MENTAL HEALTH PLANNING

John B. Leet, Planner • Advisory Committee on Mental Health • Bureau of Mental Health • Department of Mental Health & Corrections • Augusta, Maine 04330

REGIONAL REPORTS
STATE OF MAINE

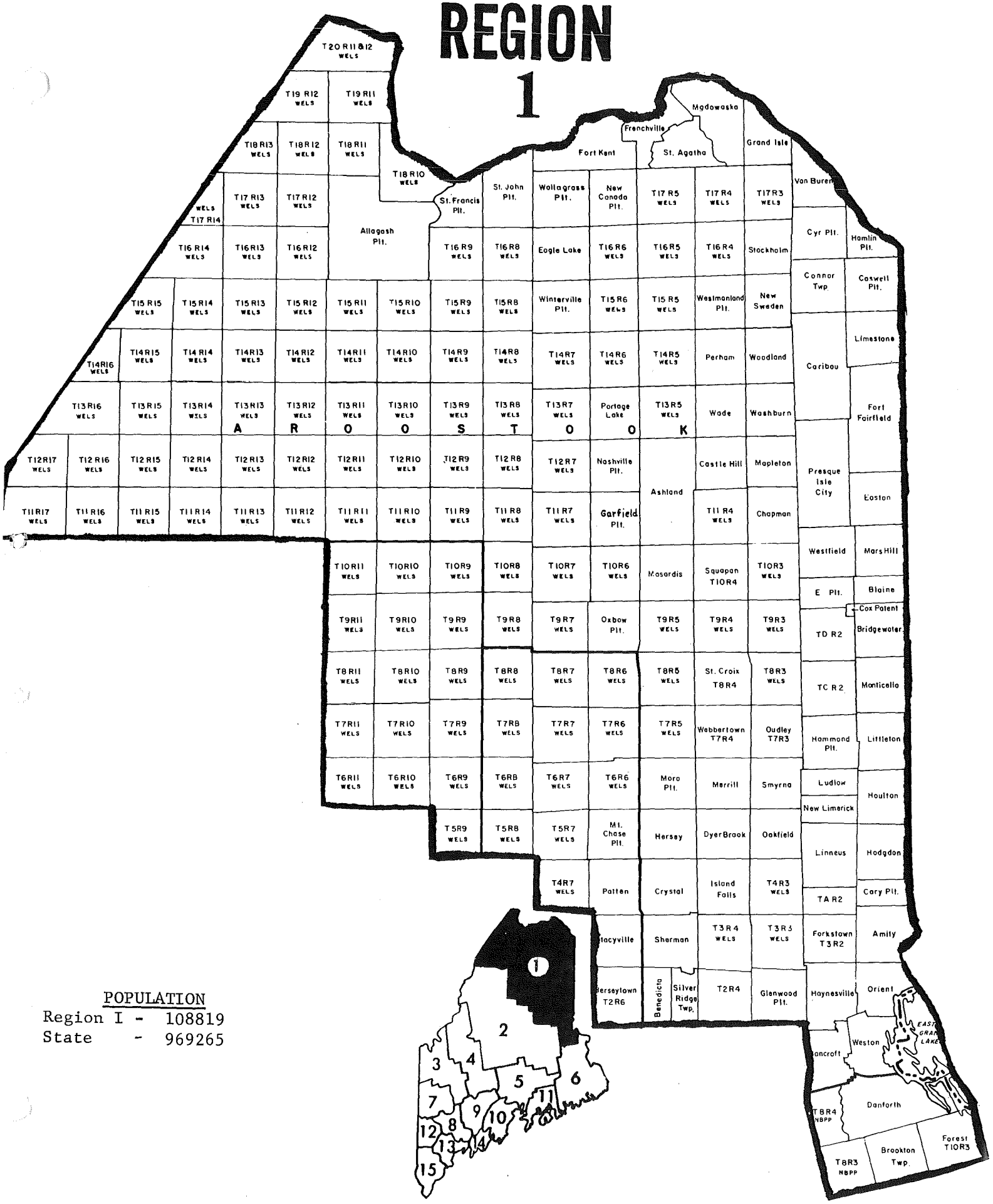
YOUR CONTRIBUTION TO MENTAL HEALTH IS UNDERSTANDING

FINAL REPORT
of
REGION #1

Maine. Advisory Committee on Mental Health

Mental Health Planner
700 State Office Bldg.
Augusta, Maine

REGION 1



POPULATION

Region I - 108819
State - 969265

PLANNING

In 1963 a committee was appointed by the president of the Aroostook County Health Council, Floyd Powell, Dean, Fort Kent State Teachers College, to study the needs of mental health services in Aroostook County and to make recommendations to meet these needs. Mrs. Irvine Clark vice-president of the Council was chairman of this committee.

The Aroostook County Health Council is composed of representatives of local health councils. Although many communities do not have health councils areawise, the county is well covered.

In January 1964 an open meeting was called by this committee with Dr. William E. Schumacher as guest speaker. At this meeting it was first learned that the national and state governments were doing something about expanding mental health services throughout the nation.

At the suggestion of Dr. Schumacher a larger committee was appointed including individuals other than health council members. This committee again appointed by the president, Dean Powell, consisted of:

Julian W. Turner	Presque Isle	district judge
Dr. Margaret S. Smith	Presque Isle	pediatrician
Dr. C. Worth Howard	Houlton	president, Ricker College
Mrs. Edith Churchill, R.N.	Presque Isle	school nurse, SAD #1
William Schofield	Presque Isle	administrator, Arthur R. Gould Memorial Hospital
Lt. Col. Ernest A. Hannah	Loring AFB	Administrator, Loring AFB Hospital
Dr. Donald P. Woods	Houlton	dentist
Richard S. Roper	Houlton	dean, Ricker College
Mrs. Irvine Clark	Washburn	vice-president Aroostook County Health Council
Mrs. Helen Rutland	Presque Isle	program associate, Maine Tuberculosis and Health Assn.
Floyd Powell	Soldier Pond	dean, Fort Kent State Teachers College

This committee met many times and from this committee an association was organized and incorporated, The Aroostook Mental Health Services, Inc. An attempt was made to select directors that represented all the region. No one refused to act as a director that was asked. This could have been due to interest generated through programs of the Health Council and also to the fact that many of the directors represented groups that were well aware of the great need of mental health services in this region.

The directors of the Aroostook Mental Health Services, Inc. are appended at the end of this report.

Mrs. Helen Rutland was appointed as coordinator for Region 1. She, or one or more directors have met several times with Mr. Leet and other regional coordinators. Information received from the state planning office has been reported to the board of directors. Surveys evaluating the needs and services of mental health resources in this area have been obtained.

Consultations have been held with Dr. Schumacher from time to time on new legislation to be proposed. A meeting was held with the Aroostook legislators and the needs of mental health services were presented. Individuals representing groups such as physicians, public health nurses, clergy, school personnel, various agencies from the State Department of Health and Welfare and law enforcement agencies made the presentation. Officers of the association met with the county commissioners to explain the need of county appropriations and individual county commissioners were contacted by directors to clarify the request for county appropriations.

Many programs have been presented by directors of the association to civic groups.

It is the intention that this association will continue to function in promoting needed services in the region and working with any services that may be provided in any capacity that may be required.

ECONOMY, GEOGRAPHY AND REGIONAL ORGANIZATIONS

Region #1 covers over 6500 square miles with a population of approximately 113,000. Potatoes, lumber, and pulp represent its major industries. However, within the past few years new potato processing plants have been established bringing the number to five within this area. Smaller industries, such as Aroostook Shoe, Indian Head Plywood located in Presque Isle and Allied Houlton Footwear Corp. in Houlton have given employment within the last four years to around three thousand persons. Fraser Paper Ltd. and the Northern Trading Co. in Madawaska provide year-round employment for over one thousand employees.

Recreation facilities such as fishing and hunting camps are scattered throughout the area. Ski slopes have been developed in most areas.

Aroostook Stat Teachers College and the Northern Maine Vocational and Technical School in Presque Isle, Fort Kent State Teachers College in Fort Kent, Ricker College in Houlton and Loring Air Force Base in Limestone, contribute substantionally both economically and culturally to the region.

There are five radio stations located in Region #1: WAGM and WEGP are in Presque Isle, WFST in Caribou, WHOU in Houlton and WSJR in Madawaska. The area is serviced by three television stations: WAGM in Presque Isle and Madawaska, CHSJ in St. John, New Brunswick and an educational station WMEM. Parts of the region are also covered by wired television.

Northeast Airlines operate out of Presque Isle with two flights each way daily. There is additional private air service also available to the public.

Houlton, Presque Isle and Caribou all claim to offer major shopping services. Presque Isle is the only city in the region.

There are five School Administrative Districts with more probable.

There is a County Chamber of Commerce and a County Health Council.

Devoted to expansion of industries and services is the Caribou Development Corp., the Presque Isle Industrial Council, and the Houlton Regional Development Corp.

The Northern National Bank with headquarters in Presque Isle has eleven branches within Aroostook. It, with other banks in the county, have deposits of around $93 million.

The years, 1964 and 1965 are the first years since 1952 that the general economy could be considered anything but poor. The last census, 1960, showed 31% of the families with less than $3,000 yearly income as against statewide figures of 22.8%.

Statistics obtained from the Division of Family Services, Department of Health and Welfare, list as of December 1964, 623 families and 1,894 adults receiving financial aid from its Division. The average payment each month, per family in March 1963 (latest figures available) was $104.14. This was the highest rate, per family, in the state.

In addition to State assistance, towns in Aroostook contributed $24,373 during the month of January 1965, covering 410 cases. This was the highest amount by towns of any county in the State.

Also in Aroostook, $1,107 was provided for nursing home care and $17,784 for other medical expenses during January 1965.

However, with the improved price of potatoes this year and the considerable additional employment due to new industries in this region, the present economic outlook is fair to good.

MENTAL HEALTH RESOURCES

The need of mental health services are clearly recognized among the special groups working directly with people such as the public health nurses, personnel of the State Department of Health and Welfare, the clergy, school personnel, and law enforcement agencies. Many persons not working directly with people seem to be unaware of the need.

Mental health services within Region #1 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 Department of Health and Welfare exclusively. It is limited to children with an occasional exception. The clinic comes to Caribou and Houlton four times a year for a two-day session in each town. This service does not begin to meet demands and since very limited diagnostic services are given it is most inadequate.

The Eastern Maine Guidance Center is used in some cases but because of the distance and cost of transportation and often the inability to obtain appointments when needed this service cannot be considered adequate.

There are no private psychiatrists in this region. There is one psychiatrist in Edmundston, N. B. His services are limited to a small

amount of "moonlighting" because he is employed by some branch of the Canadian government. The nearest psychiatrists are in Bangor and the inadequacies of such services to people from this region are obvious.

There are nine hospitals in the region with seven of them built or extensively renovated within the last ten years.

The Aroostook Medical Society recognizing the need of mental health services in this area passed a resolution in November 1964, in favor of proposed legislation to provide mental health services for this region.

Consultation services are given by some members of the clergy and the judiciary and the director of Child and Family Services of Aroostook in Caribou. These persons have expressed their need of consultation services themselves with trained personnel.

NEEDS

A complete mental health team that could provide diagnosis, treatment and counseling is needed for Region #1.

School personnel see the need greatest for emotionally disturbed children. They see the need of professional counseling for teachers in order that they recognize early symptoms of the emotionally disturbed child. They, the teachers, need guidance and counseling in dealing with such students. In one of the larger towns in Aroostook the guidance counselor estimates that 2 to 3% of students in the high school are in need of some type of mental health services.

State workers in the Department of Health and Welfare see the greatest need within the group of young adults and of adults. The emotionally disturbed parent, with severe economic pressures, large families and insufficient medical care, need counseling and often treatment. Children from such families will themselves become emotionally disturbed when living in such an environment. The needs of counseling by foster parents were stressed by this group.

Physicians recognize the need at all age levels. As a group they passed a resolution in favor of proposed legislation that would provide the full range of mental health services for this region.

The clergy, both protestant and catholic, see counseling as one of the greatest needs. Many in this group have some training themselves but are greatly handicapped with no mental health services both for referrals and educational counseling for themselves.

Law enforcement agencies and the courts deal constantly with the results of broken homes, alcoholism, juvenile crime, illegitimacy, school dropouts, and families of the mentally ill and retarded. The probation officers under the courts deal with the same problems. There is a critical need for evaluation, referral, and consultation services in this field as well as a long-term outpatient treatment program.

ACTION

Region #1 needs state money that would provide for a clinical team composed of a psychiatrist, a psychologist, a psychiatric social worker, and clerical help. This team should provide for the full range of mental health services, diagnostic, consultative and treatment. It needs also inpatient services that would provide intensive brief hospital care.

A bill to provide for these services with an appropriation for the biennium of $75,000 is included in the 1965 Supplemental Appropriation (L.D.#298). A hearing has been held on this bill and was attended by delegation from this region. We need facilities to house a clinical team and to provide hospital beds.

A bill (L.D. 493, 1965) to authorize the state to lease the TB annex in Fort Fairfield to the Community General Hospital came up for a hearing February 23. If this bill is passed it will provide space for 10 years for a Mental Health Clinic and 10 hospital beds. This bill has the support of the Aroostook Mental Health Services, Inc.

At least two branch or satellite clinics, one in the northern and one in the southern part of the county, are needed. A clinical psychologist or a psychiatric social worker should be director of these clinics.

Thirty-thousand dollars are included in the Aroostook County budget to provide part of the cost of these branch clinics. It is estimated that each clinic would cost $15,000 each year. It is hoped that grant-in-aid funds will be available to match this amount of $30,000.

At the present time this is what is hoped for for Region #1. To obtain this it will be necessary for the state legislature to:

1. Appropriate $75,000 needed for the hospital based clinic.

2. To pass the bill authorizing the state to lease the TB annex to the Community General Hospital in Fort Fairfield.

3. To approve the $30,000 contained in the Aroostook County budget for branch clinics.

4. To appropriate sufficient grant-in-aid funds to match the $30,000 county appropriation.

PROBLEMS IN PLANNING

Up to the present time we have had exceptional support from all factions in the region.

The one difficulty we have had to face, due to the size of the area and thus transportation problems, is to have representation from the extreme southern part of the region.

This report was submitted by the following members of Region #1:

Mrs. Athill Banks, former organizer and director of Maine Schools of Practical Nursing, Presque Isle Road, Mars Hill, Maine

Mr. Raymond Brennick, superintendent of schools, Union #127, St. Thomas Street, Madawaska, Maine

Mrs. Edith Churchill, school nurse, 51 State Street, Presque Isle, Maine

Mrs. Irvine Clark, president of Aroostook Health Council, Woodland Road, Washburn, Maine

Mrs. James Coyne, public health nurse, 48 Pioneer Avenue, Caribou, Maine

Mrs. Carmen Cyr, housewife, Van Buren, Maine

Rev. Robert Dischinger, director of Aroostook Child and Family Services, Caribou Road, New Sweden, Maine

Mrs. Philip Harmon, nurse, 15 Elmwood Avenue, Caribou, Maine

Mr. Hollis Irvine, bank manager, 28 Elm Street, Fort Fairfield, Maine

Mrs. Isobel Leishman, secretary, 7 Kendall Street, Houlton, Maine

Mrs. Robert MacDonald, housewife, 15th Avenue, Madawaska, Maine

Mr. Gilbert Peterson, car dealer, 33 Elm Street, Fort Fairfield, Maine

Mr. Edwin Plissey, extension agent of the University of Maine, northern district, Hall Street, Fort Kent, Maine

Mr. Floyd Powell, dean, Fort Kent State Teachers College, Fort Kent, Maine

Mr. Richard Roper, dean, Ricker College, Houlton, Maine

Margaret Smith, M.D., pediatrician, 171 Main Street, Presque Isle, Maine

Mr. Julian W. Turner, district court judge, 229 State Street, Presque Isle, Maine

Mr. Homer Ward, Sr., state legislator, Ward Road, Limestone, Maine

Donald Woods, D.D.S., dentist, 32 Highland Avenue, Houlton, Maine

Mrs. Helen Rutland, chairman, public relations committee of Aroostook Mental Health Services, Inc., Box 784, Presque Isle, Maine

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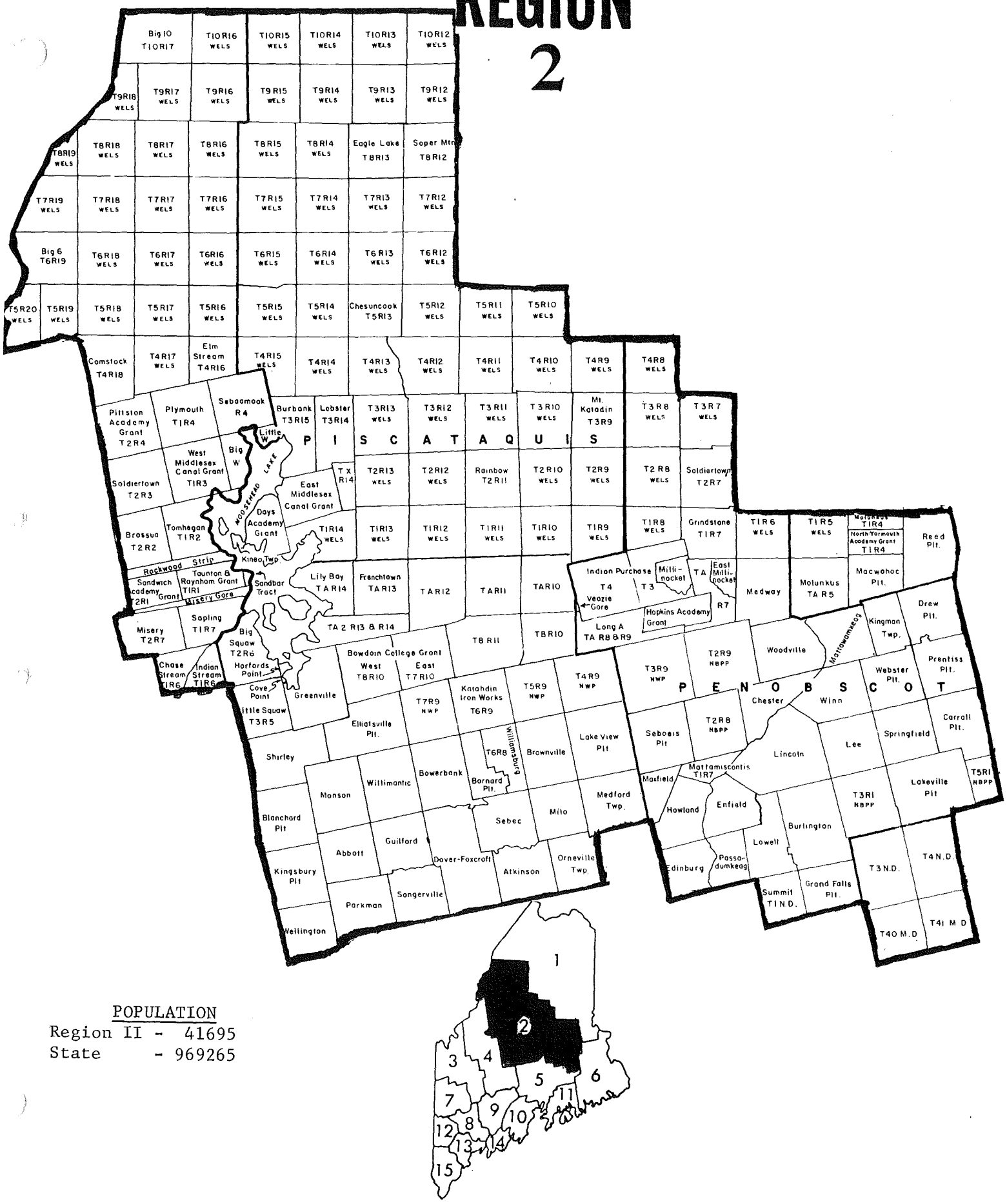
FINAL REPORT
of
REGION 2

Mental Health Planner
700 State Office Building
Augusta, Maine

REGION 2



POPULATION

Region II - 41695

State - 969265

PLANNING

In November 1964, John B. Leet, mental health planner, spoke to a small gathering of Millinocket and East Millinocket citizens explaining the "Plan for Planning" and pointing out the need for representation from the northern Penobscot and Piscataquis (Region 2) area to conduct comprehensive mental health surveys of grassroots, needs, and available services. John Spruce and Robert Emerson were appointed as co-coordinators. A regional committee was then created consisting of individuals from all major communities. The first meeting took place in Millinocket in December. Despite a freezing rainstorm, most of the members gathered at the all-day session to hear an excellent array of speakers: Dr. Peter Jonitis, state mental retardation planner; Dr. Arthur Kaplan, head of the Psychology Department, University of Maine; and John B. Leet state mental health planner. A tour of the special classes for the educable retarded elementary children in the Millinocket school system rounded out the session.

Realizing that we were late in starting and that time was of utmost essence, the overall objectives of the committee were pointed out by Bob Emerson at this meeting: to determine our most pressing comprehensive mental health problems indigenous to the area; to determine available resources for combating such problems; to recommend positive and/or corrective action to meet our needs. Survey forms were then distributed and explained in detail by Dr. Kaplan and Mr. Leet to initiate the first step of our course of action.

The committee's next meeting was held in Lincoln in March. "Juvenile Delinquency and Mental Health" was the theme. Panelists included District Judge Matthew Williams, Alcoholic Rehabilitation representative Dick Whittamore, Boys Training Center officer Al Carroll, and Probation and Parole officer George Allen. Area clergymen, police officers, recreation supervisors and school officials were invited.

Various small sub-committees were also set up to look into mental health problems of the aging, alcoholics, and mental retardation. Most of our progress occurred, of course, through organized, knowledgeable groups, namely the trainable retarded associations and health councils. We found the surveys to be extremely time-consuming on the part of the interviewers, in consideration of the results obtained. It quickly became evident to the committee that, as one respondent so aptly replied: "The most pressing mental health problem is the ignorance of the mental health field by the public!"

THE REGION

Region 2 comprises all northern Penobscot communities north of Howland-Enfield and Piscataquis County entirely. The population of the area is approximately 44,000. Major industries of the area are: paper, machinery, lumber and wood. Farming is particularly prevalent in the Piscataquis County area. Railroading also plays a large role through the area. Employment-wise, economically, and financially the northern Penobscot communities are exceptionally well-off, due to the strong business atmosphere and high wages offered by the Great Northern Paper Co. and Eastern Corp. This area could practically be termed "an oasis" being bordered by Washington, Aroostook and Piscataquis Counties. "Mill towns" always present interesting sociological material.

Many respondents felt that the large influx of "foreign elements" i.e. the French-Canadians, Italians, etc., could be considered a causitive factor of high (and increasing) teenage drinking and adult alcoholic problems noted in these particular communities. It is not this committee's function to become involved in sociological "second-guessing" or upmanship. We will, therefore, resist this temptation.

MENTAL HEALTH RESOURCES

It is apparent that a large segment of our population in this area have no idea what services are available or how they should proceed to secure these services. Generally, mentally ill patients or people with mental health problembs are referral cases from local general practitioners. This is even the case with our emotionally disturbed school children. There are no specialists in the region nor are there any mental health clinics. Our entire region is completely dependent upon the services available in Bangor, i.e., the Bangor State Hospital, Eastern Maine Guidance Center, Utterback Hospital (private) and two psychiatrists in private practice in Bangor.

Several of our communities have done admirably well in providing classes for the trainable and for the educable mentally retarded. Unfortunately, most communities still have a long way to advance in this area.

Our sub-committee on mental health and alcoholism completed an extremely active program. Alcoholics Anonymous groups are established in Mattawamkeag, Derby, Patten and Greenville Junction. It seems that these groups and this program hold the most promise for the habitual drinker at this time; although mention must certainly be made of the dedicated, if not heroic, work performed by area physicians, hospitals and sub-professionals, namely, public health nurses, law enforcement agents, clergymen, school administrators, teachers, etc.

NEEDS

All communities in Region 2 are dependent on services available in the Bangor center city area. We unanimously subscribe to the concept of "brains, not bricks" as the only realistic and practical course of action to meet our immediate mental health needs. Therefore, our communities could best be served by a traveling clinic - possibly working out of Eastern Maine Guidance Center- which would visit our l arger communities at least once weekly and avail their services to our local schools, courts, law enforcement agencies, hospitals, etc. For example, Millinocket could provide services for the northern Penobscot area and Dover-Foxcroft could accommodate the Piscataquis area. Some psychological testing and primary diagnostic work could be done in the schools by our guidance counselors and thus, through the schools, children could be referred to the traveling clinic. It is felt that such traveling clinics should be comprised of a psychiatrist, psychologist and psychiatric social worker operating on a flexible "demand basis" by substituting allied professional and/or sub-professionals.

Sociologists or caseworkers could also service our communities and assist in creating better liaison between home and school. Our present ratio of guidance counselors per number of students is much too low; thus, a third person entering the situation and being the liaison between the school and

home would be extremely advantageous. We would even go as far as to suggest that truant officers be replaced by social workers and that services (and increased costs) be shared by area communities.

Since our region is dependent upon the services available in Bangor, our communities should expect to help support the costs of desired added services, namely outpatient services of Eastern Maine Guidance, Speech and Hearing Center, etc.

In conclusion, we would like to point out that since we are so closely allied with Region 5 and almost wholly dependent upon the services of that area we have carefully scrutinized their excellent report and would like to go on record as saying we are completely in agreement with all statements, concepts and recommendations contained therein in entirety! We consider their references to encouraging coordination and increased cooperation of existing services particularly significant.

Thus, our general concluding statement of mental health needs would be the ESTABLISHMENT OF AN AGGRESSIVE STATEWIDE PROGRAM OF MENTAL HEALTH EDUCATION GEARED TO THE LAY PUBLIC.

This report was submitted by the following members of Region 2:

Mrs. Robert Burke, Taylor Street, Lincoln, Maine, housewife

Mr. & Mrs. Ernest Dodge, High Street, Guilford, Maine (Mr.) retired Legislator

Mrs. Gladys Farrell, 138 State Street, Millinocket, Maine, public health nurse

Mrs. Joseph Farmer, Jr., 19 Palm Street, East Millinocket, Maine, president Katahdin Friends of Exceptional Children

Mrs. Beatrice Gellerson, Pine Street, Dover-Foxcroft, Maine, teacher of the Dale Evans School for Retarded Children

Osborne Harvey, Sr., Millinocket, Maine, hospital administrator, Millinocket Community Hospital

Mrs. Roland Joudry, 8 Spruce Street, East Millinocket, Maine, treasurer Katahdin Friends of Exceptional Children

Mr. Orville Lampher, Lampher's Pharmacy, Dover-Foxcroft, Maine, pharmacist

Mr. Roy Mayo, Westwood Avenue, Millinocket, Maine, Great Northern Paper Company worker, president of Millinocket Junioro Chamber of Commerce

Mrs. Priscilla Millier, High Street, Milo, Maine, president of Health Council of Milo

Lloyd Morey, D.O., Central Street, Millinocket, Maine, osteopathic physician

Mrs. Edna Murchison, Lincoln Elementary School, Military Road, Lincoln, Maine Teacher

Mrs. Robert Pelletier, Pleasant Street, Millinocket, Maine, elementary supervisor principal

Mr. Warren Pressely, Jr., Greenville, Maine, superintendent of schools

Mr. John Rogers, 9 North Street, East Millinocket, Maine, personnel supervisor, director of Maine Association of Retarded Children

Mr. David Richards, Lincoln Street, Dover-Foxcroft, Maine, principal high school

Mrs. Marion Rutherford, Derby, Maine, housewife

Mrs. Raymond Rush, 153 Maine Avenue, Millinocket, Maine, director Katahdin Friends of Exceptional Children

Rev. Carl A. Russell, Jr., 93 Ohio Street, Millinocket, Maine, Clergyman

Mrs. Rodney Ross, Brownville, Maine (RFD #1) housewife

Mrs. Edwin Walden, Greenville, Maine, president of Greenville Health Council

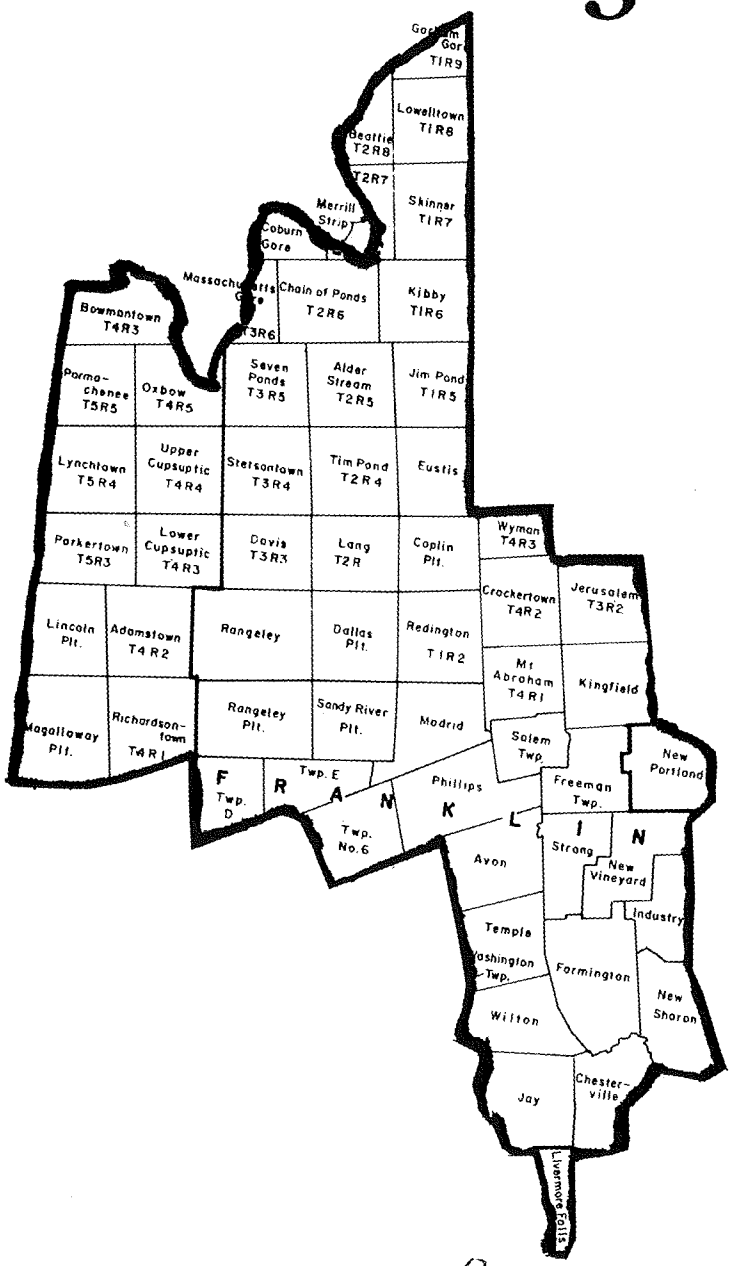
Miss Carolyn Welch, 58 Davis Street, Dover-Foxcroft, Maine, public health nurse

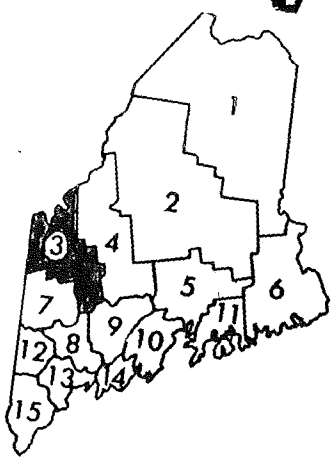
Mr. Robert Emerson, 140 Penobscot Avenue, Millinocket, Maine, pharmacist, Chairman of Committee on Mental Health and Mental Retardation of Junior Chamber of Commerce of Maine

Mr. John Spruce, 196 Lincoln Street, Millinocket, Maine, insurance agent, past presiddnt Millinocket Junior Chamber of Commerce.

FINAL REPORT
OF
REGION #3

REGION 3





POPULATION

Region III - 23813

State - 969265

PLANNING

The planning for this project was relatively easily organized and accomplished because the board of the Franklin County Counseling Services, composed of one representative from each town in the area, was willing to act as the committee. Major planning was done by the regional coordinator, Dr. Anna A. Small, director of the Franklin County Counseling Services. Two special meetings were called in order to acquaint them with the desire for a mental health survey and to enlist their cooperation in helping with interviewing. Committee members met fairly regularly at board meetings where a short time was devoted to describing current progress in the planning. In addition to the regular committee, about fourteen other people in the county were enlisted to act as an advisory board. These selected people were representative of our various professional fields and most were interviewed on a personal basis by the director at the end of the survey.

DESCRIPTION OF REGION

This area is largely rural and many sections are depressed economically at the present time. There are no cities and Farmington, the shiretown of the county, is its largest town with a population of 5,001. The area is served by one hospital, located in Farmington. The hospital has 50 beds and 13 M.D.'s serve on its staff and in the community. Farmington State Teachers College is located here. There are major industries in Livermore Falls, Chisholm and Wilton, the other towns having (in some cases) minor or auxiliary mills. The schools are united by districts which makes available better education for children than a single town could usually afford.

MENTAL HEALTH RESOURCES

The committee was asked to interview various people, representative of their home town, to determine the knowledge, nature, and extent of the mental health problems in the communities. Forty-nine interviews were completed, fourteen of these being housewives; seventeen, business citizens; and eighteen, common laborers. In many cases, it was obvious that there was little awareness of mental health problems or services. The majority, however, were very interested and listed several areas of concern. This group felt that problems dealing with aged people, delinquency, retardation, emotionally disturbed children, emotionally disturbed adults, alcoholism, economic deprivation, and illiteracy were most pressing in the order listed.

DETAILS OF THE GENERAL SURVEY

The group estimated that there were 290 aged people within this area having obvious mental health problems. They felt that reasons for this were longevity, lack of understanding from other adults, and inadequate income. The public health nurses and churches supply all their assistance at the present time and the group would like to see more home-nursing services, an old folks home, and courses available to the public on problems of this nature.

Delinquency

One hundred and ten delinquents were apparently known to those interviewed. They felt that general reasons for delinquency were inadequate home supervision, lack of church life, lack of anything to do, home problems, alcohol, and both parents working. At the present time it was felt that the guidance departments in the school, the ministers, the Franklin County Area Family Counseling Service and The Kingfield Health Council were services available. The group would like to see recreational centers, more group therapy, more extensive counseling offered, and higher economic standards so that mothers won't have to work.

Emotionally Disturbed Children

One hundred and four of such children were identified by those interviewed. The group felt that this condition was caused by poor home environments especially broken homes, lack of parental supervision, and that liquor is too easy to acquire. They feel that the guidance departments, the Franklin County Counseling Service, the clergy, teachers and doctors are presently handling these problems. They would like to see more special training for teachers so that there can be early recognition of these problems, better law enforcement, more recreational facilities for children, more full-time guidance counselors, and better education generally in the schools.

Emotionally Disturbed Adults

Fifty-four of these people were identified by the group. They felt that this condition was caused by social pressures, inadequate environment and educational opportunities, immaturity, failure to share problems and responsibilities, too little income in the home, and alcoholism. The Franklin County Area Counseling Service and the clergy were mentioned by most as the services available. They would like to see more mental health clinics available, more community educational facilities for vocational work, and better education in this line of counseling for the clergy.

Alcoholism

Seventy-nine people were listed to be known alcoholics by the group interviewed. They listed the following reasons for alcoholism: depression due to lack of jobs, availability of alcohol, changing social customs, increased tension, not enough to do, and personal problems. They felt at the present time in this area The Franklin County Area Counseling Services, the doctors, ministers, the A.A. and Alcoholic Counseling Service in Waterville were available for help. They would like to see more rehabilitation units, more people voting dry, and more job opportunities as further services.

Economic Deprivation

Sixty-six people were known by the group to be affected with problems because of economic deprivation. They felt that the causes of this condition stem from lack of education and lack of opportunity to work and they knew of no services at the present time to aid this condition. They

would like to see higher wages, adult education, and on-the-job training in order to relieve this condition.

Retardation

One hundred and twenty-three people were known to have problems in this area, the greatest percent being children who would benefit by special-class education. They listed as reasons for this condition: birth defects, not enough attention from teachers, and not enough education in everyday living. It was felt that The Franklin County Area Counseling Services, The Franklin County Friends of Retarded Children, the small school operated for trainables, special teachers in some of the larger towns, and guidance personnel were presently available to alleviate the condition; and they would like to see more help available for the very young children who are affected in the county.

Illiteracy

Five people were identified as having problems due to illiteracy and it was felt this is caused by broken homes, and that at the present time, social workers and health nurses are the only available services. They would like to have social workers to visit these people.

OPINIONS EXPRESSED BY ADVISORY COMMITTEE

These people expressed most concern in this area with teen age behavior, alcoholism, marriage problems, economic problems, family relationships, emotional disorders, and retardation. With this group, the numbers of people known and identified to have these problems were startlingly larger than the general group. One doctor estimated that at least one-half to one-third of all of his patients had neurotic problems of some kind, with a smaller proportion of his patients having obvious psychoses. Estimates made of people in the area suffering from some kind of emotional disturbance reached the figure of 2,000. Leaders in industry stressed particularly the lack of economic security as being a basis for poor mental health in this area and estimated that at least 550 people are known to be suffering from problems caused by this factor. It was estimated that more than 1,000 families are suffering from some sort of marital problems and that more than 100 people are known to be alcoholics. Industry also showed much concern with the fact that many of the people who have trouble sticking to their jobs in the area are from the employed who were school dropouts. They estimated that more than 500 people fall in this category. It was hard to estimate the number of known retarded and a survey is being made at the present time in this area of children who have I.Q.'s below 75. More than 100 people have been identified at the present time as being retarded to some extent.

Services Presently Available

The Franklin County Counseling Services, public health facilities, associated charities, public health nurses, State social agencies, guidance counselors, teachers, clergy, Franklin County Memorial Hospital, our state hospitals, and doctors are all known to be available to some extent at the present time for people who need services. The general

feeling was that all of these services are good but that none are available in enough quantity to cope adequately with the problems that exist.

Services Needed

There was general and nearly unanimous agreement among all interviewed that the services provided by the Franklin County Area Counseling Services have been helpful and a step in the right direction but should be expanded. The staff at the local hospital has already had a meeting with Dr. Schumacher and Dr. Anna Small, area psychologist, to discuss the idea of having a mental health service situated in the local hospital. There is at the present time a plan underway to enlarge the present facilities at the hospital, and there seems to be general agreement that it might make much sense to put all health services, both mental and physical, under one roof. This idea is still in the talking stage but sounds promising.

There was expression of the need of more adult education available in the area, specifically night schools giving working people an opportunity to go back and finish high school education if they so desire.

There appears to be a need for better coordination of the mental health services. Many expressed the feeling that citizens in general are not sufficiently aware of the benefits that do exist.

The establishment of a speech-hearing center probably under the supervision of the teachers college would fill a need in this area.

There is an overwhelming need at the present time for more public school special classes. It was suggested that school psychologists should be available and hired by school districts. Mr. Fearon, director of Special Education at Farmington State Teachers College would like to see the development of a school program for emotionally disturbed children which is not psychiatrically oriented but rather on a part-time special class basis with children being integrated at times during the school day into the regular classes.

The increased emphasis with all interviewed was the need for closely unified agencies who might meet regularly to discuss ongoing problems and relationships.

In general, there is agreement that the mental health needs have been partially met in most instances but for the most part there is a need for expansion of all services.

ACTION

The immediate need is for increased psychiatric services in this area. Another full-time psychologist, a social worker, and increased consultation services from a psychiatrist are needed as soon as possible. The present small unit is financed from the State and local funds, and it is hoped that Federal funds might be available for further services here.

The school districts need school psychologists, and adult education courses in the evenings. Most of the towns in this area will have to have either State or Federal aid in order to make this available.

Most towns lack facilities at the present time for special classes. These classes for educable children are not always practical in small towns but would be practical if they were made available by the school district. For the trainable children of the county, of whom eight are being served in a little school in Farmington sponsored by the Franklin County Friends of Retarded Children, there will have to be eventually extended services and more adequate housing. A big problem in this area is transportation for children who live many miles from the location of the school. At the present time, both local and State funds are being used to sponsor this small service.

A speech and hearing center could be well located at the Farmington State Teachers College, and it is quite possible that the State could make available such a facility at the College which would be available both for training of teachers and for children in the area that need such services.

