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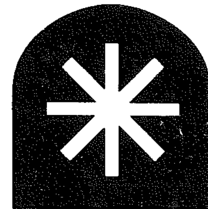
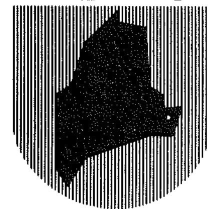
MENTAL HEALTH PLANNING

THE COMMUNITY MENTAL HEALTH CENTER SURVEY AND CONSTRUCTION PLAN
STATE OF MAINE



YOUR CONTRIBUTION TO MENTAL HEALTH IS UNDERSTANDING



SURVEY, PLANNING AND PROGRAM DEVELOPMENT

DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

Walter F. Ulmer, Commissioner

BUREAU OF MENTAL HEALTH

William E. Schumacher, M.D., Director

John B. Leet, Mental Health Planner

ADMINISTRATION OF STATEWIDE CONSTRUCTION PROGRAM

DEPARTMENT OF HEALTH AND WELFARE

Dean Fisher, M.D., Commissioner

Woodrow E. Page, Director

Fiscal Years
1964-1965

STATE OF MAINE
ADVISORY COMMITTEE ON MENTAL HEALTH
DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

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LEWISTON, MAINE

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19 COLUMBIA STREET
AUGUSTA, MAINE

MISS MARY WORTHLEY
WEST LEBANON
MAINE

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INTRODUCTION

Maine's Community Mental Health Center Survey and Construction Plan is based on the information in the surveys and recommendations made by the regional planning committees and the task force committees who have been working on an overall mental health plan for the people of Maine. The people who have for a year and a half given their time and efforts to see that their state had a workable plan represent a cross-section of the state and are from all walks of life. It is to these people that the citizens of Maine owe a debt of gratitude.

This program entails both short and long-range goals. It takes into consideration the present mental health facilities and services and future needs, and recommendations to improve or increase facilities and services in the five mental health center area. It is our belief that all of the required regulations as spelled out in the Community Mental Health Centers Act (P.L. 88-164, Title II) have been complied with, and it is our hope that this plan will provide community mental health centers which will serve all the people living in the state.

The plan presented on the following pages will require implementation if it is to be of value and will need constant modification to keep abreast of anticipated advances in psychiatric knowledge. It will need constant central coordination from the Bureau of Mental Health to capitalize on community assistance programs offered by federal, state, county, or local sources. It must be emphasized that this survey and construction plan is an integral part of the Comprehensive Mental Health Plan for the State of Maine, a plan of progressive mental health services derived from the needs expressed by the people themselves as essential to the well being of all who require these services. To this end we hope that your contribution to mental health will be understanding for those who are less fortunate in health and in need of care.

JOHN B. LEET
Mental Health Planner

DEFINITIONS

1. Community Mental Health Centers Act (Title II, Public Law 88-164); Part A: Grants for Construction of Public and Other Non-Profit Mental Health Centers. Explanation: This act provides funds for the construction of mental health facilities or centers.

2. Community Mental Health Centers Act (Amendment, Public Law 89-105, 89th Congress, H.R. 2985, August 4, 1965); Part B: Grants for Initial Cost of Professional and Technical Personnel of Centers. Explanation: This act provides compensation for professional and technical personnel for the initial operation of new community mental health centers or of new services in community mental health centers.

3. The Regulations are the Public Health Service Regulations, Part 54, pertaining to grants for construction of specialized service facilities; sub-Part C: Grants for construction of community mental health centers.

4. Comprehensive Mental Health Planning means the planning on a statewide basis for the provision of adequate mental health services.

5. Mental Health Planning Region means an area delineated primarily for planning purposes. It is made up of several communities generally related as to common boundaries, geography, ethnic groups, industry and utilizing common social agencies.

6. Mental Health Center Area means the geographic territory which includes several communities served or to be served by existing or proposed community mental health facilities, the delineation of which is based on such factors as population distribution, natural geographic boundaries and transportation accessibility.

7. Community Mental Health Center Complex means an interrelated network of facilities and services strategically located in several communities within a mental health center area which collectively provide the elements of mental health services necessary to adequately care for the residents. Services such as inpatient, outpatient, emergency, partial hospitalization, educational and consultative.

8. Core of Complex means a city or town designated as the mental health center complex because of accessibility, population, and provision of existing services.

9. Hospital Service Area means that area of the state as designated by the Commissioner of the Department of Mental Health and Corrections which is served by the Augusta State Hospital and Bangor State Hospital.

10. The State Plan means the overall mental health plan for the State of Maine composed of regional, task force, mental health center survey and construction and highlights reports.

(Definitions continued)

11. Population are the latest figures of civilian population certified by the Federal Department of Commerce with such adjustments as may be necessary to reflect changing local conditions unless otherwise specified.

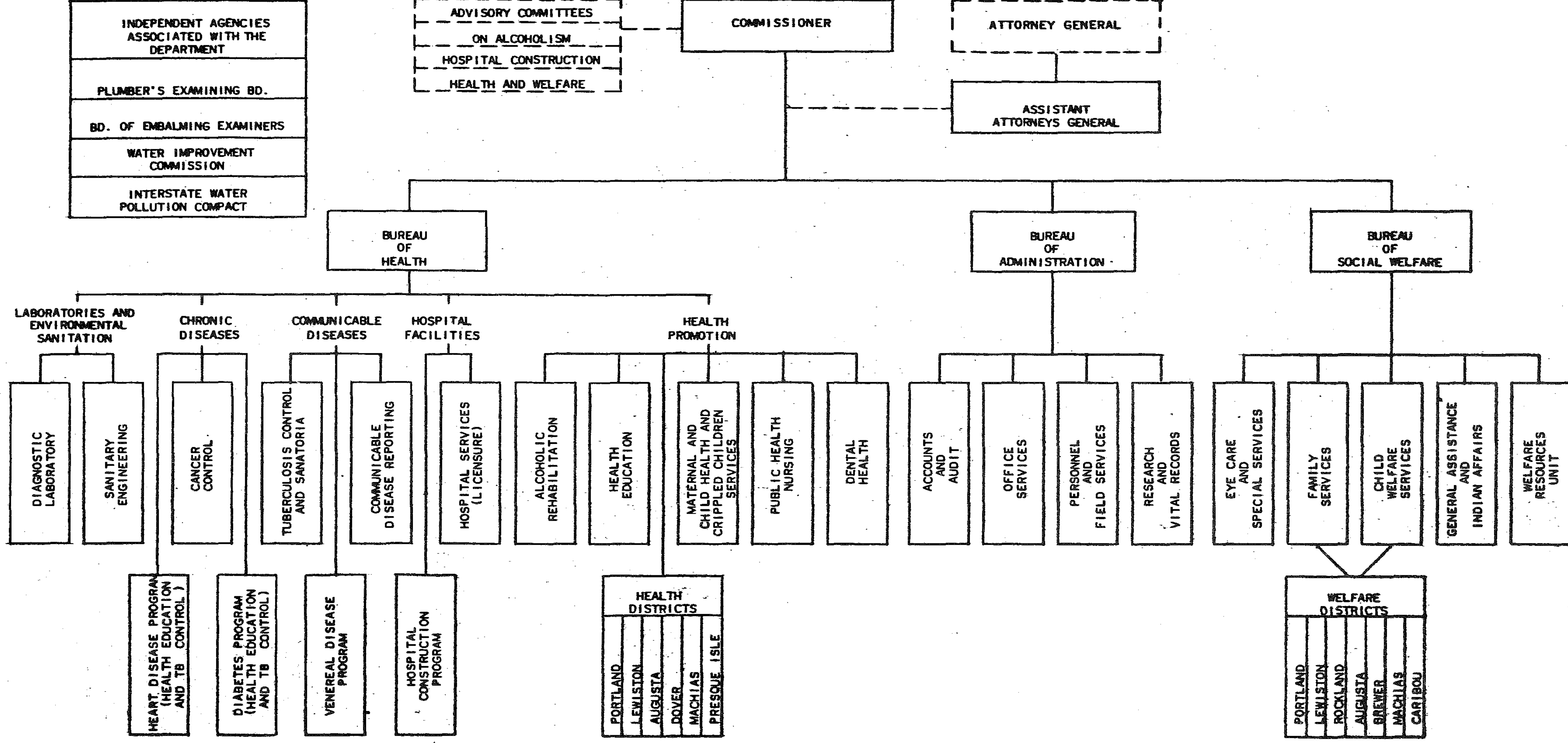
12. Construction includes construction of new buildings, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings (including medical transportation facilities); including architects' fees, but excluding the cost of off-site improvements, and except with respect to mental health centers, the cost of the acquisition of land.

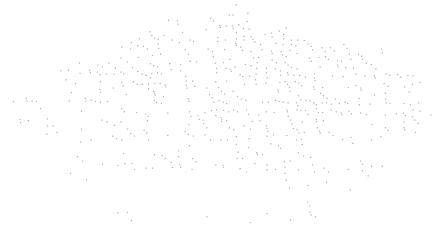
13. Cost as applied to construction or modernization means the amount found by the Surgeon General to be necessary for construction and modernization respectively, under a project, except that such term, as applied to a project for modernization of a facility for which a grant is to be made from a modernization allotment, does not include any amount found by the Surgeon General to be attributable to expansion of the bed capacity of such facility.

14. Modernization includes alteration, major repair (to the extent permitted by the Regulations), remodeling, replacement, and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with the Regulations) equipment of existing buildings.

15. Title when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Surgeon General finds sufficient to assure for a period of not less than fifty years undisturbed use and possession for the purposes of construction and operation of the project.

Note: An alphabetical glossary of mental health terms can be found at the end of this report.


STATE OF MAINE
DEPARTMENT OF HEALTH AND WELFARE
ORGANIZATION CHART
JANUARY 1, 1965
INDEPENDENT AGENCIES ASSOCIATED WITH THE DEPARTMENT
PLUMBER'S EXAMINING BD.
BD. OF EMBALMING EXAMINERS
WATER IMPROVEMENT COMMISSION
INTERSTATE WATER POLLUTION COMPACT
ADVISORY COMMITTEES
ON ALCOHOLISM
HOSPITAL CONSTRUCTION
HEALTH AND WELFARE
COMMISSIONER
ATTORNEY GENERAL
ASSISTANT ATTORNEYS GENERAL
BUREAU OF HEALTH
BUREAU OF ADMINISTRATION
BUREAU OF SOCIAL WELFARE
LABORATORIES AND ENVIRONMENTAL SANITATION
CHRONIC DISEASES
COMMUNICABLE DISEASES
HOSPITAL FACILITIES
HEALTH PROMOTION
DIAGNOSTIC LABORATORY
SANITARY ENGINEERING
CANCER CONTROL
TUBERCULOSIS CONTROL AND SANATORIA
COMMUNICABLE DISEASE REPORTING
HOSPITAL SERVICES (LICENSURE)
ALCOHOLIC REHABILITATION
HEALTH EDUCATION
MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN SERVICES
PUBLIC HEALTH NURSING
DENTAL HEALTH
ACCOUNTS AND AUDIT
OFFICE SERVICES
PERSONNEL AND FIELD SERVICES
RESEARCH AND VITAL RECORDS
EYE CARE AND SPECIAL SERVICES
FAMILY SERVICES
CHILD WELFARE SERVICES
GENERAL ASSISTANCE AND INDIAN AFFAIRS
WELFARE RESOURCES UNIT
HEART DISEASE PROGRAM (HEALTH EDUCATION AND TB CONTROL)
DIABETES PROGRAM (HEALTH EDUCATION AND TB CONTROL)
VENEREAL DISEASE PROGRAM
HOSPITAL CONSTRUCTION PROGRAM
HEALTH DISTRICTS
PORTLAND
LEWISTON
AUGUSTA
DOVER
MACHIAS
PRESQUE ISLE
WELFARE DISTRICTS
PORTLAND
LEWISTON
ROCKLAND
AUGUSTA
BREWER
MACHIAS
CARIBOU



SECTION I

SINGLE STATE AGENCY

I. SINGLE STATE AGENCY

A. Law: "Except where a single state agency is otherwise designated or established in accordance with any other state law, any state officer or agency, designated by the Governor for such purpose, is authorized to be the sole agency of the State of Maine to establish and administer or supervise the administration of any statewide plan for the construction, modernization, equipment, maintenance or operation of any facilities for the prevention of physical or mental illness or the provision of care, treatment, diagnosis, rehabilitation, training or related services, which plan is now, or may hereafter be, required as a condition to the eligibility for benefits under any federal law. Such officer or agency is authorized to receive, administer and expend any funds that may be available under any federal law or from any other source, public or private, for such purposes." (Chapter 231, Public Law, April 28, 1965)

1. Designated State Agency: The Maine Department of Health and Welfare.
2. Director of the Agency: Dean Fisher, M.D., Commissioner.
3. Health Facilities Program Director: Woodrow E. Page.
4. Table of Organization of the Department of Health and Welfare, Bureau of Health, precedes this page.
5. Documents showing evidence that the state agency has the authority to carry out the construction plan set forth in the departmental agreement are appended at the end of Section I and are as follows:
   a. Certification of Enactment. (An Act to Authorize State Participation in Federally Aided Health Facilities Programs)

b. Copy of Law: Chapter 231 Public Law approved April 28, 1965 by Governor John H. Reed.

c. Letter from Governor John H. Reed to Luther L. Terry, M.D., Surgeon General, Public Health Service, designates the Department of Health and Welfare as the sole agency for the administration of the plan.

6. State Department Having Operational Interests in the Survey, Plan, and Program Development: Department of Mental Health and Corrections. This Department, by law, has general supervision, management and control of the research and planning, grounds, buildings and property, offices and employees, patients and inmates of the institutions, bureaus and divisions under its control.

7. Director of the Department: Walter F. Ulmer, Commissioner.

8. Bureau Delegated Responsibility for Survey, Plan, and Program Development: The Bureau of Mental Health. This Bureau within the Department of Mental Health and Corrections is the state agency designated to which appropriate authority and responsibility has been delegated to develop and initiate a comprehensive statewide plan for mental health facilities and services and the community mental health centers construction plan.

9. Director of the Bureau of Mental Health: William E. Schumacher, M.D.

10. Table of Organization of the Department of Mental Health and Corrections, Bureau of Mental Health, can be found at the end of Section I.

B. Departmental Agreement

1. A joint agreement between the Department of Health and Welfare and the Department of Mental Health and Corrections

in the administration of Public Law 88-164, Title II, Construction of Community Mental Health Centers in the State of Maine follows:

"The Department of Mental Health and Corrections has entered into an agreement with the Department of Health and Welfare for the express purpose of utilizing the experience and knowledge of the Hill-Burton officials in constructing community mental health facilities approved under Maine's Community Mental Health Center Survey and Construction Plan."

2. The Agreement

   a. The Department of Health and Welfare will be responsible for the following functions:

      1. General administration (with the exceptions mentioned under item 2b)

      2. Review and process of Parts 1, 2, 3, and 4 of the Project Applications (with the exception of the review of Part 1 in respect to program (scope) and feasibility mentioned under item b2)

      3. All phases of construction and payments.

      4. Consultation with the Advisory Council.

   b. The Department of Mental Health and Corrections will be responsible for the following functions:

      1. Preparation of the State Community Mental Health Center Survey and Construction Plan, annual revisions and modifications thereof forwarding same to the Department of Health and Welfare as required by Public Health Service Regulations or the exigencies of the situation and final approval by the Community Mental Health Centers Advisory Council.

2. Consult directly with eligible project sponsors in the development of their proposed project program (scope) and feasibility in accordance with Public Health Service Regulations and review for approval Part 1 of the Project Application in respect to these items. (Title II, Part B, Public Law 89-105)

3. Administer grants for the initial cost of professional and technical personnel for centers.

3. State Committees Having Interest in Mental Health Planning and/or Services:

   a. The Advisory Committee on Mental Health has served as a program reviewing agency to the Bureau of Mental Health and as a citizens' sounding board for contemplated policy and program change. It has also been designated as the appropriate group to work in collaboration with the Bureau of Mental Health to initiate the development of a comprehensive statewide plan for mental health facilities and services.

   b. *The Maine Committee on the Problems of the Mentally Retarded is an eleven-member committee appointed by the Governor to study the problems and needs of the mentally retarded in Maine. This committee is the counterpart of the Advisory Committee on Mental Health as it is responsible for and is the delegated authority to develop and initiate the Comprehensive Mental Retardation Plan of the State of Maine.

   c. *The Interdepartmental Board on Mental Retardation makes possible joint action and mutual planning by several state agencies in regard to solutions to the

problems of the mentally retarded in Maine. Although not responsible for the Comprehensive Mental Retardation Plan, it is an integral part and plays an important role in its formulation and implementation. Its membership is composed of commissioners and members of the departments which offer services to the retarded.

*This Committee and Board are included in this report to show the relationship of coordinated planning not only between the Department of Mental Health and Corrections and the Department of Health and Welfare but also the retardation plan.

Also it should be noted later in this report under the heading "Advisory Council", the interagency council representation serves the interests of health, mental retardation, and mental health.

NOTE: Section I exhibits follow.

State of Maine

Department of State

I, Kenneth M. Curtis, Secretary of State, certify, that the paper to which this is attached, is a true copy from the records of this office.

In Testimony Whereof, I have caused the Great Seal of the State to be hereunto affixed. GIVEN under my hand at Augusta, this thirteenth day of May in the year of our Lord one thousand nine hundred and sixty-five and in the one hundred and eighty-ninth year of the Independence of the United States of America.

[signature] *Secretary of State*

IN HOUSE OF REPRESENTATIVES, April 22, 1965

Read three times and passed to be enacted.

Dana W. Childs *Speaker*

IN SENATE, April 23 1965

Read twice and passed to be enacted.

Carlton Day Reed Jr. *President*

Approved April 28 1965

John H. Reed *Governor*

APPROVED

APR 28'65

BY GOVERNOR

CHAPTER

231

PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SIXTY-FIVE

S. P. 364 — L. D. 1131

AN ACT to Authorize State Participation in Federally Aided Health Facilities Programs.

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

Whereas, the Federal Government, through P. L. 88-164, has made available assistance for construction of facilities for the mentally retarded and for community mental health centers, and through P. L. 88-443, has made available assistance for construction and modernization of hospitals and other medical facilities; and

Whereas, approximately $1,500,000 in federal funds will be available for use under P. L. 88-443, and approximately $300,000 will be available for use under P. L. 88-164, during the fiscal year ending June 30, 1965, only if certain organizational requisites are met immediately; and

Whereas, at present several facilities have applied for and are eligible for such federal grants; and

Whereas, the present and future welfare of our State is dependent upon new construction and modernization of hospital and other medical facilities, including mental retardation facilities and community mental health centers; and

Whereas, the following legislation is vitally necessary to assist in such new construction and modernization of hospital and other medical facilities, including mental retardation facilities and community mental health centers; and

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

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

Sec. 1. R. S., T. 22, §§ 1702, 1704, repealed. Sections 1702 and 1704 of Title 22 of the Revised Statutes are repealed.

Sec. 2. R. S., T. 22, § 1703, amended. The first sentence of section 1703 of Title 22 of the Revised Statutes is amended to read as follows:

'The department shall have authority to accept any federal law now in effect or hereafter enacted which makes federal funds available for public health services of all kinds ~~including the construction of hospitals and health centers~~ and to meet such federal requirements with respect to the administration of such funds as are required as conditions precedent to receiving federal funds.'

Sec. 3. R. S., T. 22, § 1709, additional. Title 22 of the Revised Statutes is amended by adding a new section 1709, to read as follows:

'§ 1709. State-wide plan; advisory council; duties

Except where a single state agency is otherwise designated or established in accordance with any other state law, any state officer or state agency, designated by the Governor for such purpose, is authorized to be the sole agency of the State of Maine to establish and administer or supervise the administration of any statewide plan for the construction, modernization, equipment, maintenance or operation of any facilities for the prevention of physical or mental illness or the provision of care, treatment, diagnosis, rehabilitation, training or related services, which plan is now, or may hereafter be, required as a condition to the eligibility for benefits under any federal law. Such officer or agency is authorized to receive, administer and expend any funds that may be available under any federal law or from any other source, public or private, for such purposes.

The Governor shall appoint a state advisory council or councils with appropriate representatives, including such representatives as are required as a condition of eligibility for benefits under any federal law, to consult with such state officer or state agency in carrying out the purposes of this chapter.

Each council member shall hold office for a term of 4 years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and the term of office of the members first taking office shall expire, as designated at the time of appointment, ¼ of the total number of members at the end of the first year, ¼ at the end of the 2nd year, ¼ at the end of the 3rd year, and ¼ at the end of the 4th year, after the date of appointment. The Governor shall designate the chairman of each such council. Council members, while serving on council business, shall receive no compensation but shall be entitled to receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. The council or councils shall meet as frequently as the chairman thereof deems necessary but not less than once each year. Upon request of 4 or more members of a council, it shall be the duty of the chairman to call a meeting of such council.

Such state officer or state agency is authorized and empowered to comply with or do any and all other acts or things necessary or required to be done as a condition to receiving federal aid or grants with respect to the establishment, construction, modernization, maintenance, equipment or operation for all the people of the State of adequate facilities and services as specified in this section, including the authority:

1. Inventory. To provide for an inventory of existing facilities of a particular category or categories thereof, and to survey the need for additional facilities;

2. Program. To develop and administer a construction program or programs which, in conjunction with existing facilities, will afford adequate facilities to serve the people of the State;

3. Administration. To provide methods of administration, including personnel standards, on a merit basis, and to require reports, make investigations and prescribe regulations;

4. Priority. To provide for priority of projects or facilities;

5. Hearing. To provide to applicants an opportunity for a hearing before such state officer or state agency; and

6. Standards. To prescribe and require compliance with such standards of maintenance and operation applicable to such facilities as are reasonably necessary to protect the public health, welfare and safety.'

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

AUTHORITY OF STATE AGENCY

Letter from Governor Reed designating the Department of Health and Welfare as the sole agency for the administration of the plans under P.L. 88-164 and P.L. 88-443.

STATE OF MAINE
OFFICE OF THE GOVERNOR
AUGUSTA

JOHN H. REED
GOVERNOR

January 29, 1965

Luther L. Terry, M.D.
Surgeon General
Public Health Service
Department of Health, Education, and Welfare
Washington, D.C.

Dear Surgeon General Terry:

In accordance with Revised Statutes 1964, Title 2, Section 4, I hereby designate the Maine Department of Health and Welfare as the sole agency for the administration of the plan, as required by Public Law 88-164, section 134 (a)(1) for mental retardation facilities and section 204(a)(1) for community mental health centers; also, as required by Public Law 88-443, section 604(a)(1) for hospitals and other medical facilities, such designation to be effective on passage of enabling legislation in the 102nd Maine Legislature.

Sincerely yours,

John H. Reed

JOHN H. REED
Governor

DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS
ORGANIZATION CHART

GOVERNOR

Commissioner

- Director Education-Research*
- Director of Personnel
- Director of Public Information*
- Supervisor of Farms

Bureau of Business Management

Director

Four Divisions

- Accounting
- Reimbursement
- Engineering and Plant Maintenance*
- Food Services*

Bureau of Mental Health

Director

Three Hospitals

- Augusta
- Bangor
- Pineland Hospital & Training Center

Five Clinics

- Augusta
- Bangor
- Lewiston
- Portland
- Fort Fairfield

Community Mental Health Grant-in-Aid Funds

Bureau of Corrections

Director

Five Correctional Institutions

- Maine State Prison
- Reformatory for Men
- Reformatory for Women
- Stevens Training Center
- Boys Training Center

Aftercare Program

- Boys Training Center

Probation and Parole Board

Director

Three Districts

District I
- Portland**
- Alfred

District II
- Augusta**
- Auburn
- Thomaston
- Belfast

District III
- Bangor**
- Ellsworth
- Houlton
- Caribou

Probation and Parole Board
- Three members
- Commissioner, ex-officio

Bureau of Educ. & Charitable Inst.

Director*

Two Institutions

- Gov. Baxter State School for the Deaf
- Military Naval and Children's Home

*Non-existent

**District Field Office

SECTION II

STATE ADVISORY COUNCIL

II. STATE ADVISORY COUNCIL

A. The Community Mental Health Centers Advisory Council was created by Chapter 231, Public Law approved April 28, 1965, which directs the Governor of Maine to appoint a state advisory council or councils with appropriate representatives, including such representatives as are required as a condition of eligibility for benefits under any federal law, to consult with such state officer or agency in carrying out the purposes of the Chapter.

B. Method of Selecting Membership: Members are selected from representatives of non-government organizations or groups and of state agencies concerned with planning, operation, or utilization of community mental health centers or other mental health facilities including representatives of consumers of the services provided by such centers and facilities who are familiar with the need for such services to consult with the departments in carrying out the construction plan.

C. Chairman: The Governor of Maine designates the chairman of the Council.

D. Tenure: Each Council member holds office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and the term of office of the members first taking office shall expire, as designated at the time of appointment, one-fourth of the total number of members at the end of the first year, one-fourth at the end of the second year, one-fourth at the end of the third year, and one-fourth at the end of the fourth year, after the date of appointment.

E. Meetings: The Community Mental Health Centers Advisory Council meets as frequently as the chairman deems necessary but not less than once each year. Upon request of four or more members of the Council, it is the duty of the chairman to call a meeting of such Council.

F. Compensation: Council members while serving on Council business receive no compensation but are entitled to receive actual and necessary travel and subsistence expenses while so serving away from their places of residence.

G. Council Organization: The Community Mental Health Centers Advisory Council was organized September 17, 1965.

H. Membership of the Community Mental Health Centers Advisory Council: Representatives of state agencies and of non-government organizations or groups concerned with planning, operation, or utilization of community mental health centers or other mental health facilities:

Robert C. Emerson, 15 Connecticut Avenue, Millinocket; Pharmacist; president-elect, Maine Pharmaceutical Association; Region II coordinator of mental health planning; term expires September 17, 1967.

Edmund N. Ervin, M.D., 2 School Street, Waterville; Pediatrician; chairman, Maine Committee on the Problems of the Mentally Retarded; September 17, 1966.

Dean Fisher, M.D., Wayne; Commissioner, Maine Department of Health and Welfare; September 17, 1968.

Frederick T. Hill, M.D., 11 Dalton Street, Waterville; medical staff, Thayer Hospital, Waterville; September 17, 1969.

Mrs. Tobie Nathanson, 4 Westwood Lane, Saco; Housewife; York County Child and Family Guidance Association; September 17, 1968.

William E. Schumacher, M.D., 14 Westwood Drive, Augusta; Director, Bureau of Mental Health, Maine Department of Mental Health and Corrections; September 17, 1968.

Mrs. Nellie Wade, 448 Lake Street, Auburn; Housewife; director, Lewiston-Auburn Child and Family Service; former member, State Advisory Committee on Mental Health; September 17, 1969.

Representatives of consumers of the services provided by such centers and facilities who are familiar with the need for such services:

Edward Y. Blewett, 1 College Street, Portland; President, Westbrook Junior College; chairman, Community Mental Health Centers Advisory Council; September 17, 1969.

Frank C. Curran, 166 Broadway Avenue, Bangor; Director, Eastern Maine General Hospital, Bangor; September 17, 1966.

Marshall J. Gerrie, D.O., 43 Roosevelt Avenue, Waterville; Maine Osteopathic Association; September 17, 1966.

