and in assuring that any actions affecting these individuals' lives are taken in accordance with Federal and State laws and regulations, as well as departmental policies and procedures.

In addition, the Office of Advocacy provides assistance, representation and a mechanism for the resolution of complaints for clients of the department. Without this service, these individuals would be unable to expeditiously resolve their concerns. Not only do the services provided by the office

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Office of Advocacy

Program Contact: Carroll M. Macgowan, Chief Advocate

benefit these clients, in that their informational needs and requests for assistance are met in a timely and professional manner, but they also benefit the Department of Mental Health and Mental Retardation by virtue of avoiding unnecessary legal actions. Because of the liaison and mediation efforts of the office, the most appropriate services are made readily accessible to clients the department is mandated to serve.

3. Program Objectives:

- a. To advocate for compliance by any institution, facility or agency administered by the Department of Mental Health and Mental Retardation with all laws, administrative rules and regulations and institutional and other policies regarding the rights and dignity of departmental clients.
- b. To receive and/or refer complaints made by clients of the department; and intercede on behalf of clients to resolve their complaints with officials of the institutions, facilities and agencies administered by the Department; and to assist and/or represent clients in the initiation of grievance proceedings and other actions.
- c. To act as an information resource regarding the rights of departmental clients. The office shall keep itself informed of all laws, administrative rules and regulations regarding the rights and dignity of departmental clients.
- d. To make and publish reports necessary to the performance of the responsibilities of the office.

4. Program Operation:

Bureau of Mental Retardation

In the Bureau of Mental Retardation, the two community advocates and the Pineland Center advocate: 1) represent clients at inter-disciplinary team meetings at which a prescriptive program for their treatment for the upcoming year is planned and developed; 2) approve and periodically observe the utilization of adverse behavior modification programs both at Pineland and in the community; and 3) initiate or accept complaints and grievances on behalf of BMR clients, including investigations of abuse. In addition, the advocates, functioning on behalf of the clients of the bureau, have handled approximately 160 grievances, encompassing the following areas:

- a. Quality, consistency or warmth of food provided in institutional or community settings;
- b. Access to generic programs, services or benefits;
- c. Freedom of association issues;
- d. Access to records;

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Office of Advocacy

Program Contact: Carroll M. Macgowan, Chief Advocate

- e. Change of residence;
- f. Access to transportation or training services;
- g. Appropriateness of special programs, including educational programs; and
- h. Patient mistreatment, neglect and abuse.

Advocates serving the Bureau of Mental Retardation client population provide information regarding rights, laws and resources to parents, clients and service providers. In-service training is provided to various groups in areas such as the use of behavior modification techniques, guardianship, admissions and discharge procedures, clients rights and utilization of appeal procedures.

Advocates for mentally retarded persons review and advise in the development of policies, laws and regulations. Historically, the office has both consulted with and participated on committees which review and comment on the state's treatment of mentally retarded clients. Examples of such committees are:

- a. The Pineland Human Rights and Assurances Committee;
- b. The Consumer Advisory Board;
- c. The Maine Committee on Problems of the Mentally Retarded;
- d. The State Developmental Disabilities Planning Council;
- e. The Elizabeth Levinson Center Human Rights and Assurances Committee;
- f. Executive Management Group at Pineland; and
- g. The Pineland Parents and Friends Association.

Bureau of Mental Health

The functions of the advocate at the Bangor Mental Health Institute and the advocate at the Augusta Mental Health Institute are similar to those of their counterparts in the Bureau of Mental Retardation. Specifically, the mental health advocates: 1) attend treatment planning meetings; and 2) assist in the investigation and resolution of client grievances, including those involving allegations of abuse, mistreatment or neglect.

Due to the nature of the mental health system, many more requests are received for information regarding the commitment process, the treatment planning process, and the discharge planning process. Advocates often act as liaisons between court-appointed attorneys, family members or other interested persons, and the mental health clients.

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In addition to the responsibilities already enumerated, advocates in the mental health institutes participate in policy making and review as well as provide in-service training to the staff of the institutions in the area of patients' rights.

Departmental

Within the department as a whole, the Office of Advocacy has been actively involved in the preparation and review of legislation impacting upon the lives of departmental clients, and acts as a referral point for the provision of civil legal services for those clients.

5. Staffing:

a. General Fund:

1) Positions authorized: 8*

2) Positions filled Sept. 1, 1981:

a) Full time: 7

b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: None

2) Other positions: None

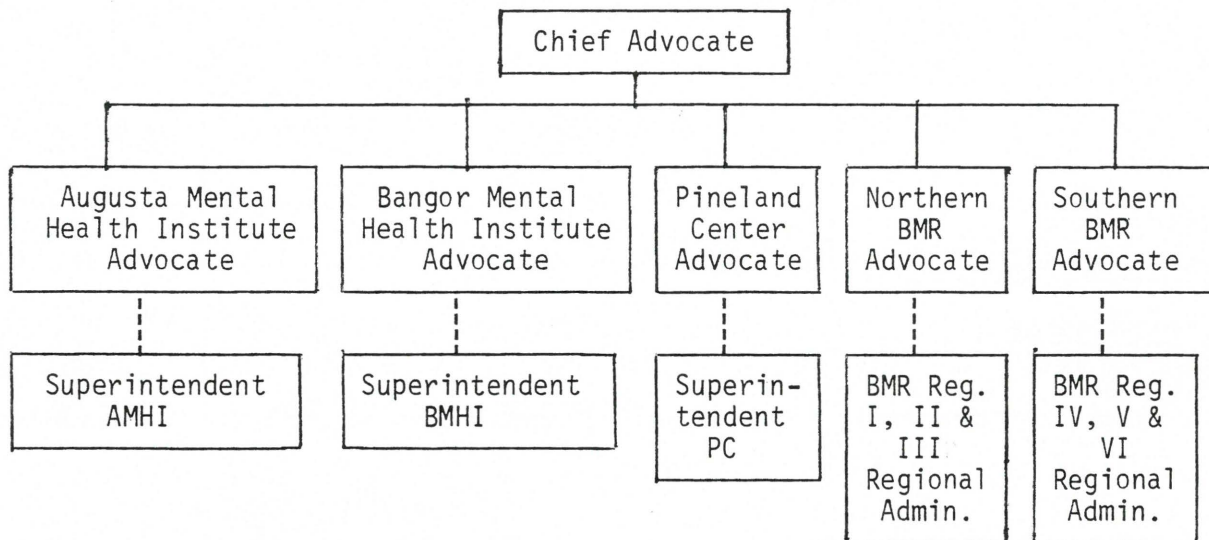
*Since September 18, 1981 the staff count has been reduced to six. The other two positions are now in the Department of Corrections.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Office of Advocacy

Program Contact: Carroll M. Macgowan, Chief Advocate

c. Organization:



d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Chief Advocate	1		
Advocate	7		

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Office of Advocacy

Program Contact: Carroll M. Macgowan, Chief Advocate

6. Financial Data:

a. Appropriation account #: 1340.1040

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G. F. Appropriation:</u>	21,880	21,880	21,880
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>21,880</u>	<u>21,880</u>	<u>21,880</u>
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>EXPENDITURES</u>			
<u>Personal Services:</u>			
General Fund	21,880	21,880	21,880
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>21,880*</u>	<u>21,880</u>	<u>21,880</u>
<u>All Other:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
 TOTAL FUNDS EXPENDED	 <u>21,880</u>	 <u>21,880</u>	 <u>21,880</u>
 Undedicated Revenue to G.F.:	 -0-	 -0-	 -0-

*The above reflects only the cost of the Chief Advocate. The other seven (7) are funded at the institutional level.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Office of Advocacy

Program Contact: Carroll M. Macgowan, Chief Advocate

7. Other Programs:

- a. The boarding and nursing home ombudsman program, operated by the Bureau of Maine's Elderly, Department of Human Services, supplies similar complaint resolutions, services for elderly clients in the boarding and nursing care system. The Office of Advocacy maintains an ongoing relationship with the Ombudsman program regarding prominent issues and a referral mechanism for clients who could be better served through an inter-agency transfer.
- b. The Medicaid Fraud and Surveillance Unit of the Attorney General's Office is responsible for the investigation of complaints brought by recipients of Medicaid funds. The Office of Advocacy has, in the past two years, developed a working relationship with this unit and regularly refers issues brought to the Office's attention which relate to financial issues of Medicaid recipients for their investigation and action.
- c. The Criminal Investigation Unit of the Attorney General's Office receives referrals from the Office of Advocacy under 34 M.R.S.A., Chapter 186-A when the potential for criminal action is indicated following an internal investigation. This unit then conducts an independent evaluation and investigation for possible referral to the Criminal Division of the Attorney General's Office.
- d. Advocates for the Developmentally Disabled is the federally funded agency authorized by a Governor's Executive Order to function as an independent protection and advocacy program for developmentally disabled persons. The Office of Advocacy refers departmental clients who can best be served by the expertise of this program. Referrals usually involve clients with special education problems and those whose interests, in the view of the Office of Advocacy, can best be served by an advocate not affiliated with the Department of Mental Health and Mental Retardation.

This program serves a similar population group; however, its focus is on a definite segment of the clientele served by the Department of Mental Health and Mental Retardation.

- e. The Department of Human Services, Division of Adult Protective and Supportive Services accepts referrals from the Office of Advocacy for community clients who, after assessment, appear to need protective or supportive services. The clients referred are predominately mental health clients living in the community. Recent referrals of institutionalized mental health clients who need an alternate's consent for medical or surgical procedures have been increasing.
- f. The Handicapped Rights Project is a contract agency providing legal services and a grievance mechanism for recipients of vocational rehabilitation services. This agency provides legal services to a

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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limited number of Department of Mental Health and Mental Retardation's clients who also receive services from the vocational rehabilitation system.

8. Program Effectiveness:

Generally, program effectiveness is high within the constraints imposed by limited staff and a highly diversified, fragmented and geographically separated client population.

Within the past year the Office of Advocacy has presented, on behalf of departmental clients, 35 major issues involving compliance with laws, rules and regulations or policies to agencies within the Department of Mental Health and Mental Retardation and to other agencies serving clients of the department. Each of these complaints had the potential for a major impact on substantial portions of the population served by the department and included such diverse issues as:

- a. Equal access for handicapped individuals to community residential housing;
- b. Clarification of the authority of the Department of Mental Health and Mental Retardation to initiate preadjudication psychological evaluations of juveniles accused of delinquent behavior;
- c. Implementation of fire code standards relating to non-ambulatory clients in boarding and nursing care;
- d. Provision of interpreter services for deaf clients being served by the Department of Mental Health and Mental Retardation;
- e. Clarification of the appropriateness of using clients' personal spending money to purchase items reimbursable under Title XIX;
- f. Clarification of the issue of informed consent for medical treatment of clients unable or unwilling to give informed consent;
- g. Clarification of transfer procedures for Bureau of Mental Retardation clients, both in Pineland Center and the community;
- h. Clarification of the right of children in ICF/MR facilities to equal access to educational opportunities;
- i. The allowance of ICF/MR clients, participating in a work program, to benefit from a portion of the wages they receive as a result of their work; and
- j. Issues regarding the interpretation and enforcement of boarding home regulations, etc..

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In addition to these concerns which have a more generalized impact on clients of the Department of Mental Health and Mental Retardation, a far greater number of individual requests for assistance and assuring compliance with laws, administrative rules and regulations, and institutional policies and procedures, have been handled, including issues such as clients' rights to have access to personal property and visitation with family members, the right of a client to be free from unnecessary medications or restraints, etc..

The Office of Advocacy receives in excess of 1,000 referrals/complaints per year. The vast majority of these are resolved by simply explaining the situation and/or referring the client to the appropriate staff person who can resolve minor concerns or grievances. Often explaining the law or policy relating to their concern effectively reduces the clients' concerns and results in termination of the complaint.

There are in any given year a number of complaints lodged by clients which require, for adequate resolution, changes in laws, regulations or policies. These are handled on a case-by-case basis and have resulted in such actions as: the drafting of a proposed sterilization law to come before the legislature in the upcoming session, filing a complaint with the Office of Civil Rights in Boston regarding two conflicting regulations in regard to program accessibility for handicapped people and exclusions from Medicaid, reimbursable placement in the community, etc.. In addition, the Office of Advocacy has represented clients in over 350 treatment or program planning sessions.

The Office of Advocacy, in functioning as an information resource regarding the rights of clients, has presented over 50 in-service training sessions to staff of the department and 20 training sessions for parents/community service providers in such areas as: the Rights of Mentally Retarded Persons under 34 M.R.S.A. Chapter 1860a; the use of behavior modification techniques in institutional and community settings; in addition there have been over 500 individual contacts regarding information to clients/parents and service providers. Within the mental health institutes, it is standard procedure for the advocate to meet with each client who is received for civil commitment to explain the process with which they will be involved and their rights within that process; and, the Office of Advocacy works on a regular basis to provide basic written information for distribution to service providers, parents and agency personnel regarding specific issues that have general applicability and need widespread exposure.

9. Future Plans

With the separation of the Department of Mental Health and Corrections into the Department of Mental Health and Mental Retardation, it is anticipated that the Office of Advocacy in the department will be able to solidify its approach to advocacy for all clients served by the department.

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The differences both procedurally and ethically in advocating for mentally disabled persons as compared to advocating for correctional clients has been a continual obstacle to a unified approach in advocating for all clients of the department. In addition, the use of the Chief Advocate's position to carry a caseload at the Maine State Prison and coordinate the activities of advocates serving the mentally ill, mentally retarded as well as corrections, has historically made adequate supervision of the advocacy network in the former Department of Mental Health and Corrections virtually impossible. It is presently anticipated that the Office of Advocacy in the Department of Mental Health and Mental Retardation shall have a greater degree of flexibility in dealing with community mental health clients, a population which has not been served in a systematic way by the Office in the Department of Mental Health and Corrections. In addition, the Office of Advocacy is now preparing to become the designated investigatory agency for the Department of Mental Health and Mental Retardation in its role as the provider of adult protective and supportive services for mentally retarded citizens of the State of Maine.

Title 22, M.R.S.A. Chapter 1666, further expands the Office of Advocacy's obligations to investigate rights/denials for clients in nursing/boarding/foster homes to include not only mentally ill individuals and persons having conditions related to mental illness or mental retardation. Along with a continued effort to increase client participation in decisions regarding their care and treatment both in state institutions and in the community care system, the Office of Advocacy recognizes and intends to address the special problems presented to both the judicial and the executive branch of State government by the increasing numbers of mentally retarded or mentally ill individuals who are becoming involved in the criminal justice system.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

Program Contact: Frank Schiller, Director, Division of Planning

1. Legislative authorization or other program mandate:

a. Legal citation:

34 M.R.S.A. § 1 (The Division was created in October, 1977 as part of a reorganization of the Department of Mental Health and Corrections and was accomplished with the use of existing positions.)

b. Other mandates:

34 M.R.S.A. §§ 1, 7 (Administration of the Department of Mental Health)

34 M.R.S.A. § 13 (State Planning and Advisory Council on Developmental Disabilities)

34 M.R.S.A. § 2003 (Mental Health Advisory Council)

15 M.R.S.A. §§ 2302, 2304 (Interstate Compact on the Disordered Offender)

5 M.R.S.A. § 11106 (State Agency Rules)

5 M.R.S.A. § 8001 et. seq. (Administrative Procedures Act)

20 M.R.S.A. §§ 3052, 3117 (Education and Rehabilitation of Disabled and Handicapped Persons)

22 M.R.S.A. §§ 7102, 7106 (Office of Alcoholism and Drug Abuse Prevention)

22 M.R.S.A. § 5306 (Agreements with Community Agencies)

P.L. 97-35, Omnibus Budget Reconciliation Act of 1981, 95 Stat. 357

2. Public Need:

The Department of Mental Health and Mental Retardation exists as a result of the needs of citizens of the state who suffer from mental illness, mental retardation and/or developmental disabilities. The Commissioner of the department is charged with meeting the needs of these citizens and their families through the development and operation of an effective system of public and quasi-public institutions and community programs that provide necessary services to these groups of citizens. To assist the Commissioner in the development, implementation, monitoring and assessment of the effectiveness of the various programs and facilities, a Division of Planning was created.

The Division of Planning facilitates departmental responses to public requests for information through:

- a. Assisting in the organization of community forums to receive comments and to promote discussion relative to departmental plans;

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Program Contact: Frank Schiller, Director, Division of Planning

- b. Developing and assisting in the operation of client-based information systems that generate fiscal, planning and evaluation reports;
- c. Organizing and advising various councils, committees and task forces;
- d. Developing management summaries and preliminary plans for federal grants and other resources;
- e. Drafting proposed legislation which reflects the changing needs of clients, court decisions or federal regulations impacting on departmental operations; and
- f. Developing special projects designed to improve departmental services.

3. Program Objectives:

The overall goal of the Division of Planning is to assist in the development of programs, plans and policies which reflect departmental philosophy and contribute to more effective and integrated service delivery.

Specific objectives of the division can be separated into one of three general categories: Plan and Program Development, Systems Development and Evaluation.

Plan and Program Development:

- a. To prepare departmental plans or guidelines in order to comply with state and/or federal mandates in the areas of mental health, developmental disabilities, federal funding and alcohol and substance abuse. These may be developed for departmental use only, or in collaboration with other agencies.
- b. To participate on committees or task forces concerned with the needs of particular client groups served by the department. Such participation enables the division to provide input from the department's perspective into the development of recommendations and programs.
- c. To coordinate with other units of the department and with other state agencies in areas of mutual concern.

Systems Development:

- a. To provide data on departmental programs, clients and operations to interested individuals, including departmental personnel, legislators, consumers and public agencies.
- b. To maintain an automated computer system in order to generate data reports. Examples of such reports are the Capital Assets Accounting System used by institutions and the Mental Health/Mental Retardation Patient Accounting System.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

Program Contact: Frank Schiller, Director, Division of Planning

Evaluation:

- a. To provide assistance in the evaluation of departmentally funded projects or programs, such as the evaluation of community residential programs for chronically mentally ill individuals.
- b. To advise the department on the potential impact of proposed legislation or regulations based on an analysis of available data. The division recently prepared a summary of opportunities and problems presented by changes in federal Medicaid regulations.
- c. To assist in the development of departmental legislation.

4. Program Operation:

The Planning Division is organized into three inter-related units: Plan and Program Development, Research and Evaluation and Information Systems.

Major objectives are identified annually through a specific process involving all major bureaus and divisions of the department. Major needs and emphases are determined by the Commissioner and routine objectives established including those required by statute or regulation. Administrative, bureau and division management staff identify needs and tasks specific to their program areas and overall priorities are established under the direction of the Commissioner. The Planning Division staff review the objectives and establish responsibility assignments and time-tables.

The division operates on a functional team approach which allows for the maximum benefit from individual abilities and interests. For example, the director may have a secondary responsibility on an assignment for which the Comprehensive Health Planner has lead responsibility. For major objectives, work plans are developed which designate tasks and sub-tasks, individual staff responsibilities, required contacts, expectations and time-tables. Outside sources are consulted as necessary to assure a quality product; these sources include clients and families, staff members, representatives of other public agencies and generally those having technical expertise and/or particular interest in the issues. The development of the State Mental Health Plan, for example, included input from over 500 individuals and as a result, a variety of perspectives were included beyond those of the planning staff.

Although meeting planned objectives is the primary goal, additional tasks are performed for departmental staff as personnel resources allow.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

Program Contact: Frank Schiller, Director, Division of Planning

5. Staffing:

a. General Fund:

1. Positions authorized: 6

2. Positions filled September 1, 1981:

a) Full time: 6

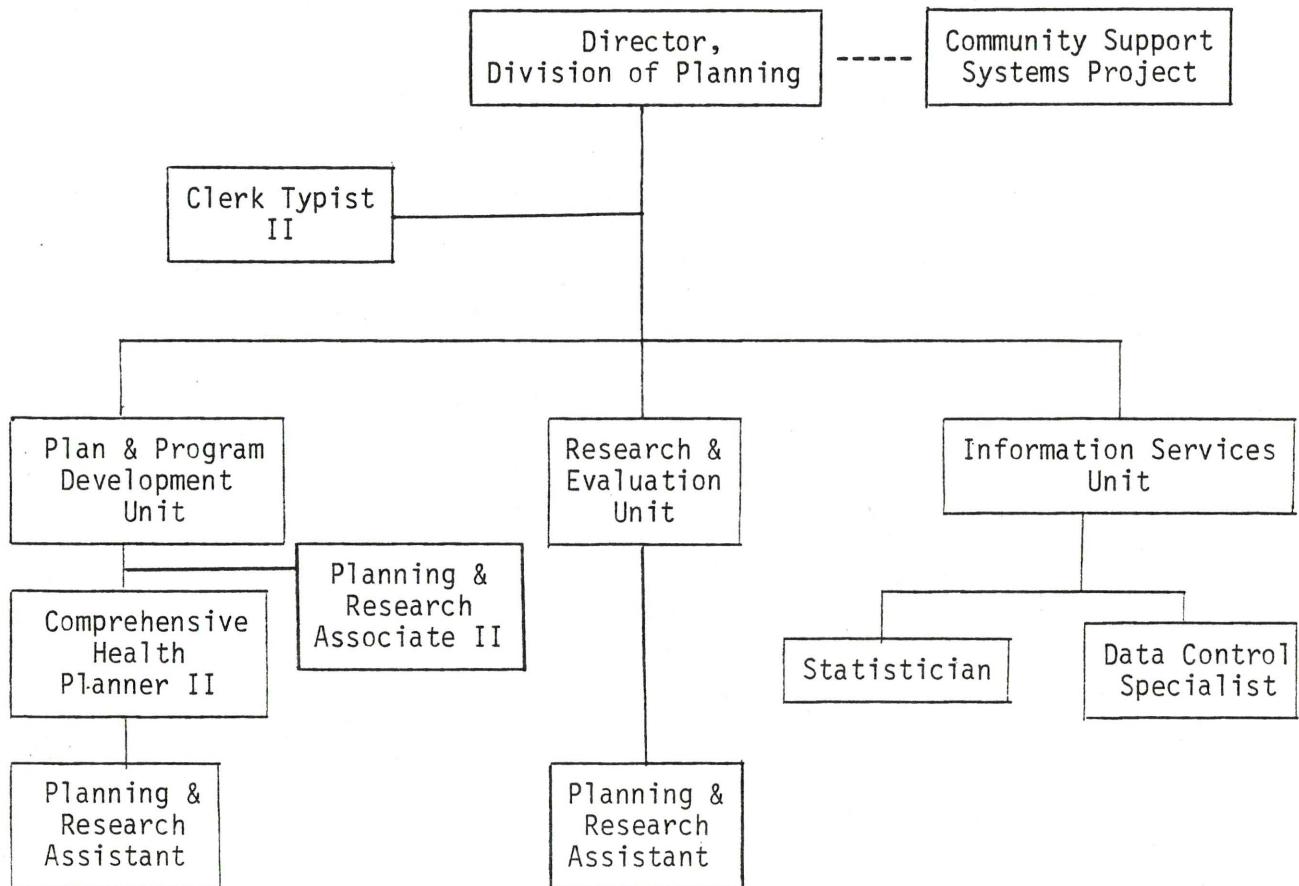
b) Other positions: 2

b. Other funds (including vacant positions):

1) Full time: None

2) Other positions: None

c. Organization:



DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

Program Contact: Frank Schiller, Director, Division of Planning

d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Director, Division of Planning	1		
Comprehensive Health Planner II	1		
Planning & Research Assistants	2		
Data Control Specialist	1		
Statistician I	1		
Clerk Typist II	1		
Planning & Research Associate II	1		

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

Program Contact: Frank Schiller, Director, Division of Planning

6. Financial Data:

a. Appropriation account #: 1340.1020

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	141,830	127,593	113,858
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>141,830</u>	<u>127,593</u>	<u>113,858</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	141,830	127,593	113,858
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>141,830</u>	<u>127,593</u>	<u>113,858</u>
<u>All Other:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
 TOTAL FUNDS EXPENDED	 <u>141,830</u>	 <u>127,593</u>	 <u>113,858</u>
 Undedicated Revenue to G.F.:	 -0-	 -0-	 -0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

Program Contact: Frank Schiller, Director, Division of Planning

7. Other Programs:

Planning units exist in other state agencies and have similar or related objectives which are complementary to this program. These programs are:

- a. Planning and Evaluation Unit, Bureau of Social Services, Department of Human Services;
- b. Plans and Policy, Bureau of Medical Services, Department of Human Services (Medicaid plans);
- c. Plans Development, Bureau of Health Planning, Department of Human Services (State Health Plan);
- d. Alcohol Drug Abuse Prevention and Vocational Rehabilitation Planning, Bureau of Rehabilitation, Department of Human Services;
- e. Planning, Bureau of Maine's Elderly, Department of Human Services (mental health elderly services);
- f. State Planning Office (A-95 review and census data); and
- g. Human Services Council, Department of Human Services (plans review).

Other private programs with service objectives similar to the department include many contract agencies, community hospitals, private clinicians and other health care providers. Some of these, such as community hospitals, have data processing and planning units that represent both an occasional source of technical assistance and a participant in the Division's plan or program development functions.

The Division of Planning differs from the listed planning agencies in that it is involved in many facets of the department's operation rather than directed to specific programs or projects within a department. It is the only state planning unit that concentrates on the needs of mentally retarded and mentally ill individuals.

Finally, the Division communicates with many federal agencies and with similarly occupied peers in other state mental health, mental retardation and corrections agencies.

Linkages with other planning units are critical from at least two perspectives. First, a premise of planning for the mentally handicapped (MH, MR, DD) is that the department does not in itself have the fiscal or programmatic resources to fully meet the entire range of basic and social, vocational-educational needs of handicapped people. Care and treatment represent only a portion of client and family needs. Secondly, no major service system operates and sustains itself in a vacuum. Departmental policies and procedures are clearly affected by other systems, and the Planning Division represents part of the mechanism to assure interaction.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

Program Contact: Frank Schiller, Director, Division of Planning

8. Program Effectiveness:

The annual process of specifying Division objectives includes an assessment of the status of the previous year's objectives, thereby providing a quantifiable basis for monitoring performance. Examples of accomplishments during the past year include:

Plan and Program Development:

- Provided extensive assistance to the Bureau of Corrections (currently the Department of Corrections) prior to, during and after the Maine State Prison lockdown. Staffing, program and classification plans were developed based upon unique needs and other states' experiences.
- Developed applications resulting in the authorization of over one million dollars in loan authority from HUD for housing for chronically mentally ill individuals.
- Developed the Maine Juvenile Code and Evaluation Plan Report as required by statute.
- Developed the 5-Year Mental Health Plan. The process of developing this plan includes a status report on the achievement of last year's objectives and the addition of objectives for another prospective year. The Mental Health Plan serves as:
 - a. a public information tool relative to the availability of mental health service;
 - b. an outline of the department's priorities and policies relating to mental health; and
 - c. a management guide for departmental managers to assess progress in achieving stated objectives.

Systems Development:

- Developed computer programs for the mental retardation needs assessment and developed the summary reports.
- Developed the revised Medicaid reimbursement provisions which expanded the funding base available for the provision of follow-up services for discharged mental health patients.
- Maintained and improved the automated information systems relating to capital assets, the department's budget and mental health institute clients.
- Refined the process and method of developing corrections population projections, resulting in levels of accuracy within 1% over a two year

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

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period, with six month increments.

Evaluations:

- Developed a comprehensive research and evaluation report on the incidence of sexual abuse and the treatment of the abuser, victims and other family members.
- Evaluated provisions of the Maine Juvenile Code.

In addition, the Division of Planning:

- Presented professional papers and/or materials at several departmental, state, regional and national level workshops.
- Responded to over 50 requests for statistical information from departmental, provider, other state agencies, the general public and other sources.

9. Future Plans:

The future plans for the Division of Planning are intended to improve its effectiveness in the three functional areas.

Improved integration of Plan and Program Development activities is anticipated as a result of the following:

- a. Increased involvement with the Developmental Disabilities (DD) Council and its staff;
- b. Participation of division staff on several sub-committees of the Mental Health Advisory Council; and
- c. Agreements with the Bureau of Health Planning and Development regarding collaboration on the State Health Plan and reporting requirements under the Alcohol Premium Law to enhance inter-departmental plan and program development.

Both Evaluation and Systems Development functions will be expanded by the addition of a Management Analyst II made available through block grant funding. Since this position will supervise the statistician and data control specialist, improvements are expected in the following areas:

- a. Methods of evaluating programs for client impact and cost effectiveness;
- b. Basic monitoring of appropriate accessibility and availability; and
- c. Existing data systems.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Planning, Research and Vital Statistics

Program Contact: Frank Schiller, Director, Division of Planning

The future plans of the Planning Division are, to a great extent, dependent upon the plans and needs of the programs within the department. These improved information systems will enable the division to provide an increased level of technical assistance to departmental programs regarding regulatory provisions and documentation/recording systems to increase its capacity to respond to their changing needs.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Division of Children's Services

Program Contact: Edward C. Hinckley, Director

1. Authorizing legislation or other program mandate:

a. Legal citation:

None

b. Other mandates:

34 M.R.S.A. Chapter 1, Department of Mental Health and Corrections

20 M.R.S.A. Chapter 406, Preschool Handicapped Children

15 M.R.S.A. Chapter 501, Maine Juvenile Code

P.L. 1977, Chapter 42, Interim Children's Services

The Division of Children's Services was created in October 1977 as part of a departmental reorganization plan approved by the Governor. Title 34, Section 12, authorizes the department to support human service programs, including children's community action programs, juvenile programs and youth service programs. Section 2001 charges the department, through its Bureau of Mental Health, with "the promotion and guidance of mental health programs within the several communities of the State." Specific departmental staff have been assigned the responsibility for children's services program development, funding and monitoring since 1973 when the Children's Psychiatric Hospital at Pineland Center was permanently closed.

The Preschool Handicapped Children Act mandates the establishment of an Interdepartmental Coordinating Committee for Preschool Handicapped Children representing the Department of Educational and Cultural Services, the Department of Human Services and the Department of Mental Health and Corrections.

The Maine Juvenile Code, § 3314.1 (c), provides for the commitment of juveniles to "the Department of Mental Health and Corrections or the Department of Human Services for placement in a foster home, group care home or halfway house or for the provision of services to a juvenile in his own home."

Section 3715 (2.) of the Interim Children's Services Act required the preparation and presentation (by January 1, 1978) to the Governor and Legislature of a report to include recommendations for coordinated policy, assessment of "the impact of children's services as presently provided by the Department of Human Services and the Department of Mental Health and Corrections," together with recommendations for legislation. From the beginning it was apparent that it was necessary to include the Department of Educational and Cultural Services as an equal partner in the development of the report. The report was compiled and presented jointly by the three departments.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Division of Children's Services

Program Contact: Edward C. Hinckley, Director

A joint legislative order (February 17, 1977) committed the legislature to adopt policies to preserve families as the primary unit for the care and nurturing of children, through approaches applicable to the Department of Mental Health and Corrections, Department of Human Services and the Department of Educational and Cultural Services, "which are the State agencies most responsible for services to children and families."

A joint legislative order (June 6, 1977) requested that the Departments of Educational and Cultural Services, Mental Health and Corrections and Human Services study the provisions of Public Law 94-142 (the Education of All Handicapped Children Act) to recommend any necessary actions required to bring Maine into compliance and to study present and future responsibilities to preschool handicapped children.

Federal regulations attendant on P.L. 94-142 and state regulations attendant on the State's special education law (20 M.R.S.A. c. 401) encourage, but do not mandate, involvement of the State's mental health agency in programming and funding for emotionally handicapped children.

2. Public Need:

The programs of the Division of Children's Services seek to respond to the mental health needs of Maine's emotionally handicapped children, ages 0-18. State Department of Educational and Cultural Services' figures indicate a total of 3,999 emotionally handicapped children, ages 3-21, as of December 1980. This represented a 21% increase over the preceding year.

During the year ending December 1980, the State's eight community mental health centers (whose catchment areas encompass the entire state) served an average active caseload of 550 at any given time, also representing an increase over the preceding year. A significant part of the centers' funding is provided by grants from the department's Bureau of Mental Health and Division of Children's Services.

All indicators of social conditions, causal or related to poor emotional health of children, such as unemployment, inflation, juvenile delinquency and crime, divorce, child abuse and neglect, alcohol and substance abuse, teenage pregnancy, etc., appear to be increasing steadily.

The need for an administrative unit focusing on the mental health and developmental needs of children is occasioned by the unique status of children in our society. Treated differently by both laws and social custom than adults, children begin life totally dependent on their families for all elements of existence. In their next 16 to 18 years, they become able to survive and function with almost total independence. Under the best of circumstances, this normal passage from dependency to independence is marked by the need for changing relationships and services unlike those developed for or appropriate to adults.

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Further, effective mental health services to children cannot be delivered exclusively within clinical settings or other formal environments, but must be flexible enough to include parents and other family members when appropriate, must impact entire peer groups during the adolescent years and must be capable of delivery both within and separate from the home.

Particularly, in attempting to develop programs aimed at the prevention of emotional disturbance or mental illness in children, there is a demonstrated need to employ professional and pre-professional workers with specific education, training and experience in child growth and development and to implement and encourage communications, information-sharing and in-service training between such children's specialists. Through its programs of grants, referrals and technical assistance, the Division of Children's Services provides a focal point for such activities.

Close to one-third of Maine's population is below the age of majority and it is estimated that the absolute numbers of children under eighteen will remain well over 300,000. These figures take note of the declining birth rate for women of child-bearing years, and probably do not place enough emphasis on the growing immigration to Maine by young families from more populous states. In short, the welfare of over 300,000 children will remain a major factor in the lives of Maine citizens for the foreseeable future, demanding an increased level of commitment to children's services on the part of public policy makers.

3. Program Objectives:

To develop, support and evaluate efficient and coordinated programs to improve the mental health of Maine children in the least restrictive and most appropriate settings possible through prevention, early intervention, family and community support and treatment activities.

"Efficient programs" are programs that are program effective, cost effective, accountable and capable of evaluation.

"Coordinated programs" are programs in which other state departments or agencies are involved in the planning, funding, regulation or evaluation.

"Least restrictive and most appropriate settings" means ensuring that prevention and early intervention techniques within the family and/or community are not possible or adequate before removal from family and/or away-from-community treatment occurs.

4. Program Operation:

The Division of Children's Services purchases mental health services through state-approved Purchase of Service agreements negotiated annually with public and private service providers. Specific agreements may be solicited by

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providers, may be sought by the Division on a "request for proposal" basis or may be suggested by other state agencies that are interested in joint funding of a particular program or activity. Examples of programs funded by the Division are:

- Community Mental Health Centers
- Bancroft North (Owl's Head)
- Elan, Inc. (Poland Spring)
- Homestead Project, Inc. (Ellsworth)
- Spurwink School (Portland)
- Sweetser-Children's Home (Saco)
- Community Shelters for Children, Inc. (Augusta)
- St. Michael's Center (Bangor)
- Families United of Washington County (Machias)
- Washington County Children's Program (Machias)
- Young Women's Christian Association (Portland)
- Freeport Community Services (Freeport)
- Youth Services Planning & Development Council, Inc. (Skowhegan)
- Androscoggin Regional Treatment Center (Auburn)
- Cumberland County Day Treatment Program (Portland)
- Alternative Program (Hallowell)
- Central Aroostook Association for Retarded Citizens, Inc. (Presque Isle)
- Southern Penobscot Regional Special Education Program (Old Town)
- Alternative School for Success M.S.A.D. #56 (Searsport)
- Winthrop Public Schools-Regional Alternative Junior/Senior Intervention Services (Winthrop)

Basic recommendations for expenditure of the year's allocation of funds are developed each spring by the director and given final approval by the Commissioner before the start of each state fiscal year. Approximately 95% of the Division's allocation is committed or encumbered in July of each year; occasional new purchase agreements are developed during the year with remaining funds. A majority of agreements run from July to June, others begin in September or October to coincide with the school year or the federal fiscal year.

Contract performance is monitored regularly through the submission of individual semiannual progress reports (for child-specific treatment programs) or quarterly narrative reports (for general prevention, intervention or family support programs). Year-end financial reports are also required and reviewed. Periodic site visits are also conducted.

The Division of Children's Services exercises general administrative control over the Military and Naval Children's Home in Bath, Maine. As described in its submission, the Home provides shelter and care for children who, through no fault of their own, lack appropriate home environments for short periods of time, generally due to family crisis.

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Coordination of activities, assessment of needs and establishment of priorities is accomplished by the Director's active membership on a wide range of interagency committees and task forces, coupled with periodic attendance at meetings of various public and private agencies' board meetings, staff meetings, etc.

5. Staffing:

a. General Fund:

1) Positions authorized: 2

2) Positions filled Sept. 1, 1981: 2

a) Full time: 2

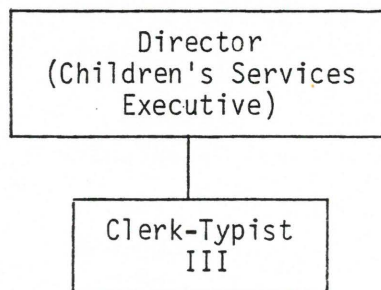
b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: None

b) Other positions: None

c. Organization:



d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Children's Services Exec.	1		
Clerk Typist III	1		

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Division of Children's Services

Program Contact: Edward C. Hinckley, Director

6. Financial Data:

a. Appropriation account #: 1340.7; 1340.1

b. Estimated revenues:

	<u>FUNDING SOURCE</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G. F. Appropriation:</u>	1,742,632	1,827,632	1,916,882
Transfers Out	-0-	(109,000)	-0-
Balance Forward	7,400		
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>1,750,032</u>	<u>1,718,632</u>	<u>1,916,882</u>

	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	42,632	42,632	42,632
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>42,632</u>	<u>42,632</u>	<u>42,632</u>

<u>All Other:</u>			
General Fund	1,586,445	1,676,000	1,874,250
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>1,586,445</u>	<u>1,676,000</u>	<u>1,874,250</u>

<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>

TOTAL FUNDS EXPENDED	<u>1,629,077*</u>	<u>1,718,632</u>	<u>1,916,882</u>
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Undedicated Revenue to G. F.: -0- -0- -0-

*Approximately \$117,280 was carried over to FY 82 as encumbered contracts in addition to the total amount expended.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Division of Children's Services

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7. Other Programs:

The Division of Child and Family Services, Department of Human Services, has similar objectives for emotionally handicapped children who are placed in State custody by courts as the result of parental abuse or neglect. In an effort to prevent such a court determination, except where absolutely necessary, the Division of Children's Services (DMHMR) has developed a number of jointly-funded cooperative therapeutic placement programs with the Department of Human Services. In these the Department of Human Services supports voluntary care of a child, and the Department of Mental Health and Mental Retardation supports mental health treatment of the child and his family; the mutual goal being the reunification of the family.

The Division of Special Education, Department of Educational and Cultural Services, has complementary objectives for the special education of emotionally handicapped children identified or referred by public school Pupil Evaluation Teams. In an effort to maintain the need for long-term residential placements away from home and out of the home community at as low an incidence as possible, the Division of Children's Services (DMHMR) has developed a number of jointly-funded cooperative day treatment programs. In these the Department of Educational and Cultural Services supports community-based special education services and the Division supports child-and-family counseling and therapy services, frequently delivered within the home; the mutual goal being improved functioning and maintenance of the family.

It is with these two agencies that the most frequent, regular (3-4 times weekly) and intense (actual development of joint policies, regulations and legislation) coordination and cooperation occurs.

Other public programs having related concerns and objectives involving Maine youth with whom coordination and cooperation occurs on a frequent basis include:

- Maine Criminal Justice Planning and Assistance Agency (Executive Department)
- Office of Alcohol and Drug Abuse Prevention (Department of Human Services)
- Maine Youth Center (Department of Corrections)
- Bureau of Mental Retardation and Bureau of Mental Health (Department of Mental Health and Mental Retardation)
- Interdepartmental Committee (Commissioners of Mental Health and Mental Retardation, Educational and Cultural Services and Human Services)
- Augusta Mental Health Institute Adolescent Unit (DMHMR)

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Program Contact: Edward C. Hinckley, Director

8. Program Effectiveness:

The effectiveness of efforts towards the objectives listed in Section 3 is determined by progress along the lines of three qualifying characteristics defined in that Section: efficiency, coordination and least restrictive/most appropriate. In brief, this progress is as follows since the fall of 1978:

Efficiency: As the result of greater clarity in the specifications of services to be purchased, the average cost to the Department of Mental Health and Mental Retardation per residential treatment placement dropped from \$10,000+ to an average of \$7,300 (1980-81). The funds thus made available were used to increase the number of children who could be supported in residential treatment placements; an increase of approximately 50 children over the same period to a 1980-81 total of approximately 165. During the summer of 1981, for the first time ever, a tri-departmental Request for Proposal was developed, advertised and subsequent provider applications were systematically processed to select a contractor for the provision of residential treatment services to 25 emotionally handicapped children.

Purchase-of-service agreements have been standardized with respect to scope and scheduling of both individual, programmatic and fiscal reporting. Pre-1978 contracts requested varying information (semi-annual, annual, biennial and even triennial reports) and information never used (monthly income and expenditure reports). In addition, definitions of the services purchased have been detailed to emphasize their mental health treatment character and provisions for better communications with both referring school systems involved and community mental health agencies have been written into the agreements.

Coordination: As indicated in Section 7, the most frequent, regular and intense coordination is with the Division of Child and Family Services (DHS) and with the Division of Special Education (DECS). No regular or structured communications existed prior to 1977; at present there are weekly "unit level" meetings; bi-monthly division/bureau level meetings; periodic meetings of the DMHMR, DHS and DECS Commissioners (comprising the Interdepartmental Committee), coupled with the regular exchange of referral, placement, discharge and financial information and forms. The Division of Children's Services (DMHMR) has played a lead role in maintaining this interdepartmental effort since the fall of 1978.

Inevitably, and by intention, this cooperation and sharing at the central office's level is being replicated on a regional basis by community mental health centers, regional DHS offices and consortia of public school systems, with resulting improvement in the effectiveness and scope of child and family service delivery.

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Other specific tri-departmental products or functions developed in the past three years include:

- A consultation, pre-application, application process for new children's services providers wishing to do business in Maine with public financial support;
- A joint contract and contract negotiation process developed for residential treatment centers now being expanded to group homes;
- Uniform cost accounting and rate establishment standards and the development of uniform "Principles of Reimbursement"; and
- Joint licensing legislation and adaptation of interstate and inter-departmental standards for residential child care facilities.

Least Restrictive/Most Appropriate: In 1977-78 only 10% of the Division of Children's Services allocation was expended for other than residential treatment. By contrast, the 1981-82 Division of Children's Services allocation was divided as follows:

<u>Type of Program</u>	<u>Percent of Funds</u>	<u>Number of Children</u>
Residential Treatment Placements	61%	165
Other Individual Placements	4%	15
Community-Based/Family Support Grants	35%	950

9. Future Plans:

Besides continuing to move towards the objectives identified in Section 3, the Division of Children's Services intends to:

- a. Develop a management information service in conjunction with the Division of Planning to help measure the individual effectiveness/progress of various types of child placements.
- b. Document and evaluate the results of prevention/early intervention mental health activities in conjunction with other public and private "prevention providers."
- c. Establish a system to prioritize children's mental health needs in relation to the presence or scarcity of resources.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

1. Authorizing Legislation or other program mandate:

a. Legal citation:

22 M.R.S.A. § § 8104 and 8105 (AN ACT to Require Interagency
Licensing of Residential Facilities and Programs for Children)

b. Other mandates:

15 M.R.S.A. Chapter 501 § 3001 et al (Juvenile Code)

22 M.R.S.A. § 3715 (Interim Children's Act)

1979, Resolves, Chapter 16 (RESOLVE, Relating to a Report on a
Single Source for Funding of and Reporting by Residential
Programs for Youth)

The roots and origins of the Interdepartmental Committee (IDC) stem from legislative intent and from citizen expectations for efficiency in the development and delivery of services to children and families in need. An early effort towards similar ends is represented by the 1973 interdepartmental TRI-PLAN: A design for Integrated Screening and Social Service to Children. Although some of its objectives were never realized in practice, a number of strong interagency links were developed. During 1975-1977, increasing realization of the extent and complexity of human service needs in Maine, new state and federal initiatives in human services and increased legislative and citizen concerns for greater efficiency of operation resulted in the development of a number of significant documents, as follows: (1) The Maine Human Service Council's Child Abuse and Neglect Task Force; (2) The Children and Youth Services Planning Project; (3) the Commission to Revise the Statutes Relating to Juveniles; and (4) the Greater Portland United Way's Substitute Care Task Force. In large part, as the result of these reports and various other Ad Hoc committees and task forces, several significant children and family service legislative documents were enacted by the 108th Maine Legislature in 1977 and 1978. These include AN ACT to Establish the Maine Juvenile Code; the Interim Children's Services Act.

In the closing days of the first session of the 108th Legislature a mandate was given to the Departments of Human Services and Mental Health and Corrections to jointly develop a long-term coordinated policy for child and family services. The departments were instructed to submit a report to the Legislature by January 1, 1978 outlining short and long term steps that would be taken to develop a systematic approach to meeting the needs of children and families in the State of Maine. From the beginning of the project, it was clear that it was necessary to include the Department of Educational and Cultural Services as an equal partner in the process of developing the coordinated policy mandated by the Legislature.

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Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

Thus, in early November 1977, a group of representatives from the three departments began meeting to address the issue of coordinating services to children and families. This "Children's Team" worked intensively for three months and produced the report "Coordinating Services for Children and Families." On January 27, 1978, this report was presented to the Second Session of the 108th Legislature.

The report outlined the combined recommendations of the three departments pertaining to the coordination of children and family services in Maine, and contained a series of recommendations, some of which required legislative action. One of the principal findings of the report was:

"...that a long-term coordinated policy that would have meaningful application to a range of services and issues could not be viewed as an isolated product; rather the policy would need to be developed through a sustained inter-departmental effort involving people at the local, regional and state levels from public and private agencies as well as the legislature."

The report recommended the Commissioners "Establish an Interdepartmental Coordinating Team composed of the Commissioners of the Departments of Human Services, Mental Health and Corrections and Educational and Cultural Services and key policy makers from those departments selected by the Commissioners, to continue the planning process and coordinating activities begun by the Interdepartmental Children's Team".

Through the already established Interdepartmental Committee process the three departments responded specifically to a Legislative Resolve: Chapter 16, RESOLVE, Relating to a Report on a Single Source for Funding of and Reporting by Residential Programs for Youth. This resolve, passed in the First Regular Session of the 109th Legislature, directed the Commissioners of the three departments to submit a written report to the Joint Standing Committee on Health and Institutional Services of the Legislature on establishing a single state source for funding of and reporting by residential programs. This report was delivered to the members of the Joint Standing Committee on Health and Institutional Services with a major recommendation being to continue to address the problems which prompted the resolve within the framework of existing interdepartmental efforts.

The three (3) departments have continued their formal coordinating relationship through the adoption of a work plan to develop and implement an inter-departmental system of residential and group care for children. The work plan addresses departmental management issues within the areas of program development, fiscal management and licensure of child caring facilities. The work plan has provided the formal mechanism and direction of these inter-departmental efforts.

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Program Contact: Nancy Warburton, Executive Director

A major portion of the work plan led to the introduction and subsequent passage of AN ACT to Require Interagency Licensing of Residential Facilities and Programs for Children. The Committee on Health and Institutional Services has requested progress reports by March 1, 1982 and January 15, 1983.

The three (3) departments are continuing to work jointly under the auspices of a new work plan under development and by virtue of the joint mechanisms currently in operation (i.e. joint contract development, joint rate setting, joint program development, etc.).

2. Public Need:

The problems of children and youth are unique in that they are a dependent segment of our population with limited legal rights and require special attention to their special needs.

Children and youth experience critical growth and development processes which will determine their ability to become fully contributing members of an adult world. During this crucial period they must rely on their families and public policy makers to provide their basic health, economic, social and educational needs.

Over the past decade as the problems and needs of families and children in Maine have grown increasingly complex, so has government's response to these problems and needs become increasingly complex. Within state government, at least three major departments (Department of Educational and Cultural Services, Department of Human Services and Department of Mental Health and Corrections) have responsibilities for Maine's children and families in the areas of education and special education, health, income maintenance, safety and protection, nutrition, and until recently, justice and corrections.

The three (3) state departments listed above all have significant responsibility for and impact on the lives of Maine children and families at risk--those who lack the basic necessities of life such as food, shelter and safety, those who are mentally, physically or emotionally handicapped and who therefore require special education and supportive assistance, and those who, as the result of such deprivation and handicaps, require residential care and treatment. Yet, for many years, these three state departments have cooperated mainly on an informal basis and principally at the local operation levels.

In Maine, as in the rest of the nation, we have entered a period which is characterized by limited resources and no new major programs or services for children and families. Therefore, existing structures and mechanisms, acting through formalized interdepartmental coordination mechanisms, hold the key to successfully addressing the complex problems facing children and families in need.

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Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

The Interdepartmental Committee has been small in relation to the overall responsibilities of the three (3) departments. However, the effort has been very significant in assuring coordination in the area of services provided to emotionally handicapped children.

The efforts of the Interdepartmental Committee have impacted primarily upon the system of services provided to a maximum of 225 emotionally handicapped children in residential placement requiring the expenditure of \$5 million dollars in state controlled funds. The efforts of the Committee have peripherally impacted upon another 200 children in group placements at an expenditure level of approximately \$3 million dollars (See Table V).

3. Program Objectives:

The Interdepartmental Committee approved a work plan in November 1979 to carefully implement coordinated key components and establish joint mechanisms in order to develop and implement a joint system of residential and group care for emotionally handicapped children.

Specific Program Objectives were as follows:

Objective #1: Assess need for and use of various kinds of residential and group care for children.

Tasks intended to accomplish this objective included completing a needs assessment, developing a system of reviewing placements and developing a system of reviewing preapplications for new agencies and applications for funding from both new and existing agencies.

Objective #2: Establish a method of developing kinds of resources and facilities to meet determined needs.

Tasks here included developing a preapplication process and package for new agencies, a single contract format applicable to all residential agencies, methods and criteria for reviewing both preapplications and applications, criteria and method for decision-making and a timetable for linking with the Licensing Unit.

Objective #3: Develop method of cost determination and rate setting for residential facilities and group care.

Toward this end, tasks focused on the development of coordinated "Principles of Reimbursement", adaptation/revision/implementation of the Cost Accounting Rate Establishment System (CARES), division of cost responsibilities and collection of cost data from residential facilities.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

Objective #4: Develop a system for tri-departmental licensure.

Objective #5: Develop method of establishing payment and cash flow and Executive/Legislative Budget Development.

Objective #6: Develop joint or complementary department placement policies.

4. Program Operation:

In 1979 the IDC was comprised of three Commissioners, the Residential and Group Care Committee and six Ad Hoc task groups (Table I). As a task group completed its assignment, it disbanded. By July 1980, only 4 task groups remained (Table II). The Residential Placement Review Committee subsequently disbanded in January 1981.

Table III represents the IDC's operational structure as it now exists. The Interdepartmental Negotiation Team, the working committee that evolved out of the Residential Placement Review Committee, deals primarily with the issues of joint contract development, consultation to persons or agencies interested in the development of new or expanded services for emotionally handicapped children and legislation affecting the three departments in the area of residential care. The Interdepartmental Fiscal Team has focused its attention on developing recommendations to streamline and strengthen the current financial management system relating to residential care. Following the enactment of P.L. 260, AN ACT to Require Interagency Licensing of Residential Facilities and Programs for Children, the Joint Licensing Task Force has concentrated on developing a comprehensive set of regulations to be used in the joint licensing process. These regulations are being adapted for Maine's use from the Guidebook on Residential Child Care, developed by the Interstate Consortium on Child Care.

Recommendations from these three task groups are forwarded to the Residential and Group Care Committee, the steering committee of the IDC. Recommendations from the RGCC are then forwarded to the Interdepartmental Committee, comprised of the three Commissioners for final approval prior to implementation.

Table IV lists those interdepartmental representatives most actively involved in this process.

5. Staffing:

a. General Fund:

1) Positions authorized: 3*

*Since the termination of federal grant funds in April 1981, the Departments of Mental Health and Mental Retardation, Human Services and Educational and Cultural Services have each assumed the responsibility of continued funding for one of the three staff positions. However, the Department of Human Services position is currently in process.