This report was submitted by the following members of Region #3:

Mrs. Muriel Bigelow, nurse, Farmington, Maine

Mrs. Olive Bradeen, housewife, Dixfield, Maine

Mrs. Lulu Cook, housewife, Phillips, Maine

Mrs. Carolyn Covert, housewife, Kingfield, Maine

Mr. M. Dean Davis, town manager, New Portland, Maine

Mrs. Velma DeMars, nurse, Rangeley, Maine

Mr. John Donald, Jr., town manager, Wilton, Maine

Mrs. Eleanor Fish, housewife, Weld, Maine

Mrs. Verna Grant, elementary school principal, North Jay, Maine

Mrs. Peter Heikkinen, housewife, Livermore Falls, Maine

Mrs. Austin Hodgkins, housewife, Temple, Maine

Mr. Irving Holbrook, farmer, selectman, New Vineyard, Maine

Mrs. Marion Peary, elementary school principal, Strong, Maine

Mrs. George Porter, elementary school teacher, New Sharon, Maine

Mr. Medary Prentiss, Jr., secondary school teacher, Farmington (Industry), Maine

Mr. Ernest Sevey, town manager, Farmington, Maine

Mr. Merton Smith, superintendent of schools, Phillips, Maine

Mr. Steven Swain, farmer, Rangeley Plantation, Maine

Mr. Robert Tague, woods operation, Stratton, Maine

Mrs. Donald Wilcox, nurse, Rangeley, Maine

Mr. John Wing, insurance agent, Stratton, Maine

Mrs. Dorothy Wright, housewife, RFD #2, Farmington, Maine

Anna A. Small, Ed.D, 17 Broadway, Farmington, Maine, executive director, Franklin County Family Counseling Service, committee chairman

ADVISORS AND CONSULTANTS

Harland Abbott, Ed.D., dean and vice president, Farmington State Teachers College, Farmington, Maine

Mrs. Harry Beach, newspaper editor, FARMINGTON NEWS, Farmington, Maine

Mr. Edward M. Brougham, representative of Bass Shoe Company, Wilton, Maine

Stanley Covert, M.D., Kingfield, Maine

Mr. Edmund C. Darey, judge, Livermore Falls, Maine

Mrs. Carl Durrell, newspaper correspondent, FARMINGTON NEWS, Farmington, Maine

Charles Eastman, M.D., Livermore Falls, Maine

Mr. Ross Fearon, professor of special education, Farmington State Teachers College, Farmington, Maine

Mrs, Raymond Hiltz, president of associated charities, RFD #2, Farmington, Maine

Harold Kearney, Ed.D., guidance counselor, New Sharon, Maine

Mr. Dwight Lander, sheriff, Farmington, Maine

Mr. Peter Mills, lawyer, Farmington, Maine

Mrs. Clarence Niles, public health nurse, Wilton, Maine

Mrs. Rodney Potter, psychiatric nurse, Farmington, Maine

Mrs. James Reed, president, Franklin County Friends of Retarded Children, 18 Main Street, Farmington, Maine

Rev. Charles Reid, Kingfield, Maine

Mr. Albert Surprenant, representative of International Paper Company, Livermore Falls, Maine

Mrs. Stanton Yeaton, newspaper correspondent, FARMINGTON NEWS, Farmington, Maine

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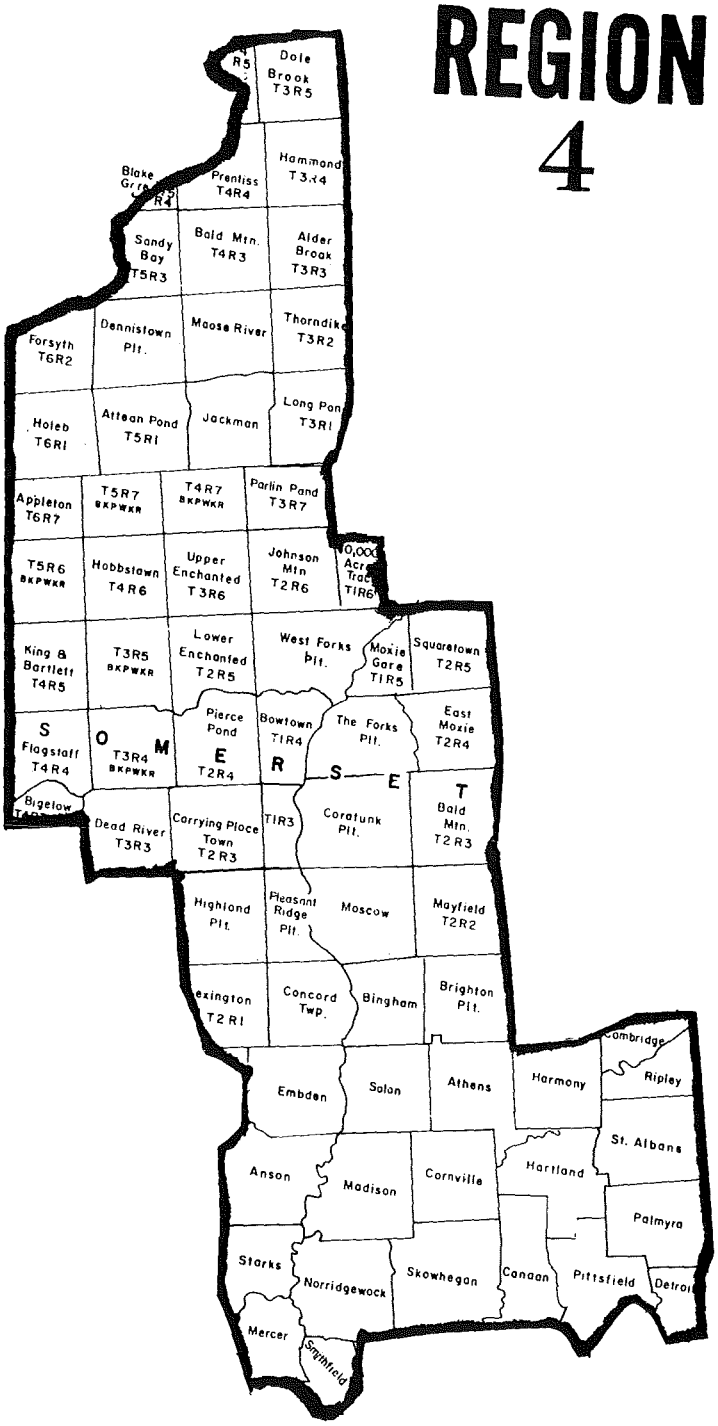
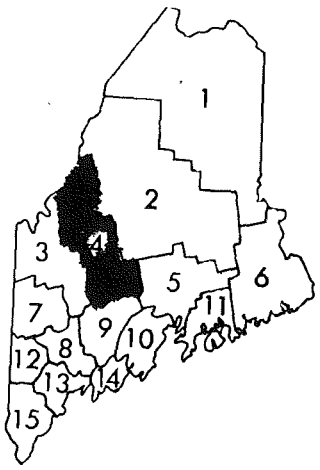
APRIL 1965

FINAL REPORT
OF
REGION 4

Mental Health Planner
Room 700 State Office Bldg.
Augusta, Maine 04330

REGION 4





POPULATION

Region IV - 32800

State - 969265

PLANNING

Upon learning of the Mental Health Program through the state mental health planner, Mr. John B. Leet, our first move was to invite Mr. Leet and Dr. Sleeper to present the program to the Co-ordinating Council of Skowhegan, a group composed of all the welfare agencies, churches, clubs and fraternal groups, and interested persons, where a definite interest was manifest.

As a result of this meeting, I was appointed by Mr. Leet as regional coordinator of Region #4, comprising the greater part of Somerset County.

After consultation with the public nurses in the Skowhegan area, several town officials, and Miss Lorna Dill, an invitation was extended to a list of persons representative of the towns within the region to meet with me on November 23, 1964.

The program was presented to this representative group and preliminary plans for organization set forth.

In the immediate weeks following, the program was further presented to community groups, P.T.A.'s and interested persons by Mr. Leet, Dr. Sleeper, Miss Dill, and myself. Films were used to supplement the presentation.

Illness prevented me from pursuing this program as would have been desired, but several of the representative groups did seek to gain knowledge of conditions in their several communities. Special mention should be made to Mrs. Granville (Helen) Edwards of Madison who went to great lengths in thorough investigation through contacts with town officials, the school department, police department, doctors, nursing homes, etc., in order to gain as much knowledge as possible of existing conditions and public reaction.

It is hoped that the program may be carried forward more vigorously in the future, with particular emphasis on available resources for clinical services, etc. An effort will also be made to solicit at least a limited cooperation with the Thayer Hospital Clinic at Waterville.

REGION

The geographical nature of Region 4 is not conducive to easy communication between the several groups and coordinator. There are few towns of any size with resources available for even a limited treatment or adequate consultation.

Most of the people are factory workers, employed in low-income services. The County Seat at Skowhegan is the largest of the communities within the region, with a population of about 7500 persons. This is also the largest shopping center in the area.

The people of the sparsely settled communities in the northern area migrate to Jackman and Bingham for schooling and community services.

MENTAL HEALTH RESOURCES

The seriousness of the mental health problem is not well known or realized in the rural areas, resulting partially from public apathy, and a reluctance to face up to the problem. The fear of "the crazy-house", "the

mental institution," the State Hospital" and"the insane hospital", etc., is still very prevalent. It is difficult in many areas to refer patients for psychiatric treatment because of the stigma attached to the so-called "head-shrinkers". There is a crying need for public education in this regard.

Our nearest clinic is the Thayer Hospital at Waterville, and, as residents of Somerset County, we do not qualify for this service through the usual channels, and the cost of professional service is prohibitive in most instances.

The larger percentage of our more serious cases are referred to the State Hospital or Utterback's Private Hospital in Bangor. Dr. Kirkpatrick of Waterville has been very helpful in isolated areas.

Resources within the area are limited to medical doctors, clergymen, school guidance directors, and the like. There are no trained professional persons (in the field of mental health) in the area.

To the best of my knowledge, the only other agency in the area dealing even remotely with the problem, is the Family Life program being initiated through the Extension Service from the University of Maine. Most cases have to be dealt with through the prevailing medical profession, and this is often handled by sedation rather than corrective methods.

NEEDS

(1) The primary need, as seen by our representative group, is for a mental health clinic in the area, perhaps on a bi-monthly or monthly basis, with a trained psychiatrist (psychologist) available.
(2) A program of education to eradicate fear and apathy and to make available resources known.
(3) More cooperation from the medical profession and public officials.

These needs have not been met to date although efforts have been made through P.T.A. groups, etc., as indicated earlier. The program of public education must be expanded if we are to accomplish our aims.

A typical example is a case in the northern area of our region where a person is known to be in need of psychiatric help but the family refuses to recognize the need or to do anything about it because of public reaction and the stigma of insanity in the family. It would seem that we have long ago outlived this ridiculous stigma,but it is still evident in the isolated rural areas, and sometimes even more so in "high places".

ACTION

It would appear that our first step in meeting these needs is to effect a cooperative program with Region #3, whose regional geography is not unlike our own.

Perhaps a clinical visitation program might be set up between the two regions which would warrant the presence of a psychiatrist (psychologist) one day in each region once or twice a month.

Communities must be made more conscious of their responsibilities in this area of public health.

We have been advised that limited funds might be made available to us through the cooperation of the county commissioners.

Our eventual goal would naturally be the establishment of a permanent clinical service in the area, perhaps through Federal assistance.

PROBLEMS

The major problem encountered in our planning has been my own inability to do all that I would have desired, by reason of illness and consequent lack of time. Distance cannot be ignored as a factor in making for close cooperation between coordinator and local representatives, but this cannot be regarded as vital.

In view of our slow start, much remains to be done in the field of education. Many existing problems are known, but to date no satisfactory method of dealing with them has been determined.

It has recently been reported that funds have been provided by Somerset County to the Kennebec Mental Health Clinic which allowed acceptance of cases from this area.

Drop-Out Study of Madison High School

A study of school drop-outs of Madison High School accompanied this report. The study covered those who left school before graduation from the year 1958 through 1962. The study attempted to establish the reasons why the student left school.

By far, the greater number of drop-outs were in the I.Q. range of 90-99.

The reasons given at the time, and on the school records were, did-not-promote (lack of academic ability) and this was by far the largest group, 77 out of 161, no apparent interest, to marry (17) disciplinary problems. But the reasons stated in a follow-up in 1965 were different. This is the list in descending order of importance.

1. Teacher-student conflicts) about equal
2. Parental apathy)
3. Personal or home economic situation
4. Inability to handle academic subjects

It was interesting that the Armed Forces Recruiters (Navy, Air Force, Army, Marines) tended to agree that these reasons are those most often told them by drop-outs trying to enlist.

This report was submitted by the following members of Region 4:

Miss Phyllis Barstow, 11 Weston Street, Augusta, Maine, public health nurse

Miss Lydia Bryant, 11 Weston Street, Augusta, Maine, public health nurse

Mrs. Natalie Cross, R.N., Brighton, Maine

Rev. Harold Dorman, RFD #2, Skowhegan, Maine, Presbyterian minister

Mrs. Roland Dugal, The Forks, Maine

Miss Lorna Dill, 6 West Street, Skowhegan, Maine, public health nurse, home visiting nurse for retarded

Mrs. Helen Edwards, R.N., 26 Pleasant Street, Madison, Maine, nurse

Mr. Nolton Gullich, Jackman Station, Maine, retired U.S. Army Captain

Mrs. Kenneth Harding, 11 Houghton Street, Madison, Maine, housewife

Mrs. Patricia Hunt, Box 337, Bingham, Maine, housewife

Mrs. Laurier Mahew, North Anson, Maine, housewife

Mr. Omar Norton, Harmony, Maine

Mrs. Eleanor McCaffrey, Norridgewock, Maine, housewife

Mr. Carl McCrillis, Palmyra, Maine, farmer

Mrs. Ruth Powers, R.N., Hartland, Maine

Mr. Valere Plourde, Jackman, Maine, high school principal

Mrs. Betty Quimby, 1 Goodrich Street, Bingham, Maine, teacher

Mrs. Beulah Reed, Harmony, Maine, housewife

Mrs. Marjorie Rowell, Solon, Maine, housewife

Mrs. Bernard Russells, Harris Station, The Forks, Maine, housewife

Mrs. Frances Seekins, R.N., St. Albans, Maine

Mrs. Isabelle Stratton, Mercer, Maine

Mrs. Mary Uhlar, R.N., Anson, Maine

Rev. Everett Wiswell, North Anson, Maine, Methodist Minister

Mrs. Betty Welch, R.N., North Anson, Maine

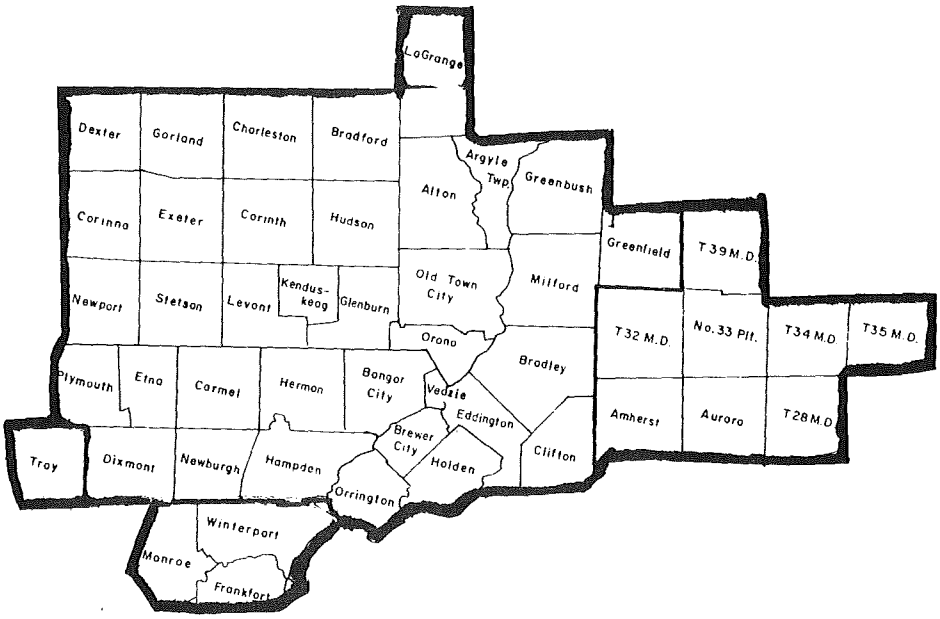
Mrs. Carl Wood, Cornville, Maine, housewife

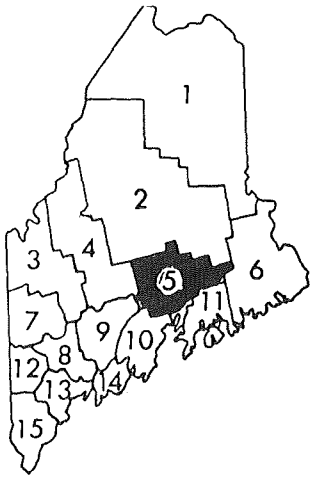
Mr & Mrs. Carroll York, The Forks, Maine

Mr. & Mrs. William York, Caratunk, Maine

Rev. Aubrey Burbank, 7 Dyer Street, Skowhegan, Maine, Methodist Minister
Committee Chairman

REGION 5





POPULATION

Region V - 111875
State - 969265

April 1, 1965

TO: John B. Leet, Planner
Advisory Committee on Mental Health
Bureau of Mental Health

This report is submitted with the conviction that the Committee and all those who have participated in the Study have carefully and thoughtfully analyzed for the first time the problem of providing adequate and usable Mental Health Services for this whole Region. We believe that our conclusions provide a valid and workable plan for implementing our findings in the next few years. Our intent has been to try to define problems, to suggest solutions, yet allow sufficient flexibility to be able to take advantage of new resources either in terms of people with particular responsibilities, skills and interest, new program emphasis, or new methods.

The Region V Mental Health Planning Committee earnestly requests that this report be carefully studied and given serious consideration as a guide to both short range and long range planning. It has been written intentionally in such a way as to emphasize needs and services, rather than to present separate reports on individual agencies.

It is readily apparent that much excellent work is being done by boards and staffs of virtually all of the agencies and organizations in the area. However, we believe that repeated emphasis upon this fact should be of secondary importance to looking ahead and raising our sights to ensure that this report shall most effectively serve its purposes as outlined above.

We hope that enough new insight has been gained and enough constructive recommendations have been offered so that all participants can confidently move forward with a better program of services, with continuous improvement year by year in the future.

Mrs. Lawrence M. Cutler
Chairman, Region V

REGION 5
MENTAL HEALTH PLANNING COMMITTEE
STEERING COMMITTEE

Mrs. Lawrence Cutler
33 Grove Street
Bangor
Maine

Mr. William Wilson
United Community Services
19 Columbia Street
Bangor, Maine

Mr. Michael Murphy
United Community Services
19 Columbia Street
Bangor, Maine

Rev. J. Stanley Stevens
214 Broadway
Bangor
Maine

Mr. Charles H. Perry
172 Main Street
Orono
Maine

Mr. G. Clifton Eames
17 Fairmount Park
Bangor
Maine

Mrs. Clark B. Fitz-Gerald
Dice Head
Castine
Maine

Mrs. H. King Cummings
24 High Street
Newport
Maine

Mrs. Norman Fay Plouff
51 Free Street
Dexter
Maine

Robert Wilson, Ph.D.
Eastern Maine Guidance Center
23 Ohio Street
Bangor, Maine

Mrs. Gordon D. Briggs
Box 70, M. R. C.
Bangor
Maine

GENERAL CONCLUSIONS:

In the course of its activities and deliberations the Committee has come to several major general conclusions which have effected many of its recommendations. These are:

1. It is essential that services be made available to the citizens of all of the communities of Penobscot County. This will involve the expansion of existent services, and the development of some new programs.

2. The building of a Regional Mental Health Facility is not of high priority.

3. A Regional Mental Health Planning Board which would be an ongoing organization should be established. This board would include representation from the total area served.

4. Certain new services are required, many are mentioned in the body of this report. Some, such as adult Day Care services and a Residential Treatment Center, have not been underlined. The Committee has not made recommendations as to which of these services have developmental priority. In fact some of the services recommended by respondents are in the mind of the committee quite unrealistic, others we would consider to have great merit. It is the opinion of the committee that such evaluation will take place as we make every effort to develop out-patient diagnostic and consultation services for the area.

5. There is great need for more inter-agency and inter-disciplinary coordination and cooperation. This is provided for in the recommendations made.

6. The committee wishes to stress the fact that it is sure that relationships with the University of Maine, United Community Services of Penobscot Valley, Inc., The State Office of Economic Opportunity, The Penobscot County Extension Association, the school systems, etc., must be developed more ardently. Further its future activities and accomplishments are directly related to its ability to work meaningfully with these groups.

7. A statewide program of public education on mental health problems is needed.

Planning:

In July the Chairman of Region V, Mrs. Lawrence M. Cutler, approached the Social Planning Division of United Community Services of Penobscot Valley, Inc., a non-profit federation of social welfare organizations, in Bangor, Maine with the request that this organization serve as coordinator and sponsor of the Mental Health Study Project for greater Penobscot County. This request was received favorably by the Social Planning Division on January 6, 1965, and was in turn approved by the Directors of United Community Services.

Under the leadership of Mrs. Cutler, a working committee of ten individuals was recruited. The charge to this Steering Committee was to develop a research program, and a timetable for its implementation. The overall objectives of the Committee's effort were to find out the following: What are the most pressing social (comprehensive mental health) problems? What resources are available for dealing with the problems? What is the nature and extent of unmet needs? What actions can be recommended to meet these needs?

In its early meetings the Steering Committee acknowledged the value of combining an evaluative and fact-finding function with that of a program of public education and community involvement, because it was immediately apparent that the term mental health was not generally comprehended. Owing to time limitations (the report being due on April 1) we chose to forego a formal public education program. Instead we sampled as widely as possible the groups of people considered best able, because of their experience and knowledge, to uncover for us the information and evaluative material we were seeking. (see Appendix I)

The Steering Committee carefully developed a contact list and then called upon its own members, members of the Social Planning Division, and citizens of adjacent communities to conduct the interviews. We agreed that the value of the interviews would be directly related to the knowledge and skill of the interviewer. It was for this reason we selected as interviewers those persons who had some background of knowledge and experience in community health and social problems.

As schedules began to arrive back at the U.C.S. offices, they were tabulated by the U.C.S. staff. Weekly meetings with the Steering Committee were held to review the findings, and to allow for progress reports. Sub-Committees were formed which worked in the Old Town, Newport, Dexter, Winterport and Hampden areas. They reported their findings to the Regional Committee. The Committee's plans for future activities are included in the recommendations. The Committee will continue to operate on an Ad Hoc basis as part of the Social Planning Activity of United Community Services of Penobscot Valley, Inc.

The Region:

The majority of the communities included in Region V fall within Penobscot County. There is slight overlap into Hancock and Waldo Counties; however, the general characteristics of the area are consistent. The Region was divided into areas which roughly correspond to sub-shopping and service areas, e.g., Newport, including Etna, Plymouth, Detroit; Dexter, including Stetson, and other adjacent towns; Old Town, including Milford, Bradley, Greenbush, Alton; Winterport and Hampden; and Bangor-Brewer. Bucksport and Castine were originally included but were subsequently ceded to Region X. The population of the communities included total 106,433 persons, but for the purposes of this report, Penobscot County figures will be used.

1. The land area is 3,408 square miles.
2. The population in 1960 was 126,346 -- an increase of 18,000 since 1950.
3. 61.9% of the total population is urban.
4. The rural population totals 48,164.
5. Just under 6,000 people live in communities with a population of less than 2,500 people.
6. Within the next three or four years close to 5,000 military persons and their families will be leaving this area as a result of the shut-down of Dow Air Force Base.
7. Persons Per Household - 3.58.
8. The percent of persons 14 and over in labor force -- Male 71.2% - Female 24.1%.
9. Median School years completed -- persons 25 years and over - 10.8; Male 10.2; Female 11.4.
10. 15.2% of the labor force consisted of married women, husbands present, with own children under six.
11. 11.5% of the persons, 14 to 17 years of age, not in school.
12. 6.6% of the civilian labor force unemployed.
13. The Median family income is $5,012.
14. 19.7% of the families have income under $3,000 per annum.
15. The percent of employed engaged in manufacturing - 29.8%.
16. The percent of Total Population with less than Five years schooling - 6.3%
17. The percent of Total Population with High School Diploma -- Male 36.1% - Female - 44.9%

Major industries of the area: paper, food, leather, textiles, lumber and wood. The larger communities are principally mercantile centers. The 200 major industries of the County have a value of product totaling $212,950,000 in 1962. This group of firms employ 10,912 persons. But the total labor force of this area is 47,372 persons so it can be seen that a majority of the labor force is not employed in industrial centers. The number of families with income less than $3,000 per annum is high (19.7%).

Communities such as Bangor, Brewer, Old Town and Orono have their own school systems but most of the communities in the County have school district systems. In the past, the major shopping area was Bangor but very recently shopping centers have developed outside of center city. Ellsworth has a large shopping center. The voluntary social services are available in principal part through agencies situated in the City of Bangor.

Mental Health Resources:

Analysis of the sub-committees' experiences in reference to the level of public knowledge or the nature and extent of mental health problems led to the Regional Committee's conclusion that there is an astonishing lack of awareness and knowledge of mental health and social problems. This is particularly so in rural areas. Here we found that where there is concern it is individual and isolated, with the possible exception of school personnel and public health nurses. This is not to infer that there is not also a serious degree of ignorance on these matters in the urban areas. We assume that this knowledge gap is state-wide, particularly where services are non-existent. Specific recommendations on this matter are listed below.

Mental health services available to the people of our area are listed in Appendix III. These agencies were all included in our study. The consensus of the Steering Committee is that an evaluation of mental health services is not possible at this time because of a lack of standardized evaluative materials, also because there is no local group competent to evaluate. Generally speaking, the findings and recommendations of this Regional Committee are evaluative in that they point out specific need areas in the mental health field, and make comment on the adequacy of specific agency programs.

Needs:

In the process of compiling the information gathered by our interviewers, it became apparent that the needs as seen by center city area varied from needs as seen by the neighboring communities. There is high correlation expressed regarding priority of need and availability of services to meet the expressed need. Alcoholism and mental retardation are frequently mentioned in the smaller communities, but not so frequently by respondents in center city. We have, therefore, broken down our listing of mental health needs into three categories: Center City, Neighboring Communities and Total Figures. The Committee developed from the responses general categorical descriptions of the needs as seen by the respondents, these are listed below. A more detailed breakdown of needs is included in Appendix V.

MENTAL HEALTH NEEDS AS SEEN BY RESPONDENTS

	Center City	Neighboring Communities	TOTAL
Increase Staff	37	16	53
Expand services of Existing Agencies	24	7	31
Coordinate Existing Facilities and Personnel	19	--	19
Develop a program of Education for Awareness and Involvement	29	12	41
Increase economic opportunities	18	4	22
Involve more School Systems	26	37	63
Family Life & Marital Education	13	4	17
Add other facilities	37	26	63
Provide Assistance to Courts, Probation and Parole, Police-woman, etc.	10	3	13
Add Centers in Neighboring Communities	--	25	25

Note: The numbers listed above refer to the number of times a specific mental health need was named by the respondents. For example, "Increasing Staff" as a mental health need was named in 37 instances by respondents in Center City; in 16 instances by respondents in Neighboring Communities; hence, this need was named in a total of 53 instances.

The Committee also developed from the responses a General Classification of Problems. This information is detailed in Appendix VI. This information indicates what needs have been met or unmet, and establishes priority so far as the respondents are concerned as to what the major need areas in the field of mental health services are. This information has been utilized by the Steering Committee of this Region in the development of its recommendations, and verifies many of the recommendations made.

I. PUBLIC EDUCATION, AWARENESS AND INVOLVEMENT

Recommendation:
THE ESTABLISHMENT OF A STATE-WIDE INFORMATIONAL AND EDUCATIONAL PROGRAM ON MENTAL HEALTH SEEMS INDICATED.
FAMILY LIFE EDUCATION PROGRAMS HAVE VALUE PARTICULARLY AT THE COMMUNITY LEVEL. HOWEVER, IT IS FELT THAT ADDITIONAL RESOURCES (STAFF AND INSTITUTIONAL) SHOULD BE UTILIZED FOR PUBLIC RELATIONS AND EDUCATIONAL FUNCTIONS IN REFERENCE TO MENTAL HEALTH.

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Noting the astonishing lack of knowledge present in reference to Mental Health, its incidence, and services related thereto, we recommend to the State Advisory Committee that consideration be given to the development of a state-wide educational and informational program to reduce the degree of opprobrium regarding mental and emotional problems and to increase the use of available services. Television spots were often suggested as the most effective method of capturing an audience. Investigation, too, of the practicality of developing and using a corps of volunteer mental health educators whose training might be a cooperative effort of the State Advisory Committee and the Continuing Education Division of the University of Maine is also suggested. CED can reach teachers who are interested in degree courses, and also, through the adult education program, bring teaching to wider interest groups in their own communities.

So many of the key people we interviewed were convinced that family life education in the public schools, beginning at the junior high school level, is the only way to change and improve attitudes that we feel we must include the idea as a recommendation. We recognize the difficulties involved in planning the curriculum of such a course, and finding sufficiently mature and competent teachers to present and discuss family life with young children, but we think it is worthwhile in the light of the variety of new teaching aids such as TV, movies, team teaching, and better reading material, to re-examine this as an educational tool. Using the roster of college trained women who are interested in teaching which the AAUW has compiled, and a willing school department, it would seem that the College of Education and the CED of the University of Maine might well cooperate in developing the special interdisciplinary training needed to train a corps of competent teachers.

II. COMMUNITY ORGANIZATION

Recommendation:
CONSULTATION AND INFORMATION SERVICE AT UNIVERSITY OF MAINE.

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The lack of broadly based groups where community social problems, needs and solutions are discussed and where action can be instituted, was immediately recognized as a major obstacle to effective planning in all these communities. It is important and relevant to note that it is essentially the same lack of organization that hampers the efforts of these communities in planning and applying for grants under the Economic Opportunities Act. The fact that small community needs are not defined, priorities are not established, and possible solutions are not proposed and evaluated, slows regional planning and participation. The real problem here is how help can be given these communities to involve citizens in an effective planning and action program. A consultation and information service for community organization at the University of Maine is strongly recommended and supported.

III. REGIONAL MENTAL HEALTH PLANNING

Recommendation:
THE ESTABLISHMENT OF A REGIONAL MENTAL HEALTH PLANNING BOARD AS AN AD HOC FUNCTION OF THE SOCIAL PLANNING ACTIVITIES OF UNITED COMMUNITY SERVICES OF PENOBSCOT VALLEY, INC.

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The Committee recommends the immediate establishment of a Regional Mental Health Planning Board associated with the Planning Division of United Community Services of Penobscot Valley, Inc. Association with U.C.S. will provide continuity in respect to planning and organization; professional advice and assistance through the U.C.S. staff; office service and record keeping through the secretarial staff.

It may well be that the staff needs of the M.H.P.B. could not be met by U.C.S. staff alone. Therefore, administrative and financial relationships with State and Federal Mental Health Planning bodies may have to be explored.

A. Membership in Regional Mental Health Planning Board
   a) Should include persons from small communities

   b) Should include professionals and Agency lay representatives

   c) Should include community-at-large members

B. Functions of Regional Mental Health Planning Board

   1. TO PLAN AND DEVELOP REGIONAL MENTAL HEALTH SERVICES, INCLUDING INFORMATIONAL SERVICES

   2. TO ENCOURAGE COORDINATING OF EXISTING SERVICES AS FOLLOWS:

      a) Out-patient clinics - Eastern Maine Guidance Center and Bangor State Hospital.

For example, out-patient clinical services are provided in Bangor by both the Eastern Maine Guidance Center and the Bangor State Hospital. There should be agreement as to the functions best served by each so that professional time is economically used. Lines of communication should be strengthened both in regard to developing service and referring patients.

      b) Eastern Maine Guidance Center and Family and Child Services of Bangor.

An effort is already started to explore ways and means of coordinating the services of these two agencies. In many ways the overlapping interests of the two agencies would make it appear efficient and economical to unite staff, housing and community leadership, while preserving for the community all the essential functions of both agencies.

c) The Good Samaritan Home and the Family agency and Eastern Maine Guidance Center should establish closer ties.

As an agency concerned with a major social problem which cuts across both family and mental health concerns, the Good Samaritan Home should be cooperating particularly in the areas of public education and research, interchange of staff skills and agency interests. Rehabilitation and group therapy and foster housing are some of the areas of common interest, in addition to the education mentioned above.

d) Speech and Hearing Center, Retarded Children, Cerebral Palsy -- It is necessary that these agencies provide as well as receive services on a consultation basis to agencies and organizations working more directly with families and individuals.

e) Alcoholics

More concern was expressed for the problems of alcoholism than any other single mental health problem.

It is our understanding that plans within the State Department of Health and Welfare for additional programming in services for the alcoholic are underway. There is also local interest in the Half-Way House concept. The Salvation Army (Bangor Citadel) will soon build a new facility which includes facilities for an Alcoholic Rehabilitation Center. The City Mission was established last year, bringing in additional services to the alcoholic. The committee feels strongly that cooperation among these services and programs is imperative.

3. CONTINUED FACT-FINDING AND EVALUATION

4. TO COOPERATE WITH STATE MENTAL HEALTH PLANNING BODIES

IV. COMPREHENSIVE MENTAL HEALTH CENTER

Recommendation:
THIS CENTER SHOULD BE KNOWN AS A REGIONAL MENTAL HEALTH CENTER.*

THE FURTHER DEVELOPMENT OF OUT-PATIENT DIAGNOSTIC SERVICES IS OF HIGHER PRIORITY IN THIS REGION THAN THE CONSTRUCTION OF A MENTAL HEALTH CENTER.

OUT-PATIENT SERVICES HAVE HIGHER PRIORITY THAN IN-PATIENT SERVICES AT PRESENT. THE PROVISION OF DIAGNOSTIC AND CONSULTIVE SERVICES AT COMMUNITY HOSPITALS IS INDICATED. COMMUNITIES SHOULD ALSO HAVE ADDITIONAL SERVICE FROM CENTER CITY.

SCHOOL SYSTEMS SHOULD BE ENCOURAGED TO CONTINUE TO DEVELOP PROFESSIONAL RELATIONSHIP WITH COMMUNITY MENTAL HEALTH SERVICES, AND WHERE POSSIBLE, PROFESSIONALS SHOULD BE HIRED BY SCHOOL SYSTEMS.

A SOCIAL SERVICE DEPARTMENT AND A FIFTEEN BED PSYCHIATRIC WARD SHOULD BE ESTABLISHED AT EASTERN MAINE GENERAL HSOPITAL.

DAY CARE FOR EMOTIONALLY DISTURBED CHILDREN SHOULD BE DEVELOPED.

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The Regional Committee accepts the concept of a Comprehensive Mental Health Center and agrees that the establishment of such a center should be the long-range goal of its regional planning effort. However, the Committee believes that the

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* For the sake of accuracy and to make subsequent discussion less confusing, we prefer to call the Comprehensive Community Mental Health Center a Regional Mental Health Center. The principal concentrations of population outside of Bangor-Brewer, such as: Old Town, Orono, Dexter, and Newport we refer to as 'communities'. Bangor is the focal point of the Region. While no part of the Region is more than one hour and a half from Bangor, more than time and automobile are involved to travel to Bangor for Mental Health or Family counseling. Bangor seems nearer for shopping and basketball tournaments than for therapy.

concept of a Comprehensive Mental Health Center is particularly appropriate for thickly settled urban communities. A Mental Health Center which serves a population as disparate and rural as Region V must be more broadly based than a Center which serves a more concentrated population. Hence, when the concept of taking Mental Health diagnosis and treatment closer to the home of the person who needs it is applied to Region V, the Out-patient Diagnostic Service is obviously the practical mobile component.

We suggest that efforts to improve or expand in-patient services either in the Bangor State Hospital or the Eastern Maine General Hospital continue. However, we do believe that the practical application of the concept of a Mental Health Center clearly indicates that close to home service means community based diagnosis and crisis treatment, with its attendant educational values. Taking service to the communities is the foundation of the plan and implementing this concept is recommended as the primary emphasis of the next five years.

There is no doubt that Center City agencies such as the Eastern Maine Guidance Center and Family and Child Services are providing services throughout the area. A recent U.C.S. study confirmed this fact.[1] Yet, the material gathered in this mental health survey indicates that a great many persons in surrounding communities are not aware of services available. Bangor State Hospital is, of course, also a Regional resource. It is felt that personnel from local agencies might well spend part time on a revolving basis in adjacent communities. Staff will not only work with school systems and community action groups at the local level, but also within the clinical programs of community hospitals.

Schools are present in every community. We assume the estimate that 8% of all school children have emotional problems is as valid for Region V's communities as for Bangor.[2] The Eastern Maine Guidance Center has successfully demonstrated that a consultation service to schools is useful as a teaching service as well as a case finding and referral source.[3] When children and families who need therapy are found, the psychologist or social worker will be there to interpret the need, to facilitate arrangements, and to help with follow-up. Many crisis problems can be handled on the spot. It is true that the adults reached this way are only those who have schoolage children. Eventually consideration should be given to part time diagnostic and consultation service at community hospitals.

The immediate objective should be to explore with community school administrations, the Eastern Maine Guidance Center, Family and Child Care, and the Psychology Department of the University of Maine, the possibilities of developing school consultation programs, possible on a contractual basis. The Committee fully recognized that the more such programs there are, the greater the demand for service at the Guidance Center and, to a lesser extent, the Family Agency.

The in-patient components of a Regional Mental Health Center will be developed in Bangor. Hospitalization for adults is presently available at the Bangor State Hsopital, and for some acute short term cases under private medical care, at the Utterback Hospital.

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1. In 1964, Family and Child Services of Bangor served 118 persons and the Eastern Maine Guidance Center served 54 in 33 communities other than Bangor-Brewer.
2. 1955 Survey
3. Bangor, 1959-65

The Committee believes that a psychiatric in-patient ward at the Eastern Maine General Hospital would immeasurably improve the mental health facilities in this area. The Administration of the Eastern Maine General Hospital also sees merit in this kind of service, and believes it will be possible to allocate approximately fifteen beds for this purpose. In order to insure that a psychiatric in-patient service is developed as an integral part of the network of community mental health services, the Eastern Maine General Hospital should be an active participant in the Regional Mental Health Planning Board.

The out-patient clinics of the hospital serve a great many people whose problems are emotional as well as physical. Medical social service would facilitate the referral of these patients to a mental health center. Even in the absence of medical social service, the Committee believes better communication between the hospital clinics and the Guidance Center is possible. A medical liaison committee may well be an appropriate coordinating vehicle.

The Regional Committee has not pursued solutions to the many administrative problems involved in coordinating in-patient and out-patient services, since the present lack of community oriented medical psychiatric personnel makes the whole question an academic exercise. If the Guidance Center is successful in attracting an acceptable psychiatrist, the picture will change. Meanwhile, it is suggested that communication with the General Hospital continue in every possible way.

The Guidance Center considers the establishment of day care for emotionally disturbed children a high priority. The Committee suggests that such a service might well result from a cooperative effort of the Guidance Center and another agency, such as the Bangor Children's Home, the Y.W.C.A., Y.M.C.A., Salvation Army, Jewish Community Center, or St. Michael's Home.

The problem of inadequate space for expanding existing services or inaugurating new services should not be an excuse for maintaining the status quo. The Committee believes that adequate housing for services not presently being offered can better be planned after experience with the service, not before. We urge that the RMHPB be concerned with borrowing housing from other agencies, churches and schools, in order to try new programs even if the physical conditions are less than perfect.

V. PROFESSIONAL SERVICES

Recommendations:

MORE PROFESSIONALLY TRAINED STAFF IN EXISTING AGENCIES IS NEEDED.

ADDITIONAL SERVICES WILL REQUIRE ADDITIONAL PROFESSIONAL STAFF.

NON-PROFESSIONAL PERSONS SHOULD BE RECRUITED FOR CERTAIN STAFF ASSISTANT FUNCTIONS THAT WOULD FREE TIME OF PROFESSIONAL STAFF.

THE REGIONAL MENTAL HEALTH PLANNING BOARD SHOULD ASSUME RESPONSIBILITY FOR PROVIDING TRAINING AND ORIENTATION.

STANDARDS AND EVALUATION OF PROFESSIONAL SERVICES ARE REQUIRED.

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It is obvious, when one reviews the schedules returned by respondents, that agencies will require additional staff if out-patient services are to reach all communities within the Region. It is implied that increased staff will allow for a speedup in service to the current caseload.

Some services not currently available but which the Committee believes should be developed are medical social service (the highest priority), a social worker assigned to the District Court to work jointly with Probation and Parole, legal aid services, and emergency services nights and weekends.

The pressures to extend existing services outside of Bangor agencies, to speed up the service to clients in Bangor, and to develop new services, all contribute to the making of a personnel crisis of sorts. The development of the Ph.D. program for clinical psychologists at the University of Maine should help in the recruiting of psychologists. Social workers are the most critical bottleneck. For this reason the Committee recommends that the RMHPB do a personnel study in order to break down the functions of the social worker's job and examine the feasibility of employing sub-professionals to perform some duties which would free the professional to concentrate on strictly professional functions. For example...many agencies require foster homes in which to place children. One person might work with all the child-welfare services and serve as a central in-take person locating suitable foster home placements. The central agency might well establish an information and referral service staffed by trained sub-professional persons. These actions would free professionals for core activity.

Professionals need to cooperate with a program designed to define mental health needs and programs. Such a program could be sponsored by the RMHPB. This Committee might set in-service training programs for area professionals and sub-professionals, public health nurses, welfare workers, teachers, clergy, M.D.s, O.D.s, law enforcement and court personnel.

The Regional Committee is concerned about professional standards and agency evaluation. The establishment of a Qualifying Board, a System of Licensing, et al on the State level, need consideration. The University might well be looked upon as a resource in these areas. The Committee feels that the University might also be called upon to define its role as a major and significant state institution insofar as social welfare matters are concerned. This institution should be a vital resource in the fields of research, consultation, evaluation and community development.

APPENDIX I
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Dow Air Force Base
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Bangor, Maine

Rev. J. Stanley Stevens
Alls Souls Congregational Church
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Bangor, Maine

Mrs. Philip E. Tukey, Jr.
42 Beecher Park
Bangor, Maine

Mrs. Richard C. Wadsworth
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Bangor, Maine

Mr. John W. White, Agent
Henry Sutcliffe Coe
15 Cross Street
Bangor, Maine

(Other interviewers are listed on the next page (Appendix II)

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Bangor, Maine

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Merchants National Bank of Bangor
25 Broad Street
Bangor, Maine

Mr. Edward A. Bonenfant, Supervisor
Maine State Department of Health & Welfare
Family Services Division
141 North Main Street
Brewer, Maine

Mrs. Lloyd M. Brown
46 West Street
Bangor, Maine

Mr. Floyd Caplow, Chief Social Worker
Eastern Maine Guidance Center
23 Ohio Street
Bangor, Maine

Mr. Albert G. Dietrich, Executive Director
Family & Child Services of Bangor
36 First Street
Bangor, Maine

Mrs. G. Clifton Eames
17 Fairmount Park West
Bangor, Maine

Mrs. Alfred Craig
Main Street
Milford, Maine

Mrs. Richard Hill
College Road
Orono, Maine

Mr. Arthur G. Eaton, Jr., Vice President
McClure-Eaton Agency
16 State Street
Bangor, Maine

Mr. Leslie M. Ohmart, Jr., Treasurer
Hinkley's Pharmacy, Inc.
103 Center Street
Brewer, Maine

Mr. Charles H. Perry, Sales Representative
Columbia Investment Company
15 Columbia Street
Bangor, Maine

Mr. George R. Rees, Manager
Maine Employment Security Commission
131 Franklin Street
Bangor, Maine

Mr. William M. Shook, Jr., Director
Bangor Health Department
City Hall
Bangor, Maine

Mrs. Harry Stern
58 Pearl Street
Bangor, Maine

Mrs. Oscar E. Webb
Main Street
Hampden Highlands, Maine

Mrs. Harvey Hillson
63 Bradbury Street
Old Town, Maine

Mrs. Albert H. Winchell, Jr.
64 Highland Street
Bangor, Maine

I. Agency Personnel

A. Public

1. Bangor State Hospital
2. Bangor Welfare Department
3. Bangor City Hospital
4. Department of Public Welfare (State)
5. Department of Child Welfare (State)
6. Overseer's of the Poor (Brewer)
7. Bangor Public Health Department
8. Brewer Public Health Department
9. Department of Vocational Rehabilitation
10. Probation and Parole
11. Veteran's Administration
12. Employment Security Commission

B. Private

1. Eastern Maine Guidance Cent
2. Family and Child Services
3. Bangor District Nursing Ass
4. Good Samaritan Home
5. Speech and Hearing Center
6. Retarded Children
7. Cerebral Palsy Center
8. Alcoholic Rehabilitation
9. Salvation Army
10. Red Cross
11. Bangor Children's Home
12. St. Michael's Home
13. Group Work Agencies - Y.W.C. J.C., B.S., Y.M.C.A.