Robert W. Hudson, 40 Nottingham Road, Auburn; District Manager, Central Maine Power Company; trustee, Central Maine General Hospital, Lewiston; September 17, 1969.

John T. Konecki, M.D., West Auburn Road, Auburn; radiologist, St. Mary's General Hospital, Lewiston; September 17, 1966.

Archibald M. Main, Jr., 1077 Washington Street, Bath; Engineer; Bath-Brunswick Unit, Association for Retarded Children; September 17, 1967.

Edward Myers, Walpole P.O., Damriscotta; Restaurant Proprietor; Pine Tree Society for Crippled Children; September 17, 1968.

Charles S. Ross, Jr., 236 Franklin Street, Rumford; Maintenance Foreman, Oxford Paper Company; Rumford School Committee; September 17, 1967.

C. Hazen Stetson, 92 Barton Street, Presque Isle; President, Maine Public Service Company; September 17, 1967.

I. Responsibilities: The Council will review the Community Mental Health Survey and Construction Plan for final approval before submission to federal officials as Maine's plan. It will also review and recommend after proper study grants to pertinent projects in accordance with priorities contained in the Community Mental Health Survey and Construction Plan as prepared by the Department of Mental Health and Corrections and approved by the Advisory Committee on Mental Health. The Plan will be reviewed once annually.

J. Relationship With Other Advisory and Planning Groups

1. The Community Mental Health Centers Advisory Council with appropriate representation serves as the advisory council for health facilities, mental retardation, and community mental health centers.
2. A close relationship exists between the Hill-Burton program of the Department of Health and Welfare, the Comprehensive Mental Retardation Plan, and the Comprehensive Mental Health Plan. This relationship has proved advantageous to all three programs by eliminating duplication of effort and helping formulate plans common and consistent to each of the programs.
3. Mental health regional planning areas were delineated from derivations of the Hill-Burton hospital service areas and regions while the five community mental health center areas presented in this plan were conceived after consultation with Hill-Burton officials.
4. These three planning bodies have appropriate representatives interested in health facilities, mental retardation facilities, and mental health centers serving on a common advisory council.
5. A committee was organized during the mental health planning period which included the executive director of the Health Facilities Planning Council, the executive director of the Maine Hospital Association, the director of Hill-Burton, the field director of the Bingham Associates Fund, the executive secretary of the Committee on the Problems of the Mentally Retarded, the mental retardation planner, and the mental health planner. This group's initial meeting consisted of a review of the planning involved in each of the programs represented.

It was evident that close association with related programs would benefit all and help the committee members in keeping abreast of progress and program developments and this information could be related to their respective boards or committees. Subsequent meetings were held and communications assured.

6. The Maine Medical Association at the outset of mental health planning passed a resolution which requested support for the program and the active participation of its members in the Maine Comprehensive Mental Health Plan. The Association was represented in mental health planning by a committee on mental health which functioned as a task force on Mental Health and Medical Practice.

7. Our planning has involved numerous organizations, agencies, councils, officials, and individuals from all areas dealing with human welfare. In response to a request from the Department of Mental Health and Corrections, Bureau of Mental Health, for an indication of willingness to participate in planning and to utilize the produced mental health plan in future programming, the following agencies and organizations indicated their willingness:

Maine Department of Health and Welfare (including welfare, child care, public health, hospital planning, nursing home licensing, etc.)
Maine Department of Education (including vocational rehabilitation, special education services, adult education, state teachers colleges, etc.)
Maine Department of Personnel
Maine Department of Labor and Industry
Maine Medical Association
Maine Osteopathic Association
Maine Nursing Association
Maine Psychological Association
Maine Junior Chamber of Commerce
Jaycee Wives

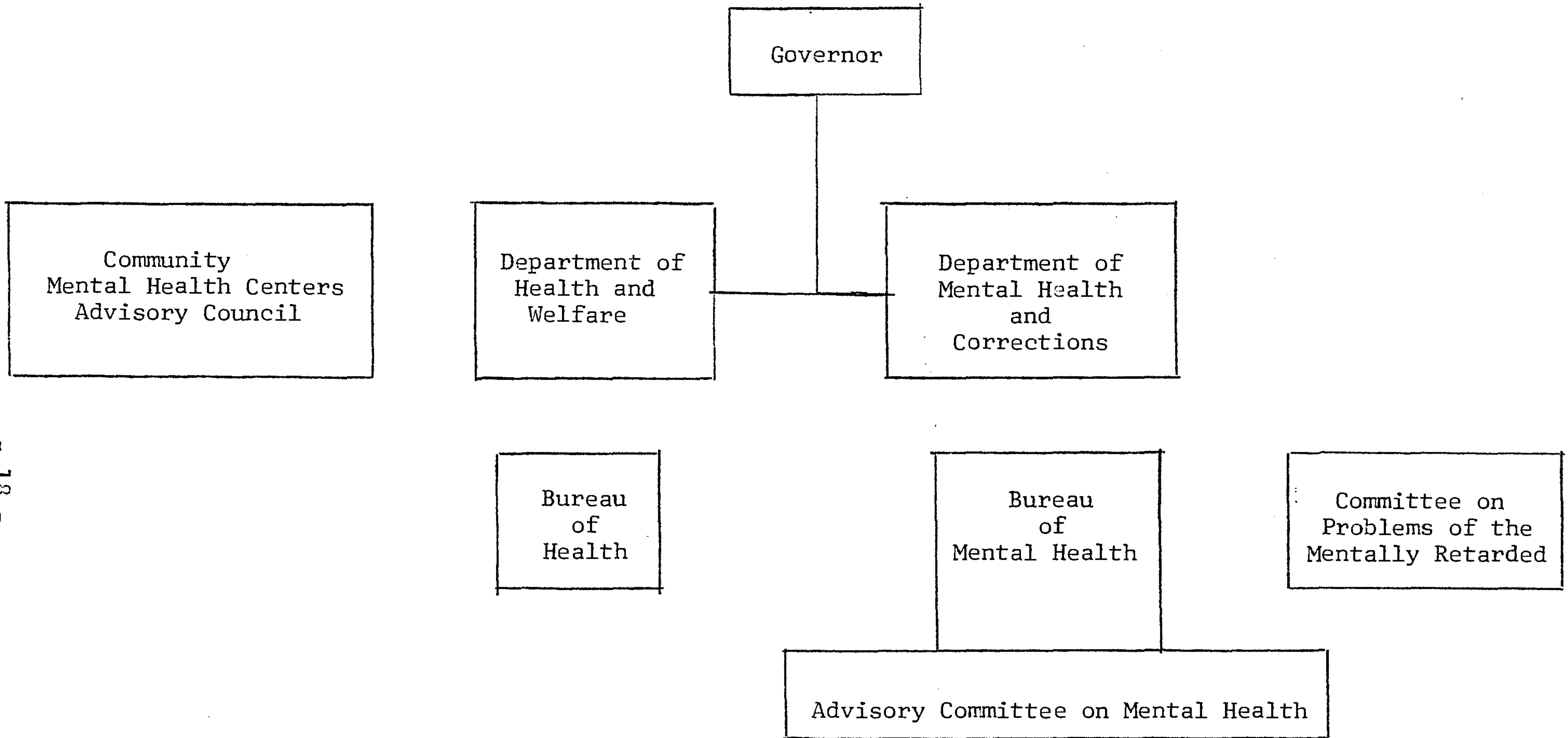
Maine Chapter, National Association of Social Workers
Northern New England District Branch, American Psychiatric Association
Interdepartmental Board on Mental Retardation
Maine Committee on Problems of the Mentally Retarded
Maine Committees on Aging, and Children and Youth
Maine Hospital Association
Maine Nursing Home Association
Maine Municipal Association
Judicial Council
Maine Bar Association
Maine Association for Retarded Children (includes all its member groups)
Maine Health Council
Maine Blue Cross and Blue Shield
Maine Congress of Parents and Teachers
VA Medical Center, Togus
Maine Teachers Association
Maine Medical Center
Portland Child Guidance Association
Sweetser Children's Home (including Kennebunk, Sanford, Saco, Biddeford Mental Health Association)
Mount Desert Island Child Guidance Association
Bath-Brunswick Mental Health Association
Child and Family Services of Lewiston
Eastern Maine Guidance Association of Bangor
Franklin County Area Family Counseling Service
United Community Services of Portland
Rockport-Rockland-Camden Mental Health Association
Southern Maine Mental Health Association
Androscoggin Mental Health Association
Bingham Associates
Portland City Welfare Department
University of Maine
State Budget Officer, Legislative Fiscal Officer, and an Appropriations Committee Member
Maine State Federated Labor Council
American Legion
Parent Teachers Association
American Association of University Women
Maine Extension Service

In addition to the above, all divisions of the Department of Mental Health and Corrections including heads of adult and juvenile correctional facilities and the director of Probation and Parole and his field officers participated.

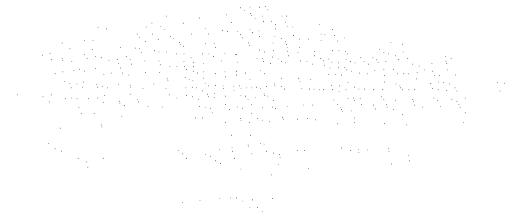
K. Coordination of Planning: The planning staff has made every effort to coordinate its planning with other planning programs within the state. It is of interest that a report prepared by

the Northeastern Research Foundation aided by the Maine Department of Economic Development advocates the coordination of all planning in the state due to the increasing trend toward local and regional planning. The report states: "Preliminary reports of several studies being carried on have focused attention upon the desirability, if not necessity, of extending the concept of planning and programming to embrace the entire structure of state government. The advantages of coordinated activity among the various government agencies have also been underlined by the participation of the state in the new federal antipoverty legislation as well as in the recent educational and manpower programs." (Planning for Development in the State of Maine, January 1965)

Note: Section II exhibits follow



Organization chart showing the relationship with relevant planning and advisory groups connected with comprehensive mental health planning. (e.g. Hill-Burton program, mental retardation, and mental health programs, etc.)

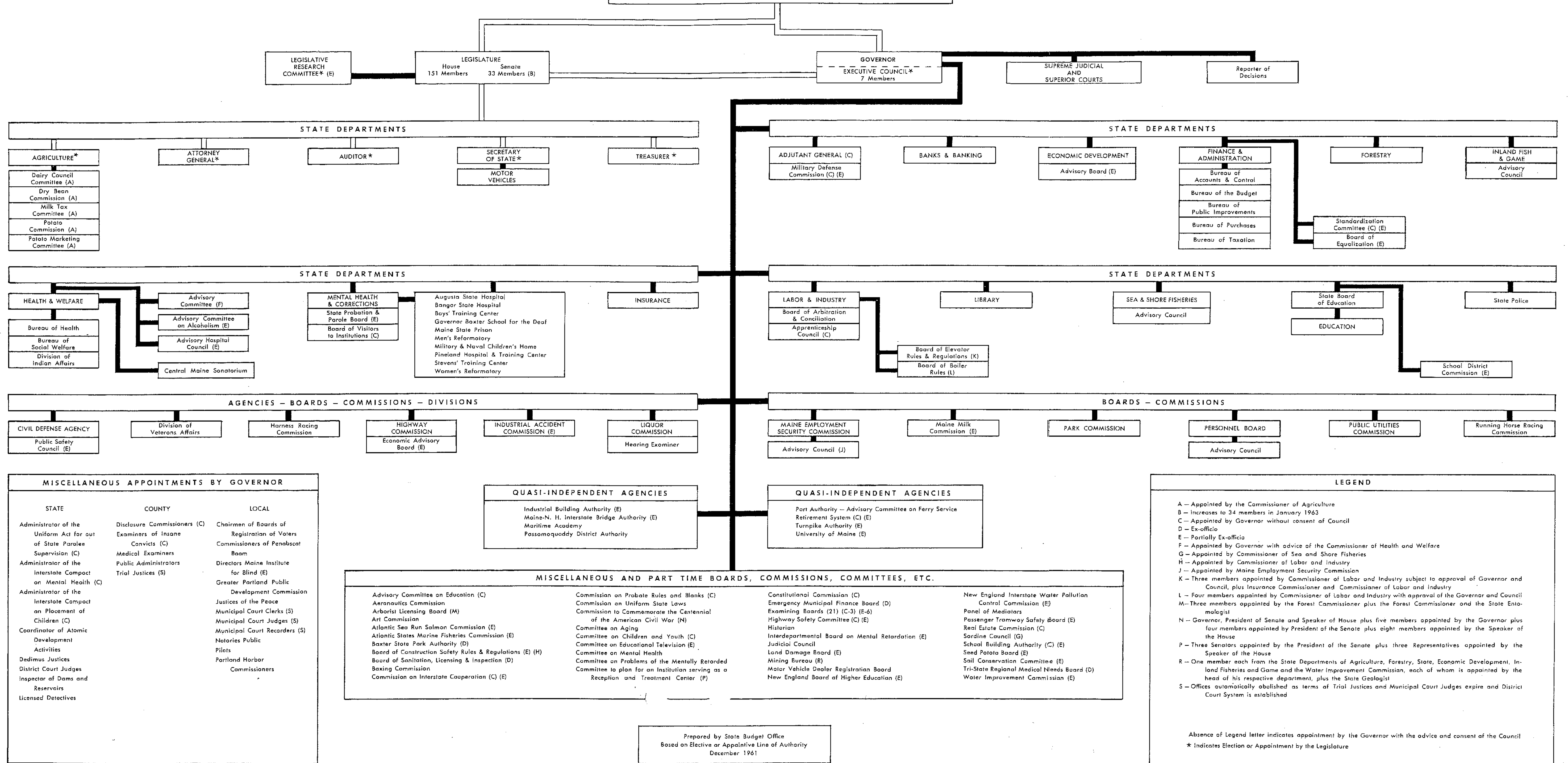


SECTION III

GENERAL CHARACTERISTICS OF MAINE

STATE OF MAINE

ORGANIZATION CHART OF STATE GOVERNMENT



III. GENERAL CHARACTERISTICS OF THE STATE

Land area in square miles: 31,012

Rank in nation: 39

Population: 969,265 (1960)

Rank in Nation: 36

Density of population per square mile: 31.3 persons

Number of representatives in Congress: 2 senators; 2 representatives

Largest city: Portland; population: 72,566

Number of cities and towns over 10,000 population: 6 towns; 12 cities

Number of counties: 16

A. Governmental Structure

1. Federal: Congressional districts: The districts for the election of representatives to Congress are comprised as follows:

   a. First district: The first district is composed of Cumberland, Kennebec, Knox, Lincoln, Sagadahoc, Waldo and York Counties. It is entitled to one representative to Congress.

   b. Second district: The second district is composed of Androscoggin, Aroostook, Franklin, Hancock, Oxford, Penobscot, Piscataquis, Somerset and Washington Counties. It is entitled to one representative to Congress. (1961, c. 196, s. 1.)

   (Effective date of these congressional districts was January 1, 1962).

2. State: Maine entered the Union in 1820. The state capital is in Augusta. The Legislature is composed of 34 senators and 151 representatives. It convenes biennually to carry

out the functions of government within the limits of the State Constitution and certain specified matters reserved to the voters of the state and not delegated to the U.S. by the Constitution. The state departments, agencies, boards, commissions, committees, and divisions of state government are depicted in the accompanying organization chart of state government.

3. County: Maine has sixteen counties. The largest is Aroostook with an area of 6,408 square miles. The smallest county is Sagadahoc with an area of 259 square miles.
   In Maine the concept of county government does not follow the general concept of strong county government commonplace in some other states. Although Maine does have county government and properly elected county officials who perform important functions such as the county treasurer, register of deeds, clerk of courts, county sheriff, county attorney, probate judge, etc., the township system is the really important form of local government in Maine.

4. Local: In Maine the town meeting is held once a year usually in the town hall. It is here that the town officials are elected and the necessary transactions to carry on the business of running a town are performed. Maine has 415 towns, 21 cities, 56 plantations, and 391 unorganized townships.
   About half of the state is wild land and has no local government. This territory is divided into units of varying size and shape but corresponding in general to the towns. These are known as unorganized townships. They are for the most part entirely unihabited except for temporary lumber

operations and sportsmen. Most of the unorganized townships are located in the northern and northwestern parts of the state. In the more populated and built-up areas of Maine the town manager or city manager type of government is becoming more common. The largest city, Portland, is located in the southern part of the state. There are 6 towns and 12 cities with a population of 10,000 or more and the majority of these employ the city manager form of government.

B. Geographical and Topographical Characteristics of the State: Maine is located in the extreme northeast corner of the United States. It is bordered by two provinces of the Dominion of Canada, namely New Brunswick on the east and north, Quebec on the north and west while New Hampshire forms the remainder of its western boundary and the Atlantic Ocean is on the south. Maine is almost as large as all the other New England states together. About one-tenth of the whole area or 3,045 square miles is water. Lengthwise, Maine extends 380 miles and its greatest width is 215 miles. The coast is irregular having thousands of indentations affording numerous fine harbors. From the New Hampshire border to Eastport, the most eastern part of the United States, the distance is about 250 miles in a straight line. In the western part of the state are found the foothills of the White Mountains of New Hampshire. Farther north Mt. Katahdin, the highest peak in New England, 5,273 feet above sea level, towers over less prominent peaks of the Appalachian Chain. Along these mountains rise all the great river systems for the state. In the southern half of the state, there are three of these great river systems: the Androscoggin,

the Kennebec, and the Penobscot. They all flow south into the Atlantic Ocean. The St. Croix River and the St. John River are well-known rivers in the eastern and northern part of the state respectively. More than 1600 lakes are scattered throughout the state.

C. Transportation: Maine has a total of 20,964 miles of state, state aid, town, and reservation roads and turnpikes. The Maine Turnpike extends from Kittery to Augusta then connects with Interstate #95 from Augusta to Howland to become one of the high spots in through transportation. Railroad passenger service in Maine is practically non-existent. The bus services have picked up where the railroad left off wherever financially feasible. Northeast Airlines schedules flights to the larger cities in Maine maintaining a seasonal schedule which is often hampered by unpredictable weather.

D. State Population Distribution:

TABLE 1

Population Growth
(thousands)

	1970	Percent Change	1960	Percent Change	1950
United States			179,326		150,697
New England			10,510		9,314
Maine	1,012	4.4	969	6.1	914

Source: U.S. Census of Population, Bureau of the Census, and Planning for Development in the State of Maine, Northeastern Research Foundation, January 1965.

Maine's projected population for 1970 is 1,012,000 as compared to the 1960 census figure of 969,000. As Table 1 illustrates, this is an estimated increase of 4.4% over the decade.

In comparison, Maine had an increase of 6.1% in population between 1950-60. Of the 55,000 gained in population in Maine over this ten-year period, 14,000 or 25% was due to an increase in military personnel. Thus, civilian population in Maine grew only 4.4% over the decade even including military personnel. Cutbacks of military installations may seriously affect the accuracy of the 1970 projections. The slow rate of population growth in Maine has been well below that of the United States.

TABLE 2

Percentage Changes in Population by Decades

	United States	New England	Maine
1950-1960	18.5	12.8	6.1
1940-1950	14.0	10.0	7.9
1930-1940	7.2	3.3	6.2
1920-1930	16.1	10.3	3.8
1910-1920	14.9	12.9	3.5
1900-1910	21.0	17.2	6.9
1890-1900	20.7	19.0	5.0
1900-1960	136.0	87.9	39.6
1900-1940	73.6	50.7	22.0
1940-1960	35.9	24.7	14.4

Source: U.S. Census of Population, Bureau of the Census
Entrepreneurial Talent In Maine, July, 1963, Page 1

Table 2 shows that from 1900 to 1960 Maine's population grew by only 40% as compared to 88% in New England and 136% in the U.S. as a whole. The divergence in rates of population growth among the states is usually influenced only slightly by differences in rate of natural increases.

TABLE 3

Maine--Population, By Counties, 1960

	1960 (thousands)	Percent Change From 1950
Androscoggin	86.3	3.3
Aroostook	106.1	10.4
Cumberland	182.8	8.0
Franklin	20.1	-3.0
Hancock	32.3	0.6
Kennebec	89.2	6.3
Knox	28.6	1.6
Lincoln	18.5	2.7
Oxford	44.3	0.3
Penobscot	126.3	16.8
Piscataquis	17.4	-6.6
Sagadahoc	22.8	9.0
Somerset	39.7	-0.1
Waldo	22.6	4.4
Washington	32.9	-6.5
York	99.4	6.3

Source: U.S. Census of Population, Bureau of Census

Table 3 indicates that the largest gains in population were the results of the expansion of air bases in Aroostook and Penobscot Counties. For example, Limestone in Aroostook County had a population of 2,400 in 1950 and with the location of a military base there, the population rose to over 13,000 in 1960. Dow Air Force Base had a similar effect on Penobscot County. Four counties actually lost population during the last decade. Furthermore today the three coastal counties of Washington, Hancock, and Waldo actually have a population 18% smaller than in 1900. The southern counties of York, Cumberland, and Androscoggin all showed increases from 1950 to 1960 although the rates of growth were well below the 1950 rates which were over 9% for each county. Cumberland showed the largest percentage gain, 8%, which was due in part to a 30% increase in Brunswick after two military bases had been established nearby.

In effect, the decades of slow population growth in Maine can be seen by examining the age distribution of the populace.

TABLE 4

Age Distribution of Population
(thousands)

	United States			Maine		
	1960	1950	Percent Change 1960/50	1960	1950	Percent Change 1960/50
Total All Ages	179,326	151,179	+18.6	969	914	+ 6.1
Under 5	20,322	16,197	+25.3	109	100	+ 9.0
5-14	35,475	24,343	+45.8	192	154	+24.7
15-24	24,091	22,303	+ 8.1	133	137	- 2.9
25-34	22,822	23,901	- 4.6	116	128	- 9.4
35-44	24,076	21,506	+12.1	119	117	+ 1.7
45-54	20,625	17,391	+18.4	106	101	+ 5.0
55-64	15,708	13,300	+18.0	87	83	+ 4.0
65 and over	16,207	12,272	+31.7	107	94	+13.8

Source: U.S. Census of Population, Bureau of the Census.

In two of the most crucial age groups, Maine's population actually declined over the decade. The 15-24 age group declined 3% and the 25-34 age group population fell by over 9%. The population of the United States as a whole in the 25-34 age bracket also fell from 1950 to 1960 or by a much smaller percentage than in Maine. Maine has suffered a loss of about 16,000 persons between the ages of 15-34 over the ten-year period.

TABLE 5

Age Distribution of Population
(percent)

	United States		Maine	
	1960	1950	1960	1950
All Ages	100.0	100.0	100.0	100.0
Under 5	11.3	10.7	11.2	10.9
5-14	19.8	16.1	19.8	16.8
15-24	13.4	14.8	13.7	15.0
25-34	12.8	15.9	12.0	14.0
35-44	13.5	14.3	12.2	12.9
45-54	11.5	11.5	10.9	11.0
55-64	8.3	8.3	9.0	9.1
65 and over	9.0	8.2	11.0	10.2

Source: U.S. Census of Population, Bureau of the Census.

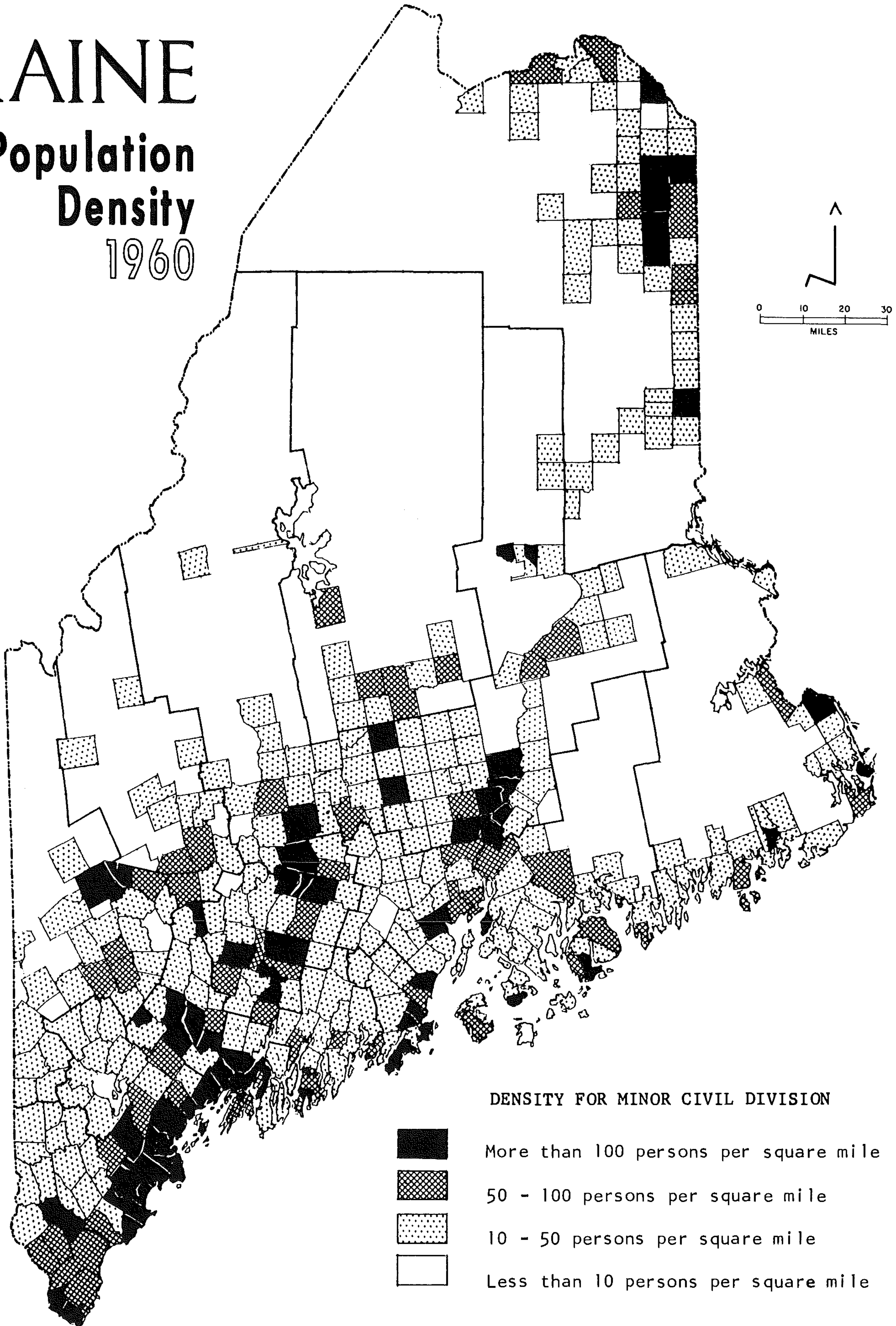
Table 5 shows the percentage distribution of persons in various age groups in 1960 and 1950. In both the United States and Maine almost 20% of the total population in 1960 was between the ages of 5-14. However, there are significant differences in the 25-54 age groups. For example, because of our out-migration only 12.2% of Maine's population was 35-44 years old in 1960 as compared to 13.5% in the United States as a whole. On the other hand, 11% of Maine's population is over 65 years old, compared to only 9% in the United States as a whole. An increasing concentration of Maine's population in the older age brackets is likely to slow down economic growth. The increased proportion of Maine citizens represented in the older age brackets implies a more conservative and less dynamic population. It should also be noted that the extent of the immigration has been limited.