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Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

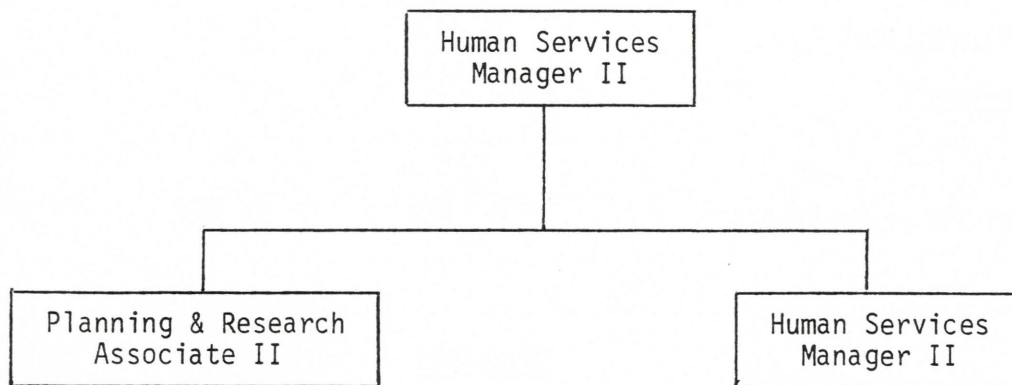
2) Positions filled September 1, 1981:

a) Full time: 2 b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: 0 2) Other positions: None

c. Organization:



d. List of positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Human Services Manager II	1 (DECS)		
Human Services Manager II			1 (vacant)
Planning & Research Assoc. II	1 (DMHMR)		

NOTE: The original interdepartmental coordination project was funded through the Federal Office of Juvenile Justice. Since the termination of federal grant funds in April 1981, the Departments of Mental Health and Mental Retardation, Human Services and Educational and Cultural Services have each assumed the responsibility of continued funding for one of the three staff positions. However, the Department of Human Services' position is currently in process.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

6. Financial Data:

a. Appropriation account #: 1340.1 (DMHMR); 3230.4 (DECS); 3322.1 (DHS)

b. Estimated Revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G. F. Appropriation:</u>	20,056	20,056	20,056
<u>Federal Funds Available:</u>	21,016	30,227	21,016
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>41,072</u>	<u>50,283</u>	<u>41,072</u>

	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	20,056	20,056	20,056
Federal	21,016	30,227	21,016
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>41,072</u>	<u>50,283</u>	<u>41,072</u>

<u>All Other:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>

<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>

TOTAL FUNDS EXPENDED	<u>41,072</u>	<u>50,283</u>	<u>41,072</u>
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Undedicated Revenue to G.F.:	-0-	-0-	-0-
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DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

7. Other Programs:

The major goal of the Interdepartmental Committee effort is to provide a framework and mechanism to enhance coordination among departments in the area of services for school aged emotionally handicapped children. Other committees/projects have similar mandates in other areas of coordination.

The Preschool Handicapped Children's Act mandates the establishment of an interdepartmental coordinating committee, representing the Departments of Educational and Cultural Services, Mental Health and Mental Retardation and Human Services and as such oversees the locally administered programs for screening, case management and purchased direct services for the pre-school handicapped population. Although similar in its coordinating function to the IDC, the Preschool Handicapped Committee differs significantly in the broad population served and by virtue of its direct involvement with children and families.

The Developmental Disabilities Council is charged with the responsibility of advocating for a network of services for developmentally disabled persons. The Council's goal is to change state policy by advocating for systems change and to provide some seed funds for service gaps.

The Community Support Systems Project focuses on the needs of chronically mentally ill persons living in the community. Its function, like the DD Council, is to advocate for systems change to ameliorate the needs of chronically mentally ill persons.

By contrast with these two groups, the IDC as a management tool works to implement systems change identified by the three Commissioners for a much smaller and more closely defined population, i.e. emotionally handicapped school aged children in need of residential services.

8. Program Effectiveness:

As illustrated in Tables I, II and III the work of the Interdepartmental Committee has been done by a series of interlocking task groups working on specific tasks of a work plan. As soon as the tasks have been completed the task group disbands. From January 1, 1979 to April 30, 1981 a total of 255 formal interdepartmental meetings were held addressing the specific tasks of the work plan. Since April, the level of commitment and time has remained the same.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

The following summarizes our progress on the various objectives outlined earlier:

The Residential Placement and Review Committee (RPRC) published a final report in January 1981 that described its success (and failure) in addressing Objective #1: Assess need for and use of various kinds of residential and group care for children. Within the context of describing programmatic and procedural resources, identifying gaps in programs and procedures, reviewing existing placements and developing a coordinated and systematic process of responding to proposals, the RPRC report focused on Maine's six residential treatment centers and other residential facilities located in one specific geographic region, namely, DHS Region III (Kennebec, Somerset, Sagadahoc, Lincoln, Knox and Waldo Counties). Those areas not addressed by the Committee were subsequently redefined and became the basis for Goal #1 under the 1981-82 draft work plan: Develop and implement an on-going program management system for the residential and group care system for emotionally handicapped children (See Future Plans).

Through development of a four-step single contract process, the IDC has established "a method of developing kinds of resources and facilities to meet determined needs." (Objective #2). The process begins with a Consultation step, designed to provide technical assistance to persons seeking to establish new residential facilities and progresses, if the person or agency is successful, through Preapplication and Application steps, culminating in a joint contract with the three departments for purchase of services. The Consultation, Preapplication and Application steps have been operational since July 1980. Difficulties in developing a joint contract document that could be approved by attorney generals in each of the three departments have delayed the implementation of the contract process.

Interdepartmental efforts since 1979 have focused on fiscal issues and the development of a state financing network. Consequently, with the execution of contracts for the 1981-82 contract year, Objectives 3 and 5 will have been completed in their entirety. The Single Source Funding Report presented to the Legislature in January 1980 included a list of funding sources available to residential programs from any agency, a description of terms under which funds are made available to the state and subsequently to residential programs, an estimate of amount of funds expected to be available for the programs in the state for the current and next state fiscal year, a description of the cycles by which funds are made available, including an indication by month of deadlines for applying for funds, the awards of funds and the fiscal year for obligations and expenditures.

The development of a system for tri-departmental licensure (Objective #4) was delayed until June 1980 because of problems in obtaining approval of a staff

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Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

position. Nonetheless, legislation was submitted to (and subsequently enacted by) the 110th Legislature to establish a tri-departmental licensing process. An initial draft of the "Rules for the Licensure of Residential Child Care Facilities," based upon a comprehensive set of licensing requirements developed by the Interstate Consortium on Residential Child Care, was completed in January 1981. Regional meetings and field tests were conducted in March 1981 and, based upon their results and input from provider agencies, the regulations are being revised for finalization through the Administrative Procedures Act.

Finally, Objective #6: Develop joint or complementary department placement policies was addressed by the IDC's Policy Development Task Group. Its product, a "Policy for Residential Placement of Children" was incorporated into the Department of Human Services Child and Family Services Manual, and has been operational since November 1980. Although a complementary policy was not developed subsequently for the Department of Mental Health and Corrections or rules updated for the Division of Special Education, the Department of Educational and Cultural Services, both departments adhere to the procedures incorporated into the DHS policy.

9. Future Plans:

It is anticipated that the Departments of Mental Health and Mental Retardation, Human Services and Educational and Cultural Services will continue their coordination efforts in the implementation of the joint administrative mechanisms of the residential and group care system in the specific areas of program review, program development, fiscal management, rate setting, contract development and licensing.

Expansion into other major areas of coordination between the departments may become necessary as cross-cutting problem areas between the departments demand interdepartmental attention and resolution.

A draft work plan for the 1981-82 contract year is currently being reviewed by interdepartmental representatives. Specific program goals are as follows:

Goal #1: Develop and implement an ongoing program management system for the residential and group care system for emotionally handicapped children.

Identification of programmatic needs, continued coordination of program development, refinement/monitoring of the contract process, continued evaluation of existing services, development of regional linkages and an overall service area plan for group homes and emergency shelters constitute the major task assignments in this area.

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Goal #2: Refine and establish an ongoing fiscal management system for the residential and group care system for emotionally handicapped children.

Specific tasks intended to accomplish this objective include the identification of a state fiscal plan, Residential Treatment Center Rate Setting, annual contract development, monitoring and audit of the fiscal system and overall refinement of the current system for Administrative Procedure Act promulgation.

Goal #3: Develop and implement a joint licensing process for residential and group care programs for children which are licensable by two or more departments.

Besides monitoring the impact of the joint licensing legislation, tasks here will focus on the finalization of the licensing regulations, development of an interdepartmental licensing process and technical assistance manuals for both provider agencies and licensing personnel. In addition, progress reports will be presented to the Joint Standing Committee on Health and Institutional Services on March 1, 1982 and January 15, 1983.

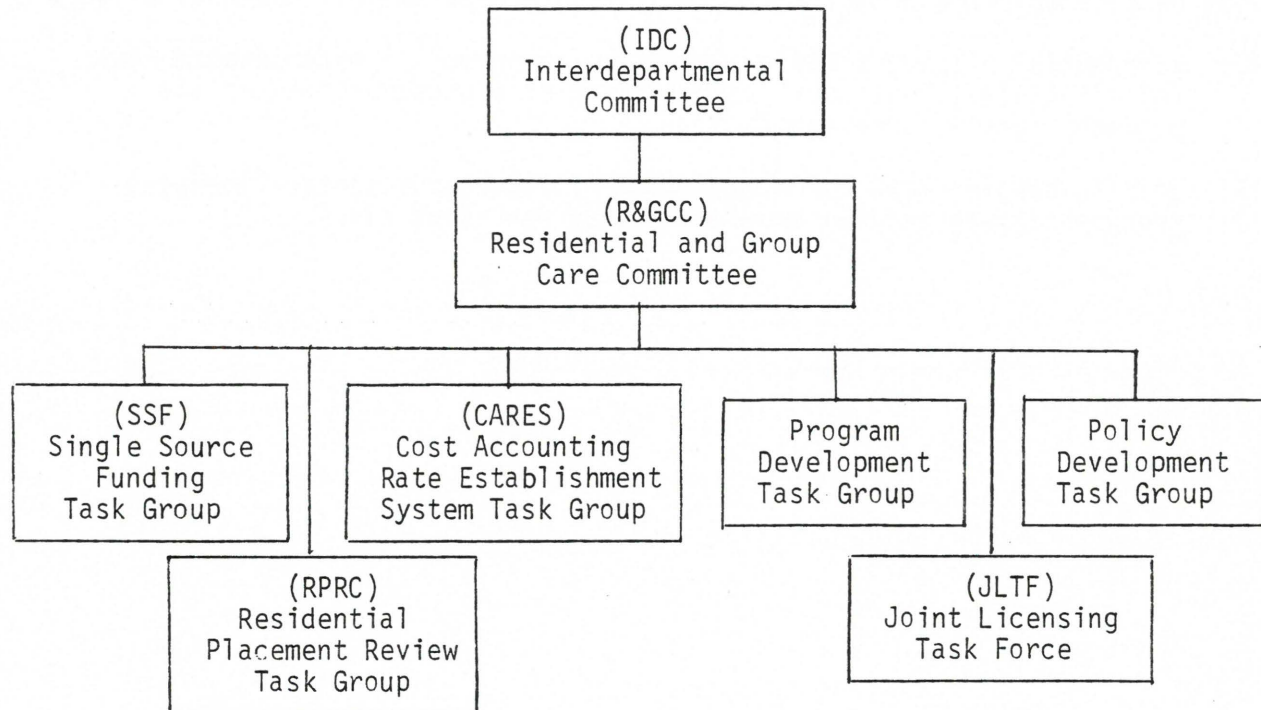
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

TABLE I

STATE OF MAINE, Departments of
Human Services
Mental Health & Mental Retardation
Educational and Cultural Services



IDC: Interdepartmental Committee comprised of the Commissioners of the Departments of Human Services, Mental Health and Mental Retardation and Educational and Cultural Services.

R&GCC: Residential and Group Care Committee comprised of Chairperson of each task group and other interdepartmental representatives.

SSF: Single Source Funding Task Group comprised of interdepartmental representatives, local school district representatives and two provider agency representatives.

CARES: Cost Accounting Rate Establishment System Task Group comprised of interdepartmental program and fiscal representatives, local school district representatives and two provider agency representatives.

Program Development Task Group: Comprised of interdepartmental representatives and one provider agency representative.

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Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

TABLE I (continued)

Policy Development Task Group: Comprised of interdepartmental representatives.

RPRC: Residential Placement Review Committee comprised of interdepartmental representatives, one local school district representative and one provider agency representative.

JLTF: Joint Licensing Task Force comprised of interdepartmental licensing representatives and two provider agency representatives.

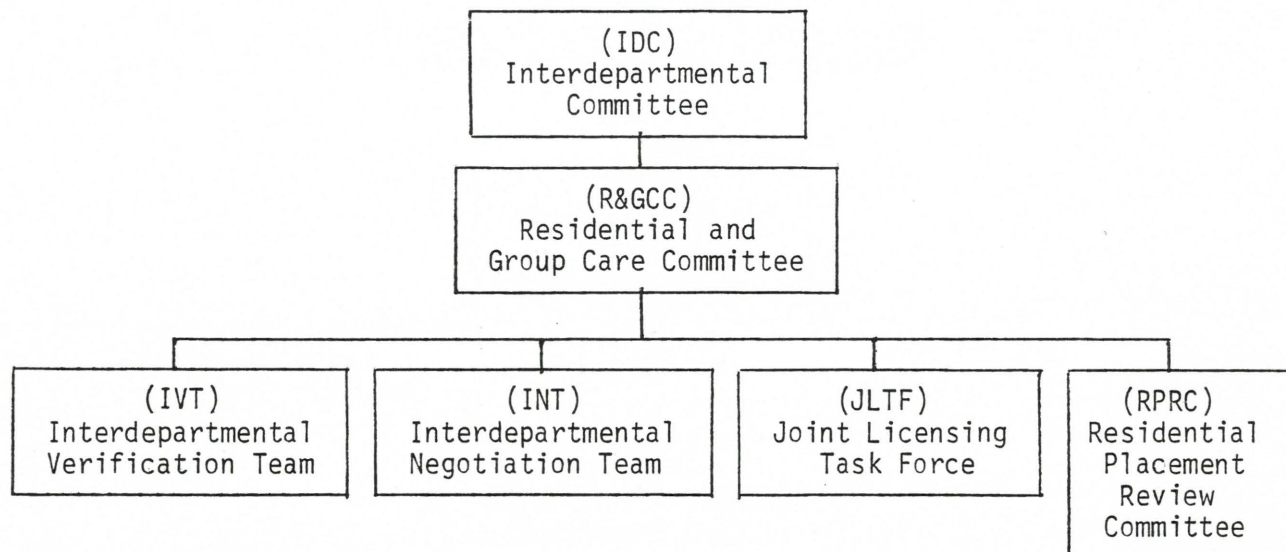
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

TABLE II

STATE OF MAINE, Departments of
Human Services
Mental Health & Mental Retardation
Educational and Cultural Services



IDC: Interdepartmental Committee comprised of the Commissioners of the Departments of Human Services, Mental Health and Mental Retardation and Educational and Cultural Services.

R&GCC: Residential and Group Care Committee comprised of Chairperson of each task group and other interdepartmental representatives.

IVT: Interdepartmental Verification Team comprised of interdepartmental fiscal representatives.

INT: Interdepartmental Negotiation Team comprised of interdepartmental program/placement representatives.

JLTF: Joint Licensing Task Force comprised of interdepartmental licensing representatives and two provider agency representatives.

RPRC: Residential Placement Review Committee comprised of interdepartmental representatives, one local school district representative and one provider agency representative.

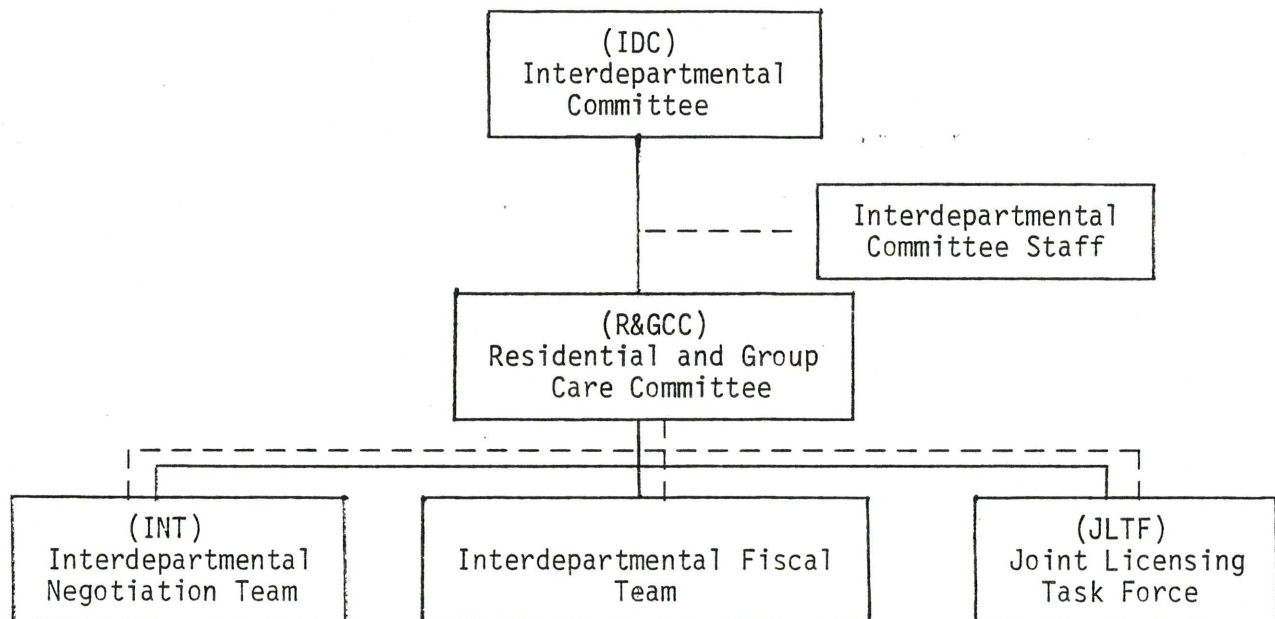
DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

TABLE III

STATE OF MAINE, Departments of
Human Services
Mental Health and Mental Retardation
Educational and Cultural Services



IDC: Interdepartmental Committee comprised of the Commissioners of the Departments of Human Services, Mental Health and Mental Retardation and Educational and Cultural Services.

R&GCC: Residential and Group Care Committee comprised of Chairperson of each task group and other interdepartmental representatives.

INT: Interdepartmental Negotiation Team comprised of interdepartmental program. placement representatives.

JLTF: Joint Licensing Task Force comprised of interdepartmental licensing representatives and two provider agency representatives.

Interdepartmental Fiscal Team: Comprised of interdepartmental fiscal representatives.

IDC Staff: Interdepartmental Committee Staff is comprised of a staff director and two staff assistants.

— — — Staff provide support services to all the interdepartmental committees as indicated by the dotted line.

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Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

TABLE IV

Individuals most actively involved from the three departments
in the Interdepartmental Committee Effort

Department of Mental Health and Mental Retardation	Department of Human Services	Department of Educational & Cultural Services
Kevin W. Concannon, Commissioner	Michael Petit, Commissioner	Harold Raynolds, Commissioner
Ronald R. Martel, Associate Commissioner, Admin.	Robert McKeagney, Deputy Commissioner	David Stockford, Director Bureau of Special Education
Edward C. Hinckley, Director, Division of Children's Services	John Wakefield, Deputy Commissioner	Greg Scott, Consultant Division of Special Education
Frank Schiller, Director Planning Division	Peter Walsh, Director, Bureau of Social Services	Nancy Merrick, Accountant Division of Special Education
Sue Bumpus, IDC Staff	Freda Plumley, Director, Division of Child & Family Services	
	Edgar Merrill, Consultant	Nancy Warburton, IDC Consultant, Executive Director
	Mildred Hart, Licensing	
	(Artha Freebury), IDC Staff	
	John Bouchard, Manager, Audit Division	

Assistance has also been received on an as needed basis from the Assistant Attorney General representing the three departments, the Department of Human Services Audit Division and the Bureau of Social Services Evaluation Unit.

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Program: Interdepartmental Coordinating Committee

Program Contact: Nancy Warburton, Executive Director

TABLE V

Residential Treatment Centers
State Financing Network (10/1/80-9/30/81)
State and LEA-Funding Commitments Per Rate Level

<u>Residential Treatment Center</u>	<u>DHS Bd/Care Treatment</u>	<u>DECS Tuition</u>	<u>DMHMR Treatment</u>	<u>LEA Tuition</u>	<u>LEA Bd/Care</u>	<u>TOTAL</u>
Bancroft	\$ 134,830	\$ 65,250	\$156,024	\$169,650	\$140,602	\$ 666,356
FAC	225,872	206,226	163,332	271,350	145,756	1,012,536
Homestead	242,835	113,055	88,770	82,907	89,309	616,876
Spurwink	107,847	74,025	138,204	139,825	125,422	585,323
Sweetser	412,944	131,552	255,969	287,770	572,789	1,661,024
St. Michael's	<u>95,963</u>	<u>-0-</u>	<u>95,832</u>	<u>-0-</u>	<u>68,676</u>	<u>260,471</u>
Sub-Total	1,220,291	590,108	898,131*	951,502	1,142,554	4,802,586
Elan	<u>183,730</u>	<u>41,470</u>	<u>79,740</u>	<u>28,710</u>	<u>48,150</u>	<u>381,800</u>
Total	<u>1,404,021</u>	<u>631,578</u>	<u>977,871</u>	<u>980,212</u>	<u>1,190,704</u>	<u>5,184,386</u>

*DMHMR responsible for \$47,500 Title XIX seed.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Military and Naval Children's Home

Program Contact: Elizabeth Dunton, Superintendent

1. Authorizing Legislation and other program mandate:

a. Legal Citation:

34 M.R.S.A. § 2951, 2953

b. Other mandates:

None

2. Public Need:

This program provides a home and care for children who lack appropriate alternative shelter and care, or may be subject to potential or actual neglect, or may, because of a family crisis, be in need of temporary care and shelter. The program provides this service on a state-wide basis and is designed to give preference to children of Maine veterans. A unique feature of the program is the provision of both long term and temporary care and shelter to sibling groups in an effort to keep the family intact during periods of crisis.

The public need is indicated by the sixty-six (66) children referred to the Home for acceptance during the past year. Seventy-five families in 15 of the state's 16 counties contacted the Home in regard to the placement of their children.

3. Program Objectives:

The primary objective is to provide a home-like atmosphere with all of the attendant attributes of living and participating in community life to children in need of temporary care and shelter. The program is designed to meet the following additional objectives:

- a. To provide this service particularly to dependents of naval and military personnel and veterans;
- b. To avoid the State being required to take custody of children because of a temporary condition or upheaval in the family caused by abuse, neglect, financial catastrophe, parental desertion and the stress that normally accompanies such a condition;
- c. To provide temporary care and shelter to those who meet the eligibility requirements and the standards set for admittance to the home;
- d. To re-unite families as soon as it is feasible to reestablish a suitable home life;

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Military and Naval Children's Home

Program Contact: Elizabeth Dunton, Superintendent

- e. To keep family groups together by accepting sibling groups whenever possible;
- f. To involve the children in community activities that are conducive to normal home life;
- g. To develop release plans that are suitable to each child's needs; and
- h. To provide an alternative to long-term placement for those children who are unable to return to their natural home.

4. Program Operation:

The program receives referrals for admittance to the Home from a wide variety of sources: the Department of Human Services, school social workers, juvenile intake officers, ministers and parents seeking voluntary placement of children. All referrals are received by the Superintendent of the Home and reviewed in consultation with the Division of Children's Services, Department of Mental Health and Mental Retardation, or such agencies or parents as may be involved in the placement. The admission procedure also requires the completion of an application, a record of the child's history and behavior and a medical examination form. If the child is accepted, an Advice of Admissions form is completed and forwarded to the Department of Mental Health and Mental Retardation's Division of Reimbursement.

The child remains at the Home until the situation that necessitated placement is resolved or the family indicates that they want the child or children returned home or to an acceptable alternative placement with another family member. Notwithstanding any prior arrangements, children are released from the Home when they reach their majority. Assistance, counseling and appropriate referrals are offered to children who leave to establish their own residence.

5. Staffing:

a. General Fund:

- 1) Positions authorized: 16
- 2) Positions filled September 1, 1981: 16
 - a) Full time: 13
 - b) Other positions: 3

b. Other funds (including vacant positions):

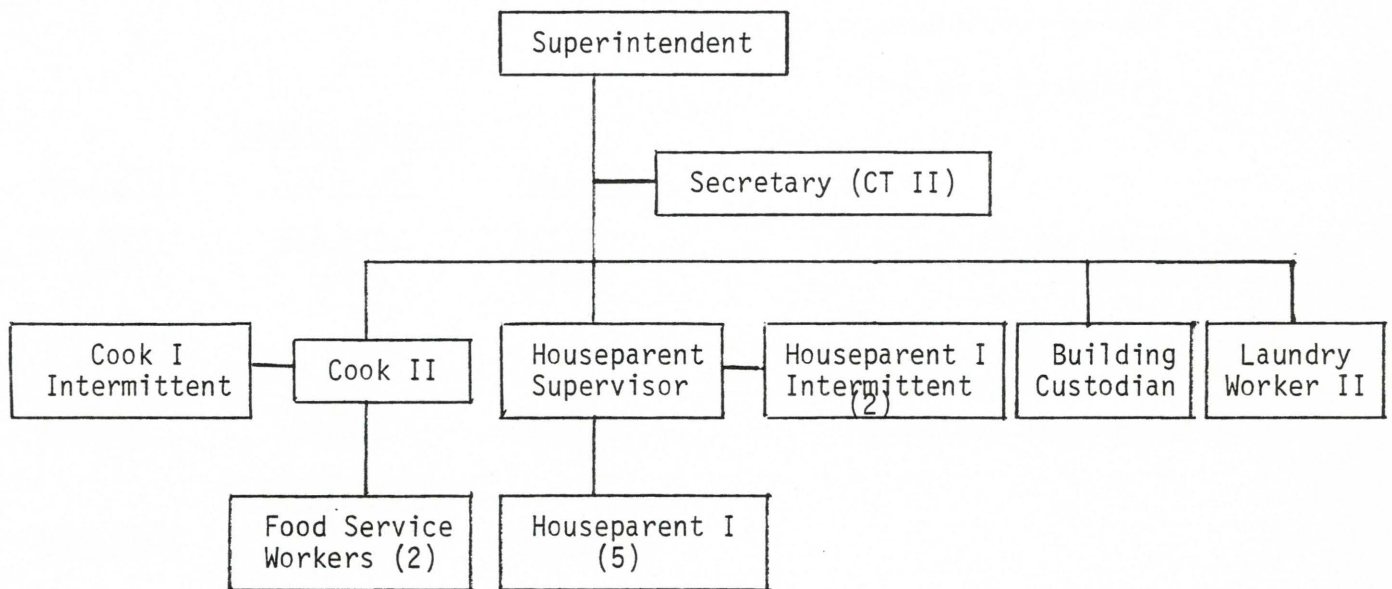
- 1) Full time: None
- b) Other positions: None

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Military and Naval Children's Home

Program Contact: Elizabeth Dunton, Superintendent

c. Organization:



d. List of positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Superintendent	1		
Houseparent Supervisor	1		
Houseparent I	5		
Cook II	1		
Food Service Worker	2		
Building Custodian	1		
Laundry Worker II	1		
Clerk Typist II	1		

Intermittent Positions:*

Cook I	1
Houseparent II	2

*Intermittent positions are used as vacation and sick relief personnel.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Military and Naval Children's Home

Program Contact: Elizabeth Dunton, Superintendent

6. Updated Financial Data:

a. Appropriation account #: 1345.1

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G. F. Appropriation:</u>	178,146	216,462	220,314
Transfers In	25,988	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>204,134</u>	<u>216,462</u>	<u>220,314</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	184,068	191,832	197,007
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>184,068</u>	<u>191,832</u>	<u>197,007</u>
<u>All Other:</u>			
General Fund	16,942	18,630	21,307
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>16,942</u>	<u>18,630</u>	<u>21,307</u>
<u>Capital:</u>			
General Fund	1,920	6,000	2,000
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>1,920</u>	<u>6,000</u>	<u>2,000</u>
TOTAL FUNDS EXPENDED	<u><u>202,930</u></u>	<u><u>216,462</u></u>	<u><u>220,314</u></u>
<u>Undedicated Revenue to G. F.:</u>	-0-	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Military and Naval Children's Home

Program Contact: Elizabeth Dunton, Superintendent

7. Other Programs:

There are numerous group homes, specialized treatment centers and foster homes available to children in need of care and shelter. The objectives of these homes are similar; however, this program differs from the broad range of homes available to children in that:

- a. It avoids the State assuming official custody of the children;
- b. It provides care and shelter to sibling groups;
- c. It only accepts voluntary placements;
- d. It is a preventive program that tends to reduce child abuse or neglect before it becomes serious;
- e. It reunites families without the intervention of courts or state agencies; and
- f. The Home is not equipped with personnel to treat or care for emotionally disturbed children.

8. Program Effectiveness:

The program provided services to twenty-one (21) families during the past year with nine (9) of those families qualifying as veterans. The program provided temporary care and shelter to fifty-six (56) children during the past year and rejected ten (10) children as not acceptable under the program's standards.

The children accepted were the victims of family crisis or neglect and acceptance into the Home prevented further neglect and alleviated the stress that accompanies such family crises. The state was not required to officially take custody of the fifty-six (56) children during the year.

The facility provides a home-like atmosphere for these children through its use of the Bath public schools and the services provided by the local YMCA, Day Camp, Boy and Girl Scout troops, churches and entertainment facilities in the city. In addition, special services were received from Hyde School and Bowdoin College's Big Brother and tutoring programs and the local CETA organization's part time jobs program.

Ten (10) sibling groups of children received care and shelter from the Home thus maintaining forty-two (42) children as family groups.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Military and Naval Children's Home

Program Contact: Elizabeth Dunton, Superintendent

During the past three years, fifty (50) out of fifty-nine (59) children who were released returned to their families under improved circumstances. Veterans' children accounted for twenty (20) of the fifty-six (56) children accepted during the past year thus continuing the founders' original intent in establishing the home. The thirty-six (36) non-veterans' children reflect the changing make-up of society; however, their acceptance was consistent with the public need for this program.

9. Future Plans:

During the next several years the department plans to modify the objectives of the program to include:

- a. Expansion of the social services aspect of the program through the addition of a social worker to work with parents in an increased effort to reunite families under the most favorable conditions and in the shortest possible separation time;
- b. Improvement of the physical plant to achieve fuel economy, meet fire and building codes and modernize equipment as needed;
- c. Increased involvement with interested community agencies and activities to broaden the social contacts of the children and increase the effectiveness of the effort to reunite families; and
- d. Examine the entrance criteria in relation to the Home's responsibility to the public, staff capabilities and the objectives of the program to determine if additional children with particular problems may be served by the program.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. § 1 Department of Mental Health and Corrections (Mental Retardation), Administration, Personnel

b. Other mandates:

34 M.R.S.A. § 1-C, Access to and Transfer of Information

34 M.R.S.A. § 2, General Powers

34 M.R.S.A. § 6, Improper Conduct of Officers of Institutions

34 M.R.S.A. § 7, Rules and Regulations

34 M.R.S.A. § 7-A, Administration of Medication

34 M.R.S.A. § 8, Institutional Officers may Sue for State

34 M.R.S.A. § 9, Funds of Deceased Patients and Inmates

34 M.R.S.A. § 11, Posting of Political Material in Institutions

34 M.R.S.A. § 12, Agreements with Community Agencies

34 M.R.S.A. § 2511, et. seq., Support at State Institutions

34 M.R.S.A. § 2561, et. seq., Interstate Compact on Mental Health

22 M.R.S.A. § 7904, Fire Safety Inspections

5 M.R.S.A. §§ 781, 782, Code of Fair Practices and Affirmative Action

15 M.R.S.A. § 2301, et. seq., Interstate Compact on Mentally Disordered Offenders

42 U.S.C. § 1395, et. seq., Social Security Act (Including Title XVIII Medicare, Title XIX Medicaid and Title XX Grants for Services)

Wuori, etal. v Concannon, etal., No. 75-80 P (D. Maine, 1978)

P.L. 97-35, Omnibus Budget Reconciliation Act of 1981, 95 Stat. 357

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Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

b. Other mandates (continued):

42 U.S.C. § 6001 et. seq., Developmental Disabilities Assistance

P.L. 94-63, 42 U.S.C. § 2689, et. seq., Community Mental Health Centers Act

2. Public Need:

The department's administration responds to a public need by providing general supervision of the grounds, buildings, employees and clients of the Augusta Mental Health Institute, Bangor Mental Health Institute, Pineland Center, Elizabeth Levinson Center, Aroostook Residential Center and the Military and Naval Children's Home. The department, through a total staff count of approximately 2,200 employees has a responsibility for an average daily population of approximately 1,000 residents in its facilities. In addition, the central administration provides assistance to approximately one hundred community agencies that receive grants or contracts totalling approximately ten million dollars annually.

The department provides management and control of services, research, planning and fiscal programs within the bureaus and institutions of the department. It also sets policy and directs procedures to ensure compliance with all laws, codes, regulations and court decisions that concern the operation of its several institutions and the care and treatment provided to its clients.

This program meets the public need by administering public funds and federal grants to assure, through contracts and awards to private and quasi public institutions and agencies, that appropriate statewide services are provided to those who are handicapped as a result of mental illness, mental retardation or developmental disabilities, including children who often must utilize these services because of a multiplicity of handicaps. The public need is indicated by the 51,000 clients who utilize the services of the department through its institutions, contracted community agencies, residential treatment centers, sheltered workshops, foster care and specialized treatment centers/schools. The department's response to changing federal and state regulations and court ordered services influences the development and administration of these services to mental health and mental retardation clients. The department is often the last resort in cases where individual needs are not sufficiently addressed by community agencies, or where courts are mandating certain services.

Throughout the state there are numerous agencies whose purpose, goals and objectives are adjunct to the department's objectives. These agencies work in cooperation with the various programs operating within the department and are a vital and necessary part of the system of care and treatment the department offers to the many citizens of the state who are in need of these services. The administration contracts with or awards grants to those programs

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Program: Administration, Mental Health and Mental Retardation

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it determines can offer a significant contribution to the department's obligations to those persons, both adult and juvenile, who are adversely affected by mental illness, mental retardation, developmental disabilities and attendant medical problems.

3. Program Objectives:

- a. To establish a statewide system of services designed to meet the needs of community clients and institutional residents and delivered to ensure a consistent level of care and concern;
- b. To establish and maintain standards to assure compliance with state and federal regulations in the department's institutions and community programs, including accreditation standards where applicable;
- c. To ensure the protection of the civil rights of its clients through management practices that are consistent with applicable laws and an advocacy service that is available to all clients;
- d. To provide services to state courts by housing and evaluating those individuals, both adult and juvenile, whom the court deems to be in need of such services;
- e. To ensure that all institutions and programs meet fire codes and safety regulations as established by state and federal authorities;
- f. To promote a program of volunteers within the department's institutions and agencies that will enhance the services offered and increase citizen awareness of the problems of the department's clients and the participation of community representatives in all phases of the department's programs;
- g. To promote public awareness of the department's programs, policies and services through an active public relations effort and to keep all interested persons informed of the events of significance that occur within the department's institutions and agencies;
- h. To provide financial and consultation assistance to local mental health and mental retardation programs that provide a necessary service to the department's clients or families;
- i. To ensure maximum cost effectiveness of all financial resources through a departmental monitoring system;
- j. To maximize federal revenues and other third-party revenues to the state's general fund through the various services provided at the department's major institutions;

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Program: Administration, Mental Health and Mental Retardation

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- k. To monitor and evaluate programs within the department and its contracted agencies, including financial audits of community programs;
 - l. To utilize federal funds appropriately and for designated purposes through application review and an effective reporting system;
 - m. To provide maximum opportunity for staff development, education and training to ensure a professional approach to care and treatment of clients;
 - n. To assure that recruitment, retention, training and utilization of personnel results in the distribution of sufficiently qualified staff to meet the needs of the department;
 - o. To assure compliance with state and federal laws and regulations on equal employment opportunity and affirmative action through review and evaluation of the department's personnel practices, staff training and ongoing implementation of affirmative action programs;
 - p. To assure that private and quasi-public agencies funded through the department are in compliance with applicable state and federal equal employment opportunity laws and regulations through on-site monitoring systems and the provision of training and technical assistance; and
 - q. To assure compliance with the collective bargaining agreements negotiated between the state and the labor unions as they affect the department's employees.
4. Program Operation:

The central administration of the department under the direction of the Commissioner's Office is comprised of a Chief Advocate, an Affirmative Action Officer, an Associate Commissioner for Programs, an Associate Commissioner for Administration, a Bureau Director of Mental Health and a Bureau Director of Mental Retardation. Each of these individuals report directly to the Commissioner and are responsible for the department's major operating divisions.

The Chief Advocate of the department is responsible for assisting clients who may be mentally or physically disabled or housed involuntarily for treatment by assuring that any actions affecting the lives of these individuals are taken in accordance with federal and state laws and regulations, and departmental, bureau and institutional policies and procedures. Specific program operations are contained in the Office of Advocacy's program justification report.

The Affirmative Action Officer coordinates affirmative action and equal employment efforts for the department through a system of monitoring and reporting established for the institutions. The primary responsibility of

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Mental Health and Mental Retardation

Program Contact: Kevin W. Concannon, Commissioner

this position is the assurance of the department's compliance with state and federal laws and regulations regarding the provision of equal employment opportunity and results-oriented affirmative action programs. The following operational functions of the Affirmative Action Officer enable the fulfillment of this responsibility:

- a. Annual preparation of a written affirmative action plan approved by appropriate government agencies;
- b. Maintenance of an internal grievance procedure for the investigation and determination of discrimination complaints filed by employees and applicants;
- c. Review of hiring and promotion criteria and procedures; monitoring employment interviews and reviewing personnel actions for potential problems areas;
- d. Provision of training for departmental personnel, particularly supervisory staff, in related areas (e.g. EEO law, Interview Techniques, Sexual Harassment, Sensitivity to Problems of the Disabled Applicant/Employee);
- e. Provision of career counseling for departmental employees; and
- f. Provision of technical assistance to private and quasi-public agencies receiving state/federal funds from the department through staff training and review and evaluation of affirmative action plans/personnel practices for compliance.

The Affirmative Action Officer visits the institutions regularly to meet with employees at all levels in order to identify potential problem areas and initiate early remedial action as necessary.

*Perfected
2nd page*

Within the central administration, the Associate Commissioner for Programs, as head of the Division of Program Services, provides supervision, leadership, direction and support to the following components: Division of Planning, Staff Development Office, Office of Information and Public Affairs, Developmental Disabilities Council Coordinator and Division of Children's Services. In addition, this person works very closely with the bureau directors in coordinating and assisting in the development of new programs and in evaluating existing programs. More specifically, the Associate Commissioner for Programs has the following functions:

- a. Assisting the bureaus to identify and respond to the needs of the mentally ill and mentally retarded, their families and the general public;

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- b. Assisting the bureaus in assuring the adequacy, availability and effectiveness of their programs;
- c. Assisting the bureaus in identifying revenues and resources for the development of appropriate programs; and
- d. Assisting the bureaus in coordination of programs and providing a focal point for collaboration with other agencies, providers and resources.

The Division of Planning and the Division of Children's Services, including Military and Naval Children's Home and the Interdepartmental Coordinating Committee, are fully detailed in separate justification reports. The Developmental Disabilities Council is charged with submitting its own justification report in accordance with the Sunset Review Law.

The Office of Information and Public Affairs has three major responsibilities:

- a. To inform the general public of programs and services provided by the department and to provide information in an effort to eliminate the harmful stereotypes which have prohibited mentally ill and mentally retarded individuals from community participation;
- b. To assure that the department is attuned to public needs and attitudes in order to respond appropriately; and
- c. To coordinate the most comprehensive volunteer effort in state government in order to enhance services to clients through increased community awareness and participation.

The following functions of the Director of the Office of Information and Public Affairs illustrate ways in which this responsibility is fulfilled:

- a. Prepares news releases concerning events within the department;
- b. Maintains daily contact with the news media;
- c. Prepares educational brochures regarding departmental services for public distribution;
- d. Prepares a daily news summary for departmental officials;
- e. Functions as legislative liaison;
- f. Consults and advises the Volunteer Services Coordinators from the institutions; and

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- g. Organizes honors recognition ceremonies for volunteers from the various programs who have made outstanding contributions to the volunteer effort.

The Staff Development Office, within the Division of Program Services:

- a. Coordinates and develops training opportunities for departmental administration and community personnel based on an assessment of training needs;
- b. Consults with institutional staff development officers on a regular basis to formulate department-wide training programs; and
- c. Arranges participation at regionally and nationally sponsored seminars for appropriate staff.

The Associate Commissioner for Administration, as head of the Division of Administrative Services, is responsible for all of the department's financial affairs, including budget preparation and administration, transfers of funds, audits of community agencies, authorization of expenditures, reimbursement for certain institutional services, and other related matters. In addition, this position has the ultimate responsibility for the department's personnel matters such as personnel action requests, the establishment of in-house policies and procedures, monitoring adherence to state mandated rules and regulations and assuring union contract compliance and resolution of disputes arising from contract interpretation.

- a. Financial Services - Administration of budgets and the management of central office accounts, i.e. food, fuel, unemployment compensation, institutional capital improvements.
 - 1) prepares and reviews budget requests (approximately \$53,000,000 for FY 82), allotment requests, financial orders and advises the Commissioner and other management staff in financial matters.
 - 2) coordinates a standardized method of accounting with institutional business managers and maintains community services accounts as well as a departmental operations account.
 - 3) assures the preparation of federal reports in compliance with grant awards utilizing established cost allocation methods.
 - 4) audits community mental health and mental retardation agencies to assure compliance with contracts/grants (an expansion of this activity will take place as a result of a shift to federal block grant funding).

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- 5) maintains close contact with Medicare, Medicaid and other third-party payors for institutional services. Within program limits, the maximization of reimbursement for such services to the state's general fund is promoted by the Reimbursement Division.
- 6) acts as liaison between the department and State Department of Finance and Administration in all financial matters.
- b. Personnel Services - Administration of community and central office personnel and the coordination of institutional personnel policies through institutional personnel officers.
 - 1) acts as the department's representative in matters relating to collective bargaining and employee relations through the Director of the Division of Personnel.
 - 2) provides liaison between the department and the State Department of Personnel relative to the selection of employees and the maintenance of established standards.
 - 3) maintains leave records and processes payrolls, performance appraisals, merit increases and other relevant actions for non-institutional personnel.
 - 4) promulgates and monitors departmental policies and procedures to assure compliance with state regulations and collective bargaining agreements while enhancing the ability to deliver programs effectively.

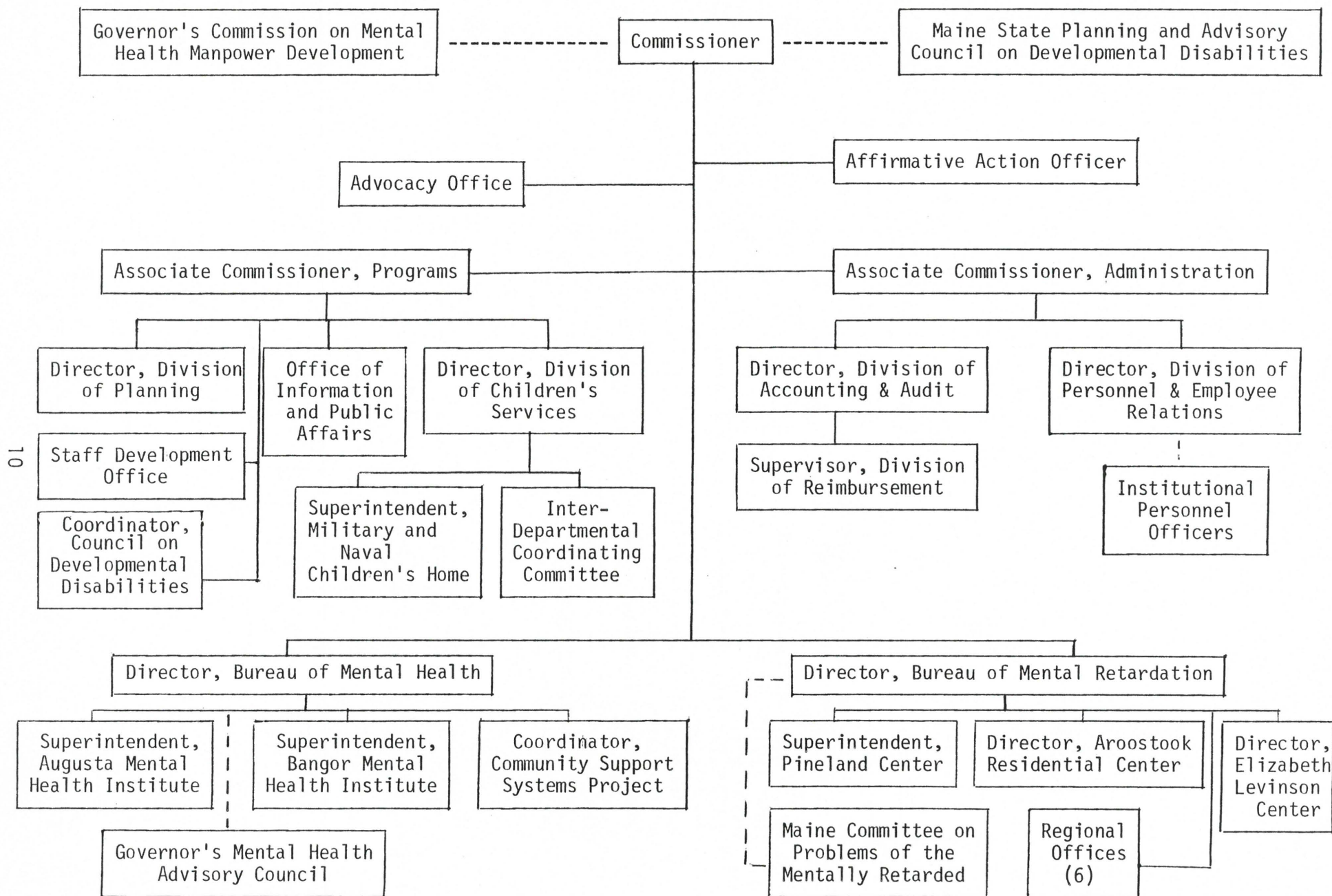
The bureau directors of Mental Health and Mental Retardation are responsible for the administration of the two largest segments of the department. The Bureau of Mental Health administers a system designed to reduce or eliminate personal anguish and suffering, social and economic disruption and the waste of human potential resulting from mental illness and related disabilities. The Bureau of Mental Retardation assures the availability of services for retarded children and adults which foster growth and independence, while maintaining an opportunity for family and community life.

5. Staffing:

a. General Fund:

- 1) Positions authorized: 30.5*
- 2) Positions filled September 1, 1981:
 - a) Full time: 27
 - b) Other positions: 1

*The count shown is actually as of 9/18/81 due to the creation of the Department of Corrections.



NOTE: By statute, the Superintendents of AMHI, BMHI and Pineland Center report to the Commissioner, however, administratively, they report to their respective bureau directors.

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b. Other funds (including vacant positions):

1) Full time: None

2) Other positions: None

c. Organization:

(See next page)

d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Commissioner	1		
Associate Commissioner, Programs	1		
Associate Commissioner, Admin.	1		
Clerk Stenographer III	1		
Senior Administrative Secretary	1		
Clerk Typist III	1		
Clerk Typists II	2		
Affirmative Action Officer	1		
Chief Accountant, MH&MR	1		
Supervisor, Reimbursement Division	1		
Reimbursement Investigator II	1		
Reimbursement Investigators I	3		
Management Analysts II	2		
Director, Division of Personnel and Employee Relations	1		
Personnel Technician II	1		
Account Clerks I	2		
Accountants I	2		
Accountants II	2.5		
Clerk Stenographers II	2		
Director, Public Information	1		
Psychologist II	1		
Staff Development Coordinator	1		
Total	30.5		

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Bureau of Mental Health

Program Contact: Michael DeSisto, Ph.D., Director

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. §§ 2001, 2002, 2004 (Creation and Purpose of the Bureau, Duties of the Director of the Bureau, Rights of Recipients of Mental Health Services)

34 M.R.S.A. § 2051, et. seq. (Community Mental Health Services, Licensing)

34 M.R.S.A. § 7 (Rules and Regulations and Patients Rights)

b. Other mandates:

34 M.R.S.A. § 12 (Agreements with Community Agencies)

34 M.R.S.A. § 2251, et. seq. (Hospitalization of the Mentally Ill)

15 M.R.S.A. § 2301, et. seq. (Interstate Compact on Mentally Disordered Offenders)

34 M.R.S.A. § 2003 (Mental Health Advisory Council, Membership and Duties)

34 M.R.S.A. § 2052 A (Licensing of Mental Health Agencies)

34 M.R.S.A. § 2105 (Community Residence for Mentally Ill Patients)

2. Public Need:

The Bureau of Mental Health administers a system designed to reduce or eliminate personal anguish and suffering, social and economic disruption and the waste of human potential resulting from mental illness and related disabilities.

According to the 1978 Report of the President's Commission on Mental Health, the incidence of emotional distress severe enough to require professional help is approximately 15% of the total population. This percentage represents about 168,700 people in Maine. Other factors such as Maine's low per capita income, high divorce rate and high level of system dependency indicate that this estimate may be conservative.

There are eight mental health geographic service areas in Maine. Agencies within these areas annually serve a total of approximately 40,000 people. There are between 1,700 and 1,800 admissions each year to the two state mental health institutes. Professionals in private practice also serve many individuals as do the inpatient units of local hospitals. Even

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considering all of these providers of service, however, it is reasonable to estimate that there are many people who are unserved.

The public mental health system has a statutory responsibility to treat certain types of clients. These include persons referred from the court system, either for involuntary commitment for treatment of mental illness or forensic cases where criminal charges are involved. These persons comprise a significant number (from 50% to 70%) of the admissions at the state mental health institutes.

Current social and cultural trends seem to reveal another type of person for whom the public mental health system has a responsibility. This is the relatively young, system dependent person who is emotionally unable to maintain an independent life. The cause of this dependency may be deinstitutionalization, the social disruption of previous decades, or increasingly difficult economic conditions.

Regardless of the cause, providers at all points of the system are seeing more and more of these young people who cannot make it on their own. Preliminary evidence indicates that these people may have contact with the public system for most of their lives.

The Bureau of Mental Health plays a major role in linking all parts of the public and private mental health community. The Bureau plans for a comprehensive system which integrates services from the health, mental health and social service areas to stretch limited resources to reach and adequately serve the greatest number of people.

3. Program Objectives:

- a. To maintain high quality mental health programs for persons admitted to the two state mental health institutes;
- b. To assure the availability of adequate and appropriate mental health programs for persons in need of such services throughout the state's eight mental health service areas;
- c. To conduct the licensing of 29 existing mental health service programs and any new facilities which may develop;
- d. To monitor for compliance contracts between the Bureau of Mental Health and agencies providing community mental health services;
- e. To administer Interstate Compact on Mental Health so that a hospitalized patient can be transferred between states when it is in his best interest, regardless of his legal residence; and
- f. To maintain involvement and participation with community groups who advocate for the needs of mentally handicapped persons and who provide much needed outreach services.

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4. Program Operation:

The bureau oversees the quality of mental health programs within the two state mental health institutes through the inter-relationship between institutional superintendents and the bureau director. This is accomplished through joint budget development, joint development of institutional and bureau goals, objectives and program plans.

The bureau is also responsible for assuring the availability of adequate mental health services for persons in need throughout the state's eight service areas by dispersion of state funds and by developing and implementing contracts with community providers. ~~Contracts with community agencies~~ are developed by the bureau director and the field operations manager, on an annual basis, through a Request for Proposal (RFP) process and negotiation with agency providers around projected services, clients and costs. The RFP is based on a variety of needs assessment activities conducted by the department, and through data collection and analysis.

The bureau staff and associated departmental personnel (Planning Division, Community Support Systems Project, etc.) review and update annually the request packages by which community mental health centers and other community agencies develop their funding request. This includes definitions of services and clients which are a priority for departmental funding. Agency contracts are also written to reflect these priorities in response to the expressed needs of the consumers of mental health services.