II. Individuals

A. Public

1. Bangor School Department
2. Brewer School Department
3. City Officials - Bangor
4. City Officials - Brewer
5. Bangor Police Department (Include Juvenile Off.)
6. Brewer Police Department
7. County Sheriff
8. Jail
9. State Police
10. Courts (all levels)
11. University of Maine
12. Husson College

B. Private

1. Eastern Maine General Hosp.
2. St. Joseph Hospital
3. Taylor Osteopathic Hospital

III. Individuals

1. Legal
2. Financial
3. Physicians (include Osteopathic Physicians)
4. Clergy
5. Corporate personnel officers
   (a) Bangor & Aroostook Railroad Company
   (b) Bangor Daily News
   (c) Bangor Hydro-Electric Company
   (d) Bangor Shoe Manufacturing Company
   (e) Cole's Express
   (f) Dead River Company
   (g) Eastern Corporation
   (h) Eastern Maine General Hospital
   (i) Fox & Ginn, Inc.
   (j) Kagan-Lown
   (k) New England Telephone & Telegraph Company
   (l) Viner Brothers, Inc.

IV. Individuals

1. Recipients
2. Interested parties
3. Non-Interested parties

LEGEND FOR APPENDIX V AND APPENDIX VI

Appendix V

The numbers listed in Appendix V opposite the statement of need refer to the number of times a certain mental health need was named by the respondents. For example:

	Center City Needs	Neighboring Communities Needs	Total Needs
Expansion of existing agencies	(24) 13	(7) 5	(31) 18
a. More intensive	3	1	4
b. More preventive	8	1	9

More preventive services/agencies was named as a mental health need by 8 individuals in center city; more intensive by 3 individuals; the not specific term Expansion of existing agencies by 13 individuals for a total under the general classification of Expansion of Existing Agencies of 24 instances in which the general need was mentioned by respondents in Center City. The same format can be followed in interpreting the neighboring community needs. The final results of center city needs and neighboring communities needs is reflected in the total needs column in which a total of 9 individuals mentioned more preventive services/agencies as a need; 4 mentioned more intensive and 18 mentioned expansion of existing agencies in a general manner. So that the general classification of expansion of existing agencies was mentioned by a total of 31 respondents as one of the basic mental health needs needed in this area.

APPENDIX VI -- GENERAL CLASSIFICATION OF PROBLEMS

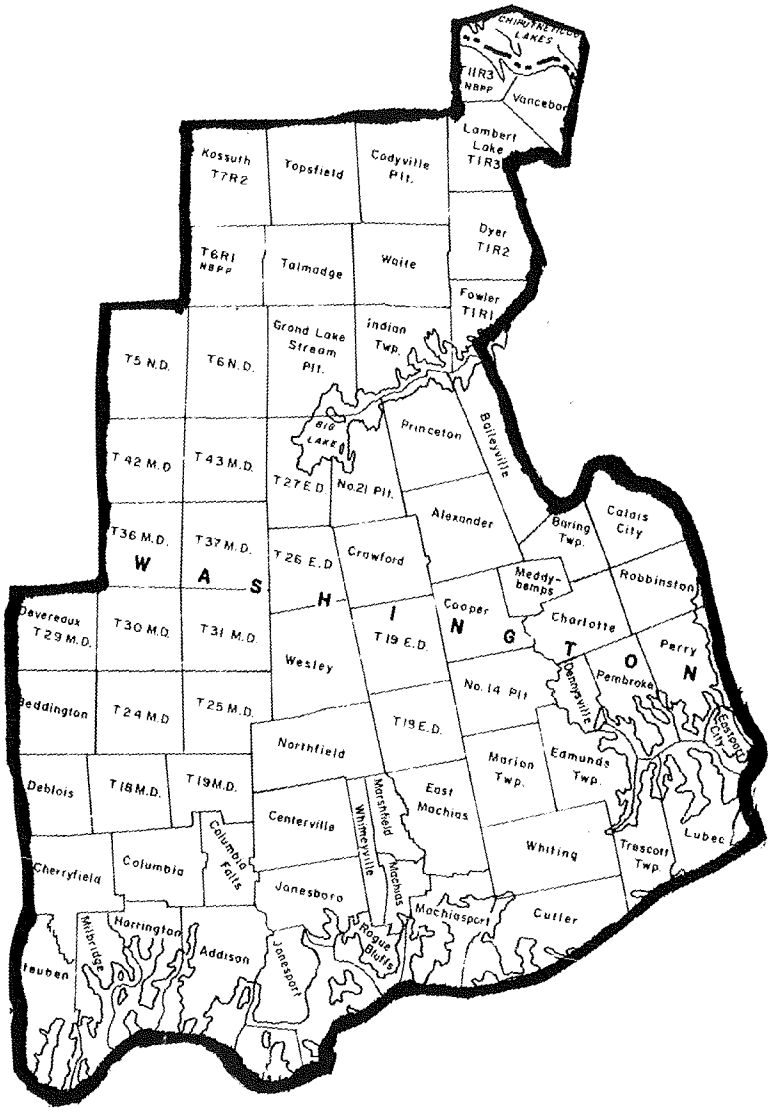
The numbers listed in Appendix VI refer to the number of times a general classification of problems was named by the respondents. For example: Family Relationships (which includes Broken Homes; Disorganization within the Family; Family finances (mismanagement); Lack of preparation for marital responsibilities; Parent-child relationships - tensions - lack of discipline)was named by 40 respondents; 18 of which expressed it as the most pressing problem for Center City; 13 as the second most pressing problem and 9 as the third most pressing problem. In surrounding communities, the problem of family relationships was named in 15 instances by the respondents; 5 of which expressed it as the most pressing problem; 3 as the second most pressing problem and 7 as the third most pressing problem. The result is that Family Relationshipws was named in 55 instance by the respondents as a mental health problem for the entire area; 23 of which expressed it as the most pressing problem in the area; 16 as the second most pressing problem in the area and 16 as the third most pressing problem in the area.

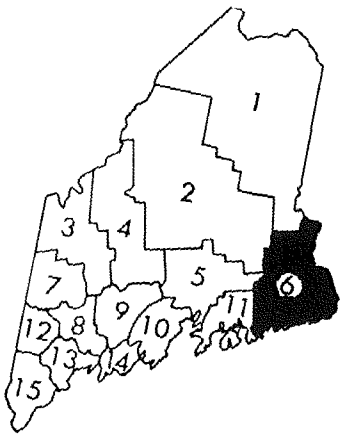
The statistical data substantiating the findings described in Appendix 5 and 6 on page 15 of this report can be obtained by writing to the Dept. of Mental Health and Corrections, 700 State Office Building, Augusta, Maine.

FINAL REPORT
of
REGION #6

Mental Health Planner
700 State Office Building
Augusta, Maine

REGION 6





POPULATION

egion VI - 32087

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Region #6 comprises all of Washington County excepting Danforth, Vanceboro, and a few townships surrounding those towns.

This division was made by the State Planning Committee because of the fact that the people in those communities habitually use Aroostook County hospitals instead of those in this county.

PLANNING

Our planning activity was organized in the fall of 1964 by the regional coordinator who wrote to and interviewed about forty people in the county in order to assemble a committee.

These people were chosen because it was felt that they were a representative cross section of professional people who, by reason of their occupations and interests, came in contact daily with numbers of Washington County residents and therefore were well equipped to understand the needs and problems of the people. Of the forty interviewed, twenty-one became committee members.

This committee has no specific plan for continuing but each member is willing to remain with the committee for as long as the committee appears to be needed and can do something useful for the county.

Since organizing, the regional coordinator has met with the committee singly and in groups to discuss the aims of the State and County Mental Health Planning Committees and to initiate the survey to be made of the county in order that we might become more familiar with our mental health problems.

For survey purposes, the State Planning Committee furnished us with public-opinion questionnaires which, we were told, could be answered by 15-minute interviews with each person contacted. We found that 15 minutes was much too short an estimate and that most interviews took an hour or more. We also found that we could not simply leave the questionnaires with people to be filled in later and returned to us, as they were much too complicated for that and served only to put the recipient into a mild state of shock from which he emerged completely withdrawn as far as the questionnaires were concerned.

From the very first it became quite evident that the questionnaires were going to reveal one great need of this area and that is the need for public education in the mental health field.

Most people seemed to think of "mental health" in terms of the unfortunate retarded, many of whom were being taken care of quietly at home, or the violently insane, who had already been sent to the Bangor State Hospital.

Other symptoms of poor mental health and even serious danger signals of mental illness were not recognized as such.

The less violently ill were just bad-tempered and ill-mannered people;

the adolescent who got into trouble was a bad kid who needed a good strapping; the alcoholic was a stupid bum who should be handled by the police department; the disturbed child was one whose mother "couldn't do a thing with him" for some mysterious reason; the withdrawn child was an exceptionally good child who caused no one any trouble; the unwed mother was a girl of corrupt morals who should be sterilized; most of the school drop-outs should be put somewhere to work out terms at hard labor-they would wish then that they had stayed in school!

Of course, these were some of the more extreme reactions but it does point up the need for education in human relations. This type of education is something which all of us could use to good advantage.

As the questionnaires were completed we met to discuss what had been learned from them and each committee member gave his own ideas as to how the format for the final report to the State Planning Committee should be answered.

ECONOMIC CONDITIONS

Washington County is primarily a fishing, lumbering, and blueberry raising area with segments of the population catering to hunters and fishermen from out of state and to transients and summer residents.

Other groups furnish services, as in any area, to both summer and permanent residents such as retail stores; garages; restaurants; theatres; filling stations; market gardeners; dairymen; a few sheep and wool growers; boat builders; poultry and egg farmers; and the usual professional people--doctors, lawyers, nurses, teachers, and ministers.

The main shopping areas are Calais, Machias, Eastport, Woodland, Milbridge, and Lubec; Calais and Machias being the two largest.

Most of the businesses of the county are small and are owned by individuals. There are the usual chain store outlets such as Newberry's, A&P, Grant's, Fishmans, etc., but, probably due to the economy of the area, there are no modern shopping centers where you can buy anything from groceries to prefabricated houses as there are in most suburban areas today.

From time to time businesses and manufacturers have attempted to create industry in various parts of Washington County but most have not established anything which gave permanent aid to our economy.

We have made no real study of why this is so but from comments of workmen and others over the years it would almost appear that a different and independent attitude toward management exists among local residents than is found in more unionized and regimented areas of the county. In fact, a common comment is that the people here are "too damned independent." The impersonal and big-corporation manner of dealing with the individual workmen is resented.

We are still used to the personal touch between employer and employee and we doubly resent being treated simply as numbers to be written down when needed and crossed off when not needed. Perhaps there is no help for this under the stress and strain of modern business methods, but certainly something is lost from good human relationships.

There are three mills producing textile products in the county, the largest of which has a payroll of about 125 people.

Four pulp and paper companies own large tracts of woodland in the county; they are Pejepsot Paper Company, St. Regis, Dead River, and Georgia-Pacific Corporation.

The largest company in Washington County is the newly arrived Georgia-Pacific Corporation which recently acquired the St. Croix Pulp and Paper mill at Woodland (Baileyville) and is bringing much needed money into the area by expanding the operation there.

The payroll money from the construction of the new addition is improving the mental health of the families of those working there and it sometimes seems that there is nothing wrong with the mental health of Washington County that a few million dollars would not cure.

In general, family incomes are low in Washington County. The 1950 census showed that 30% of the families reported incomes from $500 to $1500 per year and only about 10% had incomes of over $4000. The average family in 1950 was 3.37 people so this meant a very meagre living indeed.

Incomes, in general, have risen since 1950, but Washington County is still far behind the amount considered necessary for providing proper care and education to a large proportion of its population.

Statistics are not necessary for this observation, if one knows the county at all. Later figures show that 37.4% of the population has an annual income of less than $3000.

Much of the work available in the county is seasonal such as the sardine business, blueberry raking and canning, and the businesses catering to tourists and summer residents.

There are three hospitals in the county and four nursing homes. Our doctors and nurses are badly overworked, there being only nine doctors and one osteopath in the county.

Although one survey made in 1955 showed that 89% of the children of one school union between six years and sixteen years had decay in their permanent teeth, there are only four dentists in the county.

We need more doctors, dentists, and nurses. We need more nursing homes for the elderly, but those we have now find it difficult to get qualified help. One nursing home with a capacity of twelve beds gets as many as fifty requests per year from patients who have to be turned away.

There are many more boarding homes in the area than there are nursing homes. The general complaint of those running these homes seems to be that they are confused by what various inspectors from the State Department tell them about regulations and facilities necessary for keeping or getting a license for a boarding home.

RECREATION

Much more could be done to develop Washington County as a recreational area both in summer and winter. This would improve the mental health of those participating as well as the economy.

We do have one skiing area in Alexander which is popular and well run.

Washington County has mostly been sadly lacking in group recreational activities for all ages in which all individuals can participate. Much of the time there is simply nothing to do to spend a pleasant evening unless you go to a movie or to a beer parlor or cocktail lounge. At the latter two places you don't become especially popular with the management if you take up space nursing three ten-cent cups of coffee or a couple of cokes during a whole evening.

The recent organization of eight square dance classes in the county by Mr. & Mrs. Ray Little of Milbridge has given the people participating a tremendous boost toward better mental health. The men seem especially amazed that they enjoy this activity so much that they are actually eager to go to these classes after a hard day's work. This is a good example of how much of our physical fatigue comes from boredom and inertia and not from actual work. Over 500 people of all ages from teenagers to elderly have taken part in this square dance program.

SCHOOLS

There are eight school unions with 274 teachers in the county. Each teacher has 20 to 25 pupils in her care.

The percentage of high school drop-outs has been as high as 45% during some years in Washington County. This percentage included only those who started high school; not those who didn't start at all. Of the 55% who will probably graduate, only 25% will go beyond high school.

This percentage of school drop-outs is higher in Washington County than in the State as a whole. One statistical report quoted the reason as being "poor scholastic standing," which is a "cart-before-the-horse" type of reasoning. Many teenagers can see no future in the usual classical and general courses given in our high schools because they cannot immediately earn a living with the knowledge gained from them.

In most high schools in the county a higher percentage of students take the commercial course than any other. This is probably not because more students want to become bookkeepers and stenographers, but because

this course does prepare for a future job and the school offers no other course in actual job preparation. The few courses available in Home Economics and Industrial Arts are inadequate for any practical future use in acquiring a job.

If teenagers have parents with sufficient influence over them they may stick out four years of high school even though they don't see the practicality of the subjects offered them; but if their family life is not ideal and if the parents have lost their power to influence or the desire to influence because of marital problems, alcohol, inadequate income or some other disturbing problem, the child will lose interest, fail scholastically, and, as a result, drop out of school.

What our high schools need are courses built for the pupil who is ready to learn how to earn his own living, not rigid and traditional curriculums in which the main effort is expended in trying to force the pupil to learn something in which he has no interest.

There should be courses which would teach the young people to be plumbers, mechanics, heavy equipment operators, social workers, hospital aids, electricians, diesel operators, T.V. and radio repairmen, practical nurses, cooks, carpenters, beauticians, business managers, maintenance men, chain-saw operators and repairmen, laboratory technicians, wood lot managers, pulp industry workers, and other necessary skilled and semi-skilled workmen needed in a community.

There is a high percentage of girl drop-outs from pregnancies. This would seem to indicate a lack of proper sex education combined with insecurity and a poor emotional climate at home.

This poor emotional climate could be caused by financial problems or any of the tensions brought on by a lack of self-understanding and education on the part of the parents.

Studies have been made which show that girls, unlike boys, do not, for the most part, have intense sexual desires until the late twenties. If this is so, teenage pregnancies are not entirely the result of the search for sexual gratification, but must be a search for some other emotional satisfaction which is lacking in their relationships with father, mother and family.

We need vocational guidance directors for both upper elementary grades and high schools. There are only two vocational guidance directors in the county at present.

We need vocational training in all high schools and also some system of on-the-job training for the specific job needs of Washington County. A start has been made in this field at the Machias High School in the past few years. This year there are nine boys getting on-the-job training as garage mechanics and as stock boys in local businesses.

This vocational and on-the-job training for teenagers and young adults should be available to those who have dropped out of school for

any reason as well as those still attending. Drop-outs are the ones who need vocational training most.

There are two vocational training schools in Maine, one in Portland and one in Presque Isle. We have had no personal contact with the one in Portland, but the Presque Isle school is excellent and should be used by many more young people of the State than are now attending it. However our greatest need is not being met by these schools because a high school diploma is necessary for entrance in either of them.

We don't mean that, as these two schools are now set up, high school diplomas should henceforth not be a requirement for entrance, but we do mean that there should be vocational training classes available in schools of this caliber for the young people who have not finished their high school training for any reason.

The fact that so many of our teenagers reject the classical and academic high school curriculums may simply mean that they, unlike many of our educators, can see that these traditional subjects are not the right answer for every student; and, since they have no power to change the present school system, they simply reject it.

If there were vocational training courses in every high school or in easily available vocational training schools, we feel that there would be a great reduction in teenage drop-outs.

We appear to have a higher than average percentage of mentally retarded and physically handicapped children and adults in the county. We need schools and special all-year classes for the retarded. There should be enough of these classes at the community level so that retarded children who are capable of learning how to take care of themselves would be able to live at home. The physically handicapped also should have some recognition of their needs at the community level.

Pineland should not be expected to do the whole job for the handicapped for the entire State and for the whole life of the patient.

AGING

Our survey showed that aging is one of the big problems of Washington County and this is borne out by recent figures published by the committee working on the Work-Experience project for Washington and Knox Counties under the Economic Opportunity Act. This gives 3045 persons of 65 years or over for the two counties, and if other figures are comparable, this would indicate more than half of that number to be in Washington County.

One factor which makes aging a problem in the county is the lack of economic opportunities. This forces young people to leave the county in order to find jobs, and, since there is a tendency for people who were born here to return when they retire, this leaves us with a high percentage of elderly residents.

Many of those people who stay and grow old here have been unable to acquire enough money to carry them through their declining years in an adequate manner. Many of these stayed because lack of money for education kept them from seeking skilled jobs in other places.

Statistics for this county show that the percentage of young people (under 24) is getting smaller and of those over 65 is getting higher.

INDIAN POPULATION

There is a larger Indian population in Washington County than in other parts of Maine and for the most part, have been isolated and denied, either directly or indirectly, a fair share of such educational and job opportunities as exist.

Their exclusion from the life of the county is a traditional one caused by the circumstances of the settlement of this country and by the pauperism gradually forced upon them by the questionably superior culture of the white settlers.

Their isolation has further been forced by a pseudo-righteous resentment issuing from a high percentage of the white population in the area who have long implied that the moral standards in the Indian villages were lower than that of the white population. Statistics available do not uphold this implication. The illegitimacy rate is higher in Washington County than in the State as a whole, but no appreciable difference is noted by eliminating the Indians. This high illegitimacy rate is more likely a reflection of the lack of educational and job opportunities of the county as a whole and the emotional climate resulting from these factors.

Radio and T.V. have done much to make the young people of the villages more aware and more sophisticated, but there is still a great need for education about sex, alcohol, self-understanding and a re-establishment of pride in their Indian culture and heritage.

It should somehow be made easier for the young people to go to high school and college or to vocational schools. The minds of our young Indian population are being wasted even more than that of our young white population. They have to fight bigotry and prejudice as well as a lack of educational facilities and job opportunities.

It appears that the village at Pleasant Point in Perry has made great strides in morale, in the number of young people going to high school and in community and cultural pride since the new road was built through the village to Eastport about ten years ago. This single change in their physical relationship to the surrounding communities has apparently made them feel less isolated socially and intellectually.

A good example of this is the current revival of traditional tribal dances by about 30 people from Pleasant Point under the teaching and direction of Joseph Nicholas and Mary Moore. Not only has this activity been good for those participating and for the Indian population as a whole,

but the enthusiastic and interested response from the surrounding towns has been heartwarming, resulting in, among other things, an invitation to perform at the World's Fair.

It is felt that the village at Peter Dana Point in Princeton is still somewhat handicapped by the enforced isolation which comes from living on a dead-end road.

RESULTS OF POLL

When the statistics of our public opinion poll were broken down into categories, it was found that the following problems were most obvious in the county:

Problem	Individuals Reported
Retardation	682
Alcoholism	464
Aging	307
Emotionally disturbed adults	265
Emotionally disturbed children	232

It would seem that alcoholics and emotionally disturbed adults and children are actually all emotionally disturbed people, so these three categories should be grouped as one thus:

Emotionally disturbed adults and children	961
Retardation	682
Aging	307

It is not meant to imply that these figures are accurate as to numbers for the whole county. We questioned only a very small percentage of the population. However, we did try to question only those who were in a position to know something about the people and their needs and problems.

For instance, over 10% of the teachers of the county were questioned and over 50% of the staff working for the Department of Health and Welfare. Others polled were ministers, nurses, doctors, town officials, police, various business people and members of the Washington County Friends of Retarded Children and of the Washington County Mental Health Association.

The one single area in which to start correcting the problem involved appears to be with the disturbed child, even though the poll indicated fewer disturbed children than adults.

Disturbed children will grow into disturbed adults and raise more disturbed children, so it would seem that the child is the logical place to start. However, in order to help the child there must be trained adults who can recognize the child with personality problems and other adults with special training who know what to do about it.

RECOMMENDATIONS

To summarize, we need:

1. Special training courses for all teachers so that they can recognize the disturbed child.

2. A psychiatric clinical team consisting of psychiatrists, psychologists, psychiatric social workers, and home visiting nurses, with necessary clerical help to which teachers and parents can refer these children.

3. A psychiatrist who is available for counseling when needed by psychologists and others working directly with the children.

4. Several Social Adjustment Clinics which are adequately staffed to handle people who need help with personal and emotional problems.

5. An intensive campaign to educate people to a better understanding of what mental health means and how it applies to themselves and to family and community.

   This education should involve all fields of human relationships and personal problems such as sex, alcohol, modern drugs, personality, job adjustment, and others.

6. Year-round classes for retarded children and adults.

7. More and better equipped and better staffed nursing homes for senile and incapacitated elderly. These should not be large institutional type places, but should be small community-oriented establishments so that the patient would not have to leave his community to be cared for, but would be near friends, relatives, and neighbors.

8. More and better run small boarding homes for the elderly who do not need nursing care.

9. A Mental Health Center equipped to treat disturbed patients with problems of a more serious nature than can be handled in the Social Adjustment Clinics.

10. More guidance counselors for upper grades and high school.

11. Realistic vocational training for any teenager or young adult who desires it, regardless of monetary or scholastic standing.

12. Better recreational facilities for teenagers in which all can participate, such as square and modern dancing, bowling, skiing, swimming, skating, hiking and riding.

13. More organized recreational activities for young marrieds, middle-aged and elderly couples according to their capabilities.

These recommendations are not intended to be complete by any means. They are only a rough draft of ideas fomented by our recent survey of the county and a study of such statistics as we had available.

Much more study is needed but we feel that this is a beginning and, perhaps, if it has no other result, has brought an awareness of the concept of individual, family, and community mental health to a number of people in the county who had not thought much about the problem before.

The following are the members of the Washington County Planning Committee for Mental Health who put time and effort into making the survey of the county which resulted in this report.

Mr. Robert E. Allen, principal, Rose McGaffrey School, Machias, Maine

Emily Auclair, Secretary of Washington County Mental Health Association, Washington Street, Eastport, Maine

Mrs. Florence Beal, Member of Washington County Friends of Retarded Children, Jonesport, Maine

Mr. Raymond Bowden, guidance director, Machias, Maine

Mrs. Electa Feeney, county chairman of TB and Health Association, Machias, Maine

Rowland B. French, M.D., Eastport, Maine

Mr. James Haley, director, Child and Family Services of Machias, Machias, Maine

Jane Hinson, newspaper woman and reporter, Main Street, Calais, Maine

Mrs. Jessie Kelley, former president, Washington County Mental Health Association, Eastport, Maine

Mrs. Donna Kyser, welfare department, Machias, Maine

Guy Look, superintendent of schools, Eastport, Jonesboro, Maine

Mrs. Dorothy F. Moore, nurse, welfare department, Calais, Maine

Mr. Joseph Nicolas, Perry, Maine

Mrs. Beatrice Norton, nurse in welfare department, West Jonesport, Maine

Mrs. Nancy Peacock, welfare department, Lubec, Maine

Mrs. Evelyn Pottle, Perry, Maine

Mrs. Charlotte Smith, retired teacher, Meddybemps, Maine

Rev. Donald Stockford, minister, Christian Temple Church, Lubec, Maine

Mrs. Majorie Stockford, nurse, Lubec, Maine

Mrs. Rosie Tucker, former president Washington County Association of Retarded Children, Jonesboro, Maine

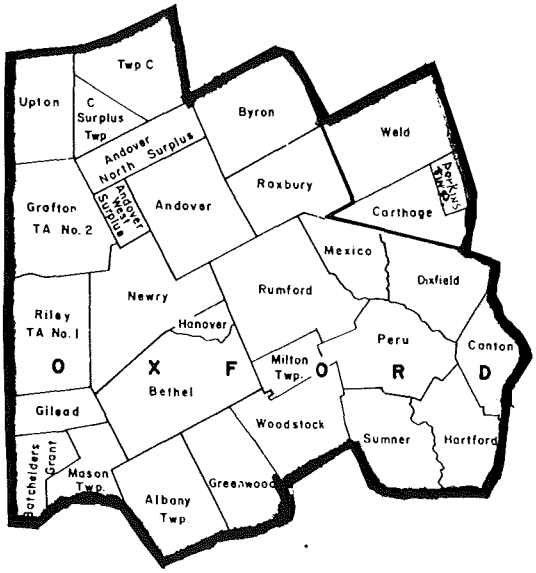
Mrs. Sara Wilson, associated with U of M Extension Service, Machias, Maine

Mrs. Virginia Pottle, Perry, Maine, committee chairman

FINAL REPORT
of
REGION #7

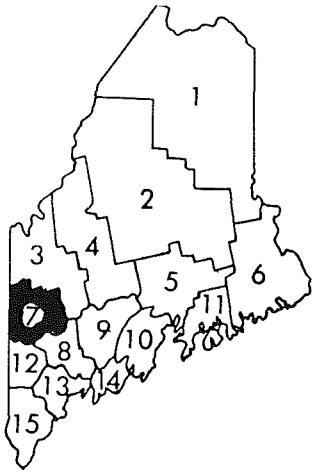
Mental Health Planner
700 State Office Building
Augusta, Maine

REGION
7



POPULATION

Region VII - 26946
State - 969265



As a result of a public meeting in the spring of 1964 sponsored by the American Association of University Women, the planning activity of Region 7 began. At this meeting, the regional coordinator was selected and, shortly thereafter, the planning committee was formed. The members of the committee represent practically every community within the region as well as a comprehensive cross-section of every profession and occupation. The active and successful participation of all of the members of the planning committee can be attributed to their common interests and desire to improve mental health for all the citizens of the region.

Following several organizational meetings, Region 7 was divided geographically and on a socio-economic basis. Each member of the committee was assigned specific groups and areas, i.e. teachers, doctors, and lawyers, to interview. The interviews and surveys were conducted in accordance with the forms provided by the mental health planner. During the course of the survey, the planning committee met monthly to discuss and attempt to solve some of the problems that were encountered in conducting the survey. During this period, the regional coordinator spoke to various fraternal and civic groups regarding the mental health survey and its eventual goals.

The committee plans to continue to educate and acquaint the public with the prevalent mental health problems in the region. It will function as a medium by which the mental health message will be conveyed to the general public through fraternal and civic organizations.

Region 7 comprises all of Oxford County north of the Bethel-Bryant Pond area. Farming, lumbering, manufacturing and the vacation-travel business are the principal activities of the region. The towns of Rumford and Mexico are the largest communities in the region serving more than 20,000 of the 30,000 population. Rumford is the site of the Oxford Paper Company, one of Maine's largest manufacturing plants. It is the commercial banking and the shopping and trade center of the region.

Bethel is the second largest township in the region with farming, saw mills, wood products and ski vacation-travel business as its principal industries. It is the site of Gould Academy, one of Maine's finest secondary schools.

There are three regional school organizations encompassing the towns of Dixfield and Canton; Andover, Mexico, Byron, and Roxbury; Hanover and Rumford.

There exists very little public knowledge of the nature and extent of mental health problems in this region. Although there are no specific mental health services available in the region, there are various members of the medical and affiliated professions and members of the clergy who act as consultants to troubled persons. There is a definite lack of public health nurses, for Rumford, the largest town in the region, does not have the services of a public health nurse.

In order to reduce the heavy caselaods, there is a great need for additional social workers to administer adequately the existing A.D.C., Old Age Assistance Program, Total Disability Program and Aid of the Blind Programs.

There are twelve physicians and one osteopath serving the region, none of whom are psychiatrists. Patients seeking help must travel 45 miles to Lewiston or the Auburn clinic to seek proper psychiatric treatment. The southern part of the region is in dire need of additional physicians.

There are approximately seventy-five active registered nurses in the region. The Rumford Community Hospital is the only general hospital serving approximately 25,000 people. Citizens from the Bethel area must travel to Rumford, Norway, or Berlin, New Hampshire for hospitalization.

There are no specialists in the region nor are there any mental health clinics. Patients suffering from mental illness are referred to psychiatrists, clinics in other counties, or to the Augusta State Hospital.

In addition to the above, some of the region's high schools have the services of a guidance director who attempts to deal with adolescent children with behavior problems. There are full-time guidance directors at Mexico and Stephens High School and the Rumford Junior High School. The submaster acts as guidance director at Gould Academy in Bethel and the principal at Woodstock High School.

The only existing mental health facility in the region is the Hope Training School for the trainable mentally handicapped children located at Mexico.

The regional survey clearly revealed that alcoholism was the paramount mental health problem in the region. Both old and young adults are greatly affected by the excessive use of intoxicants. Mental health problems of the aged, as manifested in senility and aloneness, is the second (most paramount) problem in the region. Mentally retarded children and adults is the third problem confronting the citizens of the region.

The regional survey revealed the following mental health needs:

1. part-time psychiatrist

2. full-time clinical psychologist

3. more public health nurses for early detection of mental illness

4. mental health clinic connected with the Rumford Community Hospital to prevent long-term commitment in a state institution and to provide outpatient treatment.

    a. center where physicians, attorneys, teachers and law enforcement officials can refer patients

    b. possibility of utilizing nursing home connected with Rumford Community Hospital.

5. guidance directors for schools

It is quite apparent that in order to establish a mental health clinic and to overcome the problems of mental illness, some form of financial

assistance will be necessary. Certainly the region is not economically or financially able to begin such a program on its own. Once such a program is initiated, we will have problems in finding sufficient monies in the community to sustain the program.

The problems which the members of the planning committee were confronted in conducting the survey were:

1. lack of time to conduct the interviews;

2. cumbersome and technical survey forms;

3. reluctance of individuals to discuss their knowledge and connection with mental health;

4. difficulty communicating with individuals due to their inability to comprehend the meaning of mental health.

This report is submitted by the following members of Region #7:

Miss Helen Arnold, public health nurse, Pine Street, Dixfield, Maine
Mr. Leo P. Arsenault, technician, 539 Franklin Street, Rumford, Maine
Mrs. Lester Bickford, housewife, Locke Mills, Maine
Mrs. Mollie D. Bryant, housewife, South Paris, Maine
Mr. Herbert Burger, hospital superintendent, Hanover, Maine
Rev. Lawrence D. Clark, Jr., St. Barnabas Episcopal Church, Rumford, Maine
Mr. Roland E. DeCoteau, superintendent of schools, Weld Street, Dixfield, Maine
Mr. Thomas Dickson, Jr., lumber mill owner, Rumford Center, Maine
Mrs. Barbara Douglas, housewife, Bethel, Maine
Mr. Norman K. Fergueson, millworker, Hanover, Maine
Mrs. Charles Fischer, member of Rumford School Board, East Rumford, Maine
Mrs. Nellie M. Hartford, social worker, East Hiram, Maine
Mrs. Libbie Kneeland, housewife, Bethel, Maine
Mrs. Karl V. Kraske, housewife, 45 Washington Street, Rumford, Maine
Rev. Michael O'Donnell, St. Athanasius Church, Rumford, Maine
Mr. Donald R. O'Leary, millworker, Intervale Avenue, Mexico, Maine
Mr. Timothy Parent, deputy sheriff, 51 Rumford Avenue, Rumford, Maine
Rev. Clyde W. Park, Sr., Mexico Baptist Church, Roxbury Road, Mexico, Maine
Mrs. Charles M. Smith, housewife, Main Street, Dixfield, Maine
Mrs. Fred C. Sorenson, housewife, Blayne Avenue, Dixfield, Maine
Mrs. Ranald Stevens, housewife, Bethel, Maine
Mrs. LaForest Twitchell, registered nurse, Bryant Pond, Maine

Mr. Severin Beliveau, lawyer, Trust Building, Congress Street, Rumford, Maine, committee chairman

April 30, 1965

Mr. John B. Leet, M. Ed.
Mental Health Planner
Department of Mental Health & Corrections
State House
Augusta, Maine

Dear Mr. Leet:

Since last fall, well over one hundred citizens from all walks of life in Region 8 have participated in making a study of its mental health needs.

This report represents the fruits of their labor. We realize that the element of time placed limitations on our desire to have more elaborate investigations and deliberations. Therefore, we see our results as humble yet equally recognize the significant contributions contained in the report.

This final product is submitted with the understanding it shall assist the Central Study Committee to complete a master mental health plan for Maine.

We take this opportunity to express our deep appreciation for the assistance provided by members of your department and all citizens who made the report possible.

Sincerely yours,

Neil D. Michaud

Neil D. Michaud, M.S.W., ACSW
Regional Coordinator

Nelly K. Wade

(Mrs.) Nelly K. Wade,
Regional Coordinator

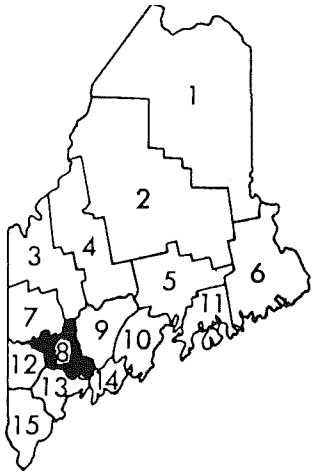
NDM/csc

REGION
8

POPULATION

Region VIII - 95126

State - 969265



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MENTAL HEALTH PLANNING

REGION 8

FINAL REPORT

Section I

PROCEDURAL ASPECTS OF PLANNING

The Central Committee headed by the State Mental Health Planner appointed the Regional Coordinators of Region 8, namely: Mr. Neil D. Michaud, M.S.W., ACSW, Executive Director of Child and Family Services and Chairman, Governor's Advisory Committee on Mental Health, and Mrs. Robert G. Wade, Member of Board of Directors and Secretary of Child and Family Services, Board Member of local YWCA, and member of the Governor's Advisory Committee on Mental Health.

The coordinators held one session to develop a list of a few knowledgeable citizens to assist in suggesting numerous persons in the area who eventually could be involved in planning for Region 8. Names of all persons who participated to some degree are listed in Appendix A. Following a meeting with these few citizens a list evolved and about twenty other people were eventually invited to attend what became the Regional Committee.

The first meeting took place August 27, 1964 at St. Mary's General Hospital. Minutes of that particular meeting are as follows:

"The Regional Coordinators used part of the session to interpret the nature of Mental Health Planning in the country, Maine and the region. Impetus for such activities originated from a message to the 88th Congress by the late President John F. Kennedy, February 5, 1963. The message was related to the prevalence of mental illness and mental retardation and called for a major national effort to reduce this serious problem. Eventually, Congress appropriated a minimum of $50,000 for 1964, and another equal amount for 1965, for each state in the union.

These funds are being allocated so the states can implement a program of planning. Each state now has a central organization which will help develop an overall plan to meet the mental health needs of its citizens in the next decade or more. The final plans have to be submitted by each of the 50 states to federal authorities on July 1, 1965.

Maine's organizational system is under the administration of Walter F. Ulmer, Commissioner of the Department of Mental Health and Corrections and Dr. William E. Schumacher, Psychiatrist, Director of the Mental Health Bureau. A Mental Health Planner, Mr. John B. Leet, has been appointed by the Department. His responsibility is to develop and coordinate overall planning in Maine. He is assisted by a professional group who serve on a Central Study Committee. Dr. Joseph Sleeper, former Superintendent of Augusta State Hospital, Dr. Arthur Kaplan, Director, Psychology Department at the University of Maine, and others serve on this Central Committee. In addition, on a state-wide level, 18 Priority Task Forces have been appointed. These are made up of ten or more outstanding lay and professional Maine citizens who will study different aspects of mental health programs and problems as they affect the whole state.

The Central Study Committee recently divided the state into fifteen different regions. Region 8 includes the following communities: Auburn, Bowdoin, Buckfield, Durham, Greene, Hebron, Leeds, Lewiston, Lisbon, Livermore, Mechanic Falls, Minot, Norway, Oxford, Paris, Poland, Turner, Wales, Webster, and West Paris.

The Committee now being organized for Region 8 will eventually have citizens representing most of the above communities. The Regional Committee will probably appoint sub committees to study the various aspects of mental health in the area. Some of the specific elements that are to be reviewed by the sub committees were identified at this meeting. They are divided into two separate categories - I Program Centered and II Problem Centered.

I PROGRAM CENTERED

1. Research and Evaluation
2. Public Information and Education
3. Hospital and Clinical Facilities
4. Psychiatric Manpower and Allied Professions
5. Financing
6. Administration
7. Legislation and Forensic Psychiatr
8. Action Mobilization
9. Rehabilitation and Employment

II PROBLEM CENTERED

1. Mental Health & Medical Practice
2. Mental Health and Welfare
3. Mental Health and Religion
4. Mental Health and Education
5. Mental Retardation (Liaison)
6. Insurance
7. Alcoholism
8. Delinquency and Corrections
9. Aging
10. Children and Youth

It was recognized that some of these areas might be consolidated or even eliminated in view of the limited time available for completion of the studies. The end results of the Regional Committee's report is to be submitted by February, 1965. It should incorporate: 1) identification of the major mental health problems in our area, 2) what services are available and an assessment of their functions, 3) recommendations for expansion, or establishment of other programs to fill the existing gaps of services."

Concurrent to creating a Regional Committe one of the coordinators mailed a letter to all First Selectmen or Town Managers of the various communities bordering the Lewiston-Auburn area. The letter requested an annual report of the community and a list of outstanding citizens who might be interested in helping with overall planning for Region 8. Most of the town officials came through with a response and a second letter went out to the various persons suggested, inviting them to attend a regional meeting which was set at a later date.

The second committee meeting of the Regional members occurred September 10 at which time a more careful analysis was made of the Region. Conclusions reached led to the establishment of fourteen different sub committees to examine certain programs and problems of mental health. These are reported in detail in Section III of this report. Two other sessions were used to assign a chairman and in some cases a co-chairman to each sub committee. Regional Committee members were assigned to contact potential chairmen. An attempt was made for each sub committee to have one citizen from a non-urban community.

In between, a Manual for Sub Committees was prepared and distributed eventually to all parties involved in planning. (See Appendix B.)

In October, 1964, a mass meeting was held at the hospital. Attending were: Regional Committee members, Chairmen and Co-Chairmen and members of the various Sub Committees and other citizens who had expressed an interest in the planning program.

William E. Schumacher, Director of the Bureau of Mental Health addressed the group on planning. Following his talk the audience was divided into three separate groups with Dr. Schumacher and the two Regional Coordinators serving as resource leaders. Questions and conclusions of the three groups were summarized in a reunited session. Refreshments after the meeting provided opportunity for further cohesiveness of the participating members.

From this point on the Regional Coordinators acted as stimulators for the various sub committees, providing data or information when deemed necessary. Each Chairman, however, was given full freedom to develop his sub committee's activity in the following months. In the interim one formal presentation was made by one of the Regional Coordinators to citizens in the communities west of Region 8. Numerous other informal contacts were made with many other citizens in the outlying areas.

The Regional Committee was called in for a meeting in March to discuss current results and set up a time schedule to review preliminary drafts of reports which eventually led to this final report.

Although no formal plan has been made to continue the Regional Committee as such, it is obvious that certain sub committees shall continue, such as Religion and Mental Health, to name one. Most of the citizens involved have an emotional investment in the area of mental health so that most likely when implementation of recommendations materialize they shall favor further involvement.

MENTAL HEALTH PLANNING

REGION 8

FINAL REPORT

Section II

DEMOGRAPHIC ELEMENTS

Region 8 is composed predominantly of Androscoggin County which is an area of 478 square miles, ranking 347th in the country. The 1962 census reveals a total population of 86,312, housing increased only by 16,000 in the last three decades. It is recognized as the "Industrial Heart of Maine" and boasts also of important agricultural, trade and service elements. There has been a decrease in rural farm population as in other parts of the country. About 16,000 persons reside in the rural areas which consists of twelve communities, mainly Durham (pop. 1,086), Greene (pop. 1,226), Leeds (pop. 807), Lisbon (pop. 5,042), Livermore (pop. 1,363), Mechanic Falls (pop. 2,195), Minot (pop. 780), Poland (pop. 1,537), Turner (pop. 1,890), Wales (pop. 488), and Webster (pop. 1,302). The balance 70,000 reside in the urban twin cities of Lewiston-Auburn.

