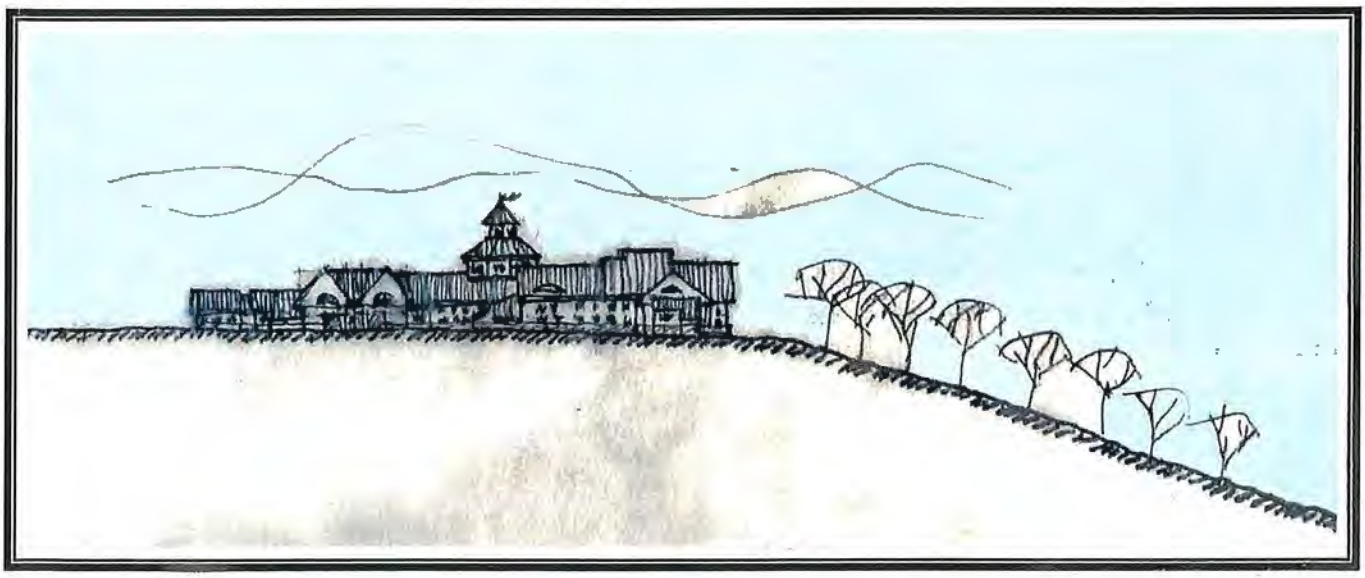
The Maine Psychiatric Treatment Initiative: Civil & Forensic

FINAL REPORT

February 29, 2000



SMRT, Inc. ◆ Pulitzer/Bogard & Associates, L.L.C. ◆ Architecture +

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SMRT, Inc.
144 Fore Street
Portland, Maine 04104
(207) 772-3846 – phone
(207) 772-1070 – fax

Pulitzer/Bogard & Associates, L.L.C.
8 Saratoga Street
Lido Beach, New York 11561
(516) 432-9007 – phone
(516) 432-3414 – fax

Architecture +
297 River Street
Troy, New York 12180
(518) 272-4481 – phone
(518) 272-1605 – fax

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The contributions of the individuals serving on the Stakeholders Group have been enormous. Under the able leadership of Chair Lynn Duby, the stakeholders have provided guidance, scrutiny, and supervision to the planning team to insure the plans meet the needs of the people of Maine.

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INTRODUCTION

The **Maine Inpatient Treatment Initiative: Civil & Forensic** project is an outgrowth of the state's continuing commitment to develop a quality service delivery system for Maine citizens with serious mental illness.

The State of Maine has invested significant financial and staff resources to develop a comprehensive mental health system that will ensure that its citizens receive appropriate treatment and support services in the least restrictive environment. Maine's commitment to a comprehensive mental health system is reflected by the most recent data of State Mental Health Agencies (SMHA). These data indicate that in Fiscal Year 1997, Maine ranked 8th in the nation in per capita expenditures for mental health services.

SMHA data provided the following comparison of Maine's FY 97 per-capita commitment to mental health services with that of other New England states.

Table 1
Comparison of Mental Health Services Per Capita Expenditures

State	Per Capita
Maine	**$88.29**
Connecticut	$99.14
New Hampshire	$99.02
Vermont	$92.38
Massachusetts	$90.19
Mean of 50 States & DC	$60.59
Median	$56.36

Although the *Bates v. Duby* Consent Decree may have focused these efforts on identified class members, the State is committed to providing client-based mental health services for all individuals in Maine with such needs. With the goal of providing treatment within the community of the consumer's family and support network, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has been committed to developing strong partnerships with community providers. Ensuring an adequate number of high quality state-operated psychiatric inpatient beds to complement community resources is one facet of this commitment.

While there has been general consensus that the physical facilities of the antiquated Augusta Mental Health Institute (AMHI) are inadequate for providing inpatient

psychiatric treatment and security for forensic and civil patients, conflicting opinions and proposals have been offered about how best to address the physical plant deficiencies. After considering numerous options, Maine legislators appropriated funding to conduct a comprehensive assessment to project the need for state-operated inpatient psychiatric beds, and to provide a design concept and cost proposal for a facility to replace AMHI.

The project was initiated in the summer of 1999, with the state's issue of a Request for Proposal. Various groups submitted proposals. Finalists were chosen to meet with Maine officials on August 19, 1999 to clarify and further explain their submissions. SMRT, Inc., in collaboration with Pulitzer/Bogard & Associates, LLC, and Architecture +, was the Project Team selected for the project.

The project included the following components:

- Preparation of a needs assessment to project the number of state-operated inpatient psychiatric beds required to adequately address the needs of forensic patients throughout the state.

- Preparation of a needs assessment to project the number of state-operated inpatient psychiatric beds required to complement the psychiatric inpatient treatment resources available within community hospitals for the civil patients of southern Maine*.

- Development of an operational and architectural program and a design concept for a new facility to replace current AMHI operations.

- Selection of a site for the recommended facility.

- Identification of the construction and annual operational costs of the recommended facility.

Maine officials, interested parties and agencies, community mental health and hospital providers, and consumers of mental health services were involved throughout the process to ensure that various perspectives were considered. A list of the agencies and individuals requested to represent the "stakeholders" in this project is provided in Appendix A in Chapter VIII. As the project progressed, many other individuals became actively involved in the process.

This document provides a brief overview of the project activities and recommendations.

* For purposes of this report, Southern Maine refers to the Department's Regions I and II: York, Cumberland, Sagadahoc, Lincoln, Androscoggin, Kennebec, Waldo, Knox. Somerset, Oxford, and Franklin Counties.

BACKGROUND OF THE PROJECT

The Augusta Mental Health Institute (AMHI) first opened its doors in October, 1840 on a site "that was chosen in order to ensure that the Legislature and Governor would never forget the hospital, as they see it when the looked out their eastern windows."* Established through a Legislative Resolve, the mission of the hospital, then known as the Maine Insane Hospital, was, in modern terms, to treat 100 actively psychotic individuals. Thus began the legacy of what is now known as AMHI.

For more than a century after opening its doors, AMHI continued to expand in size, reaching a peak census of more than 1800 patients in the 1950's. During that period little was known about helping people with mental illness recover from their symptoms, and it was common practice to remove persons with serious mental illness from society and place them in state hospitals for life. Until the 1960's, all public mental health funding flowed into the two state hospitals in Augusta and Bangor.

In the 1950's and 60's, breakthroughs in the treatment of mental illness, such as the introduction of effective psychotropic medications, made possible the development of a community mental health system that focuses on treating people with mental illness in their home communities. Beginning in the early 1970's, this shift in focus began to change the role of the two state hospitals in Maine. Rather than long term asylums for people with mental illness, AMHI and the Bangor Mental Health Institute (BMHI) became intensive treatment centers, where services last only as long as an individual's illness requires. A comparison of staffing patterns at AMHI serves well to illustrate the new role. In 1955-56, there were 506 staff who worked with an average daily census of 1840 patients. Now, 40 years later, over 300 staff work with an average daily census of 83 patients.

As the role of the hospital has changed over the years, the buildings in which the hospital is housed have become antiquated, both in the condition of the physical plant and in their capacity as an appropriate psychiatric treatment environment. It is ironic that one of the first buildings to house patients at AMHI in the 1840's is the only building remaining that still serves patients on the extensive AMHI campus.

Between 1989 and 1999, four reports on mental health in Maine recommended that the current AMHI hospital be replaced with new facilities. During the summer of 1998, in an effort to explore less costly options, an architectural firm reviewed the feasibility and cost of renovating the forensic unit. The architects concluded that the renovation cost for the forensic unit would be comparable to new construction, and renovating the existing facility would significantly compromise the program, as the current building footprint and load bearing walls would not allow for the design of a

*A *History of the Augusta Mental Health Institute* by Margaret E. Fuller, MSW and Millard A. Howard, MA, Maine – Vermont Longitudinal Research Project, Michael Desisto, PhD, 1988.

state of the art treatment facility. Additionally, the logistics of housing patients during any renovations would be extremely daunting.

As a result of the architects' conclusion, the Governor included in his 2000-2001 budget package $17.5 million to develop new forensic units, with the understanding that the civil capacity would be added in another budget cycle. The Legislature determined that more preparation was needed prior to the plan's approval, and $500,000 was allocated to the Department of Administrative and Financial Services' Bureau of General Services (BGS) to work with the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to complete the "programming study, feasibility planning and design work in fiscal year 2000 for the new Forensic Unit."

During the budgeting process, it became clear that it would be more cost effective to develop a plan to replace the entire hospital, including both civil and forensic capacity. The planning and design team concurred with this assessment. This document therefore represents a comprehensive needs assessment, program plan and concept design to replace the existing hospital capacity at AMHI.

NEEDS ASSESSMENT

Needs assessments are often based on an analysis of historical data that typically includes a five to ten year time frame. Since Maine's mental health system has changed dramatically in recent years and is continuing to evolve, historical data were of limited value for this project. For example, relying on historical data to project the number of needed civil beds would not have accounted for the continuing development of community resources. The need for state-operated civil inpatient beds is significantly affected by the availability of community inpatient beds and effective crisis services, as well as by the quality and continuity of outpatient services. Further, relying on historical data to project the number of needed forensic beds would not have accurately reflected the inpatient treatment required by individuals housed in local jails. There is consensus that jail inmates have been under-served due to lack of current forensic bed capacity.

This needs assessment process required consideration of qualitative information as well as forecasting based on available statistical data. The recommendations are based on a review of the overall Maine mental health system and information gained through discussions with DMHMRSAS administrative and clinical staff, community hospital and outpatient providers, mental health consumers, jail and prison administrators, and many interested Maine citizens.

The needs assessment was conducted for two distinct patient populations:

- Civil patients who are in need of psychiatric hospitalization but who are unable to be served within the community due to risk issues or lack of available community hospital bed space within the patient's area of residence and support.

- Forensic patients whose legal status requires treatment in a secure environment.

Projection of Need for State-Operated Civil Inpatient Beds

DMHMRSAS has established three Regions for coordinating the provision of outpatient and inpatient mental health services for designated geographic areas.

Table 2
Maine's Mental Health Regions

Region	Counties
Region I:	Cumberland and York Counties
Region II:	Androscoggin, Franklin, Kennebec, Knox, Lincoln, Sagadahoc, Somerset, Oxford and Waldo Counties
Region III:	Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties

The needs assessment was conducted to determine the number of civil state-operated inpatient psychiatric beds needed to replace current operations at AMHI. AMHI now provides inpatient services for Region I and II. State-operated inpatient hospitalization for Region III is and will continue to be provided by the Bangor Mental Health Institute (BMHI).

AMHI is currently licensed to operate 76 civil inpatient beds. These beds primarily provide the "safety net" for involuntary patients who are unable to be served within the community due to risk issues or lack of bed availability. Since Maine currently has no female forensic inpatient beds, female forensic patients now occupy four or more of the civil beds.

There has been a public perception that the state presently rejects accepting civil patients at AMHI. Historical data indicated and DMHMRSAS staff confirmed that AMHI has had sufficient bed capacity for its civil patients when no other placement options exist in the community. The misperception seems related to problems with the hospitalization pre-screening process and not with bed availability.

A forecast of civil bed need based on AMHI civil admission and discharge data from 1998 and 1999 and population projections is provided in Table 3 on page 7.

While this forecast suggests the need for 63 to 72 civil patient beds by the year 2010, the forecast does not account for major changes anticipated within the overall Maine mental health delivery system during this period. As noted previously,

consideration of current system practices and potential improvements is necessary to interpret the projection of bed need based on historical data.

DMHMRSAS is committed to developing a system for adults with serious mental illness that will ensure the availability of community outpatient and inpatient resources consistent with the level of consumer need; a system that will impact the need for state-operated civil inpatient beds. While the system as designed will provide the necessary array of services, full implementation has not yet been realized.

Improvements in the relationships between DMHMRSAS and community hospitals and between DMHMRSAS and community crisis services providers would significantly reduce the need for state-operated civil inpatient beds. Current problems within these relationships are not due to a lack of financial commitment but appear to be transitional and correctable through the developing partnership between DMHMRSAS and the community providers.

State/Community Hospitalization of Civil Patients: Although DMHMRSAS has contracted with community hospitals for several years to provide inpatient psychiatric treatment for patients hospitalized on an involuntary status, a mutually cooperative relationship has been slow to evolve.

TABLE 3
Population Forecast - Civil Patients
Based on AMHI 1998 and 1999 Admission and Discharge Data

Fiscal Year	Historical*		Population	
	Bed Days	Population**	Total Projected	Peaking Factor***
1998	20,979	51.9		
1999	19,995	58.0		
2000			59	55-63
2001			59	55-63
2002			60	56-64
2003			60	57-65
2004			60	57-65
2005			61	58-66
2006			62	59-67
2007			63	60-68
2008			63	60-68
2009			65	62-71
2010			66	63-72

* Although the female forensic patients are not excluded from the civil historical figures, the female forensic population was excluded from the civil patient forecast.

** AMHI's average monthly civil patient population ranged from 44 to 58 from January 1998 through October 1999.

*** Peaking factor was calculated by applying average standard deviation of monthly civil patient population to the number of projected beds.

- Based on the length of stay data collected from AMHI, approximately 22-25 % or 15-18 beds during this period were occupied by patients with lengths of stay of less than 30 days. The figure will grow slowly to approximately 16-19 beds by the year 2010 based on projected demographic population growth.

- Based on the length of stay data collected from AMHI, approximately 75-78 % or 40-44 beds during this period were occupied by patients with lengths of stay greater than 30 days. The figure will grow more rapidly as cases begin to stack up to approximately 46-49 beds by the year 2010.

For the purpose of this document, the term "community hospitals" refers to general hospitals that have specific units designated for psychiatric treatment while the term "community psychiatric hospitals" refers to stand-alone non-profit facilities providing only psychiatric treatment. Maine currently has two community psychiatric hospitals, Spring Harbor in Portland and Acadia in Bangor.

Contracts between DMHMRSAS and community hospitals presently exist. However, these contracts do not guarantee the availability of a community bed for a referred involuntary patient. Hospitals are required by law and standards to accept all patients who meet criteria for hospitalization; thus, the hospitals are unable to reserve the contracted beds for involuntary patients. Community hospitals also routinely staff units based on current patient census. Referrals requiring treatment beyond the ability of available staff cannot be accepted.

There is a perception that community hospitals reject involuntary patients because of reimbursement concerns. This perception seems exaggerated since DMHMRSAS ensures payment for involuntary patients served by community hospitals.

While the community hospitals have expressed the desire to increase their role in providing services for involuntary patients, they expressed concerns in three areas:

- Some patients referred to them are not from their geographic area. When such patients are admitted, the hospital no longer has the capacity to serve patients from their community. The practice of utilizing community beds even when they are not in the patient's community is the result of efforts to minimize admissions to the state-operated hospitals. The practice is inconsistent with achieving the DMHMRSAS goal of treatment within the consumer's own community. It also increases the difficulty faced by community hospitals in developing effective discharge plans.

- When patients who have been admitted to a community hospital and subsequently demonstrate the need for extended lengths of stay, transfer of these patients to state-operated hospitals, as provided by the DMHMRSAS contracts, has often been delayed.

- Discharge treatment planning by community hospitals may be compromised by the fact that patients discharged from state-operated hospitals receive priority for available community supports over patients discharged from community hospitals.