E. Industries: The paper industry is Maine's first industry ranked according to the value of its product. The food industry ranks second in value of manufactured products. The leather industry

is third; textiles, fourth; and, lumber and wood products, fifth. Countywise in rank according to value of manufactured product: first is Cumberland; second, Penobscot; third, Kennebec; fourth, Androscoggin; and, fifth, York.

Note: Section III exhibits follow

MAINE
Population Density
1960



Division of Research and Planning, Department of Economic Development, State House, Augusta, Maine

MAINE
STATE HOSPITAL SERVICE AREAS

Population
1960

AREA 1 - 405,946

AREA 2 - 563,319

LEGEND

1963

SECTION IV

CONSTRUCTION PROGRAM

IV. CONSTRUCTION PROGRAM

A. Areas

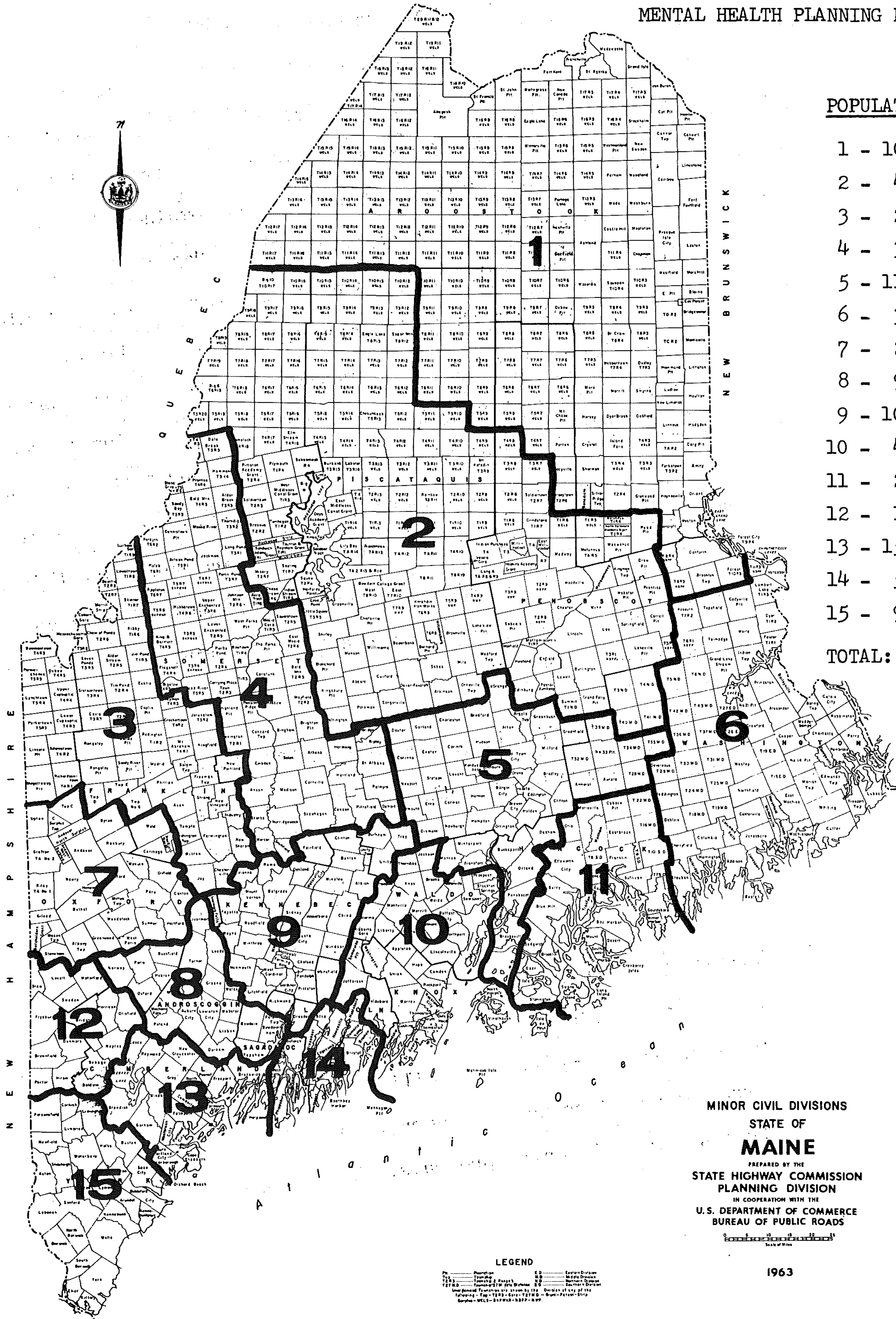
1. State Hospital Service Areas: The State of Maine is divided into two large areas designated as reception areas for the Augusta and Bangor State Hospitals by the Commissioner of the Department of Mental Health and Corrections in accordance with statutory provision. The line of demarcation which separates these areas begins at Gorham Gore in Franklin County, continues on down to the village of Rome where it follows the northern county line of Kennebec, then down the western county line of Waldo and Knox Counties. Counties to the east of this line are served by the Bangor State Hospital. The total population of these counties in 1960 was approximately 406,000. Counties to the west of this line of demarcation are served by the Augusta State Hospital and the total population served is 563,000. (Map of Maine State Hospital Service Areas on preceding page.) Based on population projections in the report prepared by the Center for Economic Research at Bowdoin College and the Maine Department of Economic Research at Bowdoin College and the Maine Department of Economic Development and the report Planning for Development in the State of Maine dated January 1965, it would appear that the eastern area will gain 15,000 and the western area 28,000 in population over the decade 1960-1970. Since the present trend shows a definite southward migration, one may assume that the larger percentage of the 43,000 gain in population will be found in the urban centers in south and central Maine.

As was noted Maine has had a very slow rate of population growth by comparing the rate of growth in Maine with that of the United States in every decade since 1890. Maine's net out-migration of 66,000 persons from 1952 to 1960 balances more or less the southward migration of the population.

2. Fifteen Planning Regions: The regional areas for mental health planning for the state closely follow an existent Hill-Burton map showing divisions of the state into medical services areas. (Map of the Fifteen Planning Regions on the following page and map of Maine Service Areas of General Hospitals at end of Section IV.)

   These service areas were first developed by the Hill-Burton officials and represented geographical territory from which patients came or were expected to come to existing or proposed general hospitals. Such factors as population distribution, natural geographical boundaries, transportation and trade patterns, proximity to existing and proposed hospital and medical facilities were considered in delineating these areas. The importance of the general hospitals to the success of the new community mental health centers program was recognized; however, the planning staff felt that the service areas used by the Hill-Burton officials were too numerous for our purposes so were combined into larger areas better adapted to our problems. This culminated in 15 regional planning areas led by volunteer regional coordinators and staffed by planning committees to whom a great deal of the credit for this report is attributed.

MENTAL HEALTH PLANNING REGIONS



POPULATION

1 - 108,819
2 - 41,695
3 - 23,813
4 - 32,800
5 - 111,875
6 - 32,087
7 - 26,946
8 - 95,126
9 - 101,264
10 - 49,379
11 - 24,760
12 - 14,138
13 - 154,543
14 - 54,303
15 - 97,707

TOTAL: 969,265

3. Mental Health Center Areas: The fifteen Mental health planning regions in most cases did not meet federal regulations for construction which call for a population of between 75,000 to 200,000 to be provided with essential mental health services in mental health center areas. We then combined the 15 regions into five mental health center areas. (Map of Five Mental Health Center Areas follows.) As a result, mental health region 1 became mental health center area 1. The remainder of the regions were joined together to form the other four mental health center areas. Long-range plans contemplate the creation of two community mental health centers in areas 2 and 5 thereby meeting federal requirements as to total population to be served by each center. Distances in both areas are such that this would be the practical approach as far as accessibility is concerned. However, for now our plans are based primarily on a complex of services in the five areas.

CORE OF COMPLEX IN THE MENTAL HEALTH CENTER AREAS

Mental Health Center Area	Core of Complex
#1	Fort Fairfield-Caribou-Presque Isle
#2	Bangor-Brewer
#3	Augusta-Waterville
#4	Lewiston-Auburn
#5	Greater Portland

B. Inventory of Facilities

The fifteen regional planning committees submitted detailed reports of existing mental health facilities and services within their respective regions as well as regional recommendations for community-based mental health programs. These reports were also used as a

MENTAL HEALTH CENTER AREAS

POPULATION

(By Area)

1 - 108,819

2 - 227,037

3 - 166,823

4 - 145,885

5 - 320,701

POPULATION

(Shaded Areas)

1 - 89,939

2 - 85,103

3 - 81,292

4 - 75,798

5 - 111,701

MINOR CIVIL DIVISIONS
STATE OF
MAINE
PREPARED BY THE
STATE HIGHWAY COMMISSION
PLANNING DIVISION
IN COOPERATION WITH THE
U.S. DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC ROADS

1963

LEGEND

five mental health center areas. The determination of the areas were based upon existing facilities and potential facilities which in turn were based upon the primary need for services. Continuity of services constitutes a problem. No complete concentration of services under one roof exists. In the two state hospitals an approximation of complete services is a goal. The great distances involved between some facilities make for complexities which will have to be faced in the future. There has been a concentration of services within the heavily populated areas with a resultant lack of services in many areas of the state which are thinly populated. Efforts have been made to supply such areas by means of traveling clinics. Distances, weather conditions, shortages of mental health personnel, and finances have all been major problems in planning. The inventory of all Maine's mental health resources including manpower is done on an area basis utilizing both facilities and services within and outside the area as components of the mental health center complex for that area. For example, the Augusta State Hospital will provide inpatient services for areas 3, 4, and 5, whereas Bangor State Hospital will provide part of inpatient services for areas 1 and 2.

An inventory of all psychiatric facilities and services in Maine listed alphabetically as submitted to the Central Study Group can be found at the end of this report.

C. Survey of Need and Ranking of Areas

Grand Total Score and Priority by Mental Health Center Area

Area	Core of Complex	Total Score	Priority
1	Fort Fairfield-Caribou Presque Isle	39.8	1
2	Bangor-Brewer	37.4	2
3	Augusta-Waterville	27.1	4
4	Lewiston-Auburn	29.3	3
5	Greater Portland	16.4	5

Note: Area determination and population are shown on the mental health center area map.

The five mental health center areas were ranked according to their relative need for community mental health centers on a ten-point scale covering six major subjects. The first two subjects were assigned a weight of three and the remaining four subjects a weight of one. In ranking the areas, available professional personnel and existing facilities were considered of major importance while the socio-economic factors, the population distribution, the usage of available facilities, and the incidence of crime reflected by probation rates and prison commitments were considered important but to a much lesser degree than the first two subjects.

Arbitrary Weight	Factors	Subject Number	Subject
3	1	1	Available Professional Personnel
3	1	2	Existing Facilities and Services
1	9	3	Area Socio-Economic Situation
1	3	4	Population Distribution
1	1	5	Usage of Available Facilities
1	2	6	Incidence of Crime
10 points			

To determine score by area and subject the formula is: For those subjects having one factor and a weight of three - rank x weight = score. For those subjects having more than one factor and a weight of one - combined rank of factors x weight ÷ number of factors = score.

To arrive at a total score and priority for each area, the following method was used. The higher the number in rank order by area indicated, the greater the need; the lower the number, the less need. The resultant rank order was then multiplied by the assigned subject weight equaling the score for the area.

TABLE 1

Subject #1:
Available Professional Personnel
(M.D.'s, D.O.'s, Psychiatrists, Clinical Psychologists)

Mental Health Center Area	**Number of Professionals	Per 100,000	*Rank Order		Weight		Score
1	65	59.9	5	x	3	=	15
2	220	96.9	4	x	3	=	12
3	209	125.3	2	x	3	=	6
4	146	99.9	3	x	3	=	9
5	413	128.7	1	x	3	=	3

*5, greatest need; 1, least need.
**Figures rounded to the nearest whole number.

Source: Area Health Survey, Knox County, Maine. Counties comparing number of doctors to population. Roswell Bates, D.O., provided figures by area for the number of osteopaths in Maine.

From the standpoint of relative needs in the light of our present knowledge, the most important factor in Maine is the lack of qualified professional personnel in sufficient number to properly care for the mentally ill and allied problems. The first line of defense from a medical standpoint in the mental health program is the availability of qualified physicians in each area. The State of Maine has 12 practicing psychiatrists in the five areas. They are located as follows:

Mental Health Center Area	Core of Complex	Number
#1	Fort Fairfield-Caribou-Presque Isle	0
#2	Bangor-Brewer	3
#3	Augusta-Waterville	1
#4	Lewiston-Auburn	2
#5	Greater Portland	6

It may be said of these 12 psychiatrists that practically all of them spend some part of their time working for governmental agencies. A few of the state-employed psychiatrists do some part-time private practice.

Mental health center areas 1 and 2 have fewer doctors than areas 3, 4, and 5. Thus area 3 has almost twice as many allopathic physicians, 106.8 per 100,000, than does area 1 with 55.3 per 100,000 population. Area 2 has 78.0, area 4, 91.7 and area 5, 97.8. Combining allopathic with osteopathic physician results in rates of doctors per 100,000 as follows:

Mental Health Center Area	
1	59.9
2	96.9
3	125.3
4	99.9
5	128.7 (having the highest number of physicians)

TABLE 2

Subject #2:
Existing Mental Health Facilities and Services
(hospitals and clinics)

Mental Health Center Area	Facilities and Services	*Rank Order		Weight		Score
1	0	5	x	3	=	15
2	8	4	x	3	=	12
3	33	2	x	3	=	6
4	11	3	x	3	=	9
5	34	1	x	3	=	3

*5, greatest need; 1, least need.

The data as shown here was obtained from the inventory forms as submitted by the various facilities to the Central Study Group and included psychiatric and other mental health facilities.

TABLE 3

Subject #3:
Area Socio-Economic Situation
(Combined factors)

Mental Health Center Area	a. Median Family Income 1960	Rank	b. Percent Civilian Labor Forces Unemployed	Rank	c. Percent Substandard Housing Units 1960	Rank	d. Telephones Available in Household Per 100,000	Rank	e. Percent Population over 25 Completed 8th Grade or Less	Rank
1	$4,111	5	6.4	3	37.50	4	1711.1	5	43.49	5
2	4,586	4	8.4	5	39.15	5	1954.1	4	32.50	1
3	4,827	3	6.5	4	33.96	3	2097.9	3	35.64	3
4	5,002	2	5.4	1	30.14	2	2130.2	2	42.74	4
5	5,282	1	5.7	2	22.75	1	2298.6	1	34.50	2

f. Child Welfare Load Per 100,000 Child Pop.	Rank	g. Divorce Annulment 1960 Per 100,000 Population	Rank	h. Illegitimate Births, 1963 Per 100,000 Population	Rank	i. Suicides 1962-64 Per 100,000 Population	Rank	Combined Total Rank		Total Factors		Score
138.9	2	149.1	1	62.9	1	28.8	1	27	÷	9	=	3
160.5	4	192.1	2	110.6	5	35.6	2	32	÷	9	=	3.6
177.2	5	257.2	5	91.5	3	50.6	5	34	÷	9	=	3.8
140.8	3	195.1	3	87.6	2	50.2	4	23	÷	9	=	2.6
110.7	1	227.0	4	93.8	4	39.7	3	19	÷	9	=	2.1

Rank - 5, greatest need; 1, least need. The economic factors which we chose to consider in relation to social disintegration were developed from the 1960 Census figures

a. The median income (in dollars) of families correlates inversely by region with the percent of families with incomes under $3,000.

b. The percent civilian labor forces unemployed. Source: Table #1 of Task Force Report on Finance. (Information obtained from the Maine Employment Security Commission 1965.)

c. The definition for substandard housing units used as "lacking hot water or plumbing (whether classified as structurally sound or deteriorating) or classified as dilapidated."

d. The telephones available to occupants in a housing unit were taken from the 1960 census of housing which was a 25% sample. The 1964 figures from the Public Utilities Commission roughly support these figures.

e. As an indication of illiteracy, we considered those age 25 and over who had had no schooling in 1960.

f. The social factors which we considered included the child welfare load in May 1965. We related this to the number of children under 18.

g. h. i. The data on divorces and annulments in 1960, illegitimate births in 1963, and suicides in the three-year period, 1962-1964, were provided by the Department of Health and Welfare, Division of Vital Statistics.

It was felt that these socio-economic data could be combined and ranked as a single unit in establishing mental health enter construction priorities. Since the tables are self-explanatory and easily read, for brevity below are listed the social disintegration factors used:

a. Median Family Income, 1960
b. Percent Civilian Labor Force Unemployed
c. Percent Substandard Housing Units, 1960
d. Telephones Available in Households Per 100,000, 1960
e. Percent Population Over 25 Completing 8th Grade or Less
f. Percent Child Welfare Load Per 100,000 Child Population
g. Divorces and Annulments, 1960, Per 100,000 Population
h. Illegitimate Births, 1963, Per 100,000 Population
i. Suicides, 1962-1964, Per 100,000 Population

Special Needs of Certain Groups Within the Area in Relation to Some of the Factors Mentioned: One would expect the child welfare load to be greatest in the areas where financial stress is greatest. This is not so as far as the Maine mental health center areas are concerned. There are pockets of poverty which more nearly explain these differences. Area 3 has the highest child welfare load, 177.2 per 100,000 children, and area 5 which has the highest median income has the lowest child welfare load, 110.7 per 100,000. The divorce and annulment rate is also highest in area 3, 257.2 per 100,000 population, and is lowest in area 1. The illegitimate birth rate is highest in area 2 and lowest in area 1. Maine has a high suicide rate with area differences.

TABLE 4

Subject #4:
Population Distribution

Mental Health Center Area	Persons Per Square Mile	Rank	% Over 65	Rank	% Under 18	Rank	Combined Total Rank		Total Factors		Score
1	15.8	1	6.80	1	42.55	5	7	÷	3	=	2.3
2	27.9	2	11.10	2	35.72	3	7	÷	3	=	2.3
3	73.9	3	12.24	5	35.05	2	10	÷	3	=	3.3
4	114.1	4	11.22	3	35.74	4	11	÷	3	=	3.7
5	156.5	5	11.59	4	34.64	1	10	÷	3	=	3.3

Rank - 5, greatest need; 1, least need (weight 1).

Size of Areas: The mental health center areas rank in size geographically as follows: Area 1, second in total area

Area 2, first

Area 3, third

Area 4, fourth

Area 5, fifth

Travel problems are greater in areas 1 and 2 than in the other three areas.

TABLE 5

Subject #5:

Usage of Available Hospitals and Clinics

Mental Health Center Area	1963 Admissions to State & V.A. Hospitals Per 100,000	Rank and Score
1	135.6	1
2	278.3	5
3	236.1	4
4	189.1	2
5	213.2	3

Rank - 5, greatest need; 1, least need (weight 1).

The Extent of Mental Illness and Emotional Disorders: The true extent of mental illness and emotional disorders cannot be accurately determined for the State of Maine. It is assumed that many mentally ill patients in Maine go outside of the state for private psychiatric care both for diagnostic and treatment purposes; many are cared for in general hospitals, possibly under non-psychiatric diagnoses.

The admissions of residents of Maine to the Veterans Administration Hospital at Togus and for the Maine state hospitals for the year 1963 were combined and the ratio per 100,000 of population to hospitalization was determined for the mental health center areas as Table 5 shows.

It will be noted that the rate of admissions per 100,000 of population range from a low of 135.6 per 100,000 of population in area 1 to 278.3 in area 2. The rates of admission in areas 2 and 3 were the highest in the state which may be due to ease of accessibility, as the state hospitals are located in areas 2 and 3 and the Veterans Administration facility at Togus is also in area 3. The lower admission rate in area 1 may be due to some extent to the low ratio of doctors to people in the area. The ratio of doctors in area 1 is 59.9 physicians per 100,000 of population, which is the lowest in the five mental health center areas in the state. The low admission rate also may be due to some extent to the relative inaccessibility of the area.

In 1962 the U.S. median number of patients in residence in state hospitals per 100,000 of population was 251.4. Maine exceeds this, having a median of 298.5; the other New England states data follow

together with rank order of the states in the U.S. for 1962. However, of the New England states, in 1962 Maine had the smallest number of patients in residence in state hospitals.

State		Rank	Order	State	
Maine	298.5	13	5	Massachusetts	387.0
New Hampshire	404.3	3	4	Rhode Island	402.6
Vermont	315.7	12	11	Connecticut	318.5
New York	517.5	2			
United States	251.4				

The U.S. ranges in resident patients in state and county hospitals are from 91.6 in Utah to 517.5 per 100,000 of population for New York.

We can expect the state hospital admission rates in Maine to continue to rise with a leveling off of the average number of state hospital patients in residence near the present level; as the number of the aged increase, unless better methods of treatment become available, nursing homes in the state are used more extensively for the care of psychotic aged, or community psychiatry within the state expands greatly. Some of the state hospital buildings do not conform to federal requirements and could be renovated or razed and rebuilt. Some new installations are indicated.

Policies regarding state hospital admissions, particularly in regard to voluntary admissions, may have a substantial effect on the admission rates of the hospitals i.e., the acceptance of acute alcoholics may result in a higher discharge rate and higher admission rates.

The fact that Maine has the lowest rate of resident state hospital patients in New England does not necessarily mean that

Maine has the lowest rate of mental illness in New England. It rather implies that: (a) available facilities are used less, or (b) advantage is taken of other treatment facilities, or (c) communities tolerate mental illness better in Maine than is true for other New England states, or (d) there is less awareness of the value of psychiatric care.

Data on the true rate of outpatient care are likewise considered to be unreliable in Maine, chiefly due to under reporting, as the outpatient data from the state hospital follow-up of released patients is not available nor is data on pre-admission evaluations and brief therapeutic interviews. Reporting of statistics of all clinics is currently being improved and will be available within the year.

TABLE 6

Subject #6:
Incidence of Crime

Mental Health Center Area	Probation May 1965 Per 100,000 Population	Rank	1963-1964 Court Commitments to Correctional & Penal Institutions Per 100,000 Pop.	Rank	Combined Total Rank		Total Factors		Score
1	445.2	5	77.9	2	7	÷	2	=	3.5
2	303.8	4	73.5	1	5	÷	2	=	2.5
3	196.9	3	90.2	5	8	÷	2	=	4
4	176.8	2	83.8	4	6	÷	2	=	3
5	155.4	1	80.9	3	4	÷	2	=	2

Rank - 5, greatest need; 1, least need (weight 1).

Note: Social disintegration may be suggested by the numbers on probation in May 1965 and the court commitments to our correctional and penal institutions in the year 1963-1964. Data were taken from reports within the Department.

The incidence of crime can roughly be measured by determining the probation rate per 100,000 of population which for mental health center area 1 is 445.2; area 2, 303.8; area 3, 196.9; area 4, 176.8; and area 5, 155.4. Court commitments for 1964 per 100,000 of population for area 1 was 77.9; area 2, 73.5; area 3, 90.2; area 4, 83.8; and area 5, 80.9. It will be noted that the number of court commitments vary between mental health center areas from 73.5 in area 2 to 90.2 in area 3.

Alcoholism and Drug Abuse: It is estimated there are 375,000 drinkers of alcoholic beverages in Maine, out of a total population of 969,265. Generally, one out of every fifteen drinkers becomes an alcoholic so, as a consequence, there are approximately 25,000 alcoholics in the state. By breakdown the distribution would be somewhat as follows:

Mental Health Center Area 1	2,800 alcoholics
Mental Health Center Area 2	5,600 alcoholics
Mental Health Center Area 3	4,300 alcoholics
Mental Health Center Area 4	3,800 alcoholics
Mental Health Center Area 5	8,500 alcoholics
Total	25,000 alcoholics

These people for the most part represent a cross-section of our society with roughly 3% belonging to that segment commonly described as "skid row". The ratio of males to females is 4½ to 1 according to existing case records, but there is reason to believe a more equal ratio exists. It is felt that females are much less inclined to seek help than males. Also, since it is much easier for them to remain hidden from society by virtue of their roles as wives, homemakers and mothers, there is less visibility and less pressure for them to seek help.

Note: Although the factor of alcoholism and drug abuse was considered as a possible subject the number of alcoholics in the State of Maine as stated above is an estimate only and the accuracy of the estimate can be questioned. Therefore, although very important, alcoholism is not considered statistically other than to state that probably Maine has its share of alcoholics and that the geographical distribution of alcoholics follows the population distribution. Drug addiction seems to be increasing so far as barbiturates and amphetamine is concerned, but narcotic addiction does not constitute a present problem in Maine.

TABLE 7

Area Ranking Summary

Mental Health Center Area	Personnel #1		Facility and Service #2		Socio-Economic #3		Population Distribution #4		Usage #5		Incidence of Crime #6		Grand Total Score
1	15	+	15	+	3.0	+	2.3	+	1	+	3.5	=	39.8
2	12	+	12	+	3.6	+	2.3	+	5	+	2.5	=	37.4
3	6	+	6	+	3.8	+	3.3	+	4	+	4.0	=	27.1
4	9	+	9	+	2.6	+	3.7	+	2	+	3.0	=	29.3
5	3	+	3	+	2.5	+	3.3	+	3	+	2.0	=	16.4

Based upon the greater the number the greater the need, the Grand Total Score indicates the following priorities for construction:

TABLE OF PRIORITIES

Mental Health Center Area	Priority
1	1
2	2
3	4
4	3
5	5

The five mental health center areas have been ranked according to their relative need for mental health services and insofar as the necessary data was available in conformance with Sec. 54.204, Title II, Public Law 88-164, Regulations of the Community Mental Health Centers Act of 1963. Determination of priority of individual projects will be in accordance with the priority of the area. Ranking of projects will normally be in accordance with the established priority except when a project with a lower priority is more urgently needed to provide adequate mental health services and exceptions may be made because of feasibility.

As construction of facilities and new services are implementted, priorities will be adjusted to reflect areas of altered situations.

Projects within each mental health center area will be considered in the light of their harmony with existing or proposed mental health centers.

In determining the relative priority of mental health projects, special consideration will be given to those projects providing services to persons located in rural communities and communities with relatively small financial resources.

Insofar as practicable and without affecting the priority of facilities serving rural communities and areas with relatively small financial resources, special consideration will be given to applications for construction of projects of a size and character consistent with efficient and economical operation.

Initial installations and additions to existing facilities will be given priority over replacements, except: (a) where replacement is of minor character and necessary to the provision of needed additional facilities and (b) where replacement is essential to eliminate an existing needed facility which constitutes a public hazard.

To the extent deemed feasible by the State Agency, special consideration will be given to facilities which will include new or expanded facilities for training mental health personnel.

Insofar as practicable, the State Agency will develop the construction program in relation to the proportionate need for each of the following types of mental health facilities: mental health centers, psychiatric beds in general hospitals, outpatient clinics, partial hospitalization, etc. In determining proportionate needs, consideration will be given to existing facilities and those under construction without assistance under the Federal Act.