As mentioned earlier Region 8 is not made up exclusively of Androscoggin County. To the west, the region overlaps into Oxford County and incorporates the communities of Norway (pop. 3,733), West Paris (pop. 1,050), Paris (pop. 3,601), Hebron (pop. 465), Buckfield (pop. 982), and Oxford (pop. 1,658). The Region reaches into Sagadahoc County on the east and incorporates the community of Bowdoin (pop. 668).

Another peculiarity about Region 8 is that although it includes the community of Livermore (pop. 1,363) to the north of the County of Androscoggin but excludes Livermore Falls (pop. est. 4,000) which is part of the county and politically, geographically, etc. tied closely to Livermore. The establishment of Region 8 comes from the Central Committee giving it a population of 98,469.

It is recommended that the Central Committee meet with representatives from the various regions bordering on Region 8 and that basic decisions be made pertaining to continued geographical inclusion or exclusion of certain communities now making up Region 8 and the other specific regions.

When discussing the demographic and other aspects of Region 8 it should be noted that data was lifted primarily from Androscoggin County. However, it is believed that there is a common element which is applicable to all communities now incorporated in Region 8.

The make up of the population is predominantly white caucasian having only 0.2 percent non-white. Emigration from the Canadian province of Quebec in the last century and the early 1900's has left its influence from the Franco-Canadian culture. For instance, in Lewiston with its population of about 44,000, 85% is Catholic. Over 10 percent of the population in the county is foreign born and over 25% native of foreign or mixed parentage.

The median age for residents of the county is 31 and over 61% are 21 years old or over. There are about 23,000 minor children seventeen or under and over 10% of the population considered 65 years old and over. In 1962, there were close to 22,000 family units. The median income for these families in 1959 was $5,113.00 with 18% earning less than $3,000.00 a year and 7.5% earning $10,000.00 and over.

A little over 21,000 residents between the ages of 5-34 were enrolled in schools in the year 1962. The majority (15,516) were in lower grades, 4,524 in secondary schools and only 1,103 in colleges or universities. About 35.5% of the residents 25 years old and older had completed high school education.

Economically, the communities rely chiefly on its few textile industries and its several small shoe shops. These twin communities, like others across the country which are dependent for its economic well-being on a few major textile factories, have suffered from the decline of the textile industry and from its migration south. The total work force which reached a recent peak in 1961 of 33,000, has decreased to 30,800 in 1963. The number of citizens employed, moreover, has decreased from 30,500 in 1959 to 28,400 in 1963.

The unemployment rate saw a drastic increase from 6.7 in 1959 to 9.2 in 1962. This situation was somewhat improved in 1963 when the unemployment rate dropped to 7.8, still well above the national average.

An analysis of the employment picture over the past five years reveals cause for concern if not alarm. The trend has been and continues to be a reduction of the total work force, a fact which suggests a steady migration of skilled and experienced workers from our community. This drain of manpower and citizenry has weakened the economic well-being of our communities, and left unattended, could spell serious economic crises for the future.

The twin communities of Lewiston and Auburn, of about 70,000, has culturally accepted the employment status of its women a number of years even before this became a national trend. For years local industries have been those that appear to be more suitable to female employment. Mainly, these are textile and shoe manufacturing.

The 1960 census shows that 45% of the population over 14 was in the labor force. This is a comparatively high figure with 40% (and sometimes lower) being a more average figure for cities of comparable size. The sizable proportion of women employed in the city is responsible for this percentage. In 1960, almost half the women in Lewiston over the age of 14 were in the labor force as compared to only 30% to 40% in most cities.

Over half of local jobs (13,700) are within manufacturing industries which most likely means women are working on a full time basis outside their homes. Retail trades provide some 5,400 jobs. The above figures combined make up some 19,261 employment positions.

It is estimated that of the 5,000 employees in the local textile industries about 48% are females. Shoe manufacturing concerns hire about 6,000 workers and an authoritative source indicates 55% of these are women. A rough canvassing of two industries that employ between 100-200 individuals reveals that 65% of their labor force are women.

Why are there so many women in our local labor force? It is basically the low wage structure found in the community. A large skilled but relatively low wage labor reserve lives in or close to the twin cities. Wages average approximately $62.00 per week as compared to $88.00 in Portland, Maine and $92.00 in Boston in February, 1962. However, although this is a serious community problem in one sense, low labor costs are also a major attraction for many industries. With the latter comment, we can expect that employment of local women will not decrease because relatively low wages and over reliance on a high percentage of low wage female workers is another community problem. Many of New England's growing industries are looking for a sizable, low cost female labor force and attracting firms which specialize in higher paying male jobs is often difficult.

MENTAL HEALTH PLANNING

REGION 8

FINAL REPORT

SECTION III

MENTAL HEALTH PROBLEMS, RESOURCES AND NEEDS

MENTAL HEALTH PROBLEMS AND RESOURCES

Region 8, as mentioned, developed fourteen different Sub Committees to study problems and programs. Not all of these have been completed but sufficient data is available to give us the following picture.

PROBLEM CENTERED

I MENTAL HEALTH AND MEDICAL PRACTICE: The Sub Committee responsible for this area were to examine: a) the degree of acceptance of mental health problems and services by the medical community; and b) examine procedures by which the needs of psychiatric patients could better be understood.

The region has only three psychiatrist who reside within its geographical boundaries. Prior to 1958, the communities could not boast of having a psychiatrist except for short intervals when it had transitory psychiatrist. In 1958, the state-sponsored clinic with a psychiatrist-director was established in Lewiston, so the medical community had some opportunity to relate to a physician-psychiatrist. In 1961, the clinic was detached from the State Hospital, 30 miles away and the physician took up residence in the community. The following year, another psychiatrist set up full-time private practice in the area. And in 1963, a third psychiatrist took up private practice in Region 8.

The void of a physician-psychiatrist in the second largest urban center in Maine over a long period of time is believed to have contributed to a relatively high degree of apathy toward the psychiatric patient by the medical community. The availability of such specialists and resources (the latter mobilized primarily from the non-medical community) has reduced the apathy to a small degree.

The Sub Committee is much more emphatic about the role of the total communities and the physicians. Its report states: "Historically speaking,

the area has never fully accepted nor supported psychiatrists to any degree, especially in private practice... A certain segment of physicians have absolutely no regard or interest in this particular area of medicine...newer physicians...have an increased desire to seek such help...are quite puzzled by the lack of such resources...and consequently have sent patients out of the area or even out of state." A questionnaire was devised by the Sub Committee which was used with selected area physicians.

It covered five specific areas:

1) Awareness of local agencies.

2) Use of resources outside of the L&A area, and use of resources out of Maine.

3) Satisfaction with existing facilities.

4) Admission of psychiatric patients to local general hospitals.

5) Use of Federal Veterans Administration facility, and difficulty in emergency admissions.

Thirty-two physicians responded to the questionnaire. Their replies are documented as follows:

1) Twenty-six indicated they were acquainted with Child & Family Services and the Androscoggin Mental Health Clinic. The balance, six, stated they had no such awareness.

2) Twenty-two replied they utilized resources outside the Lewiston area and six sent patients out of the state. Whereas, ten indicated they do not refer out of the city and twenty-five do not refer out of Maine.

3) Twenty-three physicians pointed out they were dissatisfied with the existing facilities for the mentally ill, while only six could state they were contented.

4) Equally significant is the fact that fifteen responded they could admit psychiatric patients to the general hospitals and another fifteen responded in the negative.

5) Twenty-four could say they utilize Veterans Administration in Togus for their patients but six indicated they do not.

6) Of those who do use Veterans Administration, nine indicated they have no problem admitting such patients on week-ends and ten stated the contrary.

Unsolicited opinions from three different physicians indicated a need for: 1) increased services to children; 2) better communication between Augusta State Hospital and patients admitted or discharged, and 3) clarity of admitting psychiatric patients to local hospitals.

The two major hospitals in the area provide no formal mental health services and this probably adds to the void in the area. Gains have been made in this direction, however, through the private practice of one psychiatrist. He has full status at one hospital and courtesy status at the other. One hospital has definitely allowed admissions of private patients for inpatient care. Both hospitals and their physicians have made use of consultation, but of a very limited nature.

The Sub Committee's recommendations include the following:

1) Establishment of Visiting Nurse Services Program.

2) Implement formal lectures for staffs of both hospitals and the medical societies by mental health personnel.

3) Prepare and distribute to physicians Brief Bulletins pertaining to mental health activities through the MAINE MEDICAL JOURNAL.

4) Institute well-prepared education and information program for the area public on the subject of mental health problems and programs.

5) Utilize nucleus of interested physicians to deepen concern of other colleagues and move toward appropriate use of consultative services.

6) Expand existing mental health facilities and cover gaps of existing needs.

7) Clarify status of admitting psychiatric patients to community hospitals.

8) Increase lines of communication between local physicians and Augusta State Hospital.

II MENTAL HEALTH AND WELFARE: This particular Sub Committee was to: a) determine number of patients in the mental hospital in Augusta who were recipients of welfare and residing in Region 8 under extra-mural care. Also to determine how many patients in residence could be placed in the community if funds were available; b) determine availability of funds that could be used in behalf of indigent psychiatric patients; and c) recommend changes in ordinances in county government to better meet the needs of these patients.

Data from the State Hospital revealed Androscoggin County had 107 patients in rewidence as of December, 1964. It would appear, however, that only a small percentage of patients admitted from Region 8 are economically self-sustaining. A sampling of 89 cases revealed only 20% were covered by hospital insurance. This would seem to indicate that long-term hospitalization of patients from our area would be dependent on other than personal resources to cover the costs involved. Unless such services continued through the state-sponsored institutions, it would appear the cost for short-term hospitalization in a local hospital could be met by the majority of patients requiring this service. Indigents might fall in a different category.

By statute each community appropriates funds to care for the indigent. However, psychiatric patients are given no special preference. There is some latitude and variation in interpretations as to what constitutes "responsibility" by the individual community and welfare administrators and this includes the area of the indigent patient requiring medical care. The Director of the Welfare Department of the largest city in Region 8 indicated short-term treatment in a local hospital for the welfare patient with a psychiatric problem is not only a possibility but a responsibility of the community. Since there has been a void of formal experiences in assuming costs for psychiatric patients in general hospitals, there would need to be an educational program for town and city officials in Region 8 in order for such a program to be

effective. The area of medication equally holds true. The key to this problem is that the patient "has to be a welfare recipient" prior to required hospitalization.

Citizens who are recipients of State Health and Welfare grants are normally entitled to 45 days of hospitalization paid by the state. It would appear that short-term inpatient psychiatric services at local level could not be provided for this segment of our population unless federal and state policies were changed.

A major problem for community based short-term hospitalization centers about patients who are not considered economically indigent but would be classified as "medically indigent". These citizens can sustain themselves somewhat adequately in most areas of life but cannot afford hospital insurance of an expensive nature, or if they are covered their policies frequently do not permit psychiatric hospitalization.

The Aid to Families with Dependent Children and Aid to the Disabled programs, under auspices of the Maine Department of Health & Welfare are the only two major resources that do include grants-in-aid for the mentally disabled under certain conditions. There are no figures available for this report as to what percentage of Health & Welfare recipients in Region 8 fall in this category. The local district administrators believe, however, the policies governing eligibility are too rigid and should be modified so as to allow more psychiatric patients to benefit from grants. Very limited private foundations and funds are available and those that exist do not specify they can be relied on for psychiatric patients. Church welfare programs are mentioned but were not explored for specificity. Reference is made to county level.

The recipients of State Health & Welfare Services in Region 8 have access to a very limited diagnostic program of out patient mental health services.

A team is available one day a month. The district office sees a need for these services to be available on a broader scope. Diagnosis is not only insufficient in quantity but rather frustrating when treatment is indicated but not available. Community agencies have been used but again, they too are overloaded with the demand for services. Questions have been raised as to whether such services should be available on the basis of economic status of local citizens as opposed to the general public.

The Sub Committee recommended:

1) Some exploration be given to obtaining consultative services of a specialist who might be available to different communities and assist town officials with patients who have psychiatric needs. For instance, to help mobilize financial and other resources for the patient.

2) The members also recommend the passage of state and federal legislation to expand Disability grants for strictly mental illness conditions and payment of hospitalization for such Health & Welfare recipients in both general and state institutions.

3) Increased out patient diagnostic and treatment services.

III MENTAL HEALTH AND ALCOHOLISM: Function was to:

a) determine extent services are available in Region 8 and how these may be improved; b) review laws pertaining to alcoholics and how cases of alcoholism are disposed in courts; c) determine means of further reducing problem.

Calculating the prevalence of alcoholism is a difficult task since the definition of the alcoholic may vary. One common approach is to use 2% of the population which has been arrived at through some scientific methodology. On this basis Region 8 would have an estimate of 1,960+ alcoholics requiring some degree of specialized help. However, a sampling of two rural communities with a combined population of 1500-2000 reveals only 6 known alcoholics. This figure is of course a rough sampling and subject to personal interpretation since the known alcoholic is easier to observe.

One agency specializing in services to alcoholics in the urban area served 55 in 1964 through personal interviews. No figures are available from other resource agencies, including organizations such as Alcoholics Anonymous, Mental Health Clinic, Child & Family Services, Hospitals, etc. The County Sheriff's Department, for instance, in its listing of offenses of jail inmates refers to alcohol on 207 occasions in last year's report.

The Sub Committee concluded that Region 8 has a lower incidence of alcoholism than other areas. They attribute this to: 1) lower wage structure; 2) a high rate of unemployment; 3) strict liquor laws; 4) cultural patterns of French-Canadian-American population. A breakdown in these patterns the committee members believed frequently leads to alcoholism.

Services to the alcoholic are located primarily in the Lewiston & Auburn area and include:

1) The two general hospitals, who admit acute and emergency cases but provide no special services to the alcoholic outside of temporary hospitalization.

2) Alcoholics have access but infrequently use the out patient services of the Androsooggin Mental Health Clinic and Child and Family Services. Neither of these agencies single out alcoholism as a particular area of service or study. Self-motivation on the patient's part then becomes a prime factor of agency involvement.

3) The local state office of Alcoholic Rehabilitation probably does more in the area, directly, for the alcoholic and his family. It has managed to focus community attention on the problem through its services which include education, consultation, and medication, with a heavy emphasis on education, thus leaving a gap in the area of direct services.

4) There are three indigenous groups (AA, Al-Anon, and 12 Step Group), all very active. Although attempts have been made to establish similar groups in the rural area, this has not worked out too well for lack of interest. Distance is not too far from the Lewiston & Auburn groups and outside members are welcome. However, the distance from the extreme western part of Region 8 may create a problem.

5) There are a few general practitioners, attorneys and clergymen who have special interest in the problems of the alcoholic, although they have had no formal training in this field. Their sensitivity however has provided an additional resource for the area.

It is the conclusion of this particular committee that: 1) public information programs should be upgraded in the area if we are to expose alcoholism as a problem and courses appropriate for treatment. This should aim at both lay and professionals, especially physicians and clergymen and this might be implemented through schools, civic organizations, etc. Also, a volunteer group of speakers is suggested to supplement the efforts of the one counselor now available; 2) it is also believed that an answering phone service might be available week-ends and nights to direct persons to appropriate resources; 3) an AA group should be considered for the western part of the Region; 4) the Committee strongly urges activities which provide for more coordination between existing services.

IV CHILDREN AND YOUTH

Functions: a) to examine how sub-standard housing, working mothers,family disunity, illegitimacy takes its toll on minor children; 2) to study prevalence of emotional illness among children and youth; 3) recommend means of providing more adequate services.

Only one but a most significant report came from this particular Sub Committee. It was titled: "Investigation of Mental Health Program Specifically for Primary School Children".

The study concerned itself with children in Grades I-VI in Region 8. The investigator indicates most services available seem to focus on children and youths who present the following symptoms: juvenile delinquents, school dropouts, teen-age marriages, etc. In other words the youngsters who are already coping with rather serious pathology.

The northern part of Region 8 appears to have services of the Farmington Counseling Service. The western part is void of formal services although currently studying this problem through the University of Maine Extension program. Most services in the rural areas are rendered by school guidance personnel and those in the helping professions, i.e., clergymen, physicians. It is the impression of the investigator that school dropouts and teen-age pregnancies are two major problems prevalent in the rural areas. It is felt that services should be available in the lower elementary grades so that these problems could be identified and treated early rather than delay and face even more tragic circumstances.

The investigator points to school mental health services now available in the Lewiston-Auburn area under the auspices of the Child & Family Services as a prime example of what might be duplicated in the rural areas. It is suggested that for further follow-up a detailed report prepared by Child & Family Service should be read: "Mobilizing Community Resources To Help Troubled School Children".

Project reports completed by Child and Family Services were used to supplement the contents of this particular Sub Committee.

Working Mothers*

A major area of concern for the region is that of the high ratio of female employment. A professional survey conducted in 1962 revealed that almost half of the female population over the age of fourteen were in the labor market. This represents a higher level of female employment when compared with most cities which run between 30% to 40%.

The area appears to not only accept but even expect the employment status of its women. This would seem to be a cultural phenomenon that has existed prior to the national trend of a higher ratio of female employment. Textile and shoe manufacturing have been the two major industries of the area for over a one hundred year period.

"Work" could be seen as an institution in and of itself in our area. The above survey further revealed that over 45% of the population exceeding age 14 were employed in some capacity as compared to 40% and lower in most cities. One wonders if this has contributed to the fact that only 1/3 of the population go on to higher education, the value of work being held to such a high degree.

It is speculated that females hold 15,000 of the 30,000 employment positions in our area. If this is so then we can also speculate that half of these have minor children at home. If so, then there are probably 20,000 minor children with working mothers in Region 8.

Careful analysis needs to be made of this social phenomenon as it relates to:

- increased juvenile delinquency
- the development of emotional problems

*Based on project titled: "A Proposed Agency Project For Working Mothers And Their Children", Child and Family Services, Lewiston, Maine, 1962.

- the adequacy of proper substitute care programs
- school maladjustment
- family harmony or disunity
- physical and emotional demands placed on mothers
- traumatization of young children through ill-prepared separations and placements
- youth employment and school drop outs

Family Disorganization*

If the number of families terminated by divorce is an indicator of disorganization, then Region 8 is now faced with a serious problem as observed by the following data:

DIVORCES IN ANDROSCOGGIN COUNTY

1954	188	1959	163
1955	158	1960	179
1956	161	1961	155
1957	142	1962	172
1958	135	1963	199
	784		868

If we place such high value on marriage and family then we must ask why in the past ten years some 3,284 adults and the court decided to terminate such a significant bond. We must be concerned about the tragic consequences of divorce on children. In Androscoggin County minor children involved in divorce cases has increased at an alarming rate. For instance: 1961, 212 children; 1962, 272 children; and in 1963, 355 children or a total of 839 children in a short three year period. We must be even more concerned with the issue of whether or not we are providing adequate services to these couples. Specialized services which would assist in affecting a reconciliation so that the marriage and family unit could be preserved wherever possible. A quick

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*Based on paper titled: "The Need for Specialized Services to Domestic Relations Cases in Androscoggin County", Child and Family Services, Lewiston, Maine, September, 1964.

glance at Maine and our county would reveal that both have provided basic systems to protect the legal rights and pursuits of couples in conflict. However, it is obvious we need to expand or establish professional services which might serve to protect domestic unity and thereby making it possible for the court and legal counselors to have a better share in preventing family breakdown.

Despite the fact divorce has been granted, we frequently find the aftermath of a disrupted marriage continues for many months and even years. When children are involved, often they become embroiled and even used by parents who have not resolved their inner hostilities and anxieties. Open or subtle negative feelings toward the former spouse are expressed. Children become conflicted about their loyalty to one or the other parent. Visitation privileges become a tool to gain the ends of some parents rather than benefit to the children. Support payments become another means by which aggravation between the parents can be continued and court procedures repeated. This may even result in the incarceration of one spouse in jail.

Although a divorce finalizes the dissolvement of a marriage bond, in a legal sense, it seldomly settles the emotional trauma that exists prior, during, or after such proceedings. New problems of which parents themselves are frequently unaware are produced. The one-parent family is a paradox of our contemporary society. The loneliness experienced by a mother who also has to act as a father can never be adequately expressed. The balance usually found in a normal home is seldom to be experienced by the child who faces life without a positive male figure.

Absence of a parent through divorce is nothing similar to absence by death. The personal and social implications are much greater and have an entirely different meaning. It is common to find the child of the divorced family to somehow turn this adverse situation inwardly. He has much difficulty

separating himself emotionally from the situation. He often blames himself for having contributed to the family conflicts and even breakdown of a marriage.

There should be expansion of available professional services to couples seeking divorce which would take into consideration the varying dynamics which contribute to marital disharmony.

The Regional Committee would recommend the following:

1) The development of adequate day services to care for children of working mothers.

2) Expanded counseling services to both industries that employ mothers and to the families themselves.

3) Expanded mental health services in schools.

4) Expansion of services to courts in domestic relations cases.

4) Services to one-parent families.

5) Increase level of wage scale for head of household with view of reducing females in labor force and encourage industries to area whioh place emphasis on male labor.

7) Provide work-school programs to youths so they may remain remain in school.

8) Encourage local recreation agencies to reach out for the so-called "unreachable children".

V MENTAL HEALTH AND RELIGION: The functions of this Sub Committee were to: a) determine extent clergy is involved with parishioners having mental health problems; b) determine the value of implementing education program for clergy on mental health matters; c) examine role of clergy and church in mental health activities.

The Committee has been considerably active but has yet to complete its studies. Currently a questionnaire has been devised which shall be completed by the clergy in the area. Personal interviews will follow mailing of questionnaire. The questionnaire itself shall help establish the following:

a) academic background of clergy

b) presence of clergy who have had formal courses in Pastoral Psychology

c) determine whether such courses should be available in the region

d) determine whether a local chapter of the National Academy of Mental Health & Religion should be established

e) percentage of time spent in direct pastoral counseling

f) percentage of parishioners having serious emotional problems

g) familiarity and utilization of Mental Health Resources

h) appraisal of above

i) factors contributing to harmony or discord between clergy and mental health professions

j) familiarity and utilization of techniques in area of primary prevention in mental health

VI MENTAL HEALTH AND EDUCATION

Functions: 1) to determine extent of mental health services available in area schools; 2) to review possibility of establishing special classes for emotionally disturbed children; and 3) recommendations on upgrading mental health in academic settings.

A significant step was taken in the urban cities of Lewiston and Auburn when the public school departments of these two centers entered into a mental health program with the local Child and Family Services in 1962. The latest annual report of this service is incorporated in the Sub Committee's report. Following are the views of the Sub Committee and Regional Committee in regards to providing similar services to the rural areas and the private schools.

School Mental Health Services*

On August 31, 1964, the second year of the local School Mental Health Service Program was completed. This essential community service had its beginning in October, 1962, as a joint endeavor between the School Departments in Lewiston and Auburn and the Child and Family Service Agency of Lewiston-Auburn. It called for assigning one of the agency's staff member, a professionally qualified psychiatric social worker, to Grades I-VI of the public schools in the twin-communities. The goal focussed on demonstrating the value of such services to children whose personal and social conflicts interfered with their school adjustment.

Within the first eight months of operation, educators had referred well over one hundred children to the program. Before the completion of the first year, officials of both communities saw fit to appropriate funds so these essential services could continue. This was to be Lewiston & Auburn's effort to reach troubled children in the earlier stages, in order to prevent greater adjustment difficulties from developing in later years.

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*"Annual Report on School Mental Health Services, 1963-64, Child & Family Services

The fostering of a positive working relationship between the consultant and the school personnel became a primary task for the first year. It was recognized that this could come about with a deeper understanding of the program. Consequently, considerable effort was made to lay a solid foundation so the children and the schools could be more effectively served. This was accomplished through orientation conferences with both individual and groups of teachers. Obviously, this groundwork was time well spent. The consultant soon became overwhelmed with referrals. Before the first year ended, the educators expressed a deep concern and need to have the children directly evaluated and treated by the consultant. This became a priority request that could not be minimized.

We entered the second year, therefore, with mutual agreement that the consultant would expend most of his energies in direct treatment of the children and their parents. This necessarily cut further into his schedule and made him less accessible to the school personnel. However, constructive gains were made from this change. It enabled the consultant to provide individualized attention to both the youngsters and the circumstances contributing to their problems.

In 1963-64, close to 50 new youngsters were referred for services. These, plus 82 carried over from the previous year meant the consultant had to be concerned with some 130 children during the year.

The term "direct service" is used to indicate that the troubled child is personally involved for evaluative or treatment purposes. Since the program reaches the minor child, it is recognized that the parents, as a rule, are legally responsible for his welfare. In addition, it is found that the disturbances of a young child are frequently related in some way to the parental figures. These two elements become important to any aspect of direct service to the child. First, the parents need to be aware of the concern

expressed by the school, consultant, or agency toward the child. This knowledge is viewed both as a natural and a legal right. Secondly, only through parental cooperation, understanding, and involvement can direct services be really effective. Otherwise, we find parents becoming highly threatened with the idea their child may be "disturbed" and unknowingly create obstacles which serve to disrupt treatment plans. Experience and research have demonstrated parents are usually deeply concerned about their children. Not only do they desire to do what is right, but they often are equally capable, with help, to effect certain changes in the home which result in a better adjustment for their children. Most professionals have come to recognize that providing treatment only to the minor can tend to create or confirm a feeling for the parents that they are at fault.

For the above reasons, we found that the consultant in his second year of service succeeded in encouraging as many parents as possible to participate with him. This was accomplished through 282 office or home sessions and 82 telephone interviews with the parents. Children selected for direct services were seen either at home, school or office for 165 sessions.

The technical process of direct service incorporates three parts: exploration, diagnosis and treatment. These steps are followed once a referral is made to the consultant and a conclusion is reached that the child should receive direct services. The consultant obtains all information possible from the teacher and principal; school records, present and past, are reviewed carefully for other clinical information. The parents are usually seen to obtain a detailed outlook of the child's adjustment in the earlier and contemporary years. If indicated, medical and other pertinent reports are obtained. Certain symptoms or behavioral elements displayed by the child often point to the need for further understanding or confirmation of specific underlying dynamics operating within the personality structure. This is obtained through

the agency's psychologist or psychiatrist who interviews and examines the youngster through appropriate evaluative methods. Or, the consultant may discuss the case with the above mentioned staff members. For instance, in 1963-64, there were 38 psychiatric and psychological evaluations. The exploratory phase is completed once a diagnosis has been formulated. From the diagnosis, a treatment plan evolves. The child then may enter into weekly individual sessions with the consultant. His parents may also be seen for individual sessions. At times, both parents and the child are seen together in family therapy sessions. The primary aim of treatment is related to the nature of the child's difficulty with the expressed purpose of relieving or resolving the conflicts present.

A complication ever present in providing direct services to the troubled child and his parents is that the consultant may become so engrossed in this avenue of service he tends to overlook the role of the school. Since it is the school that first becomes concerned about the child, the consultant needs to closely collaborate with the teacher, principal, or other school staff members. Many of the findings resulting from service to the family need to be shared with the educators. This enables them to attain a deeper understanding of the child's problems and thus provide an atmosphere within the school setting which will enhance a more positive adjustment. The school is a partner in the treatment process. Over 400 such collaborative sessions were held with the educators in the year 1963-64, revealing the consultant was able to maintain a close working relationship with the school personnel.

There was a marked difference in the nature of professional services between the first and second year of the School Mental Health Program. Originally, the intent was for the Child and Family Services' staff member to provide strictly a consultative type of service to school personnel. He brought with him specialized knowledge of human behavior gained through graduate studies

and experience in practice. The sharing of certain childhood dynamics was directed toward enhancing the school's ability to deal with each child who was coping with personal or social adjustment problems. His role was more interpretive in nature. During the year 1962-63, some 226 consultative sessions were held with educators. However, in 1963-64, consultative services became of secondary importance and were drastically reduced as direct services appeared to be the preferred method; only 55 sessions came within the scope of consultation. It is expected that once the schools become more familiar with the overall program, consultation will experience an increase. However, this will probably come about only when the school faculties are comfortable that those children who need direct help are receiving it.

The decrease in consultative services was partially made up through another avenue of service that was introduced in 1963-64. A mental health film entitled: "If These Were Your Children" was acquired on loan from a state department. The film vividly illustrated the various types of childhood behavior as seen in most classrooms and the language behind the behavior; the film also pointed to the significance of the teacher's reactions and interactions with the children, and the influential role she plays in the child's life. In the second part of the film, one observed a panel of experts discussing and interpreting the meaning of child behavior. The principals of all the schools covered by the School Mental Health Program agreed about the value of the film in deepening the educator's awareness of certain positive mental health principles. As a result, the film was run on eight different occasions reaching over 150 teachers. The stimulation generated by this film precipitated the development of an educational program which is expected to be carried on by and for the teaching staff of one school.

Interpretation of the program to new school personnel, community officials

and the public-at-large is viewed as a continuous process. A report entitled: "Mobilizing Community Resources To Help Troubled Children" was completed in December, 1963, by the Executive Director of Child & Family Service. This 47 page report has been distributed widely to various interested officials in the communities and in the state. In October, 1963, the consultant, executive director of Child and Family Services, and the elementary school director in Auburn presented formal papers on the program to 400 professionals attending a state-wide conference in Portland. Requests have been received from Brunswick, Portland, Waterville, Saco, etc., for further information on the program and speaking engagements to specific groups contemplating similar services in their communities.

Four hundred copies of a brochure, "School Mental Health Services," were printed and used with school and other selected persons in the twin communities. The four page booklet briefly and concisely describes the overall program and its goals.

During the year 1963-64, the consultant was invited to address four different local Parent-Teacher's organizations. He took advantage of these opportunities to acquaint some 200 parents with the School Mental Health Program. In addition, the film, "Who Cares About Jamie" was presented to these groups. It illustrated how parents and other adults can help children develop capacity to cope with the stresses and strains of daily life.

The overwhelming demand for direct services obviously meant that not all the children could be reached. Normally, Child and Family Services attempts to limit an individual staff member's active caseload to thirty. Studies demonstrate if this number is exceeded quality of service suffers and children become mere statistical figures. The school principals and the consultant attempted to set up priorities as to which children were more urgently in need of immediate counsel. The others were placed on a waiting list until termination of one of the active cases. In order to avoid a discouragement of

referrals by school personnel, a referral form was devised. Teachers could then identify the child and the nature of his difficulties. The completed forms were turned over to the consultant for final disposition.

In June of 1964, the consultant took inventory of the youngsters referred to determine whether or not the services continued to be of value. Of 130 cases it was concluded that all but 18 children derived benefits from the program and that the children and/or the schools were more able to cope with certain afflictions. The youngsters could better turn their emotional energies to academic tasks which is seen as their primary goal in the school setting.

The School Department of one community conducted an independent study with school personnel in June, 1964. The results indicate that the respondents believed over two-thirds of the children referred had shown "much or some improvement." An overwhelming majority indicated the service had helped them better understand the child and to more adequately cope with the child. The above replies were supplemented with explanatory remarks which amply demonstrated the positive attitudes toward the program and why it is now a necessary part of school services. Impressions and suggestions by those who completed the school questionnaire reveals a strong desire to not only continue but also to increase the availability of services.

We have concluded that this added service in our local public elementary schools has made considerable strides in detecting, preventing, and alleviating children's actual and potential maladjustments. The positive reception of the services shown by our twin communities, particularly by those (school personnel and parents) who have been involved, further confirms our people's willingness to accept responsibility to help children confront and overcome stresses experienced in growing to maturity.

Rural Communities

The Sub Committee's investigation focussed more on the school in rural areas of Region 8 knowing the two major cities had documented material available. It is the Committee's belief that services now available in the cities should be extended to cover Turner, Mechanic Falls, Greene, Leeds, Webster, Wales, Buckfield, Bowdoin, Poland, Lisbon and Durham. In other words, these communities are relatively small in population and geographically close to the urban centers so that they could be adequately served by the same but expanded program.

However, the western part of Region 8 represents some unique aspects. Norway, West Paris, Paris and Oxford are geographically too distant from the urban centers to conveniently use their facilities (school service wise) and yet make up a population of close to 10,000. One school (secondary) in that area estimates it has a minimum of 60 students in need of specialized help beyond what can be provided by its two guidance counselors and a part-time school nurse.

Although they have access to the Mobile Psychiatric Unit, this is limited to state Health & Welfare recipients, giving a connotation the child must be underpriviledged before being accepted. Even this service is very limited and distant. There is a complete void in the area of services for children and adults who suffer from psychoses, neuroses, or other emotional conditions. It is not unusual to find people travelling 100 miles to receive services.

Although the school mentioned earlier has 82 teachers, none have had inservice training regarding identifying, understanding and relating to emotionally disturbed children. There exists a serious need for workshops on mental health plus consultation to educators on specific cases.

A thorough study of six elementary schools in the rural areas having a total population of about 1,200 children revealed that close to 60% of these youngsters were identified as needing immediate attention and no possibility of receiving it.

All of the educators contacted were sincerely convinced of the need for a local mental health service program.

The Regional Committee with the Chairman of the Sub Committee reached the following conclusions:

1) Lewiston & Auburn school mental health program needs to be expanded. One staff member to cover 20 elementary schools, twelve principals, 178 teachers and 5,000 pupils might be a beginning but obviously could not be considered adequate in view of the number of referrals.

2) Such services should be expanded to rural communities immediately around the cities of Lewiston & Auburn.

3) Serious consideration should be given to establishing a mental health program in the western part of Region 8.

4) Thought should be given to develop special classrooms for disturbed children.

5) Consideration be given to provide services to parochial school children which number in excess of 5,000.

6) Encourage the Teachers Colleges to insert in increasing amounts courses in behavioral sciences.

7) Develop seminars and workshops in mental health for practicing educators.

VII SUB COMMITTEE ON DELINQUENCY

Functions: 1) determine extent of juvenile and adult delinquency; 2) review procedures of handling juvenile matters; 3) availability of personnel to handle criminal matters.

The Sub Committee was unable to come through with a specific report. However, some examination of this mental health related problem had been completed previously by other organizations and groups. Certain pertinent aspects of two reports* have been used to complete this section. However, it is well to recognize that data included pertains solely to the city of Lewiston since the two projects cited were limited to that community. It is recognized that the rural communities and the city of Auburn have their own particular problems regarding juvenile delinquency and adult crime. Time prevents adequate study of these areas.

It is estimated that for every child that comes to the juvenile court three others are apprehended by the police departments for acts against the communities. Lewiston-Auburn has its share of problems with its youngsters in conflict with society as other semi-urban areas in our country. For example, in 1950 our Lewiston Court disposed of some 125 juvenile matters and nine years later had to cope with 370 youngsters in one year. The national trend in juvenile delinquency is partially reflected in our own community by the great increase in the past five years as indicated in the following chart.

CHART**

YEAR	AGE UNDER 7	7	8	9	10	11	12	13	14	15	16	TOTAL
1959				14	24	28	38	49	64	82	75	338
1960	3	4	23	28	29	37	52	54	60	53	45	388
1961	2	3	11	9	17	19	34	48	64	60	42	309
1962	21	10	15	16	34	31	26	73	109	122	70	541
1963	10	4	5	13	16	29	26	55	93	107	67	428

*Mobilizing Community Resources To Help Troubled School Children, Child and Family Services, December, 1963

**Project Youth, Lewiston Youth Commission, December, 1964

Although we have witnessed an alarming increase in the number of delinquents, contrary to the national trend our rate of increase has been slightly less than the rate of increase in population of school age children. In 1959, there was a total school enrollment in Lewiston of 8,868. In that year, 338 or 4 percent of these youths were involved in delinquent activities. In 1963, with a school population of 9,845, we had 428 youths, or 4.3 percent brought to the attention of the Juvenile Police Officer. This represents an increase of 21.3 percent in juvenile delinquency. The 1964 total appears to be a near record number.

Should it matter whether one or one thousand children are in trouble of this nature? If we place value on each human being than it should be our goal to see that each troubled child has opportunity to resolve his conflicts. In the past six years our county has committed some 160 children to the state correctional institution for youths in conflicts. In a recent four year period we sentenced over 130 of our fellow adult citizens to reformatories and prisons. In our community, male juvenile offenders outnumber the female juvenile offender by 9 to 1. This is extremely wide in relationship to the national average. The significance of this situation is discussed later.

The fact that 50% of our offenders are repeaters emphasize dramatically the need for secondary preventions in the form of treatment and rehabilitation services on a multi-professional approach. The delinquent in our community has some unique characteristics. Only 16% of these youngsters are from families so economically deprived as to require financial assistance from the state. Of greater significance is the fact that only 8% of these youngsters are school dropouts. A fact which demands particular attention is that while 70% of the male juvenile delinquents are Franco-American, 60% of the female offenders are non-Franco. This fact suggests certain factors within the Franco-American culture which are non-conducive to delinquency in females.

A prominent characteristic among our juvenile offenders is a home where both parents are present. Seventy-five percent are described as intact families. With few exceptions the remaining 25% consist of fatherless homes.

From a socio-economic point of view, 85% of these families are in the low class. There seems to be a near equal distribution between the lower and upper divisions of the low class, with a slight edge favoring the upper lower class.

The descriptive picture of the local male juvenile delinquent would be a youngster between the ages of 14 and 16, who attends a public junior high school. There are equal chances that he is a repeater. He is from a Franco-American, Roman Catholic family which is economically independent, with both parents at home and classified in the upper lower socio-economic class.

The local female juvenile offender is between the ages of 14 and 16, also with equal chances of being a repeater. She attends a public junior high school. She is from a non-Franco-American family which is not Roman Catholic and which is economically independent, although not as financially secure as the family of the male offender. She also has a physically intact family with both parents at home and is assigned to the low socio-economic strata, more probably in the lower division.

Neither the juvenile officer nor the juvenile court judge has sufficient resources at their disposal to give the best attention and disposition to the youngsters who desperately need it. The alternative he has at his disposal is to either reprimand them or bring them to juvenile court. If brought to juvenile court, the judge has only two alternatives, probation or a sentence to the Boy's or Girl's Training Center. Out of these limitations the juvenile officer must settle for a verbal reprimand in the great majority of cases. The resort to reprimand has increased from 180 out of 371 cases in 1960, to 325 of 412 cases in 1963. Those sentenced to the State School has remained relatively constant, increasing only from 15 to 22.

We have come to recognize there is no one specific element that contributes toward our children developing conflict with their community. We do know that slum areas, broken homes, tense family relationships, repeated failure to succeed in important endeavors, personality deterioration, subtle and overt parental rejection, cultural or other environmental influences all in some way contribute to the overall problem. Literally hundreds of studies have been completed in our attempt to cope with the youthful offender. We have also studied adult criminals and found their own childhoods filled with conflicts.

In fact, the common theme running through the results of most of these studies point to faulty childhood development as a major contributing factor to a career in crime or anti-social acts. This provides us with a major clue as to the direction communities should take in combating juvenile delinquency and that is prevention. Yet, most of our efforts have been geared to rehabilitating the youngster who has been adjudicated a delinquent. Vast systems of probation and institutionalization have been established in an effort to prevent the youngster from breaking the law in the first place despite the fact that we can now predict fairly accurately which children between ages 5-10 will become delinquent.

There appears to be little question that services to the juvenile delinquent has to be expanded across the board for Region 8. Although there are diagnostic services available to the courts these have been used inconsistently and are not coordinated in any way. Officially, Lewiston is the only city that has a juvenile officer, who is overloaded with children coming to his attention. The rural communities have no specialized programs for children who act out their personality or family problems. Auburn unofficially assigns a member of the police department to cover juvenile matters. Treatment of the youngster and his family is limited. Child and Family Services and Health

and Welfare attempt to provide treatment but because they are overloaded only a small percentage of these youngsters can be helped.

The following recommendations are made:

1) Increased mental health manpower to provide better coordinated diagnostic services and greater quantity of treatment.

2) Initiation of group therapy and group education programs for these youngsters above and beyond work done by Child and Family Services and the Probation Department.

3) Increased police manpower with specialized knowledge assigned to work with these youngsters and their families.

4) Consultative services to police, courts and other law enforcement officials.

VIII SUB COMMITTEE ON MENTAL HEALTH AND THE ELDERLY

Functions: a) to study population trends relative to the Elderly; b) to determine availability of nursing, boarding homes and other related services.

Population Trends For Region 8:

"Census figures show that in the decade 1950-60 the population of the area increased by about 2,000 persons. Probably the increase for 1960-65 has been close to 1,000.

For those over 65, in 1960 the percentage of the total population was 10.5%. It increased to 11.3% in 1961, and is probably 11.50% in 1965. The population of Region 8 is now supposedly 98,400. Therefore the number of people over 65 in Region 8 must be about 11,300.

Number Mentally Ill:

In 1960, 1 in 10 persons in Maine were thought to be mentally ill. On this basis there are now in Region 8, 1,000 plus persons who are mentally disturbed. How many are receiving help of a constructive nature is uncertain.

The Androscoggin Mental Health Clinic which serves an area approximately the same as Region 8 reports that it deals with only one or two patients in a year who have been at Augusta. The number of patients who come to the clinic but remain at home is eight or ten a year.

Conclusions:

- If the estimate of the number of mentally disturbed is realistic, many such people are not receiving the specialized attention they need.
- The number of such is great enough to be of real concern.
- With increased attention to their needs the number proportionally will not increase greatly.

Maintaining Mental Health:

As revealed in interviews and by the replies of 8 clergymen to a questionnaire. (Fifteen were sent.)

A. Causes of extreme anxiety, or mental disturbance of the elderly who come to the Androsooggin Mental Health Clinic are as follows:

1. Occasionally it is physical deterioration or mal-function.
2. Financial worries, including how to meet medical bills.
3. Environmental, such as loneliness, or poor family relationship.

B. The special needs of the elderly, as seen by the ministers:
"Lots of love, patience and understanding"; "companionship"; "fellowship with others of like age"; "activities to keep them happily busy"; "a feeling of being useful, or at least of belonging to someone or some group, a love that is outgoing"; "to feel they are wanted and needed"; "promptness when in need of medical attention"; "help in the housework"; "nursing home near friends".
Asked: "Are any suffering because their needs are not met"?
Three said in effect: "Not especially according to my knowledge".
Five said: "Yes", because their needs as listed above are not met.
One mentioned the inadequacy of Old Age Assistance.