The quality and appropriateness of mental health services are assured through the licensing of all mental health agency providers. Licensing activities are coordinated and directed by the Bureau of Mental Health's licensing director. An annual application and site review process for each agency is conducted by the licensing director, with the field operations manager and other qualified departmental personnel participating in on-site review. For the past two years the reviews of the comprehensive community mental health centers have been done in conjunction with the National Institute of Mental Health Region I site visits. At these visits, compliance with applicable state and federal regulations is assessed.

Regulations for licensing of mental health facilities must be reviewed and revised frequently to reflect current trends and issues in mental health service delivery as they relate to community needs. This is done in compliance with the Maine Administrative Procedures Act.

The adequacy, quality and appropriateness of services funded through contracts with the Bureau of Mental Health is assured by monitoring agencies for contract compliance. Funded agencies must submit quarterly reports to the bureau, indicating the number of service units provided to date and the cost of these services. These reports are reviewed by the field operations manager and the departmental management analyst. The on-site monitoring

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process is done as part of the annual licensing site review at community mental health centers. At that time, the management analyst looks at the reporting mechanism, the service units delivered to date and the cost to date, and compares these to the agency projections. If significant discrepancies between actual and projected figures are discovered, the agency administration must renegotiate with the bureau to bring projected and actual figures into line. If the reporting mechanism itself is inaccurate, suggestions for correction are made by the management analyst and revised figures are subsequently reviewed.

The bureau director is the administrator of the Interstate Compact on Mental Health. In this capacity, he approves the transfer of hospitalized patients between states, and consults with the administration of the two state mental health institutes as to the appropriateness of the program for the patient in question, and the mechanics of transfer. Final arrangements for transfer are made through the Bureau of Mental Health.

5. Staffing:

a. General Fund:

1) Positions authorized: 4

2) Positions filled Sept. 1, 1981:

a) Full time: 4

b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: None

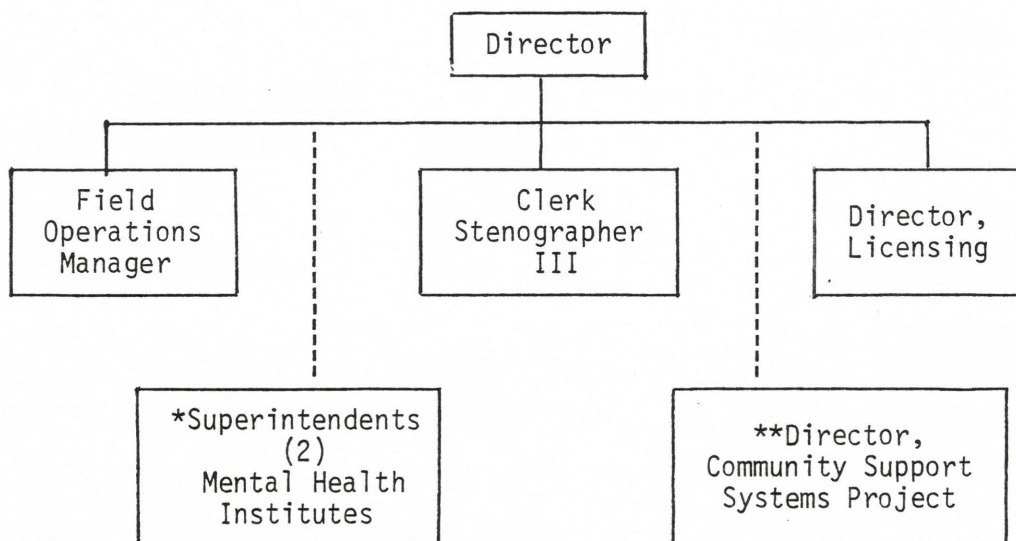
2) Other positions: None

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c. Organization:



*The Superintendents, by statute, report directly to the Commissioner; however, administratively they report to the Bureau Director.

**Until recently, the CSSP Director reported to the Director of Planning. A change has been made to more appropriately reflect the current function of the Project to that of a Bureau directed and coordinated activity.

d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Director, Bureau of Mental Health	1		
Mental Health Worker VI (Director, Licensing)	1		
Field Operations Manager	1		
Clerk Stenographer III	1		

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6. Financial Data:

a. Appropriation account #: 1340.1; 9340.2

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	102,456	99,511	99,511
<u>Federal Funds Available:</u>	-0-	26,370	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>102,456</u>	<u>125,881</u>	<u>99,511</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	84,862	86,511	86,511
Federal	-0-	26,370	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>84,862</u>	<u>112,881</u>	<u>86,511</u>
<u>All Other:</u>			
General Fund	17,594	13,000	13,000
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>17,594</u>	<u>13,000</u>	<u>13,000</u>
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>-0-</u>	<u>-0-</u>	<u>-0-</u>
TOTAL FUNDS EXPENDED	<u>102,456</u>	<u>125,881</u>	<u>99,511</u>
Undedicated Revenue to G.F.:	-0-	-0-	-0-

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7. Other Programs:

Within the Department, the Bureau of Mental Health coordinates with the Division of Children's Services to assure that special mental health services are available to emotionally disturbed children and adolescents in Maine. The Bureau of Mental Health funds community mental health centers to provide a variety of mental health services, including services to children either directly on an outpatient basis or through consultation and education. The Division of Children's Services coordinates services for individual children and through the Interdepartmental Committee works with providers of residential treatment.

The Bureau of Mental Retardation, also within the Department, assures provision of services for mentally retarded and developmentally disabled individuals. There are some who fall into both the mental retardation and mental health categories, and staff in both Bureaus must work together to coordinate services. This is especially true in cases of severe disability where individuals are dependent on the system.

The Community Support Systems Project is a federally funded program whose purpose is to encourage the development of a full range of community based services to chronically mentally ill persons. Staff from this project work with the Bureau staff in planning, needs assessment and funding areas.

The Governor's Mental Health Advisory Council is a committee of consumers and providers appointed by the Governor who review issues that affect mental health service delivery and help the Bureau plan more effectively.

The Maine Council of Community Mental Health Centers represents the interests of the 7 mental health centers and the Area V Board. The Bureau coordinates with the Maine Council on issues that affect mental health funding and planning.

Within the Department of Human Services there are several bureaus whose clients are frequently mental health service consumers. These are the Bureau of Medical Services which administers Medicaid, Bureau of Social Welfare which has Adult Protective and Child Protective Services, and the Bureau of Maine's Elderly which represents people who are often in boarding and nursing homes, some of whom have mental health problems. The Bureau of Mental Health coordinates with these bureaus about concerns, plans and any other shared issues. The Office of Alcoholism and Drug Abuse Prevention funds and approves agencies that provide substance abuse services.

8. Program Effectiveness:

- a. Both state mental health institutes are, and have been for many years, fully accredited by the Joint Commission on Accreditation of Hospitals. The Joint Commission is an independently organized, nationally recognized body that sets accepted standards for all aspects of hospital operation, both clinical and administrative, which impact on patient care. Addi-

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tionally, the National Institute of Mental Health annually surveys the two institutes for compliance with their standards for patients covered by Medicare. The results of these two processes attest to the high standards of patient care at the institutes.

- b. The Bureau of Mental Health requests funds from the legislature to help pay for mental health services provided by community agencies to people living outside the state institutions. The variety and comprehensiveness of these services expanded as each community mental health center proceeded through the Federal Community Mental Health Center's Act (P.L. 63-94) funding cycle and established the previously mandated twelve services: Inpatient; Emergency; Outpatient; Screening; Follow-Up; Services for Children and the Elderly; Alcoholism; Drug Abuse; and Consultation and Education. Their ability to provide this full range of services was greatly enhanced by the state's increasingly significant contribution to their total budgets.

Over the last several years, the department has been working to increase the availability of the full range of supportive community residences for the mentally disabled. In 1978 there was a special appropriation from the legislature for transitional living, and the Bureau of Mental Health developed a Request for Proposals. Four grants were subsequently awarded which resulted in facilities being established in Presque Isle, Biddeford, Augusta and Portland. Over the last three years, various provider agencies have been working with the department and the Federal Housing and Urban Development agency to develop additional community residential programs. These efforts will soon result in more living residences in Augusta, Caribou, Portland and Dover-Foxcroft.

- c. The Bureau annually reviews the status of 29 mental health service agencies throughout the state. Seven of these providers are community mental health centers which also receive funds from the Federal government. For two years, joint National Institute of Mental Health-Bureau of Mental Health Site Reviews were held at several of the community mental health centers on an informal basis. In the fall of 1980 this process was formalized into a joint agreement with the National Institute of Mental Health Region I Office which outlined the specific responsibilities and protocol of the Joint Site Visits.

In the case of the seven agencies licensed by the Bureau of Mental Health that provide residential treatment for children and adolescents, Public Law 260 enacted by the 110th Legislature calls for a joint licensing process by the Departments of Human Services, Educational and Cultural Services and Mental Health and Mental Retardation. A single set of regulations and a single application process replaces the three processes previously used, resulting in greater efficiency for the licensees as well as the licensors.

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- d. The Bureau of Mental Health is in the process of expanding and refining the contract monitoring mechanism for agencies that it funds. This is especially important in light of the Block Grants from the federal government which eliminate program review at the federal level.

9. Future Plans:

The mental health service delivery system is designed to respond to community and individual needs. As the social, economic and cultural climates change, the Bureau of Mental Health defines public policy to best address the variety of mental health problems of the people of Maine. To do this effectively, it is necessary to actively integrate the many aspects of social service and health care that make up a comprehensive system. The bureau will continue to involve public and private health care providers, professionals, hospitals, home and rural health agencies with the community and institutional mental health providers in the development of an efficient and effective network of services.

Part of this process is to define the roles of the components of the system. As community-based services have expanded, the role of the institutions becomes more focused. In the past, the state hospital was the primary provider of public health care. As the community agencies have become established to provide quasi-public mental health services to individuals in their local environment, the function of the state hospitals, now mental health institutes, have become, and will continue to become, more particular. A significant function is to provide residential and rehabilitative services to those multiply handicapped individuals who are severely mentally ill and for whom no adequate services exist elsewhere. Another major function is to evaluate and treat referrals from the court system, involuntary commitments for mental health treatment and forensic cases where criminal charges are involved.

Future plans for the two mental health institutes will include continuing high quality of inpatient treatment and rehabilitation for the populations just mentioned. In addition, there will be joint planning together with community providers to address the needs of a new population that seems to be emerging, young people who for a variety of emotional, social and cultural reasons become system-dependent early in life and will probably remain so. Institutes will expand their role in discharge planning and aftercare to address the needs of these people. This will be done by implementing cooperative agreements between the institution and agencies in each of the eight geographic service areas with which they relate. The agreements will include specifics about the services to be provided to persons leaving the institution and will be the basis for generating client specific data. There is no expectation that the institutions will significantly change the size of the inpatient population. Rather, the cooperative agreements and the bureau prioritization of services to the deinstitutionalized and system-dependent populations are aimed at implementing a more effective system of community based follow-up care for people leaving inpatient treatment and rehabilitation.

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The role of the Bureau of Mental Health in the development of comprehensive community services will be expanded as a result of block grant funding from the federal government. In addition to determining the best use of state funds for community mental health services, the bureau will now be responsible for allocating and administering federal funds. To do this requires an enhanced capacity within the bureau to monitor and evaluate the delivery system. This will include more sophisticated needs assessment, refinement of service definitions and ongoing prioritization of persons to be served and services to be delivered. The tasks involved in soliciting and reviewing proposals from agency providers, making funding decisions, awarding and monitoring contracts will become more complex and demanding as the bureau assumes many of the roles formerly carried out by the federal funding agency. To perform these tasks effectively, especially needs assessment and contract performance monitoring, will require additional staff in the bureau.

Another result of Block Grant funding is the increasing importance of inter-departmental coordination. Because the block includes mental health and substance abuse, and because the recently enacted alcohol premium legislation affects mental health service providers, there will be close coordination with the Department of Human Services, Office of Alcohol and Drug Abuse Prevention, to plan for the most effective and efficient use of resources.

Another aspect of these expanded roles and responsibilities is the licensing of mental health facilities. Revisions to the current regulations will address the lapsed federal regulations for community mental health centers, incorporating areas that will make licensing another tool for effective monitoring of services.

The Bureau of Mental Health is authorized to protect the rights of individuals who are receiving treatment for mental illness in any program or facility administered or licensed by the bureau. To do this, the bureau will promulgate rules and policies about the rights of the mentally ill. Organizational compliance with these rules will be assessed as part of the Mental Health Licensing process. Individual complaints will be handled by the Office of Advocacy in the department.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Augusta Mental Health Institute

Program Contact: Garrell S. Mullaney, Superintendent

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. § 2101 (Maintenance of the Institution)

34 M.R.S.A. § 2251 et. seq. (Hospitalization of the Mentally Ill)

15 M.R.S.A. § 101, et. seq. (Mental Examination and Commitment of
Persons Acquitted on Basis of Mental
Disease or Defect)

15 M.R.S.A. §2211-A (Commitment of Persons Confined in a County Jail)

15 M.R.S.A. § 2301 et. seq. (Interstate Compact on the Mentally
Disordered Offender)

34 M.R.S.A. § 136-A (Hospitalization of Persons Confined at Other
State Institutions)

b. Other mandates:

Social Security Act (including Title XVIII Medicare, and Title XIX
Medicaid, 42 U.S.C. § 1395, et. seq.

Rehabilitation Act of 1973, 29 U.S.C. § 700, et. seq.

Federal Mandate found in Jortberg, et al. v. Department of Mental Health
and Corrections, et al., No. 13-113 (D. Me. 1974)

Consolidated Standards for Child, Adolescent and Adult Psychiatric,
Alcoholic and Drug Abuse Programs administered by the Joint Commission
on Accreditation of Hospitals.

2. Public Need:

The Augusta Mental Health Institute is mandated to treat adults who require intensive 24-hour psychiatric services from the following counties: Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo and York. In addition, the Institute provides inpatient psychiatric treatment to adolescents from throughout the State. All services are provided without regard to race, creed, color, sex, national origin, ancestry, age, physical handicap or ability to pay.

National studies indicate that at least 15% of the population experience mental or emotional problems serious enough to require professional care

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at some point in their lives. This percentage increases in times of severe unemployment or other social stress. Of the 120,000 or more population at risk in Augusta Mental Health Institute's catchment area, approximately 600 each year develop episodes which are severe enough to require institutional care. As a result of this "at risk" segment, there are approximately 1,000 annual admissions to the Institute (many of these individuals require several admissions per year due to their not being able to fully cope with life outside the Institute once returned to the community).

The Augusta Mental Health Institute is the only facility, for these counties, mandated and equipped to provide care and treatment, in a hospital setting, to the following categories of patients: those who require involuntary hospitalization; those who require a secure setting; those who require extended periods of inpatient treatment and/or rehabilitation; those committed under the criminal statutes for observation, care and treatment; and those who require certain highly specialized programs not available elsewhere. In some cases, the lack of appropriate community alternatives requires that the Augusta Mental Health Institute accept some additional acute patients on a voluntary basis. The demand for mandated services is such that voluntary admissions occasionally have to be delayed or diverted to assure suitable accommodations for those most in need.

Despite adherence to the principle of utilizing the least restrictive alternative and only admitting those with a definite need, 933 patients were admitted in fiscal 1981 for hospitalization from the following community mental health center service areas:

Cumberland	258
York	104
Bath-Brunswick	31
Kennebec/Somerset	243
Tri-County (Androscoggin, Oxford, Franklin)	146
Mid-Coast (Knox, Waldo)	51
Other (Outside AMHI service area, including out of state and unknown)	<u>100</u>
Total	933

The average daily in-house census for fiscal 1981 was approximately 300. At any one time, roughly 10% of the patients have been committed by the courts under Title 15 for some phase of the "Forensic" observation, care and treatment, described later in this report under Program Operation. Although 70% of the remaining patients are admitted as emergency involuntary,

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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very few remain in this status more than one month. However, in that period of time, all (by legal mandate) must have comprehensive individualized treatment plans performed.

3. Program Objectives:

In order to fulfill its mission, thereby providing services of the quality and quantity required and expected in its legislative mandate, the Institute must meet certain program objectives. By statute the Institute must serve those patients in need of mental health services, sent to the Institute, "that accommodations permit." Only through meeting the following objectives can the Institute assure that there are suitable accommodations for those patients for whom no alternative programs or facilities are available or appropriate:

a. Patient Improvement:

Patients admitted to the Augusta Mental Health Institute must receive sufficient services so that when they leave the Institution their general functioning has been improved to the extent that inpatient treatment is, at that time, no longer required.

b. Patient Involvement:

In order to assure proper treatment, each patient must be actively involved (through an individualized treatment plan) with defined hours of specialized treatment programming each week.

c. Quality of Staff:

The maintenance of licensing and certification standards as well as individualized staff development programs are promoted in order to assure that the treatment is safe, effective and the most clinically appropriate to each individual patient.

d. Maintenance of Standards:

Standards established by the Joint Commission of Accreditation of Hospitals (JCAH), as well as Medicare and Medicaid, are met by the Institute in order to assure both quality treatment and the continued receipt of third-party reimbursement to the State's general fund. In addition (particularly in light of the large numbers of involuntary patients admitted to the Institute), each patient's right to treatment must be respected and appropriate treatment provided.

e. Continuity of Services:

Assurances are established to make certain that only those needing specialized inpatient treatment are admitted and that aftercare services are provided after discharge. The provision of aftercare services is

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mandated by the Joint Commission and such care helps to reduce the need for further hospitalization. Aftercare services are provided by community mental health centers and other service agencies.

f. Use of Resources:

Personnel and other resources available to the Institute must be efficiently utilized. This is assured through a management by objectives system and an allocation of personnel to treatment units (result-oriented staffing).

4. Program Operation:

The Augusta Mental Health Institute is organized as a system of functional treatment units in order to meet, as effectively and efficiently as possible, the objectives previously outlined. It is presently staffed and equipped to provide care and treatment to a maximum of 331 patients at any given time. In the early 1970's, the facility began a dramatic decline in census, changing from a large 1,600 bed custodial institution, isolated from the communities it served, to a modern psychiatric hospital. Without intensive treatment and pre-admission screening, the inpatient population would increase rapidly, with a corresponding decline in quality of care and treatment.

In the mid-1960's as many as 600 patients contributed their labor without any compensation in order to maintain the essential services of the hospital. At the present time, the 300-320 patients remaining are those who require intensive psychiatric treatment and rehabilitation. The discontinuation of this earlier practice, as well as the more severe condition of the evolving population, has necessitated a greatly increased staff/patient ratio. Although the actual number of staff has declined from 800 to less than 600, they serve a larger catchment area than did the 800 staff and patient "employees".

Added benefit to the state from the decline in numbers of patients has been the subsequent availability of seven (7) buildings containing 220,087 square feet for state offices, and 189,097 square feet for warehouse space. Thus, the state has avoided major capital construction or rental costs. The savings to the state in rental fees alone is estimated to be over \$1,000,000 annually. In addition, the Institute continues to provide grounds and highway maintenance as well as heat for these buildings.

Each of the functional treatment units is responsible for the total treatment and rehabilitation of its patients. In order to meet the patients' legal right to treatment, as well as to assure continuing third-party reimbursement, the Institute must assure that every patient has a comprehensive treatment plan developed and implemented. This requires clinical teams of nurses, psychologists, social workers, activity therapists and other mental health workers, led by physicians who are responsible for the

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individual's plan of treatment and its implementation. Each psychiatric unit must have one or more qualified psychiatrists. The medical staff consists of seven full-time psychiatrists, two physicians in general medicine, other part-time physicians, and representatives of all major specialties on the consulting staff. Comprehensive treatment also requires the specialized services of sheltered workshops, educational programs, medical clinics, pharmacy, laboratory and X-ray. The facility is comprised of the following units:

a. Admission Unit:

The Admission Unit has a 28-bed capacity and is equipped to provide evaluation and crisis management. Only adult patients requiring three weeks or more of inpatient services move beyond this Unit and are treated elsewhere in the Institute. A concentration of professional staff on this Unit prevents at least half of the patients admitted from progressing further into the facility, thus restoring them quickly to their home communities and minimizing the development of institutional dependency. Although primarily diagnostic, the Admissions Unit does offer such short term treatment as: chemotherapy, group psychotherapy and activity therapies. The median length of stay on this Unit is 7 days.

b. Forensic Unit:

Under Title 15, Superior and District Courts may order examinations to determine mental competency and responsibility for criminal acts. The Department of Mental Health and Mental Retardation is responsible for all examinations beyond the "preliminary" stage, and is requested to perform many of the "preliminary" examinations as well (resulting in a saving of considerable money to the Court system). Only if a clear determination cannot be made in "out-patient" examinations does the court order that the individual be placed in the custody of the Commissioner of Mental Health and Mental Retardation for observation at an appropriate institution. If the court finds the individual is either incompetent to stand trial or not guilty by reason of mental illness, the Commissioner is, again, ordered to place the individual in an appropriate institution. The Augusta Mental Health Institute is involved in each element of the above, including many of the "preliminary" examinations. There is a clear legal mandate to provide appropriate evaluation and treatment to each of the patients held under these conditions. This requires highly trained forensic psychiatrists and psychologists supported by a full team of other mental health specialists.

Until the early 1970's many of these "forensic" patients were housed in the old Maximum Security Building, a facility totally lacking in capacity to provide treatment, too costly to run and far outmoded in its construction. When it was closed in 1972, the patients housed there were integrated successfully into other psychiatric units with fewer incidents

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of escape or of anti-social behavior than had occurred under the previous system and with a dramatic improvement in the mental health of those patients. Those with long term treatment and rehabilitation needs now are provided access to the necessary programs assuring that their right to appropriate treatment is met. At present, an eight bed Forensic Unit provides short term intensive diagnostic and treatment services in a secure setting for individuals referred from the courts for observation, care and treatment and for civil admissions from state and county correctional facilities. The staff of this Unit also monitors patients committed by the courts as incompetent to stand trial and not guilty by reason of mental illness whose security and treatment needs allow them to be placed elsewhere in the facility. "Inpatient" observation on this Unit is kept at a minimum by means of extensive examinations done on an out-patient basis by the Unit psychiatrist and/or psychologist, thus avoiding more costly inpatient observation. Fifty-three such examinations occurred in 1981.

c. Transition Unit:

The 85-bed Transition Unit provides intensive treatment for actively psychotic adults who may require several months of hospitalization. These include both acutely mentally ill individuals who require intensive intervention over a period of weeks or months and chronically mentally disabled persons who are able to live in the community with occasional admissions to the hospital for further treatment. In order to meet the therapeutic needs of this population, the Unit has developed the following specialized programs:

A Reception Program provides treatment planning and program assignment. Patients requiring more than brief crisis resolution on the Admissions Unit come to the Reception area where an intensive individualized treatment plan is developed. The specialties of medicine, psychology, nursing, social work, activity therapy, vocational rehabilitation, education and pastoral services all contribute to the treatment planning process. If the patient is to be committed involuntarily, a treatment plan must be approved by the District Court judge as a legally required element of the process. While the patient's length of stay in the Reception area is flexible, the treatment plan must be implemented quickly (never more than a few days) in order to hasten the patient's recovery and minimize the length of hospitalization. The patient is referred from Reception to one of three treatment programs.

- 1) The Resocialization Program provides an emphasis on developing or restoring basic daily living skills in order to optimize community adjustment. The patients served here are frequently those with continuing psychiatric disabilities who require periodic re-hospitalization due to severe social handicaps. Social work services, activity therapy services and vocational rehabilitation are relied upon heavily to reintegrate patients into the community.

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- 2) A Behavioral Program is designed for patients who can benefit from a structured approach in which positive behavior is encouraged and strengthened and defiant behavior is extinguished or weakened. Patients who cannot benefit from "verbal" therapies and who do not follow socially appropriate norms of behavior are assigned to and treated in this program.
- 3) The Psychotherapeutic Program serves patients, usually young adults, who can benefit from individual or group psychotherapy combined with other treatment modalities in a structured setting. The treatment plan for each patient is goal oriented and time limited in the form of a contract in which the patient agrees to participate actively in working toward resolution of agreed upon problems.

d. Adolescent & Young Adult Unit:

The Adolescent and Young Adult Unit provides a specialized program for youth between the ages of 12 and 20, statewide, who require a psychiatric hospital level of inpatient treatment services. There are no other psychiatric hospital units programmed specifically for adolescents in Maine. This Unit, consisting of a 28-bed ward in the recently renovated Marquardt Building and a six-bed residential therapeutic home on the AMHI grounds provides comprehensive diagnostic and treatment services to young people (average age of 16) who have severe cognitive, emotional, behavioral or social problems. The Unit treats acutely psychotic, suicidal and homicidal teenagers, as well as those suffering from severe borderline personality disorders with short term psychotic decompensations. Most of those admitted are severely disturbed, manifesting behavioral problems intolerable to private treatment centers, their homes, schools and community. The goal is to produce enduring change, not only in young patients, but also in their families. Therefore, this Unit utilizes family therapy as its principal means of rehabilitating troubled adolescents to responsible, self-actualizing and socially acceptable functioning in their homes and communities. The growth of a strong ethical and moral value system is promoted. The City of Augusta operates the "Cony Alternative School" on AMHI grounds where adolescents from this Unit attend school together with other special education students from the Augusta area.

e. Rehabilitation & Reentry Unit:

This Unit provides comprehensive social, educational and vocational rehabilitation services through the following programs:

The Rehab Dorm is a 72-bed unit providing residential rehabilitation services for chronically mentally ill people. The patients housed there have an average time in the Institute of over 3 years. The program utilizes two wards and several rehabilitation modalities. The entire milieu is designed to build a feeling of self-reliance,

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self-worth, compatability and a general state of well-being in a chronically disabled and dependent population. The Structured Learning Therapy (SLT) program and the Special Needs Adult Program (SNAP) are integral to the Dorm program, but are offered as well to patients from other units who may need elements of these programs per their treatment plans. SLT consists of four components, each of which is a well established behavior change procedure: modeling, role playing, social reinforcement and transfer of training. It is a carefully researched modality involving group therapy, structured ward milieu, and individual training sessions designed to teach long term patients communication skills that they have forgotten or temporarily cast aside. The SNAP program is for functionally disabled persons, especially the senior population, and is based on an Occupational Therapy Model. It addresses activities such as daily living skills, grooming skills, cooking, dining, community living and social skills. The long term patients "bridge the gap" to community living through trips to the community in small groups.

The Alternative Living Program for adults consists of six former staff houses or apartments on the grounds with a capacity for 34 patients. Each provides a small supportive homelike group setting which more closely parallels the experiences that the patients are likely to encounter in the community. They constitute a transitional step for patients moving back into the community. The patients become less dependent on the Institute and subsequently more independent and self-reliant. The goal for the individual is to reach the highest level of independent functioning possible, with the ultimate goal being community integration.

An activity therapy department serves the entire facility from the Rehab & Reentry Unit. Occupational therapy, recreational therapy, movement and dance therapy and art therapy, are represented either continuously or as needed. Activity Therapy is an important component of nearly every patient's treatment program.

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

Library services to the patients are well utilized and play a significant "bibliotherapy" role. A Health Sciences Library provides the necessary support to AMHI professional staff and training programs.

In recent years the need for expanded vocational rehabilitation-sheltered workshop services has made the vocational training and employment components of the Rehab and Reentry Unit a continually enlarging program responsibility.

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Early in the 1970's the following factors required a major change in emphasis:

- 1) The Jortberg Consent Decree which prohibited unpaid patient labor;
- 2) The vocational rehabilitation needs of those psychiatrically disabled patients remaining at AMHI after patients not requiring or able to benefit from extensive psychiatric rehabilitation had been discharged; and
- 3) The judicially established right to treatment.

As a result, AMHI could meet its mandate to care for and treat the majority of its patients through focusing its long standing emphasis on work and occupational therapy more explicitly in a system of sheltered workshops and work activity centers. Over the last decade GROW (Growth through Rehabilitation and Occupational Workshops) has evolved and contracts with community organizations have been executed. This comprehensive workshop program utilizes funds generated over and above the wages paid to the workshop patient-clients to expand rehabilitation opportunities. Clients with disabilities comparable to those of AMHI patients are referred from the community mental health centers, Division of Vocational Rehabilitation, Bureau of Mental Retardation and other mental health related agencies. By extensive utilization of this modality, patients who would have remained untreated or whose treatment would have been inappropriate and ineffective have reentered the world of productive employment in varying degrees of self-sufficiency.

f. Nursing Home Unit:

The Institute maintains and staffs 70 beds certified by the Department of Human Services as a Nursing Home Unit reimbursable under Title XIX. This Nursing Home Unit is an integral part of the Augusta Mental Health Institute. It admits only from the AMHI psychiatric population assuring that those patients who are more appropriate to community nursing homes are not admitted to this program. The Unit provides a high level of professional nursing care and rehabilitation services to a population requiring total care.

The patients housed in this Unit are severely impaired both physically and psychiatrically. Their disabilities are such that they cannot be served in community nursing homes or other alternative settings. A psychiatrist from the Institute provides limited services to some community nursing homes to assist in maintaining many other psychiatrically impaired patients in community nursing homes. Through this participation in meeting the extensive need for psychiatric services to the nursing home population in the community, the Institute is able to continue at the current capacity.

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g. Infirmery & Clinics:

The 16-bed Infirmery provides a Medicare certified general hospital level of care, at less cost than would be incurred by a transfer to a general hospital, thus generating significant amounts of third-party reimbursement to the general fund. Those patients requiring surgery or intensive care are transferred to the Kennebec Valley Medical Center. Psychiatric care to patients on the Infirmery continues to be provided by the patient's psychiatric team.

The Clinic serves as a medical support service to the psychiatric units, Nursing Home and Infirmery. It is responsible for providing comprehensive medical care for all inpatients. All medical specialties are represented on AMHI's consulting medical staff, including physical therapy and dental services. In addition, AMHI is required to maintain well equipped medical support facilities: an X-ray department, laboratory and pharmacy. All are staffed by licensed personnel and meet quality standards as well as being cost effective.

h. Chaplains:

Protestant and Catholic Chaplains trained in pastoral counseling are on the staff and available at all times. Pastors from the community are encouraged to maintain contact with their parishioners.

i. Volunteers:

All Programs are improved and enriched by the dedicated services of a corps of volunteers. In fiscal 1981, approximately 550 volunteers contributed 26,451 hours of service to patients of the Augusta Mental Health Institute.

j. Support Services:

In order to provide a safe and therapeutic environment and to assure that the extensive physical plant and equipment assets are maintained and protected, comprehensive safety and preventive maintenance programs are ongoing. AMHI utilizes its own staff in the skilled trades and other service areas wherever it is determined to be more cost efficient than to obtain necessary services through contract procedures.

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5. Staffing:

a. General Fund:

1) Positions authorized: 567

2) Positions filled Sept. 1, 1981:

a) Full time: 558

b) Other positions: 5

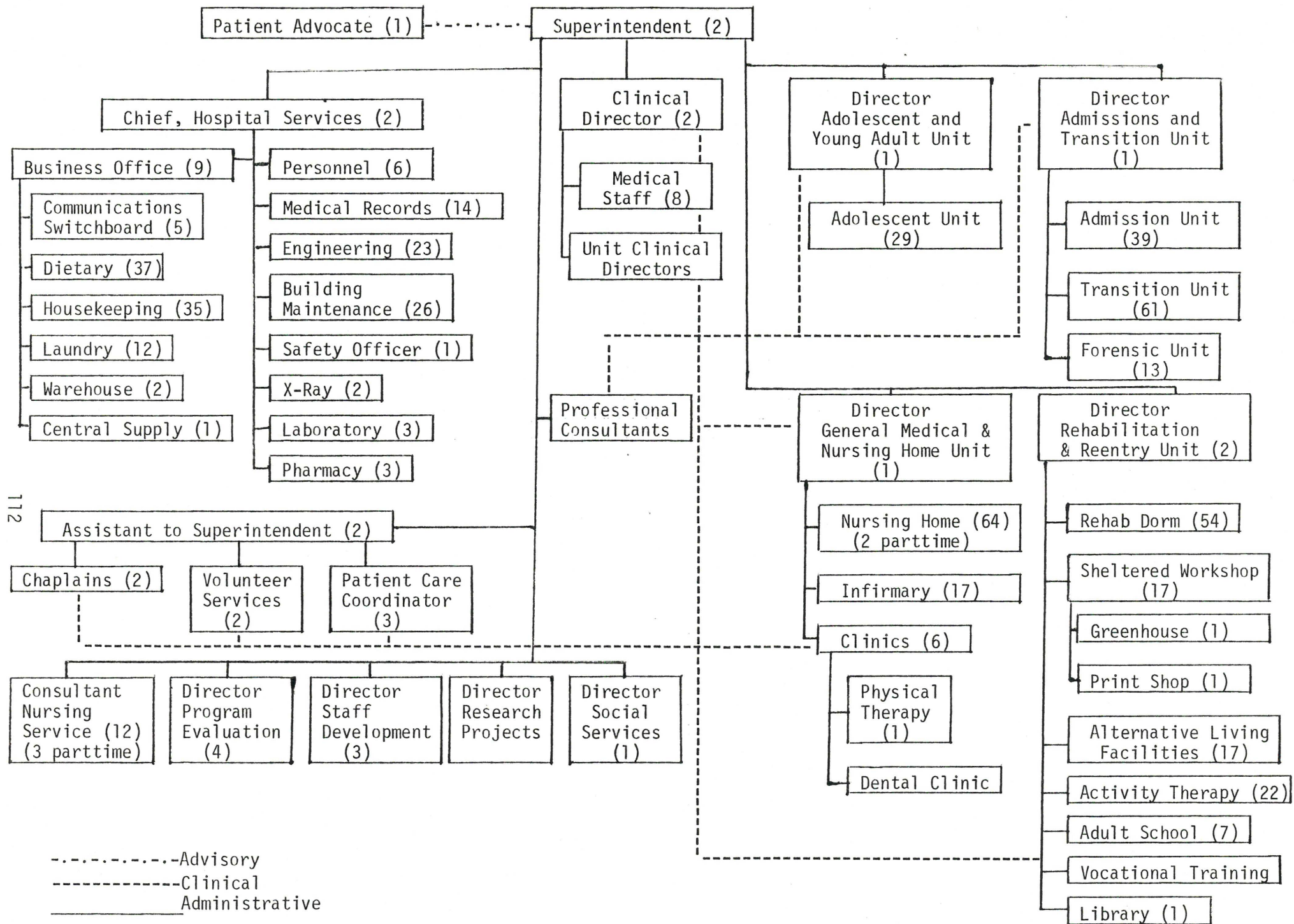
b. Other funds (including vacant positions):

1) Full time: 9

2) Other positions: 2

c. Organization:

(See chart next page).



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d. List of positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Superintendent	1		
Supervisor Special Services	1		
Chief, Hospital Services	1		
Advocate	1		
Clinical Director	1		
Departmental Personnel Officer I	1		
Personnel Technician I	1		
Business Services Manager	1		
Business Manager I	1		
Catholic Chaplain	1		
Chaplain II	1		
Mental Health Unit Directors	2		
Institutional Clothing Supervisor	1		
Storekeeper II	1		
Stores Clerk	1		
Seamstress I	1		
Seamstress II	1		
Upholsterer	1		
X-Ray Technicians	2		
Central Supply Technician	1		
Chief, Occupational Therapist	1		
Occupational Therapist I	1		
Occupational Therapist II	1		
Chief, Volunteer Services	1		
Director, Geriatric Services	1		
Laboratory Technician II	1		
Laboratory Technicians III	2		
Librarian II	1		
Medical Records Technician	1		
Manual Training Coordinator	1		
Nutrition Consultant	1		
Pharmacist	1		
Pharmacy Technician	1		
Physical Therapist	1		
Rehabilitation Consultant	1		
Reproduction Equipment Supervisor	1		
Safety Compliance Officer	1		
Statistician II	1		
Teacher Supervisor	1		
Teachers	3		
Switchboard Supervisor	1		
Switchboard Operators I	4		
Therapeutic Specialist	1		
Staff Development Coordinator	1		
Physicians II	3		

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<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Physicians III	5		
Physician Extenders	3		
Psychiatric Social Worker Assistant	1		
Psychiatric Social Workers I	4		
Psychiatric Social Workers II	3		
Psychiatric Social Worker Supervisors	2		
Human Service Workers I	3		
Director, Social Services	1		
Nurses I	2		
Nurses II	9		
Nurses III	20		
Nurses IV	5		
Nurse V	1		
Psychiatric Nursing Instructor	1		
Licensed Practical Nurses	13		
Psychologist I	1		
Psychologists II	4		
Psychologists III	3		
Psychologists IV	2		
Recreation Therapists	5		
Grounds and Equipment Foreman	1		
Heavy Equipment Operators	3		1
Light Equipment Operators	3		
Automotive Mechanic	1		
Food Service Manager	1		
Cooks I	7		
Cooks II	4		
Cook III	1		
Baker II	1		
Food Service Workers	22		
Plant Maintenance Engineers I	2		
Plant Maintenance Engineer II	1		
Boiler Operators	4		
Boiler Engineers	4		
Maintenance Mechanics	7		
Electrician I	1		
Electrician II	1		
Plumber I	1		
Plumber II	1		
Welder	1		
Clerks II	4		
Clerks III	2		
Clerk Stenographer II	1		
Clerk Stenographers III	2		
Clerk Typists II	15		
Clerk Typists III	3		
Secretaries	2		

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<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Medical Secretaries II	2		
Executive Housekeeper	1		
Custodial Workers I	25		1
Custodial Workers II	4		
Housekeeper I	1		
Mental Health Workers I	99		3
Mental Health Workers II	98		2
Mental Health Workers III	28		
Mental Health Workers IV	13		
Mental Health Workers V	11		
Mental Health Workers VI	7		
Building Maintenance Supervisor	1		
Mason Foreman	1		
Masons	2		
Painter Foreman	1		
Painters	4		
Carpenter Foreman	1		
Carpenters	5		
Locksmith	1		
Laborer II	1		
Laundry Supervisor	1		
Laundry Washman	1		
Laundry Workers I	10		
Laundry Workers II	1		
Barber	1		
Beauticians	2		
Account Clerks I	2		
Account Clerk II	1		
Accountant I	1		
Accountant II	1		
Bookkeeping Machine Operator I	1		
Psychology Assistants			2
Marketing Agent			1
Remotivation Assistant			1
TOTALS	567		11

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6. Financial Data:

a. Appropriation account #: 1350.1; 1350.9; 3350.1; 4350.1

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriations:</u>	8,666,245	10,479,179	10,781,087
Balance Forward	46,149	28,834	-0-
Transfers in	1,426,053	101,200	101,200
<u>Federal Funds Available:</u>	106,395	95,000	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	147	66,952	-0-
Revenue	221,452	345,129	318,917
Total Funda Available	10,466,441	11,123,559	11,201,204
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	8,936,293	9,301,902	9,490,883
Federal	34,956	-0-	-0-
Dedicated Account	82,392	129,358	133,886
Total Personal Services	9,053,641	9,431,260	9,624,769
<u>All Other:</u>			
General Fund	1,119,609	1,257,311	1,341,404
Federal	61,840	45,265	-0-
Dedicated Account	120,772	235,723	160,531
Total All Other	1,302,221	1,538,299	1,501,935
<u>Capital:</u>			
General Fund	52,594	50,000	50,000
Federal	36,535	57,000	-0-
Dedicated Account	15,322	47,000	24,500
Total Capital	104,451	154,000	74,500
<u>TOTAL FUNDS EXPENDED</u>	<u>10,460,313</u>	<u>11,123,559</u>	<u>11,201,204</u>
Undedicated Revenue to G.F.:	<u>1,349,861</u>	<u>1,735,000</u>	<u>1,913,000</u>

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7. Other Programs:

The Bangor Mental Health Institute is a state psychiatric hospital for northern and eastern Maine providing similar services to adults.

The Division of Children's Services, Department of Mental Health and Mental Retardation, coordinates programming for the mental health needs of children.

Psychiatric units within community hospitals provide short term, voluntary, inpatient treatment.

Six community mental health centers in AMHI's catchment area provide psychiatric services other than those inpatient services for which AMHI is responsible.

The U.S. Veterans' Administration Center, Togus, provides psychiatric services, including inpatient, for eligible veterans only.

Mental health professionals in private practice provide outpatient services on a fee-for-service basis.

Licensed nursing homes provide residential services to medically disabled persons who require this level of care; specialized psychiatric services are not provided in these settings.

8. Program Effectiveness:

a. Patient Improvement:

This is measured by a combination of clinical assessment of each patient's progress in the resolution of problems requiring hospitalization, of length of stay and by a global rating system. The patient is rated at admission and at discharge on an objective scale by direct psychological and behavioral appraisal. While the average patient upon discharge still shows impairment of functions, he is able to perform roles sufficiently to live in the community. The fact that this is accomplished with a median length of hospitalization of 15 days indicates the level of success in this area.

b. Patient Involvement:

In order to assure active involvement in treatment programs, there are requirements for 20 hours per week of formal treatment programming for each patient in the adult psychiatric units and 30 hours in the Adolescent Unit. This is correlated with the Manpower Resource allocation process identified earlier as result-oriented staffing. The hours are recorded, tabulated and used both to monitor patient involvement and as a management tool to determine the most effective assignment of staff time.

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Total treatment hours tabulated in fiscal 1981 were 458,247; the adult psychiatric units generated 253,379; the Adolescent Unit, 51,064; and the Nursing Home Unit, 153,804.

c. Quality of Staff:

All professional staff at AMHI are fully licensed or certified to perform their assigned duties. Each profession monitors the performance of its members and assigns specific privileges to individual practitioners based on credentials, experience and ability. External surveys have found that AMHI meets basic standards in all areas of professional practice.

An extensive staff development program is operated for all staff in order to assure that staff members are equipped to perform their duties appropriately. The programming includes basic orientation, mandatory training in fire safety, confidentiality and other health and safety related areas, inservice training for mental health workers and other clinical and support staff. It also invites faculty from teaching hospitals to provide clinical training to physicians and other professional staff. Each employee has an annual staff development plan with a designated number of hours which he completes, primarily from training offered at AMHI, during the course of the year. In the last two years staff completed 65,000 hours of training. Staff are sent to outside training events only for necessary instruction in areas too specialized for inservice courses.

- d. The Augusta Mental Health Institute has been accredited by the Joint Commission on Accreditation of Hospitals for 26 years. The last survey in June 1980 resulted in the maximum period of accreditation, i.e. two years.

A facility accredited by JCAH is also deemed to be in compliance with most Medicare standards. For those additional areas of Medicare concern, the National Institute of Mental Health surveyors conduct annual site visits in cooperation with the State Department of Human Services. The last Medicare survey (February 1981) reaffirmed the certification of all psychiatric units for Medicare reimbursement. Similar results were achieved by the Nursing Home (Intermediate Care Facility) Unit, which is certified for Medicaid reimbursement by the Department of Human Services. Throughout the year, an extensive Utilization Review and Medical Care Evaluation program monitors the necessity for admission and for continued stay as well as patterns of care and adequacy of documentation in order to assure that Medicare, Medicaid and other their-party reimbursement claims will be honored.

Compliance with the statutory right to treatment for involuntary hospitalization of mentally ill persons is achieved through the requirement of an individualized treatment plan and the monitoring of that plan.

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It is also measured by District Court acceptance of the treatment plan which must be presented at each involuntary commitment hearing. The large proportion of involuntary patients admitted (over 70% of admissions) would indicate grave problems should this standard be relaxed.

e. Continuity of Services:

AMHI maintains both formal agreements and continuing staff linkages with community mental health centers to assure that prescreening of prospective admissions takes place; 85% of admissions are prescreened by CMHC's. The remainder come directly from the courts or by transfer from other inpatient facilities. An aftercare plan is completed for each patient who has been treated at AMHI and is coordinated with the patient's CMHC for continued services as needed. AMHI is implementing a system of follow-up reporting from the CMHC to AMHI to assure that the JCAH mandate to arrange appropriate aftercare for each patient discharged is met.

- f. The efficient use of resources is assured through utilization of a Management by Objectives system. At the beginning of each fiscal year, the previous year's experience, the projection of need and the resources available are combined in a planning process designed to target measurable priority objectives toward which the efforts and resources of each department and unit will be directed. Monthly progress in meeting these objectives is reviewed with the superintendent. In addition, the staffing of each treatment unit is determined, not on the traditional custodial "coverage" model, but on the amount of actual treatment expected to be delivered (result-oriented staffing). If, based on bed capacity and mandated hours of treatment per patient, a unit is expected to deliver 1,000 hours of treatment per week, the numbers of professional staff and mental health workers will be adjusted to provide that capacity. On an ongoing basis, each unit maintains an "efficiency rating" which indicates whether the unit has delivered the hours of treatment for which it is staffed.

9. Future Plans:

Long Range Plans: A health care organization is continually changing in a number of dimensions in order to meet demand from the population requiring those services. The context of this planning at the Augusta Mental Health Institute targets four areas which continually affect both current and future operations. These are: social policy, organizing, manpower development and financing.

Social Policy: The institute currently operates within a framework of state and federal statutes which have evolved out of a number of United States Supreme Court decisions regarding the care of mentally ill persons. It is also affected by regulations in health, welfare and education. The legislature, by allowing for the care of all those in need, has mandated

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that the priority population for the institute's services be those patients who are mentally ill and: a) either dangerous to themselves or others; or b) unable to care properly for themselves. At the present time the District Court will not accept alcoholism, mental retardation or sociopathy as mental illnesses and, therefore, the institute provides services to patients with these conditions only when they wish to stay voluntarily and their condition can be assisted through active psychiatric intervention.

The institute does not foresee any changes in statutes at this time; however, long-range plans are based on serving the demand for services of those persons under the aegis of the current statutes. This demand is increasing as a result of social policy changes under other provisions of both federal and state law, such as those changes proposed under the current federal budget which will affect the potential for disabled persons to obtain the financial support necessary to maintain themselves in the community. Revisions in the structure of Supplemental Security Income, Medicaid, various programs under Title XX, state and local welfare and food stamp policies, and, generally, unemployment and inflation are already having an impact on the admissions rate and lengths of stay at the institute: there is an increasing demand for inpatient services as community programs narrow their focus. Without a change in the mandate of the hospital to also narrow its focus, social policy issues will necessitate either an increase in allotments to community mental health programs or an increase in the number of available beds at this facility. We project the need for an additional 30 transitional care beds by the beginning of fiscal year 1984 (to serve young chronic patients) as the hospital has had to close its doors to voluntary patients on numerous occasions in order to accommodate the increased flow of involuntary patients.

Organizing: The organizational design of the institute reflects an allocation of resources to best accomplish its mission as established by the legislature in a manner to best make decisions that impact on length of stay. These are medical and legal decisions focusing initially on the status of the patient, the need for hospitalization and the ability of the patient to return to the community with structured support. Other sections of this report outline the priority objectives of each of the treatment units. Resources are assigned to them in a manner which prevents growth in the daily census while assuring the best possible care for the mentally ill. The Admissions, Forensic and Adolescent Units are staffed with highly trained professionals who provide the latest in psychiatric technology. In light of the increased demand for services, and considering the current technology available within the field of psychiatry, the present organizational design is most efficient. More patients are treated each year than when the institute's census was five times greater than today's average daily census. The organization of the hospital must consider median length of stay, resource allocation and significant decision-making release factors (the length of post-hospital adjustment in the community) in order for staff to meet the increased demand for services. Length of stay is shortened by the provision of

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aftercare services through contracts with community agencies administered by the Bureau of Mental Health.

The Nursing Home Unit currently has a capacity of 70 beds and it is foreseen that this number will continue. Services will be available for long-term patients who have not been able to adjust successfully to community living. These patients are too difficult to integrate into private nursing homes. It is anticipated that the program will be in existence with the same capacity over the next 10 years, as considerations will be necessary for the care of patients presently in their 50's. A chief concern is the increasing number of younger patients between the ages of 20 and 30 who are requiring longer lengths of stay as their community skills deteriorate due to their mental illnesses. The demand for services also indicates a need for an additional 30-bed transitional program specifically for the young chronic patient.

Financing: The institute is financed through state General Funds and occasionally has benefited from bond issues. The buildings presently operated by the institute are all in good condition and, even with the expectation of an increased patient load, conversion of present space should be adequate. Long-range capital financing should only be necessary for the maintenance of buildings, continuation of energy-saving renovations and maintenance of up-to-date life safety features. Capital equipment is replaced as needed on an annual basis. Current allocations have kept the institute up to date with modern technology. Any expansion of the GROW Workshop will be financed through production funds and a decrease in institutional support is foreseen over the years. In summary, the institute will rely on its General Fund allocation for financing day-to-day operations, repairs, capital construction and replacement of equipment. Close coordination between the institute and community systems of care will continue to assure maximum benefits from both programs.

Manpower: The institute operates under a medical model. Academically, culturally and by practice, its physicians are well prepared to treat the problems of chronically mentally ill persons and possess a special expertise in areas such as emergency psychiatry, forensic psychiatry and adolescent psychiatry. This model calls for health-care specialists to support the professional staff; an active inservice training program is therefore maintained. An effort has been made to train psychologists, nurse practitioners and social workers. Active recruitment will continue for physicians, occupational therapists and nurses.

The institute maintains educational affiliations with various nursing and medical schools and sees such programs as a major means of future recruitment. Unlike other hospitals, AMHI has not recently experienced nursing shortages, although competition for psychiatric nurses in this particular region is intense (Togus, Kennebec Valley Medical Center and Mid-Maine Medical Center). Such competition is a factor in retention which we have chosen to address by improving the working environment through consistent clinical specialization.

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An effort will be made to join the Mental Health Manpower Commission's current effort in credentialing Mental Health Worker training within the institute and developing appropriate curriculum for Mental Health option programs within the university system. It is hoped that the State Personnel Department will develop additional policies and procedures to deal with the nuances of recruitment and competition within the health care field.

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1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. § 2101 (Maintenance of the Institution)

34 M.R.S.A. § 2251, et. seq. (Hospitalization of the Mentally Ill)

15 M.R.S.A. § 101, et. seq. (Mental Examination and Commitment of
Persons Acquitted on the Basis of Mental
Disease or Defect)

15 M.R.S.A. § 2211-A (Commitment of Persons Confined in a County Jail)

15 M.R.S.A. § 2301, et. seq. (Interstate Compact on the Mentally
Disordered Offender)

34 M.R.S.A. § 136-A (Hospitalization of Persons Confined at Other State
Institutions)

b. Other mandates:

42 U.S.C. § 1395 et. seq., Social Security Act (Title XVIII Medicare
and Title XIX Medicaid)

29 U.S.C. § 700 et. seq., Rehabilitation Act of 1973

Jortberg, et al. v Department of Mental Health and Corrections, et al.,
No. 13-113 (D. Me. 1974)

Consolidated Standards for Child, Adolescent and Adult Psychiatric,
Alcoholic and Drug Abuse Programs administered by the Joint Commission
on Accreditation of Hospitals.

2. Public Need:

A 1959 survey of the prevalence of mental illness reported that 10% of a population at any given time are experiencing mental or emotional problems to an extent that mental health services are necessary. A 1969 national study of the Joint Commission on the Mental Health of Children found that 0.6 percent of children under 18 are mentally ill, 2.8 percent are severely disturbed and 9 percent have problems of such significance that mental health treatment is required. The President's Commission on Mental Health reported in 1978 that at any time in any population, there is a need for mental health services by 15% of the population. Applying this percentage to Maine, it is estimated that 168,700 people in Maine need mental health services, and of this number, 11,124 suffer from a major mental illness that could require hospitalization.

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As described in several national publications, as well as in the State Mental Health Plan, the prevalence of poverty, single parent families and other demographic indicators suggest that Maine's mental health needs are greater than the national average.

The Bangor Mental Health Institute is part of a comprehensive system of mental health services in Northern and Eastern Maine which includes two community mental health centers with multiple branch offices, community hospitals and private providers. It is the only hospital serving two-thirds of the state's geographic area that provides services for those mentally ill patients who cannot be managed in less restrictive settings, such as community mental health outpatient programs and community hospital inpatient programs.

Categories of patients requiring admittance for care and treatment include those admitted on an informal voluntary basis, emergency involuntary patients committed under written application and certification by a physician or psychologist, patients whose admission is ordered by the District and Superior Courts, and transfers from other hospitals for the mentally ill, both in and out-of-state, upon order of the Commissioner of Mental Health and Mental Retardation.