D. Probable Location of, and Relative Need for, Facilities and Clinical Services Throughout the State: The population concentration runs in a band extending from the southern tip of Maine through Lewiston, Augusta, Bangor and then sweeps up in a curve through Houlton and Presque Isle. To the east and to the north and west the population is very scattered. This means that these regions may have to mobilize local services, as they can, and then relate them to the state services. Some counties are doing this. For the present, state funds are not sufficient to allow us to create state-supported services in these sparsely settled areas. Another factor has to do with existing facilities which would be

extremely expensive to reduplicate. Pineland Hospital and Training Center, Augusta and Bangor State Hospitals represent an investment of over $20,000,000 in their plants, and the replacement cost would probably be at least twice as much as this. (see comments under Direct Cost of Mental Illness in Maine on page 54.)

The central portion of the state is adequately served with hospital beds by the Augusta State Hospital and generally the eastern and lower portion of the northern part of the state are adequately served by Bangor State Hospital as far as numbers and location of beds are concerned. This leaves the extreme northern portion and the southern portions of the state unserved by easily available inpatient facilities. Certainly this is one of the primary needs. An inpatient facility located in Portland and another in the population center of Presque Isle-Caribou-Fort Fairfield is indicated. Additionally there are other population centers such as Lewiston-Auburn which is the second most populous area of the state, but relatively close to inpatient services at the Augusta State Hospital. Certainly this community deserves the clinic which it has, but it deserves more coordination of existing services. The northern portion and the Bangor and Portland areas have to provide broad outpatient services as well.

Basically the Plan is to maintain the Augusta and Bangor State Hospitals with improvements and expansions of their outpatient facilities and services. In Portland the outpatient clinic should be expanded to include inpatient services as well, perhaps at local expense rather than at state expense or with

partial state support and partial local support. In the Aroostook County area a facility providing both outpatient and inpatient services must be created from scratch. In the Lewiston Auburn area a consolidation of the three separately state-supported facilities should be accomplished. In Bangor the Eastern Maine Guidance Center should be consolidated in its functioning, not only with the Bangor State Hospital, but also with the Eastern Maine General Hospital. Beyond these state services which should be adequate to provide personnel for mental health consultation and diagnosis to our correctional facilities, there should be expanded state support for locally established mental health facilities and probably also for hospitalization for mental illness in the local, general non-profit hospitals. Future plans project that existing facilities and services should join together to form part of a mental health center complex in each of the proposed five mental health center areas. This will provide continuity of care.

Maine's Mental Health Plan is based upon a complex of facilities and services not necessarily under one roof, nor even under a single sponsorship but cooperatively tied together to offer adequate service to all the people of Maine. This entails utilizing facilities and services now available and supplementing them by progressively adding more on a priority basis or on the basis of availability what is needed to offer the full range of care to each mental health center area. Adequate care, available within a reasonable distance to all who require it, will remain the primary emphasis of the plan.

The community general hospitals in the state are expected to play a vital role in the success of such a plan in view of the

special consideration given to programs which are part of or closely affiliated with them. General hospitals in Maine will be requested to consider emergency services and short-term care and integration of outpatient services wherever indicated, feasible and practical.

Direct Cost of Mental Illness in Maine: The major expenditures for the care of the mentally ill in Maine are met by the state hospitals. During the year 1964-65 the operating expenditures for the Augusta State Hospital totalled $3.4 million; the Bangor State Hospital, $2.3 million; Pineland Hospital and Training Center, $3.1 million, in round numbers.

The Bureau of Mental Health in the same year spent $195,000 and the Bureau's community grant-in-aid program of $105,000 matched a similar expenditure of community funds.

The three institutions under the supervision of the Bureau represent a capital investment of $20.75 million.

Fees collected for the care of institutionalized patients amounted to over $800,000 which was returned to the general fund of the state.

Of these operational expenditures approximately 75% are spent for the payment of personnel.

This represents easily identified costs but do not include the costs of private care and the economic loss to the individuals who are mentally ill and incapacitated.

Federal financial assistance in the form of categorical grants and project grants during the year totalled slightly over $200,000. The overall plan for providing care close to home certainly will have some affect upon our large state hospitals.

It is believed that in Maine during the early years of implementation of the plan more cases will be identified and admitted earlier in the course of their illness. Thus admission will go up. On the other hand, the hospitals' first admissions and re-admissions will steadily decline as community services are able to provide better consultation and treatment services. Naturally with the improvement of facilities and services within the communities costs will rise accordingly, hopefully, borne collectively by federal, state, local and private resources.

Mental Hospitals: Mental hospitals have been inventoried and classified in accordance with the policy statement of non-conformitys found in the Hospital and Medical Facilities Survey and Construction Plan Annual Revision 1964-65 under the heading "Determination of Non-Conformance" page 12 and reads: "For long-range planning purposes the type of construction, arrangement, and location of structures containing the various types of mental health facilities contemplated under the Community Mental Health Centers Act are the determining factors in the classification of these facilities as conforming or non-conforming. Ideally all of the structures should be of first-class fire resistive construction, of modern design and proper location to provide the optimum of safety especially when inpatient services are existent and also provide facilities for the best mental care of the people of the State." For purposes of this State Plan in conformance with the Hill-Burton program the following policy on non-conformance has been established:

"MENTAL HEALTH FACILITIES STRUCTURES WHICH BECAUSE OF PHYSICAL CONDITIONS THAT MAY TEND TO ENDANGER THE SAFETY OF THE PATIENT OR EMPLOYEE OR WHICH BECAUSE OF INTERIOR OR EXTERIOR CONDITIONS PRESENT RISKS THAT ARE NOT INHERENT IN PROPERLY LOCATED STRUCTURES OF FIRST-CLASS FIRE RESISTIVE CONSTRUCTION AND MODERN DESIGN ARE CLASSIFIED AS NON_CONFORMING."

State Hospitals: State hospitals listed are under the jurisdiction of the State Department of Mental Health and Corrections. The number of beds required to provide adequate inpatient services for mental patients in Maine shall be three beds per 1,000 population. Recent re-evaluations of programs for the mentally ill indicate that this ratio is realistic, provided that nursing care facilities are available for the chronically disabled person in requiring hospital-type care.

Psychiatric Beds	1960 Census	1970 Projection
Population to be Served	969,265	1,012,000
Total Inpatient Beds Allowed	2,907	3,036
Total Existing Conforming Beds	2,136	2,907
Net Additional Beds Needed	771	

Note: Although there are 1,067 non-conforming beds, it is planned to provide 771 additional conforming beds through construction or modernization providing that nursing care facilities are provided by the state for the chronically disabled patients not requiring hospital-type care.

Based on the 1960 population figure of 969,000 people using the formula of three beds per 1,000 population, the total beds allowed should be 2,907 statewide. At present the total existing conforming beds is 2,136; therefore, there would be a need for 771 additional conforming beds statewide. At the present time there are

two mental hospitals and one institution for the mentally retarded which has a unit for emotionally disturbed children. Construction of new acute reception buildings should be considered and efforts should be made to renovate and update the existing facilities to comply with elements of service which constitute adequate care, re-emphasizing that each of our two mental state hospitals by renovation should have a discrete admission and intensive treatment service. The construction of a children's psychiatric hospital to serve the northern part of the state should also be given consideration. If federal funds are not available for construction of these buildings state, private and philanthropic sources should be sought.

TABLE 8

Conforming and non-Conforming Mental Hospitals Report

Name of Facility	City or Town	Ownership or Control	Medical Type	Bed Capacity Conform.	Non-Conform.	% Occupancy
Augusta State	Augusta	State	N & M	1,507	153	104
Bangor State	Bangor	State	N & M	312	888	99
Pineland	Pownal	State	N & M	291	0	86
Portland City	Portland	City	N & M	26	0	96
Utterback Private	Bangor	Ind	N & M	0	26	67
		State Total		2,136	1,067	

(a) Bed count change due to re-evaluation of bed space.
(b) Pineland Hospital is actually part of Pineland Hospital and Training Center (for the retarded). The hospital unit serves as a diagnostic and medical facility and also provides some continuing nursing care for totally dependent retarded. The hospital has a 75-bed capacity.

It will be noted that although there are 1,067 non-conforming beds it is planned to provide only 771 additional conforming beds through construction or modernization, providing that nursing care facilities are provided for the chronically disabled patients not requiring hospital-type care.

Recommended Placement of Mental Health Clinics: The clinics as recommended are either operative or non-operative. Such installations are to be located in or near general hospitals wherever possible. The hospitals, whenever in need of additional space, may be eligible for matching funds under the Construction Act. Also as part of the mental health center complex in their respective areas they may also be eligible for grants for the initial cost of professional and technical personnel needed to staff new services in the mental health center area. (See following pages.)

Recommended Placement of Clinics

	Location	Type of Clinic	Plan
Mental Health Center Area 1	Fort Fairfield	*Center	5 year
	Fort Kent	Satellite	5 year
	Houlton	Satellite	5 year
Mental Health Center Area 2	Bangor	Center	Operative
	Bar Harbor	Satellite	Operative
	Dover-Foxcroft	Mobile	5 year
	Ellsworth	Satellite	Operative
	Lincoln	Mobile	5 year
	Machias	Satellite	5 year
	Millinocket	Mobile	5 year
Mental Health Center Area 3	Augusta	Center	Operative
	Rockland	**Satellite	5 year
	Skowhegan	Mobile	5 year
	Waterville	Satellite	Operative
Mental Health Center Area 4	Farmington	Satellite	Operative
	Lewiston-Auburn	Center	Operative
	Rumford	Satellite	5 year
Mental Health Center Area 5	Bath-Brunswick	Satellite	Operative
	Bridgton	Satellite	5 year
	Portland	Center	Operative
	Saco	Satellite	Operative
	Sanford	Satellite	5 year
New Hampshire	Portsmouth	Center	Operative

Operative dates dependent upon the initiative of authorities in organizing and financing services.

*Operative pending employment of personnel.

**Operative pending employment of part-time personnel.

Additional Facilities Proposed and Probable Construction Sites

Community Mental Health Centers

Area	Proposed Location	Facility	Associated Institution(s)	Year
1	Fort Fairfield	Center	Community General Hospital	1975
	Presque Isle	Center	Arthur R. Gould Memorial	1980
2	Bangor	Center	Eastern Maine General	1975
	(understudy)	Center	General Hospital	1975
3	Augusta	Center	Augusta General	1975
	Waterville	Center	Thayer Hospital	1970
4	Lewiston	Center	Central Me-St.Mary's	1968
5	Portland	Center	Maine Medical Center	1970
	Biddeford	Center	Webber	1975

Other

	Proposed Location	Facility	Associated Institution(s)	Year
	Augusta	Augusta State Hospital	Augusta General	1970
	Bangor	Bangor State Hospital	Eastern Maine General	1970
	Bangor	Private Psychiatric Hospital	Utterback Private	1970
	Bangor	Childrens Psychiatric	Bangor State Hospital	1975
	Pownal	Childrens Psychiatric	Pineland Hospital & Training Center	1970
	Saco	Childrens Services	Sweetser Children's Home	1970
	Flagstaff Lake Region	Summer Camp for Emotionally Disturbed and Mentally Retarded Children	Bureau of Mental Health Dept. of Mental Health and Corrections	1970

Additional Facilities Proposed for State Outpatient Clinics
and
Psychiatric Units of the Community Hospital
(Probable Constructio

Mental Health Center Area	Proposed Location	Name of Associated Institution or Hospital	Name of Clinic	Psychiatric Beds	Year	Priority
1	Fort Fairfield	Community General Hospital	Aroostook Mental Health Clinic	20	1970	
2	Bangor	Eastern Maine General	Eastern Maine Guidance Center	15	1970	
2	Bar Harbor	Mt. Desert Island	Mt. Desert Child Guidance Clinic	10	1970	
2	Rockland	Knox General Hospital	Community Mental Health Clinic	10	1970	
3	Augusta	Augusta General Hospital (Augusta State Hospital)	Community Mental Health Clinic	10	1970	
3	Waterville	Thayer Hospital	Kennebec Mental Health Clinic	10	1970	
4	Lewiston	Central Maine General	Mental Health Center	10	1970	
4	Lewiston	St. Mary's General	Mental Health Center	10	1970	
5	Bath	Bath Memorial Hospital	Bath-Brunswick Mental Health Clinic	10	1970	
5	Brunswick	Bath Memorial Hospital	Bath-Brunswick Mental Health Clinic	10	1970	
5	Biddeford	Webber	Community Mental Health Clinic	10	1970	
5	Portland	Maine Medical Center	Maine Medical Mental Health Clinic	25	1966	
5	Sanford	Henrietta Goodall Memorial	Community Mental Health Clinic	10	1970	
			Additional Beds Needed	641		

Note: In some instances the number of psychiatric beds listed as contemplated are not realistic. This is merely a rule of thumb indicating that there should be hospital beds for short-term care provided by the hospital. Individual experiences will actually set the number.

Additional Facilities Proposed for State Satellite Outpatient Clinics
(Probable Construction)

Mental Health Center Area	Proposed Location	Name of Associated Institution	Name of Clinic	Core of Mental Health Center
1	Fort Kent	Peoples Benevolent Hospital	Community Mental Health Clinic	Fort Fairfield
1	Houlton	Ricker College	Community Mental Health Clinic	Fort Fairfield
2	Ellsworth	Maine Coast Memorial Hospital	Hancock County Mental Health Clinic	Bangor
2	Machias	Down East Community Hospital	Community Mental Health Clinic	Bangor
3	Skowhegan	Fairview Hospital	Community Mental Health Clinic	Augusta
4	Rumford	Rumford Community Hospital	Community Mental Health Clinic	Lewiston
4	Farmington	Franklin County Memorial	Franklin County Mental Health Clinic	Lewiston
5	Bridgton	Northern Cumberland Hospital	Community Mental Health Clinic	Portland

Mobile Clinics
(Probable Construction)

Mental Health Center Area	Proposed Location	Name of Associated Institution	Name of Clinic	Core of Mental Health Center
2	Millinocket	Millinocket Community Hosp.	Community Mobile Clinic	Bangor
2	Dover-Fox.	Mayo Memorial Hospital	Community Mobile Clinic	Bangor
2	Lincoln	Lincoln Hospital	Community Mobile Clinic	Bangor
2	Calais	Calais Regional Hospital	Community Mobile Clinic	Bangor
3	Skowhegan	Fairview Hospital	Community Mobile Clinic	Augusta

E. Mental Health Center Areas: The State of Maine is divided into five areas for the purposes of the plan, based upon population distribution, natural geographic boundaries, existing trade and communication patterns, the pattern of referral of patients, hospital relationship, patient preference, and other similar data. The core or center of the areas serve as the center of referral of the patients while satellite and mobile clinics supplement and add to mental health care which can be offered close to home. On the following pages these areas are described as to existing psychiatric facilities, other mental health facilities, auxiliary facilities, manpower, and projected needs that would round out an adequate mental health program.

MENTAL HEALTH CENTER AREAS

POPULATION
(By Area)

1 - 108,819
2 - 227,037
3 - 166,823
4 - 145,885
5 - 320,701

POPULATION
(Shaded Areas)

1 - 89,939
2 - 85,103
3 - 81,292
4 - 75,798
5 - 111,701

MINOR CIVIL DIVISIONS
STATE OF
MAINE
PREPARED BY THE
STATE HIGHWAY COMMISSION
PLANNING DIVISION
IN COOPERATION WITH THE
U.S. DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC ROADS

LEGEND

1963

MENTAL HEALTH CENTER AREA 1

"The County," as the people of Aroostook proudly call it, is Maine's northernmost area. It constitutes the major portion of mental health center area 1 under Maine's Mental Health Plan. Excluding the small land area in Penobscot and Washington Counties in mental health center area 1, there are 6,453 square miles. This is slightly less than the total of the other five New England states. Aroostook itself is some 230 square miles or 3.6% larger than the states of Connecticut and Rhode Island combined. The population of area 1 according to the 1960 census was 106,064. The populated areas cling to the northeast border of the state and the heaviest population is centered around an area consisting of Caribou, Fort Fairfield, Presque Isle, and Houlton.

I. Existing Facilities, Services, and Needs

A. Existing Mental Health Facilities

1. Psychiatric Facilities: There are no psychiatric facilities in mental health center area 1. Patients needing inpatient treatment travel outside the area to the Bangor State Hospital or Utterback Private Hospital in area 2. Veterans who are eligible for treatment are referred to the Veterans Administration Neuropsychiatric Hospital at Togus located in mental health center area 3. The only children's psychiatric facility is at Pineland Hospital and Training Center in mental health center area 5 in the southern part of the state.

2. Other Mental Health Facilities: Mental health services within the area are limited professionally to the traveling clinic provided by the Department of Mental Health and Corrections. This clinic provides diagnostic services to clients of the

MENTAL HEALTH CENTER AREA

POPULATION

Shaded Area: 89,939

Total: 108,819

Department of Health and Welfare exclusively. It is limited to children with an occasional exception. The clinic travels to Caribou and Houlton four times a year for a two-day session in each town.

3. Auxiliary Facilities:

   a. There are nine general hospitals in this area.

   b. There are 13 nursing homes listed in the Health and Welfare inventory under the Hill-Burton program but available information does not include their use as mental health facilities. This will be remedied in the future and the necessary information acquired.

4. Manpower

   a. At present there are no mental health professionals working within mental health settings in area 1 with the exception of the traveling clinic staff.

   b. A psychiatrist in combined public and private practice is located in Edmundston, New Brunswick.

B. Coordinated Facilities and Services Outside Area 1:

1. Bangor State Hospital (area 2) regional

2. Pineland Hospital and Training Center (area 5) statewide

3. Veterans Administration, Togus (area 3) statewide

4. Sweetser Childrens Home, Saco (area 5) statewide

5. Boothbay Harbor Summer School and Camp for Emotionally Disturbed.

6. Utterback Private Hospital (area 2) statewide

Until appropriate facilities and services are available within the five mental health center areas, the continued use of agencies that offer statewide coverage is necessary. Thus the

two state hospitals will continue to provide services in the areas already established by the Commissioner of the Department of Mental Health and Corrections. Also Pineland Hospital and Training Center, having the only children's psychiatric hospital in the state, will be listed in all five mental health center areas as a participating agency offering inpatient services for children. Another example is the Veterans Administration Hospital at Togus which will offer psychiatric care to qualified veterans from all five mental health center areas.

C. Planned Mental Health Facilities

1. Psychiatric Facilities: The Aroostook Mental Health Clinic. Action taken by the 102nd Legislature has set the stage for better mental health facilities and services in mental health center area 1. Chapter 111, Private and Special Law, authorizes the state to lease the T.B. Annex in Fort Fairfield to the Community General Hospital. This will house a mental health clinic and the hospital has agreed to provide psychiatric beds for brief intensive hospital care. Projected plans for five years hence estimate the need of psychiatric beds for this area at approximately twenty.

2. Other Mental Health Facilities: Satellite Clinics. Future plans call for the establishment of two satellite clinics located in the northern and southern part of area 1. Probable location of the clinic in the north will be Fort Kent and in the south, Houlton.

3. Auxiliary Facilities: Hospitals and Nursing Homes. Due to the newness of the plan, action programs by the communities have not been initiated but contemplated by the planning staff in the several hospitals and nursing homes in area 1. (See D. Needs)

4. Manpower

   a. Chapter 159, Private and Special Law, An Act Making Supplemental Appropriations for the Expenditures of State Government and for Other Purposes for the Fiscal Years Ending June 30, 1966 and June 30, 1967, provides funds for the biennium (1965-67) to hire a full clinical team composed of a psychiatrist, a psychologist, a psychiatric social worker and clerical help to staff the Aroostook Mental Health Clinic. This team when recruited will provide diagnostic, consultative, and treatment services.

   b. A clinical psychologist or a psychiatric social worker will staff each satellite clinic. The local clinics will be financed by local, town and county funds and matching funds from the state's community grant-in-aid program for mental health services.

D. Needs

An extended goal in the development of regional services should include the provision of the ten elements of service without duplication of effort as described in the federal description of mental health centers (to wit):

(1) Inpatient services;
(2) Outpatient services;
(3) Partial hospitalization services, such as day care, night care, weekend care;
(4) Emergency services 24 hours per day must be available within at least one of the first three services listed above;
(5) Consultation and education services available to community agencies and professional personnel;
(6) Diagnostic services;
(7) Rehabilitative services, including vocational and educational programs;
(8) Precare and aftercare services in the community, including foster home placement, home visiting, and halfway houses;
(9) Training;
(10) Research and evaluation.

E. Specific Needs or Recommendations

1. Aroostook Mental Health Services, Inc.: It is recommended that the directors of the Aroostook Mental Health Services, Inc. continue to function as the sponsoring and controlling body in carrying out the provisions of the plan and to promote and implement needed comprehensive mental health services in mental health center area 1.

2. Additional Staffing Funds

   a. In addition to the funds appropriated by the 102nd Legislature, funds will be needed to staff more adequately the clinic and the ten-bed psychiatric unit at the Community General Hospital at Fort Fairfield. The plan includes federal assistance in staffing expenses under Title II, Community Mental Health Centers, Part B, Grants for Initial Cost of Professional and Technical Personnel of Centers.

   b. The federal aid for staffing will also be utilized to more adequately staff satellite clinics in northern and southern Aroostook County.

3. General Hospitals

   a. There is need for provision for the admission of psychiatric patients on an emergency basis and for short-term care in the nine general hospitals in this area.

   b. A 24-hour telephone consultation program should be developed with the general hospitals' staff utilizing the mental health center professionals as consultants.

4. Partial Hospitalization: Long-range plans for partial hospitalization (day and night care) programs should be developed to meet the need in northern, central and southern Aroostook in populated areas.

5. Nursing Homes: Nursing homes known to provide adequate care properly licensed and willing to accept psychiatric patients should provide partial hospitalization (day or night care) for the elderly psychiatric ill.

6. Chronic Care: Long-range plans for inpatient chronic care should include regional facilities for the care of the mentally ill and mentally retarded.

7. International Cooperation: A plan should be developed on an international basis for establishing mental health services including selected services for the mentally retarded with adjacent Canadian communities.

8. Regional and Task Force Reports: Supplementary details on needs of and recommendations for other socially related problems including broken homes, alcoholism, juvenile delinquency, illegitimacy, school dropouts, etc., may be found in the regional and task force reports.

F. Probable Construction

1. Outpatient Clinic and Psychiatric Unit of the Community General Hospital:

Community	Probable Structure to House	Beds	Institution
Fort Fairfield	Psychiatric unit; Day rooms for partial hospitalization program, etc.; Staff offices.	20	Community General Hospital

Explanation: A psychiatric unit with ten psychiatric beds for short-term care has already been provided within the Community General Hospital in Fort Fairfield but is not operative. An additional ten beds are contemplated in the future. This hospital also has provided office space for a full clinical team. Future plans project this area as the core of mental health services. As more services are developed additional space will be necessary. Therefore in our construction plan we are providing for this possibility although at the time we are unable to be specific as to the size of the project nor the time element involved. We are now in the process of locating staff to commence operations in the space presently provided by the hospital.

2. Satellite Outpatient Clincs:

Community	Probable Structure to House	Institution
Fort Kent	Space for diagnostic services, examination room, waiting rooms, group therapy and office space for the clinic staff.	Peoples Benevolent Hosp.
Houlton	Same as above	Ricker College

Explanation: In Maine's Mental Health Plan these clinics will be satellites to the center clinic at Fort Fairfield.

This is explained earlier in this chapter under C. Planned Facilities and Services for this area.

G. Priority

If rank order for construction was determined only on the basis of available mental health facilities and services now existent in Maine, area 1 would rank first in the state. At present there are no mental health services outside of the yearly visits of the Department of Mental Health and Corrections traveling clinic and no psychiatric personnel at all as explained earlier in this plan. Needless to say mental health facilities and services were not the only criteria used in setting priorities for construction but were based upon several factors. The findings as described under the heading "Survey of Need and Ranking of Areas" page 38, places area 1 first in priority.

H. Accessibility (Transportation)

Mental health area 1 consists of most of Aroostook County; 16 townships in Piscataquis County, 16 in Penobscot including the towns of Danforth, Brockton, and 3 more or less undeveloped townships. Tentative plans designate Fort Fairfield as the center of the mental health center complex for area 1. Proposals have been made for satellite clinics for Houlton and Fort Kent.

1. Highways: A comparatively dense highway network serves the eastern and northern parts of the area. Present plans call for the extension of the Interstate Highway System to the Houlton area; it may later be extended even farther north. Interconnection with major Canadian highways is also planned. Historic U.S. Route 1 running north and south along the east

coast has its northern terminus at Fort Kent, the southern terminus being at Key West, Florida. This scenic highway is a big tourist attraction. Other major highways in Aroostook are U.S. Route 2 and State Highways #161 and 11.

Highway Mileage:

Fort Fairfield-Fort Kent	55 miles
Presque Isle-Houlton	42 miles
Fort Fairfield-Houlton	46 miles
Caribou-Houlton	54 miles
Fort Fairfield-Limestone	11 miles
Fort Fairfield-Van Buren	32 miles
Fort Fairfield-Caribou	12 miles
Presque Isle-Portland	291 miles
Presque Isle-Boston	389 miles
Presque Isle-Montreal	391 miles
Presque Isle-New York	603 miles

2. Air: Northeast Airlines operates two flights each way daily from Presque Isle/Houlton to other southern Maine points and also Boston, New York, Washington, and Miami. Passenger and cargo service are available.

Approximate Flight Time:

Presque Isle-Portland	1 hour 30 minutes
Presque Isle-Boston	2 hours 30 minutes
Presque Isle-New York	3 hours 30 minutes

3. Bus Service: The Bangor and Aroostook Railroad provides passenger bus service from Bangor to all major communities in area 1. This line interconnects at Bangor with the Greyhound Bus System thus jointly providing service to all points in the U.S. and also in Canada.

4. Bus Service in Mental Health Center Area 1: Service is provided to and from Bangor to Fort Kent, two trips each way daily, north and southbound. Fort Fairfield passengers to and from points of Houlton or south are provided taxi

service between Caribou and Fort Fairfield at no extra cost. Sherman and Patten passengers on the Bangor and Aroostook line connect with Howes Bus Line. Taxi service is also provided for Millinocket passengers.

5. Railroad: The Bangor and Aroostook Railroad serves all major areas in the area. This line interconnects with the Maine Central and the Canadian Pacific Railroad systems. The Aroostook Valley Railroad (a subsidiary of the Canadian Pacific) operates a short 32-mile spur line between Presque Isle, Caribou, Washburn Junction, and Sweden. Delivery to the major trade centers of Boston, New York and Philadelphia can be provided within a 24-hour period.

   Railroad Mileage:

Presque Isle-Bangor	184 miles
Presque Isle-Portland	287 miles
Presque Isle-Boston	396 miles
Presque Isle-Montreal	523 miles

6. Description: The area contains approximately 6,453 square miles and had 106,064 people in 1960. Houlton, (population 8,289) the shire town, is a commercial, shopping, banking and transportation center on U.S. Route 1 and also the terminus of U.S. Route 2. Caribou, (population 9,926) Presque Isle, (population 12,886) and Fort Fairfield (population 5,876) form a triangle approximately 15 miles to a side. Limestone, (population 13,102) east of Caribou, is a military base 56 miles north of Houlton.