C. AN IMPORTANT OBSERVATION made by Miss Macauley, Social Worker of the Central Maine General Hospital was that it comes as a great shock to many to be faced with the fact that upon leaving the hospital they must leave their home because it cannot provide the nursing care needed. The personal physician can be a great help. Miss Macauley contacts the Nursing Home to which the patient will go in an effort to make the transition less disturbing. Part of the trouble for some is their pride making them reluctant to ask for public aid. Also children are not always as considerate as they should be.

Economic Factors:

It is agreed that poverty does sometimes result in mental ill health. From the report "Poverty in Maine", dated October, 1964, we learn that in 1960, the average percent for the area was:

Androscoggin County,	families under $3000	18.3%
Oxford County,	" " "	22.2%

Those responsible for assessing need and distributing aid are: a) the State Health & Welfare Department ; b) the City Welfare Officer, for Lewiston and Auburn; c) Town Manager or Head Selectman, for the towns.

We have some evidence that some Town officers have a rather negative attitude and discourage people who apply.

Insofar as inadequate income may be a factor causing mental strain, its effect is enhanced in the present time by the fact that a great many receiving Social Security checks were employed at a time when wages were lower; and though their benefits have been increased from time to time the purchasing power of their check is still less. The average monthly return benefit in this part of Maine is approximately $75.00.

While on the positive side Old Age Assistance, Aid to the Disabled, and the Nursing Pool provide grants where need is proved, the amounts available do not seem to have kept up with the rising cost of living. Some form of medical care for the aged would provide some relief. Moreover, as time passes, more people will receive Social Security benefits larger because earned on higher wages.

Availability of Nursing Homes:

The report of a committee of doctors who investigated the situation on a state-wide basis is being publicized by the Department of Health & Welfare and should soon be in print. Therefore this Sub Committee has made a very limited study.

A. Availability: The Yellow Pages of the area telephone book list 19 Nursing and Convalescent Homes, and in addition three Rest Homes. As we often hear of persons being admitted to some nursing home, we believe

anyone needing to enter a home may find a place. For instance, in December, 1964, Montello Manor had 10 vacancies, and was planning facilities for 41 more persons.

As far as we know only Marcotte Home, Montello Manor in Lewiston, Old Ladies Home in Auburn, and the Lamp in Lisbon have buildings built for the purpose. Most, if not all the other homes in Region 8 are in converted residences of various sizes. They vary in attractiveness and quality of accommodations.

Two Homes, the Lamp and Montello Manor have been recently built to the latest specifications and are well-equipped.

Several towns in the area do not have Nursing Homes: Webster, Bowdoin, Buckfield, Leeds, Minot, Poland, perhaps others.

B. Costs:

1. Some private homes take elderly people as boarders for $25/week.
2. Montello Manor charges: Private Room - $20/day; Semi-Private - 1st 30 days - $12/day; 2nd 30 days - $11/day.
   Medical attendance provided by the patient's physician is paid by the patient and also the cost of medicines. The Manor accepts $200/month from those patients who qualify for that amount of assistance from the Nursing Pool.
3. The Lamp charges $65/week. Others charge varying amounts.
4. Most Nursing Homes now charge on a daily, weekly, or monthly rate, and do not require an initial contribution.

C. An Example of Good Care is shown in the case of Montello Manor. One patient sent by a psychiatrist improved much under the sympathetic care of the staff. Those showing mental regression, i.e. loss of memory, etc., are quite harmless and easily guided. A patient who was quite unresponsive and withdrawn was asked "as a favor" to visit at least one bedridden patient a day. Soon she was going the rounds, distributing the mail, and became very happy.

D. Measures for Improvement:

1. A law requiring adequate fire protection should be passed.

2. Every effort should be made to get nurses and aides better qualified to serve the mental and emotional needs of the elderly inmates. One step might be to encourage attendance of the staff members at lectures by experts.

3. Standards set for licensing should be rigidly enforced.

E. Other Service Organizations:

Clubs:

1. Evergreen Club - this Club for the Elderly of Lewiston-Auburn was organized several years ago and is sponsored by the YWCA. It meets regularly each month in the Kate Anthony House, Turner Street, Auburn. The average attendance is around 70.

2. Auburn Senior Citizen's Club - this Club has been in existence for nearly two years. It is sponsored by the Recreation Department of Auburn, but elects its own officers and is wholly responsible for its programs. It meets monthly in the Unitarian-Universalist Church, Elm Street, Auburn. There are no dues. People of towns adjacent to Auburn are welcomed as members. There are about 90 names on the list to whom the monthly "Bulletin" is sent. Average attendance is around 55. A club room is also available at the Church.

3. The Program for Senior Citizens of the Lewiston Recreation Department, along with its other activities, the Department promotes activities for the elderly, such as games, entertainments, bus trips financed by the Department.

4. The Town of Poland has a Community Club, membership being open to any citizens giving one dollar a year.

5. The Churches - we are sure that every pastor visits the elderly of his parish, particularly those who are shut-in or ill. However, we have not received evidence that any church of the area has drawn up a program aimed at serving the needs of its elderly members.

6. The United Baptist Church, Lewiston, employs on part-time basis a Visitor who does make special effort to call on shut-ins and those who are ill, whether at their homes or in the hospital. The Church has a room set apart as a "Parlor" with comfortable chairs, magazines, books and T.V. This is available for elderly folks.

7. The Leeds Community Church through its deacons offer gifts at Christmas, visitation and financial help when needed.

F. Housing:

Proper housing may be a factor in maintaining mental health. We

have no statistics. Mr. Raymond A. Dow of the State Welfare Office in Lewiston recently told the Auburn Study Committee that, in his opinion, the housing for the elderly in Auburn is good. Personal observation seems to confirm his opinion. Lewiston hopes to erect an apartment for low-priced housing for the elderly.

Housing for Senior Citizens in Rural Areas: Pamphlet PA-640 of the Farmers Home Administration, U.S. Department of Agriculture, states: "The Farmers Home Administration, under Title V of the Housing Act of 1949, as amended in 1962, makes direct and insured loans to provide rental housing in rural areas for senior citizens, 62 years of age or older.'

'These loans fill a housing credit gap in rural areas and offer opportunity for senior citizens to maintain their independence and to live out their lives in dignity in the communities where they have spent their working days and where their roots are deepest."

G. Additional Observations and Recommendations:

1. Planning for Retirement; Retirement is generally taking place at age 62 or 65 and is proving to be an upsetting experience for many men, more than women, that it is becoming a matter of public concern. In some places, public and private agencies are trying to prepare people to make this adjustment. However, in this area, we do not find evidence of anything being done.

We suggest that the State Committee on the Aging should prepare a plan whereby either through the State Department concerned with labor relations, or, by direct contact with Labor Unions and with employers of large groups of people, they will be stimulated to feel responsible for beginning before retirement to prepare for it.

In rural areas, Churches, Extension groups and public spirited

citizens should be alerted and given the necessary information to help prepare older people in rural areas for days of inactivity.

2. Employment for the elderly; We have no statistics on the number of people over 65 who are employed in gainful employment. No doubt many who wish to be are not. There are elderly persons, mostly women, who are employed as housekeepers for invalids or for widowers.

3. Volunteer activities; Many people among the "elderly" employ their time and talents in the service of others without remuneration. This should be encouraged as it is the best mental therapy known to us. Examples are: a) as officers and workers in the church and its related organizations; b) as Grey Ladies and Volunteers in the Hospitals; c) as "phone pals"; d) a very significant effort to thus engage elderly persons in useful activities called "HELPMATE" which has come to our attention.

We quote from their Fact Sheet: "HELPMATE is a Volunteer Bureau project of the Greater Philadelphia Section, National Council of Jewish Women, in cooperation with the Council on Volunteers of the Health and Welfare Council...HELPMATE gives the retired person an opportunity to continue his contribution to society and his community through volunteer services especially suited to him. It provides a place where the retired person may be interviewed and referred to volunteer work in approved Health, Welfare, Educational and Recreational Agencies. This project has established the need for over 1,200 older volunteers weekly in the Philadelphia area and has referred volunteers to assignments in over seventy agencies."

A professional Executive Director is employed. It received no public funds. Anyone over 60 may register as a potential volunteer.

"HELPMATE has proved the validity of the concept that THERE IS NO RETIREMENT FROM THE NEED TO BE USEFUL. The opportunity afforded by HELPMATE has brought satisfaction to the older adults... The volunteers are currently working as assistants, sales people, hospital aides, "friendly visitors" and readers to the blind, among other jobs."

Information is available from National Council of Jewish Women, One West 47th Street, New York 36, N.Y.

4. Programs which serve the physical and mental health of the elderly: These might well be introduced in Maine.

   A. Foster Homes for Older People: The plan is being successfully promoted in Pennsylvania, Connecticut, New York City, Rochester, N.Y., and other places. In several Pennsylvania counties the plan received aid from the State Office for the Aging. A family opens its home to an elderly couple or to an individual. This program is described in "Aging", August, 1964, page 3.

   B. The Homemaker Service in Sioux City, Iowa, was established by the City Public Health Department in October, 1963, to help ill and handicapped persons, including the elderly, to stay at home with their families instead of going into nursing homes or hospitals. The Service sends a homemaker into an older person's home two or three times a week to help manage the household. This service is described in "Aging", November, 1964, page 5. Also leaflet # 20201, President's Council on Aging.

   C. Day Camps for Older People: The Philadelphia Center for Older People has been conducting a summer day camp for its members since 1959. The Lewiston-Auburn Evergreen Club and Auburn Senior Citizens' Clubs have done something similar on a smaller scale. Also Lewiston Recreation Department. This is described in "Aging", June, 1964, page 5.

In CONCLUSION we suggest that:

1. More money is needed from State and Local Authorities to make possible a more aggressive program for the Elderly.

2. On the State level, the Committee on the Aging should be given a budget large enough for it to employ a full time staff and to do the things necessary for more vigorously promoting the interests and welfare of the older citizens of the state, nearly 100,000 in number.

3. More aggressive techniques in reaching out to the elderly be devised.

4. Information and Coordinating Bodies be activated or established.

PROGRAM CENTERED

IX SUB COMMITTEE ON RESEARCH AND EVALUATION

Functions: a) to review statistical systems of existing facilities; b) compare with federal and state systems; c) analyze above with view of making recommendations; d) recommendations regarding possible uniformity of statistical accounting; e) investigate feasibility of research on mental health in region; f) determine extent research is done in area; g) recommendations regarding implementation of research program.

The Committee mailed a form letter to numerous area agencies which requested essentially:

a) copies of statistical and evaluative forms or annual reports

b) enlisted ideas regarding uniform statistical accounting and formulation of research programs

The above effort resulted in five pieces of correspondence from as many agencies and three annual reports. One focussed on nature of its agency's services and expressed the opinion there is dire need for an agency to whom emotionally disturbed patients can be immediately referred. A second letter described how its character building and group work agency is related to mental health through occasional referral of its clientele to mental health services, general education on mental health, and social action by groups within the agency on matters affecting mental health. The third letter concluded very little research is done in their office (state social service program). However, reference is made to the fact that "statistics are kept up to date" and because of federal demands they find "it necessary to undertake more data collection". The writer agrees that disciplined research should be a goal for the area. A fourth letter (general hospital) explained that accounting is based on a guide published by the American Hospital Association. The same hospital depends on affiliated associations for surveys of problems and programs. The Annual Guide Issue of Hospitals is used for

comparative purposes. Strengths and weaknesses of programs and services are evaluated by the accreditation body.

The fifth letter promised suggestions in a later letter which did not materialize.

Although annual reports were received from some of the facilities, the Committee did not have time to make a comparative analysis of these, which might have provided some light on the subject. Forms used by different agencies were later collected by the Regional Coordinators. Effort has yet to be made to review these for similarities, differences and research feasibility.

The Science Research Associates in New York in their study of overall human services rendered by one particular community in a given month found that over 45% of professional services was being used by the small percentage of multi-problem families. In other words, it would appear that each community has a core of families who from generation to generation place a heavy demand on these services.

It would seem appropriate for agencies with a high degree of similarities in function to consider developing a uniform system of accounting for clients, patients or families.

Since Region 8 has been void of an active centralized coordinating body, such as a community council, ongoing research is rather unheard of in our area. Sporadic and limited research projects have been conducted by individual agencies. Such activities have been oriented mostly toward internal goals. Research aimed at reviewing factors contributing to mental health problems from an epidemiological point of view has yet to be developed. Most services have evolved from symptom oriented concepts and usually fall in specific categories.

X SUB COMMITTEE ON MANPOWER

Functions: 1) to review availability of professional manpower in Region 8; 2) to determine nature of professional background, location of manpower, functions of responsibility, and salary comparison; 3) to examine potential use of volunteers; 4) determine shortages and make recommendations on reducing same.

The Sub Committee by use of a questionnaire was able to do a significant job in reviewing availability of manpower. Although Region 8 does not have an abundance of professional personnel who deal with mental health problems a careful overview would indicate it does possess assets. A breakdown might be as follows:

Medical Psychiatrists	3
Certified Psychologists	4
Qualified Social Workers	15

In addition there are probably in the neighborhood of 30 agency trained social workers and ten-fifteen school staff members serving as guidance personnel.

Medical Psychiatrists

One psychiatrist is in full time private practice. Another is in 3/4 private practice, the balance of his time is used in consultative, diagnostic and limited treatment for one private agency and two public agencies.

The third psychiatrist is considered full time with a public agency but has private practice during off agency hours.

Qualified Psychologists

There are two psychologists at one of the public agencies (state-sponsored). One of these is on educational leave, completing his doctorates, the other (Ph.D.) conducts private practice during off agency hours and serves as a consultant to a pre-school children clinic for the retarded and a work-shop for the intellectually handicapped.

There are two other psychologists who are in the region part-time. One for a Mobile Unit and another for a private agency. Bates College has several professional people who hold degrees in psychology, but limit their time to full time faculty positions.

Qualified Social Workers

1 Mental Health Clinic
5 Child and Family Services
1 Crippled Children's Clinic Services
1 Jewish Community Center
7 Department of Health & Welfare District Office

Since the greater majority of qualified personnel are employed by the State Departments their salaries are part of the Maine civil service and personnel policies structures. Although at one time these salaries were considered incomparable with other states the state legislature has continually upgraded the salaries so that their is now some favorable comparison. A recent salary survey by an outside firm has gone a long way to rectify the situation.

A survey in 1962 by the Personnel Committee of Child & Family Services comparing its salaries with other similar and related programs in Maine and New England resulted in upgrading of salaries now commensurate and even exceeding other areas. This is further confirmed by reviewing relatively low percentage of staff turnover in local agencies as opposed to the experience elsewheres.

The availability of funds for mental health personnel have probably yet to be fully explored. Precedence has been set by the United Fund in its expending monies toward psychiatric social workers rendering service with undifferentiated caseloads which include children and adults coping with personality disorders. The municipal governments of the two cities in the region are supporting the salaries of a psychiatric social worker and part-time psychiatric and psychological services. The county government is about to embark on an appropriation to Child & Family Services which should help expand services to disturbed children. The other dozen or more rural

communities, the churches, the private schools and colleges have yet to be approached for possible participation.

The Committee's report called for additional personnel in the available resources (outlined in Facilities Sub Committee) and especially within the school systems (outlined in Mental Health & Education Sub Committee). It also suggested that such personnel make more efforts to increase level of knowledge to the "front-line professions" such as, teachers, nurses, clergy, police officers, etc. Reference is made that mental health personnel communicate more closely with the general hospitals and the medical community to increase toleration and acceptance of the psychiatric needs of patients.

The report further emphasizes the need for increased communication and information between the mental health personnel and the total public. It also called attention to the geographical distances involved in the rural areas and how availability of immediate services is important. They particularly identified the complete void of mental health personnel in rural areas.

They identified apparent unawareness of volunteer services. It is known that several agencies, such as YWCA, Jewish Community Center and Child and Family Services conduct a variety of community educational programs and that these are essentially under the guidance of volunteer groups. The American Legion, in addition, has a routine program for the mentally ill in our nearby state and federal hospitals. It is obvious however that these activities or even information pertaining to each has yet to be pulled together.

Recruitment, as a means of reducing shortages of personnel in the behavioral sciences is a most significant issue. There exists a Psychology and Sociology Club at the local college. Efforts should be made to establish similar or related clubs at high school level. Career Days are organized in most educational programs. Efforts should be made to confirm that representatives from the mental health fields are included. The rural schools especially

should be covered. "Open Day" programs should be established by the appropriate agencies and invitations extended to special groups as a means of both orientation and possible recruitment.

If any attempts were made to summarize the manpower problem probably one effective way would be to review the personal comments of a respondent. This particular person is a native of Region 8 and has demonstrated a deep interest in his community. His professional capacity as a former Municipal Court Judge, attorney, Director of the local United Fund and other civic activities places him in a unique position of sensitivity to the needs of his people:

"A good Mental Health program originates in the home with a follow through in our schools and industries (jobs). I therefore suggest that clergy and all professionals upgrade their knowledge and understanding of people in need of help. As an attorney I have seen an unbelievable rise in mental health problems. Others in my profession agree that the ordinary divorce rate and personal injury suits have brought forward situations which indicate a "sick" community climate. All degrees of mental illness have been observed, from mild neurosis to extreme psychosis but the bulk of what I have seen can be called "sociopaths", people who as a result of family difficulties find themselves unable to cope in our society. "Values" seem to be transparent. Inability to adapt or accept realistic situations are frequent. Authority means very little and people seem to be more "trapped" by their surroundings and circumstances than they are able to realistically cope with. I cannot say whether the answer is as simple as to increase all of our psychiatric services and personnel! No, the answer is more than that. It would be helpful if Child and Family Services and Mental Health Clinic had more personnel and funds, as it would also be if our schools had more guidance directors and sufficient testing to aid children solve their emotional and realistic problems. It might even be extremely beneficial if we had full time psychiatrists and psychologists to work in all our schools (Lewiston and Auburn).'

'To find the answer we must look at our communities to see if they meet our needs emotionally, materially, spiritually. In all of these areas I personally see extreme needs. Thank God for what we have. We do presently have excellent but overworked social agencies. But the problems can best be observed in the teenage and pre-teenage groups and the 25-35 year age group. It is in these areas that the present day stresses and strains exist. We therefore have to work with these areas to correct early problems before they explode into areas of serious mental disease. The State, County and Communities have to be made aware that funds are desperately needed to cope with local facilities and local problems. The State institutions are all bursting at their seams they are so overcrowded. Local problems can best be handled locally and our local hospitals should have wards and trained personnel to cope with our local problems. The Pineland Hospital should be supplemented with a "half-way" institution to take care of children in need of immediate treatment but not necessarily permanent hospitalization. There is a desperate need of and for foster homes with trained and educated parents who are ready to assume new and needed responsibilities, too many people today are taking the attitude that they are not their brother's keepers and are shedding responsibility by not participating to help the needy."

XI SUB COMMITTEE ON REHABILITATION AND EMPLOYMENT

Functions: a) to identify and evaluate facilities providing vocational and educational rehabilitation and employment for the mentally ill; b) to give consideration on how these may be improved.

The Committee broadened its scope of evaluation somewhat beyond its basic purpose by including in addition to Vocational Rehabilitation office and the Maine Employment Security office, three other programs, i.e., Androscoggin Mental Health Clinic, Child & Family Services and Occupational Training Center. All of these are identified as Educational Rehabilitation Facilities. The Vocational Rehabilitation office is listed alone as a Vocational Rehabilitation Facility.

Training Facilities category is treated as follows:

"No training facilities are available geared specifically to training just persons having a mental illness for gainful employment. However, the Division of Vocational Rehabilitation through its counselor in Region 8 can arrange training for persons who are ready by making special arrangements with area employers for on the job training. Such individuals, if qualified, can also be placed in business schools, colleges, vocational schools, industry and service occupations. Facilities outside the state are often used by the Division for selected cases.'

'The Maine Employment Security Commission and related programs such as the Manpower Development Training Act and the Youth Opportunity program also offer specialized training programs which could include persons having had mental illness and who have a satisfactory prognosis, including work potential."

Since evaluation of Child & Family Services, Androscoggin Mental Health Clinic and Occupational Center are treated elsewhere, the Committee's evaluation of facilities will be limited to the Vocational Rehabilitation office, Maine Employment Security Commission, and Training Facilities.

Vocational Rehabilitation Office:

"The one counselor assigned to cover the towns making up the Region covered by the scope of this project report is limited in the amount of time he is able to devote to the client with a diagnosis of mental illness. The present counselor has had limited training in dealing with the problem of mental illness. Geographically he covers an area much larger than Region 8, and a large number of clients must be served, including the physically disabled and the mentally retarded. It is estimated that some 45 clients were referred in the past year who had some sort of mental illness. It is estimated that 12 were initiated to some form of training program. Factors such as financial restrictions every two years on the state level, heavy caseload, large areas to serve, all seriously restrict the depth to which the mentally ill client may be served."

Maine Employment Security Commission:

"This organization maintains a staff of trained employment counselors who deal with the special employment problems of all disabled individuals. Due to large caseloads and time limitations, counseling is not always available in depth. There is probably also a need for training in the problems of mental illness which certainly are unique with regard to employment. Staffing for a large scale program would seem to be inadequate."

Training Facilities:

"Training agencies generally speaking are agreeable to acceptance of cases with a diagnosis of mental illness provided a complete diagnostic evaluation has been done and that it is reasonable to assume that the prognosis is such that they can expect the individual to be successful in training and eventual placement. These training facilities would include those previously mentioned."

The Committee believes that these facilities can be improved in the following manner:

A. Division of Vocational Rehabilitation

1. More inservice training for counselor in order that he may have better understanding of mental illness problems and thus be better able to cope with and counsel those cases referred.
2. More staff needed to fully service existing cases and extend service to those not now receiving it.
3. Establishment of more effective referral policy from institutions or organizations working with the mentally ill.

B. Maine Employment Security Commission

1. Continuation and implementation of existing referral system.
2. According to local Maine Employment Security Commission sources, inservice training program, such as workshops would be invaluable.
3. In order to fully and more adequately service persons in the mentally ill category, additional staff would be indicated.

The Committee also believes certain services should be established, such as:

A. A sheltered workshop program is needed to assist in diagnosis and evaluation of persons with mental illness. This program to provide a work adjustment and a retraining opportunity for many sick individuals.

B. A broad program of self education as to duties, responsibilities and functions of each other. Implementation of a program to make referral procedures and case flow more harmonious.

XII SUB COMMITTEE ON PUBLIC INFORMATION AND EDUCATION

Although the Regional Committee was well intended as far as activating this Committee, it never really materialized. Publicity was handled primarily by the Regional Coordinators.

XIII SUB COMMITTEE ON FINANCING, LEGISLATION AND ACTION MOBILIZATION

Remained purposefully inactive until all recommendations are in. This Committee would then become active in helping to implement suggested plans for the area.

XIV SUB COMMITTEE ON MENTAL HEALTH FACILITIES

Child and Family Services:

Child and Family Services was established in 1950, as a private non-profit agency out of concern for personally and socially disorganized families and individuals in the Lewiston-Auburn area. Its management is vested in a Board of Directors made up of twenty-seven lay citizens elected to serve on rotating basis and meet on a monthly basis. It also has a Member-at-Large body of 55 citizens who elect the Directors at an annual meeting and serve on ten standing committees. It also has an Auxiliary membership of 1,000 citizens who carry on an education program and assist the agency with material gifts. The primary source of finances for Child and Family Service has been the local United Fund of Auburn-Lewiston. The initial staff of 1950 was modest consisting of its Executive Director, who held a Doctorates Degree in Social Work, an Assistant Director, who had a Master's Degree in Social Work and a secretary. In 1957, the services of an additional social worker was obtained through increased United Fund allocations. This appeared to be the maximum of staff that could be attained in view of the United Fund's financial structure.

Between 1961-64, services of Child and Family Service was expanded considerably. In its effort to meet the needs of disturbed children and their parents, the agency in 1961 was successful in receiving a grant from the

Department of Mental Health and Corrections under its Community Mental Health Services program. This brought to the staff another social worker, a consultant in Psychiatry, a consultant in Psychology, and a part-time secretary. In 1962-63, Child and Family Service successfully demonstrated the value of professional mental health services in the elementary public schools of Lewiston and Auburn. This resulted in appropriations by Twin City officials to the School Departments to contract mental health services from Child and Family Service on a 12 month basis. The agency then brought on an additional full time and fully qualified psychiatric social worker in September, 1963.

The current staff consists of an Executive Director with a Master's Degree in Social Work, four full time, trained Social Workers, all accredited by the National Academy of Social Workers, two Consultants (Psychiatry and Psychology) who see children directly for diagnostic purposes, two full time and one part-time secretaries. The current operating budget is in the neighborhood of $53,000.00. All indications are that the County government will appropriate funds to the agency this coming year for additional psychiatric and psychological services.

In 1959, the agency was recognized as a training center for student graduate social workers by Boston College. Over 2,000 volumes of professional literature are available in the agency's library which has been annually increased and is frequently utilized by students, professionals, staff and other interested in the fields of human behavior.

Professional services are rendered to the area citizens regardless of color race, creed or economic status. Intake policies established in 1950 are considerably broad. The agency has an open door policy, whereby all referrals are accepted for initial study, determination of difficulty and whether it can render appropriate services. Last year, 1963, Child and Family Service had 556 active cases. (Cases are actually family units). These consisted of 186 cases carried over from the previous year and 370 applications during the course

of the twelve month period in 1963. These cases actually represented face to face contacts with 645 different individuals (529 adults, 116 children). Fees are charged according to ability to pay.

The bulk of the agency's services are rendered to clients who experience difficulties in the area of interpersonal relationships. Such difficulties run a wide gamut and may include impaired adjustment in the client's employment, marriage, family life, school, community, etc. Although the greater part of services consist of individual sessions, in 1962, family and group therapy was initiated as a form of treatment for appropriate clients.

The agency recognizes its responsibility in the area of prevention, therefore allows its staff to provide about 24 public addresses a year to community organizations. The staff participates in many local and state organizations interested in bettering the community for its citizens.

The Androscoggin Mental Health Clinic:

The Androscoggin Mental Health Clinic was opened in 1958, under the auspices of the Augusta State Hospital to meet the needs of area adults who cope with emotional or psychiatric disorders. Authority of the clinic was legally vested in the Superintendent of Augusta State Hospital in its initial years and later this was transferred to the Director of the newly established Bureau of Mental Health. Funds for operating the clinic have come predominantly from state appropriations under the Department of Mental Health and Corrections. The local United Fund provides a small annual allocation to care for rent and other basic administrative expenditures. The current operating budget is about $50,000.00.

The staff at the Androscoggin Mental Health Clinic first consisted of a Psychiatrist-Director, who is also a licensed physician, a certified Psychologist with a Master's Degree, an untrained (formal graduate studies) but experienced social worker and a secretary. A few years later another certified Psychologist was added along with a second secretary and a statistician. Currently, at state expense, the staff consists of the same Psychiatrist, two Psychologists (one with a Doctorates Degree and the other has nearly completed his Doctorates work),

two part-time social workers (one untrained, another fully trained), and two secretaries.

Professional services are rendered to area citizens regardless of race, creed or color. Fees are not charged. Those who can afford private services are requested to do so. Intakes are limited to referrals by official agencies and professionals in the communities. Services are rendered primarily to adults although adolescents, age 16 and up are admitted. In its first full year of operation (1958) the clinic received some 324 referrals. Last year, 1963, services were rendered to 174 patients in the clinic. The clinic accounts for its clients on an individual unit basis. This probably does not account for total applications for services. The above number was taken from the 1963 annual report of the Bureau of Mental Health.

The clinic offers psychotherapy, group therapy and with an attending physician chemotherapy. The staff is also called on by the community for consultation and public address. The Clinic's 1960 Report reveals such related activities.

Psychiatric Services to the Department of Health and Welfare:

Psychiatric Services to the Department of Health and Welfare originated around 1946, under the auspices of the same department. Financial support of this program has predominantly, if not solely, come from federal funds. Locally these services have been seen as the traditional traveling clinic. In the earlier years, the local clinic was held on a monthly basis and later increased to a weekly program. This particular agency was the forerunner of mental health services in most parts of the State of Maine, including Lewiston. Although adults were seen, the clinic focussed primarily on children's cases. When the Department of Mental Health & Corrections was created by the Legislature, authority for mental health was transferred to that department. Funds supporting the above clinic were also transferred. The Director of the Bureau of Mental Health and Commissioner of the Dept.of Health & Welfare developed a policy whereby the clinics would continue but intake would be limited to recipients of services of

the Department of Health and Welfare. Personnel were to come under the administrative auspices of the Department of Mental Health and Corrections.

The staff, which visits the Lewiston & Auburn area weekly, now consists of a certified Psychologist and a trained social worker. In addition, a local private Psychiatrist serves on the clinic for patients on the same day. This Psychiatrist provides another day a week of consultation to certain staff members of the Health & Welfare Department in the local district office.

The pro-rated budget estimated to conduct the local clinic is about $10,000.00. The clinic serves both adults and children but with emphasis on the latter. The Acting Director was gracious enough to provide us with a statistical breakdown for services in this area and they are as follows:

"During the period from July 1, 1963 to June 30, 1964 inclusive, our clinic served 83 patients directly not including those consultations, conferences, etc., (with the staffs of the various Health and Welfare agencies) regarding individuals not personally seen at our clinic. Specific statistics on these consultations and conferences are not readily available but would involve somewhat in excess of 300 clinic hours. Evaluation and treatment of collateral contacts (with parents, spouses, social workers, public health nurses, educators, law enforcement agencies, etc.) totaling 984 personal contacts with or in direct connection with the client. Of the 83 clients seen at our Auburn Clinic, 58 were under 18 years of age and 25 were 18 years of age or older. All were referred through the staffs of the various Divisions of the Department of Health and Welfare (including Division of Child Welfare, Family Services, Public Health Nursing, Services for Crippled Children, etc.). The majority of clients were referred because of social and behavioral maladjustment in the home, school, or community."

Summary:

In summary, we see that over $113,000.00 is currently expended on an annual basis in this area for general mental health services between the three agencies discussed above. Funds are received from the state government, municipal governments, the United Fund, fees and voluntary contributions.

The above funds represent some twenty-two different positions which includes fifteen professionals and seven secretarial staff members. Of the professionals seven are full time and eight part-time. There are four full time and three part-time secretaries.

A more detailed breakdown of professional positions would be as follows:

Medical Psychiatrist	(2)	1 Full Time	1 Part-Time	(5 days per mo.)
Certified Psychologist	(4)	2 Full Time	2 Part-Time	(5 days per mo.)
Qualified Social Workers	(7)	4 Full Time	3 Part-Time	(6 days per wk.)
Non-Trained Social Worker	(1)		1 Part-Time	(3 days per wk.)
Graduate Student Social Worker	(1)		1 Part-Time	(2 days per wk.)

Through their combined efforts these agencies serve approximately 800 or more afflicted citizens each year.

Despite the separate administrative identity of each unit there is considerable overlapping of services. A review of intake policies is one such significant area. All three agencies admit adults and all these agencies serve children. The Mobile Clinic and Child and Family Service both provide services to children with behavioral and social maladjustment in the home, school or the community. Both provide diagnostic services. However, Child and Family Service provides follow-up services beyond diagnostic evaluations, whereas, the state-sponsored clinic is limited in this function. It is not uncommon to have the Mobile Clinic provide diagnosis to a recipient of Health & Welfare services but the Department having to turn to Child and Family Service for for follow-up. Yet, in order to avoid confusion Child and Family Service had set up a policy whereby it does not serve Health & Welfare cases which thereby would seem to discriminate against economically deprived citizens. Since all three units serve adolescents, 16 and up, the juvenile courts and other referring

parties find themselves frequently confused as to where to refer, thus resulting at times in manipulation of all three agencies and perplexion for the afflicted person.

Child and Family Service provides services to all adults yet limits the focus of its psychiatric and psychologic consultants to children and youth. The Androscoggin Mental Health Clinic, theoretically, limits its services to adults but provides diagnosis and treatment of youths from the age of 16 and at times below.

Common elements between both agencies are that they all employ specialists from the field of behavioral sciences. All three agencies utilize services of psychiatrists, psychologists and social workers. They all serve individuals and families who are coping with psycho-social adjustment difficulties. A review of their sources of referral indicates striking similarities. All three utilize the traditional diagnostic procedures, although each may place more emphasis in one specific area. In treatment, all three utilize the professional therapeutic relationship as a basic means of restoring health or better social functioning. The availability of medical personnel adds another dimension, that of treatment by drugs. All three provide consultation to other professional groups (teachers, nurses, clergy, physicians, etc.). All three participate with local, civic or other professional organizations which aim at strengthening personal and family life.

All three provide public addresses to groups on topics related to mental health education. All three, despite the different administrative auspices, have or should have a deep interest and commitment toward the general mental health of all citizens within the area they serve.

Other Facilities:

The three resources so far discussed are primarily out patient programs serving Region 8. We want to review inpatient services. Historically and formally inpatient programs for mentally disturbed patients have never been available in Region 8. Residents requiring such hospitalization have had access to two state-sponsored hospitals and one federal Veterans Administration Facility.

A. Augusta State Hospital is located in Augusta, Maine, thirty miles from Lewiston. It was established in 1840 and is under the auspices of the State Bureau of Mental Health, Department of Mental Health & Corrections. The property includes some 601 acres and capital evaluation of buildings valued at $7,599,851.00. The latest report reveals it has an average of 1,652 patients in residence and 989 admissions within a recent 12 month period. This hospital has a net operating budget of $3,269,878.00 and employs some 630 individuals.

B. Pineland Hospital and Training Center (Children's Psychiatric Unit) was established by the Legislature in 1907 and the first patient was admitted in 1908. Pineland, formerly known as the Pownal State School, is located in a rural area with Portland and Lewiston each less than twenty miles distant. The property consists of 1,492 acres and its buildings are valued at $6,084,556.00. During the year 1963-64 the average number of patients in residence was 1,193 and an average of 564 persons were employed. The operating budget for the same fiscal year was $3,063,358.00. At the present time Pineland operates two programs. The first is its program for the mentally retarded. The second, and newer program which has only been in operation for three years, is for mentally ill youngsters between the ages of six and sixteen. It has a bed capacity of 70.

C. Veterans Administration Facility, located thirty-six miles from Lewiston, located in Togus, Maine and has a bed capacity of 869. This particular hospital admits neuropsychiatric patients from the area who are veterans. The local state Veteran's Affairs office indicates that in excess of 100 veterans from our area each year are admitted to Veteran's Administration for neuropsychiatric evaluation and/or treatment.

As mentioned earlier, the general hospitals in Region 8 have never had a formal program of in-patient service for the psychiatric patient. However, they have allowed the admission of these patients when 1) they are under private care and 2) such hospitalization does not disrupt the routine of the facility. Because of the void of psychiatrists in the area, the majority of these patients have been admitted by non-psychiatric physicians and provided with a non-psychiatric diagnosis. This probably has been done not only for medical purposes but also for hospital insurance coverage of patients with policies excluding psyshiatric hospitalization.

It is well to add that 24 hour emergency service has been available at these two major hospitals. In the past four years one community in the region has been fortunate in having a psychiatrist in private practice. His full time status as a staff member of one hospital has resulted in a more favorable climate toward in-patient services for psychiatric disorders. Both administrative and para-medical personnel have become more acceptable of these admissions by the psychiatrist.

It has to be recognized that the two major hospitals in Region 8 have coped for sometime with a void of professional mental health personnel attached in some-way to the hospitals. For instance, one hospital is without a social service department, the other although with a social service department is manned by social workers who have not completed their basic professional training (academically speaking). Neither of these hospitals have psychologists who render service within the facility. Neither hospital has a Department of Psychiatry.

There are three general hospitals in Region 8. They are:

I. Central Maine General Hospital, 300 Main Street, Lewiston was established in 1891. It is under the auspices of a lay board of trustees. In 1962-63 some 7,933 patients were admitted. There are 219 permanent beds. Plans for expansion are now materializing so these should increase. Assets in 1962 were listed at $4,019,206.00. Operating income in that year totalled $2,032,764.11. The hospital is accredited by the Joint Commission Accreditation of Hospitals and holds membership in the American Hospital Association and the New England Hospital Assembly.

II. St. Mary's General Hospital located at 45 Golder Street, Lewiston was established in 1900. It has a permanent bed capacity for 200 patients. In 1962 it admitted 6,664 patients. The hospital is administered by the Society of the Sisters of Charity, a legal corporation formed in 1892. Patients are accepted regardless of race, color, creed or economic status. Its assets of 1962 were listed at $4,814,473.00 and had operating income in that year totalling $1,885,070.00. It is accredited by the Joint Commission on Hospital Accreditation. The institution is also affiliated with the American Hospital Association, the Catholic Hospital Association and the Maine Hospital Association.

III. Stephen's Memorial Hospital is located at 50 Main Street in Norway and has a bed capacity of 33.

In reviewing facilities in Region 8, all find the existence of a variety of services and a variety of gaps. For instance, the area has a considerable amount of diagnostic services available but is very short on treatment. The available personnel seem to criss cross between these facilities. The limited supply of personnel extends into a variety of mental health programs(consultation to State

Health & Welfare office, school mental health, county child guidance, adult mental disorders, marital counseling, etc.). We believe this tends to diffuse and duplicate efforts which could be strengthened through some form of consolidation of as many of these services as possible.

From such consolidation, the Region could then move toward expending and developing other programs badly needed, such as, more consultation services to schools and other specialized groups, 24 hour emergency services to alcoholics, suicidal and other acute problems, short-term inpatient services in general hospitals, expanded out patient treatment program to children and adults, day hospital care treatment, pre-care and after care services.

The Committee believes that an effort toward integrating a number of existing facilities would be both sound economically and effective professionally. Region 8 does not have a high per capita income whereby a variety of sophisticated but separate programs can exist, such as we find in metropolitan centers. The shortage of funds and professional personnel will most likely continue to exist for some time. An integrated program could result into a major center of service to area 8. It could present a united front of comprehensive services to clientele coping with a wide gamut of problems.

The Medical and Professional Services Committee of Child and Family Service has studied the idea of an integrated program for over two years. Their findings and recommendations have been reported elsewheres. This Committee would strongly urge that their recommendations be implemented. We understand such recommendations are closely related to mental health services encouraged by the federal authorities and therefore concur with them. However, we caution the Regional Committee to ascertain what are the particular needs of Region 8, especially those of the rural communities, and provide some assurance that the proposed central facility give adequate coverage to these areas.

COMMITTEE ON PREVENTION OF SUICIDE

As early as May, 1963, the Professional Services Committee of Child and Family Services had expressed concern about the relatively high ratio of suicides in Androscoggin County. A review of statistical data revealed this problem to be higher than the state level (the latter being significantly higher than the national average). A figure of 14 per 100,000 population was arrived at for the local area. Following considerable groundwork with professionals from medical, religious, legal and social welfare fields, the agency's auxiliary body sponsored a nationally known figure to speak on the subject.

Reverend Kenneth Murphy, Director of Rescue, Inc., in Boston addressed a capacity group of professionals April 16, 1964. From this activity a formal committee was created and headed by a local psychologist, who is affiliated with the Mental Health Clinic.

Several meetings have been held by this committee. Observations made by its members include the following:

1. That the high rate of suicide might reflect the depressed economic-sociological conditions of the area.

2. That the medical community may need to increase its knowledge of the psychiatric dynamics associated with patients coping with suicidal symptoms which might be accomplished through specialized lectures or other media.

3. That professionals, such as doctors, clergymen, attorneys, social welfare personnel, educators and nurses may want to increase their acquaintance with the existing facilities and private professionals who are available to potential suicides and make greater use of these resources.

4. That effort should be made to upgrade the knowledge of the general public about suicidal dynamics in order that they may mobilize available resources to help the afflicted citizen.

5. That our general hospitals may desire to examine more closely their own potential roles in rendering more effective services (be it of an emergency or short-term hospitalization nature) to patients acutely disturbed with suicidal tendencies.

SUB COMMITTEE ON MENTAL RETARDATION

Since Maine is involved in a planning program for Mental Retardation duplication of their efforts was avoided. By coincidence, the State Planner resides in Region 8. Their final report, when completed will be reviewed and findings pertaining to Region 8 correlated with this report.

A REVIEW OF QUESTIONNAIRE UTILIZED

A very limited and independent attempt was made to use the survey questionnaire developed by the State Central Committee. These are seen as highly personalized and subjective impressions of the respondents, not necessarily reflecting the conclusions of the Sub Committee. There was insufficient use of the questionnaire to establish specific priority system or problems of mental health in Region 8. However, we can list the problems identified.

- Alcoholism
- Adolescent Problems
- Mental Retardation
- Middle Aged Depressed Females
- Adult Mental Illness
- School Dropouts
- Divorce
- Emotional Disturbances of Children
- Juvenile Delinquency
- Unemployment
- Teen-Age Marriages
- Suicides
- Unwed Parenthood

The majority of respondents emphasized the need for additional trained personnel that should be available not only to the communities in general but especially within the school settings.

SAMPLE QUESTIONNAIRE

Region_____ Community_____ Occupation_____

Communities have many mental health problems. In this community what do you consider:

(a) the three (3) most pressing mental health problems?

(b) of the three (3) which is the most pressing, second, third?

(c) now that the interview is completed, would you please list the three most pressing mental health problems in your community?

(a)	(b) 1.	(c) 1.
	2.	2.
	3.	3.

(d) What other recommendations do you have for better mental health services?

MENTAL HEALTH PLANNING

REGION 8

FINAL REPORT

Section IV

IMPLEMENTING RECOMMENDATIONS

A number of lay citizens and professionals have attempted to survey the human needs of Region 8 within a period of five months, a task that most likely should be accomplished over a five year period. In addition, it should be recognized that these activities were accomplished essentially by volunteers, the majority carrying on their daily respective jobs in the communities involved. The area has always functioned without an on-going, active, professionally oriented planning body for human services. Therefore, members who participated in the study see their own contribution as a humble one. All are aware that this study has many ramifications. They recognize the limitation of time placed upon them, both in what they could give personally and the degree to which they could examine particular facets of mental health in Region 8.

To enhance the planning study the Regional Coordinators have had to rely on a variety of study projects that had been previously completed by different organizations in the area. This was done to avoid duplication of effort by the volunteer group.