Information provided by the Maine Health Data Organization indicating the availability of community psychiatric beds in 1998 is provided in Table 4 on page 9. These data suggest that there were sufficient licensed community psychiatric hospital beds in Regions I and II to meet the general population needs. However, these figures represent maximum utilization of all licensed beds with no allowance for variations in need or time required for patient turnover.

The community hospital data for 1998 also did not include the use of AMHI civil beds. The civil bed utilization at AMHI in 1998 is provided in Table 5.

Table 4
Community Hospital Civil Psychiatric Bed Utilization - 1998

	Region I	Region II
Average Daily Bed Utilization Based on Patient County of Residence (Based on length of stay of 10.2 days)	57	74
Available Licensed Psychiatric Beds: Community Hospitals	Total: 84 SMMC: 13 Spring Harbor: 45 Maine Medical: 26	Total: 88 Pen Bay: 13 Maine General: 33 St. Mary's: 31 Mid Coast: 11
Average Daily Bed Utilization of Listed Community Hospitals (Based on length of stay of 10.2 days)	57	68

Source: Maine Health Data Organization

Table 5
AMHI Civil Bed Utilization - 1998

	Region I	Region II
Average Daily Bed Utilization Based on Patient County of Residence (Based on length of stay of 56.2 days)	26	30

AMHI is licensed to operate 103 psychiatric beds,
27 of which are dedicated to forensic patients

Source: Augusta Mental Health Institute

Thus, the 1998 data indicate an average need for 181 inpatient beds. With only an average of 146 available inpatient beds, the community hospitals would have had insufficient beds to meet completely the needs of all consumers residing in Regions I and II requiring either voluntary or involuntary inpatient hospitalization.

A survey of the community hospitals regarding the provision of involuntary and voluntary inpatient psychiatric services during the first six months of 1999 indicated that the community hospitals cannot meet the total needs of Region 1 and II for both voluntary and involuntary inpatient treatment. However, there are community beds available for additional involuntary psychiatric treatment. Table 6 confirms available community bed space if patients with lengths of stay greater than 30 days were transferred to state-operated beds.

Table 6
Maine Community Hospital Analysis: January 1999 – June 1999
ONLY ADULT PSYCHIATRIC PATIENTS

Region	Counties Served by Community Hospitals within the Region	Avg. Daily Census 1/99-6/99	Number of Licensed Beds	Number Of Operational Beds	Monthly Bed Days Available	Bed Days Used by Patients with LOS less than 30 days
Region I	Cumberland York	70.85	84	83	2490	1612
Region II	Androscoggin, Franklin, Oxford, Kennebec, Knox Somerset, Lincoln, Waldo Cumberland, Sagadahoc	69.2	88	83	2490	2025

- *Assumes patients with lengths of stay greater than 30 days (10.5 in Region I and 12 in Region II) would be transferred to state-operated beds.*

Since Spring Harbor opened 12 additional adult psychiatric beds in December of 1999, the number of licensed community psychiatric beds presently available within Region I and II has increased from 172 to 184.

Given the availability of community psychiatric beds and the potential that community hospitals may be willing to consider increasing psychiatric bed capacity to meet the need for involuntarily committed patients, DMHMRSAS is renewing efforts to expand the partnership with community hospitals that will facilitate the appropriate use of state-operated beds. General consensus of the optimal roles of the community and state-operated beds in providing inpatient psychiatric treatment includes the following:

- Ideally, community hospitals would serve only the patients residing within their geographic area.

- Psychiatric units of community acute care hospitals may be unable to effectively provide the level of treatment required by some patients. These patients would be best served by the community psychiatric hospitals and the state-operated hospitals.

- State-operated hospitals should serve as the "safety net" for patients admitted for acute treatment who meet the criteria for intensive and extended treatment.

- Patients admitted to community hospitals requiring extended care and substantial psychosocial rehabilitation would be best served by state-operated hospitals with extensive treatment resources. Duplicating this level of treatment resources in community acute care hospitals is not fiscally responsible.

- Patients admitted to community and state-operated hospitals should have the same access to residential and support services at discharge.

Given this consensus, the potential for the implementation of a state/community partnership seems likely. This consensus also reflects agreement that there remains a need for state-operated "safety net" acute beds and state-operated intermediate care beds for patients requiring extended treatment.

The goal of treatment in the least restrictive environment is reflected in current clinical practices that limit psychiatric hospitalization to brief periods followed by community support. This approach is effective for many consumers of mental health services. However, some individuals with severe and persistent mental illness or experiencing such complicating factors as substance abuse or a history of trauma require more extended treatment and psychosocial rehabilitation for adequate therapeutic effect.

AMHI Civil Patient Analysis: An analysis of the length of stay data for AMHI patients for 1998 and 1999 indicated the following:

Table 7
AMHI Civil Length of Stay: FY 1998-1999 Admissions

Length of Stay Group	Number	Percent
1-15 days	213	38.4%
16-30 days	99	17.9%
31-60 days	100	18.1%
60-120 days	80	14.4%
120 days and over	62	11.2%
Total	**554**	**100.0%**

The length of stay data from 1998 and 1999 indicate that 43.7% of AMHI civil patients had a length of stay over 30 days. A point-in-time review of the civil patients at AMHI on November 16, 1999 indicated that 64% of the current patients had lengths of stay greater than 30 days, with 22 of the patients (38%) having lengths of stay over 90 days. The increase in the number of patients with length of stays greater than 30 days reflects the increasing use of AMHI for extended care.

Additional review of the AMHI patients on November 16, 1999 confirmed the presence of persistent and serious mental illness as reflected by repeated hospitalizations. For 50% of the AMHI patients, the current hospitalization was their second since January of 1998. For six of the patients, the current hospitalization was the fourth or more since January of 1998.

Further, review of the AMHI patients on November 16, 1999 confirmed the presence of patients dual-diagnosed with substance abuse disorders and/or histories of trauma as well as serious mental illness. Patient diagnoses reflected such dual-diagnoses for 28 or 50% of the 56 cases reviewed. These numbers are consistent with AMHI patient profiles of 1998 admissions, which indicated that 45% of patients admitted had a dual-diagnosis of a substance abuse disorder.

Crisis Services: DMHMRSAS has contracted with community mental health providers in each area of the state to provide "no-reject" crisis services 24 hours a day for all individuals who experience psychiatric crises. The crisis services include: telephone consultation, evaluation, mobile crisis outreach services, placement in a crisis residential bed, and facilitation of hospitalization. A single statewide crisis care telephone line, the first in the country, ensures access to requests for mental health assistance.

DMHMRSAS staff and community providers agree that the crisis services system established during the last three years is improving. However, it has yet to achieve the consistent, effective crisis interventions that could reduce the system's reliance on inpatient psychiatric treatment.

Current deficiencies in the crisis system appear to be primarily related to the limited number of credentialed mental health clinicians in Maine and the number of large, sparsely populated areas to be served. In some rural areas, crisis workers may have limited or no face-to-face access to a psychiatrist and often must rely on telephone consultation. Reports suggest that the variable skills of crisis workers may effect clinical evaluations and the subsequent sharing of information with the consultant psychiatrist.

Although crisis workers should be "mobile" and provide intervention at the consumer's location, safety and transportation issues, particularly during non-business hours, frequently result in the consumer being required to come to a hospital emergency room for evaluation. The result of these evaluations is too often an inpatient admission. With limited access to a psychiatrist and a client's mental

health history, crisis workers may be unable to offer effective interventions other than hospitalization when the client experiences an acute psychiatric episode.

DMHMRSAS currently contracts with community crisis programs for the operation of crisis beds to divert hospital admissions when clinically indicated. However, many of the existing community crisis beds do not operate as designed. Community crisis beds are staffed 24 hours a day, but many have no consistent on-site presence of a nurse or psychiatrist, and their staffing levels may preclude the placement of persons presenting significant risk issues. Only persons who are non-violent and who are willing and able to agree that they will not engage in self-harm are accepted by many of the current crisis beds. Thus, the crisis beds do not now serve others who might benefit from a period of brief crisis stabilization.

The current process by which a person requiring intensive psychiatric treatment gains admission to an inpatient bed is often protracted, and at times dehumanizing. Pre-screening for hospitalization is typically conducted by a crisis worker within an acute medical care hospital emergency room. Pre-screenings are delayed when a potential patient arrives at the emergency room in an intoxicated condition, since the pre-screening cannot be completed while the patient's blood level suggests continued intoxication. When the decision to hospitalize is finally made, the crisis worker must canvass the community hospitals to determine bed availability and arrange for admission. AMHI placement is only pursued after all community hospitals have refused the admission. Not only is this process difficult for the patient, but it also burdens the emergency rooms of the community general hospitals.

Initiatives under consideration by DMHMRSAS to improve current crisis services include:

- Development and monitoring of performance standards for crisis services.
- Development of assessment centers and 23-hour assessment beds for persons experiencing psychiatric crises.
- Staffing community crisis beds to optimize their appropriate utilization.
- Development of a clearinghouse to streamline the process of determining bed availability in the system.
- Staff development and enhanced training for crisis workers.

DMHMRSAS has continued to fund new crisis services that will impact hospitalization rates. For example, the development of "safe houses" for consumers experiencing crises related to histories of trauma has reduced inpatient utilization for these individuals.

Residential Treatment Options: Maine has made great strides in recent years in improving the residential options available for persons with serious mental illness. The increasing availability of these options has facilitated the discharge of patients who had previously been hospitalized for extended periods due to inadequate

community resources. However, there is a relatively small group of hospitalized individuals who require a level of supervision and continued psychosocial rehabilitation not currently available in the community. Most of these individuals have experienced numerous unsuccessful community placements.

Surveys of AMHI clinical staff at two points in time in the fall of 1999 indicated that the number of AMHI patients who could be discharged to an intensely supportive residential program ranges between 13 and 19. These estimates reflect patients remaining at AMHI after years of deinstitutionalization efforts and support the need for creating a supportive residential environment that could address both treatment and safety needs. Currently, to permit hospital discharge for this type of patient, the primary option is placement in an apartment with one-to-one staff supervision 24 hours a day. This option is not only cost prohibitive (up to $300,000 per year), but is intrusive on the privacy of the consumer.

Projection of Need for State-Operated Forensic Inpatient Beds

Providing forensic inpatient psychiatric treatment is a state responsibility not readily transferable to community providers due to the unique clinical and security concerns. The State of Maine is wise to continue to assume responsibility for this population. This needs assessment was conducted to determine the number of inpatient forensic beds needed for the entire state.

Review of information provided by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute indicates that Maine has a low number of forensic patients in relation to its statewide population. An analysis of state responses to a survey of the number of current adult forensic inpatient census indicated the following:

Table 8
Forensic Inpatients per 100,000 Population

State	Forensic Inpatients per 100,000
Kansas	6.7
Virginia	5.2
New York	4.9
Minnesota	4.0
Massachusetts	3.3
Delaware	3.0
Maine	2.7

Source: NASMHPD Research Institute

Maine's relatively few forensic inpatients when compared to other states seem related to limited inpatient bed capacity rather than a lesser need for forensic

treatment. The AMHI forensic unit has been challenged to meet the needs of forensic inpatients due to limited space and the security issues related to the current space.

With only 27 forensic beds available at AMHI, patients on the forensic unit now are primarily patients who have been found not criminally responsible (NCR) or incompetent to stand trial (IST). The forensic bed space has restricted the access to inpatient psychiatric services for persons referred by Maine jails and prisons. Forensic bed space availability for correctional transfers has been further restricted by the need for the AMHI forensic unit to house two to four male patients without "legal holds" due to the inability of the current less secure civil patient units to manage these patients.

The AMHI forensic unit serves only male forensic patients, with female NCR, IST or correctional transfers now served within the civil units. Since the civil treatment teams assigned to NCR females are not forensically-focused, attention to the specialized processing for disposition options is compromised. Also, while the practice of housing the female forensic patients on the civil units would appear to minimize the secure supervision of female forensic patients, the lack of a forensic perimeter security for the females can actually result in more restrictive measures. For example, one female NCR was maintained with one-to-one supervision for five months as a security measure. As would be expected, this type of intervention was experienced by the patient as highly intrusive.

There are currently three male NCR patients at BMHI. Although the decision has been made to house all forensic patients at AMHI, the three male patients, all of whom have serious functioning impairments related to mental illness, have been permitted to remain at BMHI due to the limited security risks involved in their retention at the facility. Personal observation of these patients during the needs assessment process confirmed the clinical appropriateness of the decision to allow these patients to remain in the familiar BMHI environment.

During a review of the AMHI forensic unit on November 9, 1999, the 24 male forensic patients fell into the following legal categories:

Table 9
Legal Status of AMHI Male Forensic Patients - November 9, 1999

Legal Status	Number of Patients
NCR	12
IST	5
Pending Evaluation	1
Jail Transfers	6

Projected Need for NCR Beds: Hospitalization stays for the 12 male NCR patients currently at AMHI range from one month to 29 years, with seven of the patients having been hospitalized for more than 12 years. Prolonged lengths of stay for Maine NCR patients are common. The length of hospitalization for the four female NCR patients now at AMHI ranges from 1 to 4.5 years.

The Maine judicial system has adopted the practice of not discharging NCR patients from the custody of the Commissioner of DMHMRSAS when the patient no longer requires inpatient psychiatric treatment but placing them on hospital leave. Review of the lengths of stay of the 19 NCR patients placed on hospital leave since 1982 indicates that historically, Maine NCR patients have had extensive lengths of stay.

Table 10
Length of Stays of 19 NCR Patients Placed on Hospital Leave since 1982

Length of Stay	Number of Patients
Less than 1 year	1
1 year to 5 years	2
5 years to 10 years	5
10 years to 15 years	4
15 years to 20 years	4
Over 20 years	3

A forecast of the need for forensic beds for non-correctional patients is presented in Table 11 on page 17. Patients referred by the jails and Department of Correction were omitted from this analysis due to the consensus that the historical statistics would not provide a valid estimate of need. Projections of the number of inpatient beds required by patients transferred for correctional institutions were based on national estimates and a survey of Maine correctional agencies.

The forecast model indicates that Maine will require a total of 21 NCR patient beds by the year of 2010. This forecast, like the forecast for civil beds, is based on recent historical data and population projections and does not account for potential change within the Maine mental health delivery system during this period. As noted previously, consideration of current system practices and potential improvements is necessary to interpret the projections of bed need based on historical data.

Forecast of the need for NCR patient beds is impacted by the number of NCR admissions as well as by the number of discharges. The number of admissions has remained fairly static while the number of NCR patients approved for hospital leaves recently increased. Since 1995 there have been only seven NCR patient admissions, with four of these admissions occurring in 1997.

Significant progress in obtaining judicial approval for NCR hospital leave approvals is indicated by the fact that of the 19 NCR patients now on hospital leave, six of the leaves were granted in 1999. Implementation of a six bed halfway house for NCR

patients, the Homestead House, has permitted NCR patient movement outside of the hospital.

Table 11
Population Forecast - Forensic Patients

Fiscal Year	Historical		Projected**				
	Bed Days	Population	Female	IST	NCR	Total Projected	Peaking Factor
1997*	8,382	22.96					
1998*	9,047	24.79					
1999*	9,387	29.71					
2000			4	5	12	21	18-24
2001			4	7	12	23	20-26
2002			4	7	12	23	20-26
2003			4	7	12	23	20-26
2004			5	7	13	25	22-28
2005			5	9	13	27	24-30
2006			5	9	13	27	24-30
2007			5	9	14	28	25-31
2008			6	10	14	30	27-33
2009			6	11	14	31	28-34
2010			6	11	15	32	29-35

* Includes all forensic patients, male and female
** Excludes forensic patients from correctional facilities and jails.

- The projections are based solely on male and female NCR and IST patients. Projection of beds for jail and prison transfers is based on national data.
- Female forensic cases housed with the civil population are included for the 1999 historical population.
- A peaking factor of +/- 3 beds has been applied to the total forecast to account for monthly variations. The 3 bed peaking factor was determined by applying the standard deviation calculated from the average daily forensic census from January 1998 through October 1999. The average daily census during this period ranged from 22 to 27 patients.

If additional secure halfway house forensic beds were developed, it is likely that additional NCR patients might be placed on hospital leave. Only a few of the current 16 hospitalized NCR patients at AMHI do not have access to grounds privileges. Most of these patients continue to require staff supervision when not within the facility.

Development of a second secure forensic halfway house is highly recommended as a cost effective and safe manner to address the needs of forensic patients requiring intense supervision but no longer requiring inpatient treatment. Based on discussions with many Maine agencies and citizens, the development of such a facility has strong community support. Locating the second forensic halfway house outside of the Augusta community, perhaps in the Portland area, would permit forensic patients on hospital leave to safely reside near their support networks.