The Institute also provides psychiatric examination and observation of persons accused of a crime when ordered by the court, as well as observation, care and treatment of persons found incompetent to stand trial, and those found not guilty by reason of mental disease.

Even though the Institute serves only a third of the state's population, the geographic area of Aroostook, Hancock, Penobscot, Piscataquis and Washington Counties is vast, thereby limiting the availability of private or non-profit agency mental health services. Approximately 48 percent of all admissions in 1980 were involuntary admissions; that is, individuals who were certified as mentally ill and dangerous and for whom less restrictive settings were not appropriate.

Since 1969, with the development of community mental health services and the emphasis on short-term treatment, there has been a gradual decline in the inpatient population. In 1969, the average daily population was 1,131, while in 1980 this population was 323. The volume of admissions is about 700. While deinstitutionalization and the emphasis on community-based care has resulted in shorter periods of hospitalization because of an exacerbation of a chronic mental illness, a lack of appropriate community programs, or both, many of these individuals need re-hospitalization.

With the decline in the patient census during the 1970's, the Institute has been able to focus its resources on treatment and rehabilitation, and in effect has become a highly specialized center for the treatment of mentally ill persons who cannot be managed in the community and for those individuals committed or referred by the criminal justice system.

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3. Program Objectives:

The mission of Bangor Mental Health Institute is to diagnose, treat and improve the mental, social and physical health, and where appropriate, the vocational and economic usefulness of adults from the counties of Aroostook, Hancock, Penobscot, Piscataquis and Washington, who require intensive 24-hour psychiatric services. These services are provided without regard to race, creed, color, sex, national origin, ancestry, age, physical handicap or ability to pay.

In order to achieve this mission, and thereby to provide quality care and treatment for all patients referred for care and treatment, the Institute is required to meet the following program objectives:

a. Maintenance of Standards

In order to assure both quality care and the continued receipt of third-party reimbursement, the Institute must continue to maintain compliance with standards of care developed by external agencies such as the Joint Commission on Accreditation of Hospitals, Medicaid and Medicare.

b. Patient Treatment

In order to assure that prescriptive treatment is provided to every patient, all will receive a thorough assessment, including psychiatric, psychological, social, vocational and recreational aspects of functioning. Based on these assessments, a comprehensive treatment plan will be developed, with prompt initial and regular multidisciplinary reviews of all aspects of treatment through formal multidisciplinary team meetings. In addition, particularly in light of the large number of involuntary patients admitted and committed to the Institute, each patient's right to treatment must be respected.

c. Continuity of Care

Because of the importance of continuity of treatment between the hospital and community programs, the Institute maintains linkages and formal agreements with outside agencies for pre-admission screening to ensure the least restrictive alternative, and for discharge planning and follow-up to ensure community support services in a timely fashion.

d. Staff Training

In order to ensure the safety, effectiveness and appropriateness of treatment, and to continue to improve the quality of care, the Institute provides relevant training to all personnel and ensures the licensing and/or certification of all professional staff.

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4. Program Operation:

The treatment programs at the Bangor Mental Health Institute are organized into Admissions Services, Adult Psychiatric Programs, the Program on Aging, and Rehabilitation Services. The patient population is grouped functionally to facilitate rapid stabilization of acutely ill patients and to protect the chronic and fragile older patient from the aggressive younger population.

There are currently 535 staff positions: 339 are direct care and program staff, 196 are administrative and support. The total bed capacity is 355.

Throughout the treatment programs at BMHI all comprehensive treatment planning is done by a multidisciplinary team, including representatives of psychiatry, medicine, psychology, nursing, social work, therapeutic recreation, occupational therapy, physical therapy, and chaplaincy. The team gathers at regular intervals in multidisciplinary case conferences to review all aspects of the patient's individual treatment plan.

The support staff ensure a safe, clean, pleasant environment for patients and are responsible for the food service and other basic physical needs of patients. Furthermore, many support services are provided to the Levinson Center.

a. Admission Services

The Institute is part of a comprehensive system of mental health services which includes two community mental health centers with multiple branch offices, community hospitals, as well as local practitioners; all of whom have experience in dealing with acutely mentally ill persons. Aroostook Mental Health Center (AMHC) is the gatekeeper for the Institute in Aroostook County, and is responsible, through a cooperative agreement, for the screening of all individuals from that area and notifying the Institute prior to being transported. AMHC also participates in the discharge planning process for all patients returning to Aroostook County.

The situation is not as clear-cut in the large geographic area of Hancock, Piscataquis, Penobscot and Washington Counties. The nature and extent of involvement in pre-admission screening is not known. Many patients are referred directly by private practitioners or local hospitals, making it difficult to ensure the provision of least restrictive alternatives. Of the 574 patients admitted from that region, mental health center staff were involved in discharge planning for about 27% (155) of the patients. The lack of a coordinated gate-keeping and discharge planning function has made it difficult to ensure the appropriateness of admissions and continuity of care upon release from the Institute. The Institute and the Bureau of Mental Health have

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negotiated an agreement for these services with Community Health and Counseling Services which was implemented on October 1, 1981.

Through the initial screening process, about 90 percent of the prospective admissions are discussed with Bangor Mental Health Institute Admission Services prior to actual arrival. All individuals who come or are brought to the facility are evaluated by a mental health professional (psychiatrist or licensed clinical psychologist) and immediately escorted to the admission area by admission personnel and background information is obtained. A mental health professional assesses the presenting problem and its history in order to determine along with the patient, whether the Institute is the most appropriate resource to meet the individual's current needs. If an individual is not admitted, the staff are responsible for arranging for appropriate care until such time as the individual is transferred to a more appropriate facility.

Of the average 51 admissions per month on this 18-bed ward, 43% are directly discharged. The rest are transferred to longer stay wards appropriate for the continuing treatment of their illness. The average length of stay on the admission ward is 8.5 days.

Another ward, D-4, acts as back-up to this unit. It also houses those who have non-acute medical illnesses, and will take patients from other wards who have acute exacerbation of their psychiatric illness, and cannot be handled in their usual environment. The maximum census is 15 .

b. Adult Psychiatric Programs

1) Discharge Preparation

K-1 is a 26-bed unit where the treatment environment emphasizes preparation of individual patients for community re-entry. There is recognition of the patients' central role in their own progress.

Perhaps two things best characterize the atmosphere of personal responsibility on K-1; the open door and the step program. Patients are expected to grow in accountability for their own choices. Learning to meet the challenge of the less restrictive "open door" atmosphere is thus an integral part of K-1. Similarly, the step program is a systematic way of encouraging patients to experience growth through choosing successively more adaptive behaviors. Patients not able to utilize the step program are offered weekly and bi-weekly goal planning meetings to assist them in adapting their behaviors.

A bi-weekly community meeting of all patients and available staff is chaired by an elected patient (with monthly elections). Open

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discussion of patient grievances is encouraged, with solutions proposed by patients taken seriously and often implemented. Patients themselves assume responsibility for orienting new patients to K-1. "Family style" dining is another way in which patients are encouraged to practice acceptable behavior.

A range of individual and group treatment approaches are used on K-1. All K-1 patients have an individualized treatment program. Depending upon a patient's needs, they may be involved in group therapy (psychodrama), individual therapy (or talk sessions), family therapy, pharmacotherapy, vocational therapy, or recreational therapy.

Many patients are also involved in outside work or training. Emphasis is placed on developing rehabilitative plans in cooperation with vocational rehabilitation counselors, Growth Resource Center, Bangor Regional Rehabilitation Center and individually developed programs. Strong effective community aftercare is developed within these plans.

2) Intermediate Care Units

There are two wards (K-2, E-2) providing intensive intermediate programming for 52 patients. Community meetings are held regularly in which patients can discuss the problems of group living, changes in ward routines and rules, etc. Patients are encouraged to accept responsibility for their immediate living environment and to attend available off-unit therapeutic programs.

Chemotherapy, group, family and individual therapy leading to patients moving into the step program with more responsibility for themselves are major program elements.

The step program's goal is to enhance rehabilitation of patients so they can attain their highest level of functioning. It is a way of organizing the road to recovery by giving the patient a sense of direction, providing small progressive goals and clearly specifying what is expected before and after discharge. As patients become more involved with their psychotherapy sessions and activities, they earn more privileges. The goal of the treatment team is to have all patients involved in 20-25 hours of treatment weekly prior to discharge.

3) Continuing Care

Two wards (C-2, C-3) function as continuing care units, for a total population of 53.

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The overall goal for the program is rehabilitation, i.e., to help each resident learn or redevelop skills and techniques which enable him to deal more effectively with the environment, whether in the institution or in the community. Treatment is based on broad behavior therapy principles and focuses on helping residents to develop more flexibility in adaptive skills. Because of the nature of the problems unique to this population, treatment primarily emphasizes communication, social interaction, self-care skills and impulse control.

Therapy involves the use of community programs as well as a variety of programs and services within the Institute. For some residents the ultimate goal may be to return to the community, while for other residents the most practical goal is to help enrich their quality of life within the Institute.

4) Residential Forensic Program

Ward E-3 has responsibility for the care and treatment of individuals from the Maine State Prison, Maine Correctional Center and five county jails (Hancock, Washington, Aroostook, Penobscot and Piscataquis). The unit also is responsible for psychological evaluations ordered by District and Superior Courts.

The unit works with both psychotic and personality disordered patients. One of the tasks of the unit is to motivate patients to accept their circumstances in an appropriate manner so that they may return to their respective facilities in a more positive frame of mind. In the majority of cases it is also a responsibility to report to the court the findings of the professional staff regarding competency and responsibility for the act for which the individuals are charged.

Staff provide input into treatment decisions at a weekly meeting, with final decisions the responsibility of the Psychologist and the Program Director. Various treatment modalities are used, including individual counseling, group therapy, and chemotherapy.

c. Program on Aging

The Program on Aging comprises nearly half of the patient population of Bangor Mental Health Institute and is housed primarily in Pooler Pavilion. This program holds a fairly unique position in the health care community due to its ability to provide active treatment to the mentally and physically ill elderly. The current program population consists of patients in the following major categories:

- 1) the older acute psychiatric patient responding to active treatment;

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- 2) the older chronic psychiatric patient requiring long-term treatment in a psychiatric program;
- 3) the older organically impaired patient requiring increasing amounts of nursing care throughout the progressive course of his illness and whose family requires a high degree of support;
- 4) the physically, chronically ill patient requiring a high level of nursing care and demonstrating secondary behavioral problems that are unmanageable in other long-term care settings.

The treatment planning is accomplished by a multidisciplinary team representing psychiatry, medicine, psychology, nursing, social work, recreation, occupational therapy, physical therapy, and chaplaincy. Treatment is provided by professional and paraprofessional program staff who have gained skills in treating older patients through formal training in the fields of gerontology, geriatric medicine, gerontologic nursing or have demonstrated skills acquired through experience. Staff receive ongoing education through case presentations on each ward, visiting lecturers, and training modules on aging in addition to the regular inservice education programs available through the BMHI Staff Development Office.

Treatment philosophy is eclectic and designed to meet the specialized physical, emotional, and social health needs of the aging. The eight wards, arranged along a functional continuum, utilize treatment principles drawn from milieu therapy. Group therapy conducted by a Ph.D. level clinical geropsychologist focuses on interpersonal and psychosocial processes and remediation of behavioral problems. Individual psychotherapy, psychological testing, marital or family counseling, and predischARGE therapy are also available.

Rehabilitation occurs as part of an ongoing therapeutic activity program, including music, art, and exercise therapy, gardening, swimming, bowling, woodworking, sewing, community trips, and current events in Gero-Forum. Occupational therapists provide group and individualized retraining for the mentally or physically handicapped or sensorially-impaired in a Home Living Skills program. A fully-equipped physical therapy area is run by a registered physical therapist and certified physical therapy aide. Chaplaincy services are available to residents on a regular basis. Socialization and reality orientation, in addition to activities of daily living and intensified psychiatric nursing, are provided by nursing staff and mental health workers. Three social workers are involved in resident discharge planning and family interactions. Volunteer workers are supervised within their responsible disciplines and socialize individually or in a group setting with residents.

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As a community service, the Program on Aging's geriatric screening team, consisting of a psychologist, social worker, and nurse supervisor, consults with health facilities, boarding homes, and individual families concerning the appropriateness for admission of the aging client.

The Program is accredited by the Joint Commission on Accreditation of Hospitals as an acute psychiatric program and certified by Maine's Department of Human Services as an Intermediate Care Facility.

d. Rehabilitation Services

Rehabilitation Services at the Institute include a number of direct service departments which have a significant impact on the patient's recovery and rehabilitation. These are:

1) Chaplaincy Services

The Chaplaincy Service participates in the total resident care concept by identifying and trying to meet the spiritual needs of each patient. Two full-time Chaplains, one Protestant and one Catholic, function as members of the treatment team. Services by the Chaplains include worship and sacraments, pastoral visits, consultation and pastoral counseling and pastoral care in crisis situations. The Chaplains also function as a link between the Institution and the community-at-large and serve as resource persons for church, civic, and educational organizations and for local clergy.

2) Health Sciences Media Center

The Health Sciences Media Center offers library and audio-visual services to all staff members of Bangor Mental Health Institute, its patients and, on special arrangements, to students and citizens of the local community. It is used primarily for staff education and reference questions pertaining to the mental physical and social health of Bangor Mental Health Institute patients as well as assisting in keeping the staff up to date in their fields and in forms of therapy. The Media Center is staffed by one full time librarian and one full time audio-visual specialist. Services provided through the Health Sciences Media Center include: collection of information on mental illness; circulation of all types of educational materials and equipment; selection of material and equipment to be purchased based on staff requests and available money; audio-visual services for video-taping programs and therapy sessions; reference services and literature searches to fill staff requests; interlibrary loan services; and current awareness services which keep staff informed of new developments in their stated fields of interest.

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3) The Learning Center

The Patient Education department along with the Patient Library comprises the Learning Center which provides learning and leisure resources to the clients of Bangor Mental Health Institute and offers education geared to the aptitudes, abilities, interests and needs of all youth and adults. The unit is based on the philosophy that education should:

- a) encourage an individual to strive toward his potential;
- b) better an individual's self image; and,
- c) make him more competent in a greater variety of skills.

The Learning Center is a "drop-in" center. Services offered are: Adult Education, Adult Basic Education, High School Equivalency, Special Education, Consumer Education, Title I, Library and a variety of supplemental mini-courses like Creative Writing, Clients' Newspaper, Independent Studies, Journal Writing and others, depending on patient needs. Academic instruction occurs on all levels on a one-to-one basis.

4) Occupational Therapy Department

Occupational Therapy is the evaluation and treatment of, or rehabilitation from, a mental or physical disorder through the involvement of the individual in goal directed activities.

After assessment, patients participate in a four-week long Activities of Daily Living (ADL) course which includes training in meal planning and preparation, job-seeking skills, housekeeping, money management, communication skills, as well as other skills required to be a participating member of the home and community.

In the Program on Aging, evaluations are conducted on all new admissions. The goal of the Home Living Skills Program is to assist residents in the Program on Aging in reaching their maximum potential by providing opportunities for sharing, cooperation, performance of tasks, reality testing, renewing former roles, sensory stimulation, and improving the ability to follow directions and make decisions. Individuals are involved in small groups with a focus on meal preparation, A.D.L. skills, and community experience.

5) Physical Therapy Department

Physical Therapy is a rehabilitative discipline utilizing physical agents including heat, cold, light, water, electricity, massage, therapeutic exercise and physical rehabilitation procedures designed

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to help the individual patient achieve the maximum independence within his capacity. Physical Therapy Department personnel work with disabled patients in all parts of the Institute on referral from staff and consulting physicians. Patients are evaluated and individual treatment goals and plans are written and carried out. Patients may be seen on the ward or in the department, individually or, when advantageous, in group sessions. Department personnel also act as resource persons for treatment teams and are available for consultation or educational services to staff, families, or community workers.

6) Therapeutic Recreation

Therapeutic Recreation is a highly diverse program designed to meet the specific needs of each individual patient. Program emphasis is placed on four areas:

- a) Highly structured, goal-oriented programming designed to assist the patient in attaining identified goals or needs. Examples are Arts and Crafts, Woodshop and Ceramics.
- b) Diverse programs, such as dances, movies, picnics, swimming, bowling, trips to circus or fair which allow the patient to feel confident outside the hospital environment.
- c) Programs conducted for patients who are not able to leave their units for any number of reasons. Examples are: movies, rhythm bands, and ice cream parties.
- d) Instruction in using leisure time constructively for patients who are preparing for discharge, in order to reduce the likelihood of readmission.

7) Volunteer Department Programs

Volunteers are utilized, to the extent possible, in those areas that interest them most. Examples of areas where volunteer services are used are: teaching academic or coping skills in the Learning Center; assisting with a sports program; running a library cart; one-to-one therapy with a patient; teaching sign language, swimming, arts and crafts, home economics, botany; green house skills; woodworking; dancing; music; bowling; hair styling; nursing; typing; patient newspaper; shopping; current events; and outdoor affairs.

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5. Staffing:

a. General Fund:

1) Positions authorized: 535

2) Positions filled September 1, 1981:

a) Full time: 504

b) Other positions: 1

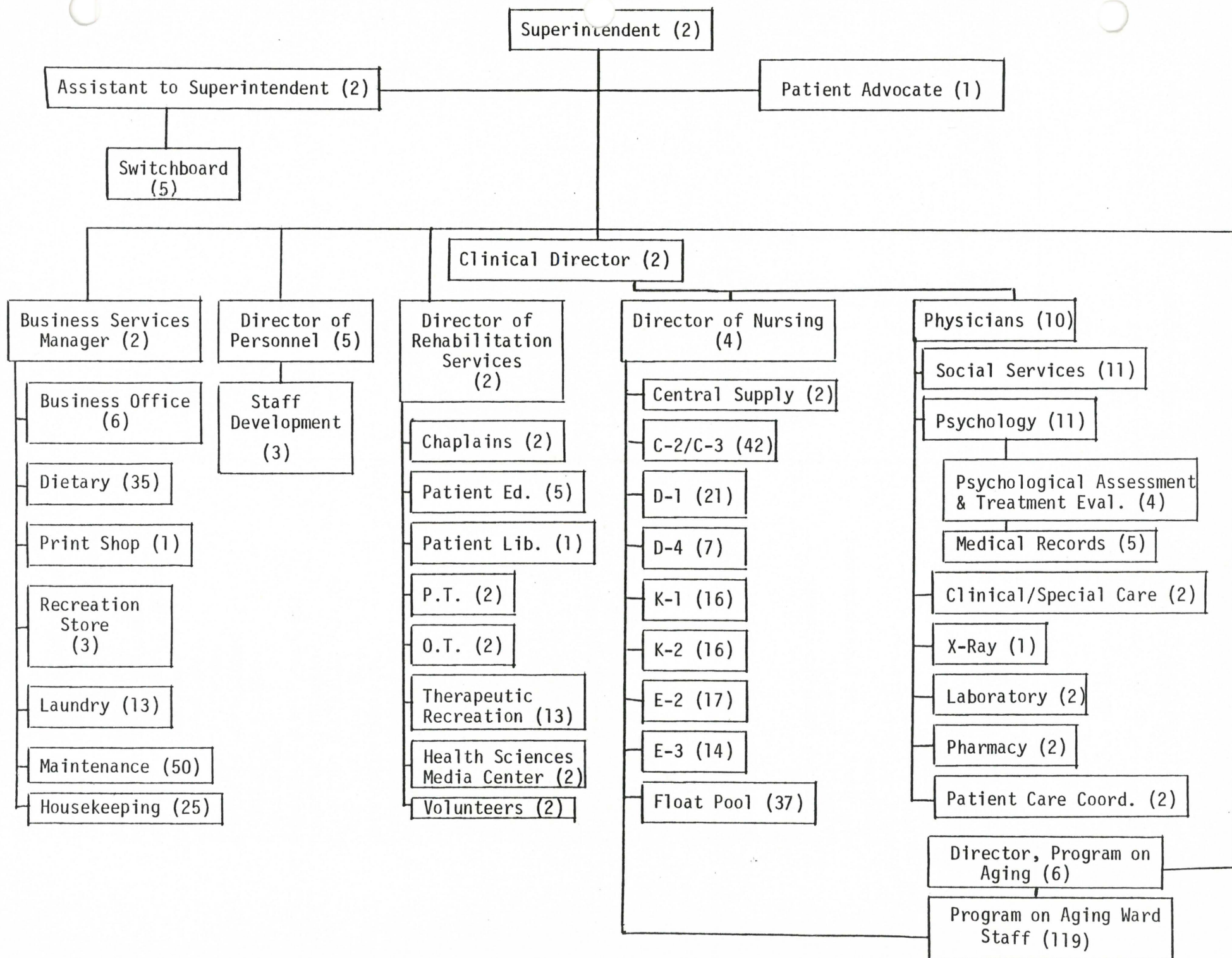
b. Other Funds (including vacant positions):

1) Full time: 2

2) Other positions: None

c. Organization:

(See next page)



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d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Accountant I	1		
Account Clerks I	2		
Account Clerk II	1		
Advocate	1		
Assistant to the Superintendent	1		
Automotive Mechanic	1		
Automotive Mechanic Foreman	1		
Baker II	1		
Barber	1		
Beautician	1		
Boiler Engineers	5		
Boiler Operators	5		
Business Manager I	1		
Carpenters	3		
Carpenter Foreman	1		
Chaplains I	2		
Chief Physical Therapist	1		
Chief, Volunteer Services	1		
Clerks II	2		
Clerk Stenographers II	5		
Clerk Stenographers III	9		
Clerk Typists II	7		
Clinical Director	1		
Cooks I	8		
Cooks II	5		
Cook III	1		
Custodial Workers I	28		
Custodial Workers II	7		
Data Entry Operator	1		
Dept. Personnel Officer I	1		
Director, Geriatric Services	1		
Director, Recreation	1		
Director, Social Services	1		
Electrician I	1		
Electrician Foreman	1		
Executive Housekeeper	1		
Food Service Manager	1		
Food Service Workers	8		
Furniture Repairmen	2		
Grounds and Equipment Foreman	1		
Heavy Equipment Operators	3		
Hospital Ward Clerks	11		
Institutional Clothing Supervisor	1		
Institutional Fire Marshall	1		
Institutional Business Manager	1		

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<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Laboratory Technician III	1		
Laboratory Assistant	1		
Laborers II	5		
Laundry Supervisor I	1		
Laundry Supervisor II	1		
Laundry Washman	1		
Laundry Workers I	7		
Laundry Workers II	3		
Librarian I	1		
Librarian II	1		
Licensed Practical Nurses	35		
Light Equipment Operators	4		
Maintenance Mechanics	4		
Maintenance Mechanic Foreman	1		
Masons	2		
Medical Records Technician	1		
Medical Secretary	1		
Mental Health Workers I	140		
Mental Health Workers II	59		
Mental Health Workers III	12		
Mental Health Workers IV	2		
Mental Health Workers VI	2		
Nurse I	1		
Nurses II	12		
Nurses III	12		
Nurses IV	2		
Nurse V	1		
Nutritionist	1		
Occupational Therapy Aides	4		
Painters	2		
Painter Foreman	1		
Personnel Technician I	1		
Pharmacist	1		
Pharmacy Clerk	1		
Physician I	1		
Physicians II	2		
Physicians III	5		
Physician Extenders	2		
Planning & Research Assistants	2		
Plant Maintenance Engineer I	1		
Plant Maintenance Engineer III	1		
Plumber I	1		
Plumber Foreman	1		
Psychiatric Social Worker Assts.	3		
Psychiatric Social Workers I	3		
Psychiatric Social Workers II	3		
Psychiatric Social Worker Supvr.	1		
Psychology Assistant	1		

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<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Psychologists II	2		
Psychologists III	6		
Psychologists IV	2		
Recreation Aides	8		
Recreation Therapists	2		
Reproduction Equipment Supervisor	1		
Seamstresses I	3		
Staff Development Coordinator	1		
Staff Development Specialist I	1		
Staff Development Specialist II	1		
Storekeeper II	1		
Stores Clerks	2		
Superintendent, Hospital	1		
Switchboard Operators	4		
Switchboard Supervisor	1		
Teachers	1	1	
Teacher Aide		1	
Teacher - Learning Disabilities	1		
Teacher - Supervisor	1		
Therapy Aide	1		
Therapeutic Specialist	1		
Volunteer Services Assistant	1		
Watchman	1		
X-Ray Technician	1		
Total	535	2	

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Bangor Mental Health Institute

Program Contact: Patricia T. Oulton, Superintendent

6. Financial Data:

a. Appropriation account #: 1355.1; 1355.9; 3355.1; 4355.1

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	7,593,909	9,582,840	9,561,055
Balance Forward	23,011	151,284	29,517
Transfers	1,140,960	63,500	63,500
<u>Federal Funds Available:</u>	28,182	47,336	61,338
<u>Dedicated Revenue:</u>			
Balance July 1	33,777	22,589	-0-
Revenue	22,518	8,375	1,300
Total Funds Available	8,842,357	9,875,924	9,716,710
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	7,649,286	8,321,166	8,504,171
Federal	24,447	16,788	61,083
Dedicated Account	21,275	1,602	1,300
Total Personal Services	7,695,008	8,339,556	8,566,554
<u>All Other:</u>			
General Fund	908,513	1,293,012	1,114,068
Federal	842	1,031	255
Dedicated Account	3,956	29,362	-0-
Total All Other	913,311	1,323,405	1,114,323
<u>Capital:</u>			
General Fund	37,356	183,446	35,833
Federal	-0-	-0-	-0-
Dedicated Account	8,475	-0-	-0-
Total Capital	45,831	183,446	35,833
<u>TOTAL FUNDS EXPENDED</u>	<u>8,654,150</u>	<u>9,846,407</u>	<u>9,716,710</u>
Undedicated Revenue to F.G.:	1,340,829	1,472,795	1,618,795

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Bangor Mental Health Institute

Program Contact: Patricia T. Oulton, Superintendent

7. Other Programs:

The Augusta Mental Health Institute is a state psychiatric hospital for southern Maine and has similar overall objectives to the Bangor Mental Health Institute.

The Division of Children's Services, Department of Mental Health and Mental Retardation, coordinates programming for the mental health needs of children.

The U.S. Veterans' Administration Center, Togus provides a 309 bed inpatient psychiatric hospital that includes alcohol and psychogeriatric programs to eligible veterans. It is the only non-State hospital that accepts emergency involuntary patients and those committed by the District Court.

The Aroostook Mental Health Center is a comprehensive mental health center that provides a wide range of mental health services throughout Aroostook County. It also provides pre-admission screening and on-site discharge planning for all patients referred to BMHI from Aroostook County through a cooperative agreement with the Institute. Its 10-bed inpatient program is housed at Fort Fairfield Community General Hospital and is a short-term unit.

The Community Health and Counseling Services is a comprehensive mental health center serving Hancock, Penobscot, Piscataquis, and Washington Counties, that provides a wide range of mental health services. It cooperates with the Institute in the areas of pre-admission screening and discharge planning through a cooperative agreement with the Institute.

The Eastern Maine Medical Center has a 22-bed inpatient unit which is an acute care unit that emphasizes short stays and reintegration into the community. The unit does not receive emergency involuntary admissions. The emergency room of EMMC is a frequent source of referrals to BMHI.

Additionally, there are a small number of community and hospital program throughout Northern and Eastern Maine with which the Institute works closely to ensure the continuity and coordination of services. None of these programs accept patients who are admitted involuntarily, who have been referred by the courts for evaluation and treatment, or who have been found not guilty by reason of mental disease. Essentially, patients referred to the Institute have exhausted all less restrictive alternatives, and referral to the Institute is the last resort.

8. Program Effectiveness:

Maintenance of Standards - The Institute continues to be accredited by the Joint Commission on Accreditation of Hospitals. The next survey by the Joint Commission is scheduled for April, 1982. The Program on

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Aging continues to be certified by the Department of Human Services as an Intermediate Care Facility under Title XIX, Maine's Medical Assistance Program. The last review of this program was in November, 1981, and the termination date of the provider agreement is February 28, 1982. Presently, there are 153 certified beds with a reimbursement rate of \$45.50 per day. Last year this program generated 1.2 million dollars of revenue for the General Fund.

Patient Treatment - All patients admitted to BMHI are thoroughly assessed in all aspects of functioning to determine their strengths and needs and referred to those programs which will best meet their needs and goals. A multidisciplinary review is completed on each patient within five working days of admission and conducted every 14 days for the first 90 days of hospitalization, and at least every 90 days thereafter. This review involves a discussion of the psychiatric, psychosocial, medical, nursing, and rehabilitative aspects of the formulated treatment plan. The results of this review and any revisions of recommendations are documented in the medical record, and must be approved by the psychiatrist. Each program is responsible for this process.

Continuity of Treatment - The Institute continues to maintain linkages and formal agreements with area hospitals and community programs to ensure continuity of care. Presently, 90 percent of all admissions from Aroostook County are screened by Aroostook Mental Health Center (AMHC) staff. In addition a staff member from AMHC comes to the Institute weekly to coordinate and discuss discharge plans with Institute staff and patients. This process has been an important factor in reducing the number of voluntary admissions to the Institute, and the rate of recidivism of patients from Aroostook County.

The Institute has a formal agreement with Community Health and Counseling Services (CH&CS) for the provision of pre-admission screening, discharge planning, and data-sharing. A new agreement has been negotiated to strengthen and enhance the service provided through the CMHCs to the more debilitated population served by BMHI.

The Institute continues to be affiliated with various training programs such as the nursing program at St. Joseph's Hospital, and the doctoral psychology program at the University of Maine. It maintains a service agreement with the Bureau of Vocational Rehabilitation.

Transfer and emergency service agreements are maintained with the following hospitals:

Blue Hill Memorial Hospital
Calais Regional Hospital
Castine Community Hospital

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Program: Bangor Mental Health Institute

Program Contact: Patricia T. Oulton, Superintendent

Down East Community Hospital
Eastern Maine Medical Center
Community General Hospital
Maine Coast Memorial Hospital
Mayo Memorial Hospital
Waldo County General Hospital
Penobscot Valley Hospital
Millinocket Community Hospital
Plummer Memorial Hospital
Mount Desert Island Hospital
St. Joseph's Hospital
James A. Taylor Osteopathic Hospital

Staff Training - For the period July 1, 1980, to June 30, 1981, 1736 staff participated in 3,377 hours of in-house staff development programs. Ninety-six staff participated in 857 hours of outside training. The goal has been to integrate and expand in-house staff development offerings with training needs of staff working in special program areas, as well as increase psychiatric training for the paraprofessional staff.

9. Future Plans:

Goals for the future include:

- a. Assure quality care through continued compliance with JCAH and DHS standards. The physical plant housing the program has undergone major renovation in the past few years, bringing it into compliance with current Joint Commission on Accreditation of Hospitals and Human Services (Medicaid) standards, on all but four wards. The second half of Pooler Pavilion is due to be renovated in fiscal year 1982. Planned capital improvements are:
 - 1) Increased accessibility for handicapped individuals of both the Pooler Pavilion and Main Building.
 - 2) Renovate the kitchen to fully comply with sanitary standards.
 - 3) Enhance the therapeutic environment by providing additional furnishings and remodeling as necessary.
 - 4) Improve the heating system in two buildings to help meet State Fire Marshall's requirements.
 - 5) Coordinate with the Bureau of Public Improvements to achieve maximum utilization of space by other state agencies.
- b. Continue to provide and improve the services required by patients and to pursue the development of rehabilitation programs.
 - 1) Initiate and complete a long-range planning process, to include a

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thorough assessment of the treatment needs and level of functioning of patients to determine the direction of future programs.

- 2) Develop a sheltered workshop program.
 - 3) Develop alternative living facilities on grounds.
 - 4) Recruit additional full-time psychiatrists.
 - 5) Develop other rehabilitation and skill-training programs based on patient needs assessment.
- c. Continue to manage the program in a manner which will improve the quality of care to patients.
- 1) Improve the goals and objectives process.
 - 2) Develop a written plan for professional services and staff composition.
 - 3) Establish procedures for the provision and monitoring of the amount of documented treatment provided to all patients.
 - 4) Refine the quality assurance program.
- d. Provide additional aftercare services to patients discharged from BMHI in order to avoid rehospitalization.
- 1) Advocate and develop resources for chronically mentally disabled persons in the community.
 - 2) Assist local agencies in the development of additional and new programs treating chronically mentally ill individuals.

Special attention will be given to improving the therapeutic environment and the development and refinement of rehabilitation programs. An unanswered question about the future is the extent to which cuts in social programs at the federal level will impact on admissions and the need for inpatient services. An expansion to meet increased demand would require the allocation of additional resources in order to maintain the quality of existing programs.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Mental Health Services

Program Contact: Michael J. DeSisto, Ph.D., Director, Bureau of Mental Health

1. Authorizing legislation or other program mandate:

a. Legal Citation:

34 M.R.S.A. § 12, Agreements with Community Agencies

34 M.R.S.A. § 2001, Creation and Purpose of the Bureau

34 M.R.S.A. § 2051, 2052, Community Mental Health Services

b. Other mandates:

34 M.R.S.A. § 2002, Duties of the Director of the Bureau

34 M.R.S.A. § 2003, Mental Health Advisory Council, Membership and Duties

34 M.R.S.A. 2052-A, Licensing of Mental Health Agencies

34 M.R.S.A. § 2104, Bureau of Community Service

34 M.R.S.A. § 2105, Community Residence for Mentally Ill Patients

P.L. 97-35, Omnibus Budget Reconciliation Act of 1981, 95 Stat. 357

2. Public Need:

The Report of the President's Commission on Mental Health (1978) estimated that 15% of the citizens of our country are in need of mental health services. Applying this percentage to Maine, an estimated 168,700 Maine citizens are experiencing mental health problems severe enough to require help or support. Indeed, this may be a conservative estimate for Maine. Traditional demographic indicators for mental disorder, including poverty levels and the prevalence of divorce and single-parent families, suggest that Maine's needs may be even higher.

Currently, community agencies supported by the Bureau of Mental Health serve about 40,000 persons per year. Although those agencies provide a wide range of mental health services to citizens of their catchment areas, recent literature, including the President's Commission (1978) and the Mental Health Systems Act (1980), has been critical of the services provided by the community mental health system to chronically mentally disabled persons. The Community Support Systems Project (Interim Report, 1979) has estimated that there are 5,000 persons in Maine meeting the federal definition of chronically mentally ill. Needs assessment conducted by the Project has shown that chronically ill individuals have significant unmet needs in the areas of supportive employment, supportive housing, socialization activities and psychosocial rehabilitation and educational services (Maine Mental Health Plan 1981-86, pp. 309-326). In

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short, available data supports the program's policy of considering chronically mentally ill persons a priority area of public need.

Both state and national planning efforts have recognized the need for access to mental health services for the elderly. In Maine, there are now 186,000 people over the age of sixty, or 16.9% of our population. Approximately 7.7% of Maine's elderly reside in nursing home facilities. Many other aged persons live in boarding homes or in isolated circumstances with limited access to mental health services.

The Maine Mental Health Plan, 1981-86, has adequately outlined the need for mental health services for severely emotionally disturbed children and their families. The increasing mobility and instability of families and increasing rates of juvenile crime, juvenile substance abuse and adolescent suicide all suggest a re-emphasis and re-direction of effort in this area.

3. Program Objectives:

The primary objective of the community mental health services program is the direction and management of available financial resources to meet public mental health needs. Associated objectives are:

- a. Development and maintenance of an equitable system for allocation of community mental health service dollars in accordance with documented need and Bureau priorities.
- b. Re-direction of mental health services to meet the needs of the chronically mentally ill population. Specifically, a 10% re-direction of dollars in FY 82 and 5% in each of FY 83 and FY 84.
- c. Maintenance of planning and program development efforts in the area of mental health services for elderly persons and seriously emotionally disturbed children.
- d. Development and maintenance of a monitoring, auditing and reporting system to identify trends in need and service delivery areas, to assess the efficacy of use of public funds, and to monitor the development of services to priority populations. Specifically, there should be at least two on-site monitoring visits per year to comprehensive providers (CMHC's) and one on-site audit per year to single-service providers, in addition to ongoing office-based contract control activities.

4. Program Operation:

The Director of the Bureau of Mental Health is statutorily responsible for the promotion and guidance of mental health programs within the several communities of the State. Operationally, the Director, with the advice of the Governor's Mental Health Advisory Council, sets funding policies for the community mental health services program by review of mental health literature,

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analysis of national and state trends in public need and service delivery models, review of performance of prior community mental health contracts, assessment of input from providers and consumers, and consideration of the amount and capacity of available financial resources. The policies are translated by the Director and Field Operations Manager into a clear statement of program funding priorities, allocation formulas, service definitions and requirements, narrative guidelines and data requirements. This statement is known as the Mental Health Request Package. The package is published and distributed to community agencies and is the basis for their request to the Bureau for funding.

The Field Operations Manager is responsible for communicating Request Package guidelines to providers, answering questions and generally assisting agencies in their preparation of proposal packages. All request package proposals are reviewed and evaluated by an intra-departmental team under the direction of the Field Operations Manager. Results of this evaluation and funding recommendations are reported to the Director and the Associate Commissioner for Administration, who together set grant awards. Those awards are communicated to service agencies and the program impact of funding decisions is assessed and unit of service levels established. On the basis of these decisions, the Field Operations Manager writes contracts for services. Funding decisions are also analyzed by the Field Operations Manager for compliance with stated funding policies and priorities.

Several small agency single-service providers are not subject to all of the requirements for proposal submission contained in the Request Package because such requirements would be too cumbersome to the administrative capacity of the agencies and not appropriate to the amount of funding involved. Such agencies are asked to submit briefer program narratives and budget packages. For new program areas where the provider is unknown or where there are competing providers, proposals may be generated through a request-for-proposal format. Proposals are evaluated, funding decisions made and contracts written in the same manner as described above.

Monitoring of community mental health service contracts is effected through review and analysis of data on revenues and expenses, types and amounts of service delivered, and client demographic data reported by providers as prescribed in the Request Package. This data is initially collected and summarized by a Management Analyst in the department's Accounting Division. Analysis and reporting of fiscal and service data is done by the Management Analyst and Field Operations Manager. On-site monitoring visits are also done by the above staff to ensure the integrity and consistency of data reported. Licensing site visits conducted under the direction of the Bureau's Director of Licensing also provide important information on service quality and contract compliance. The Bureau Director, Field Operations Manager, and Management Analyst participate in licensing visits on a rotating basis and licensing reports are reviewed. Reports of all data are prepared for the Bureau Director and corrective action decided upon by him for implementation by the Field Operations Manager.

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Program Contact: Michael J. DeSisto, Ph.D., Director, Bureau of Mental Health

For FY 1982, \$4,654,359 was awarded to the seven Maine community mental health centers plus the nine human service agencies under the aegis of the Area V Mental Health Board. Additionally, \$500,625 was allocated statewide to thirteen single-service providers.

5. Staffing:

a. General Fund:

1) Positions authorized: 4

2) Positions filled Sept. 1, 1981:

a) Full time: 4

b) Other positions: None

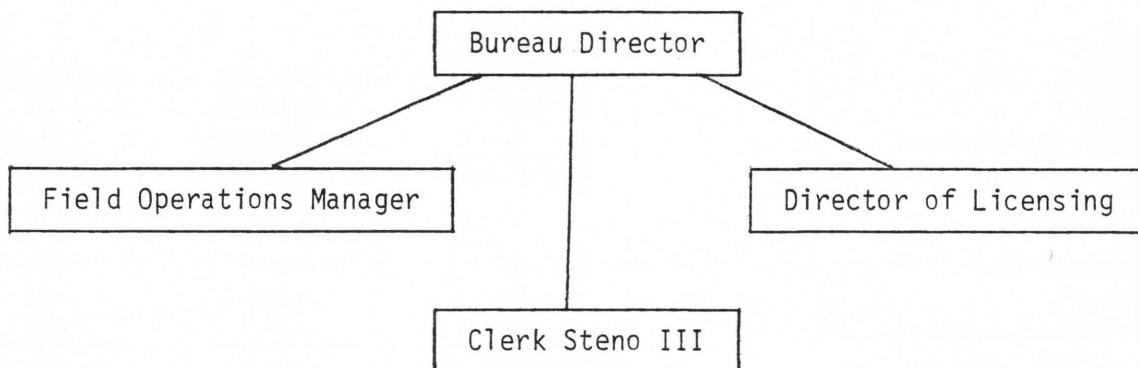
b. Other funds (including vacant positions):

1) Full time: None

2) Other positions: None

c. Organization:

All staff of the Bureau of Mental Health's Central Office relate to the community mental health services program and are shown on the following organizational chart:



d. List of Positions:

(See Bureau of Mental Health Administration)

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Program Contact: Michael J. DeSisto, Ph.D., Director, Bureau of Mental Health

6. Financial Data:

a. Appropriation account #: 1340.2; 4340.2; 9340.2

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G. F. Appropriation:</u>	4,717,906	5,154,984	5,001,491
<u>Federal Funds Available:</u>	-0-	1,609,956	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	89,000	574,656
Total Funds Available	4,717,906	6,853,940	5,576,147
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	-0-	-0-	-0-
<u>All Other:</u>			
General Fund	4,669,489	5,154,984	5,001,491
Federal	-0-	1,609,956	-0-
Dedicated Account	-0-	89,000	574,656
Total All Other	4,669,489	6,853,940	5,576,147
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	-0-	-0-	-0-
<u>TOTAL FUNDS EXPENDED</u>	<u>4,669,489*</u>	<u>6,853,940</u>	<u>5,576,147</u>
Undedicated Revenue to G. F.:	-0-	-0-	-0-

*Costs for the four staff reflected in the chart are not included. Those costs are shown in the Bureau of Mental Health, Administration, justification report.

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Program: Community Mental Health Services

Program Contact: Michael J. DeSisto, Ph.D., Director, Bureau of Mental Health

6. Financial Data (continued):

As described in Section 4, general fund appropriations for 1981-1982 in the All Other category are allocated to the seven Maine community mental health centers, the nine human service agencies under the aegis of the Area V Mental Health Board and to thirteen single-service providers. Such funds purchase emergency mental health services, community inpatient services, comprehensive outpatient services, community residential, community support, and day treatment services directed primarily at chronically ill persons, consultation and education services and forensic services.

Reflected under Federal Funds Available are revenues expected from federal block grants under the administration of the department. Funding decisions regarding these revenues have not yet been made.

7. Other Programs:

- a. Title XX (Medicare) Program, DHS: Title XX administers contracts for aftercare, day treatment and other mental health services for clients meeting their income and other eligibility criteria. The Bureau of Mental Health provides input into the development of service contracts.
- b. Title XIX (Medicaid) Program, DHS: Title XIX funds community support services for aftercare clients meeting their eligibility criteria. The Bureau of Mental Health provides input into the development of regulations as well as the licensing and certification of service providers.
- c. As of September 1, 1981, the New England Regional Office of Alcohol, Drug Abuse and Mental Health Association administers two mental health center operations grants and several consultation/education and distress grants in Maine. (This administrative responsibility will shift to the State under the block grant system.)
- d. Office of Children's Services, DMHMR: Provides planning and program development services to meet the needs of emotionally disturbed children and adolescents. The Office of Children's Services advises the Bureau of Mental Health on funding decisions concerning children's programs.
- e. Community Support Systems Project, DMHMR: As a federally funded project, CSSP provides planning and program development services to meet the needs of chronically mentally ill persons and advises the Bureau of Mental Health on funding decisions concerning that client population.

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Program: Community Mental Health Services

Program Contact: Michael J. DeSisto, Ph.D., Director, Bureau of Mental Health

- f. Governor's Mental Health Advisory Committee: Advises the Bureau Director on planning and guidance of community mental health programs throughout the state.

8. Program Effectiveness:

- a. The development and maintenance of an equitable system of fund allocation must be considered an ongoing objective. The program must be continually responsive to changes and trends in public need and developments in service delivery. Presently, our accomplishment of this objective is evidenced by praise for the system in the Minutes of the Executive Committee of the Mental Health Advisory Council (August 6, 1981) and by informal comments by several agency directors.

Each fall, the Bureau canvasses service contractors and consumer groups for recommendations in updating and improving the Mental Health Request Package. Those comments are reviewed and incorporated with staff information and opinions to generate an updated Request Package annually.

- b. Significant redirection of funds toward services for chronically mentally ill persons has been accomplished for FY 82, as shown by the following table:

CMHC COMPARATIVE SERVICE ARRAY -- FY 82--FY 81					
<u>CATEGORY</u>	<u>FY 82</u>	<u>FY 82 %</u>	<u>FY 81</u>	<u>FY 81 %</u>	<u>% INCREASE (DECREASE)</u>
Emergency	\$ 425,962	9.1	\$ 303,389	6.6	2.5
Inpatient	242,245	5.2	429,660	9.3	(4.1)
Comm. Residential	249,758	5.4	415,430	9.0	(3.6)
Comm. Support	1,301,694	28.0	832,225	18.0	10.0
Day Program	436,304	9.4	273,880	5.9	3.5
Outpatient	1,444,742	31.0	1,632,956	35.3	(4.3)
C & E	468,179	10.1	629,476	13.6	(3.5)
Forensic	85,475	1.8	107,512	2.3	(0.5)
Total	<u>\$4,654,359</u>	<u>100.0</u>	<u>\$4,624,528</u>	<u>100.0</u>	<u>-0-</u>
	Increase in funding FY82 <u>29,831</u>				
	<u>\$4,654,359</u>				

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Program Contact: Michael J. DeSisto, Ph.D., Director, Bureau of Mental Health

In summary, funding for services primarily directed at the chronically ill target population (Community Residential, Community Support and Day Program) are increased by 9.9% of Bureau of Mental Health monies from FY 81.

The actual 9.9% shift is close to the Bureau's objective of a 10% increase in services to chronically mentally ill individuals (Community Residential, Community Support and Day Program). The Bureau plans to direct another 5% of community mental health service funds to chronically mentally ill persons in each of FY 83 and FY 84. Further development of funding priorities will depend on needs assessment conducted at that time.

- c. Although several agencies funded by this program provide services to elderly persons in need, much remains to be done to address those needs. Increases in funding for community support services in the current fiscal year have enabled community mental health centers to expand their involvement in boarding homes. This expansion has taken the form of direct supportive services as well as consultation and education services to home operators and others involved in the care of older citizens. As stated in the Maine Mental Health Plan, the Division of Planning of the Department and the Maine Bureau of Elderly, Department of Human Services, will begin joint planning efforts in the next year to develop specific program development proposals for Bureau consideration in FY 1983.
- d. Under the rubric of outpatient services, several community mental health centers provide mental health services to disturbed children and their families. Further, several small agencies funded by the Bureau provide assessment, supportive services, therapeutic foster homes, shelters for troubled families and other related services. Nevertheless, there is a need for expanded program development in this area. The Maine Mental Health Plan has identified the need for the development of "homebuilder" programs characterized by intensive, problem-specific, time-limited mental health counseling delivered in the child's home or other natural setting. The Bureau of Mental Health has committed itself to the development of at least one such program in this fiscal year out of block grant revenues and will continue to support the development of such family-oriented services in the future.
- e. The objective of development of a monitoring and auditing system has been minimally achieved. The reporting system is in place and appropriate data from service providers is being generated. However, the Bureau now lacks the administrative capacity to comprehensively analyze that data and conduct necessary on-site monitoring activities and a full range of office-based data analysis and contract control activities. Presently, the Bureau is able to visit comprehensive service providers once per year and single-service providers do not routinely receive contract monitoring visits.

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Program: Community Mental Health Services

Program Contact: Michael J. DeSisto, Ph.D., Director, Bureau of Mental Health

Particularly with the advent of block grant administrative responsibility, it will be necessary to add staff to responsibly accomplish this objective.

9. Future Plans:

Program objectives and funding policies will continue to be updated to reflect changes in public need and trends in service delivery. We would expect to expand public input into the development of those policies. Although we will be responsive, we do not plan to change our objective of emphasizing services to chronically mentally ill persons and encouraging new initiatives in serving that population.

We expect to expand the base of services throughout the state by providing funding support to single-service provider agencies not traditionally funded through federal channels. We also expect to encourage consumer groups interested in developing community residential and other chronic care services in their communities.

The Bureau must expand its administrative capacity to meet both present and future objectives. Currently, the National Institute of Mental Health administers fourteen mental health service contracts in Maine. Under block grants, administrative responsibility for those services will shift to the Bureau. This increase in dollars for which the Bureau will be responsible, together with the planned expansion of the number of agencies with which we have a contractual relationship, will require monitoring staff as well as some additional planning and resource development capacity.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Mental Health Advisory Council

Program Contact: Thomas J. Kane, DSW, Chairman

1. Authorizing legislation or other mandate:

a. Legal citation:

34 M.R.S.A. § 2003 Mental Health Advisory Council (Membership and Duties)

b. Other mandates:

P.L. 94-63, 42 United States Code § 2689, et. seq. (Community Mental Health Centers Act)

34 M.R.S.A. § 2001 (Creation and Purpose of the Bureau of Mental Health)

34 M.R.S.A. § 2002 (Duties of the Director of the Bureau)

34 M.R.S.A. § 2051 (Community Mental Health Services)

2. Public Need:

The Council provides citizen contribution to the identification of needs, resources, goals and objectives for the Mental Health System. There are thirty (30) members appointed by the Governor to represent both the consumer and provider communities. The council mechanism allows the opportunity for many Maine citizens to:

- a. Review departmental policy and plans to assure that they are consistent with the needs and wishes of Maine people;
- b. Consider solutions to mental health problems which are impacted by socio-demographic and economic conditions within the state;
- c. Consider the cross cutting areas between the mental health system and the corresponding health, human service and educational systems; and
- d. Advise the department relative to the capital construction of mental health care facilities.

3. Program Objectives:

- a. To assist the Department of Mental Health and Mental Retardation in the development and direction of mental health services;
- b. To assist in the implementation of a comprehensive community mental health system through the use of subcommittees. The purpose of the subcommittees is to conduct client and system needs assessments and then make recommendations to the full Council based upon their findings. Areas targeted for subcommittees assignment are the mental

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Mental Health Advisory Council

Program Contact: Thomas J. Kane, DSW, Chairman

health needs of the following client population:

- Children
- Elderly persons
- Physically handicapped persons
- Chronically mentally ill persons
- Families in crisis

- c. To support passage of department legislation designed to improve the mental health service delivery system; and
- d. To sponsor public forums on mental health needs of Maine citizens.