The survey on mental health problems and programs has helped identify (either directly or indirectly) a variety of needs in Region 8. A sample listing would probably include the following: (non-priority based)

1. Increasing the availability of physician-psychiatrists.
2. Increasing mental health consultation and education to specialized professions and the general public, in the areas of alcoholism, psychiatric disorders, geriatrics, etc.
3. Establishing a Visiting Nurses program.
4. Broadening hospital insurance programs to include benefits for psychiatric care.
5. Changing federal and state policies governing provision of grants and hospital or psychiatric care to recipients of state categorical financial assistance programs.
6. Establishing day care services for children of working parents.

7. Creating a social worker position to act as liaison between municipal officials of our different rural communities and patients needing psychiatric or other care.

8. Testing out ability and willingness of municipalities to meet expenses of psychiatric care of indigent residents.

9. Establishing 24 hour service for alcoholics and their families.

10. Establishing 24 hour service for suicidal patients and their families.

11. Establishing 24 hour service for citizens suffering from other acute social and emotional conditions.

12. Establishing AA group in western part of Region 8.

13. Developing a program to increase coordination of existing facilities.

14. Expanding school mental health services now available under Child & Family Services to a greater proportion which should be also extended to children in private schools and the rural areas.

15. Increasing the wage scale of the head of household in order that the maternal figure may economically remain home to care for minor children.

16. Establishing a Home maker Service Program.

17. Upgrading and increasing availability of residential settings and other resources for the elderly.

18. Studying feasibility of implementing research programs in area of human behavior and human services as it may contribute to the betterment of the local area.

19. Increasing availability of professional manpower.

20. Integrating, where possible, facilities and manpower in order to acquire even more effective coverage of services in view of economic status of Region 8.

21. Establishing day hospitalization for patients in area.

22. Establishing short-term hospitalization for patients with emotional disturbances.

23. Expanding Diagnostic, Treatment, Consultation, Rehabilitation services in the area.

24. Establishing and executing methodical mental health manpower recruitment and training procedures.

25. Increasing professional counseling to families contemplating divorce.

26. Increasing availability of group counseling programs.

27. Establishing mental health satelite unit to serve western part of Region 8.

The list of recommendations obviously indicates that there yet exists a demand for a variety of services to meet the human needs of Region 8 residents. Some of these are directly related to mental health programs, others only by implication. It is necessary, however, to keep uppermost in mind that planning activities were initiated out of concern for the mental health needs of the population. The Plan for Mental Health Planning in Maine submitted by the Director of the Bureau of Mental Health to the federal authorities in June, 1963 states "The ultimate goal of Maine's mental health plan is to establish orderly and realistic steps toward improved mental health of the people of Maine". This is in alignment with the ultimate goal of the federal officials as outlined in their publication Guidelines For The Federal Grant-In-Aid Program To Support Mental Health Planning, January, 1963. Both federal and state mental health officials were convinced that the type and nature of mental health services within different geographical areas of each state would be dependent on the grass root efforts by citizens representing a cross-section of their respective communities. It is this conviction that led to the development of fifteen regional planning groups in Maine. It should be added that whenever possible these regions would involve existing resources, agencies and organized groups and not necessarily call for the development of new organizations. Region 8 has attempted to bring together representatives of different institutions, it has utilized a variety of existing reports, it has turned to officials at different levels for impressions and opinions, etc. The coordinators have acted as catalysts to bring about a unified report that could be submitted to the Central Committee.

Since all of these activities have to be related to mental health needs of citizens in the area, then a system of priorities must equally be related to these specific needs. Such priorities are influenced not only by the local scene but also by depth studies and recommendations at a national level. Let us review the latter first:

In 1960, the Surgeon General of U. S. Public Health Service requested the formation of an Ad Hoc Committee on Mental Health Activities. As part of their study and recommendations he called specific attention to:

1. Mental health needs will continue to increase in the next decade;
2. Emphasis upon community services for patients treated as out patients or when discharged from hospitals will accelerate, depending only upon Community attitude and availability of services;
3. Community services are not available in most areas of the country at this time;
4. Mental health concepts, skills and disciplines need to be extended to other program areas, as chronic disease, aging, school health, alcoholism, etc.;
5. There exists in too many areas a barrier (or lack of effective operating relationships) between mental health and general public health agencies;
6. The shortage of trained personnel in the mental health area will continue to be a deterrent in meeting effectively the needs of the communities.

Implicit in the purposes of the Committee as outlined in the full context of the Surgeon General's memorandum were two other significant points: 1) the use of public health concepts, practices and personnel in mental health programs, and 2) the integration and coordination of mental health programs with other agencies which have an impact on the well-being of large population groups, such as public welfare, schools, family services, courts, etc.

The Surgeon General's Ad Hoc Committee on Mental Health Activities in its report of August, 1962, and the Ad Hoc Committee on Planning for Mental Health Facilities in its report of January, 1961, both conclude that in recent years there has been an increasing trend for communities to assume responsibility for the care, treatment and rehabilitation of the mentally ill. Both Committees encourage this trend because it can and should provide broad community services with increasing emphasis on the <u>prevention of mental illness</u> and the <u>promotion of mental health</u>. These directions have been further supported by past and contemporary mental health planning and survey.

It is obvious from Section III of this report that Region 8 is no different than many other communities in the country. Its urban centers of Lewiston and Auburn have available a variety of services to cope with problems of mental health. But, like so many other communities, the majority of these agencies are considerably isolated from each other. Both services and personnel are fragmented. Each assume responsibility for a certain segment of community mental health needs which most likely results in a dilution of potential effectiveness.

A review of the twenty-seven recommendations listed earlier obviously leads to the need for a more comprehensive approach to our mental health problems and programs. There exists a very high correlation between Recommendations 1, 2, 4, 5, 7, 8, 9, 10, 11, 13, 14, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27.

For too long the communities of Region 8 have tended to develop services from the symptom oriented concept. It provides separate programs for alcoholics, couples in marital conflict, adult mental illness, childhood emotional disturbances, juvenile delinquency, rehabilitation, aging, mental retardation, economically deprived, etc. We have yet to fully evaluate the interrelatedness of these dynamics. Nor have we given much attention to the similarities in functions of the various agencies established to serve the afflicted citizens. A serious exploration of these two factors would obviously reveal Region 8 is probably not making the most effective use of its resources. The fragmentation of programs and efforts probably results in added confusion for patients and fall short of maximum potential use of available mental health manpower. Continued diffusion of services is also a costly item. The fact that well over $100,000 is being expended annually for out patient services in Region 8 is in itself significant, although not nearly enough to meet the overall demand for services.

Region 8 should seriously consider whether it desires to continue approaching its mental health needs in a piece-meal manner as opposed to adopting an overall

program that could have far reaching effects for residents of the area. The recommendations cited above in one way or the other point to the need for formal services in our community hospitals for certain patients. They call for improved and expanded out patient services. Included in these recommendations is the need for partial hospitalization at community level as opposed to being uprooted from home, family and community. Region 8 should develop further services of a 24 hour nature which can cope with acute situations. The recommendations point clearly to the need for consultation and educational services to special "front line" groups and special areas, such as our rural communities. Diagnostic, rehabilitative, pre-care and post care services need to be expanded to help meet the total needs of Region 8 citizens. It is further recommended that training and recruitment for mental health manpower should be considered seriously if we are to relieve the shortage of personnel. Research and evaluation needs much more attention than our region has considered worthy up to now.

The recommendations indicate that emotionally and mentally disturbed patients should be able to move from one type of diagnostic or treatment program to another, if this is deemed appropriate, without being caught up in a web of agency policies that prevent or hamper continuity of care.

The results of Region 8's study point clearly to the need for a comprehensive approach outlined by Drs. L.D. Ozarin and B.S. Brown.* The economic base of Region 8 and the State of Maine is such that it would be impractical to establish new services which might result in further partialization of total services. However, it would be practical to examine closely the possibility of integrating a number of our existing services. Where actual integration is administratively impossible, certain policies of cooperation between agencies could evolve, whereby, continuity of services would be provided.

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*Lucy D. Ozarin, M.D. and Bertram S. Brown, M.D., "New Directions in Community Mental Health Program", American Journal of Orthopsychiatry, Vol XXXV, No. 1, pp. 10 - 17.

Region 8 is aware of the fact that state officials and representatives from Child and Family Services have been exploring the above possibilities for over two years. It is recommended, therefore, that as first priority these deliberations continue and be finalized with the thought that the results should bring about a comprehensive approach to the mental health needs of our people. It is further believed that the various appropriate recommendations resulting from this particular study be included in these deliberations, especially those pertaining to increased mental health manpower and increased services to children in school.

We would specifically recommend that the State Legislature increase grant-in-aid appropriations for Community Mental Health Services so that more manpower can be made available, especially to the rural communities in Region 8.

Region 8 officials recognize that there exist other gaps of services in our area. For example, we need a visiting nurses program, homemaker services, increased availability of day care services for children of working mothers, etc. We recognize that indirectly the void of these services affect the mental health status of our citizens. Encouragement, therefore, should be given to other appropriate community groups who have interest in establishing such necessary services.

MENTAL HEALTH PLANNING

REGION 8

APPENDIX "A"

CITIZEN PARTICIPATION

William E. Schumacher, M.D., Director Bureau of Mental Health & Corr. Augusta, Maine	Member, Central Planning Committee
John B. Leet, Mental Health Planner Bureau of Mental Health & Corr. Augusta, Maine	Member, Central Planning Committee
Walter F. Ulmer, Commissioner Bureau of Mental Health & Corr. Augusta, Maine	Member, Central Planning Committee
Francis H. Sleeper, M.D. Consultant Bureau of Mental Health & Corr. Augusta, Maine	Member, Central Planning Committee
Mary A. Pierce, Statistician Bureau of Mental Health & Corr. Augusta, Maine	Member, Central Planning Committee
Neil D. Michaud, M.S.W., ACSW Executive Director Child & Family Services Lewiston, Maine	Regional Coordinator Member, Regional Committee
Mrs. Nelly K. Wade, Member Governor's Advisory Comm. on Mental Health Auburn, Maine	Regional Coordinator Member, Regional Committee Member, Mental Health Facilities
Honorable Emile Jacques Senator Lewiston, Maine	Member, Regional Committee
Sister Manseau St. Mary's General Hospital Lewiston, Maine	Member, Regional Committee
Mr. Joseph Adler, Director YMCA Auburn, Maine	Member, Regional Committee
Miss Geneva Kirk, Teacher Lewiston High School Lewiston, Maine	Member, Regional Committee
Franklin Prescott City Councilor Auburn, Maine	Member, Regional Committee
John Beale, District Manager* Old Age & Survivor's Insurance Bureau Lewiston, Maine	Member, Regional Committee

* Resigned from Regional Committee

Mrs. Charles Steele, Member, Maine Medical Auxiliary Lewiston, Maine	Member, Regional Committee
Mrs. Ethel Fleisher, Member, Andros. Valley Mental Health Asso. Lewiston, Maine	Member, Regional Committee
Mrs. Ruth Descoteau Maine Extension Service Norway, Maine	Member, Regional Committee
Richard Dube Junior Chamber of Commerce Lisbon, Maine	Member, Regional Committee
Robert D. Wakefield, M. D. Pathologist Lewiston, Maine	Member, Regional Committee Chrm., S.C. Mental Health & Medical Practice
Gilbert R. Grimes, M. D. Pediatrician Lewiston, Maine	Member, S.C. Mental Health & Medical Practice
Russell Morissette, M. D. Pediatrician Lewiston, Maine	Member, S.C. Mental Health & Medical Practice
Henry C. Thacher, M. D. Pediatrician Auburn, Maine	Member, S.C. Mental Health & Medical Practice Member, S.C. Mental Health Facilities
Paul J. Laflamme, M. D. Internist Lewiston, Maine	Member, S.C. Mental Health & Medical Practice
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Raymond Dow, Supvr. Division of Family Services Department of Health & Welfare Lewiston, Maine	Member, Regional Committee Chrm., S.C. Mental Health & Welfare
Hayward Carsley Town Manager Lisbon, Maine	Member, S.C. Mental Health & Welfare Respondent
Donald McAllister Town Manager Norway, Maine	Member, S.C. Mental Health & Welfare
Miss Lorraine Thibault, Director American Red Cross Chapter Auburn, Maine	Member, S.C. Mental Health & Welfare Respondent

Reverend Margaret A. Messer, Pastor Sixth St., Congregational Church Auburn, Maine	Chrm., S.C. Mental Health & Alcoholism
Honorable George Hunter Representative Durham, Maine	Member, S.C. Mental Health & Alcoholism
Reverend Nesbit Lello, Pastor Norway, Maine	Member, S.C. Mental Health & Alcoholism
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Reverend Carmine Centineo, Pastor Buckfield, Maine	Member, S.C. Mental Health & Religion
Reverend John Godfrey, Pastor Greene, Maine	Member, S.C. Mental Health & Religion
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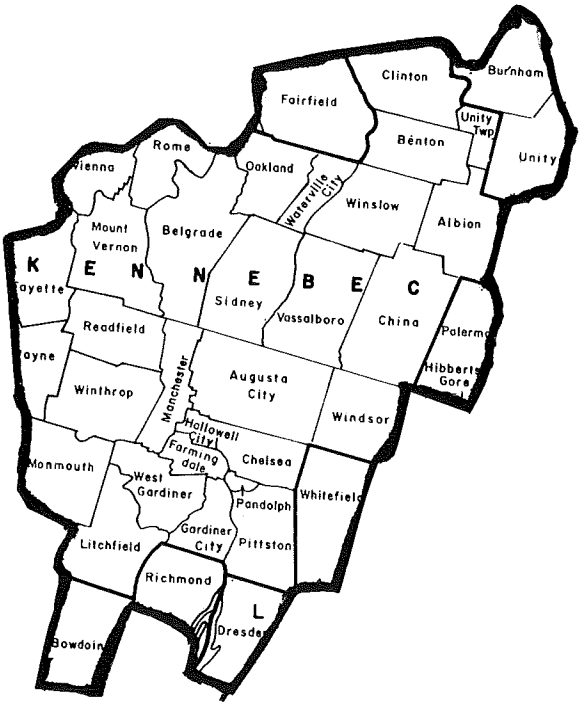
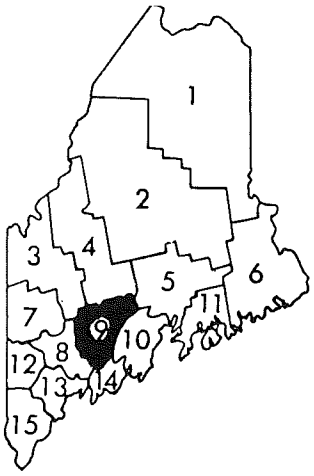
Mr. Paul Belanger	Lewiston, Maine

FINAL REPORT
of
REGION 9

Mental Health Planner
700 State Office Bldg.
Augusta, Maine

REGION 9





POPULATION

Region IX - 101264

State - 969265

Region 9, which consists of Kennebec County and two communities adjacent to the southern border of the County which have close cultural and economic ties with the City of Gardiner, is probably above average in relation to the socio-economic condition of the State of Maine. It represents neither extreme need nor extreme abundance. Its two largest cities, including the State capital, have populations of approximately 20,000 each and the population of the entire region is slightly over 100,000. Although the population distribution is primarily French-Canadian ancestry, there is a wide distribution of native New England American stock plus a variety of European cultures which in many instances seem to be extremely close-knit. Although these smaller ethnic groups are small in number they present some unique problems based primarily on cultural factors.

With the wide variety of industry in the fields of plastic, paper, wool, lumber, meat packing, as well as the physical location of Colby College in this region, we have the added element of atypical residents who have been "imported" into the area by virtue of their educational, vocational, or executive skills. Added to this is the fact that in this area are also located the headquarters for a wide variety of State and Federal agencies.

Inasmuch as this report is one of many which will be incorporated into an eventual master plan, no effort will be made to specifically outline or include the involvement, or lack of same, among the federal and State of Maine programs or institutions focused on the field of mental health.

An area of added importance is the ever-growing scope of this region as a potential center for medical services. Within Region 9, we have five community general hospitals, Thayer, Sisters, Augusta General, Gardiner General, and Osteopathic, with a bed capacity of 458. Four of these five institutions are either completely new structures or are in the process of vast expansion. In addition, within the same area is located the Togus Veterans Administration Hospital and the Augusta State Hospital. Within the confines of Region 9, we have a variety of medical specialists representing all fields of medicine. In addition, we have 26 nursing homes in the area with a total bed capacity of 555.

It has been extremely difficult to specifically evaluate individual nursing homes in the area in relation to their interests or willingness to participate in the care of the mentally ill patient. This is based on several factors, not the least of which is the fact that one of our committee members has recognized the fact that some health insurance programs specifically refuse payment for care in a nursing home if this same nursing home has among its patients a single person who is suffering from mental illness. It would seem obvious that if this policy continues, more and more nursing homes would discriminate against the mentally ill patient.

The only private social casework agency in this region is the Maine Children's Home for Little Wanderers with offices in both Waterville and Augusta. In addition to this private agency, we have a variety of divisions of the Department of Health and Welfare and Department of Mental Health and Corrections which provide specialized services to individuals or groups.

In evaluating the problems and the needs of Region 9, the committee attempted to utilize a variety of methods. First, with the cooperation of the Bureau of

Mental Health, arrangements were worked out for a thorough evaluation of the Kennebec Mental Health Clinic. This study which was conducted by a graduate student from Boston College School of Social Work is incorporated with this report in the form of an appendix. The findings and recommendations of this independent study are specific and clear-cut and need no further elaboration other than to be included as part of the regional report. Second, we tried to identify the most pressing problems via individuals and groups from various professions who attempted to evaluate the regional situation in relation to their own professional setting and the thoughts and opinions of their co-workers. The third method was an attempt through our contacts with individual people who are not necessarily connected with the study plan, to identify problems as they saw them if indeed they recognized any problem at all.

It seems apparent from the overall reports and recommendations that Region 9 is equipped with a variety of mental health services. These are for the most part operating independently with an obvious duplication of services and lack of communication and coordination. For example, many patients are known to several agencies which are trying to provide essentially the same services without any awareness of the participation of other agencies. There is also a definite lack of a full range of services for persons of all ages, as well as a lack of continuity of care for the more seriously disturbed patient.

Aside from the follow-up study and the individual committee responsibilities, the people active in this region tried to canvass a widely scattered population in regard to the overall identification of problems of mental illness. The greatest concern on the part of the general public seemed to surround the area of problems with children. These ranged from birth defects to school behavior problems, mental retardation, and early stages of alcoholism. Most of the people contacted by the committee had absolutely no knowledge of why the problem might have occurred nor did they have any particular knowledge of services available to handle such problems. In general, the community seemed aware of the fact that there is a State Hospital and that this is used for the care of the mentally ill but no understanding, or very little understanding, in relation to the use of other facilities.

RECOMMENDATIONS

1. It is the recommendation of the committee that a specific group or agency is a necessity in order to assume responsibility for guiding and supervising the implementation of any mental health plan for the region. It should be the responsibility of this group to enlist the services of the present regional committee and/or an expanded and modified mental health association to assume responsibility in this area.

2. There appears to be a dire need for continued evaluation and community support of all mental health services in the area. The committee felt that along with the inevitable duplication of services there is indeed room for more adequate use of existing services, providing all agencies and programs know of one another's overall functions and are able to work together more closely. To summarize this recommendation more clearly, it can be stated that there is a need for increased clinical activity, more adequate planning on an areawide basis, increased effective community education, and expansion of current services in order to meet a variety of unmet needs.

3. In the area of community education, it is felt that it would be of paramount importance to disseminate more information among the general public. It was the opinion of the committee that the public must first recognize that there are mental problems, know what they are, and generally understand them before any improved mental health program becomes a reality. It is felt that within the region there are multiple resources for public information and education programs. Among these are: Kennebec Journal, The Waterville Morning Sentinel, Bangor Daily News, Somerset Reporter, Portland Sunday Telegram, Gardiner Advertiser, Pittsfield Advertiser. Four radio stations located in Augusta, Skowhegan, and Waterville, as well as five television stations, including educational TV, cover all of the Central Maine area. Use of these media would be contingent on the availability of adequate mental health personnel and facilities to handle the inevitable increased demand for services.

4. There is an obvious need for the establishment and consolidation of evaluation and treatment services for younger children. It was felt that every effort should be made to develop a comprehensive guidance program within the schools to include the services of psychiatry, psychology, social work, and additional guidance counselors. Although this type of program is currently in effect on a small scale through the Maine Children's Home for Little Wanderers, it is felt that there should be more local, county and state support in promoting such programs.

5. It is recommended that a service be established which would be similar to the "street worker program" or the "roving leader program" which would be set up in such a way as to provide group work services to both school children and school drop-outs.

6. The size, geographic location, and demand for services in this region would seem to indicate the need of the establishment of a community mental health center. It is the opinion of the committee, however, that any move in this direction should be carefully worked out with similar committees in both Somerset and Knox Counties, which are currently included as Area 3 of the State Mental Health Center Plan.

As is so often the case, committees such as the one which produced this report start off in rather large numbers and dwindle as time progresses so that the bulk of the effort is the responsibility of a small handful of people. This committee has been no exception. What originally was a committee of approximately 15 people who expressed both interest and willingness to cooperate in this program, soon dwindled to no more than 6 or 8 individuals. To these individuals I wish to express my sincere appreciation for their conscientious effort and I hope that their basic ideas and philosophies have been adequately expressed in this summary report.

This report was submitted by the following members of Region 9:

John D. Arthur, 65 State Street, Augusta, Maine, psychologist

John Fickett, Neal Street, Portland, Maine, social worker, Child and Family Services, Dept. Health and Welfare

Walter Foster, Arnold Highway, Fairfield, Maine, probation and parole officer, Boys Training Center, Portland

Beverly Johnson, 14 Clifford Avenue, Winslow, Maine, nurse coordinator

Wayne N. Jones, 101 Highland Avenue, Gardiner, Maine, pharmacist

Barbara A. Pullen, 6 Blaisdell Street, Augusta, Maine, guidance counselor at Waterville, Maine

C. Bruce Wright, 7 Eaton Drive, Waterville, Maine, public relations director at Thayer Hospital

Andrew Johnston, Box 624, Waterville, Maine, administrative director, Kennebec Mental Health Clinic, committee chairman

June 1965

AN EVALUATION STUDY

OF THE KENNEBEC MENTAL HEALTH CLINIC

by
John E. Fickett

Waterville, Maine

March 31, 1965

AN EVALUATION STUDY

OF THE KENNEBEC MENTAL HEALTH CLINIC

In its application for a NIMH grant in 1962, the Kennebec Mental Health Clinic stated, "Once the clinic is fully developed and stabilized in its present pattern, we plan to design a study of treatment and/or evaluation results by interviewing patients six months after last contact with the clinic. We also plan to study the applicability of this design to other regions where professional time and services are in short supply."

This report describes the carrying out of that projected study. It was done over a five-months period, from October 15, 1964 to March 15, 1965, about two years after its plan was stated and about three and one-half years after the clinic began operations in July, 1961.

The Kennebec Mental Health Clinic claims uniqueness in two ways: (1) its professional staff serves on a part-time basis; and (2) its treatment and evaluation sessions are conducted during evening hours and limited to 26 treatment visits per patient.

The unique design of the Kennebec Mental Health Clinic and the relative stability of residence of the essentially rural population served by the clinic have enabled the designing of an evaluation study based on personal interviews with patients of the clinic and the professional persons who have referred patients to the clinic.

This study design furnished an adequate sample to permit evaluation. The sample included a sufficient number to ensure an adequate balance between persons with positive bias and persons with negative bias. The responses from patients and from referring persons complemented and/or supplemented each other. Information data was collected from persons who had actually used clinic services, and thus was first-hand and pragmatic.

The evaluation study was limited to closed treatment cases. Treatment cases (and not cases for evaluation only) permitted the patient to have sufficient contact with the Kennebec Mental Health Clinic to respond with reliable weight to the questionnaire. Thus patients who had been evaluated and had been seen in no less than two treatment sessions were selected for the sample. Closed cases (and not active cases) permitted the patient to respond to the questionnaire so that a comparison could be made between his (or her) mental health condition before and after treatment. The full potential of the sample was 180 closed treatment cases.

For the same reasons the sample of referring persons to be interviewed were limited to those professional persons who had referred patients who were treated and whose cases were closed. The full potential of this sample was 84 referring persons.

Due to limitation of time, unavailability of the potential interviewee, and other unavoidable circumstances well known to research interviewing, the full potential was reduced so that the actual sample of interviewees reached was 71 patient interviewees and 35 referring persons. This was more than 40% of the full potential, which is a very adequate sample.

In order to reach as large a sample as possible, the evaluation study was publicized by a feature article released on November 2, 1964 in the two daily newspapers in Kennebec County; a letter of introduction of the researcher was mailed to each person hopefully to be interviewed, at least two weeks before interview was planned; the researcher made as many appointments as possible by telephone; and an appointment letter was mailed six days before the appointment date, to every interviewee including those contacted by telephone.

Patient interviewees were seen in their homes, and referring persons in their offices. The questionnaire used for each is found on the next two pages.

The researcher travelled a total of more than 1,000 miles and interviewed persons in 41 communities including 17 communities outside of Kennebec County. In only five communities in Kennebec County, there were no interviews.

After greetings, each interview opened with a brief orientation to the purpose of the interview, an assurance of confidentiality, a statement that the researcher's only knowledge of the interviewee or patient was the name and address, and a request that the interviewee respond to the questionnaire with complete frankness. The researcher read a question, and then gave the interviewee as much time as desired to express his (or her) response. Then the researcher marked or wrote the response, and went to the next question. At the end of the questionnaire the researcher read the written responses and asked whether they adequately expressed the interviewee's thoughts. Revisions were then made where indicated. The researcher expressed the clinic's appreciation for the importance of the interviewee's contribution to its evaluation study.

KENNEBEC MENTAL HEALTH CLINIC
Waterville, Maine

FOLLOW-UP SURVEY OF CLOSED TREATMENT CASES

Questionnaire for Patients

1. What was the problem you had when you came to the clinic?

   1. Nervousness.
   2. Depression.
   3. Psychosomatic problems - tension headaches, nervous stomach, etc.
   4. Problems with strange thoughts and/or experiences (bizarre).
   5. Problem with alcohol.
   6. Problem with health - chronic or poor.
   7. Problem with spouse.
   8. Problem with children (re: the law, school, behavior, discipline, emotions.)
   9. Problem with job.

2. Do you feel there was any change in the problem after coming to the clinic?

   1. They did a lot to help.
   2. Things are a little better.
   3. Things are about the same.
   4. Things are a little worse.
   5. Things are much worse.

3a. (If better) You feel the clinic helped?

3b. (If not better) You feel the clinic could have helped more?

   1. By giving me medicine.
   2. By telling me how to solve my problems.
   3. By giving me encouragement and moral support.
   4. By giving me an opportunity to openly express my thoughts and feelings. (To get things off my chest.)
   5. By teaching me to understand myself and other people.
   6. By contacting those people with whom I am having trouble and getting them to treat me differently.

_____

_____

4. Since leaving the clinic, have you contacted anyone else about this problem?

   Yes_____No_____(If "yes") Who?_____

   Did they help? Yes_____No_____.

5. Have you recommended the clinic to anyone else? Yes_____No_____.

KENNEBEC MENTAL HEALTH CLINIC
Waterville, Maine

FOLLOW-UP SURVEY OF CLOSED TREATMENT CASES

Questionnaire for Referring Persons

(0) For what problem was the patient referred? (See case's referral application.)_____

_____

(0a) What was the patient's condition at time of discharge, in relation to the problem for which he (she) was referred? (See case's closing summary.)_____

_____

1. Since discharge from the clinic, has the patient been in contact with you or anyone else regarding this problem?

   1. Yes, with me. Would you specify what has been your activity with the patient?_____

   _____

   2. Yes, with (another person or agency). Would you identify? _____If you know what has been their activity, would you specify?_____

   _____

   3. No.
   4. I don't know.

2. After discharging a patient, the clinic has a policy of reporting information to the referring person. How did you use this information?

   _____

   _____

3. What is the patient's condition now, in relation to the problem for which he (she) was referred?_____

   _____

4. The clinic has a policy requesting referring persons (like yourself) to follow up patients after their discharge from the clinic. How do you feel about this policy? Would you specify?

   1. I like it. _____
   2. It's all right. _____
   3. I don't like it._____

5. Do you have any suggestions for improving clinic services? Yes. No. Would you elaborate?_____

   _____

   _____

6. Would you want to refer another person to the clinic? Yes. No. Would you elaborate?_____

   _____

   _____

Following are the responses to the Questionnaire for Patients. In response to the first question several interviewees named more than one problem, so that the sum of responses is more than the total of 71 interviewees.

Nervousness	24	Spouse	12
Depression	19	Child: re: the law	7
Psychosomatic problems	10	re: school	14
Strange thoughts, experiences	5	re: behavior	6
Alcoholism	4	re: discipline	2
Health - Chronic	1	re: emotions	8
Poor	6	Employment	1

Responses to question #2 were:

1.	They did a lot to help	26
2.	Things are a little better	25
3.	Things are about the same	12
4.	Things are a little worse	2
5.	Things are much worse	6

If the interviewee gave the first or second response to question #2, the researcher read question #3a to draw out in what way the interviewee felt the clinic helped the patient. If the interviewee gave the third, fourth, or fifth response to that question, the researcher read question #3b to draw out in what way the interviewee felt the clinic could have helped the patient more. As in the case of question #1, several interviewees named more than one response to questions #3a and #3b.

Responses to questions 3a and 3b were:		#3a	#3b
1.	Giving medicine	6	4
2.	Solving problems	15	5
3.	Encouragement and support	21	3
4.	Express thoughts (ventilation)	34	2
5.	Teaching to understand	31	3
6.	Contacting others	7	0
	Additional responses (on 2 lines)	14	16

In response to question #4, sixteen answered "yes" and all sixteen named the person contacted. Fifty-five answered "no". Of the sixteen persons contacted, twelve interviewees stated that the person helped and four stated that the person did not help the patient.

Twenty-nine interviewees said they had recommended Kennebec Mental Health Clinic to someone else. Forty-two said they had not recommended the clinic, but a number of these stated that they would if they knew someone whom they felt needed the clinic services.

Analysis of the Questionnaire for Patients reveals a correlation between the prevalence of the various problems, whether or not the patient became better, and in what way the interviewee reported the patient to have been helped or could have been helped. For example, the largest number were of those who said that a problem was nervousness, and the patient received a "lot of help", and the help came by giving the patient an opportunity to get things off his (her) chest.

As might be expected, there was a correlative tendency for those who reported that the clinic helped them, to respond that they did not contact anyone else about their problem since leaving the clinic, and for those who reported that the clinic did not help them, to respond that they did contact someone.

Of the 42 who said that they have not recommended the clinic to anyone else, 17 were among the 20 interviewees who responded that the patient's problem had not changed for the better after clinic treatment.

Responses to the Questionnaire for Referring Persons were as follows. As indicated on the questionnaire, the responses to questions 0 and 0a were obtained from the case record's referral application and closing summary, respectively. In several cases the referral application named more than one problem of the patient referred. Data on question #0 were:

Nervousness	19	Spouse		11
Depression	17	Child:	re: the law	5
Psychosomatic problems	1		re: school	12
Strange thoughts, experiences	6		re: behavior	8
Alcoholism	3		re: discipline	3
Health - Chronic	0		re: emotions	10
Poor	0	Employment		1

Data on question #0a were:

Much better	21
A little better	18
About the same	18
A little worse	0
Much worse	0
No summary in record	16

In response to question #1, 33 referring persons responded that they had seen the patient professionally since his (or her) discharge from the clinic, and all of them named the activity or capacity in which they were engaged. Three referring persons stated that another professional person had seen the patient since discharge, and named the other professional person, and two named the activity in which that other person engaged with the patient. There were 31 "no's" in response to question #1, and seven said, "I don't know."

In response to question #2, there were four kinds of answers given by referring persons regarding the use made of discharge information from the Kennebec Mental Health Clinic. These are reflected in the following list:

22 said the information was used in follow-up work with the patient;
9 said it was used in interpreting to others how to help the patient;
12 said that no use was made of the information; and
30 said that they never received any discharge report from the clinic.

There were generally six kinds of answers in response to question #3. Their names and frequency were:

Much better	20
A little better	22
About the same	6
A little worse	2
Much worse	1
I don't know	22

The reader will notice that the total number of responses to each question #0a, #2, and #3 is 73. In the interview with each of the 35 referring persons, a questionnaire was used for each patient randomly selected from those whom he (or she) referred to the Kennebec Mental Health Clinic. Fifteen of the referring persons interviewed had referred only one patient, and twenty had referred more than one. Of the 73 patients upon whom the interviews with referring persons focused, 37 were not in the sample of interviews with patient interviewees.

Questions #4, #5, and #6 on the Questionnaire for Referring Persons were not focused on a patient, but were general questions on attitude. The responses for question #4 were:

	Referred 2 or more	Referred 1
1. I like it	18	11
2. It's all right	2	4
3. I don't like it	0	0

In response to question #5, 17 of those who had referred two or more patients said "yes", and 3 said "no". Nine of those who had referred only one patient said "yes", and 6 said "no".

All 35 referring persons responded with "yes" to question #6.

Analysis of the Questionnaire for Referring Persons reveals a strong correlation between the closing summary stating that the patient's condition at discharge was better, the referring person having seen the patient after discharge, and having used the discharge report in follow-up work with the patient, and the patient's condition now as being better.

There is also a strong correlation between no closing summary in the case record, no discharge report received by the referring person, and no contact by the patient with anyone after discharge.

The 35 referring persons consisted of 15 physicians, 3 clergymen, 5 educators, 5 nurses, 1 judge, 2 probation officers, 1 clinical psychologist, 2 social workers, and 1 alcoholic rehabilitation counselor.

The 26 referring persons who responded to question #5 that they did have suggestions to improve clinic services offered 18 various types of suggestions. Some persons offered more than one suggestion.

1. There is too long a waiting period before service begins. Many cases are emergencies and need immediate attention. (5 persons suggested this.)

2. I maintain contact with the patient during treatment, and would like progress reports to help me in working with the patient. (5 persons suggested this.)

3. I would like to get a discharge report. (6 persons.)

4. Discharge reports should give more specific recommendations to the referring person on how to follow-up the patient. (4 persons, one of whom added, "It would also help me to know whether I had made a good referral".)

5. The clinic should handle evaluation cases in Augusta as well as in Waterville. (2 persons.)

6. Services should be expanded. (2 persons.)

7. The clinic should have a psychiatrist on 24-hour "on call" coverage for emergencies at all times. (1 person.)

8. The clinic should follow-up a patient who voluntarily stops treatment, to determine the reason for it. (1 person.)

9. Service should be included for very short-term and very long-term treatments. (1 person.)

10. When a patient is discharged, the clinic should make a referral back to the referring person. (1 person.)

11. I would like to receive referrals of alcoholics from the clinic. (alcoholic rehabilitation counselor.)

12. I would like my patients to be treated by a psychiatrist or social worker, not a psychologist. Psychologists are not oriented to psychodynamic casework. (1 person.)

13. Many school children don't need a psychiatrist, but a person to talk to and help them "find themselves". (1 person.)

14. The clinic psychiatrist should be invited to speak to the Kennebec Medical Society. (1 person.)

15. The clinic psychiatrist should be invited to speak to the Waterville Elementary Teachers' Association. (1 person.)

16. The clinic should provide community education of professional people on the subject of preventive mental health. (1 person.)

17. It would be very helpful to have printed information to give to parents of school children, telling them about the clinic services available to them. (1 person.)

18. The clinic has the wrong name. People don't want to be referred to a "mental health" clinic because they are afraid of the possibility of being "mental". (1 person.)

These 18 types of suggestions can be summarized into seven categories:

Suggestion #1: Shorten the waiting period.
Suggestions #2, #3, and #4: Closer and more directive communication with the referring person.
Suggestions #5, 6, 7, 8, 9, and 10: Expand the clinic services.
Suggestion #11: Let me help the clinic.
Suggestions #12 and #13: Change the therapist.
Suggestions #14, 15, 16, and 17: More community education in mental health.
Suggestion #18: Change the clinic's name.

The reader would probably surmise that it would have been very unlikely that the researcher would have been able to interview every referring person of the 71 patient interviewees seen, and that he would not have been able to interview every patient of the 35 referring persons seen. This surmise would be correct. The patient interviews were completed before the interviews with referring persons started. At the completion of all interviews it was found that 36 patients were sampled in both the Questionnaire for Patients and the Questionnaire for Referring Persons. Thirty-five other patients were sampled in the Questionnaire for Patients only, and 37 other patients were sampled in the Questionnaire for Referring Persons only. Thus a total of 108 patients were sampled.

Complete cross-analysis of the data collected regarding these three groups of patients has been made, but its inclusion in this report is not relevant. It is important, however, to report that there is direct correlation between the three groups, which permits the assumption that conclusions are applicable to the full potential of the clinic's 180 closed treatment cases.

The interpretation of the data collected on the total of 144 questionnaires, those for patients and those for referring persons, follows:

1. The Kennebec Mental Health Clinic has been notably effective in helping people with their mental health problems. A large majority of those who came for treatment received help which resulted in their becoming better able to cope with their problems.

2. The help received in treatment also appeared to have had some enduring quality. Although a substantial proportion of referring persons did not know the present condition of the patient, a large majority of those who did know the patient's present condition reported that it continued to be improved over the pre-treatment condition. Interviews were held from about one month to three years after treatment had been closed.

3. The most serious criticism of the clinic is represented by the large proportion (41%) of referring persons who reported that they did not receive any discharge report from the clinic, despite a definite policy that such a report will be sent to the referring person after treatment is closed. Most of those (72%) who did receive discharge reports made use of them, and almost all referring persons liked the clinic's policy of requesting them to follow-up the patients after discharge. Prominent among the suggestions of referring persons was that the clinic should maintain communication with the referring persons during and immediately after treatment.

4. The Kennebec Mental Health Clinic fills a real need in the area it serves. This was shown in several parts of the data. Many patients had recommended the clinic to others, and a number of those who had not, stated that it was only because they did not know anyone who needed its services, but would recommend it if they did know a person needing such help. All 35 referring persons said that they would refer another person to the clinic (and many have referred cases currently active). A number of referring persons suggested that the clinic should expand its services because the need for its services is so great.

Other interpretations could be made from the data, but their reliability would be questioned due to a significantly lower level of statistical confidence.

From the above four interpretations the Kennebec Mental Health Clinic can be evaluated as meeting a great need for most of those whom it has been able to treat and thus being effective to the limited extent in which it

serves in a treatment capacity. The Clinic reveals a serious failure in making adequate use of the willing and able cooperation of referring persons, due to a failure to maintain adequate communication with referring persons. This failure seriously distorts the Clinic's image as an agency which purports to identify itself with the professional community in the area it serves. Public distortion of its image of mental health clinics appears to be a universal problem.

Some recommendations emerge from this evaluation study:

1. The Kennebec Mental Health Clinic should reappraise the constituency of its professional staff. The data indicated that many cases could be handled by psychosocial therapy and family casework services. It is suggested that treatment be limited to short-term psychotherapy with a strong follow-up policy. Therefore, it is recommended that the clinic's professional staff should consist of a clinical psychologist and a psychiatric social worker, both on full-time service, and that part-time staff should include a psychiatrist at least two full days per week, and other psychologists and social workers as needed. This would permit a stable staff plus flexibility for expansion of services.

2. The clerical staff should be increased to a minimum of two full-time secretaries. The clerical staff is expected to serve not only the clinic but also its sponsor, the Kennebec Mental Health Association.

3. The Association should employ a full-time administrator, or at least an office manager (who could be a well-trained member of the clerical staff), to coordinate the headquarters' activity in a business-like manner. This position should be contingent upon the availability of a full-time professional person who would assume responsibility for interpretation of clinical data to referring persons, patients, etc.

4. The Clinic should take very seriously its dependence upon the area's professional community for referral of cases. It should also take very seriously its responsibility:

    1. To maintain close communication with every referring person unless otherwise indicated;

    2. To inform the referring person immediately when the patient is discharged;

    3. And to send, within one week, a written report of the Clinic's activity with the patient, and specific recommendations for follow-up by the referring person, according to his referral application and/or professional discipline.

5. Adequate cooperation with referring persons could greatly enhance the Clinic's contribution to mental health education of the professional community, and enlistment of the professional community in support and promotion of the Clinic and the Association.

6. A majority of cases come from the southern part of Kennebec County, of which Augusta is the urban center. This would indicate that planning of professional time and clerical deployment for availability of the Clinic to the public should be reappraised.

The researcher has found this evaluation study to be very fruitful in contributing to his professional experience. He expresses his sincere appreciation for the opportunity to conduct the study and the privilege of working with such full cooperation from the Clinic personnel.