The forecast that Maine will require a total of 11 IST patient beds by the year of 2010 is also significantly affected by current practices. The number of patients adjudicated to IST is increasing. Of the 22 patients admitted to the AMHI since 1995 for restoration to competency, ten were admitted since 1998. Lengths of stay of the current IST patients range from 130 to 306 days. These are unusually extended lengths of stay for restoration to competency and possibly reflect the staff's inability to obtain judicial approval for involuntary medication even though the patient has been committed for restoration to competency. While it is essential to protect patient rights in treatment decisions, IST patients who are permitted to refuse treatment may actually preclude competency restoration. Re-consideration of the current practice is recommended to reduce the length of hospitalization related to restoration of competency.

Projected Need for Forensic Evaluation Beds: Individuals may be admitted to the AMHI forensic unit for the completion of evaluations related to competency and/or criminal responsibility; however, the number of such admissions is minimal. AMHI records reflect only ten such admissions since 1995, with an average length of stay of 72 days. The majority of court-ordered evaluations are completed on an outpatient basis through State Forensic Services.

Projected Need for Correctional Forensic Beds: As noted previously, since there is consensus that individuals in jails and prisons requiring inpatient psychiatric treatment have been under-served, analysis of historical data would not have provided a valid forecast of future need. Projections for correctional forensic beds were based on national estimates and surveys of Maine correctional agencies.

The Maine Department of Correction (MDOC) has a current census of approximately 1,700 inmates. National statistics suggest that 10% of prison inmates experience some type of mental illness with an estimated one half to one percent requiring specialized treatment and placement for serious mental illness. The number of inmates requiring inpatient psychiatric treatment within a forensic hospital is largely determined by the level of services available within the correctional system.

MDOC projects the need for two inpatient forensic beds at any one time. These beds would be primarily utilized for acute treatment, with the inmate returning to the prison system after stabilization of the acute psychiatric episode. MDOC's development of the proposed Special Needs Unit at the Maine Correctional Center for inmates with serious mental illness will ensure the inmate's treatment after return to the prison system. Implementation of an involuntary medication process for prison inmates in accordance with the Supreme Court *Harper* decision might also reduce the need for the transfer of MDOC inmates to a forensic hospital setting.

Local jails of Maine now house approximately 1,100 male and 125 female inmates at any one time. The number of these inmates requiring inpatient psychiatric treatment was assessed through jail surveys, discussions with jail administrators and consumers who have been incarcerated, as well as by consideration of national trends.

Results of a survey completed by jail administrative staff indicated the following:

Table 12
Self-Reported Psychiatric Hospital Referrals - Maine Jail Survey, October 1999

Jail	Census	Annual Admissions	Annual Referrals	Reason for Referrals	Inmates Requiring Hospital Care
Androscoggin	98	5000	6	Suicidal	3
Aroostook	65	1200-1500	6-10	Suicidal/Mentally Ill	10-20%
Cumberland	325	8400	5	Suicidal/Mentally Ill	1
Franklin	19	735	3	Suicidal/Mentally Ill	1
Hancock	40	N/A	15	N/A	N/A
Kennebec	178	3068	8	Suicidal/Mentally Ill	10-12 year
Knox	40-50	1700+	3	Suicidal/Mentally Ill	1
Lincoln	32	1200	4	Mentally Ill	1-2 year
Oxford	30	1300	2-3	Suicidal	1/month
Penobscot	125	5000	7-10	Mentally Ill	1-2
Piscataquis	27	755	1-2	N/A	N/A
Sagadahoc	22	778	1	Mentally Ill	1
Somerset	54	1500	6	Suicidal/Mentally Ill	1
Waldo	24	1200	8	Suicidal/Mentally Ill	3
Washington	31	N/A	1	Mentally Ill	2
York	130	3500	7	Suicidal/Mentally Ill	3

N/A = Data not available.

Applying national estimates to the Maine jail population indicates that at any one time, approximately 184 (15% of inmate census) experience mental illness with 12 to 18 (1 to 1.5% of inmate census) requiring specialized placement due to serious mental illness. The number of inmates requiring inpatient psychiatric treatment is generally higher in jails than in prisons due to high jail turnover and the acuity of

mental illness of some inmates at admission. Maine jails reported more than 35,000 admissions each year, and given the unknown regarding new arrestees, each admission has the potential for mental illness or the risk of suicidal behavior.

Similar to the situation within prisons, the need to transfer jail inmates with mental illness for inpatient psychiatric care is partially determined by the level of mental health services available within the jail. Responses to the jail survey indicated that the availability of mental health services in Maine jails is limited at best. Given the limited on-site mental health assistance, jails have little recourse but to refer inmates with serious mental illness for inpatient treatment. Maintaining such inmates in a jail setting without appropriate follow-up is neither clinically acceptable nor safe.

Improving the admission process for jail inmates would also impact the number of forensic admissions. Development of a direct referral process between the jail and the hospital forensic staff would preclude the now lengthy, and likely unnecessary in many cases, process of requiring a second pre-screening in an emergency room of a community acute medical care hospital. Direct communication would permit collaboration in determining the most clinically appropriate level of treatment.

This needs assessment was conducted to assess the number of inpatient beds required to meet the needs of all Maine jails. Since BMHI now serves jail inmates from Aroostook, Hancock, Penobscot and Washington Counties, the establishment of a single site for all forensic correctional treatment will require a change in practice. The assurance of an adequately secure environment and forensically-based clinical treatment at the new forensic facility should compensate for the additional jail transportation requirements of the distant counties.

While the provision of additional well-staffed inpatient beds for jail inmates will improve services for persons with mental illness who are incarcerated, the level of mental health services available in the jails must be increased. Without adequate follow-up and the continuation of prescribed medication, inmates who have received effective inpatient care are not likely to maintain the functioning achieved during hospitalization.

Training law enforcement and correctional officers in identifying and effectively responding to persons with serious mental illness is also critical. Jail mental health services are compromised when security staff are not knowledgeable about mental illness or do not support the treatment process.

Finally, alternatives to incarceration for consumers disturbing the public with non-criminal mental health behavior must be found. For example, 23-hour assessment beds could provide law enforcement a viable alternative to incarceration and subsequent hospitalization, as well as enhance consumer access to appropriate levels of care. Addressing these issues would reduce the number of jail inmate referrals for inpatient treatment and limit the use of restrictive hospitalization to those instances when hospital-level care is clinically appropriate.

Summary of Projected Need for Forensic Beds: The year 2010 projected need for forensic inpatient beds based on the historical data, national estimates, proposed changes in service delivery practices and the potential for system improvements is as follows:

Table 13
Summary of Projected Need for Forensic Beds

Forensic Population	2010 Projected Beds	Rationale
NCR Patients	18-20	Based on population forecast and development of second secure halfway house beds for NCR patients no longer requiring hospitalization.
IST Patients	4-5	Based on decreasing lengths of stay and clinically aggressive treatment for restoration to competency.
Forensic Evaluations	1	Based on current practices and continuing outpatient evaluations by State Forensic Services.
Prison Transfers	2	Self-report of MDOC.
Jail Transfers	12-16	Based on national estimates and improvements in jail mental health services.
TOTAL	**37 – 44**	

The analysis of the need for forensic inpatient beds did not include the juveniles requiring inpatient psychiatric care who are in the custody of MDOC. MDOC has indicated a need for as many as six juvenile inpatient beds. Initially, juvenile forensic inpatient treatment was to be integrated into the new facility. Best treatment practices indicate that mixing adults and juveniles in the same facility is ill-advised. Discussions are now being conducted with community psychiatric hospitals to develop secure adolescent treatment beds for the juvenile forensic population. The establishment of such beds within Maine or the development of adolescent psychiatric beds within the MDOC system is crucial to end the current practice of sending some juveniles to out-of-state placements, a clinically disruptive and expensive resolution.

NEEDS ASSESSMENT RECOMMENDATIONS

While the needs assessment focused on determining the need for state-operated inpatient psychiatric beds, the analysis also identified areas which would improve the overall Maine mental health system and reduce the need for hospitalization. Recommendations resulting from this analysis are summarized below.

Recommended Construction: Based on a review of current and developing practices as well as an analysis of historical data, a Psychiatric Treatment Center designed to provide treatment and living space for 48 civil patients and 44 forensic patients is proposed. In addition, two Supportive Living Centers are proposed to provide16 residential beds for patients now hospitalized.

The Psychiatric Treatment Center is designed to serve both civil and forensic patients to permit the continued sharing of support resources and maximize the utilization of expensive treatment space. Further, if the forensic beds were to be separated from the civil beds, operation of the forensic beds would no longer qualify for Federal Disproportionate Share funding.

The Psychiatric Treatment Center will provide the following units:

- Acute Care Unit: A 24-bed unit will provide the "safety net" beds for patients who are in need of psychiatric hospitalization but who are unable to be served within the community due to risk or lack of available community hospital bed space within the patient's local service network.

- Intermediate Care Unit: A 24-bed unit will provide extended treatment for patients whose severity of mental illness requires extended inpatient treatment for therapeutic effect. Many of these patients will require specialized treatment for trauma or substance abuse as well as a biological mental illness. Patients will be admitted to the intermediate care unit on a voluntary or involuntary basis.

- High Security Forensic Unit: A 20-bed unit will provide the initial placement for all forensic patients admitted to the hospital. NCR patients and IST patients will be transferred to the intermediate care forensic unit subsequent to treatment team recommendations. Forensic patients admitted to the hospital from jails or prisons will be maintained on the high security forensic unit for their entire hospitalization. The design of this unit will allow six beds to flex from high security to intermediate care if required.

- Intermediate Care Forensic Unit: A 24-bed unit will provide extended treatment for male and female patients who have been admitted to the hospital as NCR or IST and whose functioning has permitted treatment team approval of reduced security requirements.

The provision of a high security unit will minimize the security concerns involved when housing inmate patients. The provision of a dedicated clinical staff will also permit intensive acute psychiatric treatment and the cooperative discharge planning with jail and prison staff that will optimize an inmate's potential for maintaining stability after return to the correctional setting. These are areas now frustrating the relationship between corrections and the AMHI forensic unit.

The recommendation to provide 24 male and female intermediate care forensic beds was based on factoring the information gained about current Maine treatment and management of these patients with the population forecast. In many states, the forensic patients of this unit would have been transferred from high security forensic settings to less secure civil settings. Maine's practice of retaining all NCR and IST patients on a forensic unit requires the development of a less restrictive environment for long-term treatment and maintenance.

The Psychiatric Treatment Center has been designed to provide maximum flexibility to meet evolving system needs. Six beds of the high security forensic unit are designed to allow for use either as high security or intermediate care beds. Thus, the high security forensic unit could be reduced to 14 beds and the intermediate care forensic unit increased to 30 beds if needed.

The infrastructure of Psychiatric Treatment Center will be built to enable the addition of two 24-bed units (civil or forensic) without significant change to the core structure, in the event that additional beds are required as a result of changing demographics or policy change. This expansion will not be needed if the requisite community resources are established.

An essential component of the recommendation for the construction of the Psychiatric Treatment Center is the creation of two stand-alone eight bed intensely supervised residential facilities. The Supportive Living Centers will provide safe living environments for persons with serious and persistent mental illness who no longer require hospital-level treatment, but whose needs cannot now be adequately met in the community. The Supportive Living Centers will also provide a training setting for individuals throughout the state to develop skills to effectively treat and support this challenging population. This training will permit the sharing of best practices that will facilitate the subsequent development of similar placements in other locations within Maine.

A chart comparing the bed capacity of the current AMHI patient units with the bed capacity of the proposed units of the Psychiatric Treatment Center and the Supportive Living Centers is provided in Table 14 on page 24.

Table 14
Comparison of Existing and Proposed Civil and Forensic Beds

CURRENT AMHI UNITS	LICENSED BED CAPACITY		PROPOSED PSYCHIATRIC TREATMENT CENTER	BED CAPACITY
Region I-Civil	25		Acute Care-Civil	24
Region II-Civil	25		Intermediate Care-Civil	24
Region II-Civil	26			
Civil Subtotal	76		Civil Subtotal	48
Forensic-Maximum	6		Forensic-High Security	20
Forensic-Medium	21		Forensic-Intermediate	24
Forensic Subtotal	27		Forensic Subtotal	44
AMHI Total	103		Center Total	92
Residential Beds	0		Supportive Living Centers	16
TOTAL BEDS	**103**		**TOTAL BEDS**	**108**

System Recommendations: DMHMRSAS is and will continue to work on resolving system issues impacting the need for inpatient psychiatric treatment. It is strongly recommended that DMHMRSAS accomplish improvements in the following areas during the transition construction period to ensure optimal system functioning and utilization of the new inpatient beds.

- Continuing development of the partnership between DMHMRSAS and community hospitals and community psychiatric hospitals through agreement on the most clinically effective roles for community and state-operated beds and the establishment and monitoring of performance standards. As noted previously, there appears to be general agreement about the following hospital roles:

  - Optimally, community hospitals would serve only the patients residing within their geographic area.

  - Psychiatric units of community acute care hospitals may be unable to effectively provide the level of treatment required by some patients. These patients should be served by the community psychiatric hospitals and the state-operated hospitals.

  - State-operated hospitals should serve two functions: the "safety net" for patients needing acute treatment, and a treatment center for patients who meet the criteria for intensive and extended treatment.

  - Clearly defined criteria must be established to determine when transfers from community to state-operated beds are appropriate.

  - Patients admitted to community hospitals requiring extended care and substantial psychosocial rehabilitation would be best served by state-operated hospitals with extensive treatment resources.

- Continued efforts to integrate community and hospital mental health providers in developing inpatient treatment plans and discharge plans when a patient is hospitalized in a state-operated or community facility.

- Development of state-of-the-art treatment tracks and programming for inpatients with multiple needs related to persistent and serious mental illness, substance abuse and/or histories of trauma.

- Establishment of a centralized clearing-house process for hospital admissions to address the serious problems with the current psychiatric hospitalization pre-screening process.

- Refinement of community crisis services to maximize the effectiveness of outpatient services and limit the use of hospitalization to instances in which hospital-level care is clinically appropriate. These refinements include:

  - Development of 23-hour assessment beds and the provision of psychiatric support and adequate staff for the community crisis beds that would enable safe and effective options to hospitalization.

  - Refinement of use of in-home support staff to enable consumers experiencing psychiatric crises to be safely treated in the least restrictive environment.

  - Development and monitoring of performance standards for crisis services.

- Staff development and training opportunities for hospital-based mental health staff to enhance their skills in providing state of the art treatment. Staff development and training activities for community crisis workers and case managers to enhance skills in providing crisis interventions.

- Increased university affiliations to provide additional clinical resources for inpatient and community mental health services as well as provide training opportunities that would attract additional skilled clinicians to the State of Maine.

- Development of a peer support system.

- Development of a second secure forensic halfway house located in an appropriate location to address the needs of current forensic unit patients requiring supervision but no longer requiring inpatient treatment.

- Increasing mental health support to local jails through establishment and monitoring of performance standards for community agencies responsible for these services.

- Development of an admission protocol that would permit direct dialogue and acceptance/refusal of admissions between the forensic unit and jail staff.

- Training of law enforcement officers regarding mental health issues to facilitate the appropriate disposition when mental health issues may have contributed to minor law infractions.

- Training of correctional officers in identifying the signs of serious mental illness and appropriate interventions to facilitate effectiveness of mental health services within the jails and prisons.

- Development of partnership between the Maine Department of Correction and community psychiatric hospitals to provide inpatient treatment for adolescent forensic patients.

The construction-related recommendations arriving from the needs assessment set the stage for the development of the operational and architectural program, the concept design, and the capital and operating budgets described in the ensuing chapters.

OPERATIONAL AND ARCHITECTURAL PROGRAMS

As mentioned above, the development of a Psychiatric Treatment Center and two Supportive Living Centers is recommended. Implementation of both an inpatient treatment facility and two highly supervised residential placements will complement community resources in the providing Maine citizens with state of the art treatment in the least restrictive setting.

The narrative that follows briefly describes the proposed operation of the Psychiatric Treatment Center and the Supportive Living Centers, organized by functional area. A summary of the corresponding square footage of these facilities appears in Tables 15 and 16 on pages 33 and 34, respectively, at the end of this section.

Psychiatric Treatment Center

The Psychiatric Treatment Center will allow the State of Maine to provide treatment for a full range of forensic patients, including patients referred from the state's correctional agencies, in a safe and secure environment. In addition, the Psychiatric Treatment Center will provide an appropriate number of state-operated inpatient beds for civil patients. The new facility is not designed to compete with community

hospitals for patient services, but to provide treatment for patients unable to be safely treated within the community hospitals and for patients whose severity of illness will require extended treatment and significant psychosocial rehabilitation.