4. Program Operation:

- a. The Governor's Mental Health Advisory Council meets monthly to discuss matters of departmental policy and broad program issues. Representatives from the department, including the Commissioner, staff from the Bureau of Mental Health and the Planning Division meet with the Council to present plans, issues, concerns and to discuss these matters with Council members. The Council reviews, recommends and subsequently approves the State Mental Health Services Plan as drafted by the department.
- b. The subcommittees meet as necessary to develop proposals or positions in their respective areas and present them to the Council and the department for appropriate action.
- c. The Council reviews departmental legislation and support is communicated to the Executive and Legislative branches of State government.
- d. The Council sponsors public forums throughout the state in conjunction with the community mental health centers and the department for interested citizens to express concerns and needs in the area of mental health service delivery.
- e. In the event of a vacancy in the position of the Commissioner or Director of the Bureau of Mental Health, the Council advises the appointing authority regarding qualifications of potential candidates. Council members also participate on selection committees for the appointment of mental health institutional superintendents.
- f. The Council sponsors an annual Distinguished Service Award given to an individual who has made outstanding contributions to the mental health system. In addition, through the Maine Good Practices Project, awards are also given to outstanding mental health programs.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Mental Health Advisory Council

Program Contact: Thomas J. Kane, DSW, Chairman

5. Staffing:

a. General Fund:

1) Positions authorized: None

2) Positions filled September 1, 1981:

a) Full time: None

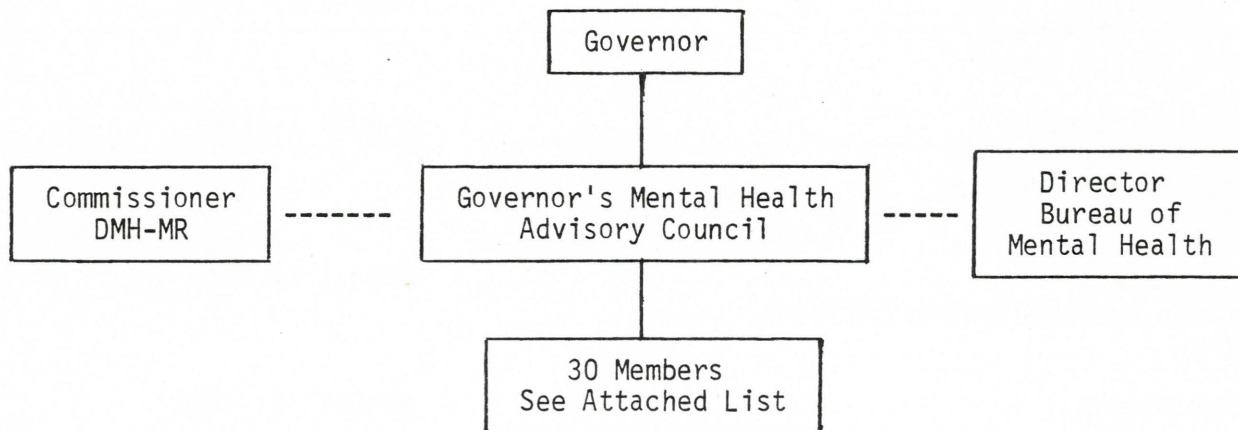
b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: None

2) Other positions: None

c. Organization:



d. List of positions:

None

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Mental Health Advisory Council

Program Contact: Thomas J. Kane, DSW, Chairman

MEMBERS

Providers

Term Expires

Alan Elkins, M.D.
Chief of Psychiatry
Maine Medical Center

June 15, 1983

Thomas Kane, D.S.W.
Executive Director
York County Counseling Services

June 15, 1983

Walter Rohm, M.D.
Chief of Psychiatry
Togus V.A. Hospital

June 16, 1982

William Barnum, M.D.
Director, Mid-Coast
Mental Health Center

August 26, 1984

Donald Chamberlain
Assistant Director of
Mental Health Services
Aroostook Mental Health Center

August 1, 1983

Wayne Walker
Diocesan Human Relations Services
Bangor

August 1, 1983

George Nieman
Executive Director
Bancroft North

August 16, 1982

Alan Boufford
Augusta Mental Health Institute

August 26, 1984

Jane Weil
Outreach Project Director
Washington County Children's Program

June 15, 1983

Adair Heath, M.D.
Child Psychiatrist
Maine Medical Center

April 9, 1983

Consumers

Marcel Morin, Lewiston

June 15, 1983

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Mental Health Advisory Council

Program Contact: Thomas J. Kane, DSW, Chairman

MEMBERS (continued)

<u>Consumers</u>	<u>Term Expires</u>
John Ballou, Esq., Bangor	June 15, 1983
Robert Morrell, Brunswick	June 16, 1982
Mrs. William Haggett, Bath	June 18, 1982
Amory Houghton, III, Cape Elizabeth	August 26, 1984
Catherine Cutler, Bangor	August 26, 1984
Louise "Jackie" Mahaney, Bangor	August 26, 1984
Virginia Hewes, Saco	August 16, 1983
Priscilla Taylor, Camden	August 16, 1983
Carol D. Stewart, Presque Isle	August 26, 1984
Joel Croteau, Biddeford	April 9, 1983
Arthur Levine, Esq., Waterville	August 26, 1984
Frances Seaman, Waterville	August 16, 1982
Patricia Carignan, Cape Elizabeth	August 26, 1984
Penny Brown, Cumberland Foreside	August 26, 1984
Elaine McCaslin, Waterville	August 26, 1984
Joan Fortin, Cumberland Foreside	August 6, 1983

NOTE: There are currently three vacancies on the Advisory Council.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Mental Health Advisory Council

Program Contact: Thomas J. Kane, DSW, Chairman

6. Financial Data:

a. Appropriation account #: 1340-1041

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriations:</u>	-0-	-0-	-0-
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	-0-	-0-	-0-

	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	-0-	-0-	-0-
<u>All Other:</u>			
General Fund	3,539	2,400	2,400
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	3,539	2,400	2,400

<u>Capital</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	-0-	-0-	-0-
 TOTAL FUNDS EXPENDED	 <u>3,539</u>	 <u>2,400</u>	 <u>2,400</u>

Undedicated Revenue to G.F.:	-0-	-0-	-0-
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DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Mental Health Advisory Council

Program Contact: Thomas J. Kane, DSW, Chairman

7. Other Programs:

The Council advises the department in areas of general policy and is concerned with the same range of programs as the Bureau of Mental Health; however, it is the only program which is specifically charged to assist the State Mental Health Authority in determining the future direction of mental health services.

The Governor's Commission on Mental Health Manpower Development has a specific mandate to identify and address problems relative to mental health manpower as opposed to the Council's involvement in the overall development and direction of mental health services. A council member is appointed to the commission to provide necessary representation.

8. Program Effectiveness:

- a. The Council reviewed and approved the Department of Mental Health and Mental Retardation's annual Mental Health Plan. This plan outlined the existing service delivery system and the goals and objectives for the coming year. The Council's subcommittees assisted in the development of this plan.
- b. The subcommittees reflect current directions in mental health service delivery and resource allocation. As the State Mental Health Authority assumes more of the functions formerly carried out by the federal government, development of criteria for grant awards, standards for program monitoring, and other related activities become increasingly important. The expertise and community orientation of the subcommittees and the ability of the Council to organize itself in response to system needs is reflected in the make-up of individual committees.
- c. The Council actively supported successful legislation calling for the creation of a separate Department of Corrections, for the Federal Mental Health Services Act and the State patient bill of rights.
- d. During March 1981, more than three-hundred (300) citizens attended nine (9) meetings entitled "The Community Meeting - where your opinion counts" across the state to talk with members of the Council and representatives of the department about their concerns and needs in the area of mental health. Fourteen (14) general areas of concern emerged, with a variety of specific comments in each; a summary of the meetings was compiled and circulated to interested persons throughout the system.
- e. Several Council members participated in the selection process to choose a replacement for the Superintendent at the Bangor Mental Health Institute. They were part of the Committee that reviewed applications, interviewed candidates and made recommendations to the Commissioner for his final decision.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Governor's Mental Health Advisory Council

Program Contact: Thomas J. Kane, DSW, Chairman

9. Future Plans:

As the role of the Bureau of Mental Health expands to meet the essential service needs of unserved and underserved populations, the role of the Governor's Mental Health Advisory Council will also expand. New committees will be formed to address the problem of dwindling resources while promoting services which will do the most good for the most people.

The tasks of the Bureau will increase as the department begins to administer federal funds through block grants. The Governor's Mental Health Advisory Council will help the Bureau target where resources should be allocated, how funding decisions will be made and how a monitoring system will be developed to further assure accountability for public dollars.

The subcommittee process will permit individual council members greater opportunity to become better informed and to collectively translate the learning process into more appropriate full Council recommendations to the department.

The Council will be involved in the development and passage of legislation, review of bureau policies and procedures, and regulations required to responsibly administer state and federal funds.

DE

MENTAL HEALTH AND MENTAL RETARDATION

Program: Adminis Bureau of Mental Retardation

Program Contact: Ronald S. Welch, Director

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. § 2601 (Declaration of State Policy)

34 M.R.S.A. § 2611, et. seq. (Bureau of Mental Retardation)

34 M.R.S.A. § 2631 et. seq. (State-Operated Facilities for Mentally Retarded Persons)

34 M.R.S.A. § 2641 et. seq. (Rights of Mentally Retarded Persons)

34 M.R.S.A. § 2651, et. seq. (Process for Provision of Mental Retardation Services)

34 M.R.S.A. § 2141 et. seq. (Rights of Mentally Retarded Persons)

18-A M.R.S.A. § 5-301 et. seq. (Guardianship for Incapacitated Persons)

b. Other mandates:

22 M.R.S.A. §§ 7904 (Fire Safety Inspections)

22 M.R.S.A. § 1811 (Licensing of Hospitals and Institutions)

25 M.R.S.A. § 2701 et. seq. (Construction for Physically Disabled Persons)

32 M.R.S.A. § 2258-A (Administration of Medications)

Rehabilitation Act of 1973, 29 U.S.C. § 700, et. seq.

Education for all Handicapped Children Act, 20 U.S.C. § 1401, et. seq.

Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6001, et. seq.

Title I, Education Act of 1965, 20 U.S.C. §§ 236, et. seq., 241, et. seq. and 821, et. seq.

Social Security Act (including Title XVIII Medicare, Title XIX Medicaid and Title XX, Grants for Services), 42 U.S.C. §§ 1395, et. seq.

Wuori, et. al. v. Concannon, et. al., No. 75-80 P (D. Maine, 1978)

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Bureau of Mental Retardation

Program Contact: Ronald S. Welch, Director

2. Public Need:

The Maine Legislature, in 1969, established the Bureau of Mental Retardation as a constructive response to the concerns of many parents and families of retarded children and adults. The concerns were based on the difficult experiences of many families in their attempts to find even basic services for their retarded relatives, short of placing them in state institutions away from their home and families.

The focus of the Bureau's responsibilities has been assuring the availability of services for retarded children and adults which foster growth and independence, while maintaining an opportunity for family and community life. Historically, mentally retarded people had been denied the possibility of such a life, and either warehoused in large institutions or cared for at home, often to the point of destruction of the entire family. The establishment of the Bureau of Mental Retardation constituted a major change in direction by mandating the new bureau to work toward the creation of a community system of services which would complement services provided at the Pineland Center.

There are some 30,000 or more mentally retarded children and adults in Maine. Most of these individuals have special needs in education, training, care and treatment that cannot be met by society's provisions for normal children and adults. This number does not reflect the much larger number of persons, i.e. parents, relatives, friends, neighbors, who are in some way affected by the inherent problems of caring for a retarded person.

The limits of mental retardation range from mild or educable retardation, which encompasses the greatest numbers of persons, to severe and profound retardation, which, although representing fewer people, presents the most problems (multiple physical and sensory handicaps, intractable behaviors and difficult medical conditions). At the Bureau's institutions, Pineland Center and the Elizabeth Levinson Center, the great majority (95%) of the residents, and of the many requiring admission, are severely and profoundly retarded.

Relative to many other states, Maine has a considerably smaller percentage of its total state population placed in state institutions for the retarded. In a recent national study, Maine ranked number three in the nation in having the smallest percentage of institutionalized people. This low rate of institutionalization is possible as a result of a legislative mandate that the Bureau of Mental Retardation meet the needs of retarded people in homes and communities throughout Maine. The regional or community-based programs of the Bureau currently serve over 2,100 mentally retarded children and adults across the State. In addition, an annual average of 300 new clients are referred to the Bureau of Mental Retardation often from family situations in which a retarded person has been cared for at home by parents or relatives who are simply too old or physically unable to carry that burden.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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Program Contact: Ronald S. Welch, Director

The majority of these people do not require institutional care, but do need the services of the Bureau's community programs to find an alternative living arrangement which allows for continued family involvement and support without the overwhelming pressures of providing 24-hour care.

Institutional services for the most handicapped of retarded people will continue to be a responsibility appropriately provided by the public sector. In order to assure that only those who truly need this service do in fact receive it, all admissions and discharges from the state institutions are processed through the regional community-based offices of the Bureau. There is currently a waiting list for appropriate (i.e., court certified) admissions to Pineland Center. Generally, however, the need is becoming less and less for long-term care and more for short-term evaluation and diagnosis, short-term behavior stabilization and training, and for various outpatient services.

3. Program Objectives:

The primary objective of the Bureau of Mental Retardation is to assure that mentally retarded persons are linked to services that address their individual needs. To this end, the Bureau is responsible for:

- a. The supervision of mental retardation programs within Pineland Center, Elizabeth Levinson Center and Aroostook Residential Center;
- b. Ensuring that mentally retarded persons residing in community residential facilities are provided with, insofar as possible, residential accommodations and access to habilitation services appropriate to their needs;
- c. The planning, promotion, coordination and development of a complete and integrated statewide system of mental retardation services;
- d. Serving as liaison, coordinator and consultant to the several state agencies in order to develop the statewide system of mental retardation services;
- e. Serving as guardian and/or conservator for mentally retarded individuals who are adjudicated by a probate court as being incompetent and who have no family/friends willing and/or able to assume guardianship responsibilities;
- f. Management of the Grant-in-Aid program for community based services;
- g. Development of additional resources from multiple sources to meet client needs; and
- h. Protection of clients' rights by assuring that appropriate services are delivered through the process required by statute.

Program: Administration, Bureau of Mental Retardation

Program Contact: Ronald S. Welch, Director

4. Program Operation:

The Central Office staff management team provides consistent and comprehensive policy direction of all bureau programs to ensure that the needs of mentally retarded persons are met in an effective and efficient manner. Regional administrators and institutional superintendents have considerable decision-making authority to allow quick and appropriate action at the local level. However, the administrative actions of these managers are carried out within the planning and policy framework established by the director and the Central Office management staff. Under the supervision and management of the director, the bureau's administrative staff, regional administrators and institutional superintendents meet to:

- a. Review the status of compliance with state and federal mandates;
- b. Address key policy issues relative to the optimal use of existing resources;
- c. Examine the coordination efforts between the institutions and community programs;
- d. Develop strategies for the development of additional services;
- e. Discuss problems that arise in specific institutions or regions; and
- f. Review the financial status of the various bureau programs.

The director also works with the Central Office administrative staff on a daily basis on policy issues and cooperative approaches with other state agencies whose programs directly affect the bureau's objectives. The results of these efforts are discussed in detail at monthly meetings with key administrators. Central Office staff maintains working relationships with their counterparts in other state agencies on an ongoing and/or project basis. The director and designated staff personnel also meet in individual work sessions with gubernatorially appointed committees, provider coalitions and consumer and advocacy groups to discuss fiscal, programmatic and policy issues.

The bureau's field operations manager coordinates with the regional and institutional social services supervisors and individual program planning coordinators to assure a streamlined and consistent flow of services to those mentally retarded people served by the bureau. The internal functions of the bureau's case management system, admissions to the state institutions and other client related issues are discussed and resolved at monthly work sessions. Additionally, the field operations manager monitors goals and objectives established quarterly for each region to assure compliance with state and federal mandates. This mechanism also provides state level supervision for overall regional activities.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Bureau of Mental Retardation

Program Contact: Ronald S. Welch, Director

The resource development manager works closely with regional resource developers in order to:

- a. Develop statewide strategies and plans to obtain services to meet documented clients' needs; and
- b. Establish and implement appropriate evaluation systems to ensure quality services.

An additional responsibility of the bureau is to negotiate with federal funding sources for new financial resources.

The Bureau manages an extensive Grant-in-Aid program. While individual grants are negotiated at the regional level, all planning for and administration of the grant program is directly under the responsibility of the director. A management analyst II serves as chief advisor to the director relative to the grant program. He also lends his expertise to the many non-profit agencies in the community and to the regional administrators relative to fiscal management issues.

The guardianship program manager has responsibility for the public guardianship of 384 bureau clients. All aspects of the client's life become the concern of the bureau and the regional office staff. All funds are received, expenditures approved and records maintained by Central Office staff. In addition, the bureau is designated as the representative payee for the receipt of funds on behalf of clients who are receiving social security, veteran's benefits and/or railroad retirement benefits. These designations occur when family members or guardians are not willing to assume control of the individual's finances.

5. Staffing:

a. General Fund:

1) Positions authorized: 7

2) Positions filled Sept. 1, 1981:

a) Full time: 7

b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: None

2) Other positions: None

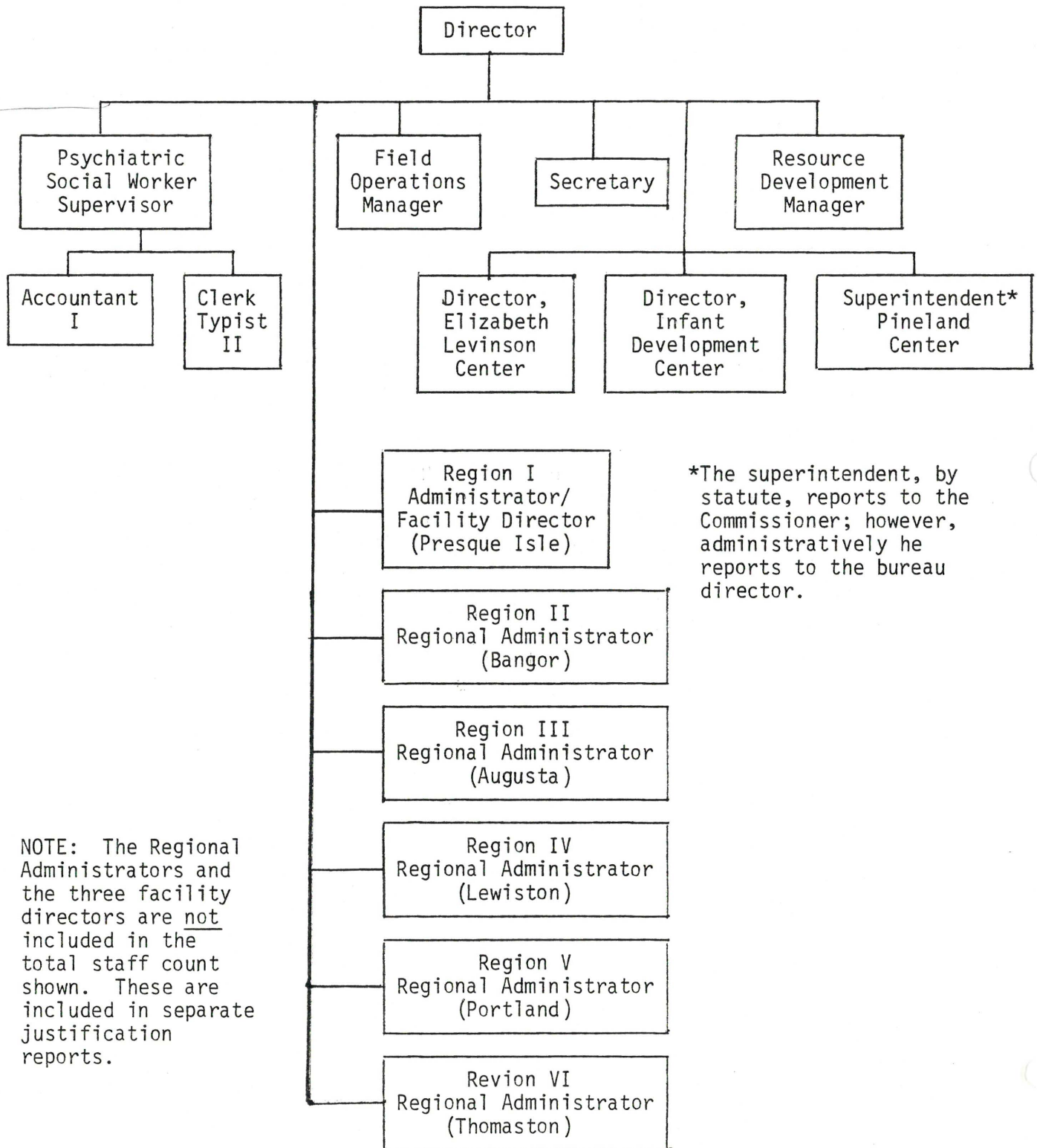
c. Organization:

(See next page)

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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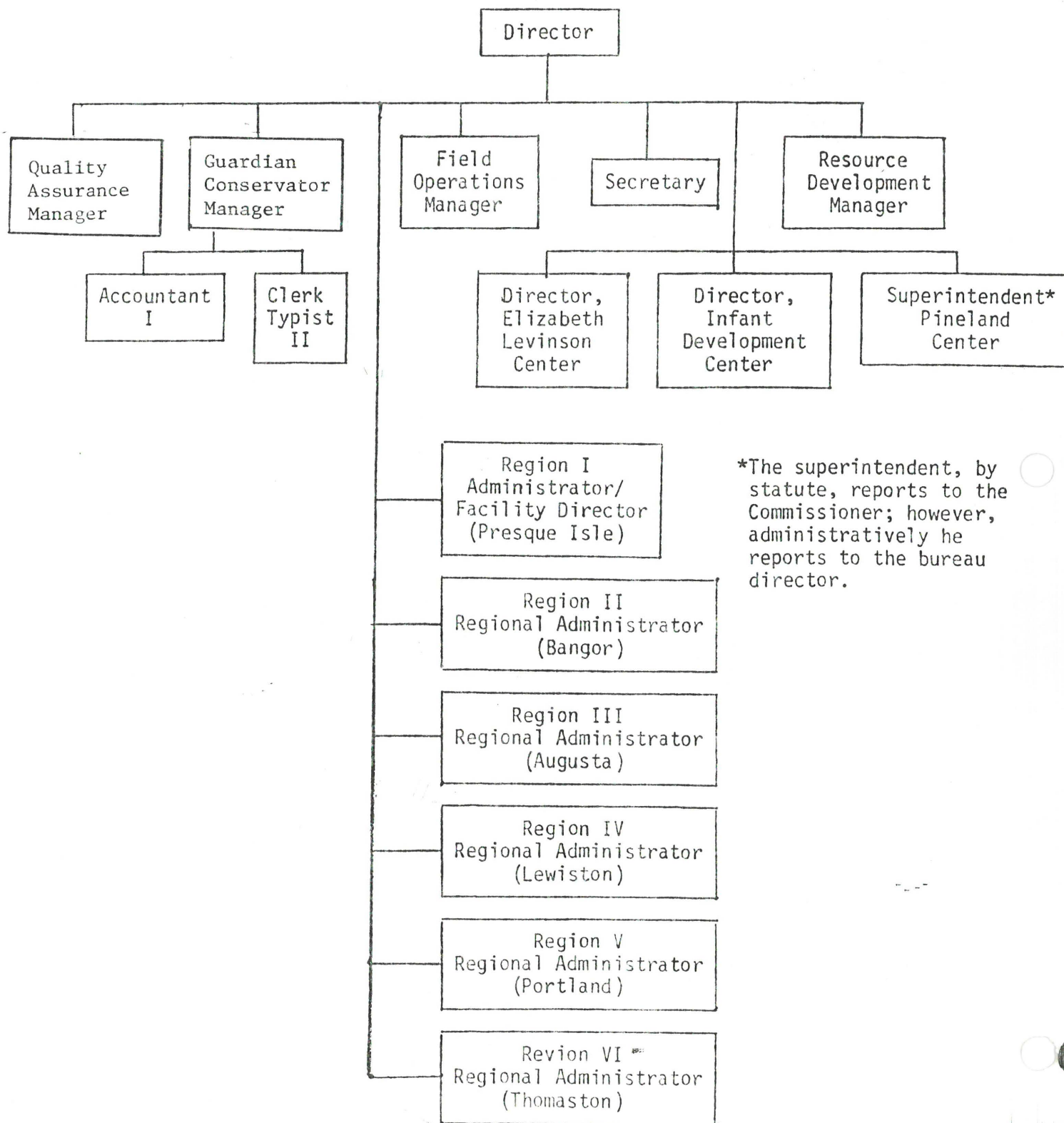
Program Contact: Ronald S. Welch, Director



DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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Program Contact: Ronald S. Welch, Director



*The superintendent, by statute, reports to the Commissioner; however, administratively he reports to the bureau director.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Bureau of Mental Retardation

Program Contact: Ronald S. Welch, Director

d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Director, BMR	1		
Field Operations Manager	1		
Resource Development Manager	1		
Psychiatric Social Worker Supvr.	1		
Secretary	1		
Clerk Typist II	1		
Accountant I	1		

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Bureau of Mental Retardation

Program Contact: Ronald S. Welch, Director

6. Financial Data:

a. Appropriation account #: 1340.1060; 1360,2001, 2003, 2091; and 4360.3

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	343,878	352,944	362,663
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	69,067	9,225	-0-
Revenue	-0-	-0-	20,000
Total Funds Available	<u>412,945</u>	<u>362,169</u>	<u>382,663</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	177,835	186,727	196,063
Federal	-0-	-0-	-0-
Dedicated Account	17,662	9,176	-0-
Total Personal Services	<u>195,497</u>	<u>195,903</u>	<u>196,063</u>
<u>All Other:</u>			
General Fund	166,043	166,217	166,600
Federal	-0-	-0-	-0-
Dedicated Account	30,546	49	20,000
Total All Other	<u>196,589</u>	<u>166,266</u>	<u>186,600</u>
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	6,635	-0-	-0-
Total Capital	<u>6,635</u>	<u>-0-</u>	<u>-0-</u>
 TOTAL FUNDS EXPENDED	 <u>398,721</u>	 <u>362,169</u>	 <u>382,663</u>
 Undedicated Revenue to G.F.:	 -0-	 -0-	 -0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Administration, Bureau of Mental Retardation

Program Contact: Ronald S. Welch, Director

7. Other Programs:

The viability of the service network for mentally retarded persons lies in the unique and complementary partnership between the bureau, parent groups, advisory bodies, professional organizations, concerned citizens and community based non-profit service providers. Historically, the state has not directly provided the majority of community-based services. Rather, the bureau has financially assisted groups in starting services, provided technical assistance, coordination, quality monitoring and delivered specialized technical services. The bureau staff works cooperatively with over 200 public and private agencies and community groups.

The Department of Human Services has responsibility for financing and licensing all non-institutional residential services for the mentally retarded. The need for close coordination between the Bureau of Mental Retardation and the Department of Human Services cannot be overstated. The degree to which such coordination can yield productive results is best exemplified in the joint development of the Intermediate Care Facilities for the Mentally Retarded Program. The commitment which initiated this joint venture has been carried through the implementation phase and on to the administration of the programs. Several areas will require continued collaborative effort. Licensing regulations should be re-examined for completeness, appropriateness and effectiveness after they have been "field tested" with actual homes in operation. The Principles of Reimbursement for ICF/MR's and Boarding Care Facilities will also require continued and shared evaluation relative to their impact on program quality, cost containment and appropriateness as applied to small non-profit agencies.

Relative to financing the development of new homes, the Maine State Housing Authority has often times been recognized as a cooperative agency. With the scarcity of mortgage money, this cooperative arrangement is pivotal to continued compliance with the court-ordered Consent Decree. It is anticipated that the bureau's relationship with the Maine State Housing Authority will continue to produce residential services for Maine's mentally retarded citizens.

Inter-agency cooperation is especially critical to the maintenance of Maine's system of Adult Community Programs. The large number of agencies which deliver these services are funded by a combination of grants and contracts from the Bureaus of Mental Retardation, Medical Services and Division of Adult Education. The Bureaus of Mental Retardation, Social Services (formerly Resource Development) and Rehabilitation have demonstrated a cooperative spirit in the joint promulgation of quality standards for these programs. However, both the Bureaus of Social Services and Rehabilitation have legitimate service priorities for groups other than the mentally retarded. The Bureau of Mental Retardation, therefore, needs to strongly

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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represent the need for continued support from these agencies. The Bureau of Mental Retardation is attempting to do this through a concerted needs assessment and planning process. By working with the Bureau of Social Services, for instance, as it begins to establish what it calls a Client-Oriented System, the needs of the mentally retarded will be documented and quantified through a process of needs prioritization. It is anticipated that through such joint planning efforts an equitable portion of the federal social services block grant will be made available for services to mentally retarded people.

In the area of vocational rehabilitation services, the Bureau of Mental Retardation has successfully negotiated with the Bureau of Rehabilitation for an increase of service to mentally retarded persons by securing federal funds which otherwise would have been lost for lack of adequate matching state dollars. As previously indicated, the Bureau of Rehabilitation serves many different populations requiring rehabilitation services. The need for a strong relationship is, therefore, imperative if mutual clients are to receive the services they need. Concerted efforts are being made to nurture that relationship.

Transportation for mentally retarded persons continues to be the center of considerable difficulty. While the 109th Legislature did establish a Bureau of Public Transportation to coordinate transportation services, the nature of this service dictates that all agencies work actively to ensure the availability of public and special transportation services.

The Department of Educational and Cultural Services has the statutory role of coordinating preschool services for handicapped children. The legislature approved the creation of seven demonstration projects to coordinate and deliver preschool services in certain areas of the state. The Bureau of Mental Retardation's Child Development Worker program has delivered services to mentally retarded children in concert with the efforts of these demonstration projects. The importance of this early intervention has been documented in terms of increased gains and reduction in the costs of long term care.

8. Program Effectiveness:

a. Institutions:

With the Federal Court Master's recommendation to terminate court jurisdiction over the Pineland Center (a recommendation subsequently accepted by the Federal District Court), Maine became the first state to achieve substantial compliance with a consent decree of this type.

The Levinson Center has effectively managed to fulfill the bureau's philosophical commitment to serving individuals in the least restrictive environment through gradual replacement of its long term component with short term contractual training. Through this emphasis on short term training, the Levinson Center prevents institutionalization while enabling more children and their families to acquire short term services.

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The Aroostook Residential Center is currently in the process of changing its focus. The Aroostook program had historically provided a five-day residential service for school-aged children who were unable to obtain appropriate educational services from their Aroostook County towns. As local educational agencies have now developed programs for mentally retarded children, the need for Aroostook Residential Center five-day services has decreased. The Maine Legislature has charged the Bureau of Mental Retardation to reorganize the Residential Center in order to be able to meet emergency placement, respite care and long range placement needs of some previously underserved Aroostook County citizens, establishing the Center as a seven-day a week Intermediate Care Facility for the Mentally Retarded.

b. Community-Based Services:

Directory 1981: Programs Serving the Mentally Retarded in Maine best illustrates the bureau's effectiveness in developing a full array of community-based homes, programs and services. It identifies all such services on a region by region basis, outlining the number of persons served and the age range served.

In addition, the Bureau has and will continue to develop new homes and programs through its Grant-in-Aid program and its development agreements with other appropriate state agencies. This development effort is based on client-specific needs which are identified by professional interdisciplinary teams.

c. Statewide System:

The effectiveness of the regional offices' ability to prevent unnecessary institutionalization is best evidenced in the fact that Maine ranks third in the nation as having the least number of people under institutional care.

d. Liaison:

As discussed previously, the Bureau of Mental Retardation has a mission of assuring that mentally retarded people receive the services they need in the least restrictive setting. This often means developing and assuring continuation of services funded by other state or federal programs. The fact that more than 2,100 mentally retarded children and adults are served in community settings paid for in part with federal entitlement funds administered by other agencies speaks to the degree to which the Bureau of Mental Retardation has maintained a productive liaison and partnership with those agencies and funding sources.

The Bureau bases this liaison effort on its own professional ability to identify client need and plan for and develop needed services by designing

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and implementing effective and efficient programs and services. By example, at the initiation of the Bureau of Mental Retardation, an Intermediate Care Facility program for the Mentally Retarded was designed cooperatively with the Department of Human Services which is now managed by the Department of Human Services with quality assurance monitoring being carried out by the Bureau of Mental Retardation.

e. Public Guardianship:

The bureau is currently public guardian for 384 mentally retarded persons who have been declared state wards by the courts due to their inability to manage their own affairs. In addition, these individuals do not have family members or friends who are willing to care for them. Guardianship responsibilities include the need to: 1) maintain separate interest bearing bank accounts for client funds; 2) reconcile monthly all receipts and expenditures; 3) disperse room and board costs and other personal spending necessarily incurred by each client; 4) assure that each client is receiving all benefits rightfully due them; and 5) provide authorization for medical treatment when the need arises.

The accounting procedures established by the bureau staff in handling client funds were very recently recognized by the Federal Social Security Administration as representing a "model" system. An award was presented to our accountant for her ingenuity and obvious concern for assuring the protection of guardianship accounts.

f. Grant-in-Aid:

The Bureau of Mental Retardation is permitted by statute to convey grants to community agencies for the provision of services to mentally retarded individuals. The bureau's responsibility is to make certain that agencies utilize grant funds appropriately and in keeping with terms established through the application/contract process.

Approximately 2.6 million of state appropriated funds will have been granted during the fiscal year to approximately seventy-five (75) agencies throughout the state. Awards are made on the regional office level with funds that have been budgeted annually in conjunction with bureau priorities. In many cases, funds are granted for the specific purpose of providing the match (seed) necessary to generate additional federal revenues, i.e. Title XX, Medicaid (Title XIX).

A follow-up system has been implemented in order to assist agency fiscal personnel in properly maintaining records. The bureau's management analyst visits each and every facility on an ongoing basis to identify

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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both fiscal and programmatic difficulties which might exist. Recommendations are then made to the respective regional administrator and the bureau director. Many potentially serious situations have been averted as a result.

g. Resource Development:

Since mid-1978 the bureau has developed over 450 new community placements for clients who had been institutionalized or living in inappropriate community settings. Funding for these placements has been facilitated through financial agreements between the bureau and major state and federal agencies, i.e. Farmers Home Administration, Maine State Housing Authority. Corresponding day programs necessary for these individuals have been developed in such skill areas as vocational training, personal care and community living.

h. Clients' Rights:

The bureau works in cooperation with the Office of Advocacy to protect the rights of all individuals receiving services in community and institutional settings. In addition, clients' rights to services are assured through monitoring of the 1,500 individual prescriptive program plans prepared annually.

9. Future Plans:

The Federal Court-ordered Consent Decree and the Maine statutes governing BMR are based on the same programmatic and philosophical principles. However, while the consent decree guarantees certain services to those people covered under the class action suit, comparable services to all other mentally retarded citizens are provided to the degree that the Maine Legislature finances those services, and to the degree that the federal government wishes to participate in that effort.

The Bureau of Mental Retardation has attempted to implement the consent decree by establishing certain "systems of compliance" which do not discriminate between "class members" and all other mentally retarded citizens. By policy, therefore, one standard of care has become the driving force behind the development of a full system of services for all mentally retarded citizens.

The long range (10 year) activities of the BMR will focus on the continued implementation of these systems of compliance. A more specific work plan which is structured around the three program areas, residential services, day programs and support services, will be developed as follows:

a. Residential Services:

It is the bureau's goal to assure that a continuum of residential alternatives is available for Maine's mentally retarded citizens. There are several levels of residential services already in place

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Program Contact: Ronald S. Welch, Director

in Maine, including independent and semi-independent living arrangements, group homes, intermediate care facilities for the mentally retarded (ICF/MR) and institutional residential services.

There are two new levels of residential services currently being planned by the bureau, Specialized Foster Care and Personal Care Services. Specialized Foster Care will support the person who, with some professional services, can experience a more independent life with a foster family. Personal Care Services, a Medicaid funded program, will provide specific professional support services for those persons requiring group home care. A proposal for the creation of this service has been presented to the Department of Human Services. Additional support has been received from both the Bureau of Maine's Elderly and the Bureau of Mental Health. Both of these forms of residential services have the advantage of being less costly than more restrictive alternatives.

In addition, the bureau is in the process of restructuring the existing boarding care and ICF/MR programs. Bureau staff are working with a specially designated legislative committee in planning and implementing changes in the reimbursement mechanisms, as well as the licensing regulations for Boarding Care Facilities. The Bureau of Mental Retardation will be exerting considerable effort in developing standards as part of the licensing regulations in order to emphasize programmatic issues of boarding care.

The Intermediate Care Facilities for the Mentally Retarded program is new in Maine (1980). It is a major level of residential service which was developed through the cooperative efforts of the Bureau of Mental Retardation and the Department of Human Services. After a year's operation, however, certain inconsistencies have been identified between the ICF/MR program and the Bureau of Mental Retardation's relevant statutes and the Consent Decree. An agreement has been reached between the bureau and the Department of Human Services to reexamine this program and, to the degree necessary, restructure the Regulations and Principles of Reimbursement.

b. Day Programs:

A number of specific objectives have been identified for future implementation of standards in an effort to continue to upgrade the quality of adult community programs:

- 1) To conduct periodic on-site evaluations to determine the degree to which each agency complies with the standards;
- 2) To require agencies to develop corrective action plans addressing those weaknesses which were identified in the on-site evaluation;

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- 3) To provide assistance and available resources to agencies based on the corrective action plans; and
- 4) To document agency needs which cannot be met with existing resources. This data will be used for both policy and management decisions on future resource allocation and funding requests to the legislature.

c. Support Services:

There are four major support services necessary to operate a professionally sound and efficient service system for mentally retarded people: case management; professional support (including occupational therapy, physical therapy, speech therapy and psychological services); institutional and early intervention and child development.

The BMR case management system has been operating on a statewide basis for over three years. This system was evaluated during the summer of 1981 by a professional consulting firm resulting in recommendations for change in the system in several areas. A major addition to the case management system will be a mechanism which will identify individual unmet needs (by type of residential and day program service) and compile data for planning purposes.

Professional services (occupational therapy, physical therapy, psychology, speech therapy) are essential to the provision of effective training programs for mentally retarded people. The goal of the bureau is to provide training for private practitioners who possess skills in these essential areas and who have the desire to work with mentally retarded individuals. Such training can be provided by utilizing in-house professional staff. This approach minimizes the need for additional state staff and shifts the costs of providing this service from the state to the federal Medicaid program by their billing on a fee-for-service basis.

It is a goal of the bureau to integrate more fully institutional services with the community system. The services of these institutions will focus more on short term training, diagnosis and evaluation, respite care and service to specialized populations rather than on long term care. The intent is to establish a single system of care for mentally retarded people in which institutions serve as a back-up to community programs and homes for the vast majority of Maine's mentally retarded citizens.

An additional bureau objective is to evaluate the impact of its child development services. Based on that evaluation, the bureau will make policy changes, realign resources and in general concentrate its efforts in serving children in those areas of service which will have the greatest lifelong impact on the child's development.

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The responsibilities and programs of the bureau have grown dramatically during the past several years. In order to keep pace with this growth, the bureau will develop a comprehensive management information system and an in-service training program that will emphasize programmatic and fiscal management.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Aroostook Residential Center

Program Contact: Terry L. Sandusky, Facility Director

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. §§ 2631, 2633 (State-Operated Facilities for Mentally Retarded Persons)

34 M.R.S.A. § 2141, et. seq. (Rights of Mentally Retarded Persons)

34 M.R.S.A. § 2651, et. seq. (Process for Provision of Mental Retardation Services)

b. Other mandates:

32 M.R.S.A. § 2258-A (Administration of Medications)

2. Public Need:

The Bureau of Mental Retardation serves approximately 300 individuals in Aroostook County who are potential residents of the Center. Currently, the Center maintains a waiting list of twenty-two (22) individuals for placement in one of the Center's twelve (12) beds plus the Center's two (2) transitional apartment beds.

The services provided by the Center are unduplicated within Aroostook County and cover four general areas:

- a. Residential services to school age mentally retarded children;
- b. Respite care for families of mentally retarded individuals;
- c. Transitional apartment programming; and
- d. Behavior stabilization programs for clients who have difficulty functioning in the community.

A recent needs assessment conducted by the Bureau of Mental Retardation identified twenty-one individuals living south of Aroostook County, including eight at Pineland Center, who need to be returned to the area for residential placement; this will enable their families to become involved in the individual treatment program. It is expected that the Center will provide transitional services to these clients.

3. Program Objectives:

The primary purpose of the Center is to provide residential services and behavioral training aimed at increasing functional independence to help the adult client learn to live in the mainstream of society.

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Program: Aroostook Residential Center

Program Contact: Terry L. Sandusky, Facility Director

Specific objectives include the provision of the following:

- a. Nine-month per year residency for children attending the Opportunity Training Center or the Helen P. Knight School for Multiple Handicapped;
- b. Respite care to families who are in need of either temporary or emergency placement of their mentally retarded child or adult in the Center's two (2) available respite care beds;
- c. Residence for adults attending either a sheltered workshop or adult day activities program;
- d. Transitional programming for Pineland Center residents who are returning to Aroostook County;
- e. Transitional programming for all residents from more restrictive residential environments to less restrictive residential placements;
- f. Transitional apartment programming to teach residents skills of independent living over a period of approximately six to twelve (6-12) months residency; and
- g. Basic teaching activities in such areas as daily living skills, basic household cleanliness, personal hygiene, individual and group social and recreational skills and overall community socialization.

4. Program Operations:

Pre-admission evaluations are conducted by the regional office of the Bureau of Mental Retardation with final screening conducted by the facility's Director and MR Program Supervisor. Decisions to admit are based on specific program recommendations developed through a multi-disciplinary approach.

Following admission, the resident is assigned a specific staff member who is responsible for the implementation of the resident's individual program plan. Quarterly monitoring and staff reviews are conducted to assess program effectiveness. Modification of the resident's program is made as the need arises and implemented by Center staff.

A professional experienced in mental retardation program administration directs the activities of the houseparents and coordinates resident related activities between the Center and community agencies. These houseparents are the primary teachers and care providers for the residents.

The following represents a typical daily routine:

- 6:30 a.m. - 7:15 a.m. Residents arise, wash, dress and straighten room.
- 7:15 a.m. - 8:00 a.m. Prepare and eat breakfast under the supervision of staff.

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- | | |
|-----------------------|---|
| 8:00 a.m. - 8:30 a.m. | Morning chores completed. |
| 8:30 a.m. - 2:00 p.m. | Residents attend community day programs. |
| 2:00 p.m. - 4:00 p.m. | Recreation and socialization activities generally in the community. |
| 4:00 p.m. - 5:30 p.m. | Individual training activities, such as speech development, personal hygiene, etc. |
| 5:30 p.m. - 6:30 p.m. | Dinner |
| 6:30 p.m. - 9:30 p.m. | Evening activities ranging from in-house arts and crafts to community activities attending plays, movies, pizza parties, etc. |
| 9:00 p.m. | Baths, prepare for bedtime, bedtime. |

In addition, special events occur throughout the year that include camping trips, overnight stays with staff, etc.

A person is discharged from the Center when one of three conditions prevail:

- a. the resident's needs can be better met in another facility;
- b. the resident has reached the training goals established and no longer requires placement; or
- c. the emergency or respite care need has been eliminated.

5. Staffing:

a. General Fund:

1) Positions authorized: 15 ✓

2) Positions filled Sept. 1, 1981:

a) Full time: 9

b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: None

2) Other positions: None

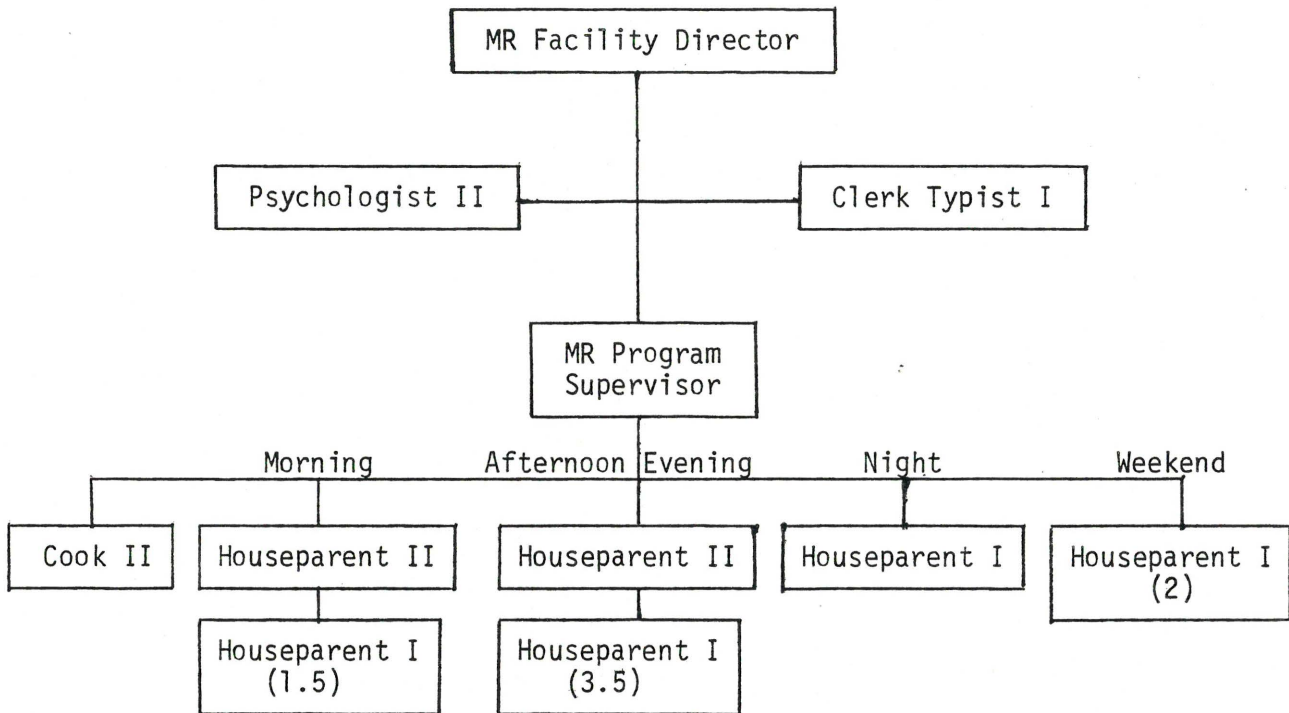
c. Organization:

(See next page).

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Aroostook Residential Center

Program Contact: Terry L. Sandusky, Facility Director



d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Facility Director	1		
Clerk Typist I	1		
MR Program Supervisor	1		
Cook II	1		
Houseparent II	2		
Houseparent I	8		
Psychologist II	1		

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DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Aroostook Residential Center

Program Contact: Terry L. Sandusky, Facility Director

6. Financial Data:

a. Appropriation account #: 1366.1; 1366.9; 4366.1

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	147,910	276,233	361,081
Balance Forward	2,146	2,752	900
Transfers	26,087	-0-	-0-
<u>Federal Funds Available:</u>	-0-	-0-	-0-
<u>Dedicated Revenue:</u>			
Balance July 1	5,146	3,677	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>181,289</u>	<u>282,662</u>	<u>361,981</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	134,426	219,668	236,396
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>134,426</u>	<u>219,668</u>	<u>236,396</u>
<u>All Other:</u>			
General Fund	32,474	54,717	115,515
Federal	-0-	-0-	-0-
Dedicated Account	369	3,677	-0-
Total All Other	<u>32,843</u>	<u>58,394</u>	<u>115,515</u>
<u>Capital:</u>			
General Fund	6,466	3,700	10,070
Federal	-0-	-0-	-0-
Dedicated Account	1,100	-0-	-0-
Total Capital	<u>7,566</u>	<u>3,700</u>	<u>10,070</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>174,835</u>	<u>281,762</u>	<u>361,981</u>
Undedicated Revenue to G.F.:	2,472	96,000	174,000

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Aroostook Residential Center

Program Contact: Terry L. Sandusky, Facility Director

7. Other Programs:

Other programs which limit their services to residents of Aroostook County are:

1 The Houlton Residential Center is a 34-bed ICF/MR for severely and profoundly retarded individuals.

1 The Green Valley Group Home is a six-bed ICF/MR for moderate to mildly retarded individuals and is used as a community placement for clients who are discharged from the Center. Conversely, Green Valley residents who are experiencing behavior problems may be referred to the Center temporarily for behavior stabilization.

10 In addition, there are eight private boarding homes and two foster homes in Aroostook County providing long term care. However, they lack the professional resources necessary for specialized treatment and utilize the Center for such services as respite care and behavior stabilization.

12 8. Program Effectiveness:

The Center's effectiveness in addressing the objectives outlined in Section 3 is demonstrated by the following accomplishments:

- a. The nine-month per year residency program for children attending either the Opportunity Training Center or the Helen P. Knight School for Multiple Handicapped has been very effective. Two of last year's clients are moving to semi-independent apartment living this year. The other two residents will return for continued training with plans to move them to group home placement later this year.
- b. Respite care has worked well this past year for families able to take advantage of the Center's five-day service. Thirty-seven residents were admitted for respite care services in order to meet the crisis and/or relief needs of the resident's family.
- c. Of the four clients attending either a sheltered workshop or adult activities program, one will be moving in the Center's transitional apartment and the other three will be moving to a new group living facility in Eagle Lake when it opens later this year.
- d. Although transitional programming for Pineland residents returning to Aroostook County is a projected activity, the Center has already accomplished this for two extremely difficult Pineland Center residents. They are successfully residing in the community, one in a foster home and the other in a boarding care facility.

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- e. Transitional programming for clients returning from more restrictive environments has been successful in that after one year the six residents placed in lesser restrictive settings continue to function well. All residents who returned to their families have continued to adjust and maintain an acceptable level of behavior.
- f. Four of five transitional apartment residents continue to live independently in the community. These individuals had resided at the Center for various lengths of time over the past three years.
- g. All residents have demonstrated improvement in those areas of functioning addressed by the facility's basic teaching activities.

9. Future Plans:

The primary change occurring is the conversion of the Center from five-day service to seven-day service which will open the Center to a larger group of mentally retarded clients. Numerous concerns have been expressed regarding the inadequacy of a five-day service, particularly in the area of providing respite care which can be needed at any hour of the day during the week. Emergencies cannot always be resolved by 5:00 p.m. Friday afternoon.

The Center will also focus on enhancing its behavior management capabilities. Transition and crisis intervention services require intensive staff involvement. Contracts for expanded professional services, i.e., psychology, speech therapy, occupational and physical therapy, have been executed to give the staff significant consultative support. These efforts will allow the Center to manage more difficult and complicated behavior.

Compliance with the standards for licensure as an intermediate care facility for the mentally retarded will provide the initiative for developing a more intense behavior stabilization program. The conversion will generate Federal revenues to the general fund equal to approximately 60% of the Center's operating costs.

The planned changes will help stabilize the Pineland Center Census by providing services to county residents closer to home.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Mental Retardation Services

Program Contact: Ronald S. Welch, Director, Bureau of Mental Retardation

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. § 2641, et. seq. (Community-Based Services for Mentally Retarded Persons)

34 M.R.S.A. § 2141, et. seq. (Rights of Mentally Retarded Persons)

34 M.R.S.A. § 2651, et. seq. (Process for Provision of Mental Retardation Services)

34 M.R.S.A. § 2601 (Declaration of State Policy)

b. Other mandates:

Education for All Handicapped Children Act, 20 U.S.C. § 1401, et. seq.

Regulations Governing Licensing and Functioning of Intermediate Care Facilities for the Mentally Retarded, adopted pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396

Wuori, et.al. v. Concannon, et. al., No. 75-80 P (D. Maine, 1978)

2. Public Need:

The Bureau of Mental Retardation was created by the legislature in 1969 in response to the needs of mentally retarded persons. Those needs were first described by a variety of citizens: the public at large, physicians, parents and relatives and mentally retarded persons themselves. It was also mandated to assist in the establishment of community-based mental retardation services in recognition of the fact that many of the 1,600 persons at the Pineland Center in 1969 could be served more appropriately in programs nearer to their homes and that home-based services should be developed.

Presently, there are approximately 340 residents at the Pineland Center while the remainder have resumed their lives in the community closer to friends and family. Since 1969 there have been fewer admissions to Pineland as persons who in earlier decades would have been placed in the institution are served by community programs. Today, of the 2,600 clients of the Bureau of Mental Retardation, approximately 2,200 are served in local communities.

Services for mentally retarded persons are found in a variety of community-based agencies. Such services may range from day and residential services to specialized services like occupational therapy. Many service requirements of mentally retarded persons can also be met through regional

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transportation programs, adult education programs and others. To adequately meet the needs of mentally retarded persons, regional office caseworkers coordinate the varied services into a meaningful overall program.

Nearly 300 mentally retarded people each year become clients of the Bureau of Mental Retardation. In many cases, these individuals have never before received services. The rate of referrals can be directly attributed to three major factors:

- 1) Families of retarded children and adults no longer "closet" their retarded relatives and the historical "shame and blame" of mental retardation has all but disappeared;
- 2) Families are aware of the rights to services and are reaching out for help; and
- 3) The Bureau of Mental Retardation and numerous private agencies serving mentally retarded people have become visible in Maine's communities. Families now know where to go for help.

3. Program Objectives:

The objectives addressed by regional offices are derived from state law and the Pineland Consent Decree and are:

A. The provision of Individual Program Planning to:

1. assess the person's needs;
2. develop a prescriptive program plan of services for the person; and
3. determine the suitability and quality of needed services for the person.

B. The provision of Case Management Services to provide protective and supportive services to those persons who are incapacitated by reason of mental retardation and who, with some assistance, are capable of living and functioning in society.

C. The development of Program Resources for day and residential services to:

1. ensure that mentally retarded persons residing in community residential facilities, including nursing homes, boarding homes, foster homes, group homes or half-way houses licensed by the Department of Human Services, are provided with access to habilitation services appropriate to their needs; and
2. assist in the establishment and expansion of community-based mental retardation services and programs for mentally retarded persons residing in the community.

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- D. The provision of services to preschool children, aged 0-5, who are in need of developmental services.