This report of "An Evaluation Study of the Kennebec Mental Health Clinic" is

Respectfully submitted,

John E. Fickett

John E. Fickett

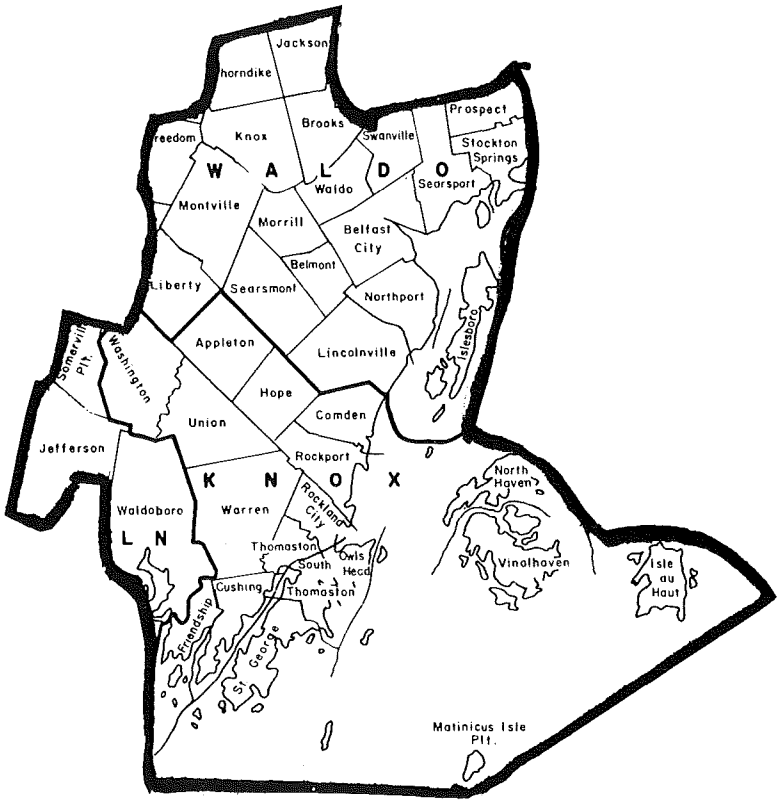
Waterville, Maine
March 31, 1965

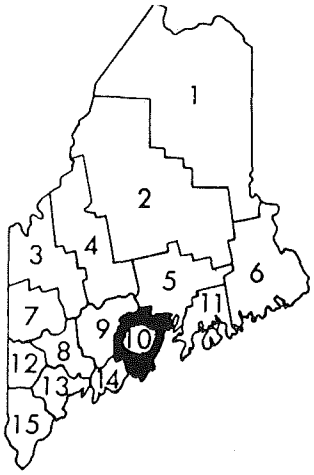
FINAL REPORT

OF
REGION #10

Mental Health Planner
700 State Office Building
Augusta, Maine 04330

REGION 10





POPULATION

Region X - 49379

State - 969265

Region #10 consists of Knox County and part of Waldo. It contains the cities of Rockland and Belfast, the towns of Camden and Thomaston, and many small villages. The area borders on the ocean and has some lovely coastal towns and some of Maine's most beautiful scenery. A drive from Camden to Searsport when the sun shines on blue and sparkling water is unforgettable. Much of the employment is seasonal - lobstering, fishing, blueberry and sardine canning, and tourism. This is particularly true in Waldo. Knox has many more year-round industries. Waldo does have a large poultry industry. Considered healthwise the picture in Waldo County is not a happy one. Several factors point this up. By Economic Opportunity Act standards, Waldo is considered the second most impoverished county in Maine, only Washington County being more so, and the relationship between poverty and poor health has been well established. Waldo has been underdeveloped economically and has a small population. Low-wage scales in seasonal food processing industries, lack of unionization, low-farm incomes give a picture of too frequent unemployment.

The 1960 census figures show 53.8% of all housing units to be substandard, one reason perhaps why industrial growth is slow.

Waldo leads all other Maine counties on the basis of admission to State mental institutions. The figure is at the rate of 278.4 admissions annually per 100,000 of the population. The figure for the state is 167.9.

Waldo is at the bottom of the list of the counties sending students to college in Maine, and Maine is at the bottom of the list of states in the United States.

Waldo is high in draft rejection, 46%, due to failure to meet service standards in health and education. And the infant mortality rate is nearly the highest in the state.

The program of the anti-poverty act is very much needed here.[1] After this bleak picture we will point out the positive features.

Belfast, the one city in Waldo County, has a general hospital with 70 beds. There is what could be called a branch of Sweetser Home in Belfast. There used to be a Home for Wayward Girls in the city. It ceased to function and the corporation sold the property, and gave the money to Sweetser Home in Saco and it still continues to support a cottage there. In return Sweetser conducts a clinic in Belfast one day a month, chiefly for children. The evening before the clinic a discussion with a group of mothers concerned with problems in raising children is held. The service of this clinic to the public is more of a diagnostic nature than treatment. There is a guidance director in the school which works with the clinic. There is also a remedial reading teacher for the district, SAD #34. Referrals of young people for treatment are made to the Eastern Maine Guidance Center in Bangor.

When the office of the Welfare District was stationed in Belfast, some of the workers in all the agencies concerned with the better welfare of people got together and formed a Council. They had found that some 3 or 4 agencies would be going to the same family. By talking over the problems of the families together they eliminated this duplication, were able to save the time of the worker, and give better service. The Council proved to be an exciting thing.

[1]Figures are from the EOA Survey by Charles Peirce

When the Welfare Office moved to Rockland this Council was abandoned and one was started in that city.

Belfast is fortunate in its public health nurse, Miss Gammon, a strong force in the community for better health. She wants a dental clinic, a pre-natal clinic and a nutrition class for young mothers.

There is a part-time Extension Agent working in the city.

The schools have a Special Education class for the educable retarded and would much like to have one for the trainables.

The probation and parole officer feels many problems would be solved if there were a vocational high school in Belfast.

The picture of need in Waldo is one that could be repeated in many sections of Maine, and is one that can no longer be endured in this affluent society in which we live.

Knox County presents a different picture economically and healthwise in general, but has very few mental health resources, only these services given by Health & Welfare.

Aside from seasonal business, Knox has a printing plant, a cement plant, electrical machinery factory, leather tanning, chemical and plastic factories, and others.

The population is dense--it is a small county -- 78.3 persons per square mile, while the state average is 31.2.

Knox has a high ratio of doctors, 1 for every 816 people. For Maine, 1 for every 1,114 people. For Waldo, 1 for every 2,263 people, by far the lowest ratio in the state. Four of the doctors in Rockland are Board specialists.

Knox County has some interesting features. Its population over 65 is highest in the state - 15.6%, for Maine 10.9%, for the United States, 9.2%. It has, as one could expect, the highest death rate. Also the lowest birth rate in Maine. The Methodist denomination is planning to build a State Residential home for the aging in Rockland.

There are two hospitals in Knox County: Knox County General Hospital in Rockland with 86 beds, Camden Community Hospital with 30 beds. The Knox Community Hospital, a fine hospital, has a complex of buildings and the community envisions it as a health center for the area.

The Hospital is particularly interested now in two things connected with mental health.

1. The development of an extended care unit with rehabilitation services built on the grounds of the hospital area. This is a coming trend. "Most doctors are frankly not interested in the care of the chronically ill and elderly in the nursing home environment." (*2) Care is simpler when they are near a hospital.

*2 - Area Health Survey Knox County October 1963.

There is very great need in the United States for acceptable facilities to care for long-term patients. In the United States 32.1% of the need is met. In Maine 6.1% of the need is met. Maine ranks 50th in the number of beds available for long-term care.

2. "Patients with acute mental illness should be admitted, and patients admitted for other diseases who sometimes develop mental illness should be cared for. This service does not require extensive facilities. It is more a matter of education of hospital personnel".*3

Knox Hospital also envisions in its health center home nursing services and a mental health clinic.

There is a mental health clinic in the works in Knox County being sponsored by the Mental Health Association. The history of this Association is interesting. It was sparked by the Council of Social Agencies and in particular by one of its most active members, Mr. Clarence Allen, a retired school teacher, a human dynamo who is involved in everything good in the community, and runs a summer camp besides.

The Council of Social Agencies has been in existence for five years. It was organized by a representative of Veterans Affairs and the Executive Secretary of the Red Cross and covers twenty social agencies. At a typical monthly meeting will be the district health nurse, director of Child Welfare, three or four clergymen, administrator of the hospital, the police chief, the school guidance directors, town manager, Red Cross representative, director of Hands (boarding home for the retarded), representative of the Veterans Association, and parole officer. Common problems are discussed. Through these meetings the functions of each agency have been well defined. Each knows what he can expect of the other, as a resource, and the group works together well as a whole. An example of cooperation and coordination of agencies so much desired not only in Maine but country wide.

Out of this Council came three things:

1. A casework study sponsored by Health and Welfare using this Council as a basis for working with multi-problem families.

2. A Homemaker Service project also sponsored by the Department of Health and Welfare.
   The supervisor of the State Homemaker Service came to Rockland, took twelve to thirteen housewives, made them into homemakers. They went into ADC homes, taught them home management, how to cook, how to wash and clean. They went as a friend. Contrary to the popular picture of the ADC mother as a Scarlet Woman, they are too often depressed and discouraged, weighed down. They went into homes of older people, got them a hot meal a day, shopped for them, took clothes to the laundry, drove them where they needed to go. A very successful project which proved the need.

3. The third thing was a Mental Health Association very keenly interested in a clinic for the area, which would provide services for the schools, "It is so much needed," - and services for all citizens in the area. A full clinic.

*3 Area Health Survey Knox County October 1963

This Association is incorporated. Money seems available. The present problem is personnel.

The recommendations for this area are:

1. A full mental health team, located in the Knox County Hospital complex.
2. Services started for the schools.
3. A boarding home with a warm supportive atmosphere for emotionally disturbed children.
4. Day care for children of working mothers.
5. Full advantage be taken of the Economic Opportunity Act programs for Waldo County.
6. Organized recreational facilities in Waldo and Knox.
7. A vocational high school in Belfast.
8. A class for the trainable retarded in Waldo.

The following are the members of the Region #10 Committee:

Mr. Christy Adams, 7 Masonic Street, Rockland, Maine, lawyer, former court judge.

Mr. Lawrence Averill, Sheepscot, Maine, educator.

Mr. Philip Cameron, 62 Warren Street, Rockland, Maine, counseling officer in Thomastonschools.

Mr. Caspar Cerravino, Rockland, Maine, assistant superintendent of Rockland district schools.

Mr. Robert A. Clark, 68 Masonic Street, Rockland, Maine, interested citizen in mental health.

Mr. Robert L. Clark, Union, Maine.

Barbara Doaks, High Street, Rockport, Maine, psychologist.

Miss Charlotte Donnell, Sheepscot, Maine, retired social worker.

Mr. Benjamin Drisco, Sea Street, Rockport, Maine, research scientist.

Winnefred Erskine, Wiscasset, Maine, housewife.

Grace Foster, Ph.D., Friendship, Maine, psychologist.

Mrs. Charlotte Francis, Wiscasset, Maine, educator, head elementary schools in Wiscasset.

Edith Grimes, High Street, Vinalhaven, Maine.

Mrs. Rita Holden, 122 Main Street, Thomaston, Maine, head of Red Cross in Rockland.

Peter Holz, M.D., 51 Elm Street, Camden, Maine, pediatrician.

Mr. Harvey Hope, Four Corners Road, Pemaquid, Maine, selectman.

Mr. Elwood Ireland, Whitefield, Maine.

Rev. Gerald B. Kinney, 3 Dunn Street, Thomaston, Maine, minister.

Mr. Galen Lagassie, 423 Main Street, Rockland, Maine, judge for district court.

Helen F. Lange, 17a Dunn Street, Thomaston, Maine, welfare worker.

Elizabeth Leavens, 17a Dunn Street, Thomaston, Maine, housewife.

Mrs. Gordon Merriman, Damariscotta, Maine, housewife.

Rev. Haig J. Nargesian, 33 Chestnut Street, Camden, Maine, episcopal minister.

Mrs. Polly Nichols, Long Cove Point, Chamberlain, Maine, psychiatric social worker.

Mr. G. William Porter, 196 N. Main Street, Rockland, Maine, counseling officer in Rockland schools.

Mrs. Ralph C. Powell, Bristol Road, Damariscotta, Maine, housewife, background in welfare.

Gilmore Soule, M.D., 22 White Street, Rockland, Maine, general practitioner, operates group therapy unit in general hospital.

Mrs. Madelyn Turffs, Washington, Maine, investigator for Division of Reimbursement, Dept. Mental Health and Corrections.

Mr. W. David Verrill, 4 Summit Road, Rockland, Maine, manager of the Portland National Bank of Rockland.

Mr. Clarence E. Allen, 69 Chestnut Street, Camden, Maine, retired educator, camp director, former headmaster in Boston school. Committee Chairman.

JUNE 1965

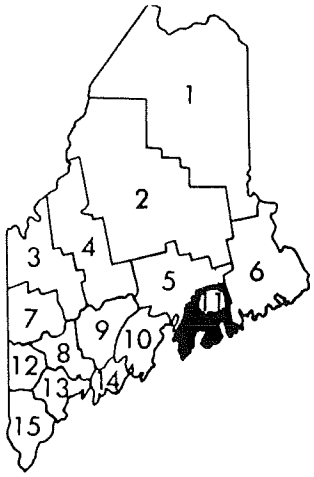
FINAL REPORT

OF

REGION 11

Mental Health Planner
State Office Bldg.
Augusta, Maine

REGION
11



POPULATION

Region XI - 24760

State - 969265

Directory of School Unions, Towns, and Superintendents of Hancock County *

School Union No.	Names of Towns	Superintendent's Name and Address
76	Brooklin Deer Isle Isle au Haute Sedgwick Stonington	Mr. Ozias H. Bridgham Deer Isle, Maine
88	Amherst Aurora Clifton Dedham Eastbrook Eddington Holden Mariaville #33 Plantation Osborn Plantation Otis Waltham	Mr. Philip F. Lucey R.#1, East Holden, Maine
91	Bucksport Orland Orrington	Mr. Paul J. Brown Bucksport, Maine
92	Ellsworth Franklin Lamoine Surry	Mr. G. Frank Sammis Ellsworth, Maine
93	Blue Hill Brooksville Castine Penobscot	Mr. Albert L. Skidds Castine, Maine
96	Gouldsboro Hancock Sorrento Steuben Sullivan Winter Harbor	Mr. Reginald H. Haskins Sorrento, Maine

*Taken from Maine Educational Directory 1964-65, State Department of Education. The towns underlined have been served in the last two years. Union #98 is now being served by Mount Desert Island Child Guidance Association.

THE PLANNING OF A MENTAL HEALTH PUBLIC OPINION POLL

The Hancock County Mental Health Association had over two years worked with the superintendents of schools, in its school consultation program, and it seemed natural that this relationship should be continued in the work of the comprehensive mental health planning.

On November 19, 1964, Mr. John B. Leet and Edwin D. Wright met with the superintendents at their regular monthly meeting in Castine. Mr. Leet introduced the planning and his own relationship to it as the executive planner. The stereopticon display of the organization of planning was used, accompanied by the narration read by Mr. Leet. Dr. Arthur Kaplan of the University of Maine met with the Committee for its second meeting and explained the proceedures to be taken.

In view of the lack of previous systematic publicity on Region #11's part it was found important that more direct information be given the communities of Hancock County about the work of the planner and his organization. Meetings were therefore planned in the eastern, middle, and western parts of the County.

The Parent Teachers Association in Sullivan organized a public meeting in Hancock Elementary School and heard Mr. Leet and Dr. John Cass of the State Department of Education.

The Parent Teachers Association of Bucksport arranged a similar public meeting and heard Mr. Leet and Dr. Cass.

A similar meeting was held in Ellsworth with Mr. Leet and Dr. William E. Schumacher, Director of the State Bureau of Mental Health again showing the slides and giving careful description of the planning.

On February 2, the coordinator met with interviewers in Hancock. On February 12 he met with interviewers in Bucksport. On March 1, 10, and 17 he met with interviewers in Ellsworth.

City and Towns which finally contributed to the Public Opinion Poll:

Ellsworth, City of
Bucksport, Town of
Hancock, " "
Sullivan, " "
Deer Isle " "
Gouldsboro, Village of
Penobscot, " "
Winter Harbor, Town of
Blue Hill, "
West Gouldsboro, Village of
South Penobscot, " "
West Sullivan, " "
Surry, Town of
Franklin, "
Sunshine, Village of
Orland, Town
Sorrento, "

MENTAL HEALTH RESOURCES

The level of public knowledge of mental health is not deep and it is factioned. The term mental health is used, it seems from the replies obtained, more in the sense, "What is wrong with individuals or with the town or city!" The tenor of the "problems" reported seems to imply, on the one

hand, that of mental illness and, on the other, that of conditions in the respective communities and interpersonal relationships, which are not adequate. This is reflected in our tabulation of the public opinion "votes".

And still when looked at as a whole, the public opinions voiced come very close to the findings of Alexander Leighton's in "Sterling" County in Nova Scotia, relative to the incidence of mental illness, of which the first three were: poverty, secularization, and cultural cross currents.

The lack of employment opportunities produces "financial pressures" in families. The many and rapid changes in conditions of living have altered the traditional community life, largely conditioned by transportation facilities of the automobile and motor boats. The super markets and other concomitants of the overall industrialization of neighboring states, change the economy from the barter economy to a cash economy, only with little cash available.

The cultural cross currents can be seen partly in a ground swell of fractional values and mores. There is moreof 19th century values and ways of living than meets the eye of casual observer. And the fact that the coastal region has a fairly large population of summer guests coming back each year, as well as the seasonal influx of tourists, has developed an economic dependency in the Region and cultural influences not indigenous to the local communities.

The secularization of the communities is obvious and is a concomitant to the deep social changes. The image of the church and its moral authority may still be with the generations of the grandparents and the great grandparents. It certainly is not consciously or otherwise in the minds of the younger generations of parents and children.

Wherever mental health problems are defined, this compiler has the feeling that the list of problems furnished by the interviewers may have to some extent influenced both interviewer and respondents.

It is unmistakable that the existence of mental problems in an individual have a strong reflection of guilt and shame on the part of friends and relatives of persons involved. Mental disturbance or illness has still the status of wrong living. More people should read Butler's Erewhon!

THE MENTAL HEALTH SERVICES

The above seem to be reflected in the feeling about Bangor State Hospital, which still in wide areas of opinion reflect not so much that it is mental health resource, as a place housing persons who cannot get along in the family and community. This latter image is changing, but changing very slowly.

The Eastern Maine Guidance Center on the other hand, is considered a resource for disturbed emotions and behaviors. The Family and Children's Services, Inc., Bangor, is listed, and the Hancock County Mental Health Association is given honorable mention. In cases of drinking problems the AA's are listed, sometimes local, sometimes out of town.

Bar Harbor and Ellsworth School Unions maintain a special class for retarded children. Under resources are listed various physicians, clergymen, teachers, nurses, psychologists, probation officers, police officers.

Evaluation of mental health services as to adequacy and frequency of their use seem not to be warranted. The replies are few, and the ranking of their use is scattered, and should not be used even if it is used in a public opinion poll. This applies to any part of the questionnaire where a quantative or ranking opportunity is given.

THE NEEDS FOR MENTAL HEALTH COMMUNITY SERVICES

The needs may well be reflected in the waiting for appointments of referral to the Eastern Maine Guidance Center. Except in unusual pressing need for an individual or family, a referral must wait for appointment. The Family and Children Services, Inc. also have a waiting list. Calls for help in disturbed or disorganized families have increased for the County Mental Health Association.

Hancock County has much in common with the depressed area, the Sterling County in Alexander Leighton's report. The most pressing need felt in Hancock County for a mental health program is a vigorous, planned educational activity, beginning perhaps with the professional personnel, physicians, clergymen, attorneys and law enforcing personnel, and teachers as individuals. This work, it would seem, can best be done through the active existing organizations in this area, especially the PTA and the Women's Clubs. Our best responses to requests for support have been from these organizations in Hancock County.

The Plan

The immediate efforts of the Hancock County Mental Health Association is described in the paper "Expansion of Services in 1965-66" and the paper appears following these remarks. The plan is to set up a social worker-psychologist team to serve the county as a family counseling unit through visits to the towns now having the Association's service through the schools: Ellsworth, Bucksport, Blue Hill, Deer Isle and Hancock. A strong educational campaign as indicated above must be developed using lay personnel, instructed by the Association.

Income

The source of income will come primarily from the city and towns in Hancock County, for the expansion for 1965-66. Seven thousand five hundred dollars ($7,500) is the present goal. This money income will be increased by grants-in-aid from the Bureau of Mental Health to the extent of money spent in 1965-66. To this will be added special funds solicited from organizations and individuals and, of course, membership fees and contributions. The Association is at present considering charging fees for family service counseling from non-contributing towns or areas. The quantative aspects of the poll and the ranking of needs and their importance, would, if reported statistically, imply a degree of accuracy misleading because numbers really are very unrealistic.

PROBLEMS IN PLANNING

The problems of planning the Public Opinion Poll were first the lack of available time on the part of the planners and interviewers. Secondly, individuals were uncertain and puzzled about being involved in the activity for which they were recruited. The aura about mental health problems has already been mentioned. Relationships in a predominantly rural area are much more personal than in larger population centers. People are much more aware of each other and hence shy away from discussing problems related to mental health. Dr. Schumacher's story about the eight inmates escaping the Mental Health Hospital and which were found quickly, by noon twenty-three were recovered, is not only funny, but conveys more truth than poetry.

Within the time available and the local conditions, the response seemed adequate for the purpose of the Poll.

HANCOCK COUNTY MENTAL HEALTH ASSOCIATION
ELLSWORTH, MAINE

TABULATION
OF
OCCUPATIONAL STATUS OF RESPONDENTS
TO
MENTAL HEALTH OPINION POLL

April 1965

Occupation	Number	Percent
Government officials or employees	10	6.5
Police	3	2.0
Clergy	8	5.2
Physicians	6.	3.8
Attorneys	1	.7
School teachers, administrators	24	15.7
Youth leaders	7	4.6
Pharmacist	1	.7
Housewives	44	28.7
Nurses	12	7.8
Farmers, lobstermen and fish factory workers	5	3.3
Tradesmen	5	3.3
Merchants and Mercantile employees	19	12.4
Occupation not given	8	5.2
Total number of respondents	153	

TABULATION OF

THE THREE MOST PRESSING MENTAL HEALTH PROBLEMS

Mental Health Problem	Number of "votes"				Weighted # of "votes"	
	Most	Rank	Second	Third	Votes	Rank
Retardation	33	1	16	18	144	1(highest)
Adolescent Problems	23	3	29	11	142	2
Drinking	28	2	20	12	136	3
Overall Community Problems	22	4	15	19	115	4
Emotional disturbance	11	5	10	18	71	5
Aged	10	6	13	13	69	6
Family	9	7.5	10	5	52	7
Economic	9	7.5	4	5	40	8
Problems relating to sex	2	9	3	1	13	9
Total	147		120	102		
Incomplete Record	6					
	153					

Problem: Over-All Community Life

Phases of community life listed by respondents; vote as most, second, and third most pressing mental health problem.

Most Pressing: Lack of Youth Center; lack of employment opportunities; apathy; no vocational school; lack of guidance; lack of respect for schools and teachers; too many pressures; lack of training facilities; lack of communication between persons; low educational level; cultural differences; lack of environmental health.

Second: Lack of programs for aged; apathy; interference of parents with teachers; disagreements in homes; mental retardation; problems of the aged; family disintegration; teen-age pregnancies; lack of moral tone; lack of parental maturity; influence of TV; drinking; poor sex training facilities; prevalence of adolescent problems; lack of public health agencies.

Third: Employment opportunities; apathy; dependency; lack of training facilities; inability of people to adjust to new situations; drinking; absence of moral leadership; loneliness; materialistic attitudes of children; low standards of behavior; mental retardation; lack of youth supervision; poor attitudes toward mental illness.

The Expansion of Services in 1965-66 of the Hancock County Mental Health Association

The Association's Board of Directors have already approved the continuation of its school consultation service, now operating in five elementary schools: Deer Isle, Blue Hill, Bucksport, Ellsworth and Hancock. Expansion of this service for the year 1965-66 may be described in terms of

1. addition of one social worker to the professional staff;
2. expansion of area in the County now being served; and
3. expansion of the type of service now given.

1. The Addition of One Social Worker to the Professional Staff

This increase in manpower will enable the Association not only to increase a proportional part of its service, but it will also be possible to differentiate the service by adding a follow-up counseling practice by a full-time worker to its present diagnostic-consultative activity in the schools.

2. The Expansion of Territory Now Being Served

The service of the Association in Hancock County has entailed working with the school superintendents, and the approach to the towns in the County for their support has made us think in terms of the school unions which are organizations of the towns' school work. The schools are one, if not the focal point of interest and concern of the County's families.

A listing of the towns of the County is attached on page 1. They are listed by school unions. The towns, which the Association is now serving, are underlined. It will be seen that no service is being given in School Union #88, the northernmost part of the County. It seems reasonable that the Association offer its services to this school union, thus expanding the territory served. It is not difficult to conclude, that to bring the services of the Association geographically to every town would be to extend itself even more than a mile wide and less than an inch thick, wider and thinner than Mississippi. A reasonable plan would be to arrange for the Association's professional staff to be housed in a specific town, preferably the large population center of the county. And it is natural to think of an arrangement to be worked out with the respective school unions by which service might be given to requests for consultation from the other schools in the Union.

3. Expansion of Services in Territories Served

While the Association so far has given service mainly in the five elementary schools listed and underlined, it has also responded to requests from junior and senior high schools, as well as from single adults and husbands and wives.

The school consultative service, it has been agreed, is the principal's program; and the service has been variously utilized:

a. It may have been essentially a fact-finding program, seeking answers to grade placement of pupils, to unusual behavior, or to seek to obtain an objective answer to questions between parent - principal - teacher.

b. Again, it may have been attempting, in addition to the practice described in "a", more active consultation with parents, which gave opportunity to recommend referral of the child to the family physician, to an ophthalmologist, or to an available pediatrician.

c. And, last, the service has been used fully, involving first the basic practices described in "a" and "b". In addition all the teachers remained after school for a veritable faculty seminar in which the principal, as moderator and teacher and psychologist pooled information about the pupil in question, working out from this more serviceable point of vantage specific ways to help the pupil, thus pooling knowledge and understanding of principal - teacher - parent for the benefit of the pupil.

Each school has been visited a full day every two weeks of the school year.

By the increase of staff manpower, by serving every school union, and by integrating its work in cooperation with the local schools as described, the Association is expanding its activity to constitute a Family Counseling Service.

To make the Association a viable organization it needs to inform individuals and organizations of its purposes and activities. There is a need for each Director of the Board to be sent a record (minutes) of

meetings of the Board, of the Executive Committee, and of committee meetings. Such records serve not only as records but also as directives for the executive staff to function in line with decisions made by the organization. There is a need for a news letter to members, say one every three months, to keep the interest of members by telling of the many facets of the Association's work.

4. Expansion of the Number of Directors of the Board

In line with the principle "No Taxation without Representation", the number of directors has been increased from 15 to 25. The present Board felt that the various parts of the county should be more fully represented; that the increase in numbers will facilitate bringing the needs for community mental health activities before the Association, as well as enable a larger number of men and women to speak for the Association.

The Association has courageously set as its goal for the year, July 1, 1965 - June 30, 1966, a budget of $7500.00. This will be augmented by grants-in-aid by the State Mental Health Bureau to the extent of money spent in that fiscal year.

It has made a good beginning in its appeal for support by the towns of the County. These contributions will be supplemented by memberships and by individual gifts of friends subscribing to the work of the Association.

Written by: Edwin D. Wright
Executive Director

Problem: Overall Community Life

What recommendations do you have for better mental health?

Comment by an average citizen --

"Mental Retardation - I do not know of any children or adults who are considered to be below average."

"Alcoholism - I have not seen anybody staggering down the street that I knew was the result of alcohol drinking."

"Adolescent - Am not familiar with juvenile delinquency."

"Aged - I suppose the same as any town."

"Adult Mentally Ill - Not familiar with the term."

"Emotional Disturbance or Mentally Ill Child - Not familiar with the term."

"Adult Offender - Only what the newspaper say."

"Recommendations - As much employment as possible."

A businessman says - "Live and let live - as comment"

A Girl Scout Leader says: "In my position as a Girl Scout Leader, I have, fortunately, not come across any mental problems. Since I have very little contact with other groups, I don't feel qualified to answer the questionnaire."

A member of the Regional Committee says:

"The enclosed polls seem to indicate the following major concerns:

a. Alcoholism
b. Mental retardation
c. Problems of the aged
d. Emotionally disturbed children
e. School dropouts
f. Unwed mothers

It seems quite evident from the expressions received that people want a contact with professional people located within the area. There seems to be a need for help in personal planning as well as professional services in individual cases. There appears to be a wide range of need encompassing the very young and the aged.

Behind many of the comments appears a feeling of insecurity because of a meager economy. Leadership seems to be lacking - professional as well as political (community)."

A teacher says - "More professional help for school children. Full time elementary guidance man. A youth program such as YMCA, Boy's Club of America, better scouting - Full time school psychologist (preferable to full-time guidance department)."

Another Teacher says: "There is a need in this community for a trade school to train boys who have not the mental ability or desire to cope with the present high school courses.

For many years there has been intermarriage among people lacking high mental ability and cultural background until we are getting too many children who have no knowledge or appreciation of good manners, neat dress, or interests beyond their own small world. I believe trade school, cultural training and youth groups could eventually change this."

A Tradesman says: "The most pressing mental health problem is lack of purpose. We need a club with gym facilities for adults. Recreation program for children and teenagers. Restriction of cars. No licenses until 18. No recreation program will work as long as the high school crowd can run around in cars. Drinking in cars is very common here among the teenagers. Young children should not be left on their own after school - mothers working or just not interested."

A Businessman says: "The three most pressing mental health problems are Cultural Differences, Alcoholism, Lack of proper education. These problems have always existed in this poor area and I see no solution to the problem."

A Law Enforcing Officer says: "If we can mutually agree that no one form can possibly cover rus and urbs, the small community and the big city, I expect I can follow the REGIONAL COMMITTEE REPORT form and give you much more in my own words. I can't give you a clear picture without it.

Sooooo, let's start on "Suggested Contacts".

1. No clinics on the island. (nearest would be Ellsworth, 50 miles away or Bangor 1½ hours by car)
2. Police: Local: I am a Constable. We have a police, mostly for traffic violators in the Town at the end of the Island.
   State: They come on call, but mostly for traffic control or when things really get out of hand.
3. Courts: Traffic court on Island. Nearest criminal court at Ellsworth.
4. Welfare workers: As such Unemployment Ins. clerks and Mother's Aid charity checkers uppers.
5. Clergy: Eight religious for one island. Two trained. They do their best.
6. Physicians: One subsidized. One doctor for 3,000 people. Add, one medical doctor. We also have one not so medical.
7. Attorneys: None
8. Personnel Offices: None
9. Public Health nurses: One, a darned good one, who works out of Ellsworth but covers far more territory than this island so she is spread out thin.
10. Reporters: None
11. Alcohol Rehabilitation: None
12. School teachers, administrators, guidance, nurses:
    School teachers we got. Administrators we got. That's all.
13. Youth Leaders: Aside from churches we have one troop of Boy Scouts, ditto Girl Scouts.
14. Pharmacists: We have two.
15. County Agents: Occasionally
16. Social Agencies (Private) None
17. Town Officials: Three Selectmen, Tax Collector, Town Clerk, Sealer of Weights and Measures.
18. Probation and parole officers: We have none.
19. Others: Yes, we have some others. (Do gooders without portfolios)

A Housewife says: "The chief concern is to improve relationship of children and school teachers. We have a wonderful school program and good teachers, but there is concern in regard to retaining said teachers because of interference of parents and lack of interest and respect of children. She feels it is too bad the smart children have to be held back because of very slow children and hopes for special class to care for the handicapped."

Another Housewife says; "The main problem of this area is poverty and its effects - apathy, ignorance, poor diet, etc. Somehow a way must be found to overcome the vicious cycle which poor people cannot escape. But it will have to be a prolonged and concentrated effort, not pie-in-the-sky promises dangled at election time. It will need personnel competent to educate people in skills needed for the region in which they live."

A Housewife says: "The State will have to accept the idea that a sizeable expenditure will be necessary in order to remedy the evidently serious mental health problems. Much of these funds should be spent on the more economical preventive measures, rather than an elaborate clinical facilities, etc.

The high cost of obtaining an education in Maine results in poorly trained persons who are not equipped with the skills needed to earn a satisfactory standard of living for themselves and their families."

A Community Grocery Store Owner says: "The three most pressing mental health problems are Lack of Initiative; Alcoholism; Low Standard for behavior..... I think this town needs a social service program where the three above mentioned problems can be met on an individual basis. First of all, the younger people - 13 to 20 need counseling and guidance when they do not receive such training at home. The young people need a program such as this because oftentimes there is little incentive given at home for these young people to improve themselves and reach for a higher standard of living."

This report was submitted by the following members of Region #11.

Mr. Oxias H. Bridgham, Deer Isle, Maine, superintendent of schools, Union #76.

Mr. Paul J. Brown, Bucksport, Maine, superintendent of schools, Union #91.

Mr. Reginald H. Haskins, Sorrento, Maine, superintendent of schools, Union #96.

Mr. Philip F. Lucey, East Holden, Maine superintendent of schools, Union #88.

Mr. Floyd Matthews, Bar Harbor, Maine, superintendent of schools, Union #98.

Mr. G. Frank Sammis, Jr., Ellsworth, Maine, superintendent of schools, Union #92.

Mr. Albert L. Skidds, Castine, Maine, superintendent of schools, Union #93.

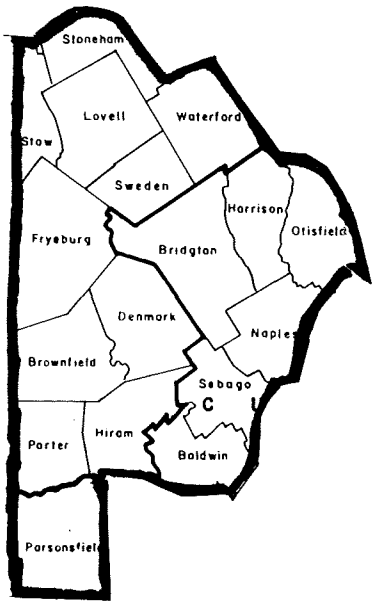
Mr. Edwin C. Wright, 50 Union Street, Ellsworth, Maine, director, Hancock County Mental Health Association, committee chairman.

May 1965

FINAL REPORT
on
REGION 12

Mental Health Planner
700 State Office Building
Augusta, Maine 04330

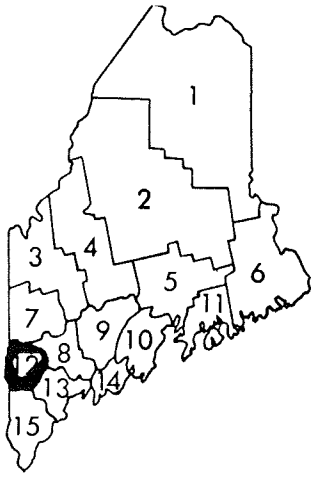
REGION 12



POPULATION

Region XII - 14138

State - 969265



PLANNING

Region 12 is in southwestern Maine on the New Hampshire border. The Town of Bridgton is the central town, both geographically and economically. The area includes five towns on the New Hampshire border: Stow, Fryeburg, Brownfield, Porter, and Parsonfield, plus Cornish, Hiram, Baldwin, Sebago, Denmark, Naples, Bridgton, Harrison, Otisfield, Waterford, Sweden, Lovell and Stoneham. The towns are in the foothills of the White Mountains and include Pleasant Mountain in Bridgton as a major ski area. The area is mostly rural with many lakes.

The socio-economic structure of the area is primarily geared to the recreation business with a considerable influx of transients in the wintertime, coming to Pleasant Mountain and the adjacent eastern slope area of New Hampshire for skiiing. The stable population of 15,000 rises to about 75,000 during July and August with a great influx of summer visitors. There are eighty-four boys' and girls' camps in the area plus a multitude of privately owned cottages, as well as many guest and tourist houses and large trailer and camping areas. Sebago State Park alone has more people in it on a weekend than the permanent population of this entire area. In addition to the tourist and recreation business, Fryeburg is a fairly well developed farming area with small farms scattered throughout the rest of the towns. A considerable amount of lumbering is done in the area. There are a number of small industries, including Bridgton Knitting Mill and multiple woodworking mills. A new thirty-two bed general hospital opened in Bridgton in October, 1964, and has attracted two new physicians to the area so that the medical problems of the communities are now being adequately met.

No complete demographic study was undertaken, but the population of the area is quite stable with a slight preponderence of older people who have retired here.

The most pressing mental health problems as ascertained by our committee in its surveys and multiple meetings with other groups were as follows: 1. The lack of any psychiatrically trained person who is available within the financial means of the population to whom psychiatric problems can be referred. Private psychiatrists are beyond the means of the great bulk of the population of Region #12. The psychiatric clinics in Lewiston and Portland are almost inaccessible to people from this area, mainly because they are so greatly overloaded. 2. The lack of counseling services which could give advice and direction to emotionally disturbed people and their families, as to the best method of dealing with their problems.

The mental health problems of this area seem to fall in no specific group but ran the gamut from emotionally disturbed children through adolescent behavior problems, adult mentally ill and the problems of the aged, including senility. There is the usual amount of juvenile delinquency and problem children in school. The area is very well supplied with recreational facilities for all ages and does not suffer for lack of diversion for certain groups as do more urban areas.

The available resources for handling mental health problems at the present time are extremely minimal. The new hospital does admit emotionally disturbed persons on an acute basis but there is no psychiatrist to handle the problems that are beyond the general practitioners. Outpatient psychiatric services are practically non-available to people of this area, except as they are supplied by general practitioners, clergy, courts and police within their very limited scope. There are no social public or private agencies which concern themselves with mental health in this area. At the present time our resources are completely inadequate for the needs in the area of mental health.

The conferences and discussions with members of the community, as well as the survey of the area convinced the committee that there is a serious and immediate need for a mental health clinic in this area. To meet the problem adequately, this clinic should include a psychiatrist, a clinical psychologist, a psychiatrically oriented social worker, and a secretary suitably housed. This is the minimum functional mental health unit which could be expected to meet the needs of this area. This clinic would need an annual budget of $40,000 or about $2.50 for each person in the area. Such a clinic is in the long-range planning of this community at this time with implementation of this as soon as possible.

Plans for implementation have already begun with contact of the towns involved, some of whom voted at their last town meetings to appoint a representative to a regional planning committee to evaluate the problem and bring back a definite proposal for action at the various town meetings next March. Some search is already underway for personnel to get concrete figures as to the salaries necessary. The plan is to present a definite budget to the towns for a start on the program next year. Whether we will attempt to set up the ideal clinic at once or simply start with the most pressing problem, that is, a psychiatrist, depends on the feelings of the towns prior to their town meetings, specifically as to whether we budget fifty cents per person, one dollar per person, or more, for appropriation by each town. This will also depend on what aid is available for such a clinic from the state and federal government at the time we need to put the articles in the various town warrants.

This report was submitted by the following members of Region 12:

Mrs. Charles Bennett, Sweden, Maine, summer camp owner

Mr. Fred Crouse, Bridgton, Maine, principal of high school

Mrs. Betty Dyer, Naples, Maine, housewife

Mr. Reginald Fickett, Casco, Maine, foreman in woodworking mill

Mr. Rodney Kimball, Waterford, Maine, laborer

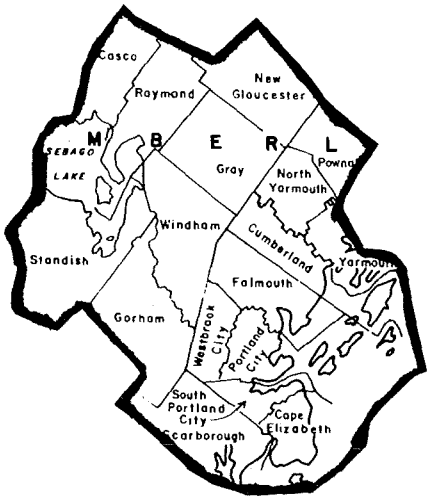
Mr. Philip Richards, Fryeburg, Maine, headmaster, Fryeburg Academy

A. Dewey Richards, M.D., 11 Gage Street, Bridgton, Maine general practitioner, Committee Chairman

FINAL REPORT
of
REGION #13

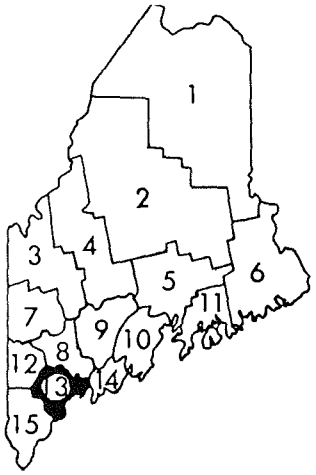
Mental Health Planner
700 State Office Building
Augusta, Maine 04330

REGION 13



POPULATION

Region XIII - 154543
State - 969265



INTRODUCTION

Region 13 has as the hub of its geography the cities of Portland, South Portland and Westbrook surrounded by 15 other towns of varying sizes. The core of this region is Portland, the largest urban center in the State of Maine.

The total population of Region 13 is in the neighborhood of 160,000 (see Appendix 1 for listing of all municipalities included in the region).

The City of Portland has most of the characteristics of a large city. It is the focal point of business and industry for the area with most of the surrounding communities representing suburbia, or the living centers for those who are employed in the city. The city has its share of fine residential and poverty stricken areas. It has what might be considered a generally good system of governmental and voluntary health and welfare services, several of which are dedicated to the cause of better mental health. Located in the area are five hospitals, the largest of which is the Maine Medical Center which is both a treatment and teaching institution. While the other institutions, with the possible exception of the Osteopathic Hospital, function primarily on a community basis, the Medical Center functions as a statewide facility due to the nature and scope of its many services and high quality medical care.

In summary, it might be stated that the Greater Portland metropolitan area which comprises Region 13 appears to have all of the characteristics of any thriving metropolitan area. Included in this is its fair share of mental health problems.

BACKGROUND TO REPORT

In 1962, through the medium of a special committee, a professional survey of the Greater Portland community was conducted. This survey represented a total review of the entire system of health, recreation and welfare services on both the governmental and voluntary level. Major recommendations were developed for the improvement of services and relating them more effectively to the needs of the people of the community. It is the Committee's view that, regardless of the field of service, the implementation of the recommendations contained in the survey will continue to have a direct impact upon the overall mental health of the community. Such recommendations as increasing of subsistence welfare grants, improvement of general services to the aging, the development of a generalized public health department and the development of more effective services to youth, to name a few, can all have a direct impact upon the community's mental health. However, for purposes of this report, the Committee does not attempt to analyze in great depth each of the recommendations of the survey, but merely wishes to emphasize the obvious fact that a well organized, properly functioning system of human welfare services can be a most effective line of defense in the mental health battle.

The Citizens Survey Report did contain several specific recommendations in regard to mental health treatment facilities, and one of the purposes of this report is to reaffirm those findings, for it would appear from the reports of individual communities that the greatest immediate mental health need is the establishment of a community based mental health center which would function as the focal point for not only treatment but mobilization of all of the forces of the community which play upon the mental health of its citizens.

METHOD OF STUDY

The Region 13 Committee was initially organized on the basis of careful selection of at least one or more individuals from each of the communities in the district. One individual from each community was designated to secure the information and viewpoints of key personnel in regard to mental health needs. This information was gathered, either through a series of interviews conducted by the community representative, or through the medium of meetings called by the representative in the community. A guideline schedule (see Appendix 2), entitled "Local Community Report on Mental Health Services" was used as the basis for securing the information.