In accordance with the *Rights of Recipients of Mental Health Services,* Section B, Rights in Inpatient and Residential Settings, the Psychiatric Treatment Center "shall be designed to afford recipients comfort and safety, shall promote dignity and independence and shall be designed to make a positive contribution to the efficient attainment of treatment goals."

The Psychiatric Treatment Center is designed to accommodate an initial population of 92 patients. In the event that additional civil or forensic patient beds may be required in the future, programming space, support services and the utility infrastructure of the facility will be sized to accommodate a future expansion of up to 140 beds. Economies of scale in construction and operating costs will be realized if additional treatment beds should be needed as the result of changing demographics, service delivery practices or policy changes.

The Psychiatric Treatment Center will be both a physically and staff secure facility. The exterior walls and windows of the building's perimeter will be designed and constructed to meet the highest levels of security in conformance with industry standards, and will serve as the primary line of security for the facility. Architectural or estate fencing will be used to define property line demarcations. This approach will allow patients the freedom to move securely and safely throughout the facility as well as on the adjacent grounds.

A state of the art security electronics system will be utilized to allow staff to safely supervise patient movement and provide for personal safety. All security features will be sensitively designed so as to be unobtrusive and blend in with the normative and therapeutic environment of the facility. While electronic technology will be used to enhance the security of the hospital, in no instance will the use of electronic surveillance substitute for staff supervision and interaction.

On-line computer terminals will be placed in appropriate areas to ensure that needed information is readily available to staff involved in the decision-making and treatment processes.

Proposed operations of the various functional areas of the Psychiatric Treatment Center are as follows:

Public Lobby/Administration: The public lobby will be the primary access point into the Psychiatric Treatment Center through which all staff, visitors and patients with grounds or community privileges will pass. A receptionist will be present in the public lobby from 7:00 AM to 8:30 PM every day to greet, process and direct visitors to the administrative offices or the visitation area.

The administrative area will provide adequate space for administrative oversight and clinical supervision of Psychiatric Treatment Center activities, as well as for the efficient processing of facility and patient documentation. The administration area is divided into the following sub-areas:

- Superintendent's Office
- Mailroom/Switchboard
- Administrative Services
- Operational Services
- Clinical Services
- Clinical Support Services
- Patient Records
- Administrative Support

Sufficient training space has been included within the Psychiatric Treatment Center to promote the clinical skills of staff and the development of university affiliations. These affiliations will enhance patient treatment and offer clinical training opportunities for Maine residents.

Staff Support: Staff support areas include a staff break room and male and female staff shower and dressing rooms. The showers and dressing rooms will be essential when weather emergencies require staff presence for extended periods.

Patient Units: Civil and Forensic: The four patient units of the Psychiatric Treatment Center will provide space to conduct varying levels of treatment in order to address individual patient needs. Constant observation and seclusion and restraint rooms will provide the interventions and staff supervision required when a patient is experiencing the acute phase of mental illness or is behaving in a manner that presents a risk of harm to self or others. It is DMHMRSAS's goal to develop alternatives to seclusion and restraint as crisis care, in which case these rooms will be utilized for alternative treatment. Unit treatment areas will include the programming space and indoor/outdoor leisure space to facilitate the recovery process.

While the focus of treatment on the acute and intermediate care units will differ, based on the patients being served, the principles of care will be the same. All units will provide multidisciplinary treatment consistent with the patient's current mental status. All patients will be afforded active treatment focused on the reduction or management of symptoms and behaviors that led to the admission and the development of skills that will promote enhanced functioning over a sustained period.

The patient units are designed based on a cluster concept. Each unit is comprised of two to three clusters; each cluster providing bedroom and leisure space for four to sixteen patients. Each unit also has treatment space and multipurpose rooms for program activities. Offices for members of a patient's treatment team are located

within the patient's unit to facilitate staff-patient interaction, staff-staff interaction and consistency in the treatment team process.

The patient units will permit the zoning and closure of staff office and programming space when these areas are not in use. This will limit the space requiring staff supervision to areas where the patients are present. The units will also allow the flexible separation of the bed space within designated clusters to meet the clinical needs of specific patient groups.

Patients of the high security forensic unit will remain on the unit unless escorted by staff to the visitation area or medical clinic. These patients will receive treatment and dining within the secure unit. Patients of the high security forensic unit will not interact with patients of the intermediate care forensic unit or the civil patient units. However, a section of the high security forensic unit is designed to flexibly provide safe housing for intermediate care forensic patients if needed.

Centralized Programming Services: Although treatment and programming space will be provided on each patient unit, programming efforts will be focused within a centralized Treatment Mall for patients who have recovered from the most acute phase of psychiatric disturbance. The Treatment Mall will provide the patient services and programs required for therapeutic benefits and enhanced quality of life. Since the Treatment Mall will be located within the secure perimeter, patients will be afforded freedom of movement and choice of program involvement without risk to the safety of the patient or community. Patient participation in Treatment Mall activities will provide the patient and staff the opportunity to evaluate the patient's ability to cope with group situations in a community-like environment.

Programming options to be offered on the Treatment Mall include the following: psychotherapeutic groups, psychoeducational groups focused on understanding mental illness and activities of daily living, academic training, art and music therapy, pottery, vocational services, cooking groups, horticulture groups, structured leisure activities, and therapeutic exercise. Psychotherapeutic groups will address issues related to mental illness as well as problems related to substance abuse and trauma.

Space for religious services, unstructured leisure activities, indoor and outdoor recreation, and large group activities will also be provided. Offices for the chaplain, patient advocate and peer specialists will be located in this area, thereby facilitating patient access to these important resources. The patient library, barber/beauty shop, small patient chapel, and gymnasium will also be located on the Treatment Mall.

Admission/Discharge Area: A central admission/discharge area will be provided for all forensic and involuntary civil patients entering and leaving the Psychiatric Treatment Center. These patients will be admitted to the admission/discharge area through a secure garage that will serve as a vehicular sallyport and permit a controlled environment as well as an area protected from inclement weather.

Clinical staff of the patient unit accepting the patient will come to the admission/ discharge area to complete the admission process. A medical records clerk will assist in the preparation of documentation related to the admission.

The admission/discharge area will also serve as the exit and entry point for the transport of patients for off-site medical care, community appointments and court appearances. Further, the area will serve as the entry and exit point for individuals brought to the Psychiatric Treatment Center from correctional facilities for the completion of court-ordered evaluations by State Forensic Services staff.

Visitation: Since visitation of the patient by family and friends often serves to promote a patient's mental health, the Psychiatric Treatment Center will provide optimal opportunities for visitation. Visitors will be encouraged to consider the patient's involvement in therapeutic programming when scheduling their visits.

The visitation area will provide a multipurpose room for court commitment and other administrative hearings related to a patient's hospitalization. This multipurpose room will also be used by for group meetings that will include both patients and persons from the community. Such groups include the National Alliance for the Mentally Ill, Alcoholics Anonymous, and peer support groups.

Medical Support Services: Medical Support Services will provide patients of the Psychiatric Treatment Center with medical and dental care. This area will also house pharmacy services and provide sleeping accommodations for medical clinicians providing night coverage.

State Forensic Services: State Forensic Services coordinates and performs such court-ordered forensic evaluations as: competency to stand trial evaluations, criminal responsibility evaluations, pre-sentencing reports, and periodic assessments of the mental functioning and prognosis of individuals previously determined to be incompetent to stand trial (IST) or not criminally responsible (NCR).

Although State Forensic Services is not funded through the Psychiatric Treatment Center, its location within the hospital will facilitate the completion of court-ordered evaluations for patients of the forensic units, particularly patients who have been found IST or NCR. The location will also provide a secure environment when individuals are transported from jails or prisons for court-ordered evaluations.

Food and Laundry Services: While institutional linen will be laundered by a private provider, a laundry pick-up and distribution system is accommodated in the new facility. A production kitchen for the preparation of meals for patients and staff will include areas for meal planning, preparation, cooking, serving, cleaning, and storage. Dining areas will be located on patient units and on the Treatment Mall.

Building Access and Patient Safety Services: A centralized Building Access Center will monitor and coordinate the hospital's security, safety and communications systems. Building Access Center activities include observing and controlling the hospital's entrance and exit traffic; monitoring the institution's communication, fire alarm/detection and personal alarm systems; issuing emergency keys and monitoring the issuance of all facility keys; monitoring and operating electronically controlled doors; and monitoring CCTV operations and perimeter security. Redundant touch screen door control and communication capabilities will allow one staff member to operate all necessary equipment and systems.

Facility Management Services: Adequate space is allocated for housekeeping and maintenance staff to maintain the hospital's physical plant. While DMHMRSAS will outsource major maintenance and repairs, the hospital's maintenance staff will perform routine and preventive maintenance to ensure that all building systems are functioning properly. Facility management areas include space for minor repairs and housekeeping functions, as well as a warehouse with a loading dock/staging area sufficient to meet the needs of the Psychiatric Treatment Center.

Site: The Psychiatric Treatment Center's exterior is designed to ensure the facility has a residential appearance and reflects the hospital's mission of treatment for persons with mental illness. When fencing is used, it will primarily be estate fencing. Two separate parking areas will provide adequate space for staff, official visitors, and the general public.

Supportive Living Centers

The Supportive Living Centers will provide staff-secure and safe home environments for persons with serious and persistent mental illness for whom community placements have proved unsuccessful. Unobtrusive measures such as security exterior glazing and estate fencing of outdoor areas will ensure resident safety while facilitating free movement within the facility.

While space for psychosocial rehabilitation and psychiatric treatment will be provided within the Supportive Living Centers, their primary function will be to provide a supervised living environment from which residents may safely access community resources.

Existing houses or similar structures will be rehabilitated for use as Supportive Living Centers. Each Supportive Living Center will include eight private resident living areas configured around common leisure, dining, treatment and recreation space. Each of the individual resident living areas will include a sitting area and a private restroom and shower as well as a bedroom area. The sitting area will provide space for personal activities and quiet time and will be equipped to permit use of a personal television, computer and/or telephone. The individual living areas will have ample storage and display space for personal belongings.

Although part-time staff will assist with food preparation and house maintenance, residents will be expected to participate in these activities with staff support at a level consistent with their clinical status.

Architectural Program Summary

The architectural program summaries presented in Tables 15 and 16 represent the net and gross square footages for each of the functional areas of the Psychiatric Treatment Center and Supportive Living Centers.

Explanation of Square Footage Requirements: The total net usable or assignable (net square footage) of each functional area represents the actual, usable space for each area. A departmental grossing factor was applied to the total net square footage of each component to accommodate necessary circulation space within functions, mechanical shafts, and other unassigned areas that are part of the component.

In any facility, additional square footage is also needed for major enclosed circulation and mechanical rooms that related to the overall facility rather than individual components, as well as the building structure and exterior "skin." This additional gross area is computed by multiplying the sum of the individual building components by a building grossing factor, as illustrated at the bottom of the chart.

Table 15

Architectural Program Summary – Psychiatric Treatment Center

Number	*Functional Area*	*NSF*	*GSF*	*Notes*
	INDOOR SPACES – PSYCHIATRIC TREATMENT CENTER			
1.000	Administration/Public Lobby	8,885	11,176	
2.000	Staff Support	600	750	
3.000	Patient Units: Civil	17,915	26,873	
4.000	Patient Units: Forensic	18,180	27,270	
5.000	Centralized Programming Services	9,610	13,454	
6.000	Admission/Discharge Area	2,045	2,659	
7.000	Visitation	1,669	2,100	
8.000	Medical Support Services	3,160	4,108	
9.000	State Forensic Services	1,585	1,981	
10.000	Laundry and Food Services	3,810	4,897	
11.000	Building Access and Patient Safety Services	380	503	
12.000	Facility Management	7,900	9,225	
13.000	Site	0	0	See Outdoor Spaces, below
	SUBTOTAL	**75,739**	**104,994**	
	Building Gross Factor (10%)	7,574	10,499	Includes Mechanical/Electrical, Building Gross, and Major Circulation
	TOTAL	**83,313**	**115,493**	

Note: NSF is the net usable or assignable area. GSF includes a departmental grossing factor to accommodate necessary circulation space within functions, mechanical shafts, and other unassigned areas that are part of the component.

Number	*Functional Area*	*NSF*	*GSF*	*Notes*
	OUTDOOR SPACES – PSYCHIATRIC TREATMENT CENTER			
	TOTAL	**112,500**	**112,500**	

Table 16

Architectural Program Summary - Supportive Living Centers

Number	*Functional Area*	*NSF*	*GSF*	*Notes*
	INDOOR SPACES – SUPPORTIVE LIVING CENTERS			
1.000	Living Areas	3,100	4,185	
2.000	Common Areas	1,850	2,498	
3.000	Staff Office Area	430	538	
4.000	Facility Maintenance and Support	580	696	
	SUBTOTAL	**5,960**	**7,916**	
	Gross Factor (10%)	596	792	Includes Mechanical/Electrical, Building Gross, and Major Circulation
	TOTAL	**6,556**	**8,708**	**Total interior square footage for 1 facility**
	x 2 FACILITIES	**13,112**	**17,415**	**Total interior square footage for 2 facilities**

Note: NSF is the net usable or assignable area. GSF includes a departmental grossing factor to accommodate necessary circulation space within functions, mechanical shafts, and other unassigned areas that are part of the component.

Number	*Functional Area*	*NSF*	*GSF*	*Notes*
	OUTDOOR SPACES – SUPPORTIVE LIVING CENTERS			
	TOTAL	**2,000**	**2,000**	**Total exterior square footage for 1 facility**
	x 2 FACILITIES	**4,000**	**4,000**	**Total exterior square footage for 2 facilities**

STAFFING RECOMMENDATIONS

Staffing for both the Psychiatric Treatment Center and the two Supportive Living Centers for enhanced treatment and programming for 108 persons with serious mental illness is the same as is now provided at AMHI for 103 licensed patient beds.

Staffing levels for the Psychiatric Treatment Center patient units will meet or exceed those required by the *Bates v. Duby* Consent Decree. The staff mix on each shift will be adequate to address the clinical needs of the patients.

While the staffing levels of the Psychiatric Treatment Center will not exceed those currently at AMHI, the enhanced physical plant will permit greater staff investment in programming and treatment activities. The physical limitations of AMHI that compromise patient treatment opportunities will no longer exist. The significant staff time now spent to ensure adequate patient safety and security and provide custodial care due to the physical plant will no longer be required. Thus, staff of the Psychiatric Treatment Center will have the space and additional time to devote to patient treatment and activities.

The new construction will result in a significant reduction in the need for facility maintenance staff. Eight of the current positions are being transferred to the Bureau of General Services to provide on-going maintenance for the state office buildings on the AMHI campus.

The total staffing for the Psychiatric Treatment Center and Supportive Living Centers is 311.9, as compared to the current AMHI staffing of 327.5. However, staffing for the proposed facilities does not include the ten member Reintegration Team now in AMHI's budget but proposed for transfer to the Central Office budget, and the eight maintenance positions being transferred from AMHI's budget to the Bureau of General Services. The increase of 2.4 positions in the proposed staffing is related to additional clinical coverage which may be provided through professional service contracts.

Even though the number of direct care positions will not change with implementation of the proposed staffing plan, the plan will provide enhanced services through:

- Addition of 11.6 staff dedicated to patient programming
- Provision of 28.4 staff to operate Supportive Living Centers
- Dedicated Building Access and Patient Safety staff

While the proposed staffing reflects changes in current staff roles and functions, all current AMHI staff whose job functions change as a result of the proposed staffing plan will be provided training and reassignment to new positions.

A comparison of the current staffing of AMHI with the proposed staffing for the new facilities is provided in Table 17.

Table 17
Staffing Comparison

	CURRENT AMHI STAFFING	PROPOSED STAFFING FOR NEW FACILITIES	POSITION TRANSFERS
Administrative Positions	43	42	0
Direct Care Positions	223	223	0
Support Positions	51.5	46.9	8*
Reintegration Team	10	0	10**
TOTAL	327.5	311.9	18

* Maintenance positions transferred to Bureau of General Services
** Reintegration Team positions transferred to DMHMRSAS Central Office

Note: *All AMHI staff whose job functions may change as a result of the proposed staffing plan will be provided the opportunity, through training, to be reassigned to a new position*

SITE ANALYSIS

Site selection for any facility usually begins with the owner and/or user defining the key selection criteria that are specific to the particular project needs. In this case, the Project Team worked closely with DMHMRSAS to establish key custom criteria. Following that, several more site specific and development cost related criteria were added to identify available sites that fundamentally meet the selection criteria.