4. Program Operations:

Regional Offices of the Bureau of Mental Retardation perform several important functions and are responsible for carrying out Bureau of Mental Retardation policy at the local level. As regional units of state government, the principal roles relate to determining clients' needs for services, preparing individual program plans for service and ensuring that persons in need gain access to appropriate, quality services; this is a primary function of social work staff who monitor the services provided. Direct services are provided through contracts with private, non-profit agencies that specialize in the treatment of mental retardation. To the extent possible, joint funding agreements are made with local and regional agencies offering public services such as transportation, housing and social and health services. Regional program operations involve the following elements:

a. Individual Program Planning:

When mentally retarded persons are in need of service, an Individual Program Plan is developed that prescribes required services and the individuals or agencies responsible for their provision. Each client's plan is reviewed annually.

b. Case Management:

Case management is provided to mentally retarded clients of the Bureau by caseworkers who coordinate needed services into an effective plan. Caseworkers are an important link between the client and the various agencies providing those services allowing for the close supervision of mentally retarded persons in the community while being cognizant of their rights.

c. Child Development Services:

The Bureau of Mental Retardation, through its regional office system, provides services to children between the ages of birth and five when such children are determined to be developmentally delayed; at age five the children become eligible for educational services. Child development workers located in each region provide in-home programming to developmentally delayed children as well as train parents to assume part of the programming responsibility.

d. Resource Development:

A major regional office function is the development of resources for mentally retarded persons. This is approached in a number of different ways. On an individual basis, needs are first identified in the pre-

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scriptive program plan. When required services are not available, efforts are initiated to develop and provide them. Each regional office employs a Resource Developer whose principal role is to identify approaches to meet service needs. Since the Bureau contracts with private non-profit agencies for the majority of services required by mentally retarded persons, resource development becomes fairly complex in that a variety of agencies may be needed to provide required services. As much as possible, resource development efforts are aimed at integrating mentally retarded persons into general community services. In specific terms, this means that public and private resources are utilized as much as possible, i.e. transportation, health entitlement programs, rather than establishing separate or duplicative services.

On an annual basis the unmet service needs from individual prescriptive program plans are compiled by service type and location, allowing accurate projections for internal budgeting and legislative requests.

e. Grant-in-Aid:

Each regional office prepares an annual budget to provide funds for a variety of programs serving mentally retarded persons. Generally, grants are made to private, non-profit agencies that have a commitment to mental retardation services. The grants typically provide for a portion of the cost of day programs or specialized services and payments are made on a quarterly basis following the submission, review and acceptance of a financial report of the previous quarter's expenditures. The Grant-in-Aid program shares service costs with other state, local and federal funding sources.

f. Quality Control:

Service quality is maintained in a number of different ways on both an individual and system-wide basis.

Within the region, the individual program plan, a key quality assurance mechanism, is monitored by bureau caseworkers. Through the Grant-in-Aid program, an agency failing to provide agreed upon services may be penalized by termination or modification of the contract. Boarding homes and foster homes serving mentally retarded persons are licensed by the Department of Human Services and certified by the appropriate regional office on an annual basis.

Within the system, services are monitored for quality assurance through the Inter-Agency Standards for Adult Community Programs, developed cooperatively by the bureau and the Department of Human Services. These standards address both the quality of services as well as the general functioning of those agencies providing contractual programs.

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g. Boarding Home Certification:

Each Regional Administrator is required to certify boarding homes serving mentally retarded persons on an annual basis. To achieve certification the boarding home must subscribe to the principle of normalization and provide services that are required in the prescriptive program plan. Caseworkers are in frequent contact with boarding home operators and mentally retarded residents to assure that the conditions of boarding home certification are maintained.

5. Staffing:

a. General Fund:

1) Positions authorized: 116

2) Positions filled Sept. 1, 1981:

a) Full time: 101

b) Other positions: 2

b. Other funds (including vacant positions):

1) Full time: 11

2) Other positions: None

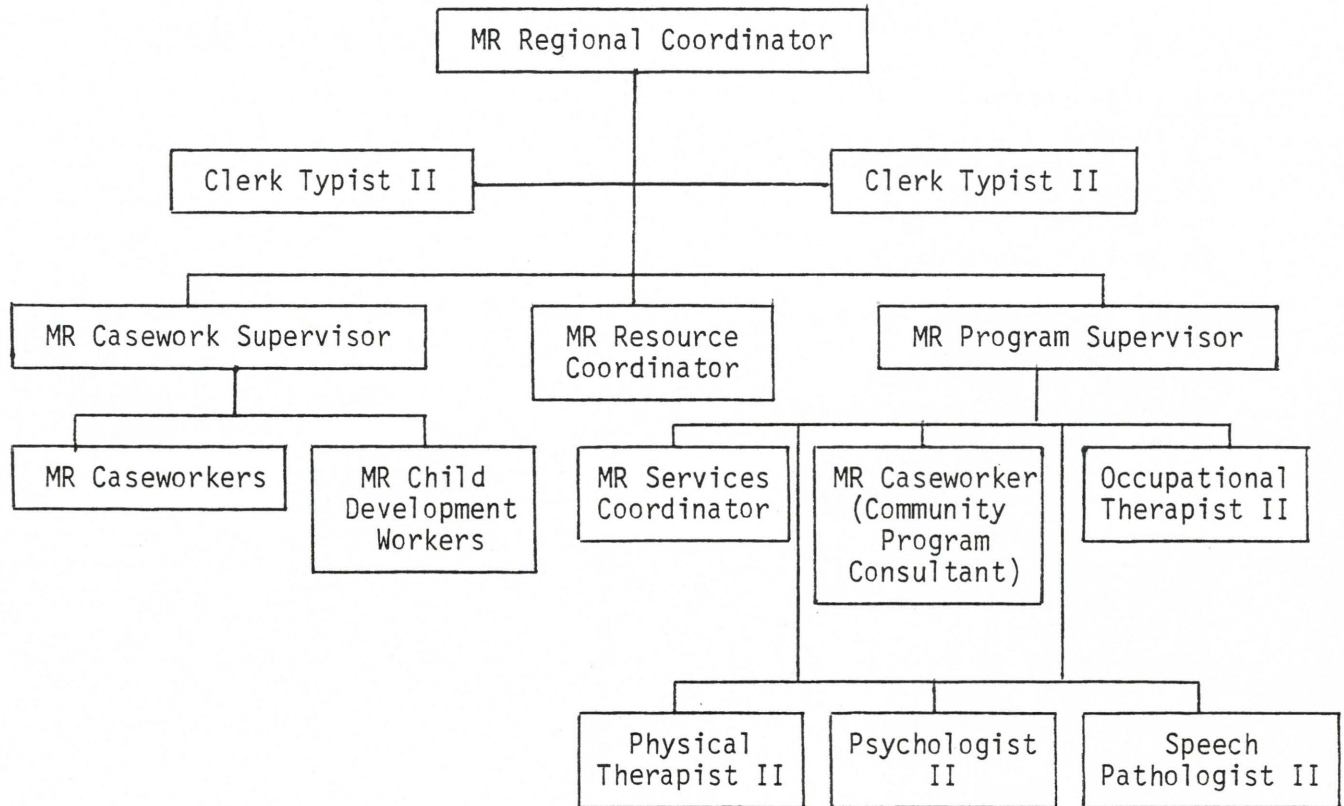
c. Organization:

(See next page)

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While this chart represents the organizational structure of a typical region, some variations exist due to the utilization of contractual services, i.e. child development, occupational therapy, physical therapy.

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Program: Community Mental Retardation Services

Program Contact: Ronald S. Welch, Director, Bureau of Mental Retardation

d. List of positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
<u>Region I (Aroostook)</u>			
MR Caseworkers	5		
MR Child Development Workers		3	
Account Clerk II	1		
MR Casework Supervisor	1		
MR Service Coordinator	1		
<u>Region II (Washington, Penobscot, Piscataquis)</u>			
MR Regional Coordinator	1		
MR Child Development Workers		3	0
Clerk Typists II	3		
Public Health Nurse I	1		
Occupational Therapist II	1		
Speech Pathologist II	1		
MR Resource Coordinators	2		
Resource Center Supervisor	1		
MR Caseworkers	8		
Psychologist II	1		
MR Casework Supervisor	1		
MR Service Coordinator	1		
MR Program Supervisor	1		
Physical Therapist II	1		
<u>Region III (Kennebec, Somerset)</u>			
MR Regional Coordinator	1		
MR caseworkers	12		
Clerk Typists II	2		
MR Casework Supervisor	1		
MR Resource Coordinator	1		
MR Service Coordinators	2		
MR Program Supervisor	1		
<u>Region IV (Androscoggin, Franklin, Oxford)</u>			
MR Regional Coordinator	1		
MR Resource Coordinator	1		
MR Child Development Workers	1	2	
Physical Therapist II	1.5		
Psychologist II	1		
Occupational Therapist II	1		
Therapy Aide II	1		
Speech Pathologist II	1		
MR Program Supervisor	1		
MR Caseworkers	7		
Carpenter	1		

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<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
<u>Region IV (continued)</u>			
Clerk Typists II	2		
MR Child Development Worker	1		
MR Casework Supervisor	1		
MR Service Coordinator	1		
<u>Region V (Cumberland, York)</u>			
MR Regional Coordinator	1		
MR Service Coordinators	2		
Occupational Therapist II	1		
Physical Therapist II	1		
Speech Pathologist II	1		
Psychologists	1.5		
Clerk Typists II	3		
MR Caseworkers	10		
MR Program Supervisor	1		
MR Casework Supervisor	1		
MR Resource Coordinator	1		
Crisis Intervention Worker	1		
<u>Region VI (Knox, Waldo, Lincoln, Sagadahoc)</u>			
MR Regional Coordinator	1		
MR Child Development Workers		3	
MR Resource Coordinator	1		
Occupational Therapist II	1		
Physical Therapist II	1		
Speech Pathologist II	1		
Psychologist II	1		
MR Caseworkers	7		
Clerk Typists II	2		
MR Casework Supervisor	1		
MR Service Coordinator	1		
MR Program Supervisor	1		
TOTAL	116	11	

4.5
-
6.5
5
11.5
-
11.5
0
23

23

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Program Contact: Ronald S. Welch, Director, Bureau of Mental Retardation

6. Financial Data:

a. Appropriation account #: 1360.2; 3360.2; 4360.2

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	4,563,828	5,626,155	5,807,749
Transfers	221,275	-0-	-0-
Balance Brought Forward	538,732	517,370	-0-
<u>Federal Funds Available:</u>	343,788	468,511	511,086
<u>Dedicated Revenue:</u>			
Balance July 1	2,614	-0-	-0-
Revenue	-0-	350	350
Total Funds Available	<u>5,670,237</u>	<u>6,612,386</u>	<u>6,319,185</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	1,840,135	2,247,248	2,271,294
Federal	122,911	248,280	266,195
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>1,963,046</u>	<u>2,495,528</u>	<u>2,537,489</u>
<u>All Other:</u>			
General Fund	2,899,682	3,887,018	3,531,013
Federal	226,005	220,231	243,306
Dedicated Account	2,291	350	350
Total All Other	<u>3,127,978</u>	<u>4,107,599</u>	<u>3,774,669</u>
<u>Capital:</u>			
General Fund	9,020	9,259	5,442
Federal	6,257	-0-	1,585
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>15,277</u>	<u>9,259</u>	<u>7,027</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>5,106,301</u>	<u>6,612,386</u>	<u>6,319,185</u>
Undedicated Revenue to G.F.:	-0-	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Mental Retardation Services

Program Contact: Ronald S. Welch, Director, Bureau of Mental Retardation

7. Other Programs:

Services are provided to mentally retarded persons by many agencies within state government. Within the Department of Mental Health and Mental Retardation, Pineland Center offers residential services to mentally retarded adults whose complex needs require institutional care. It offers a service that is not available within the regional service network, thereby complementing rather than supplanting community services.

The Levinson Center and the Infant Development Center provide programs for children. The Infant Development Center provides services to children between the ages of birth and age five in southern Maine. These services are provided within the home while specialized services are offered at the Center. The Levinson Center, on the other hand, offers day and residential services to severely and profoundly mentally retarded children on a state-wide basis. Child development workers from each of the regional offices work in conjunction with both centers.

The Bureau of Mental Health supports a variety of activities for persons with mental illness, including those mentally retarded persons who meet the eligibility criteria for mental health services.

The Bureau of Rehabilitation, Department of Human Services, supports a variety of vocational services and programs for which mentally retarded persons are eligible. Because severely handicapped persons constitute a priority population for the Bureau of Rehabilitation, many mentally retarded persons are able to avail themselves of their services. At the regional level there is a close working relationship with Bureau of Rehabilitation staff regarding the specific needs of handicapped persons and service programs developed to meet those needs.

The Division of Special Education, Department of Educational and Cultural Services, has statutory responsibility for meeting the educational needs of handicapped persons between the ages of five through twenty. Regionally, bureau staff work closely with special education staff and school district administrative personnel to offer child development services for preschool aged children and program planning assistance for school-age children.

Regional office staff also coordinate with the regional staff of the Division of Hospital Licensing, Department of Human Services, which licenses boarding homes and Intermediate Care Facilities for mentally retarded persons. The Bureau of Mental Retardation's regional office has specific certification and program quality assurance responsibilities in each of these types of residences; therefore, close coordination is essential.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Community Mental Retardation Services

Program Contact: Ronald S. Welch, Director, Bureau of Mental Retardation

8. Program Effectiveness:

Individual program planning is provided by regional office staff and is the basis for client services. It is also an important tool for planning over-all future services for the mentally retarded population. Regional offices prepare 1,500 prescriptive program plans annually, and of that number, approximately 15% are for new referrals. Referrals are received at a rate of 250 persons per year. During the past year, 178 persons received prescriptive program plans while the balance were referred to other, more appropriate agencies.

A total of 2,200 clients statewide are involved in day programs provided through the community mental retardation system. Since mid-1978 over 750 new community placements have been developed for clients who had been institutionalized or living in inappropriate community settings. Maine is ranked third in the nation for having the fewest number of mentally retarded persons residing in institutions and considered to be on a par with other states in the provision of quality day programs.

An internal evaluation has indicated that the majority of clients are receiving services in community programs that meet their individual needs. Efforts are being made to expand these services for the more substantially handicapped.

As with day programs, there have been significant developments in residential services. The most widely used residential service that did not exist two years ago is the Intermediate Care Facility for the Mentally Retarded (ICF/MR) program, through which 238 persons are presently served. The ICF/MR program is 70% reimbursable with federal medicaid funds.

The following chart indicates the number of clients in each of the community residential settings:

ICF/MR.....	238
Foster Home.....	190
Family or Relatives.....	788
Boarding Home, 6 persons or less.....	338
Boarding Home, 7-15 persons.....	60
Boarding Home, 16 persons or more.....	219
Independent/Semi-independent living.....	127
Nursing Homes.....	123
Other.....	72
Total	2,155

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Program Contact: Ronald S. Welch, Director, Bureau of Mental Retardation

The regional mental retardation system provides services to 400 preschool children who are developmentally delayed. These services include programming in the child's home as well as center-based group activities and professional consultations, i.e., physical and occupational therapy. A primary indication of the success of this program is the small percentage of this age group who require institutional care; only four children under age ten are at Pineland Center.

9. Future Plans:

Future plans for Community Mental Retardation Services are to continue in the principal areas of activity established in statute, namely, individual program planning, case management and resource development. However, efforts will be concentrated in the areas of resource development and quality assurance.

In order for the regional offices to continue to comply with their mandated objectives, an increased number of community-based day and residential services will need to be developed. To accomplish this, available state funds must be utilized effectively and supplemented, whenever possible, with federal assistance. The bureau is currently studying the feasibility of obtaining reimbursement for day and residential services through Title XIX (Medicaid). Negotiations with the Department of Human Services, which administers these funds, will continue.

In addition, the legislature authorized (during its one day session on September 25, 1981) the transfer of that portion of Title XX funds presently being allocated for mental retardation services by the Department of Human Services to the Bureau of Mental Retardation (DMHMR). As a result, community providers will be able to negotiate funding requests directly with the bureau's regional offices for both social services funds (Title XX) and state dollars presently granted through the bureau. The legislative intent was to make certain that the priorities established by the state in community services for the mentally retarded would be consistent and monitored by the bureau that has legislative responsibility to provide for persons with mental retardation.

Therapeutic foster homes offer an attractive and viable alternative to more costly intermediate care facilities. Community Mental Retardation Services will increase its efforts to recruit and train foster parents to deal with the specific needs of severely and profoundly mentally retarded persons.

Despite certain service gaps, the Bureau of Mental Retardation through its regional office system has made significant gains in developing community-based alternatives to institutional care. Future efforts will focus on maintaining a professional level of service to mentally retarded persons through the implementation of a regionalized system of quality assurance.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Elizabeth Levinson Center

Program Contact: John B. Larrabee, Director

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. §§ 2631, 2634 (State Operated Facilities for Mentally Retarded Persons)

34 M.R.S.A. § 2141 et. seq. (Rights of Mentally Retarded Persons)

34 M.R.S.A. § 2651, et. seq. (Process for Provision of Mental Retardation Services)

b. Other mandates:

22 M.R.S.A. § 7904 (Fire Safety Inspections)

22 M.R.S.A. § 1811 (Licensing of Hospitals and Institutions)

25 M.R.S.A. § 2701, et. seq. (Construction for Physically Disabled Persons)

32 M.R.S.A. § 2258-A (Administration of Medications)

Rehabilitation Act of 1973, 29 USC § 700, et. seq.

Education for all Handicapped Children Act, 20 USC § 1401, et. seq.

Developmentally Disabled Assistance and Bill of Rights Act, 42 USC § 6001, et. seq.

Title I, Education Act of 1965, 20 USC §§ 236, et. seq., 241, et. seq. and 821, et. seq.

Social Security Act (including Title XVIII Medicare, Title XIX Medicaid and Title XX Grants for Service) 42 USC § 1395 et. seq.

Wuori, et.al. v Concannon, et. al., #75-80P (D. Maine, 1978)

2. Public Need:

The Elizabeth Levinson Center serves severely and profoundly retarded children, ages two (2) to twenty (20) in a combined residential and training program. Referrals for admission come through the Bureau of Mental Retardation Regional Offices located throughout the state.

The primary need met by the Center is Emergency Respite Care and Respite Care for families with severely and profoundly retarded children. Emergency Respite Care is indicated when a child's family or foster parent is in

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crisis--hospitalization, illness, death, mental health disorder, alleged abuse, etc.--and the child must be admitted to the Center immediately. Respite Care is provided to families (guardians, foster parents) who need to have residential care for a severely and profoundly retarded child who is living at home. Such respite care is provided for short periods of time of up to twenty-one (21) consecutive days, and no more than sixty (60) days per calendar year by statute. Respite care provides these families with a rest, vacation and a "breathing space" from the constant care of an often difficult-to-manage multiply handicapped child. It is conceivable that if every family or foster home that utilized the Center for respite care did not have that service, their child or children could become permanent residents of an institution. Respite care, therefore, is considered a preventive and significantly cost effective service.

Families of mildly retarded or non-multiply handicapped children may be able to take advantage of a friend or relative to provide respite care in the community. Families of children with severe and profound retardation, compounded by multiple handicaps (blind, deaf, palsied, etc.) and specific medical needs (tube feeding, cardiovascular problems, respiratory problems, tracheotomies and numerous syndromes) could not be served anywhere but at a licensed Intermediate Care Facility for the Mentally Retarded (ICF/MR) that has the necessary medical and professional personnel to care for this individual. The Center fulfills this requirement as an ICF/MR .

The second need met by the Center is the provision of residential and program services for severely and profoundly retarded children (whose functional levels are below that of normal two year olds) with severe aggressive and self-mutilating behaviors. Until this unit was created many children with these problems were sent to costly out-of-state facilities. The Center provides eight licensed beds to provide that service closer to home and at a more reasonable cost.

A third need met by the Center is the provision of Contracted Training. This program provides a family and their child with six-months (renewable) training and residential services. A written agreement (Service Contract) is developed with the family and the Center specifying respective responsibilities for training, transportation, carry-over programming to the home, duration of programming according to individual needs, and a program review schedule. This program, unique to the Levinson Center, provides parents with specific evaluations and training methods or elimination of negative behaviors which may prevent that child from taking part in community school programs, for example: A child may not be able to attend public school because he is unable to control his bowels for non-medical reasons. An evaluation, program and home follow-up provided by the Center would enable that child to be enrolled in a public school program.

A fourth need of families is met through Short Term Evaluations. This affords families of severely and profoundly retarded children an opportunity to place a retarded child at the Center for a complete evaluation and recommendations for program development. This service is provided for

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periods of eight weeks, after which time the child can be returned to his home community. Since many of these children must travel to the Center from distant parts of the state, the Center offers short term residence while the evaluations are being completed. Medical, psychological, speech and hearing, psychiatric, social motor, therapeutic and educational areas are addressed by the evaluations.

A fifth need of families of severely and profoundly retarded children is fulfilled through Foster Home placements. Many parents are unable to cope with their severely retarded child, for a variety of reasons. The Center provides placement for some of these children with licensed families who are trained, evaluated and monitored by Center staff. Foster homes for severely multiply-handicapped children are extremely difficult to recruit and maintain without intensive ongoing support from Center staff.

Beyond the residential and educational program aspects, the Center provides the following services:

- a. On-site staff training for Center staff and community agencies serving similar clients;
- b. Off-site staff training for Center staff and community agencies;
- c. Parent-counseling and training (on-site and in home). To be expected, parents are often not prepared to deal with a multiply-handicapped, severely retarded child. Their mental health needs, marriage stability and meaningful nurturing of their handicapped child depends on the support and counseling of a professional social worker experienced in this area. Often this worker may be able to actively involve parents with other parents of retarded children to strengthen the support of the family;
- d. Equipment/literature/technical assistance resource to sister agencies, community group homes and hospitals; and
- e. Reorientation and training for Bureau staff.

3. Program Objectives:

The primary purpose of the Elizabeth Levinson Center is to provide short-term residential and educational services to Maine's severely and profoundly retarded children. Following a comprehensive evaluation and an individualized program at the Center, a more normative and natural return to the community home is insured. The Center functions as one of three mental retardation state residential institutions (in addition to Pineland Center and Aroostook Residential Center). Its role within the State plan is to provide intensive training for severely and profoundly retarded children ages two to twenty.

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The Center's goal is to maximize the potential of severely and profoundly retarded children by increasing the complexity of their behavior and broadening and enhancing their ability to cope with their environment. It is believed that parents should be provided opportunities for maximum involvement with their child. This may not necessarily involve returning the child to the home of his natural parents, but will in all cases involve maintaining relations with the parents to help them accept goals that will result in the best possible rehabilitation for the child.

The Center is not designed to be a terminal facility for mentally retarded children, but rather a training facility that will increase the retarded child's potential. The development and training of community resources helps to facilitate maintaining the retarded child at home or in an appropriate community residence.

The following are specific program objectives for the Center:

a. Provision of Residential Services:

Emergency Respite Care - up to twenty-one (21) days
Respite Care - up to twenty-one (21) days
Contracted Training - up to six (6) months--can be extended
Long Term Training - up to twelve (12) months for children with
severe behavior disorders

b. Provision of Individual Client Programs:

As mandated By Chapter 229, the Federal Developmental Disabilities Act and P.L. 94-142, all children who do not attend community-based school programs must be provided a minimum of five (5) hours daily intensive educational programs. In addition, specialists and therapists are utilized to address specific treatment problems.

c. Provision of Activities:

As required by regulation and licensing, each child residing at the Levinson Center is provided with specific leisure time activities every weekend and during school holidays or vacations. Activities are documented for each child and appropriate supervision is provided according to the child's needs through an activities coordinator. A specialized adaptive therapeutic swim program is provided to children who have motor disabilities.

d. Provision of Foster Home Placement and Respite Care in Foster Homes:

Because of the disposition of the natural family or the demanding needs of multiple-handicapped children, some children are placed in foster homes following training at the Center. Respite Care Foster Home placement has been offered to families whose children may be higher functioning than children in residence. Often children regress without peer

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models. A twenty (20) hour coordinator recruits potential foster parents, helps them to become licensed, supports them through training and counseling, and monitors their payment through the Department of Human Services.

e. Provision of Expert Medical and Dietary Services:

As required by law and licensing, provision of special medical consultants and physicians are made available to all children. Around-the-clock nursing staff are required to administer medications, follow through on treatment plans and periodically examine children. Complete medical evaluations are provided, including special testing and lab work. Dietary evaluations and ongoing changes in nutrition are made weekly to fit the special needs of medically indigent children.

f. Provision of Staff Development and Training:

The very nature of the mission of the Center "treatment and care of severely and profoundly retarded children" requires highly trained professionals in the field of mental retardation, child development and behavior management. All staff, including support staff, are required to participate in self-improvement training, workshops, seminars or activities presented at the Center or off site. Staff performance and client achievement are usually correlated to staff training.

4. Program Operations:

The program operation for the Levinson Center can best be described from the perspective of services delivered to individual children.

The Elizabeth Levinson Center accepts referrals for admission from the six regional offices of the Bureau of Mental Retardation. A regional office caseworker and Center social worker make an intake visit to the family and present the case for consideration to the Program Referral Committee (made up of professional staff, representatives of various disciplines, parents and public school personnel). Following acceptance to admit, a Service Contract is written stating goals, responsibilities of the parties, and date of discharge. An individual Program Plan (IPP) is developed and program reviews are conducted monthly or quarterly depending on the Service Agreement Contract. Throughout the child's residence, parents are actively involved with their individual program in order to mitigate the separation adjustment and to increase the potential for transition of the program into the home once the child is discharged.

Formal documentation of virtually every legal, safety, training, medical and social aspect of the child's program is kept daily, monthly and quarterly in accordance with licensing and statutory requirements.

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Changes, reviews and revisions of each child's program are done through the interdisciplinary team (IDT) of professionals and child development workers in accordance with licensing and statutory requirements.

5. Staffing:

a. General Fund:

1) Positions authorized: 65*

2) Positions filled September 1, 1981:

a) Full time: 62

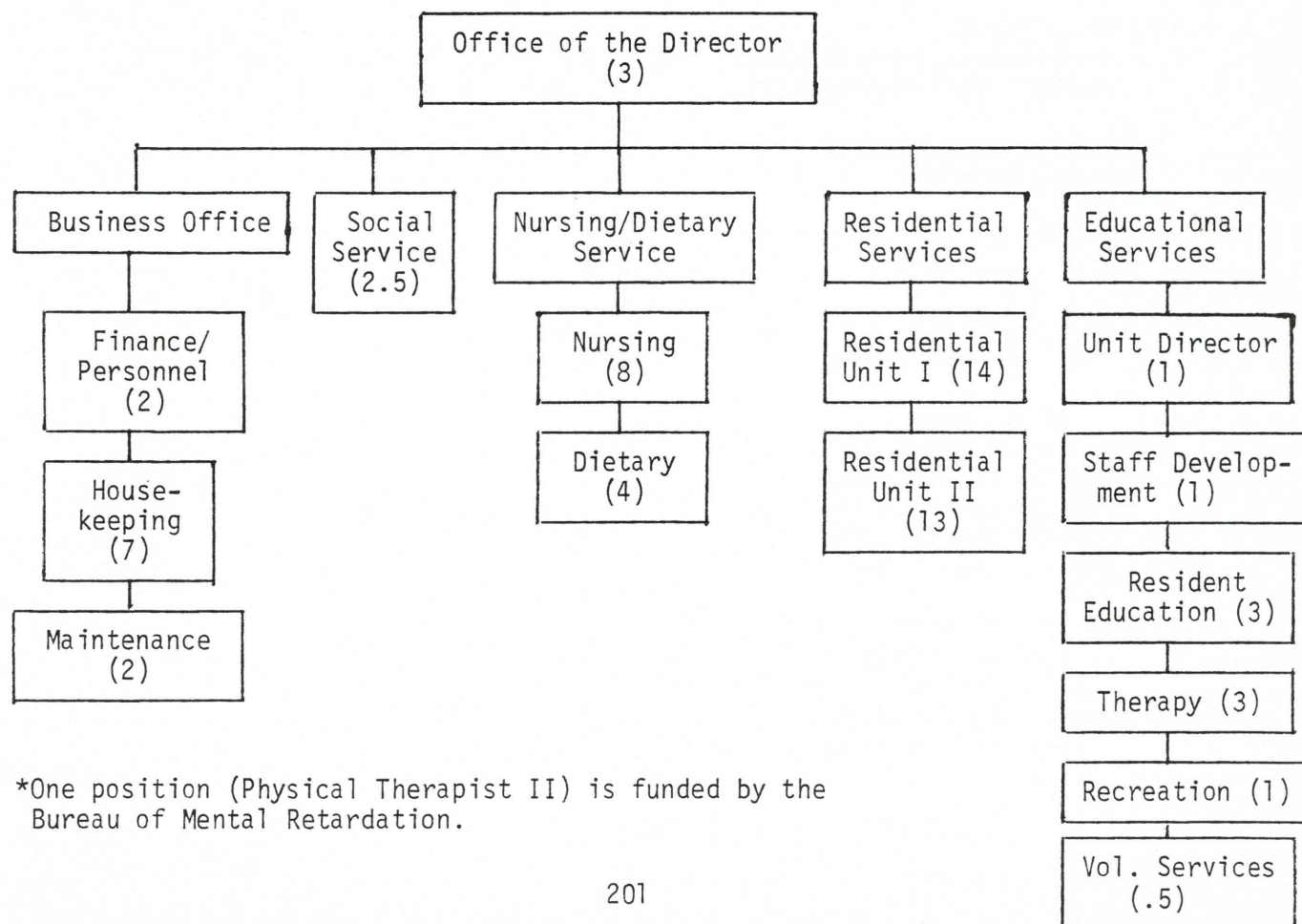
b) Other positions: 2

b. Other Funds (including vacant positions):

1) Full time: None

2) Other positions: None

c. Organization:



*One position (Physical Therapist II) is funded by the Bureau of Mental Retardation.

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d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
OFFICE OF THE DIRECTOR			
Director, MR Facility	1		
Clerk Typist III	1		
Clerk Typist II	1		
BUSINESS OFFICE			
Finance/Personnel			
Business Manager II	1		
Account Clerk II	1		
Housekeeping			
Custodial Worker II	1		
Custodial Worker I	6		
Maintenance			
Maintenance Mechanic	1		
Carpenter	1		
SOCIAL SERVICE			
Psychiatric Social Worker	2		
Mental Health Worker III	.5		
NURSING/DIETARY SERVICE			
Nursing Service			
Nurse III	1		
Nurse II	4		
LPN	3		
Dietary Service			
Food Service Worker	4		
RESIDENTIAL SERVICES			
Residential Unit I			
Mental Health Worker V	1		
Mental Health Worker III	2		
Mental Health Worker II	2		
Mental Health Worker I	9		
Residential Unit II			
Mental Health Worker V	1		
Mental Health Worker III	2		
Mental Health Worker II	2		
Mental Health Worker I	8		

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<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
EDUCATIONAL SERVICES			
Unit Director			
Treatment Specialist	1		
Staff Development			
Developmental Specialist	1		
Resident Education			
Teacher, Learning Disabilities	3		
Therapy			
Physical Therapist II	1		
Occupational Therapist I	1		
Therapy Aide	1		
RECREATION			
Mental Health Worker II	1		
VOLUNTEER SERVICES			
Mental Health III	<u>.5</u>		
TOTAL	65		

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6. Financial Data:

a. Appropriation account #: 1368.1; 1368.9; 3368.1; 4368.1

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	860,898	1,140,171	1,153,233
Balance Forward	13,299	-0-	-0-
Transfers In	106,299	4,595	-0-
<u>Federal Funds Available:</u>	10,440	-0-	3,912
 <u>Dedicated Revenue:</u>			
Balance July 1	5,190	2,139	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>996,126</u>	<u>1,146,905</u>	<u>1,157,145</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	873,905	988,301	1,014,834
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>873,905</u>	<u>988,301</u>	<u>1,014,834</u>
 <u>All Other:</u>			
General Fund	89,125	118,018	127,212
Federal	4,309	3,410	3,410
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>93,434</u>	<u>121,428</u>	<u>130,622</u>
 <u>Capital:</u>			
General Fund	7,315	33,852	11,237
Federal	1,578	502	502
Dedicated Account	3,051	2,139	-0-
Total Capital	<u>11,944</u>	<u>36,493</u>	<u>11,739</u>
 <u>TOTAL FUNDS EXPENDED</u>	<u>979,283</u>	<u>1,146,222</u>	<u>1,157,195</u>
 Undedicated Revenue to G.F.:	<u>266,000</u>	<u>519,000</u>	<u>572,000</u>

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7. Other Programs:

The Elizabeth Levinson Center offers a full spectrum of services to severely retarded children and their parents on a statewide basis. As such, it is Maine's only complete service for mentally retarded children. Other similar or complementary programs include:

The Multiple Handicap Center of Penobscot Valley is a private day school in Bangor that offers transitional services to residents of the Levinson Center who are being mainstreamed into public school programs.

Pineland Center in Pownal serves children who are medically indigent through its hospital unit, Benda. Pineland also offers two-day diagnostic services for children, while the Levinson Center provides short-term services for children. In addition, Pineland provides long-term services for adults.

Aroostook Residential Center in Presque Isle offers a five-day residential program for mild to moderately retarded children and adults.

Houlton Residential Center is a private residential Intermediate Care Facility for mentally retarded young adults. The facility uses the Levinson Center as a resource for programs and staff, and some Levinson Center clients are placed in the Houlton Center.

Treats Falls House is a large group home for mentally retarded adults. Located in Orono, it is utilized by the Levinson Center for placement of children. The two agencies maintain a close relationship in staff training and program resources.

Opportunity House is comprised of two six-bed ICF/MR group homes in Bangor and Orrington serving severely retarded adults. The group homes utilize the Levinson Center's staff for training and program development.

The Foster Grandparent Program recruits senior citizens under an ACTION-funded program as volunteer aides for children residing at the Levinson Center.

8. Program Effectiveness:

a. Provision of Residential Services:

In recent years a shift from long term to short term services has occurred, allowing the Center to serve more families and their children. For instance, in the past year the Center provided the following:

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<u>Residential Service</u>	<u>Numbers Served*</u>
Emergency or Respite Care	81
Child Development Center Evaluation	2
Short Term Evaluations	7
Contracted Training	11
Behavior Unit	8
Long Term Training	16
Foster Home Program	12

Eight (8) children attended the Downeast Public School

One (1) child attended the Capri Street School

One (1) child attended the St. Joseph's School

Seven (7) children attended the Multiple Handicap Center of Penobscot Valley

*Population days for FY 1981 = 8,039

b. Provision of Individual Client Programs:

All programs offered at the Center are reviewed and evaluated by the Program Director, the Licensing Division of the Department of Human Services and the Interdisciplinary Team.

- 1) Eighty-one (100%) of the Respite Care children received a full day of school programming at the Center;
- 2) Ten (50%) of the Contracted Training and Behavior Unit children received a full day of school programming at the Center;
- 3) Ninety-five percent of all children received some physical or occupational therapy and twenty-five percent of the children received intensive Physical Therapy or Occupational Therapy programs;
- 4) Twenty percent of the children received Speech Therapy;
- 5) Ten to fifteen percent of the children received direct services of a Child Development Specialist;
- 6) Twelve percent of the children received direct services of a clinical psychologist (All children are evaluated at least yearly by a psychologist).
- 7) Twenty to twenty-five percent of the children received the services of a pediatric psychiatrist.
- 8) Ten percent of the children received intensive compliance or behavior management training.

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c. Provision of Activities:

All children are included in at least two outside activities monthly, often utilizing volunteers or students under the supervision of an Activities Coordinator. In the summer months, this increases to four major activities monthly. Thirty to forty percent of the children participate in the adaptive therapeutic swim program as part of their overall motor therapy program. Each child participates in at least three major trips (circus, rodeo, fair) per year.

d. Provision of Foster Home Placement and Respite Care in Foster Homes:

Twelve children have been successfully placed and maintained in foster homes. Many other children are eligible and ready for this program. The parttime (20 hours) Coordinator has been very resourceful and tenacious in recruitment and monitoring considering the severity of the children's handicaps.

e. Provision of Expert Medical and Dietary Services:

All children are provided with complete 24-hour a day medical services, evaluations and treatment. The Center has terminated a contract with Eastern Maine Medical Center for pediatric physician coverage and provided more complete coverage by obtaining five pediatric physicians (over two provided by the hospital for ten hours per week) each coming in daily and billing medicaid directly with no cost to the Center. Virtually every type of medical consultant known has served the Center at some time. Tufts Medical School places its students at the Center for essential exposure to the field of mental retardation. More comprehensive, individualized treatment has resulted. Following approval by the Governor and the Legislature in the last regular session, the Center will operate its own kitchen to provide specific dietary requirements to children. Since opening in 1971, the Center has received its food on carts from the Bangor Mental Health Institute, an undesirable arrangement which proved difficult at best and often out of compliance with laws and licensing for pediatric dietary services. A registered dietary consultant was obtained under a contract to insure the most appropriate food service operation during transition to the new kitchen which should open in January of 1982. Dietary assessments and requirements are reviewed monthly for all children.

f. Provision of Staff Development and Training:

All new staff are required to satisfactorily complete a three to four day orientation program. Further, fifty percent of the staff have taken Certified Nurses Aide Courses (required) at the Center, with the other fifty percent to be completed in the next six months. Staff are required to participate in at least two major conferences in their respective area per year. Additionally, the Center sponsors conferences and workshops with hospitals, colleges and universities that staff are required

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to attend. In the fall and spring of every year the Center conducts a Reorientation Week, comprised of in-service training, clinical courses, etc., for all staff to participate. A vast video tape library is supported by grants and donations and is heavily utilized by the community of professionals throughout the State. Weekly in-service training is offered to take advantage of the staff shift overlap. Staff turnover at the Center has been substantially minimized by hiring qualified professionals and continuously motivating and challenging them with self-improvement opportunities. Those staff that do leave often stay in the "system", continuing to benefit the handicapped population by way of their intensive training and experience at the Center.

9. Future Plans:

To continue to serve severely and profoundly retarded children and their families in need of emergency respite care, respite care, short-term evaluations and contracted training.

To continue to offer comprehensive specific behavior management for severely retarded and disruptive children, saving the cost of out-of-state placement and providing smoother transition and return to home.

To operate a nutritionally sound dietary program specifically designed for each child, studying the effects and improving the system in conjunction with the University of Maine, Orono. Dietary intake control has shown improvements in level of intelligence, motor ability, vision and behavior.

Continue to serve the state, especially all those agencies who serve the handicapped and retarded, as a comprehensive resource and training site for clients, staff and parents. Concentration will be on short term programs for children with multiple handicaps, especially behavior problems that prohibit them from participating in their home/school community programs.

As more children come for short term residence, in-house school programs will be provided rather than outside community school during their stay. Concentration will be on obtaining reimbursement from the Federal Medicaid program or sending school district.

The utilization of the respite care program is expected to increase in future years. As mentioned earlier, respite care is considered to be a very valuable preventive service and in that regard has very significant cost effective benefits. To assist in funding the expansion of this program, the Bureau of Mental Retardation will explore with the Department of Human Services the development of a mechanism to receive third-party Federal Funds (Title XIX).

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Elizabeth Levinson Center

Program Contact: John B. Larrabee, Director

The Elizabeth Levinson Center, as a community resource center, will continue to develop the expertise required to assist in the development, maintenance and evaluation of community facilities for mentally retarded children. Future program emphasis will be in the areas of early identification and treatment services for mentally retarded children within the community as well as training programs for the staff of community agencies.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Infant Development Center

Program Contact: Margaret I. Bruns, Director

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. § 2641, et. seq. (Community-Based Services for Mentally Retarded Persons)

34 M.R.S.A. § 2141, et. seq. (Rights of Mentally Retarded Citizens)

34 M.R.S.A. § 2651, et. seq. (Process for Provision of MR Services)

34 M.R.S.A. § 2601 (Declaration of State Policy)

b. Other mandates:

Education for All Handicapped Children Act, 20 United States Code, § 1401, et. seq.

Wuori, etal. v Concannon, etal., No. 75-80 P (D. Maine, 1978)

2. Public Need:

Based on 1975 estimated census updates, there are 81,740 children in Maine below the age of five. Using incidence figures from the Bureau of Education for the Handicapped, U.S. Office of Education, 6% of these children can be estimated to be handicapped. An additional 2-3% can be estimated to have developmental lags which places them from 6-12 months below the norm in one of the developmental areas. Using the 6% incidence figure, it can be estimated that there are 4,904 Maine children between birth and age 5 who are handicapped. An additional 990 children between the ages of 3 and 5 who are developmentally delayed would benefit from early intervention.

The rate of development between birth and age five is greater than any other period in a person's life. Most of the foundation skills for personal independence--feeding, dressing, walking, talking--are learned during this time. Intervention during this critical period can have a great impact in the handicapped child's life. Intervention at this age should occur primarily in the home setting through the combined efforts of the family and professional. This type of home-based programming is provided by the Bureau of Mental Retardation Child Development Workers based at the Infant Development Center and each of the Bureau of Mental Retardation Regional Offices.

According to the 1976-77 State Developmental Disabilities planning document, there are an estimated 2,104 developmentally handicapped children under five years of age in southern Maine. The Infant Development Center program was developed by the Bureau of Mental Retardation, with assistance from the Division of Maternal and Child Health, Department of Human Services, and Pineland Center, to specifically address the needs of this population. Direct services are delivered to families and to agencies who also provide services to young children in southern Maine. Assistance is provided the Bureau of

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Program Contact: Margaret I. Bruns, Director

Mental Retardation Child Development Worker program in other regions through the provision of professional evaluations for clients when they are not available locally and through the development of inservice training programs focusing on the specific needs of those serving the birth to five handicapped population.

3. Program Objectives:

The goal of the Infant Development Center is to provide comprehensive early intervention services to families of developmentally delayed children in southern Maine. The program is based on the philosophy that early intervention (newborn to five years) helps a child with developmental delays or potential delays achieve the maximum level of performance. Each of these children should be given the opportunity to be involved in a program as soon as a developmental problem has been identified.

Specific program objectives of the Center include:

a. Identification and Screening

To provide an identification and screening system which is easily accessible to families and community agencies.

b. Developmental Assessment

To provide developmental assessments in the areas of gross and fine motor development, self-help skills, social emotional growth, cognitive development and speech and language development.

c. Individual Program Plans

To develop individual program plans utilizing the interdisciplinary team process, incorporating the child's family and when possible any other agencies providing services to the child.

d. Home Based Programming

To provide ongoing home programs, to assist parents in establishing and carrying out a developmental program for their child, based on the child's and family's individual needs.

e. Center Based Developmental Programs

To provide developmental programming in a classroom setting, on an interim basis, when placement in a regular pre-school program is not possible.

To provide a means of learning through socialization and play in a supervised setting.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Infant Development Center

Program Contact: Margaret I. Bruns, Director

f. Consultation to Other Agencies

To provide assistance to agencies serving developmentally delayed children (examples: preschool and day care programs, Head Start, foster care homes, day care homes and Child Protective Services) through screening, developmental assessment and ongoing consultations to assist in the implementation and updating of programs.

g. Assistance in Public School Placement

To facilitate the integration of developmentally delayed children into the public school system by keeping parents informed of the educational rights of their developmentally delayed child and by participating in local Pupil Evaluation Team conferences to identify appropriate program and service needs.

h. Mental Health Services to Families

To provide the families of Infant Development Center clients assistance in the area of mental health through needs assessment, short-term intervention and linkage with community resources.

i. Parent Groups

To facilitate the development of and provide ongoing assistance to local parent support groups.

j. Integration of Services

To facilitate the integration of services to young developmentally delayed children through:

- 1) Joint inservice training with staff of other agencies;
- 2) Participation in joing interdisciplinary team evaluations with community agencies; and
- 3) Participation on advisory boards and coordinating committees of agencies providing similar or related services.

k. Newsletter

To disseminate information concerning the Infant Development Center and related parent group activities, pertinent workshops and conferences and educational materials relating to parenting skills.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Infant Development Center

Program Contact: Margaret I. Bruns, Director

4. Program Operation:

Referrals are accepted from any agency or individual who suspects a child is showing developmental delays, the only stipulation being that the referral has been discussed with the child's parent or guardian and they have indicated a willingness to become involved with the program.

An initial home visit is then scheduled to familiarize the family with the Infant Development Center's services and to assess the needs of the child and the family. The Denver Developmental Screening Test, informal observation of the child, and parent interviews are utilized in the needs assessment. This is usually completed by the Mental Retardation Caseworker.

Intake conferences are held weekly to review all available information on each child referred, assess the need for services, assign a case manager and make initial program recommendations including those professional evaluations and/or consultations which the screening results indicate are appropriate. If Infant Development Center services are not deemed appropriate at this time, an attempt is made to identify and assist parents in contacting a more appropriate resource. The intake team is made up of the Center Director, Mental Health Worker IV, Mental Retardation Services Coordinator, Mental Retardation Caseworker and any additional staff who may have seen the child up to this time.

If there are indications at the time of intake that there are mental health problems within the family which may interfere with the implementation of programming for the child, an attempt is made at this time to involve the Mental Health Consultant (Family Support Specialist).

The Intake Team reviews the program with the case manager three months following the intake conference.

The largest portion of the Infant Development Center's programming occurs in the home setting (approximately 80%). Each staff member is responsible for maintaining a caseload, with the majority of the home programming being carried out by the four Child Development Workers under the supervision of the Mental Retardation Services Coordinator.

It is the responsibility of the case manager to develop the individual program plan with the child's parent, involving the appropriate professionals through developmental assessments and/or consultations.

Developmental Assessments occur at the Center, and may involve any or all of the following professionals: Occupational Therapist, Physical Therapist, Educational Specialist, Psychologist or Speech Therapist, depending on the individual child's needs. A parent conference is held two weeks after the assessment to review the evaluation results and develop a program plan. When possible, other agencies serving the child are involved in the parent

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conference. Coordination of the developmental assessments, chairing of the parent conference and completion and distribution of the reports is the responsibility of the Mental Health Worker IV.

Consultations occur in the child's home with the case manager and child's parent present. Program recommendations are discussed at the time of the consultation. Frequently, consultations are used as a follow-up to a developmental assessment to evaluate progress and update programs.

The Infant Development Center has two developmental classes which meet two mornings a week (9:00 - 12:30) and a play group which meets two afternoons per week (2:00 - 4:00 p.m.). The Educational Specialist is responsible for the organization and supervision of the Infant Development Center classroom and play groups. The staff is made up of a full-time teacher aide, two foster grandparents and two work study students. The children's ages range from eighteen months to five years. Due to transportation problems, these programs are limited to the Greater Portland area.

A case may be inactivated by the Infant Development Center program for any of the following reasons: 1) child reaches school age; 2) child's needs are being met by another agency; 3) family relocates; 4) the child's needs have been met and services are no longer necessary. The case manager completes a written report stating the reason for closing the case and follow-up contact is made within three months and noted in the child's file.

The Mental Retardation Services Coordinator and the Mental Retardation Case-worker are responsible for coordination of the parent support groups. The groups have become well established and relatively autonomous. The Infant Development Center staff's major role at this time is to act as resource persons to assist the groups in meeting their independently defined goals and needs.

5. Staffing:

a. General Fund:

1) Positions authorized: 13.5

2) Positions filled Sept. 1, 1981:

a) Full time: 12

b) Other positions: 1

b. Other funds (including vacant positions):

1) full time: 2

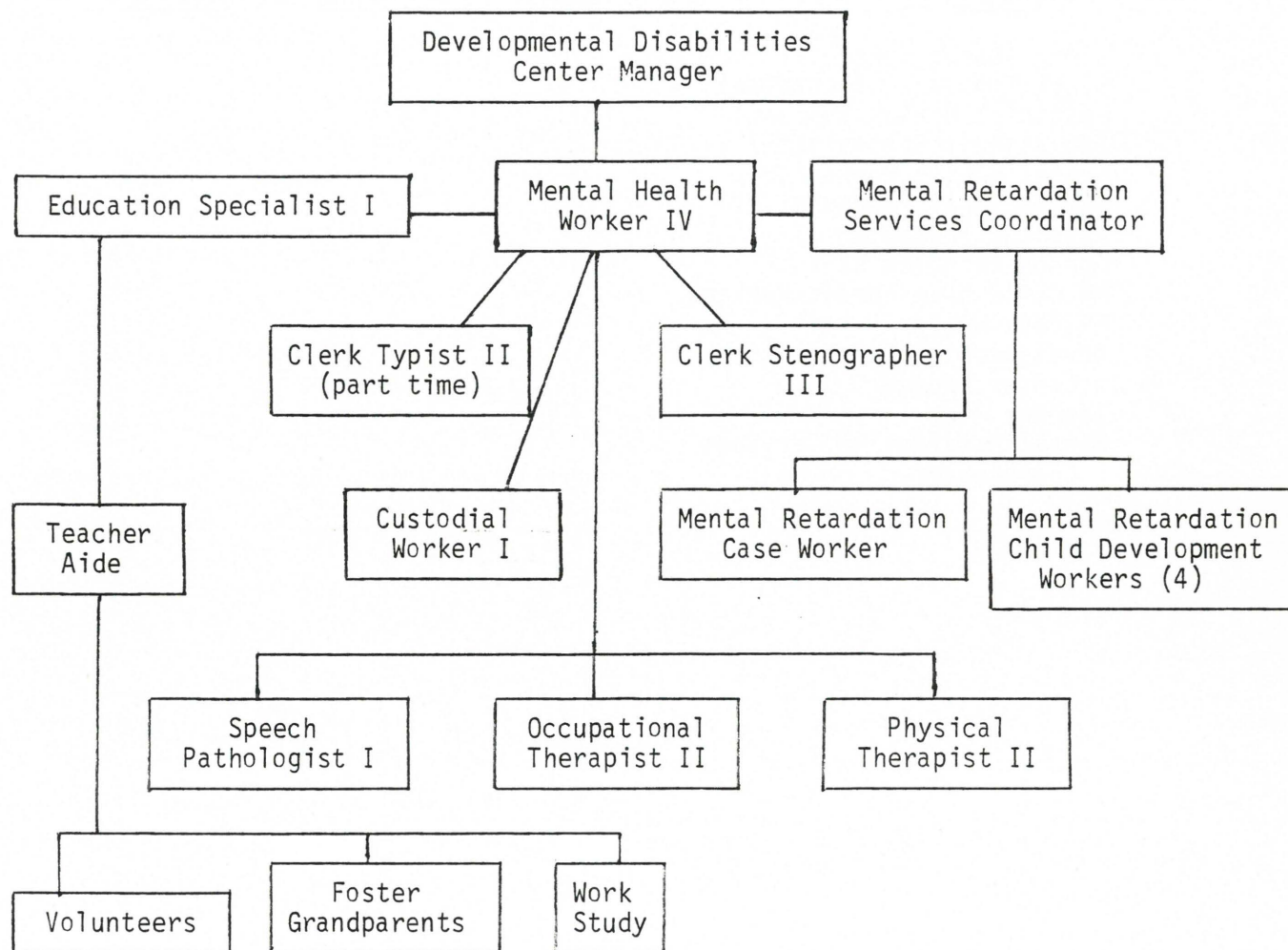
2) Other positions: None

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Program Contact: Margaret I. Bruns, Director

c. Organization:



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d. List of positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Clerk Stenographer III	1		
Clerk Typist II (parttime)	$\frac{1}{2}$		
Custodial Worker (vacant)	1		
Educational Specialist I	1		
Mental Health Worker IV	1		
Occupational Therapist II	1		
Physical Therapist II	1		
Speech Pathologist I	1		
MR Child Development Workers	2	2	
MR Case Worker	1		
Developmental Disabilities Center Manager	1		
Teacher Aide	1		
Mental Retardation Services Coordinator	1		

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Program Contact: Margaret I. Bruns, Director

6. Financial Data:

a. Appropriation account #: 1360.2005; 3360.2004

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	196,077	273,050	273,050
<u>Federal Funds Available:</u>	48,339	39,755	39,755
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>244,416</u>	<u>312,805</u>	<u>312,805</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	156,121	215,422	215,422
Federal	48,339	39,755	39,755
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>204,460</u>	<u>255,177</u>	<u>255,177</u>
<u>All Other:</u>			
General Fund	39,178	57,628	57,628
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>39,178</u>	<u>57,628</u>	<u>57,628</u>
<u>Capital:</u>			
General Fund	778	-0-	-0-
Federal	-0-	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>778</u>		
 TOTAL FUNDS EXPENDED	 <u>244,416</u>	 <u>312,805</u>	 <u>312,805</u>
 Undedicated Revenue to G.F.:	 -0-	 -0-	 -0-

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7. Other Programs:

At this time the Infant Development Center is the only agency in southern Maine providing home-based developmental programming. Agencies providing complementary services include:

Public Health Services provide home-based medical services. Public health nurses are a major referral source for the Center and provide assistance in the areas of medical and nutritional care.