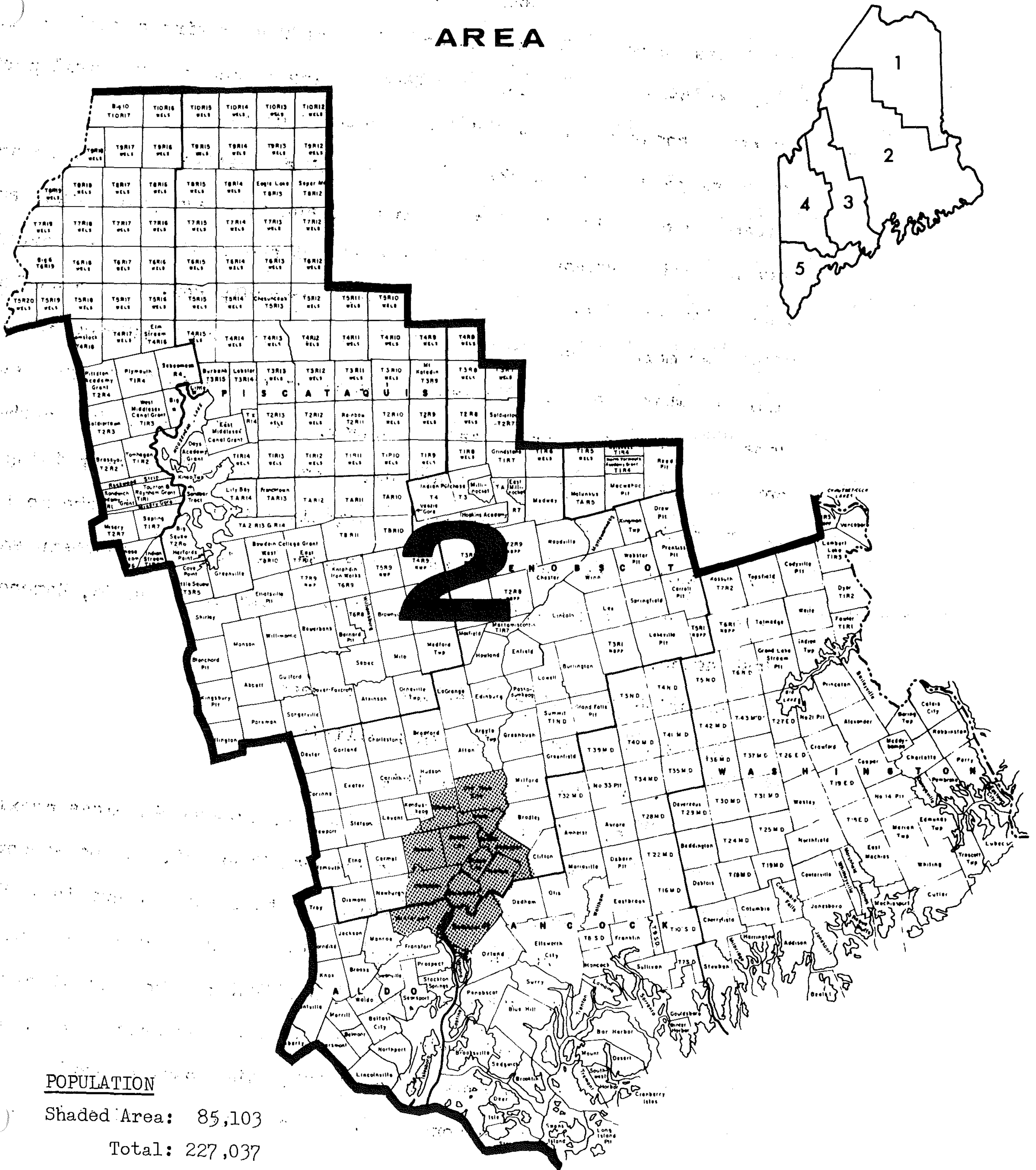
   In the northerly part of the area Van Buren, (populatinn 4,679) Madawaska, (population 5,507) Fort Kent, (population 4,761) are located 75 miles, 100 miles, and 125 miles respectively north, northwest of Houlton.

The shaded areas on the mental health center map show the concentration of population along the Maine and New Brunswick borders. Less than one-fifth of the land area is under cultivation, the western part being largely timberland; and, from a practical standpoint, largely uninhabited. Eighty-eight percent of the land area of Aroostook County is forest.

Note: Mental Health Center Area 1 Exhibits follow.

MENTAL HEALTH CENTER

AREA



POPULATION

Shaded Area: 85,103

Total: 227,037

MENTAL HEALTH CENTER AREA 2

Mental health center area 2 is comprised of five entire counties: Piscataquis, Penobscot, Waldo, Hancock, and Washington and a very small part of southern Aroostook and no rthern Somerset Counties.

The total population is 227,037. The central core of this entire area is centered around the cities and towns of Bangor, Brewer, Old Town, and Orono. Together with suburban centers these cities and towns have an aggregate population in excess of 60,000. Bangor, commonly referred to as "Center City" has more mental health facilities and services than any of the communities which make up the mental health center area. Like the legendary Rome all roads in area 2 lead to Bangor. The terrain of the northwestern part of area 2 is forest, mountains, lakes, and streams comprising the great northern Maine wilderness. Sparsely settled, it is the most extensive wildland area east of the Mississippi River. The southern and eastern part of the area are the coastal counties of Waldo, Hancock and Washington.

I. Existing Facilities, Services and Needs

A. Existing Mental Health Facilities

1. Psychiatric Facilities

a. Within the city of Bangor, located in close proximity to the Eastern Maine General Hospital, is the Bangor State Hospital which admitted its first patient in 1901. The hospital property consists of 240 acres with buildings evaluated at $4,041,007. During the year 1963-64 the average number of patients in residence was 1,198 and admissions numbered 747. The hospital employs 403 full-time persons. (1200 beds) This hospital has a catchment

area of 405,946 people. This includes eight of the sixteen counties and covers three-quarters of the land area of the state.

b. Also within the city of Bangor located in close proximity to both the Bangor State Hospital and the Eastern Maine General Hospital is the Utterback Private Hospital. This facility is a licensed 26-bed private psychiatric hospital. Its rate of admission is between 400-450 patients per year. Two psychiatrists assume medical responsibility for all patients with a primary diagnosis of mental disorder.

2. Other Mental Health Facilities

   a. Eastern Maine Guidance Center, Bangor: This center is a cooperative effort between the state and the community. This clinic has nine persons on its staff (two federally supported) with an operating budget of approximately $50,000. While its efforts are primarily with children, clients also include adults.

   b. Psychiatric Services to the Department of Health and Welfare, Department of Mental Health and Corrections: This provides mental health services to the various divisions of the Department of Health and Welfare. The program places particular emphasis upon direct consultation to workers of other programs. Cities and towns in area 2 served on a routine basis by a psychiatric social worker include Brewer, Ellsworth, and Machias.

c. Mount Desert Island Child Guidance Association: This is a non-profit, voluntary, community mental health agency. It has three primary sources of income: contributions from friends, state community mental health services program, and fees. The professional staff includes a trained social caseworker as executive director, a consulting psychiatrist and psychologist. In a little over three and one-half years, the Association served more than 200 individuals or families.

d. Hancock County Mental Health Association: The purpose of the Association is to inform the communities of Hancock County in the area of mental health and aid activities to promote community mental health. The Association employs a psychologist. Recently funds have been acquired to hire a full-time social worker. This Association also participates in Maine community mental health services program.

e. Sweetser Childrens Home (area 5) has an outpatient clinic once a month at Belfast.

3. Auxiliary Facilities

a. Eighteen general hospitals (refer to Hospital and Medical Facilities Survey and Construction Plan 1964-65 Department of Health and Welfare) are located in area 2.

b. There are a number of nursing homes listed in the Hospital and Medical Facilities Survey and Construction Plan inventory under the Hill-Burton Program but available information does not include their use as mental health facilities.

c. Chronic disease hospitals: Neither the Bangor Chronic Disease Hospital nor St. Joseph's Hospital in Bangor are listed as having psychiatric units. Recent inquiries reveal that St. Joseph's Hospital regulations allow admission of psychiatrically ill patients with exceptions and that an attending psychiatrist is available.

4. Manpower

The major portion of psychiatric manpower in area 2 is concentrated in the Bangor area due to the facilities located there. Excluding doctors at the Bangor State Hospital, there are two full-time psychiatrists in private practice with affiliation at Utterback Private Hospital. The remaining psychiatrists listed in the inventory of manpower are consultants who may or may not be from area 2.

The statements above pertaining to psychiatrists apply with equal validity to other professional groups, i.e. psychiatric social workers, psychologists, public health nurses.

B. Coordinated Facilities and Services Outside Area 2

1.. Psychiatric Facilities

a. Veterans Administration, Togus (see area 3, Part B, Summary of Psychiatric Facilities) statewide

b. Pineland Hospital and Training Center (see area 5, Part B, Summary of Psychiatric Facilities) statewide.

Until appropriate facilities and services are available and needed the continued use of agencies outside the area is necessary.

2. Other Mental Health Facilities

a. Boothbay Harbor Summer School and Camp for Emotionally Disturbed (see area 5, Part C, Other Mental Heath Facilities) statewide

C. Planned Mental Health Facilities

1. Psychiatric Facilities

a. This area should contemplate construction of a childrens psychiatric hospital preferably in the Bangor area to service areas 1 and 2.

b. Future plans of the hospital should include implementation of programs designed to activate community participation in providing patient facilities and services.

c. Eastern Maine General Hospital is making provision for psychiatric patients.

2. Other Mental Health Services

a. A traveling clinic operating out of the Eastern Maine Guidance Center or the Bangor State Hospital and having offices located at Dover-Foxcroft, Millinocket, and Lincoln should be established.

b. A traveling clinic for Washington County should be established.

c. Consultation services provided at Ellsworth and Bar Harbor are the hancock County Mental Health Association and the Mount Desert Child Guidance Association.

D. Needs

An extended goal in the development of regional services should include the provision of the ten elements of service without

duplication of effort as described in the federal description of mental health centers (to wit):

(1) Inpatient services;
(2) Outpatient services;
(3) Partial hospitalization services such as day care, night care, weekend care;
(4) Emergency services 24 hours per day must be available within at least one of the first three services listed above;
(5) Consultation and education services available to community agencies and professional personnel;
(6) Diagnostic services;
(7) Rehabilitative services, including vocational and educational programs;
(8) Precare and aftercare services in the community, including foster home placement, home visiting, and halfway houses;
(9) Training;
(10) Research and evaluation.

E. Specific Needs or Recommendations

1. Future plans may call for the consolidation of all mental health services in "Center City." A long-range study is anticipated to project the most practical approach in providing the populace with adequate facilities and services and, if housing is needed, construction should be contemplated.

2. There is need of acceptance of psychiatric patients on an emergency basis in the general hospitals in the area outside of Bangor since plans have already been made for that service in Bangor.

3. A 24-hour telephone consultation program should be developed with the general hospitals' staff utilizing the mental health center professionals as consultants.

4. Consideration should be given of a regional chronic disease center housed in some of the facilities of the Bangor State Hospital.

5. Please refer to regional reports 2, 5, 6, 10, 11 for supplementary information.

6. Long-range plans contemplate the division of area 2 into two mental health center complexes. This area covers the largest geographical area and exceeds the maximum federal catchment area. The southern part along the coast constitutes the largest economically depressed section in the state. It has been losing poulation in the last two decades at an alarming rate. The population is sparsely distributed along the coastline and it will be extremely difficult to staff installations with properly qualified professional personnel. Inasmuch as Maine is not a wealth state it is felt that we should concentrate in the early stages of implementation of the statewide plan on the places more thickly populated where funds are available and where the most good can be done for the greatest number. On the other hand realizing the coastal areas needs, our future plans should involve funds appropriated by the legislature as matching funds for construction and staffing and not depend upon the communities because of their economic condition. For the time being and until more adequate plans can be made to divide area 2 into two distinct mental health center complexes the present plan with Bangor-Brewer as the core of the complex utilizing satellite and mobile clinics to serve outlying areas should suffice.

F. Probable Construction

1. Outpatient Clinic and Psychiatric Unit (Mental Health Center0:

Community	Probable Structure to House	Beds	Institution
Bangor	Psychiatric unit; Day rooms for partial hospitalization program, etc.; Waiting rooms; staff offices.	15	Eastern Maine General

Explanation: A psychiatric unit with fifteen psychiatric beds for short-term care has been recommended. If regional mental health services are to be coordinated, and professional staff concentrated for maximum economy and efficiency it is important that plans now project this possibility. It is evident that Bangor has many surrounding communities dependent upon it for mental health services. Therefore the intent of this area in providing a comprehensive community mental health center should be to work toward realizing the ten elements of service in the quantity and quality needed to meet the mental health needs of the several communities known to utilize health facilities in the Bangor area.

2. Satellite Outpatient Clinics:

Community	Probable Structure to House	Institution
Ellsworth	Space for clinic - Hancock County Mental Health Clinic	Maine Coast Memorial

Explanation: The needs may well be reflected in the waiting for appointments of referral to other areas that fortunately have services to offer. Except in unusual pressing need for an individual or family, a referral must wait for an appointment. Since the present offices may be needed in the future for medical services plans should provide for space for a clinic with waiting rooms.

Community	Probable Structure to House	Institution
Machias	Space for clinic staff	Down East Community Hospital

Explanation: Future plans contemplate a clinic to service this coastal area with periodic visits to Calais.

3. Mobile Clinics:

Community	Probable Structure to House	Clinic	Associated Institution
Millinocket	Office Space	Millinocket Mental Health Clinic	General Hospital
Dover-Foxcroft	Office space	Dover-Foxcroft Mental Health Clinic	General Hospital
Lincoln	Office space	Lincoln Mental Health Clinic	General Hospital
Calais	Office space	Calais Mental Health Clinic	General Hospital

Explanation: See area 2, C. 2, a&b

4. Hospital (children):

Community	Probable Structure to House
Bangor	Childrens Psychiatric Hospital

Explanation: It is anticipated that additional hospital beds will be needed in the future for psychiatrically ill children. Authorities in this field have recommended that this hospital service the identical area now serviced by the Bangor State Hospital and that it be in conjunction with the Bangor Mental Health Center.

5. Bangor State Hospital:

Community	Probable Structure to House	Institution
Bangor	Admissions and intensive treatment building	Bangor State Hospital

G. Priority

The rank order of this area according to the relative need for community mental health centers construction described under the heading "Survey of Need and Ranking of Areas" page 38, is two.

H. Accessibility (Transportation)

Mental health center area 2 consists largely of Piscataquis Penobscot, Washington, Hancock, and Waldo Counties and the northern part of Somerset County. Five townships of southern Aroostook County are also included. The population of area 2 is 227,037. Serving mental health center area 2 are four railroads, a major airline, intra-state and through trucking lines, bus companies, and a deep-water port for ocean shipping. The Bangor area functions as the trans-shipment point for many goods moving to and from northern Maine and eastern Canada. Warehousing, trucking terminals, and rail freight yards with attendant services are located in the core area. Distances and travel times from Bangor by various methods of transportation are given below.

1. Highways: With the completion of Interstate Highway 95, the area will have direct highspeed road connections with southern Maine and the rest of New England as well as with southern Aroostook County. The driving time from Bangor to Boston is reduced to under four hours now that the limited access roadway is opened.

   Already nearing completion is the so-called industrial spur route connecting industrial areas in Bangor with a major

interchange on the interstate system, and work on other interstate projects including interchanges and roadway in the Bangor to Old Town section will be undertaken shortly. On other highway routes in the region, modernization, relocation and improvement projects are constantly being designed and carried out on both urban and rural roads in the interest of improving traffic circulation and providing for greater highway safety.

Highway Mileage:

Bangor-Portland	133 miles	Bangor-Ellsworth	26 miles
Bangor-Bucksport	19 miles	Bangor-Lincoln	48 miles
Bangor-Eastport	123 miles	Bangor-Millinocket	85 miles
Bangor-Calais	128 miles	Bangor-Greenville	79 miles
Bangor-Machias	83 miles	Bangor-Old Town	12 miles
Bangor-Bar Harbor	46 miles	Bangor-Belfast	35 miles
Bangor-Guilford	46 miles	Bangor-Boston	239 miles

2. Air: Northeast Airlines regularly schedules passenger and cargo flights. It operates from Dow Field in Bangor to northern Maine, southern Maine, Boston, and New York. Summer service is also provided to the Bar Harbor area.

Approximate Flight Time:

Bangor-Presque Isle	45 minutes
Bangor-Portland	48 minutes
Bangor-Boston, Mass.	1 hour 25 minutes
Bangor-New York	2 hours 13 minutes

3. Bus Service in Mental Health Center Area 2: Hudson Bus Lines provides local service to the Bangor, Brewer, Orono, Old Town areas and connects with northern and southern Maine.

4. Railroads: Four railroads provide some passenger service to all major populated centers in the region and provide through connections with lines serving New England, eastern Canada, and the rest of North America. These include:

Maine Central Railroad operates from Bangor to Points in southern Maine, northeastward to Vanceboro, and east to Calais and Eastport. Within the region branch lines operate from Brewer Junction to Bucksport, from Washington Junction to Waukeag, Newport Junction to Dover-Foxcroft, and Pittsfield to Harmony.

Bangor and Aroostook Railroad operates from the Bangor area to Aroostook County, the port of Searsport, and Greenville at the southern end of Moosehead Lake. Connections are made with the Maine Central Railroad at Northern Maine Junction and the Canadian Pacific Railroad at Brownville Junction.

Canadian Pacific Railroad trackage extends across the northern part of the region and provides connections with both the Maine Central Railroad and the Bangor and Aroostook Railroad.

Belfast and Moosehead Lake Railroad, extending from Belfast on Penobscot Bay to the Maine Central Railroad at Burnham Junction, serves towns in Waldo County.

Railroad Mileage:

Bangor-Portland	135 miles
Bangor-Presque Isle	188 miles
Bangor-Boston, Mass.	250 miles

5. Water: The port of Searsport, second to Portland in Maine's overseas waterborne commerce, is loated 25 highway miles south of Bangor on Penobscot Bay.

The Penobscot River is navigable to Bangor, with major concentrations of terminal facilities in the Bangor-Brewer

area (coal and oil wharves) and at Bucksport (paper-loading facilities for coastal and inland waterway barge traffic). Eastport and Calais are more than 100 miles from Bangor. Washington, Hancock and Waldo Counties are among the least prosperous areas in the state and it may be necessary to establish clinics in those areas. Routes 9 and U.S. 1 are the main routes traveling in an easterly direction from Bangor to Calais and in the case of U.S. 1 from Bangor to Machias and then northerly to Calais. An excellent network of good roads extends in all directions from Bangor.

Note: Mental Health Center Area 2 Exhibits follow.

MENTAL HEALTH CENTER

AREA

POPULATION

Shaded Area: 81,292

Total: 166,823

MENTAL HEALTH CENTER AREA 3

The major portion of this area is known as the central Kennebec V-lley. The southern part of this area is characterized by a high degree of urbanization mostly concentrated in the centers of Waterville, Winthrop, Fairfield, (25,000) Augusta, Hallowell, Gardiner, Randolph (33,000). The population of the entire area stretching from northern Somerset County southward to the Atlantic Ocean is 166,823. It includes the entire counties of Somerset, Kennebec, Knox and parts of Lincoln and Sagadahoc. The shaded areas (population 81,292) depicted on the mental health center area map covers the planned mental health center complex utilizing all mental health facilities and services available.

I. Existing Facilities, Services and Needs

A. Existing Mental Health Facilities

1. Psychiatric Facilities

a. The Veterans Administration at Togus provides psychiatric inpatient service to veterans in Maine. This facility has a 508-psychiatric bed hospital staffed with adequately trained professional and non-professional personnel. Located only five miles from the Augusta State Hospital, it is an important component of the mental health center complex in this area as well as statewide.

b. The Kennebec Mental Health Clinic is sponsored by the Kennebec Mental Health Association which secures public and private support from organizations and community funds and from the state. The clinic was begun with wide community support in June 1961 with headquarters at the Thayer Hospital, Waterville. It provides mental health

consultation and evaluation and treatment for select cases. Typical problems are concerned with adolescent adjustments at home or school, marriage conflicts, anxiety states, acute depressions, unusual changes in personality, and personal conflicts.

Fully trained psychiatric social workers and clinical psychologists compose the staff working part time under the direction of Price A. Kirkpatrick, M.D., psychiatrist. The administrative director and secretary work full time. Each patient is seen first by a team and then evaluated by the staff. Originally intended for Kennebec County residents, patients beyond this area are occasionally seen when time is available. Fees are moderate, based on ability to pay. No one is refused for lack of resources. The director of the clinic has a working relationship with the Seton Hospital and the Osteopathic Hospital in Waterville, and the Central Maine Sanitorium in Fairfield.

c. Augusta State Hospital: Located on the Kennebec River within the city of Augusta is the Augusta State Hospital which admitted its first patient in 1840. It is the seventh oldest state hospital in the U.S. The hospital has property of 601 acres and a capital evaluation of buildings amounting to $7,599,851. For the year 1963-64 the average number of patients in residence was 1,652 and there were 989 admissions for the year. This hospital has a catchment area of approximately 563,319

people. It includes eight of the sixteen counties in the southwestern part of the state.

d. Psychiatric Services to Health and Welfare: Homebase of this clinic is the Vickery-Hill Building in Augusta. Until recently this clinic's primary support was from federal funds. Services are rendered throughout the state to clients of the Department of Health and Welfare exclusively. A full team consisting of a psychiatrist, psychologist, and psychiatric social worker routinely serves the Portland, Auburn, Lewiston, and Augusta areas. All other areas are served on a routine basis by a psychologist and psychiatric social worker.

e. Thayer Hospital, a general hospital located in Waterville provides psychiatric care including inpatient diagnosis, emergency consultation and education and rehabilitation services. No psychiatric units exist as such since the beds are integrated with the general, medical, and surgical services.

f. Mansfield Clinics: Also located at the Thayer Hospital, this clinic offers a comprehensive evaluation for the child with a handicap. Children up to the age of twelve are seen by numerous disciplines to assure a thorough evaluation of each child.

Any physician from Kennebec, Somerset, Waldo, Lincoln, Piscataquis, Knox, and Washington Counties may refer a child for evaluation and is responsible for continuing care and further interpretation of the clinic findings.

g. Seton Hospital: The newly opened Seton Hospital in Waterville is accepting psychiatric inpatients.

2. Other Mental Health Facilities

a. Psychiatric Services to Health and Welfare: This is a traveling clinic with its headquarters in Augusta and field office at 463 Main Street, Rockland. It provides mental health services to the various divisions of the Department of Health and Welfare in this area. The program places particular emphasis upon direct consultation to workers of other programs. Appointments are made with clients to be seen at the field office in Rockland.

b. Clinic for Mentally Retarded Pre-School Children: Supported by federal funds this clinic is located at Thayer Hospital and is administered by the Division of Maternal and Child Health and Crippled Children Services, Department of Health and Welfare.

3. Auxiliary Facilities

a. General Hospitals: Only two of the ten general hospitals in area 3 have formalized mental health services supervised by a psychiatrist; they are the Thayer Hospital in Waterville and the Knox General in Rockland.

b. Nursing Homes: There are 34 nursing homes listed in the Health and Welfare inventory under the Hill-Burton program but available information does not include their use as mental health facilities.

4. Manpower: There are two psychiatrists in full-time private practice in this area. A few doctors in public service engage in limited private practice. Other mental health professionals such as psychologists, psychiatric social workers, etc., from the Veterans Administration at Togus and the Augusta State Hospital act as consultants to mental health clinics during nights and weekends.

B. Coordinated Facilities and Services Outside Area 3:

1. Bangor State Hospital (area 2) regional
2. Utterback Private Hospital (area 2) statewide
3. Childrens Psychiatric Hospital at Pineland Hospital and Training Center (area 5) statewide
4. Sweetser Childrens Home, Saco (area 5) statewide
5. Boothbay Harbor Summer School, Inc., and Youth Study Center (area 5) statewide
6. Spurwink School, Portland (area 5) statewide

C. Planned Mental Health Facilities

1. Psychiatric Facilities

a. Augusta State Hospital: Future plans of the hospital should include implementation of programs designed to activate community participation in providing patient facilities and services. Construction of a new acute reception building should be considered and continuing efforts to renovate and update the existing facilities to comply with elements of service which constitute adequate care should be supported whenever financially and economically feasible.

1. Develop a traveling clinic for regional after-care and precare where such local services do not exist.

2. Formalize a program of partial hospitalization.

3. Develop telephone consultation services on a regional basis utilizing staff of the Augusta State Hospital on a 24-hour per day basis.

4. Continue development of a formal community outpatient clinic.

5. Improve facility for the care of the mentally ill criminal and the socially hazardous offender.

b. Kennebec Mental Health Clinic

1. Continue expansion of services to adjacent communities of Somerset County.

c. Knox General Hospital

1. Activate an outpatient clinic.

2. Make provisions for hospital admission of psychiatric patients.

d. Maine State Prison

1. Establish a psychiatric ward.

e. Summer Camp Program

1. A summer camp program for emotionally disturbed children is planned.

2. All Other Mental Health Services

a. The general hospitals in area 3 should develop formal programs for admitting psychiatric patients both on an emergency basis and short-term care. Hospitals in this area having 100 beds or more should plan on a psychiatric unit or integrated psychiatric beds.

b. Day and night programs should be given consideration and implemented wherever and whenever feasible.

D. Needs

An extended goal in the development of regional services should include the provision of the ten elements of service without duplication of effort as described in the federal description of mental health centers (to wit):

(1) Inpatient services;
(2) Outpatient services;
(3) Partial hospitalization services, such as day care, night care, weekend care;
(4) Emergency services 24 hours per day must be available within at least one of the first three services listed above;
(5) Consultation and education services available to community agencies and professional personnel;
(6) Diagnostic services;
(7) Rehabilitative services, including vocational and educational programs;
(8) Precare and aftercare services in the community, including foster home placement, home visiting, and halfway houses;
(9) Training;
(10) Research and evaluation.

E. Special Needs or Recommendations

1. The Kennebec Mental Health Clinic and the Augusta State Hospital Outpatient Clinic and other local mental health services in the area should define their responsibilities and coordinate their activities.

2. There is need for provision for the admission of psychiatric patients on an emergency basis and for short-term care in the general hospitals in the area.

3. The Augusta General Hospital should make provision for allowing admission of psychiatric patients.

4. Develop facilities for a professional training program.

5. Please refer to regional reports 4, 9, 14 for supplementary information.

F. Probable Construction

1. Outpatient Clinic and Psychiatric Unit (Mental Health Center):

Community	Probable Structure to House	Beds	Institution
Waterville	Psychiatric unit; Day rooms for partial hospitalization program; Staff offices; Waiting rooms	10	Thayer Hospital

Explanation: Although at present this hospital provides office space for a mental health clinic and integrated beds for psychiatric patients, provisions should be made, in the event of consolidation of mental health services in this area or lack of space, for construction to house expanded services developed under the community mental health program.

Outpatient Clinic and Psychiatric Unit (Mental Health Center):

Community	Probable Structure to House	Beds	Institution
Augusta	Psychiatric unit; Day rooms for partial hospitalization; Staff offices; Waiting rooms	10	Augusta General or Augusta State

Explanation: A coordinated effort where facilities and personnel could be utilized efficiently and more effectively in the Augusta area should be planned. This could supplement the work already provided by the Kennebec Mental Health Clinic and help the outpatient clinic at the Augusta State Hospital to ally more closely to the community.