A first-cut assessment of the sites was then performed to narrow the field. As a final step, the Project Team worked closely with various stakeholder groups and City officials in the Augusta area, and came to recommend the AMHI site as the best available, all things considered. The narrative that follows briefly describes the site selection process for the new Psychiatric Treatment Center.

Beginning in September 1999, the Project Team met with representatives of DMHMRSAS to establish the most critical characteristics of a site in order for that site to be considered as suitable for the intended uses. These custom criteria

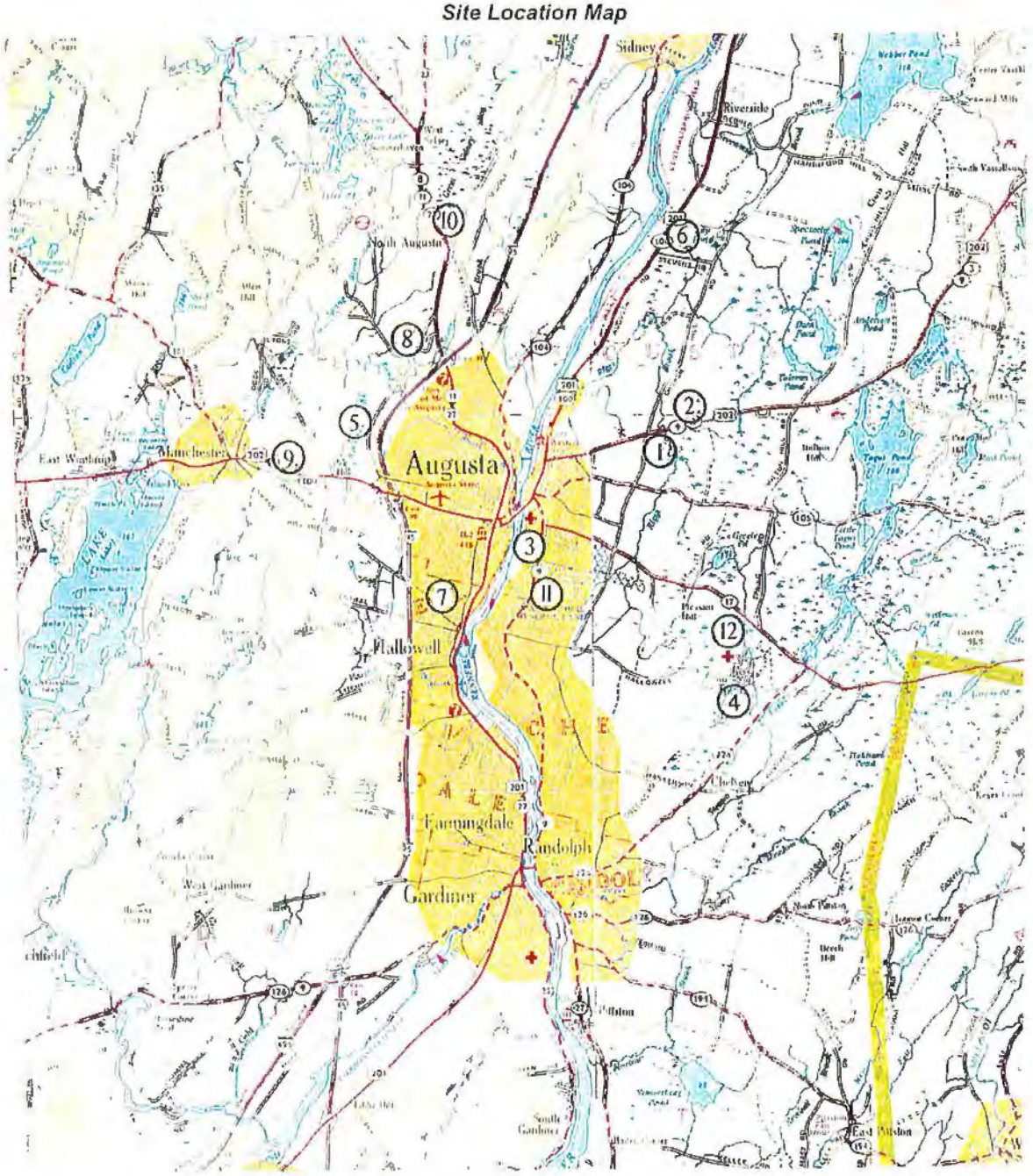
included such considerations as location with respect to clients and existing workforce, distance from an acute care hospital, and distance from an interstate highway. More specifically, the list of custom criteria is as follows:

- Parcel of sufficient size and configuration to support the program needs, both now and for future expansion
- Proximity to an existing acute care medical hospital
- Proximity to existing workforce
- Proximity to civil client base (based on needs assessment)
- Proximity to interstate access point
- Proximity to locations offering "independent services" (convenience stores, etc.)
- Proximity to existing transportation services
- Physical buffer to achieve patient privacy
- Federal funding opportunities/constraints

A list of more general criteria includes cost to purchase, cost to develop, soils, wetlands, topography, regulatory issues, availability of utilities, zoning issues, encumbrances, hazardous materials impact, etc.

Two basic categories of sites were considered likely candidate sites. They included land already owned by the state or other government entity, and land currently for sale. The state/federal government-owned sites include the AMHI campus, Togus and the Stevens School in Hallowell. Other available land included nine sites in the Augusta area that were of a sufficient size and within the threshold "proximity" range to be considered viable. These sites are illustrated in the Site Location Map in Figure A on page 38.

Figure A
Site Location Map



Members of the Project Team visited the 12 sites, took photographs, reviewed secondary data (USGS maps, zoning maps, etc.), evaluated them against the criteria, and narrowed the finalists to four sites:

- A 51 acre site on the corner of Route 3 and Church Hill Road
- A 70 acre site on Route 3, just east of the Church Hill Road intersection
- An approximately 20 acre developable area on the AMHI campus.
- An approximately 20 acre developable area on the Togus campus

The other eight sites did not make the first cut for various reasons, including remoteness, natural resources issues, utilities, configuration, absence of suitable independent services, traffic concerns and time/distance to Maine General Hospital (the acute care hospital identified in the custom criteria).

Throughout the site selection process and more aggressively as evaluation of the four finalist sites began, DMHMRSAS solicited comments from the key stakeholder and community groups involved. These included the DMHMRSAS Stakeholders Group, the Augusta City Manager, the Capitol Planning Commission, the Augusta City Council, the Augusta State Facilities Master Planning Committee, and the Capitol Riverfront Improvement District Commission. Once it was established that each of the four sites satisfied to relative degrees such criteria as size, configuration, proximity to existing workforce and civil client base, it became clear that two criteria emerged as critical to the final selection. Those were relative distance to Maine General and place in the community.

With regard to proximity to an existing acute care facility, the criterion is defined simply as "the closer the better." With all other things being equal, it is critically important that a client be transported in the shortest possible time to the hospital.

The notion of independent services was clarified to include more than the ability to walk to the store and get a pack of candy or other personal items. It must offer a client the opportunity to become part of the community: to observe it, to reacquaint oneself with it, and to participate in it to increasing degrees as individual health was restored.

Noting that the two Route 3/Church Hill Road sites offer a degree of opportunity to walk to a convenience store, they both failed to provide the richness and diversity of opportunity that a more in-town location could offer. Similarly, the Togus site, aside from its being the furthest from Maine General of the four finalists, also lacked any real opportunity to reestablish personal connections with the larger community. In the final analysis, of the 12 sites assessed, the AMHI site emerged as the preferred site that best meets the defined needs of the proposed Psychiatric Treatment Center.

While implementation of the Supportive Living Centers is fundamental to this project, the Centers are not designed to be co-located with the Psychiatric Treatment

Center. Indeed, from the perspective of many consumers of mental health services and interested Maine citizens, the location of the Supportive Living Centers in separate locales is essential.

CONCEPT DESIGN

Site Planning

The proposed location for the new facility is at the southernmost end of the existing Augusta Mental Health Institute (AMHI) campus. The site comprises approximately 20 acres, and is bounded by the Kennebec River on the west, Hospital Drive on the north, and the Campbell barn on the east. The AMHI property line forms the southern boundary of the site, past which the land drops into a deeply wooded swale. The neighboring land use to the south consists of scattered, low-density residential development. The central portion of the site is relatively flat. The western side slopes towards the river.

The proposed building and site development will be placed to take best advantage of the flat upper portion of the site. The long, two story residential portion of the building will follow the crest of the slope, following the contour, and taking advantage of panoramic views to the river and Capitol building to the west. The remainder of the building extends to the east, giving way to a passenger drop off, parking (210 spaces total), and service access.

The site will be served by all new utilities. New landscape planting will be provided that will unify the facility with the campus setting, provide shade and visual interest, and soften the visual impact of parking, drives, and other vehicle areas.

Design Objectives

The conceptual design included in this report is a first literal representation of the rooms, departments, functions and inter-relationships described in the Operational and Architectural Program. The development of this design has also been guided by a review of applicable codes, standards and national guidelines for freestanding inpatient psychiatric hospitals. The guidance and insights gained from stakeholders, staff, and State officials during on-site hands-on design charettes and design reviews have had significant additional influence on the conceptual design.

The design strives to meet the following objectives:

- Optimize the use of staffing resources by the design of a facility that operates efficiently.
- Provide an environment that supports patient dignity, autonomy and privacy.
- Protect patients, staff and citizens with a facility that achieves a high degree of security.

- Achieve outcome objectives through a facility that facilitates therapeutic efficacy.
- Develop a building that is comfortable within its physical context and that presents a non-threatening non-institutional expression.

Components and Locations

Program components have been arranged on the site to take advantage of important relationships with both external points of site access and views across the river. More public program elements (and support elements requiring truck access) are located towards the front of the site, facilitating public access and simplifying internal security zoning. More private residential elements are located at the back of the site, allowing them to capitalize on the lovely views into the woods and across the Kennebec Valley.

Residential units are directly connected to a treatment mall, facilitating access during day and evening hours without security compromise. The treatment mall is itself designed so that differing patient cohorts can occupy it simultaneously. Program elements are organized around a series of defined outdoor courtyards, which provide secure outdoor areas for patient recreation and therapeutic programs. By using building elements as security barriers around all or parts of these courts, the need for expensive security fencing that might have an objectionable appearance is minimized.

Flexibility and Growth

The conceptual plan and program are developed to permit a high degree of flexibility to accommodate future changes in census, patient type and treatment modalities. If population demands sometime in the future require additional bed space, the building and site plans have been designed to accommodate a two story, 48-bed addition. The core administrative, support and treatment facilities provide sufficient capacity to support these two additional residential units.

The residential units have been designed to allow any unit to be easily transformed to accommodate a different patient cohort. In addition, five beds in each adjoining unit can re-aggregate to adjacent nursing units to accommodate temporary or permanent census conditions, and sub-specialty units can be arranged to allow reallocation or reclassification in response to changes in patient census.

Building Access and Patient Safety

The building is designed as an important contributor to the facility's security program. External access is localized and controlled. Ordinary vertical circulation is concentrated in three easily supervised and monitored nodes. Emergency egress is organized so that patient discharge flows into secured outdoor areas.

The internal zoning of the facility is designed to minimize cross-circulation patterns between differing categories of users and to provide internal circulation patterns that become defined and concentrated during evening and night hours to smaller and more easily supervised zones. The location of program elements within the building is designed to enhance both passive and active staff supervision.

Appearance

The use of a series of courtyards around which the program develops allows the large undifferentiated mass of the building to be allocated among a series of smaller, more human-scaled building elements. The use of narrower wing elements around these courtyards provides significant amounts of natural light and views within all treatment areas and provides roof spans that can reasonably accommodate the sloping roofs that will assist in the development of a non-institutional character. The primary goal of the design is to provide a facility that looks as good as it functions, and reflects the ultimate goal of a therapeutic rather than an institutional milieu.

COST ESTIMATES

Operating Costs

The annual operational costs for the Psychiatric Treatment Center and the two Supportive Living Centers were estimated based on analysis of the current AMHI expenditures, review of the compensation for Maine state employees, and consultant estimates of utility costs for the new facilities.

The annual operational costs of the new facilities were based on the FY2000 dollars to facilitate a comparison with current AMHI operations. Thus, the operational cost estimates for the new facilities reflect current dollars and will need updating based on the year that the facilities become operational.

Current AMHI Expenditures: The FY2000 AMHI expenditures were determined through discussion with DMHMRSAS financial staff to ensure that supplemental fund requests and transfers as well as the existing budget were accurately reflected. For example, utility costs reflected in the AMHI budget are actually offset by credits from state office buildings on the AMHI campus. Further, while funds for overtime expenses are not budgeted for AMHI, the funds required are obtained by annual transfers of funds from other DMHMRSAS accounts.

Personal Services (Employee) Costs: The salary for each staff position of the new facilities was based on an analysis of current AMHI personnel costs to ensure that the presence of staff with extended years of service and higher compensation levels were accurately represented. Benefit costs were estimated to be 40% of salaries based on discussions with AMHI administrative and personnel staff.

Reintegration Team: The Reintegration Team includes physicians, clinicians and administrative positions now included in the AMHI budget but whose primary function is to assist in the transition of patients to the community. DMHMRSAS has determined that this team will not be included in the budgeting for inpatient treatment in the future, but will be included in the Central Office budget; thus, the Reintegration Team was not included in the operational costs for the new facilities.

Professional Services (Contract Staff) Costs: Since DMHMRSAS has relied on contracts to ensure adequate psychiatric coverage for AMHI, these positions were continued as contract positions for the Psychiatric Treatment Center.

Professional Services (Non Staff) Costs: These costs include numerous contracts with community providers for such necessary operational services as laundry, phlebotomy and specialized consultations. These costs fluctuate based on the patient population being served. The estimates for these costs for the new facilities were developed by multiplying the current AMHI annual per patient cost of $3,229 by the number of individuals to be served by the new facilities.

Miscellaneous Non-Personnel Costs: These costs include the provision of food, medication, and treatment supplies. These costs fluctuate based on the patient population being served. The estimates for these costs for the new facilities were developed by multiplying the current AMHI annual per patient cost of $22,557 by the number of individuals to be served by the new facilities.

Utility/Repair and Maintenance Costs: The utility/repair and maintenance costs for the new facilities were developed based on an engineering analysis of the new facilities.

Table 18
Operating Cost Analysis: Comparison of AMHI to New Facilities

Augusta Mental Health Institute FY 2000			**NOTES:**
Number of Licensed Beds		103	
Number of Staff		318	Excludes positions proposed for transfer to Central Office Budget
Staff/100 Patients		308.25	
Total Personal Services (AMHI Employee) Costs		$ 13,149,452.00	
Reintegration Team		$ 859,397.00	
Overtime Costs		$ 175,000.00	Funds not budgeted; annual Transfer from other DMHMRSAS Accounts
Professional Services Costs-Contract Staff		$ 1,827,124.00	
Professional Services Costs-Non Staff		$ 332,611.00	Includes community contracts (laundry, phlebotomy)
Repairs and Equipment		$ 284,086.00	For entire AMHI campus
Utility Costs (Utilities and Fuel oil)		$ 1,019,754.00	
Misc. Non-Personnel Costs		$ 2,323,420.00	Includes food, medication, Supplies, operations
Credit for Non- Hospital Utilities on AMHI Campus		$ (500,000.00)	
Total Estimated Expenditures		**$ 19,470,844.00**	Includes budget plus transfers/ Requests of $975,000

Projected Psychiatric Treatment Center (FY2000 dollars)			**NOTES:**
Number of Licensed Beds		92	
Number of Staff		283.5	
Staff/100 Patients		308.15	
Total Personal Services (Employee) Costs		$ 11,818,250.00	
Reintegration Team		0	
Overtime Costs		$ 100,000.00	
Professional Services Costs-Contract Staff		$ 1,791,455.00	
Professional Services Costs-Non Staff		$ 297,068.00	Includes community contracts (laundry, phlebotomy)*
Repairs and Equipment		$ 50,000.00	Estimated figure based on new building
Utility Costs		$ 400,000.00	Estimated by SMRT for new building only
Misc. Non-Personnel Costs @ $22,557/patient		$ 2,075,244.00	Includes food, medication, supplies, operations **
Total Estimated Operating Expenditures		**$ 16,532,017.00**	

* Professional Services Costs-Non Staff estimated at current AMHI annual per patient cost of $3,229.