Head Start, Day Care and private preschool programs provide center-based programs for 3-5 year olds. The Infant Development Center provides assistance in integrating developmentally delayed children into these programs.

Waban Preschool Program provides comprehensive center-based developmental programs for 2.5 to 5 year old developmentally delayed children in southern York County.

Holy Innocents Respite Care provides respite care services to families of Infant Development Center clients.

Child Development Workers based in Bureau of Mental Retardation Regional Offices provide home-based developmental programs in other areas of the state.

8. Program Effectiveness:

A. Identification and Screening

In the last year there were 183 children referred to the Infant Development Center. The disposition of these referrals were as follows:

- 27 - screening indicated--no services were necessary
- 28 - children referred to a more appropriate service provider
- 71 - children received home-based programs
- 10 - children received a combination of home- and center-based programs
- 31 - developmental assessments or consultations were provided to other agencies which continued as the primary service provider
- 10 - families refused services
- 6 - moved out of catchment area shortly after referral

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B. Developmental Assessment

The following is a breakdown of the evaluations provided by the interdisciplinary team during the last year:

42 - occupational therapy evaluations

53 - physical therapy evaluations

27 - educational evaluations

44 - speech evaluations

46 - psychological evaluations

There were 52 parent conferences held following evaluations to review findings and develop program plans in cooperation with the child's family and other agencies serving the child.

C. Individual Program Plans

Individual program plans are developed for each child receiving ongoing direct services from the Center. In addition to the previously mentioned developmental assessments (Section B), each therapist provides an average of fifteen consultations per month to assist in the development and implementation of the program plans.

D. Home-Based Programming

The Center maintains an average of 145 active cases at any given time. Between 75 and 80 percent of these children receive individual home-based programs. Although the frequency of visits varies according to the needs of the child and family, an average of three home visits per child per month are made.

E. Center-Based Developmental Programs

Thirty-four children have participated in the Center's two developmental classrooms in the past year.

Fifteen children have been involved in the Center's play group.

F. Consultations to Other Agencies

Handicapped children in the three to five year age range frequently can be integrated into a regular preschool program if assistance is provided in program development and implementation. In 30 of the referrals received last year, this was the primary service goal. A large number of the three to five year olds receiving home-based programming are also

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involved in a preschool program with which Infant Development Center staff consults on a regular basis.

G. Assistance in Public School Placement

Assistance has been provided to local Pupil Evaluation Teams in identifying appropriate educational programs and services for approximately 25 children. Developmental Assessments and program recommendations were provided to the school system and in the majority of the cases at least one Infant Development Center staff member attended the P.E.T. meeting.

Information concerning the rights of the handicapped child is provided on an individual basis, within the home program. The Infant Development Center parent groups have sponsored two workshops in this area.

H. Mental Health Services to Families

The consulting Family Support Specialist has provided direct services in the area of mental health to thirty-six families. A much larger number of families have been serviced indirectly through individual consultation with Infant Development Center staff, participation in case conferences and the provision of inservice training to the staff.

I. Parent Groups

There are presently two Infant Development Center Parent Support Groups which meet monthly. The Center staff was also instrumental in the development of a Down's Syndrome Parent Group in the Portland area. The parent groups have sponsored three workshops in the last year. Two of the groups have developed their own resource libraries.

J. Integration of Services

- 1) Inservice training programs are provided monthly, and twice each year a full week of inservice training is scheduled. Staff members from other agencies providing related services have been involved in the majority of these programs both as leaders and as participants.

Medical students being trained through the Pediatric Division of the Maine Medical Center each spend a half-day with Infant Development Center staff.

- 2) The Infant Development Center Physical Therapist participates in the Maine Medical Center Neonatal Unit follow-up clinic evaluations two afternoons per month.

The Infant Development Center Occupational Therapist is a member of the Project Co-Step interdisciplinary team.

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The Infant Development Center Physical Therapist, Occupational Therapist and Speech Therapist are members of the diagnosis and evaluation team of the Southern Maine Developmental Clinic.

- 3) The Infant Development Center is represented on the following advisory boards and committees involved in planning services for young handicapped children:

- Project Co-Step Coordinating Committee
- Interdepartmental Coordinating Committee for Preschool Handicapped Children (Vice-Chairman)
- Children's Task Force (Chairman)
- Maine Early Intervention Consortium

K. Newsletter

The Infant Development Center newsletter has a mailing list of 150 families and agencies providing services to young children. It is distributed monthly.

9. Future Plans:

The major goal of this program over the next ten years will be to increase the level and quality of services available to infants and toddlers with developmentally handicapping conditions by: 1) providing encouragement and assistance in the development of similar early intervention programs throughout the state; 2) providing training focused specifically on developing skills in assessing and providing programming for very young handicapped children and their families; and 3) encouraging the identification and provision of assistance to infants and families at earlier ages.

A new state law which could impact positively on this program would be to require preschool education for handicapped children from 3-5 years of age. The Infant Development Center could provide assistance in the development of these programs. The focus of direct service to clients would then be on the birth to three year old population.

Lack of federal funding support, particularly in Title XX services, could have negative impact directly on the Child Development Worker programs and indirectly on the decrease in services available to handicapped children and their families. In the past, federal emphasis on early education for handicapped children has been the impetus for the development of this type of program. Without that emphasis, the future development of similar programs may become extremely difficult.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Pineland Center

Program Contact: George A. Zitnay, Superintendent

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. § 2631, 2632 (State-Operated Facilities for Mentally Retarded Persons)

34 M.R.S.A. § 2141, et. seq. (Rights of Mentally Retarded Persons)

34 M.R.S.A. § 2651, et. seq. (Process for Provision of Mental Retardation Services)

b. Other mandates:

22 M.R.S.A. § 7904 (Fire Safety Inspections)

22 M.R.S.A. § 1811 (Licensing of Hospitals and Institutions)

25 M.R.S.A. § 2701, et. seq. (Construction for Physically Disabled Persons)

32 M.R.S.A. § 2258-A (Administration of Medications)

Rehabilitation Act of 1973, 29 U.S.C. § 700 et. seq.

Education for All Handicapped Children Act, 20 U.S.C. § 1401, et. seq.

Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6001, et. seq.

Title I, Education Act of 1965, 20 U.S.C. §§ 236, et. seq., 241, et. seq., and 821, et. seq.

Social Security Act (including Title XVIII Medicare, Title XIX Medicaid and Title XX Grants for Services) 42 U.S.C. § 1395, et. seq.

Wuori, et. al. v. Concannon, et. al., No. 75-80 P (D. Maine, 1978)

2. Public Need:

There are some 30,000 or more mentally retarded children and adults in Maine. Most of these individuals have special needs in education, training, care and treatment that cannot be met by society's provisions for normal children and adults. This number does not reflect the much larger number of persons, i.e. parents, relatives, friends, neighbors, who are in some way affected by the inherent problems of caring for a retarded person.

Pineland
Center

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Pineland Center

Program Contact: George A. Zitnay, Superintendent

The limits of mental retardation range from mild or educable retardation, which encompasses the greatest numbers of persons, to severe and profound retardation, which, although representing fewer people, presents the most problems (multiple physical and sensory handicaps, intractable behaviors and difficult medical conditions). At the Bureau's institutions, Pineland Center and the Elizabeth Levinson Center, the great majority (95%) of the residents, and of the many requiring admission, are severely and profoundly retarded. It is to their special needs in education, training, care and treatment that the efforts of Pineland Center are directed.

Needs of Pineland Residents and Clients: Pineland's special programs in education and training are aimed at developing the best possible potentials of this very handicapped group, and at providing the special care and treatment required for their multiple physical and medical problems.

There are presently some 334 residents living at Pineland. Of these, 239 are profoundly retarded (I.Q. 0-19), 76 are severely retarded (I.Q. 20-35), 18 are moderately retarded and one is mildly retarded (I.Q. 52-68).

An indication of Pineland residents' needs can be suggested by a brief description of their handicaps. Some 95% have one or more other handicapping conditions in addition to mental retardation: deafness-10.4%; blindness-15.1%; unable to walk-31.0%; seizure problems-53.3%; no regular speech-69.9%; paresis and plegias-29.9%; and scoliosis-22.3%.

Many other mentally retarded persons are seeking admission to Pineland Center, but are refused because of limited bed space. In the recent Martti Wuori Case Report to the Court, Mr. Lincoln Clark, the Special Master for the Federal Court, states "Now, again, however, a long list of applicants awaits admittance to Pineland to receive the benefits of its specialized services".

Respite and Temporary Care: In addition to the regular court certified admissions for longer stays at Pineland, there is a public need for several kinds of short term stays:

- a. Respite Care: This permits the parents or other caretakers of a retarded child or adult some time off from their responsibilities, which can be constant and continual. Parental illness and hospitalization, for example, might result in a request for respite care of a retarded child.
- b. Medical: This allows for lengthier examination, analysis and treatment of a patient's condition--as for example, medical stabilization of seizure activity, or for longer dental treatment (extractions, etc.) and for various medical conditions.
- c. Emergency Restraint: This permits stabilization and management of a client's disruptive behaviors that have made it impossible for him to stay in his community placement.

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In the last fiscal year, there were 90 short-term admissions. This number is reflective of Pineland's limited bed capacity rather than the extent of the needs of this type of admission. Many requests have had to be denied.

Outpatient Services: Pineland Center also meets many different needs of the retarded in the community by providing various outpatient services. Well over 1,000 individuals received outpatient services in the last fiscal year from Pineland. These services are in addition to the numerous laboratory tests that Pineland does for residents and inmates in other state facilities.

- a. Dental: Foremost among these outpatient services are those of the Pineland Dental Clinic, which treats outpatients who come by appointment to Pineland, and also treats patients in their communities through its Dental Outreach program. Many mentally retarded persons have special dental problems and also may require special handling. In too many cases, they may not be welcome in a community dental office.
- b. Genetic: Some conditions causing mental retardation may be genetically inherited, even though both parents are physically and mentally normal. There can often be great anxiety on the part of parents of the retarded person or of his adult brothers and sisters relating to future births. Pineland's Genetic Counseling Service provides testing, advice and counsel as to the nature of the condition, the probability of normal births and the percentage of risk for abnormal births.
- c. Medical: Seizure evaluation and control, better management of medical conditions and the use of medications are needs of community outpatients being met by Pineland medical clinics.
- d. X-Ray: X-Rays are done for outpatients who attend Pineland's various clinics. This service is also performed for the Maine Youth Center, Maine Correctional Center and the Governor Baxter School for the Deaf.
- e. Laboratory Tests: Pineland's laboratories perform standard/specialized tests. These are done for the community, other retardation facilities, the mental health institutes at Augusta and Bangor, Maine's correctional facilities and other hospitals and clinics as well. In the last fiscal year, Pineland's laboratories performed 2,100 tests for nearly 1,400 persons who were not residents at Pineland.
- f. Other: Evaluation and guidance have been provided by the Occupational Therapy, Physical Therapy (including highly specialized adaptive equipment), Psychology, Education, Communication and Program Services components.

Community Education, Information and Consultation Services: Pineland Center provides to the community much needed knowledge about the education, training, care and treatment of mentally retarded persons. The community audiences include parents, relatives, guardians, teachers, nurses, therapists, other professionals and paraprofessionals, boarding home operators, religious and

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benevolent groups, public and private college and high school groups, and the general public. Among the methods used are tours of Pineland and its resources, programs and services; talks, lectures, demonstrations, and slide and film presentations given both at Pineland and in the community; and, personal and telephone consultations with, as well as written communications from, qualified staff members.

3. Program Objectives:

The Maine statutes, in defining the purpose and mission of Pineland, include the need to provide training, education, treatment and care for severely or profoundly mentally retarded citizens. The primary objectives are delivered through multiple components to ensure the level of client services, to maintain compliance with the Consent Decree, and to fulfill the Intermediate Care Facility/Mental Retardation Residential and Developmental Training Center regulations.

The developmental age range of Pineland residents, their functional and behavioral problems, along with their major secondary handicaps, indicate the intensity of treatment and training necessary to maintain, eliminate or increase client functions and behaviors.

Specific objectives to achieve the most appropriate level of training, education, treatment and care for each client are as follows:

- a. To provide residential treatment both long and short term which emphasizes training in dressing, grooming, eating, toileting and other activities of daily living;
- b. To provide medical and psychological treatment which maintains or improves the residents' physical or psychological status;
- c. To provide a thorough evaluation and treatment program of physical, occupational, communication, psychological and recreation therapies to maintain or increase residents' levels of independence with skills and behaviors;
- d. To provide a total treatment program based on residents' needs through the Interdisciplinary Program Plan (I.P.P.);
- e. To provide a structured day program to accomplish specific training and education as directed by the I.P.P.;
- f. To provide resident information to families, guardians and correspondents;
- g. To provide out-patient diagnostic and evaluation services;
- h. To provide the least restrictive residential and treatment program on a continuum from institutional placement through community placement;

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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Program Contact: George A. Zitnay, Superintendent

- i. To provide adequate preparation for staff involved with the training, education, treatment and care of long and short term residents; and
- j. To provide prevention services through genetic counseling, public information and education.

4. Program Operation:

Pineland Center provides treatment, training, education and care to those mentally retarded citizens it receives, admits, domiciles, examines, evaluates and discharges.

Program decisions are made by appropriate departmental personnel and therapeutic decisions are initiated by staff who possess the necessary license, registration or certification. Decisions are based on Pineland clients' individual and group needs as determined by the I.P.P. process, and to maintain compliance with the Consent Decree (Appendix A, Appendix B, and the Stipulation Agreement) and with the ICF/MR regulations.

The major elements of the service delivery system designed to meet the program objectives of increasing, maintaining or eliminating client functions and behaviors are described as follows:

a. Training

Training programs are designed and evaluated quarterly and annually through the Individual Program Plan (I.P.P.) process. The I.P.P. includes long and short term plans and goals and serves as the primary focus for all client programs.

Client training programs are delivered in seven Developmental Training Centers at Pineland one Developmental Training Center located at Freeport Towne Square. Training utilizes an interdisciplinary style which incorporates psychological principles, and is carried over into the Residential Treatment areas. Approximately sixty clients attend training programs in the community. Daily statistics are maintained on client attendance and program hours, and are monitored for one week each month to determine Consent Decree compliance.

Training components include: Occupational, Physical, Communication, Recreation, Education, Pre-Vocation, Vocation and Residential therapies with direction from the Psychology and Medical Departments as needed.

- 1) The Communication Therapy component conducts evaluations, provides speech and language therapy, and advises and consults on carry-over programs. In addition, in-service training is provided to other staff working with residents with communication deficits. Audiology services are available under contract, and include hearing evaluations, hearing aid fittings, earmold and swimplug impressions as well as consultations and equipment calibration.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Pineland Center

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- 2) The Occupational Therapy component delivers gross and fine motor development programs, Activities of Daily Living with particular emphasis on feeding programs and sensory motor integration programs, and developing and maintaining specialized splints.
- 3) The Physical Therapy component designs, fabricates and maintains adaptive equipment, monitors individual treatment programs, arranges appropriate clinics and provides consultation as necessary.
- 4) The Recreation Therapy component performs gross and fine motor evaluations and develops individual and group activities which include physical education, aquatics and leisure time training.
- 5) The Residential Therapy component includes those activities and treatments which are conducted in the residential setting and are performed by residential staff. Specific training includes feeding, toileting and dressing programs, along with programs implemented in the residence to maintain or improve client functioning and ameliorate client behavior. During the past fiscal year, approximately 333 clients received 4,367 hours of residential therapy weekly.

b. Education

The Education Program includes preacademic and fundamental academic programs for children at Pineland's Berman School who are between the ages of five and twenty-one years and those young adults over twenty-one who continue to be appropriate at Berman, as well as the children who attend Woodfords and Riverton Schools in Portland. Specific educational elements include Occupational, Physical, Communication, Recreation, Psychological and Pre-Vocational therapies.

Religious education is conducted at Pineland by providing weekly Catholic and Protestant services and special services on holidays. Jewish services were provided on 26 occasions at Pineland, with two visits to Synagogues by residents. There were 273 clients who attended church services at Pineland and 65 clients who participated in community church services.

c. Treatment

Treatment at Pineland includes psychological and/or physical evaluations and diagnosis, and is delivered to residential clients, outpatients and clients from other state agencies. The services available include: Residential and Medical admissions, Clinical and Medical Photography Laboratory services, a comprehensive Dental Clinic and X-Rays. Extensive evaluations include Genetic Counseling, Communication and Hearing assessments, Educational, Psychiatric, Physical and Occupational Therapies, Orthopedic, Psychological and Medical evaluations. Treatment is primarily delivered to mentally retarded citizens, but treatment also includes contact with and counseling of families, guardians, parents and others.

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There were one hundred and ten residents seen in seven clinics (Eye, Scoliosis, Dermatology, and Ear, Nose and Throat) conducted by consulting physicians at Pineland and eleven residents seen at three clinics in the community (Central Maine Medical Center, Kennebec Valley Medical Center and Speech and Hearing Clinic). Six residents received out-patient services at community hospitals (Parkview, Mercy and Mid-Maine Medical). Thirty-eight residents attended consultations at the office of the consultants (Eye, Dermatology, ENT, Orthopedic, Podiatry, Urology, Digestive Specialist). There were also twenty-two operations performed on Pineland residents at four community hospitals (Maine Medical Center, Central Maine Medical Center, Mercy Hospital and Parkview Hospital).

During the past fiscal year, the Clinical Laboratory has provided a full range of diagnostic laboratory tests and genetic services to Pineland residents, as well as to clients from Maine Youth Center, Maine Correctional Center, the mental health institutes and community residents through the Bureau of Mental Retardation regional offices, community hospitals, outpatients through the Pineland Clinic and individual families. The laboratory performed a total of 20,500 tests. Thirty-one percent of these were for other than Pineland residents, representing over \$30,000 annual savings to the state.

The Genetic Service provided by Pineland has been a most valuable program for families of the mentally retarded. The program has been enhanced by a Federal Genetic Disease Act Grant of \$27,000 during this past year. The program continues to expand not only as new families become involved, but also as other relatives of present cases desire information. Of the thirty-six families involved in the program, only one involved a Pineland resident. Additional activities associated with the Genetics Program include lectures to high school students, training to Pineland and bureau employees and presentations at scientific meetings.

The Pineland Center Dental Clinic provides comprehensive dental treatment excluding orthodonture and complicated oral surgery. From July 1, 1980 June 30, 1981, the following number of dental visits were recorded in the appropriate categories:

	<u>Visits</u>
Residents	1,196
Outpatients (seen at Pineland Center)	1,273
Outpatients (seen in the Community)	387
Total	<u>2,856</u>

Inservice training is provided by the X-Ray Department to other departments as requested. The radiologists provide training to Pineland physicians on a weekly basis, as well as to interns from the Osteopathic Hospital. Services are provided not only for the retarded population, including residents of boarding and nursing homes, but also for employees of Pineland and the Governor Baxter School for the Deaf. A total of 1,056

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patients were seen by the X-Ray department during the last fiscal year.

The Medical Photography department administers Electroencephalograms and Electrocardiograms and provides emergency X-Ray coverage and medical photography.

During the fiscal year, the Psychology Department conducted 471 evaluations, 498 treatment or therapeutic activities and provided 1,498 consultations. Considerable hours are devoted to Interdisciplinary Team and other client related meetings as well as in-service training efforts. Psychologists are involved in the Judicial Certification process and participate in various standing and ad-hoc committees.

The Social Services Department is responsible for arranging community placements, preparing annual guardianship plans for those clients under Public Guardianship and participating in judicial certification hearings. In addition, the department coordinates contact with families and guardians. A total of 36 clients were successfully placed in the community during FY 81.

d. Care

Client Care is primarily based on the resident's medical condition. All Pineland clients are classified into three levels for appropriate care under the Intermediate Care Facility/Mental Retardation Program. A plan of care for each and every client is centered around physicians' orders which provide the basis for the day-to-day activities of the clients. Nursing staff provide assistance to residential program staff in interpreting the needs of the clients.

Presently, Nursing Services provides a 100-hour in-service education course for direct care staff. This course is formulated to give specific training in care of residents and to ensure that clients receive the specific standard of care needed to encourage their maximum self-development. Nursing staff follows up on all accidents and injuries to residents. Nursing coverage is provided as mandated by the ICF/MR regulations.

5. Staffing:

a. General Fund:

1) Positions authorized: 736

2) Positions filled September 1, 1981:

a) Full time: 713

b) Other positions: 7

b. Other funds (including vacant positions):

1) Full time: 2

2) Other Positions: 2

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c. Organization:

(See next five pages)

Chart I - Overall Organization

Chart II - Residential Services

Chart III - Program Services

Chart IV - Medical Services

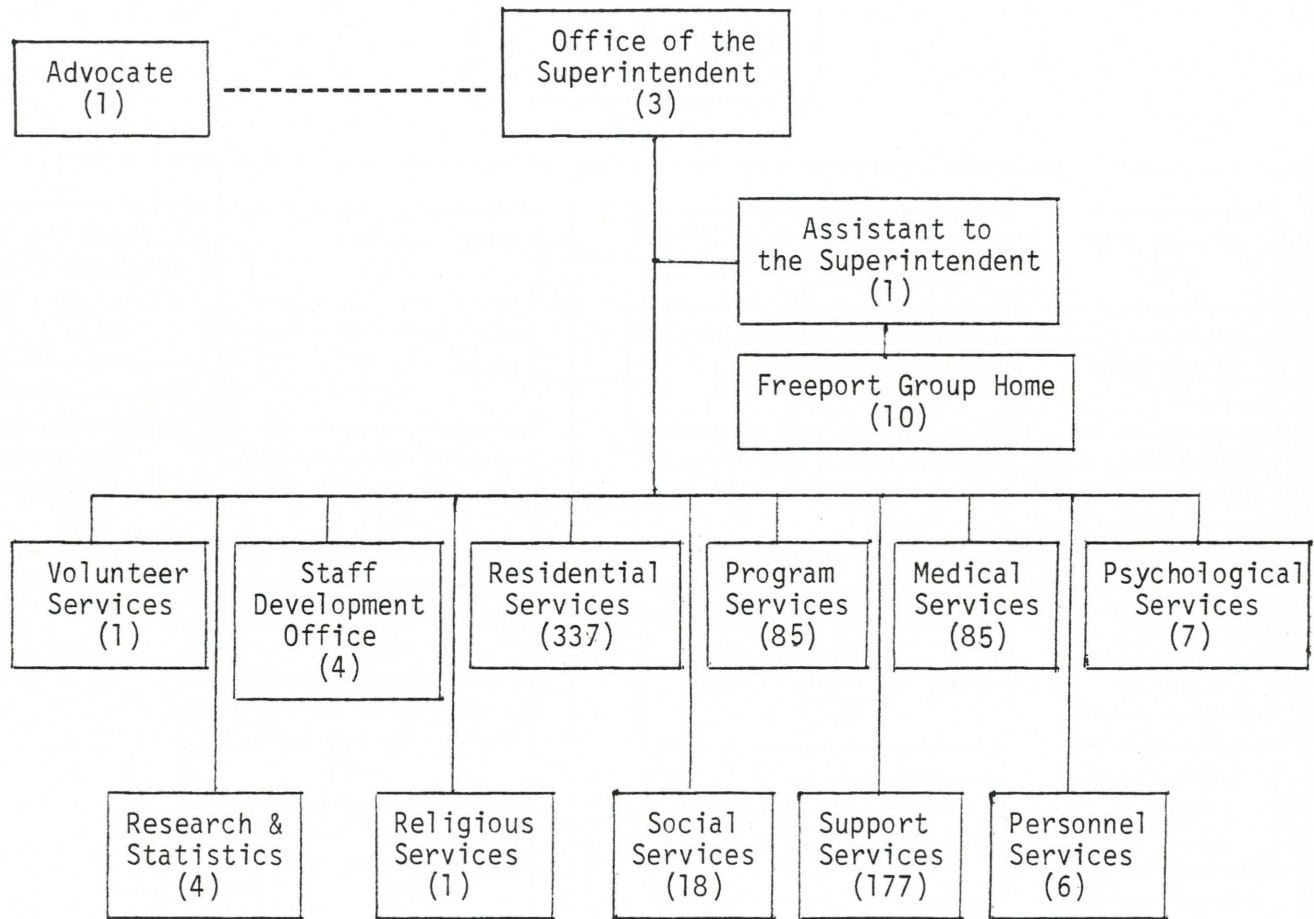
Chart V - Support Services

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Program Contact: George A. Zitnay, Superintendent

CHART I

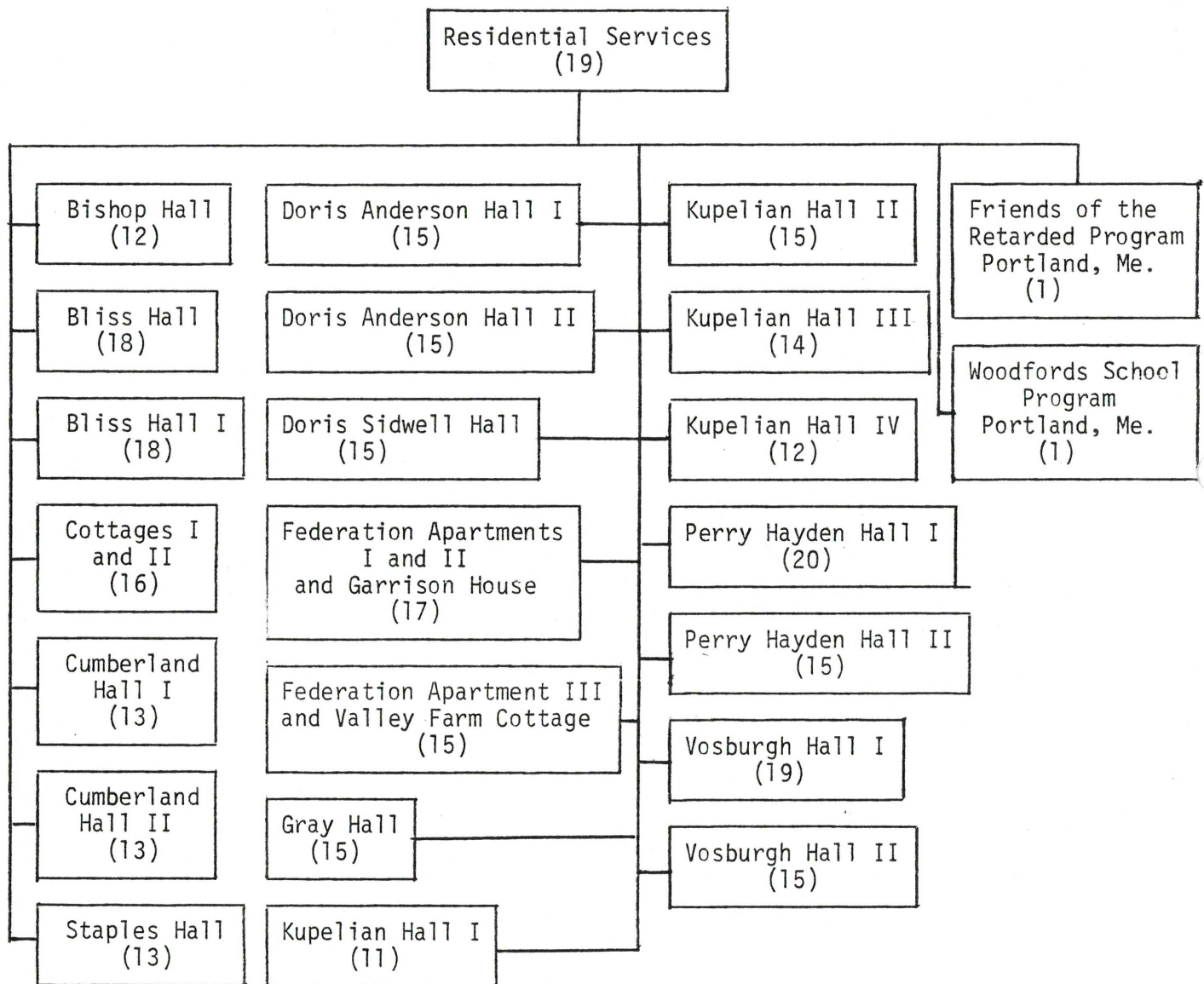


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CHART II

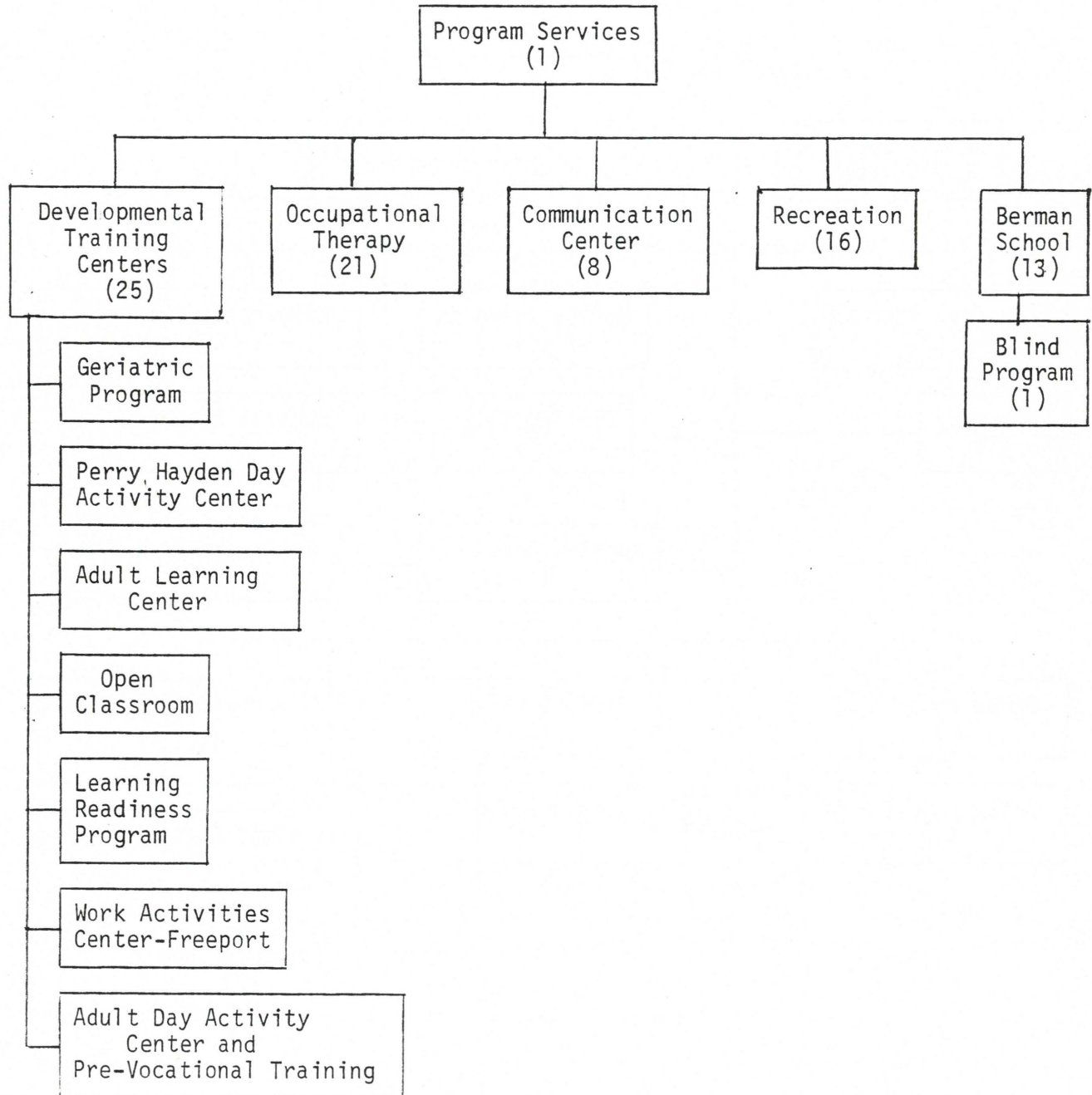


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CHART III

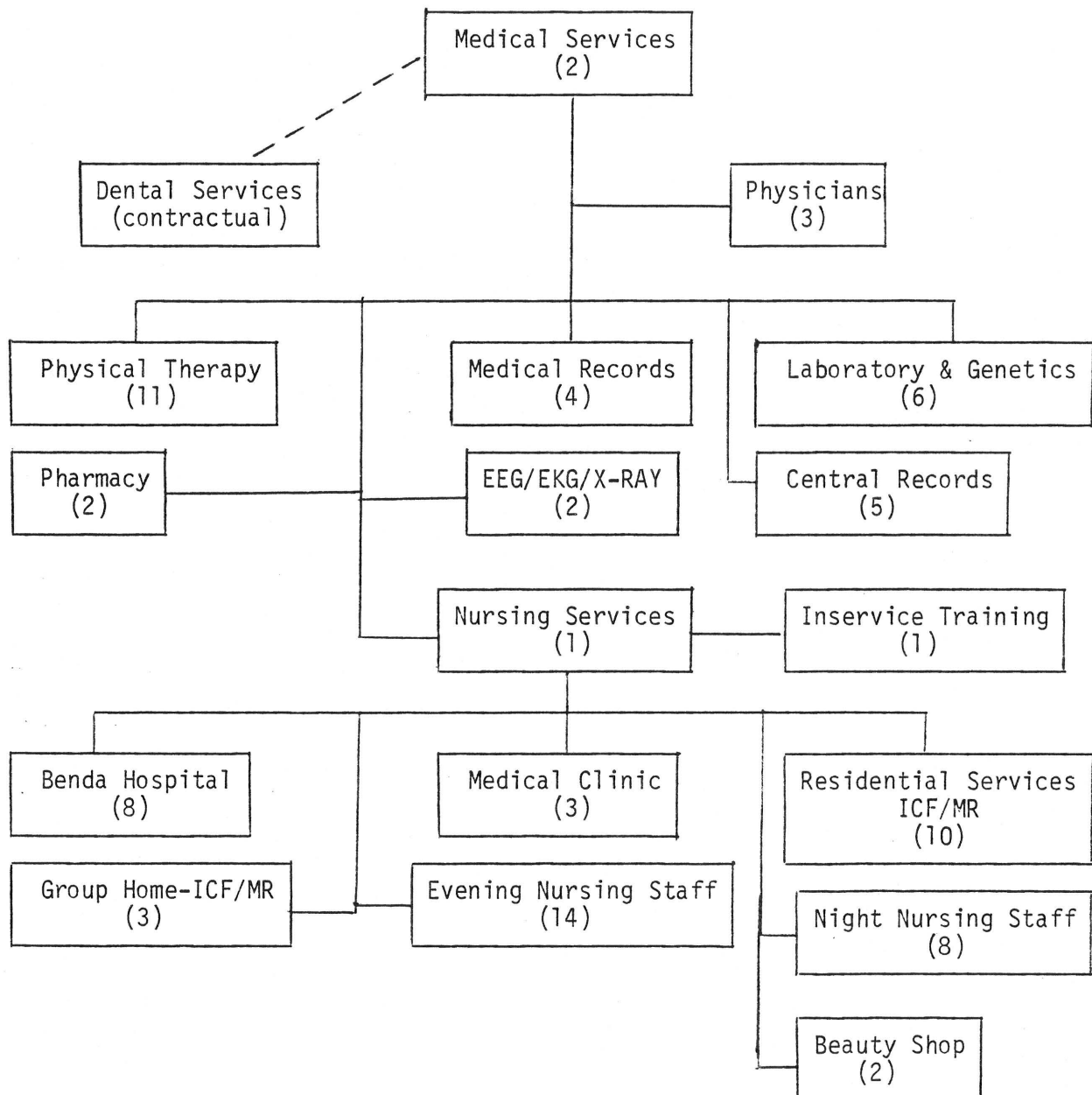


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Program Contact: George A. Zitnay, Superintendent

CHART IV

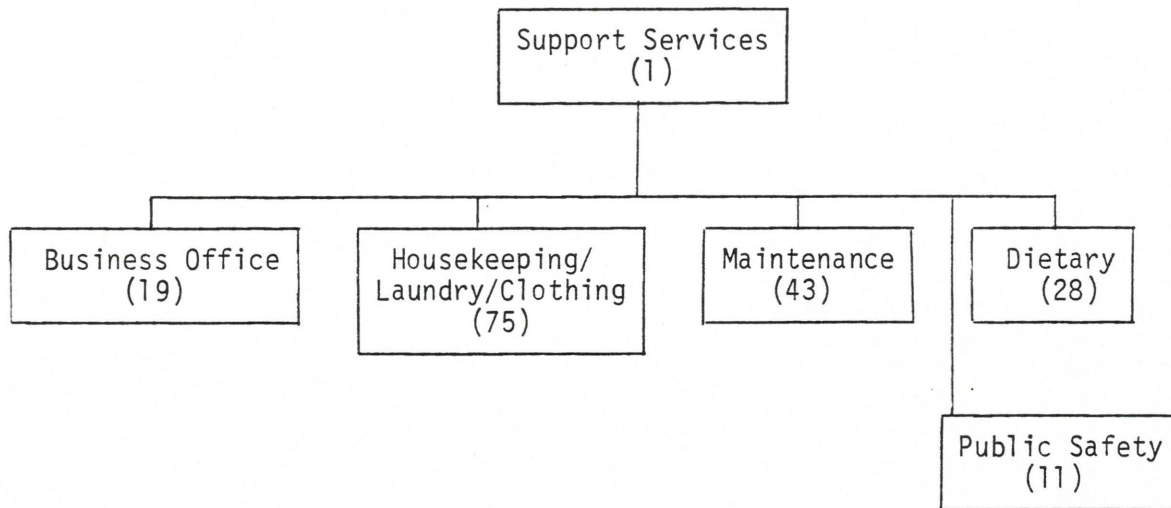


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CHART V



DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Superintendent	1		
Assistants to the Superintendent	2		
Clerk Stenographers III	3		
Clerk Stenographer II	1		
Social Research Scientist	1		
Clerk Typists III	4		
Clerk Typists II	16	.5	
Clerk Typist I	1		
Chief, Volunteer Services	1		
Advocate	1		
Chief, Residential Services	1		
Mental Health Worker VI	1		
Mental Health Workers V	8		
Mental Health Workers IV	3		
Mental Health Workers III	23		
Mental Health Workers II	42		
Mental Health Workers I	255		
Houseparents II	2		
Houseparents I	8		
Supervisor, Special Services	1		
Chief Occupational Therapist	1		
Occupational Therapist II	1		
Occupational Therapists I	4		
Occupational Therapy Aides	14		
Medical Secretaries	2		
Chief Speech Pathologist	1		
Speech Pathologist II	1		
Speech Pathologists I	2		
Speech Therapy Aides	4		
Director, Recreation	1		
Recreation Therapists	3		
Teacher/Principal	1		
Teacher-Blind, MR	1		
Teachers, Learning Disabilities	17		
Institutional Teacher Aides	4		
Teacher Aides MH&MR		2	
Vocational Trades Instructors	2		
Manual Training Coordinators	6		
Procurement Specialist	1		
MR Program Supervisors	4		
Psychology Assistant	1		
Clinical Director	1		
Physicians II	3		
Nurse V	1		
Nurse IV	1		
Nurses III	5		
Nurses II	16		
Recreation Aides	10		

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List of positions (continued):

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Licensed Practical Nurses	16		
Nursing Assistants I	16		
Pharmacist	1		
Pharmacy Technician	1		
X-Ray Technician	1		
Medical Photographer	1		
Director, Inst. Laboratory Services	1		
Laboratory Technician III	1		
Laboratory Technicians II	2		
Laboratory Technician I		.5	
Chief Physical Therapist	1		
Physical Therapist II	1		
Physical Therapist I	1		
Physical Therapy Aides	6		
Therapy Aide II	1		
Baker I	1		
Psychologist IV	1		
Psychologist III	1		
Psychologists II	4		
Planning & Research Assistant	1		
MR Director of Social Work	1		
MR Casework Supervisors	2		
MR Resources Coordinator	1		
MR Services Coordinator	1		
MR Caseworkers	7		
Medical Records Technician	1		
Reproduction Equipment Supervisor	1		
Business Services Manager	1		
Chief Safety Officer	1		
Senior Safety Officers	3		
Safety Officers	7		
Business Manager I	1		
Accountant II	1		
Accountants I	2		
Account Clerks II	2		
Account Clerks I	2		
Clerk III	1		
Switchboard Supervisor	1		
Switchboard Operators	4		
Storekeeper II	1		
Stores Clerks	2		
Institutional Services Supervisor	1		
Laundry Washmen	3		
Laundry Worker II	1		
Laundry Workers I	6		
Laborer II	1		

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List of positions (continued):

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Custodial Workers II	4		
Domestic Workers I	56		
Manager, Dietary Services	1		
Cook III	1		
Cooks II	3		
Cooks I	10		
Food Service Workers	8		
Light Equipment Operators	4		
Heavy Equipment Operators	3		
Supervisor, Grounds & Transportation	1		
Automotive Mechanics	2		
Janitor/Bus Drivers	3		
Plant Maintenance Engineer I	1		
Maintenance Mechanic Foreman	1		
Boiler Engineers	5		
Boiler Operators	4		
Machinist	1		
Building Maintenance Supervisor	1		
Plumber Foreman	1		
Plumber II	1		
Plumber I	1		
Painters	2		
Mason	1		
Carpenter Foreman	1		
Carpenters	5		
Electrician Foreman	1		
Electrician II	1		
Maintenance Mechanics	3		
Plant Maintenance Engineer III	1		
Dept. Personnel Officer I	1		
Personnel Technician I	1		
Staff Development Coordinator	1		
Staff Development Specialist II	1		
Staff Development Specialist I	1		
Chaplain I	1		
Seamstresses I	2		
Seamstress II	1		
Institutional Clothing Supervisor	1		
Locksmith	1		
Barber	1		
Beautician	1		
Total	736	3	

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6. Financial Data:

a. Appropriation account #: 1364.1; 1364.9; 3364.1; 4364.1

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>G.F. Appropriation:</u>	10,226,446	12,089,112	12,536,069
Balance Forward	90,727	42,711	-0-
Transfers	1,910,919	82,950	32,950
<u>Federal Funds Available:</u>	34,339	21,277	17,115
<u>Dedicated Revenue:</u>			
Balance July 1	123,534	28,970	-0-
Revenue	37,706	38,000	38,000
Total Funds Available	<u>12,423,671</u>	<u>12,303,020</u>	<u>12,624,134</u>
	<u>EXPENDITURES</u>		
	<u>1980-1981</u>	<u>1981-1982</u>	<u>1982-1983</u>
<u>Personal Services:</u>			
General Fund	10,988,579	10,795,947	11,118,588
Federal	23,153	20,568	17,115
Dedicated Account	29,309	-0-	-0-
Total Personal Services	<u>11,041,041</u>	<u>10,816,515</u>	<u>11,135,703</u>
<u>All Other:</u>			
General Fund	1,129,019	1,368,826	1,400,431
Federal	8,877	709	-0-
Dedicated Account	68,640	48,350	36,000
Total All Other	<u>1,206,536</u>	<u>1,417,885</u>	<u>1,436,431</u>
<u>Capital:</u>			
General Fund	67,783	50,000	50,000
Federal	-0-	-0-	-0-
Dedicated Account	34,321	18,620	2,000
Total Capital	<u>102,104</u>	<u>68,620</u>	<u>52,000</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>12,349,681</u>	<u>12,303,020</u>	<u>12,624,134</u>
Undedicated Revenue to G.F.:	4,880,816	5,980,591	6,401,591

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7. Other Programs:

Pineland Center occupies a unique role in providing very specialized services for some 340 severely and profoundly retarded persons who also have serious multiple handicaps and complex medical problems. Pineland also provides several types of respite care, various outpatient services to more than 1,000 persons and a variety of community-directed activities.

Similar residential service programs are limited in number and are estimated to total from 50 to 100 beds statewide. There are, however, many services and programs available for mentally retarded persons who are at higher levels of functioning, and who are less severely handicapped and medically involved.

Other state residential facilities for mentally retarded persons are the Aroostook Residential Center in Presque Isle and the Elizabeth Levinson Center in Bangor. The Aroostook Center serves mildly to moderately retarded persons from Aroostook County. The Levinson Center serves severely and profoundly retarded children age two to twenty, but normally limits placements to six months or less. Transfers between Pineland and these facilities have been minimal.

There are a number of private boarding, group and nursing homes for retarded persons in the state. These homes include: Treats Falls, Houlton Residential Center, Ocean View, Our House, Hayden House and the Gardiner Group Home. Because of the lack of vacancies and the intense nature of the care required, it is difficult to place residents from Pineland into any of these community facilities.

The Department of Human Services certifies ICF/MR facilities and determines client eligibility under Title XIX (Medicaid).

Most referrals to Pineland are made through the six regional offices of the Bureau of Mental Retardation. Community placements from Pineland are, for the most part, similarly arranged.

8. Program Effectiveness:

"The parties concur with the findings that Pineland Center is so fully in compliance with the Consent Decree as to merit the recommendation that the Court proceed to discharge Pineland Center from its jurisdiction."

Martti Wuori Case Report to the Court

Internal evaluation for effectiveness resulted in the following statistics for the past year:

- a. A total of over 1,000 quarterly and 572 annual client reviews were conducted through the Individual Program Plan (I.P.P.) process;

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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- b. Over 1,200 client evaluations were conducted for Pineland clients by the various disciplines and the Medical Department; approximately 2,000 clients received out-patient services;
- c. A total of 2,959 family and guardian contacts were made to communicate client information;
- d. Approximately 30,000 hours of programming were delivered to Pineland clients per month; an additional 7,000 hours resulted from the use of Camp Tall Pines during the summer;
- e. Sixty-seven percent of the Pineland client population averaged thirty or more program hours per week; the remaining clients were either medically excluded from full day programs or receiving partial programs;
- f. Client absenteeism from program participation was less than twelve percent;
- g. Certification of Pineland Center programs by the Department of Human Services as Developmental Training Centers generated approximately \$900,000 to the state's general fund;
- h. Certification of nearly all Pineland residents by the Department of Human Services as ICF/MR reimbursable generated approximately \$5.2 million to the state's general fund;
- i. In-service training totalling 9,451 hours was provided for Pineland staff; 128 employees participated in workshops, facility visitations or educational leave. In addition, Pineland and the University of Southern Maine provided Associate Degree courses for twenty-five direct care staff; and
- j. Ninety-five volunteers provided 21,764 volunteer hours to Pineland clients; an additional 357 individuals volunteered their services for special events.

9. Future Plans:

During the next ten years the plan for the operation of Pineland Center will generally reflect the state of the art as it pertains to the care and treatment of the mentally retarded, the outcome of federal legal proceedings and the impact of the economy on the expenditure of public dollars.

Pineland Center will continue to maintain approximately 350 beds. However, these beds will serve a wide variety of populations including the multiply handicapped on a short-term basis, de-emphasizing long-term care. Pineland will specialize in serving critical populations of Maine citizens who require special medical, behavioral, educational, vocational or social intervention. The services provided by Pineland to individuals with specialized needs will be comprehensive, community oriented and will include training programs for carry-over into the client's home.

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Mentally retarded individuals with behavioral problems who provide difficulty to their families and their communities are particularly difficult to serve. These individuals are mildly to moderately retarded and exhibit antisocial behavior of an aggressive and assaultive nature. These individuals have historically been unsuccessful in many programs within both institutional and community settings. Because of the nature of their dual problem, it has been difficult to provide a stabilized program to meet their needs. Pineland Center can serve as a specialized resource for intervention, stabilization, vocational training and education for this behaviorally disruptive group of mentally retarded citizens.

Planning for this service will require a comprehensive approach involving Pineland Center, the community and other state agencies. A specialized program to deal with these behaviorally and socially disruptive clients located at the institution will provide a service that currently does not exist in Maine. As part of this program, outreach and training in community homes will also be provided in order to facilitate a meaningful transition for the individual from the institution to the community. Special workshops, in-service training and support services will be provided to public safety agencies who are currently involved with this population, as public education will be essential to the success of this program.

Future plans also call for more emphasis to be placed on outpatient and day services utilizing the highly trained and competent professional staff at Pineland Center. Day services involving medical, educational, counseling and vocational training will be expanded to serve as a resource for individuals for whom no comparable services exist in the community and for training individuals to work in the community with this population. Pineland Center will provide support services to the community program. Research and development of new programs, new techniques and methodologies will be conducted at the facility. Training programs at all levels will be implemented for parents, staff and community providers. Finally, affiliations with a wide range of universities and colleges will be developed to assist in the costly and complex training of specialists to meet the need of Maine citizens.

Pineland Center will continue to pursue the following:

- a. The least restrictive alternative for its clients, developing personalized and quality program services;
- b. Accreditation by professional organizations, certification as an ICF/MR and compliance with the standards of the Consent Decree; and
- c. Development of a comprehensive computer program in cooperation with the Bureau of Mental Retardation and the Division of Planning.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Maine Committee on Problems of the Mentally Retarded

Program Contact: J. Daniel Gendron, Chairman

1. Authorizing legislation or other program mandate:

a. Legal citation:

§ 2613 Maine Committee on Problems of the Mentally Retarded; duties

There shall be a Maine Committee on Problems of the Mentally Retarded composed of 12 members, consisting of one member from the House of Representatives appointed by the Speaker of the House and one member from the Senate appointed by the President of the Senate, the President of the Maine Association for Retarded Citizens and 9 representative citizens appointed by the Governor, who shall designate a chairman. Appointments shall be made for 3 years. Members of the committee shall serve without pay, but will be reimbursed for expenses on the same basis as state employees. The terms of the members serving on the effective date of this Part shall not terminate or be modified as the result of this Part.

The duties of the Maine Committee on Problems of the Mentally Retarded shall be to act in an advisory capacity to the commissioner and to the director of the bureau in assessing present programs, planning future programs and in developing means to meet the needs of the retarded in Maine.

b. Other mandates:

§ 2614 State Planning and Advisory Council on Developmental Disabilities

(1) Council established. The Governor shall establish a State Planning and Advisory Council on Developmental Disabilities and appoint appropriate representatives, not only including such representatives as are required as a condition of eligibility for benefits under the Act entitled "Developmental Disabilities Services and Facilities Construction Act of 1970" as enacted by P.L. 91-517 on October 30, 1970, by the Congress of the United States, but also ensuring that there is at least one representative from each of the regions established by the bureau. This council shall consult with the director of the bureau in carrying out the purposes of this chapter.

(2) Sole administering agency: powers. Except where a single state agency is otherwise designated or established in accordance with any other state law, the bureau is designated to be the sole agency of the State to establish and administer any statewide plan for the construction, equipment, maintenance or operation of any facility or related services, which plan is now or may hereafter be required as a condition to the eligibility for benefits pursuant to the provisions of the Federal Act specified in subsection 1. The bureau is also authorized to receive, administer and expend any funds that may be available under this Federal Act or from any other sources,

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public or private, for such purposes.

Pineland Consent Decree.

2. Public Need:

Based on national incidence figures, there are 30,000 mentally retarded children and adults in Maine. The Bureau of Mental Retardation actively serves approximately 4,000 mentally retarded people per year, including those who are served through state institutions. Many of the remaining 26,000 people are either retarded children in public or private educational settings, or children up to 5 years of age or retarded adults being cared for at an often tremendous burden to family or relatives.

The life-long needs of most mentally retarded people can be and often are extensive and complex. In addition, mentally retarded people are not always capable of speaking for themselves. Families have historically yielded to the pressures of society and have quietly kept their retarded children or relatives at home. Only within the last 10 to 15 years have mentally retarded citizens "come out of the closet". This emergency has brought to light the extraordinary and often destructive forces that caring for certain mentally retarded people at home has had on many Maine families. It has also demonstrated that, given the opportunity and certain support services, mentally retarded people can often do the skills necessary for a happy and meaningful life.

The Maine Committee on Problems of the Mentally Retarded serves as the common public voice for all of Maine's mentally retarded citizens. The committee provides a public forum in which any issue concerning a retarded person or program serving retarded people can be brought. In its capacity as an advisory body to the commissioner of the department and director of the bureau, the committee has direct access to the "decision-makers" in its attempt to help resolve problems brought before it.