2. Outpatient Clinic and Psychiatric Unit (Satellite):

Community	Probable Structure to House	Beds	Institution
Rockland	Clinic (staff offices and waiting rooms); Psychiatric beds; Day rooms for partial hospitalization, etc.	10	Knox General

Explanation: For some time now the people in this area have been planning for a full clinical team, hopefully, located at the Knox General Hospital. If, and when space is needed, provisions for matching funds should be available under the present federal program.

3. Satellite Clinic:

Community	Probable Structure to House	Associated Institution
Skowhegan	Staff offices; waiting rooms	Fairview Hospital

Explanation: In the event that the mental health needs of this area are not being met by the agreement now in operation between Somerset County and Kennebec Mental Health Clinic, provisions should be made for a satellite or mobile clinic.

4. Augusta State Hospital:

Community	Probable Structure to House	Associated Institution
Augusta	Admissions and intensive treatment building	Augusta State Hospital

Explanation: This is a primary project for two main reasons. (1) It should be the final major construction necessary for psychiatric ward type buildings at the Augusta State Hospital for the predictable future except for building replacement. (2) It is in a key location to convert what is now a veritable hodge-podge of different type buildings into distinct functional areas so that a chronic hospital and an acute psychiatric treatment hospital will be created with an outpatient treatment center and a medical, surgical and dental center existing between them. Each of these hospital units will be less than a 1,000 beds and can be arranged so that personnel can be better trained for specific tasks and better used for them instead of being

diffusely prepared for the many purpose type of building uses that we now are forced to continue. This new building will be of class 1 construction with the same basic accessory areas that now exist in the last two treatment buildings, the Deering and the Marquardt.

G. Priority

The rank order of this area according to relative need for community mental health centers construction described under the heading "Survey of Need and Ranking of Areas" page 38, is four.

H. Accessibility (Transportation)

The area is in the south central part of the state and consists largely of Kennebec, Somerset and Knox Counties. The population of area 3 is 166,823. Most of the population is concentrated in the southern part of the area particularly in the Waterville-Augusta area. Route 201 extends from Augusta along the Kennebec River to The Forks where it leaves the Kennebec and veers to the northwest through Jackman to the Quebec border. North of Bingham the area is very sparsely settled. South of Bingham the area has an excellent network of roads.

1. Highways: The area has excellent road connections to other large Maine centers to Canada and to Boston and points farther south via the Maine Turnpike, which extends from Augusta to the Maine-New Hampshire line at Kittery. Other major highways serving the area are Routes 201 and U.S. 1 extending south to Brunswick and Portland and Boston. An

extension of the Turnpike as part of the federal interstate system extends from Augusta to Bangor and Old Town.

Highway Mileage:

Augusta-Jackman	110 miles	Augusta-Clinton	28 miles
Augusta-Thomaston	39 miles	Augusta-Waterville	19 miles
Augusta-Rockland	41 miles	Augusta-Winthrop	10 miles
Augusta-Bingham	60 miles	Augusta-Madison	47 miles
Augusta-Pittsfield	47 miles	Augusta-Skowhegan	37 miles

Highway distance from the central part of the region to Boston is 165 miles; to New York, 380 miles.

2. Air: Northeast Airlines operates regularly scheduled service from Augusta and Waterville to Boston, New York, Washington and Miami as well as to points in northern and eastern Maine. Waterville has one northbound and one southbound flight daily; Augusta has four flights daily in each direction.

   Approximate Flight Time:

Augusta-Boston	1 hour 5 minutes (non-stop)
Augusta-New York	2 hours 15 minutes (non-stop)

3. Bus Service: The Greyhound Bus Lines operates a route to Quebec via Augusta, Waterville, Skowhegan, Bingham and Jackman.

4. Railroad: The area is served by the Maine Central Railroad. Mainline trackage extends south from Waterville to Portland via Lewiston and via Augusta and Brunswick and north from Waterville to Northern Maine Junction and Bangor. Branch lines connect Oakland and Bingham, Fairfield and Skowhegan, and Pittsfield and Harmony. There is no passenger service.

5. Water: The Kennebec River is navigable for about 24 miles from its mouth upstream to Augusta.

Note: Mental Health Center Area 3 Exhibits follow.

MENTAL HEALTH CENTER

AREA

POPULATION

Shaded Area: 75,798

Total: 145,885

MENTAL HEALTH CENTER AREA 4

The "Industrial Heart of Maine," as Androscoggin County is sometimes referred to, and its sister counties of Oxford and Franklin constitute mental health center area 4. The twin cities of Lewiston and Auburn with its proposed coordination of mental health services is the planned hub or core of the mental health center complex of these three counties. The total population of this area is 145,885, the bulk of which is in the more populated areas of Farmington (5,001) Rumford-Mexico, (15,048) and Lewiston-Auburn (65,253).

I. Existing Facilities, Services and Needs

A. Existing Mental Health Facilities

1. Psychiatric Facilities

a. Androscoggin Mental Health Clinic: This clinic was opened in 1958 under the auspices of the Augusta State Hospital. It is one of five state community-supported mental health clinics under the Bureau of Mental Health. Its services include help to area adults with emotional or psychiatric disorders.

b. Psychiatric Services to Department of Health and Welfare, Auburn Psychiatric Clinic (traveling): This clinic visits the Lewiston-Auburn area weekly. State-supported its recipients are limited to the Department of Health and Welfare public health cases.

c. St. Mary's General Hospital, Lewiston: Administered by the Society of the Sisters of Charity, this hospital has a bed capacity for 232 patients and is accredited by the Joint Commission on Hospital Accreditation. Future plans call

for the expansion of hospital emergency services to psychiatric patients on a 24-hour basis and short-term inpatient services.

d. Central Maine General Hospital, Lewiston: Also accredited by the Joint Commission on Hospital Accreditation, this hospital has 173 conforming beds. For a number of years now this facility has admitted psychiatric patients for short-term care and provided emergency care on a 24-hour basis.

2. Other Mental Health Facilities

a. Child and Family Services, Lewiston: This is a private, non-profit agency providing professional consultation services to families and individuals with personal and social problems including psychiatric and psychological consultation to children. Its management is vested in a board of directors made up of twenty-seven lay citizens and has a current staff of approximately five full-time professionals, two consultants, (psychiatry and psychology) and two full-time and one part-time secretary. Its major support is from state and local funds.

b. Franklin County Area Family Counseling Service, Inc., Farmington: A countywide family counseling service, this clinic employs a psychologist whose services include diagnosis, treatment, guidance, counseling, and education. Towns in the area are pro-rated on a population basis and matching funds are provided by the state.

c. Clinic for Mentally Retarded Pre-school Children, Lewiston: Supported by federal funds, this clinic is located at the Central Maine General Hospital and is administered by the Division of Maternal and Child Health and Crippled Children Services, Department of Health and Welfare.

3. Auxiliary Facilities

a. General hospitals: Four of the five general hospitals in this area figure prominently in the planning of mental health services of this area. Both the Central Maine General and St. Mary's hospitals are components of the proposed mental health center in Lewiston offering short-term care and emergency psychiatric services. The Rumford Community and Franklin County Memorial hospitals in Rumford and Farmington respectively will play important roles in future plans for their areas as well as in the mental health center complex for area 4.

b. Nursing homes: There are 34 nursing homes listed in the Health and Welfare inventory but available information does not include their use as mental health facilities.

4. Manpower: Area 4 has only three psychiatrists who reside within its borders, two of which are in full-time private practice and one the director of the Androscoggin Mental Health Clinic. For the past two to three years local and state officials have discussed the consolidation of a number of existing resources in the Lewiston-Auburn region. This would bring together 15 professionals and seven clericals. Of the professionals seven are full time and eight part time. A detailed breakdown of professional positions would be as follows:

Psychiatrist	(2)	1 full time	1 part time
Psychologist	(4)	2 full time	2 part time
Social Workers	(7)	4 full time	3 part time
Non-trained social worker	(1)		1 part time
Graduate student social worker	(1)		1 part time

In Farmington, a psychologist who is director of the Franklin County Area Family Counseling Service, Inc., is the total of present psychiatric and mental health manpower in this area.

B. Coordinated Facilities and Services Outside Area 4:

1. Bangor State Hospital (area 2)
2. Utterback **Private** Hospital (area 2)
3. Augusta State Hospital (area 3)
4. Veterans Administration (area 3)
5. Childrens Psychiatric Hospital at Pineland Hospital and Training Center (area 5)
6. Sweetser Childrens Home (area 5)
7. Boothbay Harbor Summer School, Inc., and Youth Study Center (area 5)
8. Spurwink School (area 5)

C. Planned Mental Health Facilities and Services: A comprehensive approach to the mental health needs of this area is to consolidate all existing mental health resources in the Lewiston-Auburn region and ally closely with the Franklin County Area Family Counseling Service, Inc., and new services implemented in the Rumford area (hopefully a satellite clinic). Facilities outside of the mental health center area such as the Augusta State Hospital, Pineland Hospital and Training Center, the state mobile

psychiatric clinic, and other regional and statewide services would continue to play their respective roles in providing needed services to the entire mental health center area. The long-range plan of development includes working toward a comprehensive program of care including in proper proportion to the population served the ten elements of comprehensive mental health services.

1. Psychiatric Facilities: Mental Health Center--A plan to provide a comprehensive approach to the mental health needs of this area has been under study since early in the planning program. Land has been obtained adjacent to the well-integrated St.Mary's General Hospital in Lewiston. It has been proposed that a building be constructed at this site and that it serve as the central unit for mental health activity. This would comply with Maine's Mental Health Plan for this area as the location is in Lewiston, the recommended core of mental health center area 4. The basic intent of the plan is to consolidate services now dispersed throughout this core area. The following agencies and staff will be consolidated in the above mentioned building:

Agency	Staff	Estimated Operating Budget
Child and Family Service	10	$61,000
Androscoggin Mental Health Clinic	7	50,000
Mobile Psychiatric Clinic (1 day a week)	3	10,000
Vocational Rehabilitation Office	2	9,000
Alcoholic Rehabilitation	1	7,000

The central unit would have the following functions:

1. Outpatient services
2. Diagnostic services
3. Alcoholic and vocational rehabilitation services
4. Pre- and post-care services
5. Consultation and education services
6. Mental health manpower training
7. Emergency services
8. Partial hospitalization (day care)

2. Other Mental Health Facilities: Satellite Clinics--Future plans call for the establishment of a satellite clinic located in Rumford, preferably located in the general hospital. Another satellite clinic already operable is located in the Farmington area and is known as the Franklin County Area Family Counseling Service, Inc. Future plans project the possibility of locating or relocating this clinic at the general hospital in Farmington. These two satellite clinics would serve the upper part of area 5 having a direct relationship to the mental health center located in the Lewiston-Auburn area.
3. Auxiliary Facilities: Central Maine General Hospital and St. Mary's General Hospital--The Central Maine General Hospital and St. Mary's General Hospital under the proposed plan would offer emergency and short-term care while it is planned that the hospital in Rumford and Farmington would offer emergency service until such time that the patient could be transferred to Lewiston-Auburn or a state facility outside the area.

4. Manpower:

Proposed Staffing for all Elements in the Program

Type of Staff	Year one			Year Two		
	Number		Hours	Number		Hours
	Full Time	Part Time	Per Week	Full Time	Part Time	Per Week
Psychiatrists	1	1	47	1	1	47
Clinical Psychologists	3		38 each	1		38
Social Workers	6		38 each	6		38 each
Psychiatric Nurses	1		38	1		38
Occupational Therapists						
Other:						
Vocational Counselor		1	5		1	5
Alcoholics Rehabilitation Counselor	1		38	1		38
Clerical	5		38 each	5		38 each

Availability of the above-mentioned staff will be assured primarily through consolidation of a number of existing resources at local level keeping in mind that additional new services will necessitate hiring additional personnel. New services created by the implementation of this plan should consider utilizing funds provided by the Public Law 89-105, Grants for Initial Cost of Professional and Technical Personnel of Centers.

D. Needs

An extended goal in the development of regional services should include the provision of the ten elements of service without duplication of effort as described in the federal description of mental health centers (to wit):

(1) Inpatient services;
(2) Outpatient services;
(3) Partial hospitalization services, such as day care, night care, weekend care;
(4) Emergency services 24 hours per day must be available within at least one of the first three services listed above;
(5) Consultation and education services available to community agencies;

(6) Diagnostic services;
(7) Rehabilitative services, including vocational and educational programs;
(8) Precare and aftercare services in the community, including foster home placement, homevisiting, and halfway houses;
(9) Training;
(10) Research and evaluation.

E. Specific Needs or Recommendations: The specific needs and recommendations for mental health center area 4 composed of planning regions #3, 7, and 8 are spelled out in the regional reports and are too extensive to list. It is suggested that because of the completeness of the studies made in regions 3, 7 and 8 that the reader obtain a copy of the regional reports from the mental health planner in the Department of Mental Health and Corrections.

F. Probable Construction

1. Outpatient Clinic (Mental Health Center):

Community	Probable Structure to House	Associated Institution
Lewiston	Day rooms for partial hospitalization; Staff offices; Waiting rooms	St. Mary's General Central Maine General

2. Satellite Clinics:

Community	Probable Structure to House	Institution
Rumford	Staff offices; Waiting rooms	Rumford Community Hospital
Farmington	Same as above	Franklin County Memorial

3. General Hospitals

Community	Probable Structure to House	Beds	Institution
Lewiston	Psychiatric beds	10	St. Mary's
Lewiston	Psychiatric beds	15	Central Maine

G. Priority

The rank order of this area according to relative need for community mental health centers construction as described under the heading "Survey of Need and Ranking of Areas", page 38, is three.

H. Accessibility (Transportation)

Mental health center area 4 consists largely of Franklin, Oxford, and Androscoggin Counties. The population of the area is 145,885; 75,798 live in the immediate Lewiston-Auburn vicinity.

1. Highways: An excellent network of first-rate roads center at Auburn and Lewiston. Lewiston is tentatively suggested as the core of the mental health center complex. The northern section of the area is sparsely settled.

   All weather highways throughout the region, rail freight service to key points, and landing fields for business aircraft provide the basis for movement of goods and people to, from and within area 4.

   Major highways in the region provide good accessibility to the south (routes 26, 27, and 4) as well as to New Hampshire, the central part of Maine, and the Canadian Maritime provinces (U.S. Route 2). To the north, connections with Canadian highways provide direct access to Quebec. Immediately outside the region at Waterville, Augusta, Lewiston, and Auburn are interchanges with Interstate Route 95 and the Maine Turnpike, high-speed (limit 70 miles per hour) superhighways that link Maine with the northeast and the rest of the nation.

Several intra-state carriers serve the region with five trucking companies based at Rumford, three at Farmington, and two at Rangeley. In addition, the principal communities are on regularly scheduled routes of through interstate carriers.

Highway maintenance, as well as scheduled route reconstruction and modernization, is a key part of the State Highway Commission program. In winter, snow removal is handled efficiently and quickly by experienced crews. Only for very short periods during severe storms, perhaps as infrequently as once a year, is some curtailment of highway movement necessary.

Highway Mileage:

Lewiston-Rangeley	87 miles
Lewiston-Kingfield	70 miles
Lewiston-Rumford	41 miles
Lewiston-Bethel	46 miles
Lewiston-South Paris	20 miles
Lewiston-Norway	21 miles
Lewiston-Livermore Falls	21 miles
Lewiston-Farmington	46 miles
Lewiston-Wilton	46 miles

2. Air: Scheduled air passenger service is available within an hour's drive of most points in the region, less time than is required in many metropolitan areas to reach outlying air terminals. Airports at Lewiston-Auburn serve regularly scheduled Northeast Airlines flights to Boston with connections to New York.

Approximate Flight Time:

Augusta-Boston	1 hour 30 minutes
Augusta-New York	2 hours 30 minutes
Lewiston-Boston	1 hour 30 minutes
Lewiston-New York	2 hours 30 minutes

There are also regularly scheduled flights from Portland to Boston and New York, as well as to northern Maine points.

3. Bus Service: The Blue Line connects Lewiston with Canton, Peru, Dixfield, Rumford, Farmington Wilton, Livermore, Turner, Livermore Falls, and Auburn. Buslines operate in the region connecting Berlin, New Hampshire, with Portland via Bethel, Paris, and Norway, and from Bangor through to Montreal via U.S. Route 2.

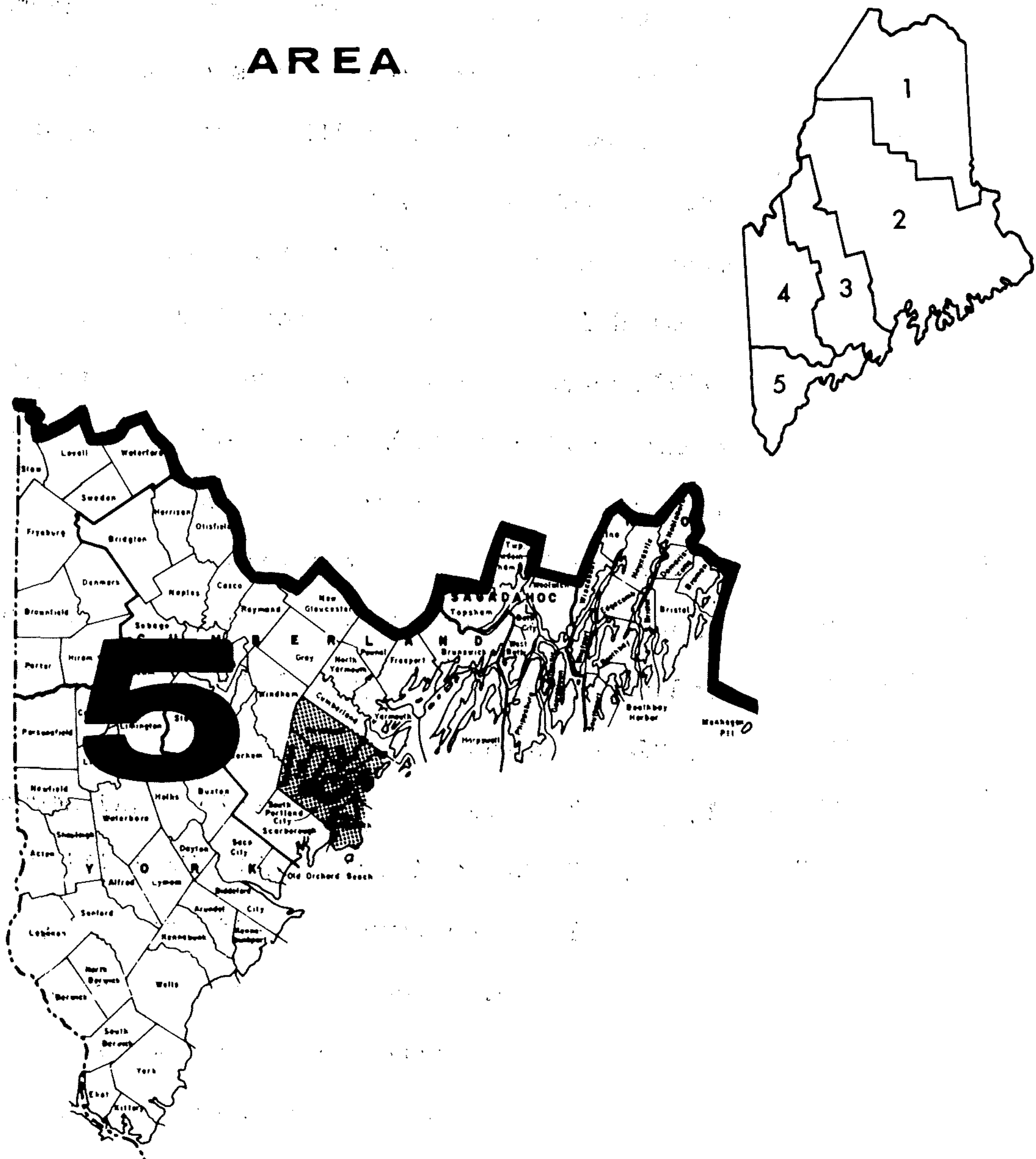
4. Railroads: The Maine Central Railroad operates two branch lines with freight service into the region. These lines terminate at Farmington and Rumford. They join at Livermore Falls and connect with the system's main line at Leeds Junction, just north of Lewiston. Through connections to the Boston and Maine and Bangor and Aroostook railroads are also provided.

   The Canadian Natinnal Railways Grand Trunk Line crosses the southwestern corner of the region. This line links the communities of Bethel, South Paris, and Norway with the port of Portland, as well as providing service to Canadian points. Crossing the extreme northern tip of the region is the Canadian Pacific Line which links the Maritime Provinces with the St. Lawrence Valley. Passenger service is not available.

Note: Mental Health Center Area 4 Exhibits follow.

MENTAL HEALTH CENTER

AREA



POPULATION

Shaded Area: 111,701

Total: 320,701

* Tentative geographic division.
Area may be sub-divided further.

MENTAL HEALTH CENTER AREA 5

The counties of Cumberland, York, and Sagadahoc make up the major portion of area 5 with remaining parts of Oxford and Lincoln completing the area. Unique among mental health center areas of the state, it contains the state's largest city and the principal manufacturing complexes. It has good transportation facilities, excellent schools and fine hospitals. Located in the more populated southwestern part of the state it has 320,701 inhabitants. This constitutes one-third of the total population of the entire state; 111,701 of the inhabitants are concentrated in the Greater Portland area which has been ideally designated as the core of one of the mental health center complexes for area 5. Future plans will project another center within this area covering the southern part of Oxford County and all of York County with the core of the complex tentatively designated as Biddeford-Saco.

I. Existing Facilities, Services and Needs

A. Existing Mental Health Facilities

1. Psychiatric Facilities

a. Sweetser Childrens Home, a voluntary nonprofit treatment school for emotionally disturbed children, is located in Saco. Funds for the support of Sweetser are derived from tuition, individual contributions, organizations, and endowments of three former childrens homes. In addition to a psychiatrist, a psychologist, and a social worker, the home has a pediatrician, consulting surgeon, dentist, optometrist, nurse and ophthalmologist. All except the nurse are on a part-time basis. The staff also participates in the Community Child and Family Guidance Clinic for citizens of northern York County. This is an outpatient clinic for families and children.

b. York Mental Health Association: This Association has no services except those purchased from the Portsmouth Mental Health Clinic. It was organized by the Women's League of York, Inc., and by the local health officer of the town of York. The Bureau of Mental Health provides them with $1200 and they raise an additional $1200 for the Portsmouth clinic.

c. Portland City Hospital was organized by the city for indigents and private patients. They have restraining units such as those for the aged, alcoholics and psychiatric patients. Surgery patients are usually referred to the Maine Medical Center. They have city physicians and surgeons and a part-time psychiatrist. They have no social worker or psychologist except for the one serving the city of Portland.

d. Pineland Hospital and Training Center was established by the Legislature in 1907 and the first patient was admitted in 1908. Pineland, formerly known as Pownal State School, is located in a rural area with Portland and Lewiston each less than twenty miles distant. This institution is the only one of its kind in the state offering inpatient services to the mentally retarded and more recently to mentally ill youngsters between the ages of 6 to 16. The property consists of 1,492 acres and its buildings are valued at $6,084,556. During the year 1963-64 the average number of patients in residence was 1,193 and an average of 564 persons were employed.

e. Psychiatric Services to Health and Welfare, Portland Psychiatric Clinic, (traveling): Consultation services and direct patient treatment by a psychiatrist, a social worker, and a psychologist are provided. Homebase of this clinic is the Vickery-Hill Building in Augusta. State-supported, the services are rendered throughout the state to clients of the Department of Health and Welfare exclusively.

f. Bath-Brunswick Mental Health Association: Sponsored by the Bath and Brunswick United Funds, Bath and Brunswick School systems, the towns of Topsham, Arrowsic and Harpswell, the Davenport Fund, the Bingham Fund and the state community mental health grant-in-aid program, it is staffed by a full-time psychiatric social worker, a psychiatrist and psychologist. It serves children under 18 and parents of children under 18. Other adults are offered diagnostic services only and are then referred to other resources for treatment. Clinics are held in the Bath and Brunswick general hospitals.

g. Child and Family Guidance Center, Saco: This center operated locally and operates community mental health supported clinics at the general hospitals in Biddeford and Sanford, serving clients with emotional disturbances, marriage problems, family and school problems. It is staffed by a full-time social worker and secretary and by a consultant psychiatrist and psychologist.

h. Maine Medical Center, Portland: This is a state-supported clinic staffed by a full-time psychiatrist, psychologist, psychiatric social worker and secretary, with additional consultative services from local professionals. The clinic serves acutely psychotic patients and offers consultation services to physicians in the Greater Portland area so that with evaluation and recommendations they may care for their own patients.

i. Portland Child Guidance Clinic: Supported by the United Fund and the state community mental health grant-in-aid program, this clinic is staffed by a psychiatrist, psychologist, social worker and secretary and offers individual and group psychotherapy principally to children including supportive therapy to the parents of the clients.

2. Other Mental Health Facilities

   a. Spurwink School, Portland: This school accepts pre-psychotic cases and children with neurotic character structures. Intramural class settings are supplemented with tutoring when necessary. Public school attendance is arranged when clinically indicated. Psychological testing and speech therapy are included in rehabilitation. It is a residential school for boys ages 5 to 12.

   b. Boothbay Harbor Summer School, Inc., and Youth Study Center provides for the diagnosis and treatment of children and adolescents with emotional, social adjustment, educational and speech problems. They are operating

both outpatient clinic services as well as residential summer programs for children and adolescents with emotional, social adjustment, educational, and speech problems. They have 14 consultants.

3. Auxiliary Facilities

   a. General hospitals: There are twenty general and two federal hospitals within area 5.

   b. Nursing homes: There are approximately 55 nursing homes listed in the Health and Welfare inventory of long-term care facilities but available information does not include their use as mental health facilities.

4. Manpower: Mental Health center area 5 having the greatest population also has the greatest number of mental health professionals. The Maine Medical Center in Portland alone, in a recent survey, listed six psychiatrists on its attending staff. This is unprecedented in the state considering there are approximately twelve privately practicing psychiatrists listed in the inventory of the five mental health center areas. This same area has the highest number of physicians per 100,000 population. Other professionals in the mental health field including psychologists, social workers, nurses, etc., evidently follow the same pattern. You will note that the inventory of psychiatric facilities and other mental health services for this area is much larger than other areas and substantiates the need for, and the existence of these professionals.

B. Coordinated Facilities and Services Outside Area 5

1. Bangor State Hospital*(area 2) regional
2. Utterback Private Hospital (area 2) statewide
3. Augusta State Hospital (area 3) regional
4. Veterans Administration, Togus (area 3) statewide
5. Portsmouth Mental Health Clinic, New Hampshire

C. Planned Mental Health Facilities: In order to meet the mental health needs of this area it would appear to be necessary to establish two community mental health centers. Each would be the focal point around which the total comprehensive programs of facilities and services would revolve. The main center of activities will be located in an area already recognized or identified as the most logical and practical place by past experience. The two community centers could develop individually while still maintaining a close working relationship. Facilities outside of the mental health center area 5 such as the Augusta State Hospital, Utterback Private Hospital, Portsmouth Mental Health Clinic, and other regional and statewide services would continue to play their respective roles in providing needed services to the entire mental health center area until these services can be provided within the area.