** Miscellaneous Non-Personnel Costs estimates at current AMHI annual per patient cost of $22,557.

Projected Supportive Living Centers (FY2000 dollars)			**NOTES:**
Number of Residents		16	
Number of Staff		28.4	
Staff/100 Residents		177.50	
Total Personal Services (Employee) Costs		$ 1,078,980.00	
Overtime Costs		$ 12,000.00	
Professional Services Costs-Non Staff		$ 51,664.00	Includes community contracts (laundry, phlebotomy)*
Repairs and Equipment		$ 10,000.00	Estimated
Utility Costs		$ 34,000.00 -	Estimated by SMRT
Misc. Non-Personnel Costs @ $22,557/resident		$ 360,912.00	Includes food, medication, supplies, operations **
Total Estimated Operating Expenditures		**$ 1,547,556.00**	

* Professional Services Costs-Non Staff estimated at current AMHI annual per patient cost of $3,229.
** Miscellaneous Non-Personnel Costs estimates at current AMHI annual per patient cost of $22,557.

Analysis of Operational Costs: Providing state-of-the-art treatment for 108 individuals in the new Psychiatric Treatment Center and two Supportive Living Centers will cost the state **$18,079,573** (in current dollars). In comparison, the FY 2000 costs for the operation of the 103 licensed AMHI beds is **$18,611,447**, which excludes the costs for the Reintegration Team. Translating this differential into the cost per patient day results in the following efficiencies:

- AMHI: 37,595 patient days at **$495.05** per day
- New Facilities: 39,420 patient days at **$458.64** per day

This translates into a **3%** decrease in daily operating costs, while actually increasing the overall number of positions working in the new facilities. This is achievable, as the new facilities will be more efficient to maintain and operate. For example, maintaining security within the new Treatment Center will become more efficient when aided by the proposed state of the art facility design and security electronics. This will enable the eventual reassignment of positions, upon completion of a transition process, into direct patient treatment and services.

Capital Costs

Table 19
Capital Cost Analysis by Component

A. Construction		$23,098,600.
B. Administrative Cost and Reserve		$ 3,414,360.
C. Fees and Services		$ 2,987,040.
D. Supportive Living Center		$ 1,000,000.
	Total Project Cost	**$30,500,000.**

The $30,500,000 capital budget for the project includes both the Psychiatric Treatment Center (92 beds) and the Supportive Living Centers (16 beds).

The budget presented reflects the standard Bureau of General Services Budget format, which includes construction, administrative cost and reserve and fees and services.

The construction cost per square foot of $200 is estimated for the Psychiatric Treatment Center and includes projected site development costs. This cost per square foot is based on comparisons with similar facilities; it also reflects the current construction climate in the State of Maine.

Administrative cost and reserve includes furniture and equipment, legal and insurance costs as well as project contingency. The contingencies are based on percentage of construction cost. At this point a 5% bidding contingency and a 5% program and design contingency are being carried.

Fees and services include architect/engineer fees based on the BGS standard fee schedule, specialty consultants, regulatory approval fees and consultants, transition costs, life cycle analysis, clerk of the works, special inspections and reimbursables.

The project budget also includes $1,000,000 dedicated to the development of Supportive Living Center projects. Funds would go toward the purchase, renovation and expansion of existing residences.

The site selected for the project is a parcel on the existing Augusta Mental Health Institute property. There are a number of buildings on this parcel, of no historic significance, which must be removed prior to start of construction. The cost of removal and replacement of these structures is not included in the budget.

II. NEEDS ASSESSMENT

II. NEEDS ASSESSMENT

Purpose of Needs Assessment

The purpose of this needs assessment was to develop a reasonable projection of the number of state-operated inpatient psychiatric beds required to adequately meet the needs of forensic patients throughout the state, and to assess the need for state-operated beds for non-forensic patients in southern Maine that would complement the psychiatric inpatient treatment resources available within community hospitals. These assessments were to guide the projected capacity of a state-operated psychiatric hospital to replace the current operations at the Augusta Mental Health Institute (AMHI).

Thus, the needs assessment was conducted for two distinct patient populations:

- Civil patients who are in need of psychiatric hospitalization but who are unable to be served within the community due to risk issues or lack of available community hospital bed space within the patient's area of residence and support.

- Forensic patients whose legal status requires treatment in a secure environment.

Needs Assessment Process

Needs assessments are often based on an analysis of historical data that typically include a five to ten year time frame. Since Maine's mental health system has changed dramatically in recent years and is continuing to evolve, historical data were of limited value for this project. For example, relying on historical data to project the number of needed civil beds would not have accounted for the continuing development of community resources. The need for state-operated civil inpatient beds and effective crisis services is significantly affected by the availability of community inpatient beds as well as by the quality and continuity of outpatient services. Further, relying on historical data to project the number of needed forensic beds would not have accurately reflected the inpatient treatment required by individuals housed in local jails. There is consensus that jail inmates have been under-served due to lack of current forensic bed capacity.

The needs assessment process utilized recent historical data in developing patient population forecasts using the Institute at the George Washington University's Prophet Simulation model. A brief description of this model is provided in Appendix B. It is important to note that these forecasts did not reflect recent system and policy changes, and the final projections for inpatient bed requirements were adjusted with consideration of this critical information.

As noted, the needs assessment process required consideration of qualitative information as well as forecasting based on available statistical data. The final recommendations are based on a review of the overall Maine mental health system and information gained through discussions with DMHMRSAS administrative and clinical staff, community hospital and outpatient providers, mental health consumers, jail and prison administrators, and many interested Maine citizens. Throughout the process, these groups were invited to review the data and preliminary findings. Their questions and comments were used to further refine the needs assessment.

The agencies and individuals providing written comments about this project are listed on Appendix C in Chapter VIII. Copies of these comments can be obtained by contacting Katie Fullam Harris at DMHMRSAS.

The needs assessment process also included site reviews of AMHI, Bangor Mental Health Institute (BMHI), and community hospitals; review of the documents listed in Appendix D in Chapter VIII; consideration of national data and trends; and collection of data from the following sources:

- Patient admission and discharge data from the Maine Health Data Organization.
- Surveys reflecting the resources of the three Regions.
- Surveys reflecting the resources available within community mental health providers.
- Surveys reflecting the resources available within community hospitals.
- Surveys reflecting the service needs of Maine jails.
- Patient data from AMHI and BMHI.

Projection of Need for State-Operated Civil Inpatient Beds

The State of Maine has developed a system for adults with serious mental illness, designed to ensure the availability of community outpatient and inpatient resources consistent with the level of consumer need. Three Regions have been established for coordinating the provision of outpatient and inpatient mental health services for designated geographic areas.

Table 20
Maine's Mental Health Regions

Region	Counties
Region I:	Cumberland and York Counties
Region II:	Androscoggin, Franklin, Kennebec, Knox, Lincoln, Sagadahoc, Somerset, Oxford and Waldo Counties
Region III:	Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties

Each region contracts with community providers to provide psychiatric services, case management services, outpatient services, peer services, crisis services, residential options and community hospital beds, vocational services, transportation, etc.

The needs assessment was conducted to determine the number of civil state-operated inpatient psychiatric beds needed for Regions I and II; the services now provided at AMHI. State-operated inpatient hospitalization for Region III is, and will continue to be, provided by the Bangor Mental Health Institute (BMHI).

AMHI is currently licensed to operate 76 civil inpatient beds. These beds primarily provide the "safety net" for involuntary patients who are unable to be served within the community due to risk issues or lack of bed availability. Since Maine currently has no female forensic inpatient beds, female forensic patients now occupy four or more of the civil beds.

There has been a public perception that the state presently rejects accepting civil patients at AMHI. Historical data indicated and DMHMRSAS staff confirmed that AMHI has had sufficient bed capacity for its civil patients when no other placement options exist in the community. The misperception seems related to problems with the hospitalization pre-screening process and not with bed availability.

A forecast of civil bed need based on AMHI civil admission and discharge data from 1998 and 1999 and population projections is provided in Table 21 on page 51. While this forecast suggests the need for 63 to 72 civil patient beds by the year 2010, the forecast does not account for major changes anticipated within the overall Maine mental health delivery system during this period.

The mental health system designed by DMHMRSAS will ensure the availability of community outpatient and inpatient resources consistent with the level of consumer need and impact the need for state-operated civil inpatient beds. The system as designed will provide the necessary array of services: however, full implementation has not yet been realized.

Improvements in the relationships between DMHMRSAS and community hospitals and between DMHMRSAS and community crisis services providers would significantly reduce the need for state-operated civil inpatient beds. Current problems within these relationships are not due to a lack of financial commitment, but appear to be transitional and correctable through the developing partnership between DMHMRSAS and the community providers.

State/Community Hospitalization of Civil Patients: Although DMHMRSAS has contracted with community hospitals for several years to provide inpatient psychiatric treatment for patients hospitalized on an involuntary status, a mutually cooperative relationship has been slow to evolve.

TABLE 21
Population Forecast - Civil Patients
Based on AMHI 1998 and 1999 Admission and Discharge Data

Fiscal Year	Historical*		Population	
	Bed Days	Population**	Total Projected	Peaking Factor***
1998	20,979	51.9		
1999	19,995	58.0		
2000			59	55-63
2001			59	55-63
2002			60	56-64
2003			60	57-65
2004			60	57-65
2005			61	58-66
2006			62	59-67
2007			63	60-68
2008			63	60-68
2009			65	62-71
2010			66	63-72

* Although the female forensic patients are not excluded from the civil historical figures, the female forensic population was excluded from the civil patient forecast.

** AMHI's average monthly civil patient population ranged from 44 to 58 from January 1998 through October 1999.

*** Peaking factor was calculated by applying average standard deviation of monthly civil patient population to the number of projected beds.

- Based on the length of stay data collected from AMHI, approximately 22-25 % or 15-18 beds during this period were occupied by patients with lengths of stay of less than 30 days. The figure will grow slowly to approximately 16-19 beds by the year 2010 based on projected demographic population growth.

- Based on the length of stay data collected from AMHI, approximately 75-78 % or 40-44 beds during this period were occupied by patients with lengths of stay greater than 30 days. The figure will grow more rapidly as cases begin to stack up to approximately 46-49 beds by the year 2010.

For the purpose of this document, the term "community hospitals" will refer to general hospitals that have specific units designated for psychiatric treatment while the term "community psychiatric hospitals" will refer to stand-alone non-profit facilities providing only psychiatric treatment. Maine currently has two community psychiatric hospitals, Spring Harbor in Portland and Acadia in Bangor.

Contracts between DMHMRSAS and community hospitals presently exist. However, these contracts do not guarantee the availability of a community bed for a referred involuntary patient. Hospitals are required by law and standards to accept all patients who meet criteria for hospitalization; thus, the hospitals are unable to reserve the contracted beds for involuntary patients. Community hospitals also routinely staff units based on current patient census. Referrals requiring treatment beyond the ability of available staff cannot be accepted.

There is a perception that community hospitals reject involuntary patients because of reimbursement concerns. This perception seems exaggerated since DMHMRSAS ensures payment for involuntary patients served by community hospitals.

While the community hospitals have expressed the desire to increase their role in providing services for involuntary patients, they expressed concerns in three areas:

- Some patients referred to them are not from their geographic area. When such patients are admitted, the hospital no longer has the capacity to serve patients from their community. The practice of utilizing community beds even when they are not in the patient's community is the result of efforts to minimize admissions to the state-operated hospitals. The practice is inconsistent with achieving the DMHMRSAS goal of treatment within the consumer's own community. It also increases the difficulty faced by community hospitals in developing effective discharge plans.

- When patients who have been admitted to a community hospital and subsequently demonstrate the need for extended lengths of stay, transfer of these patients to state-operated hospitals, as provided by the DMHMRSAS contracts, has often been delayed.

- Discharge treatment planning by community hospitals may be compromised by the fact that patients discharged from state-operated hospitals receive priority for available community supports over patients discharged from community hospitals.

Information provided by the Maine Health Data Organization indicating the availability of community psychiatric beds in 1998 is provided in Table 22 on page 53. Since the community hospital data for 1998 did not include the use of AMHI civil beds, the civil bed utilization at AMHI in 1998 is provided in Table 23. Supporting documentation for these tables is provided in Appendix E in Chapter VIII.

Table 22
Community Hospital Civil Psychiatric Bed Utilization - 1998

	Region I	Region II
Average Daily Bed Utilization Based on Patient County of Residence (Based on length of stay of 10.2 days)	57	74
Available Licensed Psychiatric Beds: Community Hospitals	Total: 84 SMMC: 13 Spring Harbor: 45 Maine Medical: 26	Total: 88 Pen Bay: 13 Maine General: 33 St. Mary's: 31 Mid Coast: 11
Average Daily Bed Utilization of Listed Community Hospitals (Based on length of stay of 10.2 days)	57	68

Source: Maine Health Data Organization

Table 23
AMHI Civil Bed Utilization - 1998

	Region I	Region II
Average Daily Bed Utilization Based on Patient County of Residence (Based on length of stay of 56.2 days)	26	30

AMHI is licensed to operate 103 psychiatric beds,
27 of which are dedicated to forensic patients
Source: Augusta Mental Health Institute

The 1998 data indicated an average need in Regions I and II for 181 inpatient psychiatric beds. With 172 licensed inpatient beds, the community hospitals would not have had sufficient beds to meet the needs of all consumers residing in Regions I and II requiring either voluntary or involuntary inpatient hospitalization. AMHI beds provided a necessary "safety net" resource. The need for a "safety net" resource is further validated by the fact that the 172 community bed figure represents maximum utilization of all licensed beds with no allowance for variations in need or time

required for patient turnover. The community hospitals provided a "peaking factor" of 15% to account in fluctuations in bed need. Thus, the number of licensed community beds consistently available was estimated to be 146.

A survey of the community hospitals regarding the provision of involuntary and voluntary inpatient psychiatric services during the first six months of 1999 indicated that the community hospitals still can not meet the total needs of Regions 1 and II for both voluntary and involuntary inpatient treatment. However, there are community beds available for additional involuntary psychiatric treatment. Table 24 confirms available community bed space if patients with lengths of stay greater than 30 days were transferred to state-operated beds. Supporting documentation for Table 24 is provided in Appendix F in Chapter VIII.

Table 24
Maine Community Hospital Analysis: January 1999 – June 1999
ONLY ADULT PSYCHIATRIC PATIENTS

Region	Counties Served By Community Hospitals within the Region	Avg. Daily Census 1/99-6/99	Number of Licensed Beds	Number Of Operational Beds	Monthly Bed Days Available	Bed Days Used by Patients with LOS less than 30 days
Region I	Cumberland York	70.85	84	83	2490	1612
Region II	Androscoggin, Franklin, Oxford, Kennebec, Knox Somerset, Lincoln, Waldo Cumberland, Sagadahoc	69.2	88	83	2490	2025

- *Assumes patients with lengths of stay greater than 30 days (10.5 in Region I and 12 in Region II) would be transferred to state-operated beds.*

Since Spring Harbor opened 12 additional adult psychiatric beds in December of 1999, the number of licensed community psychiatric beds presently available within Regions I and II has increased from 172 to 184.

Given the availability of community psychiatric beds and the potential that community hospitals may be willing to consider increasing psychiatric bed capacity to meet the need for involuntarily committed patients, DMHMRSAS is renewing efforts to expand the partnership with community hospitals that will facilitate the appropriate use of state-operated beds.

It is interesting that no community hospital reported difficulty with the legal processes related to a patient's involuntary status, a major concern of the community hospitals early in the contracting process. The community hospitals did express concern that some patients referred to them are not from their geographic area. When such patients are admitted, the hospital no longer has the capacity to serve patients from

their local area. The practice of utilizing community beds even when they are not in the patient's community is the result of efforts to minimize admissions to the state-operated hospitals. The practice is inconsistent with achieving the goal of treatment within the consumer's own community. It also increases the difficulty faced by hospitals in developing effective discharge plans.

The community hospitals also expressed concern about patients who, once admitted, demonstrate the need for extended lengths of stay. Transfer of these patients to state-operated hospitals as provided by the DMHMRSAS contracts has often been delayed. It is important for community hospitals to free up these acute beds in order to maintain balance within the system.

Mental health consumers expressed concerns that when hospitalized within the community hospitals, their case managers and psychiatrists may not be consulted or involved in their treatment, and that their Individual Service Plans (ISPs) may not be considered in community hospital treatment planning. Present lapses in the continuity between outpatient and community hospital services were partially attributed to perceived barriers in sharing confidential patient information. The fact that the community social workers cannot be reimbursed for follow-up of a client when the client is hospitalized likely also contributes to gaps in continuity of care. Reports that these problems are being addressed at many community hospitals with improvements toward the goal of continuity of services are encouraging.