3. Program Objectives:

The program objectives of the Maine Committee on Problems of the Mentally Retarded are threefold:

- a. to act in an advisory capacity to the commissioner and to the director of the bureau in assessing present programs, planning future programs and in developing means to meet the needs of the retarded in Maine;
- b. to be active and reactive on issues brought before the committee or on behalf of any mentally retarded person, whether the issue be specific to one person, to a single program or to the entire service system; and
- c. to impact on legislative and congressional action as it related to programs and services for the mentally retarded citizens of Maine.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Maine Committee on Problems of the Mentally Retarded

Program Contact: J. Daniel Gendron, Chairman

4. Program Operation:

- a. The committee holds monthly meetings (often in various locations across the state). The meetings are public. Each member reports on his/her local activities since the last meeting.
- b. Committee members do "field work" in the geographical area from which they come. They are publicly identified as local representatives of the committee to which any interested party can address an issue.
- c. Periodic "advisory sessions" are held between either the chairperson or a subcommittee and the commissioner and/or the director. The director attends all committee meetings.
- d. The committee members participate in public hearings and legislative hearings and offer testimony on behalf of the committee relative to matters concerning the mentally retarded.
- e. The committee frequently corresponds in writing on issues regarding the mentally retarded with the Governor, state agency officials, the legislature and its committees, and other statewide advocacy and service organization.
- f. The work of the committee is carried out by its members, with assignments made either on a volunteer or by the chairperson.
- g. Decisions are made by a majority vote of the committee members present and in consideration of any public comment made on the issue at hand.

5. Staffing:

N/A

6. Financial Data:

All Other - Travel, meals and meeting place expenses are covered by the All Other account of the Bureau. FY 81 \$4,355.92.

7. Other Programs:

The Maine Committee on Problems of the Mentally Retarded seeks to coordinate its activities with each of the following organizations:

- a. The Developmental Disabilities Council has a broad federal mandate of assuring that all state agencies are fulfilling their obligations to all developmentally disabled citizens, of which the mentally retarded is only one portion.
- b. The Consumer Advisory Board has been established by the Pineland Center Consent Decree to recruit volunteer "correspondents" for each of the

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Maine Committee on Problems of the Mentally Retarded

Program Contact: J. Daniel Gendron, Chairman

approximately 1,000 mentally retarded people included in this class action suit, and to assure that their rights are not abridged.

- c. Advocates for the Developmentally Disabled has been designated by the Governor as the federally mandated "Protection and Advocacy" agency (required under the federal Developmental Disabilities Act). The organization has primary responsibility for client specific advocacy services.

8. Program Effectiveness:

The Maine Committee on Problems of the Mentally Retarded has been successful in meeting their stated objectives in a variety of ways. Some examples in recent months would be:

a. Objective #1:

- 1) We have worked with the Bureau of Mental Retardation in the development of plans for meeting the transportation needs of the mentally retarded. Committee members have attended public hearings, served on committees, advised regional transportation planners and gathered supportive data to assist in the state transportation planning.
- 2) We have spent a great deal of time in advising and assisting the bureau as they developed and reassessed the state ICF/MR licensing requirements.
- 3) The committee has been most active in seeing that the Pineland Consent Decree is carried out. A member of this committee serves as chairperson of the Consumer Advisory Board, established by the Consent Decree.
- 4) The committee has provided advice to the commissioner on concerns of Maine citizens as they relate to the overall operation of both Pineland Center and the Elizabeth Levinson Center.

b. Objective #2:

- 1) In this area, the committee has been extremely active. We have responsibility for the removal of all inappropriate "time out" devices brought to our attention.
- 2) We have kept close watch on the state's representative payee program in order to prevent misuse of these funds.
- 3) The committee has served as a public vehicle for persons who have concerns in the overall state operation, as it relates to the care of the mentally retarded.
- 4) The committee has closely monitored the crisis intervention program, as

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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well as the state's Behavioral Modification Program.

- 5) Committee members have assisted in the development and supervision of many group home programs across the state.

c. Objective #3

- 1) Perhaps this has been the committee's strongest contribution, as members have written letters, made phone calls and had direct contact with both state and national legislators in the development of legislation that would affect our state's mentally retarded citizens.
- 2) Committee members appear at most public hearings on legislative documents affecting the mentally retarded.
- 3) The committee has advised the commissioner on proposed department legislation, as well as developing supportive data.
- 4) Committee members actively seek legislative supporters for proposed legislation.
- 5) Committee members attend workshop sessions, as well as legislative hearings, to insure that the rights of the mentally retarded citizens of Maine are properly addressed.

9. Future Plans:

Realizing that the problems of the mentally retarded are constantly undergoing change, the Maine Committee on Problems of the Mentally Retarded also see a need for their goals and objectives to continually be reevaluated. With this premise in mind, the following have been determined to be some of the long range goals of this committee.

On the level of administrative procedures, the committee has made several recent innovations in their method of operation:

- a. all committee meetings will be conducted in accordance with "Roberts Rules of Order";
- b. the chairperson has appointed a committee to see that the committee's overall purpose is clearly defined in a mission statement;
- c. a vice-chairperson shall be selected by the committee; and
- d. the committee will request occasional meetings with the Governor to discuss specific issues.

While the committee sees no immediate change in their overall objectives, they would like to note that the present committee's intentions are to place

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their greatest emphasis on addressing major issues and statewide problems facing the retarded citizens of Maine. The committee feels the key words are major issues.

The committee has developed a list of specific long-term objectives and goals that, at the present time, they feel will be the committee's main focus during the next several years:

- a. to continue to prepare, introduce and actively support progressive legislation that will enrich and protect the needs of Maine's mentally retarded citizens (i.e. zoning, sterilization, etc.);
- b. to see that the quality of care now being provided to Maine's mentally retarded continue to improve;
- c. to ensure that transportation needs of our state's retarded citizens are fully addressed and that necessary funds are made available to ensure that no retarded individual is denied access to programs due to the lack of transportation;
- d. to constantly strive to upgrade the training of those people entrusted with the delivery of services to Maine's mentally retarded;
- e. to ensure that the rights of the retarded, as defined by federal and state laws, are constantly protected;
- f. to promote, at all levels, programs in research and development that will better the lives of present and future retarded citizens of Maine;
- g. to provide leadership and support to ensure that funding is available for all state and community-based programs serving the retarded;
- h. to develop plans that will continue to create an even greater public awareness of the needs of the retarded;
- i. to continue to support and seek to expand, where appropriate, existing programs offered to the retarded citizens of Maine;
- j. to provide assistance, where needed, to all parent groups/organizations designed to serve the retarded;
- k. to assist in the development of community alternative living programs;
- l. to provide support in the development of statewide programs designed to promote recreation and leisure time activities for the mentally retarded, (i.e. Special Olympics, Special Arts Festival);
- m. to monitor the Supplemental Security Income program, as it affects the retarded;

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- n. to support the expansion of generic services made available to Maine's mentally retarded citizens;
- o. to continue to serve as an advocacy group to all Maine citizens in regard to problems of the mentally retarded;
- p. to assist the Bureau of Mental Retardation in the development of their state plan, as it relates to the mentally retarded; and
- q. to promote and support the ongoing cooperation among all branches of state government, as it relates to the development of services to the mentally retarded.

The committee realizes that these objectives reflect a commitment on their part and stand ready to be judged accountable in future years.

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Program Contact: John E. Greene, Executive Director

1. Authorizing legislation or other program mandate:

a. Legal citation:

34 M.R.S.A. § 13, P.L. 1981, Chapter 42

b. Other mandates:

Executive Order # 5 FY 81/82 issued by Governor Joseph E. Brennan dated November 3, 1981

P.L. 95-602, Title V, § 512, 92 Stat. 3015, "Rehabilitation, Comprehensive Services and Developmental Disabilities Amendment of 1978" (enables rehabilitation, independent living and developmental disabilities programs at the federal and state levels)

2. Public Need:

Maine has approximately 17,700 developmentally disabled citizens. Approximately three percent (3%) of all live births involve a substantial disabling condition. Because of a relatively higher mortality rate, the percentage of developmentally disabled persons within the general population sharply decreases as they move along the age range.

Total General Population	1,124,660
Total DD population	17,700
<u>Age</u>	
0 - 2 = 1,739 - 9.85% of DD population	
3 - 17 = 5,525 - 31.29% of DD population	
18 - 64 = 9,771 - 55.39% of DD population	
65+= 570 - 3.23% of DD population	

Traditionally, for a number of reasons (higher costs, more time, less immediate response to treatment, etc.), the needs of severely disabled people, such as the developmentally disabled, have not been fully met. Because of the nature and early onset of the disability, a developmentally disabled person often lacks the background or ability to speak on his or her own behalf. Consequently, a public forum, as provided by the Developmental Disabilities Council, is needed to offer consumers, parents and family members, and other interested persons, the opportunity to meet with state agency representatives and other providers to address the needs and concerns of developmentally disabled persons.

3. Program Objectives:

The primary purpose of the Maine State Planning and Advisory Council on Developmental Disabilities is to improve and enhance the network of services

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available to developmentally disabled persons of all ages in Maine.

A developmental disability is defined in P.L. 95-602, Section V as "a severe chronic disability of a person which,

- a. is attributable to a mental or physical impairment or combination of mental and physical impairments;
- b. is manifested before the person attains age twenty-two;
- c. is likely to continue indefinitely;
- d. results in substantial functional limitations in three or more of the following areas of major life activity:
 - 1) self-care;
 - 2) receptive and expressive language;
 - 3) learning;
 - 4) mobility;
 - 5) self-direction;
 - 6) capacity for independent living; and
 - 7) economic self-sufficiency; and
- e. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services which are individually planned and coordinated."

(This new definition, established by P.L. 95-602, mandates a departure from the definition which specified the categories of mental retardation, cerebral palsy, epilepsy, autism and certain learning disorders.) This new definition has broadened the range of impairments which may be covered by the developmental disabilities program. Persons with functional limitations in three or more areas of major life activities are the focus of the DD Council's activities.

General objectives of the DD Council are:

- a. to conduct an annual review and examination of the network of services to developmentally disabled persons;
- b. to develop, in conjunction with the administering agency, an annual state plan that both reports on the current status of the service network and makes specific recommendations for filling service gaps that are identified in the annual review;

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- c. to conduct informational, advocacy and influencing activities with the legislature and the affected state agencies and the Governor's Office;
- d. to recommend specific uses of the direct services portion of the Council's basic grant to develop or provide services to fill gaps in the service network; and
- e. to develop and submit reports, through the Governor, to the Secretary of Health and Human Services, as the secretary may reasonably request.

For program year 1982 (October 1981 - September 1982), the Council will focus on the following specific service areas:

- a. Child Development Services - Early identification, diagnosis and evaluation, early intervention (therapy and treatment) and parent training and involvement. The Council will focus on the 0 - 2 year old population as the most vulnerable and the most amenable to treatment, hence most effective in terms of cost/benefit ratios.
- b. Housing Alternatives - Personal care, zoning and respite care. This activity will have a primary focus on housing for adults with secondary emphasis on respite care for children.

4. Program Operations:

The Maine State Planning and Advisory Council on Developmental Disabilities was established in 1971 by an Executive Order. The Council now consists of twenty-five members appointed by the Governor or serving by virtue of their office in a state agency. Gubernatorial appointees are developmentally disabled persons, parents or other family members, and representatives of non-state provider agencies. The membership reflects a regional distribution across the state, as well as an attempt to equitably represent the various disabilities associated with the target population.

The Council is staffed by an executive director and a secretary as well as a training and information coordinator. In addition, planning, administrative and clerical support is provided as needed. Other sources of manpower, such as consultants, special projects, etc. are utilized as needed.

By utilizing a range of approaches and devices such as staff research, review of state plans and other documents, surveys and hearings, the council conducts its annual review of Maine's service network. From this review, the planning, informational, advocacy, influencing and other activities are conducted.

Through monthly meetings the council examines the issues of:

- a. the network of services which includes policies, planning, levels and accessibility of services, geographic distribution, costs, case management, continuity of services, etc.;

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- b. identification of target population--birth records, medical information, client profiles, information management (referrals, follow-up, results, etc.), movement through the service network; and
- c. advocacy and influencing--public education and information, in-service training, research and reports and other activities as appropriate.

5. Staffing:

a. General Fund:

1) Positions authorized: None

2) Positions filled September 1, 1981:

a) Full time: None

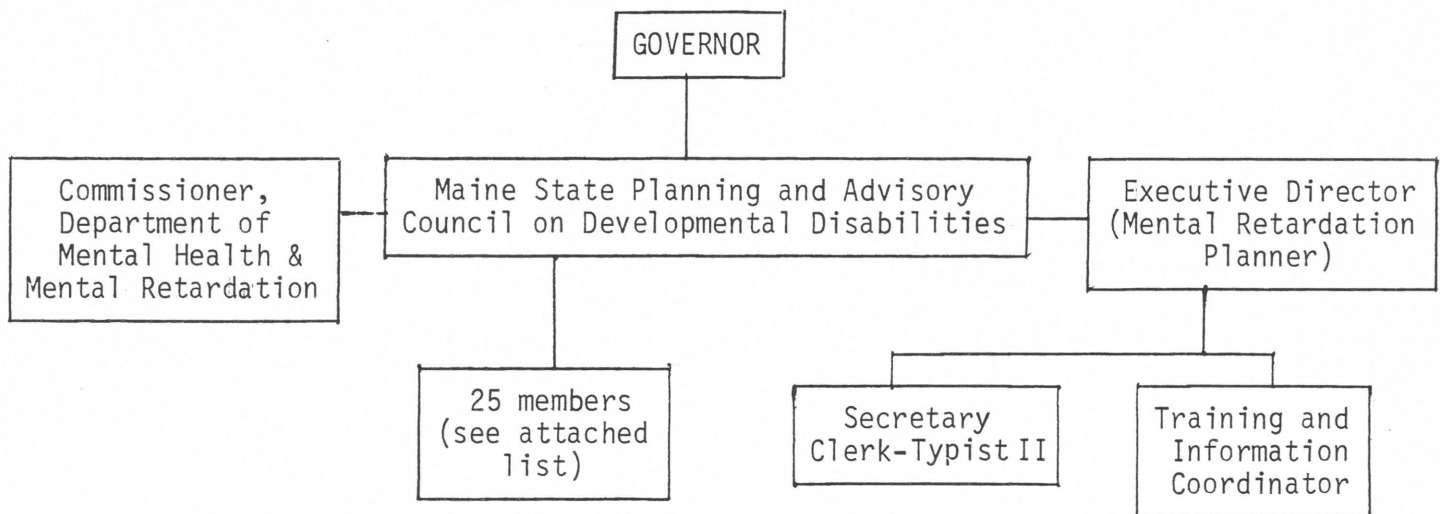
b) Other positions: None

b. Other funds (including vacant positions):

1) Full time: 2

2) Other positions: 1

c. Organization:



d. List of Positions:

<u>Title</u>	<u>General Fund</u>	<u>Federal Revenue</u>	<u>Other Revenue</u>
Mental Retardation Planner		1	
Clerk Typist II		1	
Training & Information Coordinator			1

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Program: Maine State Planning and Advisory Council on Developmental Disabilities

Program Contact: John E. Greene, Executive Director

MEMBERSHIP OF THE STATE PLANNING COUNCIL

Representatives of Federally Assisted Programs:

1. Ronald S. Welch, Director, Bureau of Mental Retardation, Department of Mental Health and Mental Retardation
2. Harold Reynolds, Commissioner, Department of Educational and Cultural Services
3. Michael Petit, Commissioner, Department of Human Services
4. Kevin W. Concannon, Commissioner, Department of Mental Health and Mental Retardation
5. Carroll M. Macgowan, Chief Advocate, Department of Mental Health and Mental Retardation

Other Required Representatives:

6. Dr. Jurgen Homann, Director of Behavior Science Program, Eastern Maine Medical Center
7. Marjorie Gray, Special Education Teacher, S.A.D. #17
8. William Haney, Executive Director, Pine Tree Society for Crippled Children
9. Dale Lowe, Executive Director, Green Valley Association for Retarded Citizens
10. Geraldine Paterson, Consulting Nurse, Mid-State United Cerebral Palsy
11. Vacant

Persons with Developmental Disabilities:

12. Herbert Leavitt, Augusta
13. Nancy Tracy, Hallowell
14. Vacant
15. Vacant

Persons Representing Individuals with Mental Impairing Conditions:

16. Edeltraut Thiele, Fort Kent, Maine
17. Carol Boston, Augusta, Maine
18. Lauret Crommett, Augusta, Maine

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MEMBERSHIP (continued)

19. Deborah Schall, Brunswick, Maine

20. Vacant

21. Vacant

Parent of Institutionalized Person:

22. Vacant

Other Representatives of Individuals with Developmental Disabilities:

23. Josephine Emanuelson, Chairman, Portland, Maine

24. Debbie Tuck, Belfast, Maine

25. Vacant

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

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6. Financial Data:

a. Appropriation account #: 3360.2006; 2009; 2010; 2016

b. Estimated revenues:

	<u>FUNDING SOURCES</u>		
	<u>1980 - 1981</u>	<u>1981 - 1982</u>	<u>1982 - 1983</u>
<u>G. F. Appropriation:</u>	-0-	-0-	-0-
<u>Federal Funds Available:</u>	284,600	250,000	250,000
<u>Dedicated Revenue:</u>			
Balance July 1	-0-	-0-	-0-
Revenue	-0-	-0-	-0-
Total Funds Available	<u>284,600</u>	<u>250,000</u>	<u>250,000</u>
	<u>EXPENDITURES</u>		
	<u>1980 - 1981</u>	<u>1981 - 1982</u>	<u>1982 - 1983</u>
<u>Personal Services:</u>			
General Fund	-0-	-0-	-0-
Federal	15,813	31,896	33,491
Dedicated Account	-0-	-0-	-0-
Total Personal Services	<u>15,813</u>	<u>31,896</u>	<u>33,491</u>
<u>All Other:</u>			
General Fund	-0-	-0-	-0-
Federal	261,940	218,104	216,509
Dedicated Account	-0-	-0-	-0-
Total All Other	<u>261,940</u>	<u>218,104</u>	<u>216,509</u>
<u>Capital:</u>			
General Fund	-0-	-0-	-0-
Federal	689	-0-	-0-
Dedicated Account	-0-	-0-	-0-
Total Capital	<u>689</u>	<u>-0-</u>	<u>-0-</u>
<u>TOTAL FUNDS EXPENDED</u>	<u>278,442</u>	<u>250,000</u>	<u>250,000</u>
Undedicated Revenue to G.F.:	-0-	-0-	-0-

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

Program: Maine State Planning and Advisory Council on Developmental Disabilities

Program Contact: John E. Greene, Executive Director

7. Other Programs:

a. Governmental:

Committee on Problems of the Mentally Retarded - This group is designated by the Governor to advise and consult with the Bureau of Mental Retardation. Their interest lies in the population of the state that is mentally retarded.

Mental Health Advisory Council - also designated by the Governor; specifically designed to study the manpower needs of the mental health system in the state.

Governor's Committee on Employment of the Handicapped - A group designated by the Governor to study the employment needs of handicapped people.

Interdepartmental Coordinating Committee (residential and preschool programs) - A special purpose group established by the Governor to coordinate programs and services for handicapped preschool and school-age children.

Maine Independent Living Council (MILC) - The policy making group for the Vocational Rehabilitation Independent Living Program.

b. Private:

Advocates for the Developmentally Disabled - A private not-for-profit group dedicated to Case Advocacy and Community Education on behalf of the developmentally disabled.

Association for Young Children with Special Needs (AYCSN) - A private group of providers, parents and other concerned people dedicated to the needs of young special needs children.

Maine Association of Handicapped People (MAHP) - A private group dedicated to full participation and integration of handicapped people into the mainstream of society.

8. Program Effectiveness:

Since its inception in 1971, the Council has met an average of once every month and has collected information and conducted numerous statistics on the service network as it exists in Maine. The Council has developed an annual plan each year that has been used to guide the Council's activities within the system. Advocacy and influencing activities have been carried out with consistently improving results (preschool handicapped children's projects, "set-aside" for state purchases, etc.). Through its direct service grants, the Council has put more than one and a half million dollars into the developmental disabilities service network in support of housing, education, children's services and other programs.

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For example, in FY 81 the Council granted funds to:

- a. the Maine State Housing Authority for development of group homes for mental health/mental retardation/developmental disabilities clients;
- b. the Advocates for the Developmentally Disabled for support of housing and children's services in advocacy;
- c. the Southern Maine Child Development Center for diagnosis, evaluation and case management services for 0 - 5 year old developmentally disabled children;
- d. the Aroostook County for development of a coordinated system of identification, diagnosis and evaluation of DD children.
- e. Mid-State United Cerebral Palsy for therapy and parent training for DD children and their families;
- f. North Eastern Maine United Cerebral Palsy for therapy and parent training for DD children and their families; and
- g. Cornerstones of South Paris for therapy and infant stimulation for DD children.

Almost all of the programs initiated with the help of DD Council funds are still in existence and are continuing to provide services for the developmentally disabled (e.g. Mobius, Inc. in Damariscotta, Community Shelters, Inc. in Augusta, Inland Associates, Inc. of Lewiston).

This success rate is due to the Council's and the administering agency's practice of careful selection of grantees and the requirement that grantees have available funds from other sources to augment the grant.

The Council has commissioned a number of studies that have been distributed to the Governor's Office, affected agencies, the legislature and interested groups and individuals (e.g. Maine's Compliance with Special Education Laws, Developmentally Disabled Persons Housing Needs Survey, a primer on special education).

9. Future Plans:

The Maine Planning and Advisory Council on Developmental Disabilities will continue its focus on the system's network of services for the developmentally disabled. The basic program objectives will remain the same with a continuing emphasis on the needs of infants and small children and the residential needs of adults and older children.

The scope of the Council's work will broaden as the various levels of government struggle with the responsibility of the structure and funding of the

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service network. If the federal government is successful in its attempts to reduce its financial participation, the Council will need to work more intensely with state and local governments as the responsibilities for meeting the needs of developmentally disabled citizens would be shifted to the state and local level.

Governor Brennan has recently appointed six new members to the Council. New members will receive training and orientation regarding the mission and purpose of the Council. The new members reflect the broader target groups made necessary by the new definition and the background necessary for examining the priority service areas of child development and housing alternatives.

SUNSET REVIEW

SUMMARY 1982

SUPPORTIVE DOCUMENTS
AND
BACKGROUND INFORMATION

GOVERNOR'S MENTAL HEALTH MANPOWER COMMISSION

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1. Executive Order No. 7, FY 79, March 20, 1979 Creating the Governor's Mental Health Manpower Commission.
2. Extract from the Public Health Service Act.
3. An Introduction to State Mental Health Manpower Development.
4. Background Materials: Why Manpower Development? Why Maine?
5. Year One Status Report.
6. Year Two Status Report.
7. Survey of Primary Physicians - SSRI.

SUNSET REVIEW

SUMMARY 1982

SUPPORTIVE DOCUMENTS
AND
BACKGROUND INFORMATION

STAFF DEVELOPMENT OFFICE

TABLE OF CONTENTS

1. Background and Purpose.
2. Current Program Activities
 - A. Boarding Home Training - report attached.
 - B. Behavior Management.
 - C. Primary Care Training - report attached.
 - D. Career Mobility Training - report attached.
 - E. 2% Technical Assistance.
 - F. University Interns.
 - G. Law Enforcement Officers.
 - H. Rehabilitation Training.

Sunset Review Back-up Materials

CSS Project

Maine's Chronically Mentally Ill - Summary of the Interim Report - March 1979

State of Maine Mental Health & Corrections - Interim Report - December 1978

State of Maine Mental Health & Corrections - Final Report for Year 1 - Jan. 1980

Status Report - Minority Populations & The Mental Health System - September 1979

Status & Direction - April 1980

Evaluation Plan for the Maine CSS Project - March 1980

Three-Year CSS Action Plan - May 1979

Year III Plan - June 1980

Year III Plan (Revised) - August 1980

Year III Management Plan - September 1980

Progress Report: Year II - April 1980

Year II - Final Report - January 1981

Family Support Group Organizing Materials - September 1981

Executive Summary State of Maine CSSP Implementation Grant - August 1981-July 1982
(Catalog of Federal Domestic Assistance 13,242-Mental Health Research Grants)

State of Maine Application CSSP Implementation Grant - August 1981-July 1984
(Catalog of Federal Domestic Assistance 13,242-Mental Health Research Grants)

STATE OF MAINE

Inter-Departmental Memorandum Date January 6, 1982

From Ronald R. Martel, Assoc. Comm. Administration
Elizabeth Dunton, Superintendent

Dept. Mental Health & Mental Retardation

Dept. Military & Naval Children's Home

Subject Direct Care Justification - Sunset Review Back-up Data

The Children's Home has five house parents on staff; two are on duty in direct care for 24-hour shifts. They work four days on and 1½ days off. Also, the Superintendent and houseparent supervisor work shifts so there are three on duty.

Whether we have 15 or 20 children, the direct care is necessary because we are dealing with teenaged mixed groups. We never know when we will have an emergency placement. We service children from the ages of two to 18.

ED/ss

Maine Department of Mental Health and Mental Retardation

Office of Children's Services

411 State Office Building, Station 40, Augusta, Maine 04333 (207) 289-3161

SEPH E. BRENNAN
Governor

KEVIN W. CONCANNON
Commissioner



EDWARD C. HINCKLEY
Director

7 January 82

TO: Ronald R. Martel
Associate Commissioner (Administration)

FROM: Edward C. Hinckley

RECEIVED

JAN 7 1982

SUBJECT: SUPPLEMENTAL "SUNSET REVIEW" MATERIAL

Department of
Mental Health & Mental Retardation

Current means of assessing program effectiveness include the following:

- (1) Individual treatment reports In the case of residential treatment placements, semi-annual progress reports as well as discharge reports are required from the provider for each child. These detailed reports address such topics as "Report of progress toward educational and treatment goals," "Report of child's adjustment to residential care and treatment," "Psychological and/or psychiatric report," and "Report of any family contacts and/or involvement in the child's treatment."
- (2) Success at maintaining or re-establishing the family unit In the case of family support/early intervention programs, the initial referral to the provider agency is because of some family crisis that has the potential of breaking up the family unit; i.e., a child is in danger of being removed from the family. The effectiveness of the intervention is measured in part by the prevention of this removal or the early return of the child if removal for respite purposes is judged to be appropriate.
- (3) Provision of supplemental services A number of programs supported by the Office of Children's Services permit the provision of services during the summer or after-school hours to supplement those provided by other agencies for emotionally handicapped children. Individual case-by-case documentation shows change in home and school behavior, and in academic performance and a significant number of children receiving such services have avoided institutionalization as a result of them.
- (4) Degree of parental involvement Without exception, the greater the degree of parental involvement in the program and services provided to the handicapped child, the greater the effectiveness of those services in producing permanent changes in the child's behavior and emotional growth. An increasing number of providers are actively involving parents during the course of treatment (or other service deliveries) as in the case of the residential program that has a room reserved for parents at the facility where they can stay on-site and learn sign language techniques to use at home with autistic children having limited verbal communication skills.
- (5) Success at returning handicapped children from regional, homogenous, day special education programs to public school programs in their home communities. One of the largest such regional programs reports - after two years of operation - not only a significant reduction in the number of out-of-district residential referrals, but also a success rate of more than 25% in returning students to their own school systems.

(continued)

(6) Student response Obviously, a significant measure of any child-oriented program's effectiveness is the response of the children. Although not all learning is pleasureable, many older emotionally handicapped children are able to verbalize and internalize their understanding of the value of a program even while they vividly describe why they don't like being in it. In a number of activities connected to public school special education efforts, chronically truant and/or delinquent adolescents are demonstrating nearly perfect attendance (and improved academic and social performance) in "alternative" programs that include large amounts of individual, group and family counseling.

cc: Wilson

Edward C. Hinckley

In what manner is the Information Office trying to change the harmful stereotypes purportedly held by the public regarding the mentally retarded?

By developing a series of filmed public service spots depicting mentally handicapped people in "normal" settings, learning skills of community value, by stressing that similarities between mentally retarded people and the general population are much more persuasive than the dissimilarities.

By reiterating that early diagnosis can help prevent mental illness from developing into problems which remove people from productive participation in society.

State of Maine
Department of Human Services
Department of Mental Health and Corrections

Affirmative Action Guidelines for Grants

Written Plan

Grantee agencies with 15 or more employees must have a written plan for affirmative action signed by the chief executive officer of the agency which contains the following:

1. Policy Statement - a general statement of commitment to equal employment opportunity with an affirmation that the agency will not discriminate in hiring, promotion, training, layoff, termination or any other personnel action or policy. This statement must be distributed to employees and recruitment sources and a record kept of the documentation.
2. Person designated responsible for AA.
3. Internal/external dissemination.
4. Numerical breakdown of workforce by race/sex.
5. Numerical goals and timetables.
6. Identification of problems with goals and timetables for solution.
7. Provision for annual update.
8. Provision for AA for handicapped.

Other Requirements

In addition to having a written plan and a designated affirmative action officer, the grantee agency must:

1. Examine its personnel policies and procedures and correct any which may appear to discriminate even if there is no intent to do so.
2. Review its workforce to evaluate the effectiveness of the agency's affirmative action program and to identify instances where there may have been failures to comply with equal employment opportunity laws. When instances of discrimination are discovered they must be corrected and the correction documented.

Grantees requiring technical assistance or staff training should contact Susan Clark at the Department of Human Services or Laurel Shippee at the Department of Mental Health and Corrections and such assistance will be provided free of charge.

AA Checklist For Human Services/Mental Health and Corrections
Contractors and Grantees

Name of Agency _____

Number of Employees _____

Funding Source(s) _____

Name of Contact Person _____

Is this person the Affirmative Action Officer _____

1. Do you have an Affirmative Action Plan? Yes _____ No _____

2. Does it contain:

- a. Policy Statement _____
- b. Person designated responsible for AA _____
- c. Internal/external dissemination _____
- d. Numerical breakdown of workforce by race/sex _____
- e. Numerical goals and timetables _____
- f. Identification of problems with goals and timetables for solution _____
- g. Provision for annual update _____
- h. Provision for AA for handicapped _____

3. Has training been provided for supervisors in fair employment practices/
employment laws? Yes _____ No _____

If yes, please state when and briefly describe training.

9 AM
1/8/82

STATE OF MAINE

Inter-Departmental Memorandum Date December 16, 1981

To Ron Martel, Associate Commissioner, Adm.

Dept. Mental Health and Mental Retardation

From John B. Larrabee, Director JBL

Dept. Elizabeth Levinson Center

Subject Sunset Review "Back-Up" Information

I am providing you with a listing of questions, information, definitions, and references by section number, that should be helpful in responding to Committee members or staff. My sixth sense tells me, however, that the kind of questions asked will be ones that we won't be readily prepared for and a "I'll get back to you" response should be given, until a more comprehensive response can be given.

1. Authorizing legislation or other program mandate:

- a.) "Givens"
b.)

2. Public Need:

- a. Question What does the Elizabeth Levinson Center provide to families and clients for Respite Care Services - just custodial care?

Response No. A full spectrum of in-house school programs, activity programs, medical services, clinical evaluations, dietary and therapy services are provided.

- b. Question What about children who fall through the gaps? That don't fit Elizabeth Levinson Center admission criteria? What happens to them?

Response Although not the rule, exceptions around the admission guidelines have been made when a child or their family is in a desperate situation, the child is at risk, or all other resources have been exhausted.

- c. Definition: Service Agreement A written document recording the mutual agreed services that will be provided by the family, the Bureau Regional Office, and the Center. Following admission, a specific Individual Program Plan is designed, representing goals and objectives and how they will be reached and by whom, during the clients residence at the Center.

- d. An example of an Individual Program Plan is attached (Attachment A)

- e. A flow chart, demonstrating client referral and movement is attached (Attachment B)

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Department of
Mental Health & Mental Retardation

f. Defined Severely and Profoundly Retarded at Center.

Children who function below two years (2 years on the Bayley Scales of Infant Development), are multiply-handicapped, and are usually considered untestable in terms of a verbal IQ test (Stanford Binet)), but would fall below 25 I.Q. if tested.

- 25% of these children are deaf or have serious hearing loss
- 5% of these children are blind or have a serious vision loss
- 40% or more are non-ambulatory with severe spasticity, contractures, or cerebral palsy
- 60% or more have significant orthopedic problems or deformities (scoliosis, osteoporosis, etc.)
- 95% or more experience significant fine or gross motor coordination difficulties
- 40% have total incontinence of bowel and bladder
- 10% utilize gastrostomy for feeding
- 50% have serious behavior problems (self-abuse, abuse to others, aggression, pica, rumination, smearing, etc.)
- Other syndromes or anomalies that further inhibit functioning include:

Lennox - Gestau Syndrome
Cornelia De Lang Syndrome
Leigh's Encephalopathy
D'Autille's Syndrome
Hawk's Syndrome
Conradi's Syndrome
Neurofibromatosis
Leukodystrophy
Leukemia
Dermatitis
Hypo-glycemia
Severe Allergies
Chronic Arthritis
Hydro-cephaly
Micro-cephaly
Quadriplegia/Hemiplegia
Cardio vascular problems
Respiration/Aspiration (tracheotomy)
Hypotonia

3. Program Objectives

Second paragraph beginning with "The Center's goal is to maximize . . .", the first sentence is taken from the goal and philosophy of the Presidents Council on Mental Retardation.

a. Provision of Residential Services an additional service is added - "Residential Training" allowing longer than six-month admissions for difficult-to-place clients whose community resource alternatives are next to non-existent.

b. Provision of Individual Client Programs

Every child residing at the Center, including children receiving respite care or emergency respite care, are included in a five to six hour a day school program, either in the community or at the Center. These school programs encompass all curricula areas (e.g. speech and language, physical therapy, occupational therapy, daily living skills, toileting, feeding, and dressing) and are directed by certified/licensed instructors.

4. Program Operations

Define Interdisciplinary Team (IDT) A team of individuals that periodically/regularly meets to set goals and objectives for mentally retarded clients. The participants may vary by professional discipline depending on the needs of the client but always include a team leader (facilitator), the client (if possible), the parent/guardian/correspondent, and an individual who works daily with the client.

5. Staffing

Three staff under the "Office of the Director" include the Director and two clerk typists who do all the clerical work for the staff.

Seven (7) housekeeping staff include staff that do major custodial work as well as laundry, bed-making, and general housekeeping. This number of positions was established in 1971 when the facility was thought to be twice the size that it is (Allocation was cut.).

Therapists (3) serve community (Hancock, Penobscot, Piscataquis and Washington Counties) with outreach services and evaluations as well as in-house clientele.

The carpenter is utilized by Bureau of Mental Retardation client workers in the community in making adaptive equipment for physically handicapped children forty (40%) percent of the time. The carpenter can make equipment at 50-15% of the cost of equipment purchased retail.

6. Financial Data

This info can be checked against other budget years, cost of living, inflation factors, etc..

7. Other Programs

Major difference between Pineland and Levinson. Levinson serves only 2-20 year olds (children), provides Short Term Evaluation for eight (8) weeks, and seventy (70%) percent of the Elizabeth Levinson Center's annual number of clients served is for Respite or Emergency Respite Care.

8. Program Effectiveness

- a. This information is extrapolated from daily census and monthly population reports.

All children who didn't attend an outside community based school attend the Elizabeth Levinson Center operated school program.

- b. This information can be supported by each clients master file which includes a copy of a Service Agreement stating reason for admission, an Individual Program Plan, and all medical, psychological, and clinical evaluations or reports.

- c. Documentation of activities is found in client master file, as required by ICF/MR licensing and certification.

- d. Specific data is available on numbers of licensed Foster Homes and operators, monitoring, and Elizabeth Levinson Center support (financial and staff).

- e. Dietary Will provide copies of ICF/MR Independent Program Review and Licensing/Certification Exit Interview reports and deficiencies if requested.

Medical Copies of previous contracts with Eastern Maine Medical Center (\$17,000 to 20,000 per annum) from 1971 to 1979 compared to 1979 to 1981 contracts (\$5,500) can be provided if requested.

- f. Regulations (ICF/MR) requiring staff training and training documentation in each staff personnel file.

Evaluations of conferences, workshops, courses are available upon request. Too, confidential personnel supervisory conferences are documented, reflecting staff attendance, especially ^{the} need for attendance in specific training required in job performance.

Staff turnover has decreased as a result of support of staff training and development. Turnover in 1977 (78%), 1980 (31%), National Average (30%)

9. Future Plans

Based on management planning (resulting from needs assessment, with Bureau of Mental Retardation administrative staff (monthly).

In keeping with legislative mandate and Bureau mission and philosophy.

Please do not hesitate, at any time, to call Larry Hamilton or myself for clarification or more extensive information.

JBL/nms

Enclosures

ATTACHMENT A

INDIVIDUAL PROGRAM PLAN (IPP)

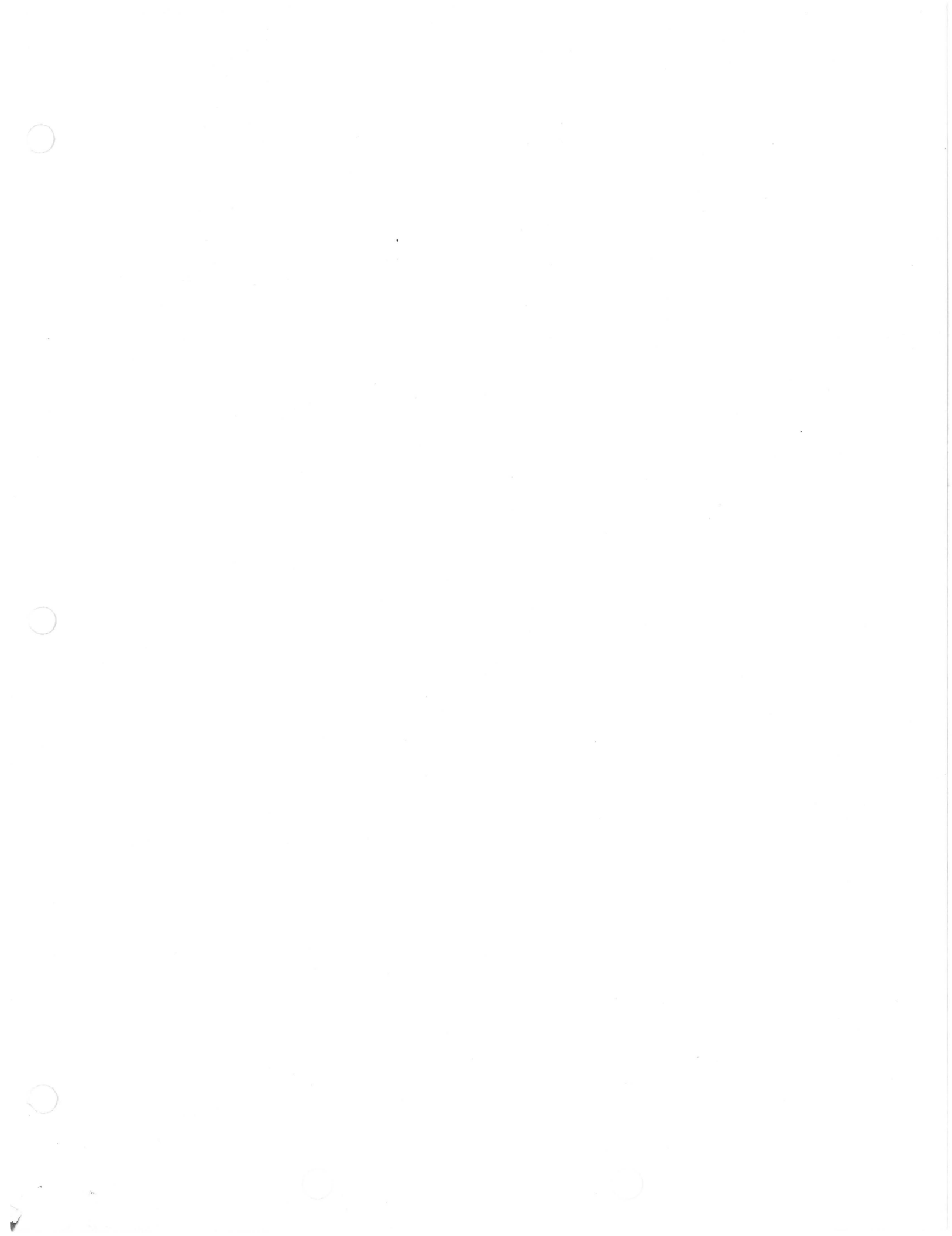
Name Danny C
Date May 1981

SERVICE OBJECTIVE	PROVIDER RESPONSIBLE	DATE OF INITIATION	DATE OF REVIEW	MONITORING RESPONSIBILITY NAME	* REHABILITATION PLAN REQUIRED YES
. Monitor leukemia (in remission)	Dr. T	Continuing	Monthly	Betty E	X
. Seizure control	Dr. T	Continuing	Monthly	Betty E	X
. Audiological evaluation	Dawn D M.S., Audiologist	April 8, 1981	Annually	Betty E	X
. Dental evaluation	Dr. C	May 4, 1981	Bi-annually	Betty E	X
. Neurological work-up	Dr. G Dr. E	May 26, 1981 (CAT Scan) June 29, 1981 (neur. eval)	As needed	Betty E Andrea S	X
. Psychiatric consultation	Dr. G	April 24, 1981	As needed	Andrea S	X
. Psychological consultation	Andrew S	May 1981	As needed	Andrea S	X
. BRIAAC evaluation and therapy	Barbara L Child Devel. Spec.	BRIAAC 3/81 Therapy weekly	Weekly	Andrea S	X
. Refinement of living skills	Cindy B Elvera W	Continuing	Monthly	Margo R Andrea S	X
. Dressing: appropriate selection of clothes, tying shoe	Cindy B Elvera W	Continuing	Monthly	Margo R Andrea S	X

INDIVIDUAL PROGRAM PLAN

Name Danny C
 Date May 1981

SERVICE OBJECTIVE	PROVIDER RESPONSIBLE	DATE OF INITIATION	DATE OF REVIEW	MONITORING RESPONSIBILITY NAME	* REHABILITATION PLAN REQUIRED YES	
11. Hygiene: will not resist toothbrushing, hand-washing & facewashing	Cindy B. Elvera	Continuing	Monthly	Margo R. Andrea S	X	
12. Toileting: a) 100% success b) will indicate need to use toilet	Cindy B. Elvera W.	Continuing	Monthly	Margo R. Andrea S	X	
13. Cognitive skill development	Cindy B. Elvera W.	Continuing	Monthly	Margo R. Andrea S	X	
14. Interfering behaviors decreased a) aggression b) running away	Cindy B. Elvera W.	Continuing	Monthly	Margo R. Andrea S	X	
15. Increase attention span	Cindy B. Elvera W.	Continuing	Monthly	Margo R. Andrea S	X	
16. Speech consultation.	Sara F. Betsy F., Speech Clinicians	March 12, 1981	Monthly	Andrea S		X
17. Occupational therapy.	Rosa L. OTR	May 8, 1981	Weekly	Andrea S		X



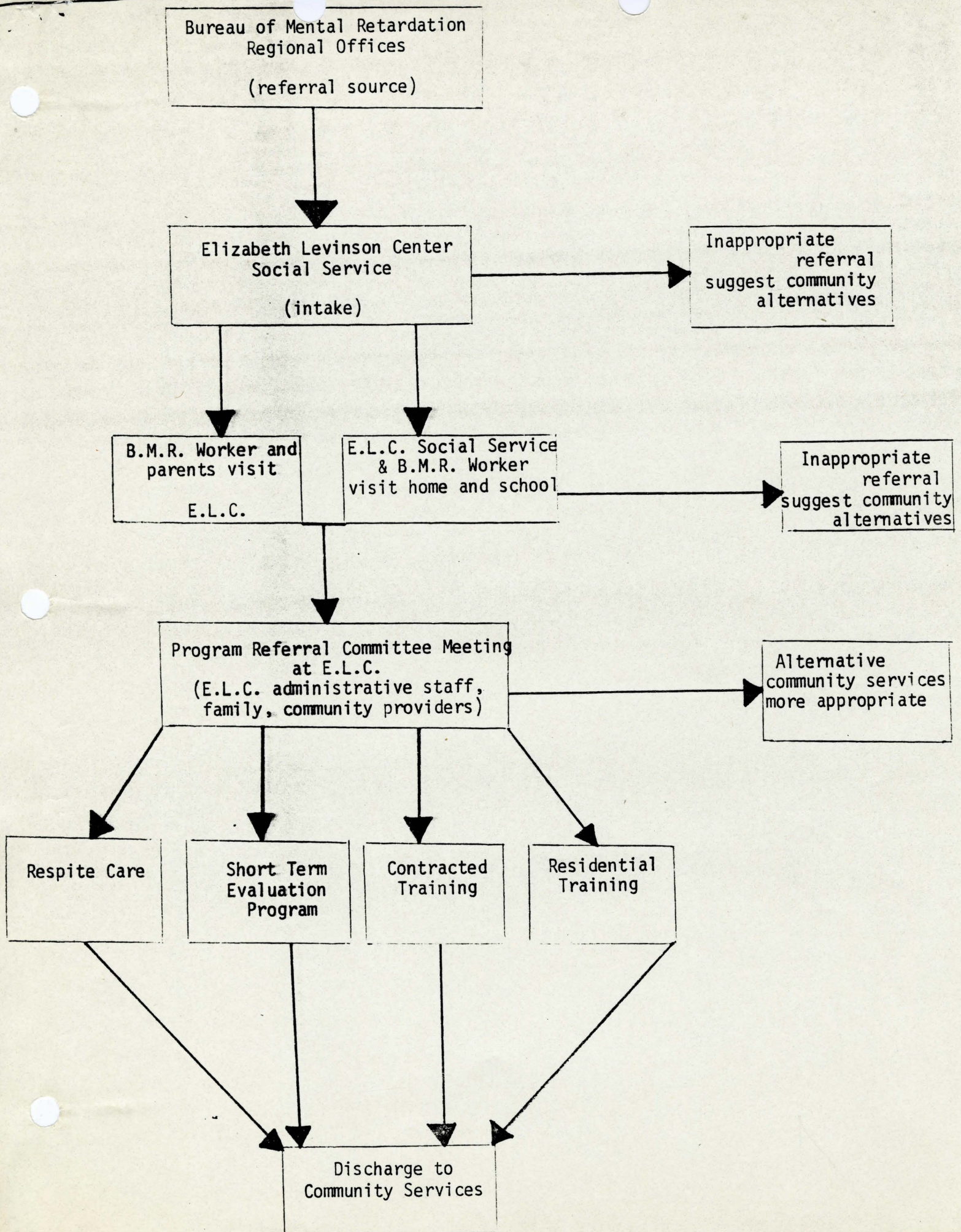
INDIVIDUAL PROGRAM PLAN

Name Danny C
Date 8/20/81

2 service objectives have been added to the original IPP of 5/81

SERVICE OBJECTIVE	PROVIDER RESPONSIBLE	DATE OF INITIATION	DATE OF REVIEW	MONITORING RESPONSIBILITY NAME	* HABILITATION PLAN REQUIRED YES NO
18. Danny will visit his home accompanied by a CDW once a month. Overnight visits will begin when Dad returns from Scotland.	Cindy B Ron B	1st visit: Sept. 25, 1981	Monthly	Andrea S Margo R	y
19. Danny will visit a licensed community home at least once a month, with a staff person to aide in the transition from ELC to his home.	Cindy B Ron B	8/81	Monthly	Andrea S Margo R	x

**An Habilitation Plan is a specific methodology document, often listing tasks in order of achievement.



27 July 1981

INFORMATION ON SUNSET LAWS

Sunset Act: Section 13 M.R.S.A., Chapter 23

§ 502 - Purpose: to establish a system of periodic justification of departments and agencies...and for termination of agencies that have out lived their purpose.

§ 503 - Definitions:

Department - specified in § 507 and § 1,3,5,7 & 9

Any bureau, agency, office, commission or any other body or official within or advisory to...

Independent agency - any bureau, agency, office, commission or other body or official of State Gov. listed in § 507 subsection 2, 4, 6, 8 & 10 or which is not or is not part of the legislature, judicial, county, municipality or special district.

§ 504 - Reports

1. a justification report as scheduled

2. A. a description of each program and activity - ref. authorizing legislation, organizational charts and a description of objectives.

B. account for or estimate the amount of monies:

received or expected

source of all monies

disbursed or expected to be disbursed by program by department or independent agency

fiscal year preceding

fiscal year of

fiscal year following

C. identification and description of other government or private programs or activities having the same, similar or complimentary objectives

D. an analysis (quantified as much as possible) of the extent the objectives have been reached. A prospective analysis of how the objectives will be met for the next 10 years.

Submit to Legislative Adm. Director no later than 10/31/81

Department and Independent Agencies - ??

§ 507 Subsection 3.-B - Department of Mental Health & Corrections

4.-B

(12) State Planning and Advisory Council on Developmental Disabilities

- (13) Maine Committee on Problems of the Mentally Retarded
- (14) Governor's Committee on Employment of the Handicapped
- (15) Division of Community Services

4.-A

- (14) Maine Human Services Council

Department's Programs and Activities etc.

1. Commissioner's Office

- a. Chief Advocate
- b. Associate Commissioners
- c. Affirmative Action
- d. Nutrition Services
- e. Information Services
- f. Personnel
- g. Accounting
- h. Planning & Review
- i. Mental Health Manpower Commission
- j. D.D. Council

2. Bureau of Mental Health

- a. State Hospitals - AMHI and BMHI
- b. Elizabeth Levinson Center
- c. Aroostook Residential Center
- d. Licensing
- e. Community Mental Health Centers
- f. Boarding Homes/Sheltered Workshops
- g. Mental Health Advisory Council

3. Bureau of Mental Retardation

- a. Community Social Services
- b. Pineland Center
- c. Regional Administrative Offices
- d. Boarding Homes/Sheltered Workshops

4. Bureau of Corrections

- a. Probation & Parole
- b. Parole Board
- c. Court Intake (juvenile)
- d. Jail Inspection
- e. Adult Institution
- f. Juvenile Intake *Institution*
- g. Volunteer Services

5. Community Support System Project

6. Division of Children Services

- a. Children's Services Council

7. Interdepartmental Committee

PLEASE CIRCULATE AND RETURN TO SUE WELLS

If you have any of the materials mentioned in the letter, please attach. Thank you.

~~FRANK ELLIS~~
~~DAVID LAWLOR~~
~~DAVID MINER~~
~~PAM BUGOSH~~
SUSAN WYGAL
BRENDA HARVEY

hita - can you do this?

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JUN 26 1986

Department of
Mental Health & Mental Retardation

416/535-8501

June 10, 1986

1001 Queen Street West
Toronto, Ontario
M6J 1H4

Director
Bureau of Mental Health
Mental Health & Mental Retardation Department
State House Station #40
Augusta, Maine 04333
U. S. A.

Dear Sir/Madame:

The Public Information Officers' Committee of the Ontario Psychiatric Hospital is trying to compile an inventory of information available in North America about mental health and mental illness. Over the years, we have had many requests from people seeking information about mental health. We feel that there is a real need for an inventory of this information and it may help prevent duplication of effort as well as improve public education. This list will be available to the general public as well as people with a specific interest such as students.

I would like to know if you publish any booklets, leaflets, pamphlets or audio-visual tapes about schizophrenia, affective disorders, suicide, mental illness in general, aging, community mental health or any other related subject. If you do, please send me a list including the date of publication, the target-audience, for example: students in psychiatry; hospital; general public; etc.

I would appreciate receiving three samples of each one no later than July the eleventh, because this is a summer project. If they are not free, please tell me the prices. We will purchase if necessary. Please forward to me:

Christian Riou, Public Relations Assistant
Queen Street Mental Health Centre
1001 Queen Street West
Toronto, Ontario
M6J 1H4

Telephone: (416) 535-8501 Ext. 380 or 199

In helping with this inventory you will contribute a great deal to public education about mental health. We will send you a copy of the inventory when it is complete.

Thank you very much.

Yours truly,

Christian Riou

Christian Riou, Public Relations Assistant

CR/ss



Ontario

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JUN 26 1986

Department of
Mental Health & Mental Retardation

Ministry
of
Health

Queen Street
Mental Health
Centre

416/535-8501
June 10, 1986

1001 Queen Street West
Toronto, Ontario
M6J 1H4

Michael J. Desisto, Director
Borough of Mental Health
Mental Health & Mental Retardation Department
State House Station #40
Augusta, Maine 04333
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CR/ss