1. Psychiatric Facilities

   a. Community Mental health centers: One of the community mental health centers should be located in Portland. With the medical education and mental health services

*Patients may be admitted outside of the hospital district with the approval of the Commissioner of the Department of Mental Health and Corrections.

already provided by the Maine Medical Center, this would seem to be the most logical place to start.

b. The second community mental health center should be located in the Biddeford-Saco area.

2. Other Mental Health Facilities

   a. Satellite Clinics

      1. The Bath-Brunswick Mental Health Clinic is already operative and is described under the heading "Existing Mental Health Facilities," page 126.

      2. Long-range plans for the implementation of a mental health clinic sponsored mainly by the communities in the general vicinity of Bridgton have already been undertaken.

      3. The Community Child and Family Guidance Clinic servicing the southwestern part of area 5 with Sanford as its base of operation is recommended as a satellite clinic.

      4. The communities in the extreme southern part of York County would continue to utilize the Portsmouth Mental Health Clinic.

3. Auxiliary Facilities: General hospitals now housing available mental health services are:

Hospital	Community	Service
Maine Medical Center	Portland	Maine Medical Mental Health Clinic
Bath Memorial Hosp.	Bath	Bath-Brunswick Mental Health Clinic
Regional Memorial	Brunswick	Clinic and Guidance Center
Webber	Biddeford	Traveling Clinic
Henrietta Goodall	Sanford	Child and Family Guidance Center

Future plans for the care of the mentally ill will include utilizing long-term care facilities to supplement present mental health facilities.

D. Needs

An extended goal in the development of regional services should include the provision of the ten elements of service without duplication of effort as described in the federal description of mental health centers (to wit):

(1) Inpatient services;
(2) Outpatient services;
(3) Partial hospitalization services such as day care, night care, weekend care;
(4) Emergency services 24 hours per day must be available within at least one of the first three services listed above;
(5) Consultation and education services available to community agencies and professional personnel;
(6) Diagnostic services;
(7) Rehabilitative services, including vocational and educational programs;
(8) Precare and aftercare services in the community, including foster home placement, home visiting, and halfway houses;
(9) Training;
(10) Research and evaluation.

E. Special Needs or Recommendations

1. The community mental health centers as well as the satellites should define their responsibilities and coordinate their activities. This would involve all the mental health facilities and services in this area and would mean developing a clear understanding of the part each facility or service plays in realizing essential services as well as other elements of service in the right amounts, without too much overlap to the population to be served.

2. The clinics should in all instances work toward providing services for both adults and children.
3. Aftercare services to patients discharged from state institutions should be instituted.
4. Consultation to schools, community agencies, and others in need of such services should be provided.
5. An educational center ultimately providing residencies and internships in psychiatry, psychology and psychiatric social work is a special need.
6. Inservice training and institutes for teachers, social workers, ministers and others relative to mental health concepts should be planned.
7. General community education regarding mental health needs and resources should be provided.
8. Research in mental health with emphasis upon development of preventive programs should be started.
9. Nursing homes known to provide adequate care properly licensed and willing to accept psychiatric patients should provide partial hospitalization (day or night care) for the elderly psychiatric ill.
10. Long-range plans for inpatient chronic care should include regional facilities for the care of the mentally ill and mentally retarded. The population of chronic patients already in the state hospitals is aging and producing a major internal geriatric problem for the hospitals. At the same time there is an increase in the proportion of older patients being admitted to our state hospitals in recent years. Chronic

care centers should be constructed in proximity to the state's existing medical centers to care for those patients who do not require specialized medical and adjunctive services.

11. The general hospitals should develop formal programs for admitting psychiatric patients both on an emergency basis and for short-term care.

12. A 24-hour telephone consultation program should be developed with the general hospitals' staff utilizing the mental health center professionals as consultants.

F. Proposed Construction

1. Community Mental Health Center:

Community	Probable Structure to House	Associated Institution	Year
Portland	Mental Health Center	Me. Medical	1970
Biddeford	Mental Health Center	Webber	1975

2. Outpatient Clinics and Psychiatric Units:

Community	Institution	Clinic	*Psy. beds	Year
Portland	Me.Medical Center	Me.Medical Mental Health Clinic	25	1966
Biddeford	Webber	Community Mental Health Clinic	10	1970

3. Satellite Clinics:

Community	Institution	Clinic	*Psy. beds	Year
Sanford	Henrietta Goodall	Mental Health Clinic	10	1970
Bath	Bath Memorial	Bath-Brunswick Mental Health Clinic	10	1970
Brunswick	Regional Memorial	Same as above	10	1970
Bridgton	Northern Cumberland Hosp.	Mental Health Clinic		1970

*Psychiatric

4. Childrens Services:

Community	Institution	Service	Year
Saco	Sweetser Childrens Home	Children	1970
Pownal	Pineland Hospital and Training Center	Children	1970

Completion of Childrens Psychiatric Unit at Pineland Hospital and Training Center: The present rumpus or dayrooms provide nothing but an empty desolate space, not conducive to anything but physical activities. Acoustic ceiling is needed to reduce the noise level which, because of the type of construction and patient, is excessive. This creates an atmosphere which results in poor therapy. These areas need to be divided so that patients wishing to pursue their scholastic studies may have an area apart from those engaged in watching television or playing games. Two therapy rooms with two-way mirrors are urgently needed so that patients in their rooms may be observed at all times without the observer being seen. A play area in the basement for use when the weather will not permit outside activities is essential if the patient is to be afforded the treatment necessary. Better lighting and closet space is needed in the rooms for the older patients to provide a better and more homelike atmosphere for the patients.

Renovations to Hedin Hospital at Pineland Hospital and Training Center: Present office space for Psychiatric Social Service Department and Occupational Therapy Department is inadequate due to a large increase in staff and the need for space to provide occupational therapy to the patients in the Childrens Psychiatric Hospital. The noise level from the clatter of

several typewriters in the clerical office is not conducive to good working conditions. There is a definite need for an adequate facility to house a medical library for professional personnel. The existing room in the basement of the building is inadequate in size.

Infirmary Building Renovation at Pineland Hospital and Training Center: Noise in day room areas each housing 30 low-grade patients reaches a level at times which is almost unbearable.

Shaded areas are needed in order that the patients may be taken outdoors during good weather. Practically all of these patients are on medication which precludes their being allowed to remain in the direct rays of the sun. The awnings serve a two-fold purpose, beside providing protection for the patients when outdoors, they will help keep the building more comfortable during hot weather by keeping the direct sunlight out of the building. This building has been unbearably hot during past summers as there has been no way to keep the sun from shining through the windows.

Swimming Pool at Pineland Hospital and Training Center: This therapeutic swimming pool will be divided into two units, one an instructional and recreational area, and the other a hydrotherapy area for the physically handicapped, to include stairs, and ramp. These two areas will be separated by a three-foot concrete catwalk and a screen, so as to allow for dual programs.

The building shall include storage area, pumps and filters plant, control room, and adequate sound system.

The hydrotherapy unit will afford needed treatment for the physically disabled children, including the cerebral palsied youngsters. Also of major importance is its value to the psychiatric patient. This patient must have constructive therapeutic exercise so as to release aggression, hostility and tension in a way which will channel his behavior into a normal pattern. This is best accomplished in a structured therapeutic physical education and recreational program which is inherent in any swimming program.

5. Related Facility:

Community	Facility	Institution
South Portland	Intensive treatment and guidance center	Boys Training Center

This is a one-story, 24-bed structure, plus the supervisors' quarters. The building will have 24 individual rooms (4 security), a recreation room, two classrooms, an interview room and a service kitchen. Off the recreation room will be toilet facilities, showers, linen and clothing areas. Project will contain approximately 10,000 square feet.

The intense treatment and guidance center building will be for the more emotionally disturbed, aggressive, disoriented, unstable boys, who require intense treatment and is an administrative bed unit. The intent and purpose of this center is to prepare boys who are not ready, due to their disorders,to live in an open cottage setting, to return to the open cottage

unit to satisfactorily complete those parts of the program required to the rehabilitative processes of the individual child.

G. Priority

The rank order of this area according to relative need for community mental health centers construction as described under the heading "Survey of Needs and Ranking of Areas," page 38, is five.

H. Accessibility (transportation)

Mental health center area 5 consists largely of Cumberland, Sagadahoc, and York Counties. The population is 320,701 with a concentration of 111,701 in the Greater Portland area. The city of Portland is tentatively selected as the core of the mental health center complex. This area eventually will be served by two centers. Transportation between the center and most of the cities and towns in the area is by private cars.

1. Highway: Southwestern Maine offers excellent highway facilities. The Maine Turnpike, a modern express highway with limited access roads, extends from Kittery to Augusta (106 miles). Other main highways in the region are U.S. Routes 1, 201, 202, 302, and Routes 100 and 96. The Maine State Highway Commission maintains the highways in an orderly and efficient manner which insures 24-hour per day freight movements year round.

<u>Highway Mileage</u>:

Route	Miles	Route	Miles
Portland-Kittery	50 miles	Portland-Bath	34 miles
Portland-Saco Biddeford	16 miles	Portland-Boothbay Harbor	57 miles
Portland-Sanford	34 miles	Portland-Damariscotta	52 miles
Portland-Brunswick	30 miles		
Portland-Boston	109 miles		
Portland-New York	313 miles		

2. Air: Northeast Airlines operates several daily flights to Boston, New York, Washington, and Miami from its southwestern Maine terminal in Portland. This air terminal also services regularly scheduled flights to northern Maine communities. Northeast Airlines also maintains a terminal at Lewiston-Auburn.

Approximate Flight Time.

Portland-Boston	36 minutes
Portland-New York	1 hour 29 minutes

3. Bus Service: The Eastern Greyhound connects Portland with Lewiston, Augusta, Bangor, Bar Harbor, Calais, St. Stephen, Belfast, Portsmouth, New Hampshire, and Boston, Massachusetts, and intervening towns and other points in the U.S. and Canada. Greyhound and the Bangor and Aroostook cooperate in a daily through bus service from Fort Kent to New York. The chief mode of passenger transportation in this area is by private car.

   The Brunswick Transportation Company connects Portland with South Windham and Gorham, North Yarmouth, Biddeford, Saco, Old Orchard Beach and Berlin, New Hampshire, and towns on the way to Berlin northbound Friday and Saturday only, southbound Saturday and Sunday.

   The Vermont Transit Lines with Greyhound connect New Hampshire, Vermont, and Montreal.

   The Portland-Yarmouth line connects the two areas.

4. Railroad: The Boston and Maine, the Maine Central, and the Canadian National Railway Grand Trunk Line railroads offer efficient rail-freight service throughout most of Maine's southwestern region. The railroads also offer connecting freight schedules with the nation's larger railroads on a year-round basis. The focal point for the region's rail network is in Portland, where the Portland Terminal company handles the region's freight shipments of approximately 7,000,000 tons annually.

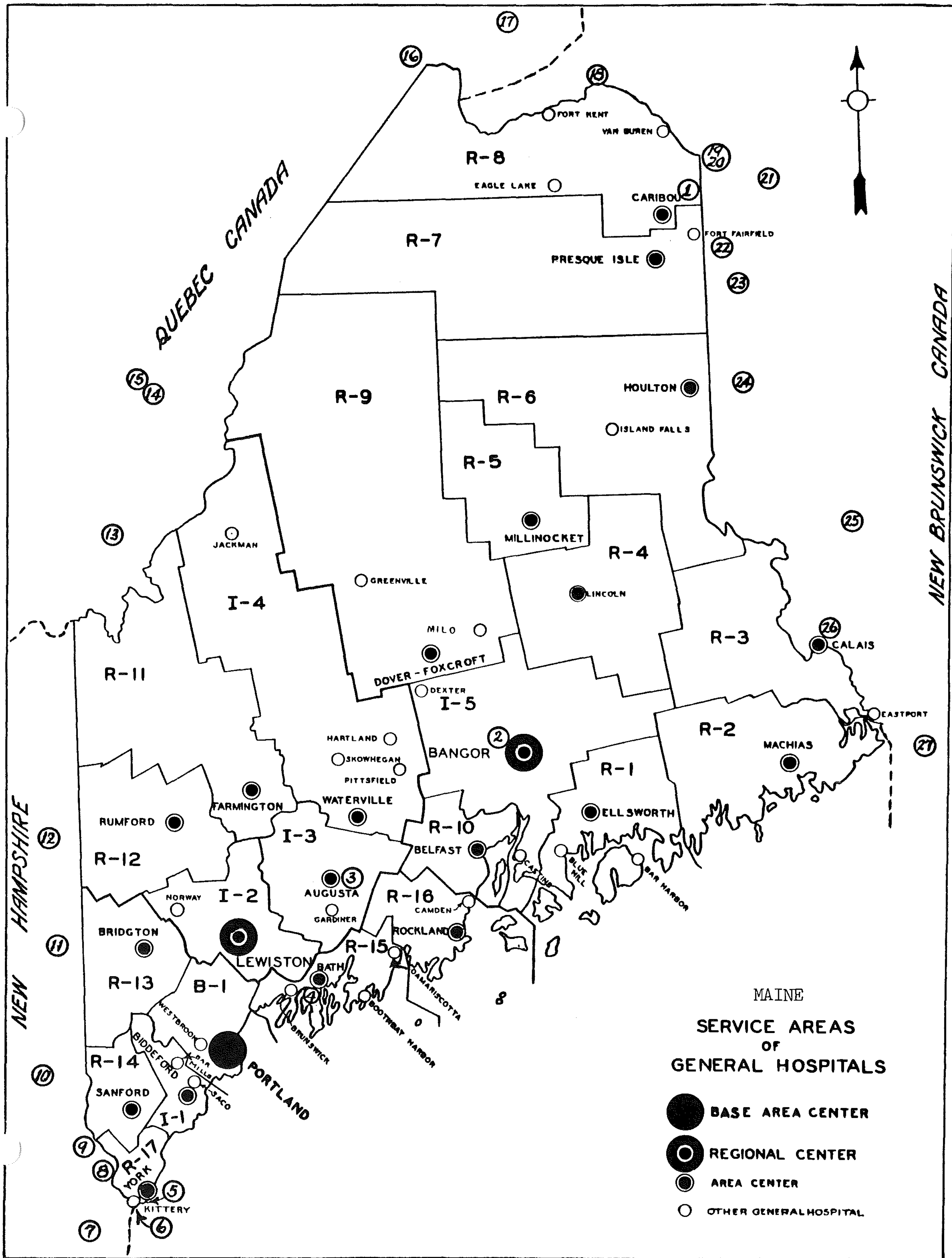
   Railroad Mileage:

Portland-Boston	115 miles
Portland-Montreal	295 miles
Portland-New York	345 miles
Portland-Philadelphia	438 miles

5. Water: One of the best deep water ports in the country is located in southwestern Maine in Portland. The ship channel has a depth of 35 feet at mean water low and is ice free. Port of Portland is also served by a modern $1½ million pier which is owned by the state and managed by the Maine Port Authority. The Portland Terminal Company offers rail-ships accommodations at two modern piers.

Note: Mental Health Center Area 5 Exhibits follow.

Also Section IV Exhibits follow.



QUEBEC CANADA
NEW BRUNSWICK CANADA
NEW HAMPSHIRE
R-1
R-2
R-3
R-4
R-5
R-6
R-7
R-8
R-9
R-10
R-11
R-12
R-13
R-14
R-15
R-16
R-17
I-1
I-2
I-3
I-4
I-5
B-1
FORT KENT
VAN BUREN
EAGLE LAKE
CARIBOU
FORT FAIRFIELD
PRESQUE ISLE
HOULTON
ISLAND FALLS
MILLINOCKET
LINCOLN
JACKMAN
GREENVILLE
MILO
DOVER-FOXCROFT
DEXTER
CALAIS
EASTPORT
MACHIAS
BANGOR
HARTLAND
SKOWHEGAN
PITTSFIELD
WATERVILLE
FARMINGTON
RUMFORD
ELLSWORTH
BELFAST
CASTINE
BLUE HILL
BAR HARBOR
AUGUSTA
GARDINER
CAMDEN
ROCKLAND
NORWAY
BRIDGTON
LEWISTON
BATH
DAMARISCOTTA
BOOTHBAY HARBOR
BRUNSWICK
WESTBROOK
PORTLAND
BIDDEFORD
BAR MILLS
SACO
SANFORD
YORK
KITTERY
MAINE
SERVICE AREAS OF GENERAL HOSPITALS
BASE AREA CENTER
REGIONAL CENTER
AREA CENTER
OTHER GENERAL HOSPITAL

MAINE

REGIONAL INTEGRATION OF GENERAL HOSPITALS

REGIONAL CENTER

AREA CENTER

OTHER GENERAL HOSPITAL

FORT KENT
VAN BUREN
44
22
EAGLE LAKE
CARIBOU
FORT FAIRFIELD
PRESQUE ISLE
HOULTON
28
ISLAND FALLS
171
158
116
MILLINOCKET
JACKMAN
GREENVILLE
LINCOLN
79
MILO
85
48
91
CALAIS
DOVER - FOXCROFT
128
DEXTER
EASTPORT
HARTLAND
SKOWHEGAN
PITTSFIELD
BANGOR
83
MACHIAS
18
26
FARMINGTON
RUMFORD
WATERVILLE
35
ELLSWORTH
BLUE HILL
20
41
46
49
BELFAST
CASTINE
BAR HARBOR
AUGUSTA
NORWAY
30
CAMDEN
21
GARDINER
BRIDGTON
LEWISTON
ROCKLAND
18
BATH
78
38
BRUNSWICK
DAMARISCOTTA
34
BOOTHBAY HARBOR
WESTBROOK
PORTLAND
BAR MILLS
34
16
SACO
BIDDEFORD
SANFORD
50
YORK
KITTERY

MAINE

Fort Kent
Allagash
Van Buren
Limestone
Caribou
Washburn
Fort Fairfield
Presque Isle
Ashland
Mars Hill
Houlton
Smyrna Mills
Sherman
Haynesville
Rockwood
Millinocket
Danforth
Macwahoc
Jackman
Greenville
Mattawamkeag
The Forks
Lincoln
Topsfield
Dover-Foxcroft
Milo
Flagstaff
Howland
Stratton
Guilford
Calais
Bingham
Dexter
Wilsons Mills
Oquossoc
Rangeley
Solon
Corinna
New Portland
St. Albans
Perry
Wesley
N. Anson
Madison
Newport
Amherst
Aurora
Skowhegan
Beddington
Whiting
Bangor
Brewer
Upton
Farmington
Hampden
Norridgewock
Machias
New Sharon
Dixmont
Cutler
Fairfield
Rumford
Dixfield
Waterville
Bucksport
Newry
Albion
Prospect
Jonesport
Gilead
Bethel
China
Belfast
Ellsworth
Milbridge
Gouldsboro
Bluehill
Castine
S. China
Winthrop
Bar Harbor
Lynchville
Augusta
Sedgwick
S. W. Harbor
South Paris
Gardiner
Stow
Camden
Richmond Cor.
Deer Isle
Rockport
Auburn
Waldoboro
Warren
Lewiston
Dresden
Rockland
Fryeburg
Thomaston
Wiscasset
Topsham
Bath
Friendship
Brunswick
Port Clyde
Hiram
Boothbay Har.
Gray
New Harbor
Cornish
Fosters Corner
Porter
Harpswell
Popham Beach
Portland
Gorham
So. Portland
Acton
Scarboro
Alfred
Saco
Biddeford
Sanford
Berwick
Wells
Kittery

MAINE HIGHWAY SYSTEM

MAINE

TRANSPORTATION

(EXCLUDING HIGHWAYS)

AROOSTOOK
PISCATAQUIS
SOMERSET
PENOBSCOT
WASHINGTON
FRANKLIN
OXFORD
KENNEBEC
WALDO
HANCOCK
KNOX
LINCOLN
ANDROSCOGGIN
CUMBERLAND
YORK

Ft. Kent
St. Francis
Van Buren
Limestone
Caribou
Ft. Fairfield
Presque Isle
Ashland
Mars Hill
Houlton
Patten
East Millinocket
Millinocket
Danforth
Vanceboro
Mattawamkeag
Jackman
Greenville
Milo
West Enfield
Dover-Foxcroft
South La Grange
Woodland
Calais
Bingham
Harmony
Old Town
Eastport
Skowhegan
Pittsfield
Bangor
Brewer
Machias
Farmington
Burnham
Bucksport
Rumford
Waterville
Oakland
Ellsworth
Hancock
Livermore Falls
Searsport
Bethel
Belfast
Augusta
South Paris
Lewiston
Auburn
Richmond
Rockland
Fryeburg
Wiscasset
Brunswick
Westbrook
Portland
Saco
Biddeford
South Berwick

Kennebec River
Penobscot River

0 10 20 30 miles

N

KEY

Railroads

AV	Aroostook Valley
B&A	Bangor and Aroostook
B&M	Boston and Maine
B&ML	Belfast and Moosehead Lake
CN	Canadian National
CP	Canadian Pacific
MC	Maine Central

Water

Navagable River

Deepwater Port

Air

Airport - regular service

Airport - summer schedule only

Prepared by
Division of Research and Planning
Department of Economic Development
State House Augusta, Maine
1964

SECTION V

RELATIONSHIP TO OTHER PLANNING EFFORTS*

*Refer to Section II, under item J. Relationship With Other Advisory and Planning Groups.

SECTION VI

METHODS OF ADMINISTRATION

VI. METHODS OF ADMINISTRATION

A. Publicizing the Plan: At least thirty days prior to the submission of the State Plan to the Surgeon General, the State Agency will publish in newspapers having general circulation throughout the State a general description of the proposed construction program and the State Plan will be available for examination and comment by interested persons at all reasonable times prior to submission to the Surgeon General.

B. Project Construction Schedules

1. Directly after approval of the State Plan by the Public Health Service a Project Construction Schedule will be developed for community mental health centers and submitted to the Public Health Service. This Schedule will include projects, the approval of which is recommended by the State Agency out of the allotment for the fiscal year involved and will be developed in accordance with the principles and priorities contained in the approved Plan and the Regulations. The Schedule will be developed by actively soliciting applications from interested or sponsoring groups in the order of priority by areas.

2. Selection of projects will be based on:

   a. the priority of the project as determined in accordance with the principles outlined in the State Plan for determination of relative need;

   b. the intent of sponsoring agencies, expressed in writing, to begin construction within a reasonable length of time;

c. the ability of the sponsoring agency to meet the financial requirements for construction, maintenance, and operation of the proposed facility;

d. the scope of the proposed project in terms of the services and facilities it is expected to make available to its area; and

e. the degree of local support of the project and local recognition of the need as expressed by the extent of public participation in planning and financing of the project.

3. At least three months prior to making application for Federal funds for a project the Applicant will request a pre-design conference. Participants normally will be the Applicant's representatives, including the project architect, the State Agency representative, and the Public Health Service Regional Architect or Engineer. Pertinent existing structures will be examined as to code requirements and the development of the project planning will be reviewed.

4. An application for funds under the Federal Act must be submitted to the State Agency prior to August 1 to qualify for consideration during the succeeding fiscal year. It shall consist of the following:

   a. Part 1 of the Project Construction Application (Form PHS 62-1), which includes a description of the proposed project, the staffing, the need, the type of construction, the Architect's estimated cost of construction and equipment, the costs of maintenance and operation and various assurances.

b. Schematic plans for proposed project. It must be shown that the project plans fit into a logical long-range plan for the complex. Consideration shall be observed in such planning of the inter-relationships between the Applicant facility, and other existing or anticipated related facilities in connection with long-range regional planning.

c. Proof that the required financial resources for the Applicant's share of the project costs have already been acquired. (At least one-third of the Applicant's share should be in cash or other liquid assets free of encumbrances and not more than one-third should be a construction loan. If a loan is contemplated, prior arrangements should be made for it, but the actual loan need not be made until contract time.)

d. Reference should be made to the pertinent Section of this Plan covering the type project for which an application for funds is being made for any additional application requirements.

5. Filing of Part 1 of the Project Construction Application incurs no obligation or commitment upon the State Agency.

6. The sponsor of a project, which has received tentative approval for an allocation of Federal funds, shall prior to December 1 file an approval Part 3 of the Project Construction Application (Form PHS 62-7, Site Information) and preliminary plans through Stage 2.

7. A project, which fulfills the requirements described in Item 6 shall prior to May 1 file approvable Stage 3 (final) Plans and Specifications and Part 4 of the Project Construction Application (Form PHS 62-8).
8. Failure to fulfill the requirements outlined in Items 6 or 7, may cause the project to be removed from the Project Construction Schedule and its tentative allocation may be rescinded, thereby enabling the State Agency to substitute another high priority project prepared to fulfill such requirements.
9. The State Agency, upon request from the Project Applicant, may extend the time limitations set forth in Item 6 or 7, if extenuating circumstances warrant such action and if such extension would not effect possible loss of Federal funds to the State. The request for extension must state the reason for the delay and give satisfactory assurances that the project will be processed without further delay.
10. If a project is removed from a Project Construction Schedule by the State Agency, the Schedule will be revised to include the next highest priority project which meets the requirements for inclusion.
11. The fact that a project is excluded from a Project Construction Schedule for any of several reasons will not change the project priority rating (although for other reasons this priority may change). Such projects will be considered for inclusion in each succeeding Project Construction Schedule.

12. If a project is in the highest priority group, Part 1 of the Project Construction Application may be approved and forwarded by the State Agency prior to approval of the Project Construction Schedule. If the project is not in the highest priority group, Part 1 of the Project Construction Application will not be submitted until the Schedule is approved.

13. Priorities of areas change when the complete Project Construction Schedule for the State has been approved by the Public Health Service.

14. After approval of the Project Construction Schedule by the Public Health Service, a listed project will not be removed therefrom unless the applicant:

    a. voluntarily withdraws;

    b. fails to submit the required documents within the time limit specified;

    c. fails to comply with the prescribed rules and regulations relating to finances, plans, specifications, records, etc.; or

    d. fails to initiate the construction within a reasonable period of time.

C. Standards of Construction and Equipment

1. Construction, modernization and equipment of projects assisted under the Federal Act will comply with all existing local requirements, and with the Regulations. They will also comply with Maine State Hospital Rules and Regulations (or their revisions) developed under Chapter 405, Title 22, R.S. 1964 (An Act Relating to Licensing Hospitals and Related

Institutions in the State of Maine) and with safety rules and regulations promulgated by the State Insurance Department.

2. Copies of standards (except local ones) are available for inspection at the State Agency.

D. Inspection by the State Agency: The State Agency will make adequate inspections of construction projects to determine that services have been rendered, that the work has been performed and purchases have been made in accordance with the approved plans and specifications.

E. Construction Payments

1. Requests for construction payments shall be submitted by applicants to the State Agency at the times prescribed by Section 54.208(a) of the Regulations.

2. Under existing law, the State is authorized to make payment of Federal funds to all types of applicants.

3. Federal funds will be paid to the State Treasurer.

4. The State will promptly remit or credit all payments of Federal funds received by the State for payment to applicants for approved construction funds.

F. Personnel Standards Merit System: The program will be administered in accordance with the Standard for a Merit System of Personnel Administration as set forth under the Regulations (54.205a) including any subsequent amendments thereof.