Mental health consumers reported that discharge planning from community hospitals was at times inadequate. Discharge treatment planning by community hospitals may now be compromised by the fact that patients discharged from state-operated hospitals receive priority over patients discharged from community hospitals for available community supports.

On-going dialogue between the state and community hospital providers has been initiated to resolve system issues and to clarify the optimal role for each group within the system. General consensus of the optimal roles of the community and state-operated beds in providing inpatient psychiatric treatment includes the following:

- Ideally, community hospitals would serve only the patients residing within their geographic area.

- Psychiatric units of community acute care hospitals may be unable to effectively provide the level of treatment required by some patients. These patients would be best served by the community psychiatric hospitals and the state-operated hospitals.

- State-operated hospitals should serve as the "safety net" for patients admitted for acute treatment who meet the criteria for intensive and extended treatment.

- Patients admitted to community hospitals requiring extended treatment and substantial psychosocial rehabilitation would be best served by state-operated hospitals with extensive treatment resources.

- Patients admitted to community and state-operated hospitals should have the same access to residential and support services at discharge.

Given this consensus, the potential for the implementation of a state/community partnership seems likely. This consensus also reflects agreement that there remains a need for state-operated "safety net" acute beds and state-operated intermediate care beds for patients requiring extended treatment.

The goal of treatment in the least restrictive environment is reflected in current clinical practices that limit psychiatric hospitalization to brief periods followed by community support. This approach is effective for many consumers of mental health services. However, some individuals with severe and persistent mental illness or experiencing such complicating factors as substance abuse or a history of trauma require more extended treatment and psychosocial rehabilitation for adequate therapeutic effect. Such patients are best served by state-operated or community psychiatric hospitals with extensive treatment resources. Duplicating this level of treatment resources in community acute care hospitals is not fiscally responsible.

AMHI Civil Patient Analysis: An analysis of the length of stay data for AMHI patients for 1998 and 1999 indicated the following:

Table 25
AMHI Civil Length of Stay: FY 1998-1999 Admissions

Length of Stay Group	Number	Percent
1-15 days	213	38.4%
16-30 days	99	17.9%
31-60 days	100	18.1%
60-120 days	80	14.4%
120 days and over	62	11.2%
Total	**554**	**100.0%**

The length of stay data from 1998 and 1999 indicate that 43.7% of AMHI civil patients had a length of stay over 30 days. A point-in-time review of the civil patients at AMHI on November 16, 1999 indicated that 64% of the current patients had lengths of stay greater than 30 days, with 22 of the patients (38%) having lengths of stay over 90 days. The increase in the number of patients with length of stays greater than 30 days reflects the increasing use of AMHI for extended treatment.

Additional review of the AMHI patients on November 16, 1999 confirmed the presence of persistent and serious mental illness as reflected by repeated hospitalizations. For 50% of the AMHI patients, the current hospitalization was their second since January of 1998. For six of the patients, the current hospitalization was the fourth or more since January of 1998.

Further, review of the AMHI patients on November 16, 1999 confirmed the presence of patients dual-diagnosed with substance abuse disorders and/or histories of trauma as well as serious mental illness. Patient diagnoses reflected such dual-diagnoses for 28 or 50% of the 56 cases reviewed. These numbers are consistent with AMHI patient profiles of 1998 admissions, which indicated that 45% of patients admitted had a dual-diagnosis of a substance abuse disorder.

Community Mental Health Services: We concur with the findings of a 1992 study that evaluated the number of psychiatric beds required to adequately meet Maine's needs for hospital-level care; namely, that inpatient bed demand will decrease if there is medically capable 24 hour staffed crisis stabilization and medically-capable continuous community treatment and support. Thus, it was essential to evaluate the availability of community outpatient services as well as the availability of community inpatient beds in determining the need for state-operated inpatient psychiatric beds.

According to NASMHPD data, in FY 97 Maine spent $24,256,000 of General Fund dollars for the following community services:

Table 26
Community Mental Health General Fund Expenditures, FY 97

Case Management	$12,771,600	53%
Crisis Services	$ 6,765,000	28%
Outpatient Services	$ 4,327,000	18%
Day Treatment	$ 392,000	1%

Source: National Association of Mental Health and Program Directives

DMHMRSAS budgets indicate a continuing and increasing commitment to assisting community providers in facilitating a continuum of treatment services are available for the citizens of Maine with serious mental illness. In FY 94, community services accounted for 41% of mental health general funding; in FY 97 the percentage was 64%; and, in FY 99 the percentage increased to 70%. This commitment to community-based mental health services exceeds that demonstrated by many other states.

Substantial progress has been made in implementing the outpatient system as designed; however, there are areas in which further improvement will decrease the need for psychiatric hospitalization.

An overview of the adult outpatient mental health services within Regions I and II, as reported by regional staff, is as follows:

Table 27
Outpatient Mental Health Services Available in Regions I & II

	Region I	Region II
Total Population of Region	316,801	518,674
Total Clients	6,575	9666
Clients Assigned to ACT Teams	177	120
Clients Assigned to ICMs	145	252
Clients Assigned to CSWs	2009	3794
Number of Crisis Beds	17	18
Number of Available Residential Placements	253	375
Group Home Beds	127	80
1:1Supervised Apartments	0	28
Supported Apartment Beds	49	64
Boarding Home Beds	0	169
Total Other Community Beds	77	34

Maine has developed a tiered case management system with the goal of providing the most intensive support for individuals identified with the most significant needs. The range of services within the tiered system includes:

- Assertive Community Treatment (ACT) Teams: The most intensive services are provided by ACT community mental health provider clinical teams assigned to those consumers with persistent and serious mental illness whose needs have not been adequately met by the standard service array. The ACT teams typically include a psychiatrist, psychiatric nurse and case manager. The ACT teams operate flexibly and work to ensure that individuals are living successfully in the community.

- Intensive Case Managers (ICMs): ICMs are state-employed case managers assigned to persons with serious mental illness whose needs are exacerbated by additional stressors such as homelessness or contact with the correctional system. ICMs are assigned to no more than ten clients and can thus provide intensive support to clients who have very great needs in accessing treatment, medication, housing and other supports.

- Community Support Workers (CSWs): CSWs are community mental health providers who provide case management services to persons with mental illness who have not demonstrated the need for intensive case management.

Although effective case management services are essential to ensuring that consumers receive clinically appropriate levels of treatment and support, the skill level of individual case managers is now reported to vary widely. A recent consultant study indicated that the disparities in case management skills are likely related to the limited number of trained clinicians within the state and the frequent turnover in these positions. Until these factors can be addressed, additional staff training and intensive supervision of the services provided by the case managers is critical to the overall mental health delivery system.

While mental health consumers generally reported that their case managers were responsive during regular business hours, there is limited access during non-business hours. When case managers are not available, the consumer must rely on the support of crisis workers. Crisis staff may have inadequate information about the consumers or insufficient time to address their concerns, potentially exacerbating the consumer's difficulties. The consumers reported that the availability of a 24-hour support "warm-line" for clients to access their case managers in emergency situations could improve the present situation.

Crisis Services: DMHMRSAS has contracted with community mental health providers in each area of the state to provide "no-reject" crisis services 24 hours a day for all individuals who experience psychiatric crises. The crisis services include: telephone consultation, evaluation, mobile crisis outreach services, placement in a crisis residential bed, and facilitation of hospitalization. A single statewide crisis care telephone line, the first in the country, ensures access to requests for mental health assistance.

DMHMRSAS staff and community providers agree that the crisis services system established during the last three years is improving. However, it has yet to achieve the consistent, effective crisis interventions that could reduce the system's reliance on inpatient psychiatric treatment.

Current deficiencies in the crisis system appear to be primarily related to the limited number of credentialed mental health clinicians in Maine and the number of large, sparsely populated areas to be served. In some rural areas, crisis workers may have limited or no face-to-face access to a psychiatrist, and often must rely on telephone consultation. Reports suggest that the variable skills of crisis workers may effect clinical evaluations and the subsequent sharing of information with the consultant psychiatrist.

Although crisis workers should be "mobile" and provide intervention at the consumer's location, safety and transportation issues, particularly during non-business hours, frequently result in the consumer being required to come to a hospital emergency room for evaluation. The result of these evaluations is too often an inpatient admission. With limited access to a psychiatrist and a client's mental health history, crisis workers may be unable to offer effective interventions other than hospitalization when the client experiences an acute psychiatric episode.

DMHMRSAS currently contracts with community crisis programs for the operation of crisis beds to divert hospital admissions when clinically indicated. However, many of the existing community crisis beds do not operate as designed. Community crisis beds are staffed 24 hours a day, but many have no consistent on-site presence of a nurse or psychiatrist, and their staffing levels may preclude the placement of persons presenting significant risk issues. Only persons who are non-violent and who are willing and able to agree that they will not engage in self-harm are accepted by many of the current crisis beds. Thus, the crisis beds do not now serve others who might benefit from a period of brief crisis stabilization with medical support.

Mental health consumers also advocate for the option of in-home support during psychiatric crises, reporting that in-home support during these times could be the most effective and normalizing intervention. While in-home support resources are now available, it is likely that enhancing these services would provide another clinically-effective alternative to inpatient treatment.

DMHMRSAS continues to fund new crisis services that will impact hospitalization rates. For example, the development of "safe houses" for consumers experiencing crises related to histories of trauma has reduced inpatient utilization for these individuals.

Hospital Pre-Screening Process: The current process by which a person requiring intensive psychiatric treatment gains admission to an inpatient bed is often protracted, and at times dehumanizing. Pre-screening for hospitalization is typically conducted by a crisis worker within an acute medical care hospital emergency department.

The timeframe from when a consumer is referred or presents him/herself with a crisis until the consumer is transferred to a hospital ranges from 6 to 48 hours. While waiting for hospital admission, the client may be maintained in the hospital emergency department. Staff and consumers related stories of consumers waiting in the emergency waiting room or on a gurney behind curtains, at times in restraint, for as long as 24 to 36 hours. At times, the client is alone, with very limited mental health support.

The extent of this counter-therapeutic practice is reflected best by the number of emergency physician reports that Maine General in Augusta now receives:

approximately 1,400 such referrals each year. While the current practice is, at best, questionable from a mental health perspective, the practice also burdens and disrupts the medical operations of the emergency departments throughout the state. The emergency room at Maine General has ten beds, and at times may have up to three beds occupied by persons awaiting psychiatric hospitalization.

Several factors contribute to the current lengthy prescreening process within hospital emergency rooms:

- Crisis workers meet clients at acute care hospital emergency departments, especially during non-business hours, since this may be the safest location available to them.

- If a client is intoxicated when appearing at the emergency department for crisis intervention, pre-screening for psychiatric hospitalization is delayed until laboratory testing indicates the client is no longer under the influence of alcohol or drugs. If a crisis worker is advised that a client is intoxicated, the crisis worker may not appear at the emergency room until the client's blood alcohol level is below 0.08 indicating the client is no longer intoxicated.

- Completion of the prescreening often requires telephone consultation with a psychiatrist or other clinicians with the credentials required for completing the process.

- Once there is a decision to hospitalize, the crisis worker must canvass the community hospitals to locate an available bed and obtain approval for the admission. After the crisis worker provides the available clinical information, the community hospital contacts their internal staff for a decision and then relates the decision to the crisis worker. AMHI placement is only pursued after all community hospitals have refused the admission. When this happens, the referral process must be repeated with AMHI admissions staff.

The hospitalization pre-screening process must be improved. Modifications may require rethinking of long-standing practices and consideration of the development of adequately staffed psychiatric emergency rooms where interim treatment as well as evaluation could be completed. A centralized system with access to current bed availability information and the ability to recommend where the client should be hospitalized would likely also improve the current system.

Initiatives undertaken by DMHMRSAS to improve current crisis services include:

- Development and monitoring of performance standards for crisis services.

- Development of assessment centers and 23-hour assessment beds for persons experiencing psychiatric crises.

- Staffing community crisis beds to optimize their appropriate utilization.

- Development of a clearinghouse to streamline the process of determining bed availability in the system.

- Staff development and enhanced training for crisis workers.

Residential Treatment Options: Maine has made great strides in recent years in improving the residential options available for persons with serious mental illness. The increasing availability of these options has facilitated the discharge of patients who had previously been hospitalized for extended periods due to inadequate community resources. The monumental efforts of DMHMRSAS staff, community providers and numerous Maine citizens to improve community support resources must be acknowledged. Access of people with serious mental illness to independent living and meaningful work continues to improve.

However, utilization and anecdotal data suggest that the available residential resources remain inadequate to fully meet the need. Housing remains a gap for persons with mental illness in most states, and Maine's commitment to develop appropriate residential options is important. There is a relatively small group of hospitalized individuals who require a level of supervision and continued psychosocial rehabilitation not currently available in the community. Most of these individuals have experienced numerous unsuccessful community placements.

Surveys of AMHI clinical staff at two points in time in the fall of 1999 indicated that the number of AMHI patients who could be discharged to an intensely staff-secured and supportive residential program ranges between 13 and 19. These estimates reflect patients remaining at AMHI after years of deinstitutionalization efforts, and support the need for creating a supportive residential environment that could address both treatment and safety needs.

Currently, to permit hospital discharge for this type of patient, the primary option is placement in an apartment with one-to-one staff supervision 24 hours a day. This option is not only cost prohibitive (up to $300,000 per year), but is intrusive on the privacy of the consumer. Consumers reported that some people living in an apartment with one to one supervision actually will seek brief admissions to a crisis bed in order to escape the constant monitoring. The consumers were quick to add, however, that this type of placement was an innovation that could become effective with refinement, and certainly was a preferred option to continued hospitalization.

The needs assessment suggests that the development of supportive residential environments for patients with numerous unsuccessful community placements would provide an important link in Maine's overall mental health system that is currently

missing. The development of such resources would be both clinically appropriate and cost effective in serving a group of individuals with challenging needs.

Summary of Projected Need for Civil Beds: Based on the needs assessment, the development of 48 state-operated inpatient psychiatric beds and 16 intensely supportive residential beds is recommended to replace the current civil beds of AMHI and meet the needs of Regions I and II. Details regarding construction and system recommendations are provided in the Needs Assessment Recommendations below.

Projection of Need for State-Operated Forensic Inpatient Beds

Providing forensic inpatient psychiatric treatment is a state responsibility not readily transferable to community providers due to the unique clinical and security concerns. The State of Maine is wise to continue to assume responsibility for this population. This needs assessment was conducted to determine the number of inpatient forensic beds needed for the entire state.

Review of information provided by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute indicates that Maine has a low number of forensic patients in relation to its statewide population. An analysis of state responses to a survey of the number of current adult forensic inpatient census indicated the following:

Table 28
Forensic Inpatients per 100,000 Population

State	Forensic Inpatients per 100,000
Kansas	6.7
Virginia	5.2
New York	4.9
Minnesota	4.0
Massachusetts	3.3
Delaware	3.0
Maine	2.7

Source: NASMHPD Research Institute

It is interesting to note that of the 38 states responding to the NASMHPD survey, three reported that the forensic inpatient population was decreasing, 18 reported that the population was increasing, and 17 reported no change in the forensic inpatient population.

Maine's relatively few forensic inpatients when compared to other states seem related to limited inpatient bed capacity rather than a lesser need for forensic treatment. The AMHI forensic unit has been challenged to meet the needs of forensic inpatients due to limited space and the security issues related to the current space. The existing physical configuration of the forensic unit also compromises patient treatment opportunities due to the limited areas for treatment and activities as well as the staff time diverted from clinical interventions and required to ensure adequate patient safety and security.

With only 27 forensic beds available at AMHI, patients on the forensic unit now are primarily patients who have been found not criminally responsible (NCR) or incompetent to stand trial (IST). The forensic bed space has restricted the access to inpatient psychiatric services for persons referred by Maine jails and prisons. Forensic bed space availability for correctional transfers has been further restricted by the need for the AMHI forensic unit to house two to four male patients without "legal holds" due to the inability of the current less secure civil patient units to manage these patients.

The AMHI forensic unit serves only male forensic patients, with female NCR, IST or correctional transfers now served within the civil units. Since the civil treatment teams assigned to NCR females are not forensically-focused, attention to the specialized processing for disposition options may be compromised. Without such attention, a female patient's movement through the legal system may be needlessly delayed.

Also, while the practice of housing the female forensic patients on the civil units would appear to minimize the secure supervision of female forensic patients, the lack of a forensic perimeter security for the females can actually result in more restrictive measures. For example, one female NCR was maintained with one-to-one supervision for five months as a security measure. As would be expected, this type of intervention was experienced by the patient as highly intrusive.