In the main, excellent response was experienced throughout the district, with several communities agreeing to continue the discussions beyond the fact-finding stages necessary to the report.

The reports were then discussed individually in the general Committee with the following representing the consensus or major common denominator of concern to the entire area.

SUMMARY OF MOST PRESSING PROBLEMS

Based on both the tabulated findings as well as the expressed viewpoints of key personnel in each community, it would appear that the principal mental health problems would be rated as follows: 1) adolescent behavior; 2) emotional disturbance of children; 3) mental retardation; 4) alcoholism; 5) aged; 6) adult mentally ill; 7) adult offender.

There was general agreement in most communities that, while the region does have such services as an adult psychiatric clinic at the Maine Medical Center, a part-time child guidance clinic, a family and children's casework agency as well as a variety of other health and welfare services, these are extremely inadequate, in terms of size, to cope with the need. Each of the above named facilities has limitations. For example, the Maine Medical Center Clinic currently serves only adults on a short-term limited basis. The Child Guidance Clinic operates on a part-time basis, with at least a two to three month waiting list. Child and Family Services also has waiting lists, sometimes of long duration.

FINDINGS AND CONCLUSIONS

As stated previously, the highest ranking area of need seems to be in the field of adolescent and children's behavior problems. Reports from the school system indicated that the schools recognize that a substantial number of children are emotionally disturbed. However, these disturbances are not recognized early enough and treatment in sufficient quantity is not available to them. Certain areas in which improvement seems indicated are as follows:

A. At the present time the Junior and Senior High Schools, through their administrators, counselors, teachers and attendance officers are attempting to handle a major mental health assignment with too small a number of people available to do the work. Junior High counselors who seem to receive

the greatest impact of the problem in school feel that the greatest need for help in the mental health problem would be through the use of qualified guidance counselors in elementary schools working in close cooperation with home-school social workers. If need for mental health is recognized in its early stages there would be less evidence of the emotional explosion in mental health in the Junior and Senior High School. The present ratio of one guidance counselor to 400 children should be substantially reduced.

B. In the education of teachers, particularly for those on the elementary level, there should be more courses of a socio-psychology type so that these teachers would have a greater awareness of mental health problems and ability to recognize them in the early stages of development.

C. Adequate psychiatric team consultation, including psychiatric, psychological and social service time should be immediately available when problems are found.

D. An effective system of referral to resources for psychiatric treatment should be developed. In the viewpoint of many, such does not exist at the present time and there is lack of coordination and cooperation among agencies which in many respects are dealing with the same problems and sometimes with the same families.

The above findings illustrate the need for substantial community education on the problems of mental health.

In the field of mental retardation the need is also seen for early recognition and diagnosis beyond singular dependency on psychological testing. Sometimes the symptoms of retardation are indicative of other problems. The individual child must be evaluated as a total and complete entity for the purpose of developing his full potential, both in the education system and the community. Programs in the school systems are currently inadequate to assist the truly retarded child at all ages and levels of development with emphasis on helping each child to develop to the maximum of his potential. In many respects the mentally retarded child is still treated as a second-class citizen of the community.

For those individuals who have already been committed to institutions, more adequate follow-up must be provided at the point of discharge. Such discharge should be part of a planned arrangement in cooperation with local community resources so that the individual will not be exploited, nor become a hazard to himself or the community.

The problem of alcoholism is still complicated by negative community attitudes and insufficient resources for the treatment of alcoholism. It is interesting to note that in a United Community Services survey of Cumberland County physicians, conducted in 1959, alcoholism rated second only to mental illness and emotional disturbance on the part of the doctors' viewpoints regarding the greatest health needs of the community. Mental retardation was third.

The need for increased inpatient facilities to give adequate medical and psychiatric care is most essential. After the alcoholic has been treated medically, all of the facets of the community should be coordinated to treat and rehabilitate the patient, and particularly for follow-up work with the patient's family. Here again the necessity for more effective coordination of effort is most apparent.

The problem of the adult who is mentally ill requires immediate accurate diagnosis and the development of treatment recommendations. A local facility should be developed for inpatient care to negate the necessity of commitment and patient's being away from family, friends and other forms of assistance. Such facility should be available as long as diagnosis indicates that patient may be returned early to community living, perhaps with continued outpatient treatment. Under this arrangement, the centralized State facility would be used for long-term and chronic cases.

There is also a need for more effective follow-up of patients and coordinated aftercare programs to assist them to adjust to community living and to achieve the ultimate in rehabilitative potential.

GENERAL RECOMMENDATIONS

The foregoing findings and conclusions demonstrate the need for broad gauged community education in the problems of mental health. In addition, each of the areas covered clearly shows the need for a central diagnostic and treatment center, adequately staffed with qualified psychiatrists, psychologists, social workers and psychiatric nurses who will offer quick and efficient consultation and treatment. Such a center would also work effectively with all ancillary personnel such as physicians, teachers, ministers and police to develop to the utmost the community's potential for attacking the vast problem of mental and emotional illness at all levels. The community mental health center should be primarily located at the Maine Medical Center and brought about by a major expansion of its present outpatient facilities to include services to both adults and children, as well as creation of sufficient inpatient facilities as may be required for effective service.

These recommendations are a reiteration of those already presented to the community in the Citizens Survey Report of 1962 as well as the report of the Hospital Planning and Chronic Illness Advisory Committee in October of 1964. Such a center would become the hub of all mental health services for the area as well as the focal point of coordinated effort in the interest of patient care.

The mental health center would provide the following functions:

1. Immediate diagnosis of all patients in need of such services.

2. Treatment on both an inpatient and outpatient level of those patients who can remain in the community or can be expected to return to the community in a relatively short period of time. Included in this group would be aftercare services to patients who may be discharged from State institutions.

3. Consultation to schools, community agencies and others in need of such services.

4. An educational center ultimately providing both residencies and internship work in psychiatry, psychology and psychiatric social work.

5. Inservice training and institutes for teachers, social workers, ministers and others relative to mental health concepts.

6. General community education regarding mental health needs and resources.

7. Research in mental health with emphasis upon development of preventive programs.

The establishment of such a center would provide a focal point of mobilization of effort currently lacking in this region. It is strongly and unanimously recommended by the Committee.

OTHER FACTORS TO BE CONSIDERED

As the new mental health center is developed a clearer delineation of competency and responsibility should be worked out in regard to those who currently are working in the field of mental health. Reports from several communities suggested that a good deal of mental health counseling is done by such individuals as guidance counselors, local clergy and physicians where there is an obvious lack of coordination between individuals as well as some indication of "amateur therapy". In all such cases, while genuine concern for the individual probably motivated the action, the lack of knowledge of resources available, or skill necessary to handle the case, prevented proper treatment. The community mental health center would take the lead in helping individuals at various levels of mental health services to define more clearly, not only their area of competency, but the limits to which they should go in working with emotionally disturbed people. Lack of coordination as well as sufficient qualified services does encourage a considerable amount of well-meaning "dabbling", sometimes at a critical point in a person's emotional life.

Also needing to be defined would be the role of various services in the field of mental health, including those provided by the center itself, the school guidance system, Child and Family Services and other agencies.

FINANCING PATTERNS

Because the Committee is recommending the creation of greatly expanded in-patient services as well as outpatient facilities on the local community level, it cannot ignore the question of financing of these admittedly expensive services. It would appear that no single source of either governmental or voluntary funds would be able to develop such a program. Therefore a combination of both tax and voluntary monies must be sought from such sources as the Federal and State governments, local communities and voluntary giving.

Should the State of Maine concur in the decentralization concept, it should begin an assessment of its present financing system, which requires a greater bulk of mental health money to be allocated to the three major institutions at Augusta, Bangor and Pineland. A decentralized program cannot depend solely upon local or area financing, but must have the continued underpinnings of statewide support.

SUMMARY

The Committee is convinced that the procedures utilized during the course of this review have created a substantial degree of interest among the citizenry of Region 13 on the need for more effective mental health programs and services. The Committee stands ready to assist in whatever way may seem feasible to implement the recommendations.

UCS MENTAL HEALTH COMMITTEE

The following individuals contributed to this report:

Portland:
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Mrs. Scott M. Damren
Niles L. Perkins, Jr., M.D.
Edward J. McGeachey
Hon. Louis Bernstein
Mrs. Lloyd C. Haley
Mrs. David W. Armstrong
Mrs. Harold D. Jones
Miss Margaret Payson

Cape Elizabeth:
Mrs. Harris Hinckley, Chairman
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Robert B. Williamson, Jr.
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Raymond and Casco:
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North Yarmouth and New Gloucester:
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Mrs. Richard M. Boyd

Cumberland:
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Miss Theresa McNeil, R.N.

Gorham:
Dr. Kenneth T. H. Brooks

Westbrook:
Mrs. Frederic E. Brinnick
Donald K. Saunders

Falmouth:
G. Damon Hoffses
James M. Fox, D.O.
Edward G. Asherman, M.D.

South Portland:
Paul F. Chantal

Sebago:
Mrs. Beverley Allen, R.N.

Pownal:
Peter W. Bowman, M.D.

LOCAL COMMUNITY REPORT ON MENTAL HEALTH SERVICES

1. Contact or call together for a meeting as many of the following as possible:

   School superintendents, town nurses, police chiefs, overseers of the poor, physicians, attorneys, judges, nursing home proprietors, clergy.

2. Discuss the mental health situation in your community in order to answer the following questions:

   I. Description of your community

      a. geographical - urban or rural

      b. the economy - industrial, agricultural, small business, other

      c. the people - principal occupations, general racial backgrounds, etc.

      d. to what degree do the people in your community understand what mental illness is?

   II. Summary of Mental Health Resources:

      a. What specific mental health services now are being used by your community?

      b. Are they adequate?

      c. What other resources in your community try to handle these problems at the present time?

   III. Summary of Most Pressing Needs

      a. Principal mental health problems - please number 1 through 7 in order of incidence in your community

         _____ Mental Retardation - Children and adults who are considered to be below average in their overall intellectual performance. Problem may center around community, family and/or retarded individual.

         _____ Alcoholism - Excessive drinking beyond control of individual, to the extent it causes them to become physically ill, have trouble with job, have difficulty with family and interpersonal relationships.

         _____ Adolescent Problem Behavior - Behavior that is either detrimental to the individual, community or family. e.g. school dropouts, juvenile delinquency, sexual problems, etc.

         _____ Aged - Mental health problems of the aged as manifested in senility, eccentric behavior, aloneness, etc.

         _____ Adult Mentally Ill - Adults with mental illnesses, acute or chronic, requiring the complete range of services available to the physically ill.

_____ Emotional Disturbance or mentally ill Child - children with mental illnesses, acute or chronic, requiring the complete range of services available to the physically ill.

_____ Adult Offender - Those adults posing problems to police or courts because of apparent mental disorders.

b. Services needed in or near your community to meet these needs

1. Immediate

2. Long range

IV. Financing

a. How could your community finance or help to finance such services?

April 1965

This report was submitted by the following members of Region #13:

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Edward G. Asherman, M.D., physician, 131 Chadwick Street, Portland, Maine.

Mr. Linwood Brown, director, Sweetser-Children's Home, 50 Moody Street, Saco, Maine.

Mr. Roger B. Gorham, underwriter, insurance company, 57 Exchange Street, Portland, Maine.

James M. Fox, Jr., D.O., physician, 491 Stevens Avenue, Portland, Maine.

Mr. G. Damon Hoffses, manager of J. H. Goddard, stockbrokers, 161 High Street, Portland, Maine.

Mrs. Harold D. Jones, civic leader, 191 Pine Street, Portland, Maine.

Miss Margaret Payson, civic leader, 188 Pine Street, Portland, Maine.

William E. Schumacher, M.D., director, Bureau of Mental Health, Dept. of Mental Health and Corrections, 700 State Office Building, Augusta, Maine.

Mr. Robert B. Williamson, Jr., lawyer, 57 Exchange Street, Portland, Maine.

Mr. Lawrence E. Fine, assistant director, United Community Services, 142 Free Street, Portland, Maine, co-chairman.

Mr. Joseph Klug, director, United Community Services, 142 Free Street, Portland, Maine, co-chairman.

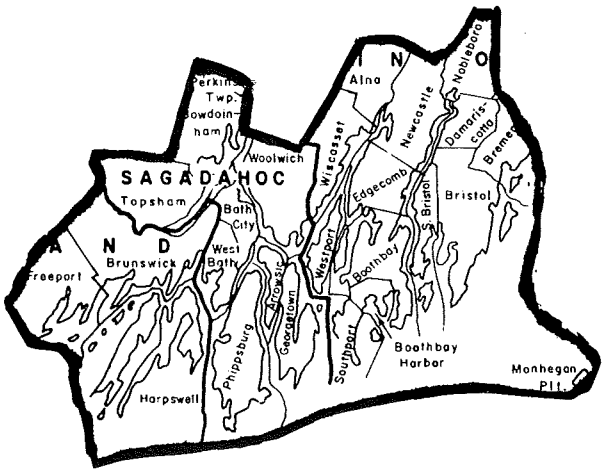
FINAL REPORT

of

REGION #14

Mental Health Planner
State Office Building
Augusta, Maine

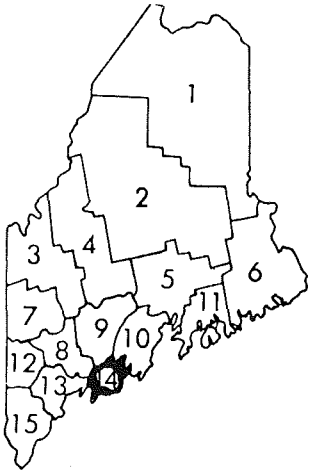
REGION
14



POPULATION

Region XIV - 54303

State - 969265



PLANNING

Planning for the comprehensive mental health plan in Region #14 was initiated by Mr. John Leet, mental health planner, by contacting Mr. Richard A. King, executive director, Bath-Brunswick Mental Health Association, and Mr. Philip Johnson, principal of Coffin School in Brunswick, asking them to be co-coordinators of the planning committee. Both Mr. King and Mr. Johnson accepted. The co-coordinators met initially with Mr. Alfred Senter of Brunswick, a member of the Board of the Bath-Brunswick Mental Health Association, and long-time friend of mental health. Mr. Senter suggested a number of people to work on the committee, and with this group as a nucleus, eventually formed a committee whose names appear at the end of this report.

At the initial meeting, the coordinators explained the purpose of the group to be essentially as follows:

1. Investigate the major mental health problems in Region #14 in the most inclusive terms.

2. Consider the existing facilities in the area for meeting mental health needs.

3. Suggest what facilities would be needed to augment the existing facilities to the point where mental health needs were being met adequately.

At several initial meetings the group discussed the above questions with an eye to informing ourselves of the situations before questioning lay people. When we felt we were ready, we held a meeting to acquaint ourselves with the techniques of using the State suggested questionnaires, then interviewed many people of many backgrounds throughout the area. We concentrated on people who might have direct experience with mental health problems through their work such as teachers, doctors, lawyers, clergymen, and police officials.

At subsequent meetings, we analyzed and discussed the results of the questionnaires and planned further work. We then assigned two members of the committee the work of writing a section of the report and reconvened to put the report together in final form, with any committee member free to make suggestions about any part of the report. We have no specific plans to continue to meet, since our basic purpose seems accomplished, if in somewhat abbreviated form. If new needs arise, however, it is very likely that the group would be willing to undertake additional tasks.

INTRODUCTION TO REGION #14

The following towns represent Region #14:

Alna	Bowdoin	Bath
Arrowsic	Bowdoinham	Brunswick
Boothbay	Bremen	Bristol

Damariscotta	Monhegan Plantation	Southport
Edgecomb	Newcastle	Topsham
Freeport	Nobleboro	West Bath
Georgetown	Phippsburg	Westport
Harpswell	South Bristol	Wiscasset
		Woolwich

Region #14 is largely composed of small seaside and farming communities with a fair degree of economic stability. The people are engaged in fishing, lobstering, maritime trades, farming and farm services, with some light industry and Naval and Air Base employment. Their background is largely Maine Yankee, but the area also has many young families from other parts of the nation, and a solid background of older, retired people from all over the east. Bowdoin College in Brunswick is a major educational-cultural center. In the summer, tourist services engage many of the area's people, and the entire atmosphere of many of the towns changes as both population and outlook enlarge with the influx of summer residents.

The communities of Damariscotta, Bath, Boothbay, and Brunswick have hospitals. In addition, Bath has the Hyde Rehabilitation Center and the Elmhurst Training School for the retarded. Bath and Brunswick share the offices of the Mental Health Association organized a few years ago, which has received steady support and referrals from the surrounding communities.

All of these communities have easy access to Lewiston and Portland, which serve as major shopping centers. Dental and medical services are available in almost all these communities, often in combined clinic form with hospital affiliation.

MENTAL HEALTH RESOURCES

Level of Public Knowledge

The town of Harpswell, for example, has for a number of years annually contributed a sum of money for the aid of the Bath-Brunswick Mental Health Association. In each instance, the town meeting vote has been unanimous.

This in itself would indicate:

1. That there is at least an awareness in the community that attention is being given in the mental health area to the field of mental health.

2. That attention to this subject is worthwhile, particularly as the expenditure was (originally) earmarked for the benefit of the children of the town.

3. That it may even mean a masked acknowledgement that there are mental health problems in the community which need attention.

However, despite the willingness to expend public funds for this cause, it is doubted that more than a fraction of the people know what it is all about. Even the better educated among those interviewed disclosed fuzziness as to the meaning of "mental health" and the scope which the term involves. Likewise, it was obvious that few were aware of the services available and when and how to take advantage of such benefits.

Mental Health Services

The most obvious mental health service within Region #14 is the Bath-Brunswick Mental Health Association and Guidance Center. This is a private clinical service providing casework, psychiatric outpatient treatment, and psychological evaluation to children under the age of 18, and/or their parents.

To be eligible for service the patient must reside within certain geographic limits. The area served is all within Region #14, but covers only about one-half the area described by the limits of Region #14. In other words, the population of nearly half of Region #14 is not eligible for service from this clinic because of their place of residence. Another block is ineligible by virtue of their marital status, childlessness, or age.

The clinic has several other shortcomings as well. It has experienced a rather unstable existence since its founding in 1961. Intake policies have been vague and personnel changes frequent. The current director has only been on the job some eight months. Thus far, his work is promising, however, he has recognized that the demand for services is growing and will continue to expand beyond the limits of existing facilities and personnel. There is a growing waiting list at the present time.

Ideally, this clinic would appear to be the logical focal point for expansion of services to cover the area not now eligible for clinical services from this or any other existing service. Expansion of financial resources and personnel would appear to be crucial factors governing this problem.

Within Region #14 there are some services available for the mentally retarded. The Bath-Brunswick Association for Retarded Children operate the Elmhurst Center in Bath, which is an educational program for the trainable retarded. The communities of both Bath and Brunswick operate within the public school system classes for the educable retarded. There are no services for the educable retarded provided by most of the outlying communities and these services are sorely needed and every effort should be made for services for these children.

The town of Brunswick has on an experimental basis at the present time a school social worker who is providing mental health services within the public school system. Arrangements have been recently completed for the services of this worker to be extended for another academic year,

after which time it will become the responsibility of the town to continue and add to this program. There is a vital need within the school system for this type of service, although it is recognized that such services are probably beyond the financial resources of many of the communities within the region.

Guidance programs are well established in most of the high schools within the region. Several of the junior high schools also have guidance programs providing services for this age level.

Other mental health services within this area include one psychiatrist with a part-time private practice residing in Brunswick, and another residing outside the region but serving residents of the region. The Hyde Rehabilitation Center has within its facilities a speech and hearing therapy program providing services to the residents of the area. Other services are those found on a statewide basis.

Augusta State Hospital, Children's Psychiatric Hospital at Pineland, and Veterans Administration Center at Togus are the three primary resources for inpatient treatment for residents of Region #14. All of these facilities, I am sure, are being evaluated by other facets of the mental health planning program. Staff shortages at Augusta and Pineland inevitably hinder the effect of these facilities. Responsibility for this must rest with the legislature and with the shortage of trained personnel available.

Within the confines of this region are two military installations, one Navy and one Air Force, with a combined strength of three thousand servicemen and women. Added to these are their dependents. The Navy has responsibility for the medical care of the personnel of both installations, as well as their dependents. There are no military psychiatric services available locally and, therefore, heavy reliance is placed on private resources. Hospitalization, if required, is affected at military hospitals out of the region or, in the case of dependents, locally under the Medicare program if a private psychiatrist can be found to take the case.

NEEDS

It is not felt that we can with any degree of certainty assign a priority of importance to various mental health problems. We would, however, like to comment on several, as well as pass on some comments of persons interviewed by our Committee.

Adolescent Behavior

While closely allied in emphasis by the interviewees with mental retardation, this subject (variously referred to as adolescent behavior, teenage behavior, youthful offenders, dropouts, etc.) would appear to be the most pressing mental health problem.

Invariably the cause is laid at the doorstep of the home. As one clergyman stated: "Two-thirds of the cases start in the home." This gentleman knew of 50 such cases between 12 and 20. Quotes from other

citizens will give the picture: "Both parents ignore their children and children do not learn to behave." "Parents and children do not communicate with each other." "Parents are too occupied with their own interests and think that material things are more important than their children." "Too much is granted the children too easily." "TV has caused children not to know how to amuse themselves; it is not the content of TV, but the fact that it is there." A school principal gave broken homes as a cause and further laid the blame on the community as a whole: "Nothing in the town interests them. Children are looking for something to do." In sympathizing with mischief, he said: "They must express themselves in some way. They need a recreation center." He was referring to more than ten youngsters between 10 and 15.

Mental Retardation

This term as broadly applied by those interviewed pertains to a grave problem. In searching for causes, the semantics involved break it down into two meanings: (1) lack of education and (2) physical defects.

(1) By far the greatest impact is from ignorance due to lack of education. Much of this problem deals with individuals who have been transplanted to this region, specifically, servicemen and their families. Information in this field is primarily derived from two sources: the Navy relief nurse at the Brunswick Naval Air Station and an elementary school principal.

The nurse, in dealing with enlisted families, cites hundreds of cases of: "Poor bringing up"; "Have not learned discipline"; "Impulsiveness"; "Lack of moral responsibilities to each other or to their children"; "Lack of initiative"; etc. In short, she deplores the absence of moral and ethical qualities which normally should have been passed on from past generations to the present.

The principal speaks of three children from one family who are incapable of functioning at grade level. One boy, 17, is having difficulty with the 6th grade. These Air Force children are from a broken home, a family of low socio-economic status which moved here from the mountains of West Virginia. From an educator's point of view, it is a serious problem, and a community problem.

(2) Physical defects as causes of mental retardation are of less prevalence and most often referred to as "accidents" or "accidents at childbirth". Also in this category, "bad habits" as causes of physical deterioration resulting in mental retardation.

Alcoholism

Here we have a problem interrelated with adolescent behavior, mental retardation, and the home. In answering the question, "Why did the problem occur?", a most competent reporter in speaking of some ten cases between 16 and 25 replied: "Lack of education and supervision in the home. The children have plenty of free time and no one knows where they are; nor how they try to out-do each other. Liquor is available where it shouldn't be. How do they get it under age? There is laxity by the

authorities who should find out where the young get it; and put a stop to it. Parents should help in ferreting this out." Of the old, 30 to 65, she added: "It began with teenage drinking."

Two clergymen, in referring to cases 18 years and up, stated: "We are concerned with emotional immaturity of persons who fastened on alcohol as an escape." "It is a weakness of willpower." "The cause is often found in the work environment." And, "The fault often lies in incompatibility with the wife."

One of the clergyman was specific in his own needs: "I want to know what to do when an alcoholic comes to the pastor. I want to be enlightened as to how and when a person is to be referred to Alcoholics Anonymous or to the Mental Health Association. I want to be able to pick up the phone and know where to call. Few clergymen are trained in the field of alcoholism." He declared: "Although the church and AA have one thing in common, love, the AA is able to do more than the church." He urged closer relationship between the clergy on the one hand and the AA and the Mental Health Association on the other.

Aged

The problem of the elderly is common in this region. Causes given by those interviewed are varied: "Lack of motivation." "No financial security." "No home of their own." "Lack of interest by their children." "Loneliness." "Has been deserted and left alone by spouse." "It is pertinent to coastal areas; the public has been reticent and negligent toward these people."

Marital Problems

This is evidently a larger problem than most will admit. It may be characterized, in contrast to the majority of mental health problems, as one about which one does not speak and, hence, remains largely hidden.

As revealed by those interviewed, features of this difficulty seem to be: "Sexual incompatibility. For women, boredom, lack of motivation, lack of reason for being. For men, failure to recognize that the wife's unhappiness is a problem, lack of ability to talk things over, lack of reassuring the wife."

While mentioned in several interviews, one interviewer considered marital problems as the most pressing of all problems.

Comments

While it is a fact that through the ages attempts have been made to solve mental health problems, it is only within the recent years that mental health as a science has begun to break out of its cocoon. Through specific education, social workers, psychologists and psychiatrists have emerged as guiding lights in this area of darkness.

The Bath-Brunswick Mental Health Association is a product in our area of this specific education and an adjunct and help to the clergy, the courts,

the school administrators, the doctors and assorted organizations. But this education must not stop with those who are learned in other (though allied) fields. It must reach down to the kernel of our society - the home - the parents.

There is scarcely a single phase in the above limited investigation of mental health problems but originates in the home with parents steeped in ignorance and laxity in their parental responsibilities. Our mission as a mental health association is not merely to employ qualified men of scientific concepts or to run clinics, but to tackle the sources where this devastating epidemic has its beginnings.

As a small attempt in this direction, two methods are recommended:

1. Establishment of a lecture series of three to be offered in the several communities for the benefit of parents. Subjects: family relations both the ethical, moral and practical responsibilities of child-rearing as well as husband and wife attitudes. Such a package of subjects to be presented (preferably) by our executive director with a brief subject talk followed by discussion.

Sponsoring organizations for such series may well be a PTA. However, the series should not be on PTA nights, but stand on its own feet as a distinct event for the community benefit.

2. To further break down a very real ignorance as to what <u>is</u> a mental health problem, the following is recommended:

The publishing each week in our local press, under a constant heading, of a brief description (say 5 inches) of a definite, different, and interesting mental health case (without its solution) at the end of which, in each issue, a statement such as - "If you have such a problem, please contact Mr. Richard King, executive director, Bath-Brunswick Mental Health Association," with address and telephone number.

If these suggestions are carried out the impact will be far reaching. Of this we are convinced.

We have a duty to make the parents of our area the direct beneficiaries of the newly-discovered science of mental health. This is a challenge.

ACTION

As noted earlier in this report, there is within Region #14, an already existing mental health service, namely, the Bath-Brunswick Mental Health Association and Guidance Center. It is the opinion of this planning committee that this already established service should logically be the nucleus for an expanded service reaching communities within the area not already served by that facility. This agency already serves the primary centers of population within that area, and it is doubtful that the remaining communities could feasibly support a separate mental health facility, individually or collectively.

This does, however, pose some problems, notably those of distances. Although Region #14 is relatively small, transportation does present obstacles to the provision of mental health service, particularly if any intensive treatment is to be anticipated. It is recommended, therefore, that consideration be given to the establishment of branch offices of the Bath-Brunswick Mental Health Association and Guidance Centers in other communities, such as perhaps Wiscasset, Damariscotta, and Boothbay. These would not, of course, be full-time clinics, but rather on the nature of a traveling clinic, with headquarters being the present clinic office at the Bath Memorial Hospital.

Obviously such an expanded program would necessitate a greatly expanded clinical staff and budget. Such a concept, however, is not without precedent since several clinics currently operating within the State, including the Bath-Brunswick Mental Health Association, are maintaining programs with services being provided in several locations.

In addition to an expansion of the geographical area served by the Bath-Brunswick Mental Health Association, it is recommended that the type of services be expanded, which would re-enforce the necessity for additional offices, facilities, and personnel. The services are now limited by economic necessity to children and their parents. Eligibility standards should be enlarged to include marital difficulties, whether children are involved or not; alcoholism; problems of the aged; and most especially, a provision for leadership and inservice training for parents and for professionals in the area who are in contact with people in need of mental health services. We felt it especially critical that these people - physicians, attorneys, clergymen, teachers, police - be offered the opportunity to learn about mental health problems so that their important first-hand counsel, advice and simple friendship could be of more benefit. Attorneys are acting as marriage counselors every day; physicians are constantly called upon to help people with psychosomatic illnesses, as well as offer advice in all areas of mental health needs. Clergymen deal frequently with these same problems; teachers know very well the devastating effects of mental health problems on the teaching-learning process. These educated and intelligent professionals are desperately in need of training in dealing with the emotional problems of those they serve. It seems only logical that in following Dr. Schumacher's program analagous to "first-aid stations", and in accepting Dr. Menninger's advice concerning the simple warm and sympathetic approach can be most employed by laymen, as far as the mental health disciplines are concerned, that the Bath-Brunswick Mental Health Association should and could act as a leadership center in supplying this important for in-service training.

Offering help to parents in a general way, in addition to specific treatment once a difficulty has arisen, should also be considered as an important function in any expanded service available in Region #14. Public meetings, seminars, abbreviated courses of instructions for parents, led by Bath-Brunswick Mental Health Association personnel and supported by schools, could make real inroads in our major problems of lack of public understanding of mental health problems and needs. An additional factor to be considered, though not limited to Region #14, is the fact that a booming technology and increasing leisure time are creating additional needs in the area of recreation. Many of the communities in Region #14 are sadly deficient in recreational facilities and leadership

for children. Dr. Menninger's thesis that in order to be successful in the prevention of mental health difficulties we must improve our basic society is the case in point. Communities must work together effectively to supply creative outlets for the needs of these people. Coastal communities are in a transitional stage from the old economy of self-sufficient farmer-fisherman to the era of modern suburbia. The simple individual recreation of the past, like the simple virtues of the past, are no longer adequate to prepare people for the high pressure world of personal interaction toward which we are moving.

It is recognized by the committee that mental health services of the type that we are recommending are very expensive-type services, and therefore, serious consideration must be given to the funding of a program such as we have outlined.

Certainly such a program must ideally have a high degree of stability if it is to engender the confidence of the perhaps relatively unstable persons it is designed to serve. Broad community support must be enlisted. Support through the area United Funds is essential, but the contribution of tax dollars from the various communities served is also a source of relatively stable financial backing. The process of obtaining these tax dollars would also result in a degree of public education as support was enlisted.

At the present time the caseload of the Bath-Brunswick Mental Health Association shows a disproportionate number of military families. It would appear that serious consideration should be given to the possibility of making a request for direct financial support from the military establishments within the area.

Another possibility is that the Bath-Brunswick Mental Health Association terminate its status as a privately financed agency and be incorporated into the State Bureau of Mental Health as a fully State financed program.

PROBLEMS IN PLANNING

One of the problems we encountered in planning is the usual one of finding people who are capable and at the same time able to take the time from already busy lives to engage in still another activity. We also found, through the use of the questionnaires, that the fund of information about mental health possessed by the layman, as well as by people who should be closely connected with the mental health movement, such as teachers, doctors, and clergymen, is woefully inadequate. We understand, of course, that involving people personally in the mental health program is probably our major contribution to the comprehensive mental health plan, whether or not any important specific planning for improved facilities result from our work, we feel that this public relations aspect of our work has been reasonably well carried out.

This report was submitted by the following members of Region #14.

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Miss Winnefred Erskine, Alna, Maine, retired

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Mrs. Daniel Sterling, 20 Hawthorne Street, Brunswick, Maine, housewife, women's editor, BRUNSWICK MERCHANT

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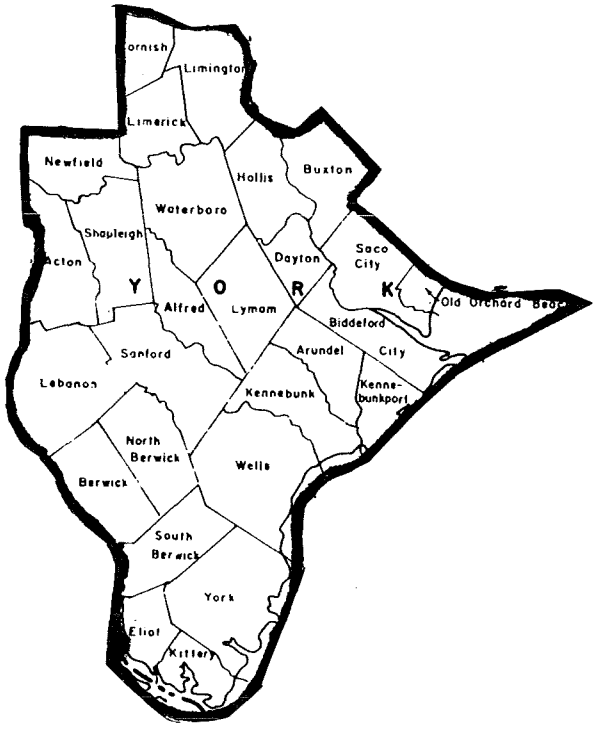
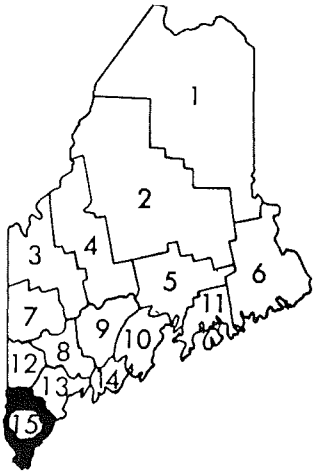
MAY 1965

FINAL REPORT
of
REGION #15

Mental Health Planner
700 State Office Building
Augusta, Maine

REGION 15





POPULATION

Region XV - 97717
State - 969265

Region 15 is located at Maine's southwest corner, extending from the seacoast to the New Hampshire boundary. It is the most intensively developed recreational area in the State, having a number of large and many small industries, a diversified agriculture, commercial fishing and small boat building, with woodlot cutting supplying considerable lumber-finishing activities.

Biddeford-Saco on opposite sides of the Saco River is the largest industrial, commercial, banking, and shopping area in the region. It is the site of the Pepperell Mills, the Edwards Plant of the Saco-Lowell Company which manufactures automotive parts, machine gun parts, and some electronics. There are also diversified small industries. Both cities also have farming activities in outlying areas and commercial shopping centers for large summer resort areas of Wells, Kennebunk, Kennebunkport and Old Orchard Beach. These communities have the largest concentration of summer hotels, tourist courts, motor hotels, cottage colonies and recreational facilities.

Kittery is the site of the Portsmouth Navy Yard and has important vacation travel facilities. Eliot is a residential and farming town for the Kittery-Portsmouth area.

Berwick, North Berwick and South Berwick are small industrial, commercial and farming areas.

Sanford is the largest community in Maine still retaining the town form of government. It is the location of Nasson College. American Cyanimid, Pioneer Plastics and Seamloc Carpet are among its largest industries.

Other towns in central and western York County have fruit orchards, farming, lumbering, small industries and vacation travel developments, including youth camps, resorts, tourist places and cottage colonies on various lakes and ponds. These include Alfred, Lyman, Waterboro, Dayton, Hollis, Buxton, Lebanon, Acton, Shapleigh, Newfield, Parsonsfield, Limington, Limerick and Cornish. Kezar Falls village, partly in Parsonsfield, has a woolen mill and other small industries in service trades.

To ascertain the needs of mental health in Region 15 a survey was undertaken in the Sanford area and in the Old Orchard-Biddeford-Saco area. The Sanford area survey was conducted by the Community Health Association sponsored by the town of Sanford and in the Biddeford-Saco-Old Orchard area the responsibility was assumed by the Association of University Women.

In the Biddeford-Saco area the survey team consisted of eighteen women, nonprofessional but diversified in background and interests. A questionnaire was worked out and the surveyors contacted hospitals, industries, attorneys, physicians, schools, clergy, law enforcement officials and individuals. In addition to the questionnaire form of survey there was a follow-up by personal conversation, phone calls, interviews, etc. It was interesting to note that in this study almost every individual or agency contacted had been called upon to do some type of counseling in the past in their everyday work. Almost all felt a need for professional guidance of some sort, giving as an example a psychiatrist, a psychologist or a social worker. The public health nursing associations in Region 15 were very helpful in making information available.

These associations are probably the first ones to be contacted in many of the social and emotional situations that occur in our communities and according to the statement of one of the nurses no health agency is equipped to meet all of these needs. She said they were good listeners and they attempt to find the cause and solution of the trouble. Resources that are needed are often not available and the problems remain unsolved. City departments of welfare feel that they have limited financial aid for the needy, a lack of social workers in either the city or community and they are somewhat handicapped by the fact that most of the overseers are politically appointed.

The American Red Cross gave limited service to servicemen, veterans and their families, but felt a great need for counseling services of some sort. The Salvation Army was very helpful in making information available to the survey group. The York County Children's Aid Society, a private agency set up to handle foster home placement for neglected children, felt that more services should be available in this area. The Sweetser-Children's Home, a private agency for residential treatment of emotionally disturbed children made its records available to the Committee and gave some help in conducting the survey. Sweetser's program is pretty much limited to a residential one, but offers counseling and some psychological assistance to public schools when time permits. St. Andre's Hospital, offering services to unwed mothers, has the only residential home in our district for caring for the unwed mother and offering an adoption program as well.

In the western part of the region the survey was conducted by the Sanford-Springvale Community Health Association. Contacts were made with school principals, ministers, priests, agencies, lawyers, doctors, nursing homes, industries, teachers of special classes, college administrators, scout leaders, guidance directors, selectmen, nurses, social workers, hospital administrators, chief of police, Y.M.C.A. director and child welfare director. In the area, difficulties in family relationships seemed to top the list. This was considered the most vital area for preventive professional help as it is the key to so many other problems such as child and parent relationships, marital adjustments, deserted families, divorce, etc. The importance of correcting severe emotional disturbance in children or preventing small problems from becoming greater cannot be overestimated. Lack of resources to meet this need wastes potential human resources and adds up to far more cost to the community later. School difficulties, social adjustment to teachers and to other children, mental blockings to learning, truancy, physical difficulties such as speech defects and mental retardation, antisocial behavior at home and school, destructiveness in the community, adolescent problems, vocational guidance, sex problems and personal adjustment problems are among those most frequently brought to our attention. Most persons interviewed felt that they did not have time emough or understanding enough to help those who are severely disturbed - for example - the alcoholic, illegitimacy, absenteeism from work, labor misfits, borderline mentality, etc., problems of the aged, planning for retirement, developing hobbies, interests for leisure time, the need for companionship and the feeling of being useful, housekeeper services, the meaning of illness and disability for the individual and his family are among the problems which need to be met by community resources.

Health, finances, senility, housing, convalescent homes and recreation are other aspects of the overall problem.

Each person interviewed was asked "What happens to these people with problems now?" "Do you feel that there is a need for a guidance counseling service?" "What type of service do you feel would most adequately meet these needs - a family casework agency, a mental health clinic, a child guidance clinic, outpatient clinic or the local hospital or some other?" "Would you refer someone to or use consultation services of such a program?" "Would you help support such a program?"

The communities in Region 15 are presently organized to meet specific community needs and are offering limited services in their areas of recreation, public health, welfare, employment, etc. Many individuals who work in the fields of education, medicine, law and religion are giving their spare time to people who need advice and counsel. Often this can be a difficult and time-consuming job. Each person interviewed in this survey had been called upon daily to give counseling services or other assistance to someone in trouble, someone who could no longer handle his problems alone. Frequently the solution to these problems requires special professional knowledge and skills.

The agencies and individuals surveyed expressed a desire for some source where they could consult a specially trained individual, experienced in working with problems. One outstanding theme throughout the interviews over the entire region was the need for community-wide education in the field of mental health.

As a result of the studies made in Region 15, eight communities combined their resources a year ago and organized a traveling community child and family guidance clinic. This clinic is now operating far beyond its capacity to do a complete job for the community and meet all of the needs. As a result of the studies and having watched the clinic operate for one year, there are certain recommendations that we would like to make.

Firstly, we feel that it is important that this whole area should become better informed about mental health. We can do this in many ways - by sponsoring workshops, study groups, and by attending lectures given by recognized specialists in the field. Furthermore, we can be aware of the extent of the problems in our local area and decide to do something constructive about them.

There are many pressing needs in this region. The present Community Child and Family Guidance Clinic should be expanded to include all of the areas of Region 15. At the moment there are certain communities in the Limington area that are not being covered by this clinic, due to the lack of funds and staff. We have not included the southern part of the district, the Berwicks and Kittery, again because of lack of funds and staff. These areas should be included in this clinic setup.

The need in the area of special education for retarded children and for children with special problems is a pressing one and particularly in view of the difficulty of getting children into Pineland and the new policy of Pineland - keeping retarded children in their own communities.

The public schools in Region 15 badly need counseling services. Only a few of the high schools have guidance counselors. There is no service of any kind available to the children in the lower grades except what little can be

offered through the services of the Child and Family Guidance Association and Sweetser-Children's Home. The public schools should have some specialized services available to detect and treat problems occurring in early childhood.

Services for the alcoholic are not available in this area. This is an increasing need, particularly because of the high degree of recreational facilities available.

We feel that there should be some method of providing social work services and consultation to the courts in our region. Aging is an increasing problem - services must be developed for caring for the problems of this group.

The need in our district is not for buildings - it is for personnel and funds to enlarge and incorporate services to individuals.

The following are members of the Region #15 Committee:

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Mrs. Jon Nathanson, 4 Westward Lane, Saco, Maine, president of American Association University Women, Maine Chapter
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Mr. Leo Pelletier, 27 Ellsworth Street, Springvale, Maine, city clerk
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Mrs. Eleanor Rice, West Elm Street, Sanford, Maine guidance director
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Mrs. Elizabeth Smith, [illegible] Kennebunk, Maine, housewife
Mrs. J. Edward Smith, [illegible] chard Beach, Maine, housewife
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Mr. George S. Thayer, 15 Howard Street, [illegible]gvale, Maine, insurance agent
Rev. Clement Thibodeau, Pine Street, Springvale, Maine
Mrs. Eleanor Travis, Jay Street, Springvale, Maine, former social worker

Mr. Linwood Brown, 50 Moody Street, Saco, Maine, executive director, Sweetser-Children's Home, committee chairman