G. Conflict of Interest: No full-time officer or employee of the State Agency, or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs, will receive funds from the applicant, directly or indirectly, in

payment for services provided in connection with the planning, design, construction, or equipping of the project.

H. Financial Records

1. The State Agency agrees to retain all documents coming into its possession, which relate to any expenditure under the Federal Act for a period of at least one year beyond its participation in the program.

2. The State Agency will require that an Applicant who has a project under the Federal Act maintain adequate fiscal records and controls and establish suitable property inventory records covering all equipment of more than nominal value; and further that the Applicant retain such fiscal and inventory records and other pertinent documents for a period of at least three years after the final payment of Federal funds to the Applicant.

3. The Comptroller General of the U.S. or his duly authorized representatives shall have access for the purpose of audit and examination to the records specified in paragraph H. 1.

I. Transfer of Allotments

1. Intrastate-Not less than 30 days after the allotments under the Federal Act are made for any fiscal year, if there have been no approvable applications for a portion of the funds, the State Agency may submit a written request to the Surgeon General that its allotment, or a specified portion thereof, for community mental health centers be added to the allotment for mental retardation facilities all within the limitations specified in the Regulations Section 54.202c.

2. Interstate--Not less than one year after the Federal allotment for community mental health centers is made for any fiscal year, there having been no approvable application for such allotment or a portion thereof, the State Agency may submit a request in writing to the Surgeon General that this allotment, or a specified portion thereof, be added to the corresponding allotment of another State for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a community mental health center in such other state, providing that there are proper assurances that such completed community mental health center will accept patients form the State of Maine without discrimination.

J. Fair Hearings

1. If an Applicant feels that the State Agency has made a final unfair ruling, he may make request in writing to the State Agency for a fair hearing before the Community Mental Health Centers Advisory Council, the Chairman of which will be the Chairman of the hearing. Generally accepted procedures for the presentation of material, admissibility, time limitations, relevancy, and arriving at recommendations will be followed.

2. Actions of the State Agency which will entitle the Applicant to a hearing includes:

   a. denial of opportunity to make formal application;

   b. rejection or disapproval of application; and

   c. refusal to reconsider an application.

3. Appeals from decisions or actions of the State Agency must be made by the applicant, in writing, within 30 days from the date of the adverse decision by the State Agency.
4. The appellant will be notified in writing of the time and place of hearing. The time and place of the hearing, which is determined by the State Agency, will be reasonably convenient for the appellant.
5. The appellant is entitled to be represented by friends or counsel, if he so desires. The appellant and other persons interested and concerned with the council's decision are entitled to present pertinent evidence in the way desired, subject to reasonable procedures of admissibility and methods of presentation.
6. The appellant is entitled to examine all evidence and to question opposing witnesses.
7. The decision of the council will be made in writing within thirty days from the date of the hearing, and will be based on the evidence presented at the hearing.
8. A stenographic record of the hearing will be made, and, upon request of the appellant, will be transcribed and made available for examination.

SECTION VII

STATE STANDARDS FOR MAINTENANCE AND OPERATION OF CENTERS

SECTION VIII

RECORD KEEPING AND REPORTING

SECTION IX

ASSURANCES OF NON-DISCRIMINATION

SECTION X

ANNUAL REVIEW AND MODIFICATION OF THE STATE PLAN

SECTION XI

FEDERAL SHARE

SECTION XII

CHANGE OF STATUS OF FACILITY

SECTION XIII

GOOD CAUSE FOR OTHER USE OF FACILITY

VII. STATE STANDARDS FOR MAINTENANCE AND OPERATION OF CENTERS

A. Minimum Standards for Operation and Maintenance

1. An application will not be approved unless the State Agency is assured that as a minimum the completed project will be operated, maintained, and licensed as provided by Chapter 405, Title 22, R.S. 1964, with its promulgated Rules and Regulations or their subsequent revisions.

2. The community mental health center complex with certain exceptions are not included in the provisions of Chapter 405, Title 22, R.S. 1964, but are operated on the basis of standards of the State Department of Mental Health and Corrections, details of which will be furnished to the State Agency and the Public Health Service by the Department upon request.

3. The Department of Mental Health and Corrections shall set forth the policies and criteria to be used in evaluating adequacy of financial support for the maintenance and operation of each community program of which such facilities are a part.

4. Further requirements include the State's responsibilities to local mental health programs in terms of financing, consultation and/or supervision, and any consequent systems of reports from the local programs to the State.

VIII. RECORD KEEPING AND REPORTING

A. Adequate and Necessary Reports: The State Agency will make such reports, in such form and containing such information, as the

Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the corrections and verification of such reports.

IX. ASSURANCES OF NON-DISCRIMINATION

A. The State Agency will obtain assurance from each applicant that all portions and services of the entire facility for the construction of which or in connection with which, aid under the Act is sought will be made available without discrimination on account of race, creed, color or national origin; and that no professionally qualified person will be discriminated against on account of race, creed, color or national origin with respect to the privilege of professional practice in the facility.

X. ANNUAL REVIEW AND MODIFICATION OF THE STATE PLAN

A. Annual Review: The State Agency will from time to time, but not less often than annually, review its State Plan and submit to the Surgeon General any modifications thereof which it considers necessary to administer the annual allotment for each category of facilities under the Federal Act. At least biennially the submission will contain, as a minimum, a complete construction program, revised as necessary.

XI. FEDERAL SHARE

A. A Uniform Rate for all Projects in the State

1. Uniform Rate: The Federal share of the cost of all projects approved in Maine for the fiscal year July 1, 1964 through June 30, 1965, will be 58 percent.

The Federal share of the cost of all projects approved in Maine for the fiscal year July 1, 1965 through June 30, 1966 will be 58 percent. However, a project may be fractionalized. In this event the Federal share of that portion of the project accepted for participation will be 58 percent during both fiscal years 1965 and 1966. The percentage of Federal participation for projects will be redetermined annually.

XII. CHANGE OF STATUS OF FACILITY

The State Agency will promptly notify the Surgeon General in writing, if at any time within 20 years after the completion of construction, any facility which received funds under Federal Act Title II, Public Law 88-164 is sold or transferred to any person, agency, or organization not qualified to file an application under Federal Act Title II, Public Law 88-164 is not approved as a transferee by the State Agency, or ceases to be a public or non-profit community mental health center as defined in the Act.

XIII. NONDUPLICATION OF GRANTS

No grant may be made after January 1, 1964, under any provision of the Public Health Service Act, for any of the three fiscal years in the period beginning July 1, 1964, and ending June 30, 1967, for construction of any facility described in Title II, Public Law 88-164, unless the Surgeon General determines that funds are not available under Title II, Public Law 88-164 to make a grant for the construction of such facility.

XIV. GOOD CAUSE FOR OTHER USE OF FACILITY

If within 20 years after completion of any construction for which a

construction grant has been made the facility shall cease to be a public or nonprofit community mental health center, the Surgeon General in determining whether there is good cause for releasing the applicant or other owner of the facility from the obligation to continue such facility as a public or other nonprofit community mental health center, shall take into consideration the extent to which:

(a) the facility will be devoted by the applicant or other owner to use for another public purpose which will promote the purpose of the Act; or

(b) there are reasonable assurances that for the remainder of the 20-year period other facilities not previously utilized for the care of the mentally ill will be so utilized and are substantially equivalent in nature and extent for such purposes.

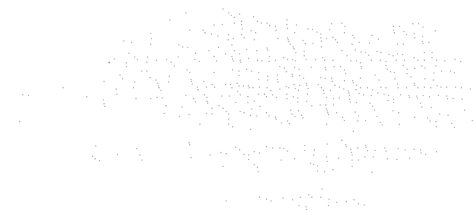
CONCLUSION

There are many problems that will necessarily have to be solved by communities themselves. This plan is primarily an attempt to outline the initial steps to realize construction of mental health facilities. It in no way undertakes to solve all the problems which may exist within the five mental health center areas.

Wherever possible the construction plan has emphasized the close association of mental health services with the general hospitals. This has been and will continue to be an objective of the Comprehensive Mental Health Plan for Maine, in that "the patient suffering from mental illness should receive the same excellence of medical and ancillary health services as quickly, easily, and efficiently as the patient suffering from physical illness."[1] And no hospital service should be considered complete unless it is able to treat the whole man and any health problem he may have.

[1] MORE FOR THE MIND, Canadian Mental Health Association, 1963.

INVENTORY FORMS



EXHIBITS

AN ACT TO PROVIDE EXPANDED COMMUNITY MENTAL HEALTH SERVICES

I. GENERAL DESCRIPTION

Heretofore the Department of Mental Health and Corrections has been appropriated funds for state-staffed and operated mental health services, i.e., for the Augusta State Hospital, Bangor State Hospital, Pineland Hospital and Training Center, the Eastern Maine Guidance Center at Bangor and the Androscoggin Mental Health Clinic at Lewiston. The Community Mental Health Services Program adds to these services by authorizing the Department to make grant-in-aid funds available to local governments and eligible organizations for approved projects in the area of mental health.

The program places the responsibility for further development of community mental health services in the State of Maine upon the community itself. In so doing it becomes necessary that the community initiates and supports mental health programs which the state is not now providing and is not likely to provide for some years to come in light of the immensity of the problem.

II. WHAT ORGANIZATIONS ARE ELIGIBLE?

Any municipality or other governmental unit is eligible to receive benefits under this program and municipalities or governmental units may join together toward this end.

Any non-profit organization organized primarily "for the improving of community mental health and welfare" is also eligible to receive benefits under this program. Such organizations include existing groups, as well as those which may be established solely to develop community mental health.

III. WHAT TYPE OF PROJECTS ARE ELIGIBLE?

A. Diagnostic and Treatment Services Project: This type project is one which offers direct professional service to individuals with personal problems and to those persons who are emotionally or mentally disturbed.

Projects of this type include mental hygiene clinics, child guidance clinics, family counseling services and other services requiring the direct services of psychologists, psychiatric personnel and/or social case workers.

B. Consultation Services Project: This type of project is one which offers professional services to persons in the community who work directly with individuals with personal problems or who are emotionally or mentally disturbed. The consultant's main job is to help the worker (minister, physician, teacher, nurse, welfare worker, court and probation personnel) to better understand the emotional problems and disorders of those with whom they are working.

C. Educational Services Project: This type of project undertakes to educate the community in the area of mental health. A project could encompass any or all of such programs as:

1. a survey of the community's or district's mental health needs and resources;
2. organize and conduct workshops, speaking programs, film programs for:
    a. general district consumption or
    b. specific groups (teachers, clergymen, physicians)

IV. WHEN TO MAKE APPLICATION

Since this law is one which provides for state grant-in-aid funds to community mental health programs, initiated and supported by the community, there seems to be three basic steps which need to be taken by any governmental unit or non-profit organization before making application to the Department for a grant-in-aid.

A. Survey the community mental health needs in the area of interest (municipality, county, school district).

B. Select the type of project to be supported (diagnostic and treatment; consultation; education).

C. Raise funds necessary to implement the program and to employ the necessary personnel.

MAINE COMMUNITY MENTAL HEALTH SERVICES PROGRAM

State Aid Regulations
(Revised July 1, 1961)

The following rules and regulations have been promulgated and adopted by the Department of Mental Health and Corrections as authorized by the law entitled "An Act Providing Expanded Community Mental Health Services." These regulations should be considered together with the material describing the Community Mental Health Program.

These regulations apply only to projects for which a grant of funds appropriated under the above law is sought.

GENERAL POLICIES

I. GRANTS

A. Funds granted by the state may not substitute for local financial support or replace anticipated resources of local origin. Substantial community support, either by local contributions or from local tax revenues will generally be a prerequisite for grant-in-aid.

B. The maximum grant for any one program shall not exceed, in any single year, one-half of the operating expenses, after deducting from said expenditures income from fees, if any, received for services rendered.

C. Increased local support for agencies receiving grant-in-aid funds should be encouraged in order to gradually reduce both the proportionate share and the maximum amount of state support allocated.

II. REIMBURSEMENTS

State aid will be forthcoming quarterly for the three months'period ending September 30, December 31, March 31, and June 30, in the form of reimbursements for expenditures for the particular quarter. It

must be stressed that reimbursement is only for payments actually made during that quarter.

A. Expenditures Subject to Reimbursement Shall Include:

1. Salaries and expenses of personnel;
2. Approved facilities and services provided through contract and other agreements;
3. Operating expenses and maintenance costs;
4. Such other expenses as may have been previously approved by the Department.

B. Expenditures Excluded from State Aid:

1. Expenditures for which state or other reimbursement is claimed under any other provisions of law;
2. Capital expenditures including real property, equipment, improvements or additions;
3. Organizational expenses including membership drives, fund drives, newsletters, etc.

III. FEES

A. Fees may be charged for services approved under this law, provided that services shall not be refused to any person because of his inability to pay a fee.

B. Fee schedules and rules for determining ability to pay shall meet the approval of the Department.

C. All fees collected in a quarter must be deducted from operating expenses for that quarter for which state reimbursement is requested.

D. Services for which reimbursement is sought must not be refused to any person because of his race, creed or national origin.

IV. PERSONNEL

Insofar as possible, personnel for whom reimbursement is claimed shall be professionally qualified. As a guide the Department will use the professional qualifications established for similar positions by the State Department of Personnel but will not necessarily be bound thereby in making its final evaluation in any position.

V. REPORTS, REVIEWS AND EVALUATION OF SERVICES

A. Organizations operating approved programs shall submit such reports as may be required by the Department of Mental Health and Corrections.

B. Requests for reimbursement shall be made quarterly on forms which shall be provided by the Department of Mental Health and Corrections.

C. Any authorized representative of the Department of Mental Health and Corrections may visit, examine or inspect any service or facility and may audit the financial accounts and related records of any organization or service requesting or receiving aid under this law.

D. Receipts and expenditures of grant-in-aid funds must be recorded in the regular books of account of the organization; such records must be centralized and available for examination at any time. It is not necessary to maintain separate records, except in agencies having an affiliation with a corporate body of diverse and other services. All work sheets used in preparation of requests for reimbursement shall be retained for future reference. All expenditures must be supported by receipted invoices or cancelled checks on file for purposes of audit with the books of account of the program.

E. There shall be an annual audit by an independent auditor, acceptable to the Department of Mental Health and Corrections, of the books of each program involving state aid where the total annual budget of the program equals or exceeds $5,000. Report of such audit shall be forwarded to the Commissioner of Mental Health and Corrections.

VI. HOW TO APPLY FOR FUNDS

A. Application forms may be obtained from the Bureau of Mental Health, Department of Mental Health and Corrections, State Office Building, Augusta, Maine.

B. Applications for renewal of grant-in-aid must be submitted annually, indicating changes (if any) in program, personnel or budget. Services currently participating in the grant-in-aid program will be given preference over new services when available funds are limited. Failure to re-apply prior to April 1 will be interpreted to mean that the community mental health program is no longer desirous of obtaining financial aid from the state. Applications for renewal received later than April 1 will be considered with new programs in alloting available funds.

C. Applications for support of new programs will be considered when the community service has been organized to the point of developing a budget, securing local support and/or initiating services. Applications (for fiscal year beginning July 1) received prior to May 1 will receive priority in the allocation of available funds.

VII. APPROVAL OF PROGRAM

A. Each applicant will be notified by the Department as to whether or not the program has been approved and the maximum amount of grant-in-aid allocated for the program. The maximum state participation shall not exceed one-half of the operating costs, less fees. Capital outlay is not reimbursable.

B. Each program approved for grant-in-aid is covered by contract which is forwarded to the grantee for signature. Maximum reimbursement shall be limited to the amount approved in the contract, unless a revised plan and budget has been subsequently approved.

VIII. CHANGE IN PROGRAM

A. After a program has been approved, any change (including staff, administrative personnel, etc.) must be reported to the Department.

B. Request for increase in grant-in-aid may be made at any time by submitting a description of the expanded program and a revised budget. Approval of grant-in-aid will be dependent on available funds and will continue for the remainder of the fiscal year.

REQUIREMENTS FOR COMMUNITY MENTAL HEALTH SERVICES PROGRAM SUPPORT FOR PROGRAMS FOR TRAINABLE RETARDATES

In order to qualify for partial support (up to one-half of operating expenditures) from the Department of Mental Health and Corrections, it is necessary that programs for the trainable retarded meet certain minimum standards.

It is necessary to insure that the health and safety of those receiving services from such programs are safeguarded and that those included in such programs, because of recognized difficulties, have been adequately diagnosed and evaluated. It is the intention of the Department to insure that program goals of increasing self-reliance, skill improvement and enhanced social abilities are fostered and that instruction is planned around these goals.

REQUIREMENTS

I. Housing

A. Buildings or rooms used for centers must be inspected and approved by local fire departments annually. It must be certified in writing that they meet the minimum requirements for school buildings. Certificate of the current inspection must be posted, and expired certificates kept on file with the program's records.

B. The local health officer must certify annually that sanitary conditions are satisfactory. A certificate of this inspection must be posted, and expired certificates kept on file with the program's records.

C. A medical or osteopathic physician must be selected as the center's physician for emergency matters. The center personnel must have his telephone number immediately available.

II. Pupils

A. Prior to enrollment each pupil must present a birth or baptismal certificate, and a certificate of successful vaccination or a medical statement of reason precluding vaccination. It is strongly suggested that each child also be immunized against polio, diphtheria, pertussis and tetanus.

B. Each pupil must present a report of an examination by a medical or osteopathic physician, containing information about any existing physical disability and the pupil's general physical condition for information of teaching personnel. Examination must be repeated every year and special notation made of the pupil's sight and hearing.

C. Each pupil must have had professional physchological testing and the results must be on file. The test results must indicate the intellectual level as "educable", "trainable" or "dependent". Psychological examination must be repeated every two years to age 16 and thereafter as felt necessary. This requirement may be temporarily waived on request if professional phsychological services cannot be obtained.

D. All records are considered confidential and for the information of program personnel and other professional personnel with a valid interest in the record information. They must be kept under lock and key when not in use.

E. There are no requirements relative to sex, age, multiple disability, toilet training, self-care, behavior, etc.

These are matters to be determined by the local advisory board with the advice of teaching personnel.

F. Each pupil must present a telephone number of a person responsible for him in the event of sickness or emergency. This number must be immediately available to the teacher.

III. Teachers

A. All teachers must be at least high school graduates or have passed a high school equivalency examination.

B. They must have had teacher training and/or experience as teachers of the mentally retarded. Those persons without teacher training, but who have taught other than the retarded (e.g. nursery school) and those who have cared for but not taught the retarded may qualify as teachers in these programs by completing course work in the teaching of the retarded.

C. Teachers' assistance must be age 18 or over, and must be a proven responsible person with experience in working with children.

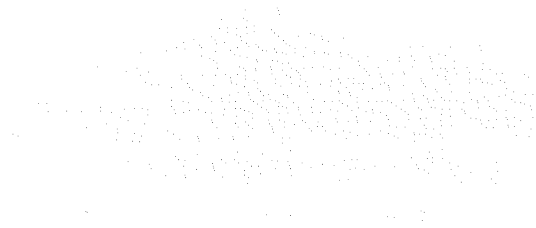
D. Teachers' aides must be age 16 or over and have demonstrated ability to work with the retarded.

E. Classes are limited to 10 pupils for one teacher, or 13 pupils to one teacher with one assistant or aide. The minimum size of classes will be 3 pupils.

F. Teachers must maintain a cumulative record on each pupil, indicating attendance and containing descriptive notes of the pupil's activities.

State Grant-in Aid under the Community Mental Health Services program is limited to programs for trainable retardates. In the case of

programs including both trainable and educable retardates of school age (6 to 21 years), that portion of the program for educables (of age 6 to 16 years) may not be subsidized. There will be no exceptions to this limitation of Grant-in-Aid for mixed programs, without specific approval of the Department of Mental Health and Corrections.



GLOSSARY

GLOSSARY OF MENTAL HEALTH TERMS

This list is designed to familiarize you with definitions of some of the words and terms used in the mental health field. They also give an indication of the range of the many different kinds of mental health services which can be developed.

Aftercare: Services given to patients after they are discharged from a mental hospital.

Aftercare clinic: Unit which provides psychiatric care and treatment for patients released from mental hospitals on convalescent status.

Branch hospital: Special facility where selected groups of patients may live under more suitable special conditions than in an all-purpose mental hospital.

Community mental health center: Service which provides diagnostic service, outpatient treatment, day-, night-, and 24-hour hospital care, transitional and aftercare services for state mental hospitals and by consultation with other services, agencies, and professional individuals in the local community serves as a center for prevention of mental illness and promotion of mental health.

Community mental hospital: A small open mental hospital located in the community and organized as a therapeutic community designed to retrain patients to meet normal stresses of living. It receives patients on a voluntary or compulsory basis, carries on prehospital and posthospital outpatiant services and consultation services to other community health and welfare agencies and professional workers.

Consultation: Services of a professional mental health worker qualified to deal with mental or emotional problems which provide advice to the professional staff of another agency or to professional workers concerning cases, clients and patients. Use of mental health personnel to assess the abilities of a patient to make use of services of an agency or professional worker. Assistance offered by a mental health professional to a worker in another professional discipline or agency to enable him to improve the quality of his professional performance in dealing with the problems of patients or clients.

Day-care centers: Rehabilitation services for former mental hospital patients which provide a meeting place and professional staff for social and vocational retraining.

Day-care centers for children: Facilities for children with less serious emotional disturbances who can remain at home with their family but are too disturbed to be treated in outpatient clinics or who are unable to attend a regular school program.

Day-care centers for retarded: Training Centers which provide socialization, habit training, special education and prevocational training to retarded individuals often in combination with parent counseling and psychiatric or medical supervision.

Day-care services: Special facilities or centers which provide psychiatric care and treatment for patients during the day while they live at home at night.

Day hospital: Facility where all activities and programs of a psychiatric hospital are made available during the day while for the remaining period the patients return home to spend the night and are members of their family and community.

Special facility or arrangement within a mental hospital which enables the patient to come for treatment during the day and then return home for the night.

Diagnosis: Determination of the factors responsible for the emotional problems of a patient and the degree of psychiatric impairment or type of mental illness usually by a combination of psychiatric examination, psychological workup and social assessment of the environmental situation.

Diagnostic service: Study to determine the mental health needs and problems of a specific individual believed to be suffering from an emotional disturbance.

Domiciliary service: Psychiatric care given to patients in their homes through home visits and treatment by psychiatric teams or workers.

Emergency service: Facility where patients can receive psychiatric care on an emergency basis at any time during the day or night. Psychiatric care which is made available at any time to persons with an emotional disorder as soon as a crises arises either in a hospital or by the psychiatric treatment team going out into the community to see patients.

Ex-patient club: Facility for former mental patients where they have opportunity to participate in group social activities under supervision to help them gain assurance and confidence in social situations.

Family care: Situation where a chronic mental patient is placed with a carefully selected family as a boarder. Expenses are paid by the state or a social agency and the patient and the family are supervised by a social worker or public health nurse.

Five-day hospital: Psychiatric institution where patients go home on weekends.

Halfway house: A community residency facility under supervision of trained personnel for mental patients able to profit from group activity and living and to earn money in a job to help pay for their maintenance.

A transitional living situation for discharged mental patients who have no home to return to or who are not accepted by their family or relatives.

Transitional facility for persons who no longer need hospitalization but are not yet ready to assume fully independent living which provides an opportunity for gradual re-establishment of family, work, and social relationships and a temporary place to live after leaving a mental hospital while the ex-patient gets used to living with others in the normal world.

Inpatient services: Intramural mental health clinical or psychiatric services provides to patients living 24 hours a day full time within a hospital or institutional setting.

Inpatient services in general hospital: Facilities to provide psychiatric care and services to patients in a general hospital.

Mental health education: Activities carried out by trained mental health personnel to communicate to other professional workers and to the general public what has been learned from clinical relationships concerning the problems of human personality. Use of professional mental health personnel to transmit to other agencies, worker, and the public the understanding which they have to people and psychological problems.

Night hospital: Facility where services of a psychiatric hospital are made available to patients during the night hours.
Arrangement where patients enter the mental hospital at the end of the day and receive psychiatric treatment and supervision during the evening or night and return to work in the community the next morning.
A facility for psychiatric patients able to work in the community during the day but who require specialized treatment or supervised care in a mental hospital after working hours.

Outpatient psychiatric clinic: Unit that provides mental health and psychiatric services to ambulatory patients who live at home. It is under the direction of a psychiatrist who has regularly scheduled hours in the clinic and assumes full medical responsibility for all the patients.

Outpatient services: Extramural mental health services provided by a clinical facility to which the patient comes for scheduled hours of psychiatric treatment while living in own home and community.

Outpatient therapy: A psychiatric service which provides treatment for mental patients who have left the psychiatric hospital but still require some form of long-term care or treatment to prevent re-hospitalization.

Partial hospitalization: Services which provide care during the day, night or the weekend to patients who are in the mental hospital for a varying number of hours during the day or night and then return to home or job for the reaminder of the 24-hour period.

Precare services: Mental health services givwn to individuals before their admission to a mental hospital.

Prevention: Public health distinguishes three levels of action to control the incidence of disease. These concepts can be applied to mental illness.

Primary prevention: Efforts to prevent the disease from arising in the first place through measures to reduce the occurrence and incidence of new cases of mental illness in a population during a certain period through focusing attention on factors influencing the production of mental illness and on the reduction of the risk of mental illness by lessening harmful influences or stresses or by increasing the capacities of individuals to deal with stress in a healthy way.

Secondary prevention: Reduction of the prevalence of established cases of mental illness at any particular time by a reduction of the duration of the illness through early detection and identification of the mental disorder and provision of prompt and effective treatment to get troubled people into care as soon as possible before their disorder reaches unmanageable proportions or threatens them with lifetime disability.

Tertiary prevention: Efforts to reduce or ameliorate the effects and disabilities resulting from mental illness and to rehabilitate the individual following the acute phase of his mental illness.

If a mental health program is to succeed in controlling the incidence of mental illness or minimize its effects, it should embrace all three levels of prevention.

Rehabilitation: Opportunity for restoration of a patient, as far as possible, to the previous level of functioning before the onset of a mental illness and to maintain this adjustment effectively.

Use of any kind of clinical,social or vocational services designed to limit the degree of handicap of an individual who has been mentally ill.

Residential treatment center: Special facility for severely emotionally disturbed children who require intensive, 24-hour psychiatric treatment away from their homes in a therapeutic milieu.

Screening: Methods of identifying patients with overt mental illness and of detecting incipient emotional disorders by means of testing, interviewing and psychiatric checkup.

Sheltered workshop: Facility for former mental patients who are able to work under close supervision and who receive assistance in marketing their products.

State mental hospital: Institution for the mentally ill or retarded which is run by the state government and supported from state funds.

Therapeutic community: A cooperative movement within a mental hospital or a special facility aimed at promotion of better communication between staff and patients through encouragement of previously unexpressed attitudes and feeling which stresses the importance of the total environment of the patient and of social factors in the development and treatment of mental illness.

Therapeutic farm: Farm situations for individuals with mental or emotional disorder who need long-term, relatively inexpensive living arrangements which permit outdoor living and a simple life or for former patients who have been in a mental hospital for a long period and need time to make adjustment to living in society and the community.

Training: Provision of a supervised learning or education experince which will develop or enhance the professional skills of workers.

Walk-in clinic: Service facility where an individual can receive psychiatric care and treatment without a previous appointment.

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