There are currently three male NCR patients at BMHI. Although the decision has been made to house all forensic patients at AMHI, the three male patients, all of whom have serious functioning impairments related to mental illness, have been permitted to remain at BMHI due to the limited security risks involved in their retention at the facility. Personal observation of these patients during the needs assessment process confirmed the clinical appropriateness of the decision to allow these patients to remain in the familiar BMHI environment.

During a review of the AMHI forensic unit on November 9, 1999, the 24 male forensic patients fell into the following legal categories:

Table 29
Legal Status of AMHI Male Forensic Patients - November 9, 1999

Legal Status	Number of Patients
NCR	12
IST	5
Pending Evaluation	1
Jail Transfers	6

Projected Need for NCR Beds: Hospitalization stays for the 12 male NCR patients currently at AMHI range from one month to 29 years, with seven of the patients having been hospitalized for more than 12 years. Prolonged lengths of stay for Maine NCR patients are common. The length of hospitalization for the four female NCR patients now at AMHI ranges from 1 to 4.5 years.

The Maine judicial system has adopted the practice of not discharging NCR patients from the custody of the Commissioner of DMHMRSAS when the patient no longer requires inpatient psychiatric treatment, but placing them on hospital leave. Review of the lengths of stay of the 19 NCR patients placed on hospital leave since 1982 indicates that historically, Maine NCR patients have had extensive lengths of stay.

Table 30
Length of Stays of 19 NCR Patients Placed on Hospital Leave since 1982

Length of Stay	Number of Patients
Less than 1 year	1
1 year to 5 years	2
5 years to 10 years	5
10 years to 15 years	4
15 years to 20 years	4
Over 20 years	3

A forecast of the need for forensic beds for non-correctional patients is presented in Table 31 on page 67. Patients referred by the jails and the Department of Correction were omitted from this analysis due to the consensus that the historical statistics would not provide a valid estimate of need. Projections of the number of inpatient beds required by patients transferred from correctional institutions were based on national estimates and a survey of Maine correctional agencies.

The forecast model indicates that Maine will require a total of 21 NCR patient beds by the year of 2010. This forecast, like the forecast for civil beds, is based on recent historical data and population projections, and does not account for potential change within the Maine mental health delivery system during this period. As noted

previously, consideration of current system practices and potential improvements is necessary to interpret the projections of bed need based on historical data.

Forecast of the need for NCR patient beds is impacted by the number of NCR admissions as well as by the number of discharges. The number of admissions has remained fairly static. while the number of NCR patients approved for hospital leaves recently increased. Since 1995, there have been only seven NCR patient admissions, with four of these admissions occurring in 1997.

Significant progress in obtaining judicial approval for NCR hospital leave approvals is indicated by the fact that of the 19 NCR patients now on hospital leave, six of the leaves were granted in 1999. Implementation of a six bed halfway house for NCR patients, the Homestead House, has permitted NCR patient movement outside of the hospital.

If additional secure halfway house forensic beds were developed, it is likely that additional NCR patients might be placed on hospital leave. Only a few of the current 16 hospitalized NCR patients at AMHI do not have access to grounds privileges. Most of these patients continue to require staff supervision when not within the facility.

Development of a second secure forensic halfway house is highly recommended as a cost effective and safe manner to address the needs of forensic patients requiring intense supervision, but no longer requiring inpatient treatment. Based on discussions with many Maine agencies and citizens, the development of such a facility has strong community support. Locating the second forensic halfway house outside of the Augusta community, perhaps in the Portland area, would permit forensic patients on hospital leave to safely reside near their support networks.

Projected Need for IST Beds: The forecast that Maine will require a total of 11 IST patient beds by the year of 2010 is also significantly affected by current practices. The number of patients adjudicated to IST is increasing. Of the 22 patients admitted to AMHI since 1995 for restoration to competency, ten were admitted since 1998. Lengths of stay of the current IST patients range from 130 to 306 days. These are unusually extended lengths of stay for restoration to competency, and possibly reflect the staff's inability to obtain judicial approval for involuntary medication even though the patient has been committed for restoration to competency.

While it is essential to protect patient rights in treatment decisions, IST patients who are permitted to refuse treatment may actually preclude competency restoration. Reconsideration of the current practice is recommended to reduce the length of hospitalization related to restoration of competency.

Table 31
Population Forecast - Forensic Patients

Fiscal Year	Historical		Projected**				
	Bed Days	Population	Female	IST	NCR	Total Projected	Peaking Factor
1997*	8,382	22.96					
1998*	9,047	24.79					
1999*	9,387	29.71					
2000			4	5	12	21	18-24
2001			4	7	12	23	20-26
2002			4	7	12	23	20-26
2003			4	7	12	23	20-26
2004			5	7	13	25	22-28
2005			5	9	13	27	24-30
2006			5	9	13	27	24-30
2007			5	9	14	28	25-31
2008			6	10	14	30	27-33
2009			6	11	14	31	28-34
2010			6	11	15	32	29-35

* Includes all forensic patients, male and female
** Excludes forensic patients from correctional facilities and jails.

- The projections are based solely on male and female NCR and IST patients. Projection of beds for jail and prison transfers is based on national data.
- Female forensic cases housed with the civil population are included for the 1999 historical population.
- A peaking factor of +/- 3 beds has been applied to the total forecast to account for monthly variations. The 3 bed peaking factor was determined by applying the standard deviation calculated from the average daily forensic census from January 1998 through October 1999. The average daily census during this period ranged from 22 to 27 patients.

Projected Need for Forensic Evaluation Beds: Individuals may be admitted to the AMHI forensic unit for the completion of evaluations related to competency and/or criminal responsibility; however, the number of such admissions is minimal. AMHI records reflect only ten such admissions since 1995, with an average length of stay of 72 days. The majority of court-ordered evaluations are completed on an outpatient basis through State Forensic Services.

Projected Need for Correctional Forensic Beds: As noted previously, since there is consensus that individuals in jails and prisons requiring inpatient psychiatric treatment have been under-served, an analysis of historical data would not have provided a valid forecast of future need. Projections for correctional forensic beds were based on national estimates and surveys of Maine correctional agencies.

The Maine Department of Correction (MDOC) has a current census of approximately 1,700 inmates. National statistics suggest that 10% of prison inmates experience some type of mental illness, with an estimated one half to one percent requiring specialized treatment and placement for serious mental illness*. The number of inmates requiring inpatient psychiatric treatment within a forensic hospital is largely determined by the level of services available within the correctional system. MDOC projects the need for two inpatient forensic beds at any one time. These beds would be primarily utilized for acute treatment, with the inmate returning to the prison system after stabilization of the acute psychiatric episode.

MDOC's development of the proposed Special Needs Unit at the Maine Correctional Center for inmates with serious mental illness will ensure the inmate's treatment after return to the prison system. Implementation of an involuntary medication process for prison inmates in accordance with the Supreme Court *Harper* decision might also reduce the need for the transfer of MDOC inmates to a forensic hospital setting.

Local jails of Maine now house approximately 1,100 male and 125 female inmates at any one time. The number of these inmates requiring inpatient psychiatric treatment was assessed through jail surveys, discussions with jail administrators and consumers who have been incarcerated, as well as by consideration of national trends.

Results of a survey completed by jail administrative staff regarding their referrals and admissions for inpatient psychiatric treatment are provided in Table 32 on page 69. The information provided by the jails was compared to jail admission data from AMHI and BMHI to determine consistency. The jails reported about 90 annual referrals for inpatient placement. AMHI data indicated 64 jail admissions from July 1, 1998 through June 30, 1999, and BMHI reported approximately 25 annual jail

* *An Introduction to Correctional Psychiatry* by Jeffrey L. Metzner, MD in the Journal of the American Acadmey of Psychiatry and the Law, Volume 25, Number 3, 1997.

admissions. The data comparison was consistent, and verified perceptions that jail inmates with serious mental illness have been under-served by the state hospitals.

Table 32
Self-Reported Psychiatric Hospital Referrals - Maine Jail Survey, October 1999

Jail	Census	Annual Admissions	Annual Referrals	Reason for Referrals	Inmates Requiring Hospital Care
Androscoggin	98	5000	6	Suicidal	3
Aroostook	65	1200-1500	6-10	Suicidal/Mentally Ill	10-20%
Cumberland	325	8400	5	Suicidal/Mentally Ill	1
Franklin	19	735	3	Suicidal/Mentally Ill	1
Hancock	40	N/A	15	N/A	N/A
Kennebec	178	3068	8	Suicidal/Mentally Ill	10-12 year
Knox	40-50	1700+	3	Suicidal/Mentally Ill	1
Lincoln	32	1200	4	Mentally Ill	1-2 year
Oxford	30	1300	2-3	Suicidal	1/month
Penobscot	125	5000	7-10	Mentally Ill	1-2
Piscataquis	27	755	1-2	N/A	N/A
Sagadahoc	22	778	1	Mentally Ill	1
Somerset	54	1500	6	Suicidal/Mentally Ill	1
Waldo	24	1200	8	Suicidal/Mentally Ill	3
Washington	31	N/A	1	Mentally Ill	2
York	130	3500	7	Suicidal/Mentally Ill	3

N/A = Data not available.

Applying national estimates (reference provided on p. 68) to the Maine jail population indicates that at any one time, approximately 184 (15% of inmate census) experience mental illness with 12 to 18 (1 to 1.5% of inmate census) requiring specialized placement due to serious mental illness. The number of inmates requiring inpatient psychiatric treatment is generally higher in jails than in prisons due to high jail turnover and the acuity of mental illness of some inmates at admission. Maine jails reported more than 35,000 admissions each year, and given the unknown regarding new arrestees, each admission has the potential for mental illness or the risk of suicidal behavior.

Similar to the situation within prisons, the need to transfer jail inmates with mental illness for inpatient psychiatric care is partially determined by the level of mental health services available within the jail. Responses to the jail survey indicated that the availability of mental health services in Maine jails is limited at best.

Results of the jail administrative staff survey regarding the presence of mental health or nursing staff is presented in Table 33.

Table 33
Mental Health Staff - Maine Jail Survey, October 1999

JAIL	Psychiatrist Weekly Hours	Social Work/Psychologist Weekly Hours	Nursing Weekly Hours
Androscoggin	0	15	40
Aroostook	PRN	4-5	40
Cumberland	3	40	N/A
Franklin	N/A	18-20	N/A
Hancock	?	N/A	N/A
Kennebec	0	7	84
Knox	0	0	0
Lincoln	0	4	0
Oxford	By appt.	On-call	0
Penobscot	0	25	84
Piscataquis	On-call	2	N/A
Sagadahoc	On-call	On-call	N/A
Somerset	1.5	6	0
Waldo	On-call	On-call	On-call
Washington	0	0	4
York	2	27	40

Given the limited on-site mental health assistance, jails have little recourse but to refer inmates with serious mental illness for inpatient treatment. Maintaining such inmates in a jail setting without appropriate follow-up is neither clinically acceptable nor safe.

The availability of inpatient psychiatric beds for jail inmates and the provision of a dedicated forensic unit staff to permit effective intensive acute psychiatric treatment and cooperative discharge planning with jail staff will improve services for persons with mental illness who are incarcerated. However, improvements in the jail mental health delivery system are also required to ensure a full continuum of services.

System problems that need to be addressed to ensure adequate access and clinically appropriate response to consumers who become involved with the criminal justice system include:

- The presence of mental health assistance within the jails must increase. Without adequate follow-up and the continuation of prescribed medication, inmates who have received effective inpatient care are not likely to maintain the functioning achieved during hospitalization. It is unclear whether or not the jail surveys accurately reflect the presence of community support staff. DMHMRSAS contracts with community mental health providers require continuing care for

consumers when incarcerated. Performance standards should be established and monitored to ensure that these community-based services are provided within the jails.

- Development of a direct admission referral process between the jail and the hospital forensic staff would preclude the now lengthy, and likely unnecessary in many cases, process of requiring a second pre-screening in the emergency department of a community acute medical care hospital. Direct communication would permit collaboration in determining the most clinically appropriate level of treatment. DMHMRSAS is exploring an admission modification that would permit direct dialogue and acceptance/refusal of admissions between forensic unit and jail staff.

- Training of law enforcement officers regarding mental health issues to facilitate the appropriate disposition when mental health issues may have contributed to minor law infractions. The unfortunate fact that people with serious mental illness are unfairly discriminated against and often incarcerated, when actually requiring treatment for acute psychiatric distress, could be addressed through better training of law enforcement officers.

  DMHMRSAS has recently developed staff positions to "ride along" with law enforcement staff that should facilitate on-the-job training and mental health consultation. However, substantial training and consultation will be required to adequately address the current perceptions.

- Alternatives to incarceration for mental health consumers disturbing the public with non-criminal mental health behavior must be found. While mental health training for law enforcement officers is essential, officers now have limited options to incarceration when mental health issues are involved. The development of 23-hour assessment beds could provide law enforcement a viable alternative as well as enhance consumer access to appropriate levels of treatment.

- Training of correctional officers in identifying the signs of serious mental illness and appropriate interventions is essential. Even with sufficient jail mental health staff, services will be fragmented if the correctional officers are not aware of and involved in the on-going treatment process.

Addressing these issues would reduce the number of jail inmate referrals for inpatient care, and limit the use of restrictive hospitalization to those instances when hospital-level care is clinically appropriate.

This needs assessment was conducted to assess the number of inpatient beds required to meet the needs of all Maine jails. Since BMHI now serves jail inmates from Aroostook, Hancock, Penobscot and Washington Counties, the establishment

of a single site for all forensic correctional treatment will require a change in practice. The assurance of an adequately secure environment and forensically-based clinical treatment at the new forensic facility should compensate for the additional jail transportation requirements of the distant counties.

Projected Need for Juvenile Forensic Beds: This analysis of the need for forensic inpatient beds did not include the juveniles requiring inpatient psychiatric care who are in the custody of MDOC. MDOC has indicated a need for as many as six juvenile inpatient beds. Initially, juvenile forensic inpatient treatment was to be integrated into the new facility. Best treatment practices indicate that mixing adults and juveniles in the same facility is ill-advised.

Discussions are now being conducted with community psychiatric hospitals to develop secure adolescent treatment beds for the juvenile forensic population. The establishment of such beds within Maine or the development of adolescent psychiatric beds within the MDOC system is crucial to end the current practice of sending some juveniles to out-of-state placements, a clinically disruptive and expensive resolution.

Summary of Projected Need for Forensic Beds: The year 2010 projected need for forensic inpatient beds based on historical data, national estimates, proposed changes in service delivery practices, and the potential for system improvements is as follows:

Table 34
Summary of Projected Need for Forensic Beds

Forensic Population	2010 Projected Beds	Rationale
NCR Patients	18-20	Based on population forecast and development of second secure halfway house beds for NCR patients no longer requiring hospitalization.
IST Patients	4-5	Based on decreasing lengths of stay and clinically aggressive treatment for restoration to competency.
Forensic Evaluations	1	Based on current practices and continuing outpatient evaluations by State Forensic Services.
Prison Transfers	2	Self-report of MDOC.
Jail Transfers	12-16	Based on national estimates and improvements in jail mental health services.
TOTAL	**37 – 44**	

NEEDS ASSESSMENT RECOMMENDATIONS

While the needs assessment focused on determining the need for state-operated inpatient psychiatric beds, the analysis also identified areas which would improve the overall Maine mental health system and reduce the need for hospitalization. Recommendations resulting from this analysis are summarized below.

Recommended Construction: Based on a review of current and developing practices as well as an analysis of historical data, a Psychiatric Treatment Center designed to provide treatment and living space for 48 civil patients and 44 forensic patients is proposed. In addition, two Supportive Living Centers are proposed to provide16 residential beds for patients now hospitalized.

The Psychiatric Treatment Center is designed to serve both civil and forensic patients to permit the continued sharing of support resources and maximize the utilization of expensive treatment space. Further, if the forensic beds were to be separated from the civil beds, operation of the forensic beds would no longer qualify for Federal Disproportionate Share funding.

The Psychiatric Treatment Center will provide the following units:

- Acute Care Unit: A 24-bed unit will provide the "safety net" beds for patients who are in need of psychiatric hospitalization but who are unable to be served within the community due to risk or lack of available community hospital bed space within the patient's local service network.

- Intermediate Care Unit: A 24-bed unit will provide extended treatment for patients whose severity of mental illness requires extended inpatient treatment for therapeutic effect. Many of these patients will require specialized treatment for trauma or substance abuse as well as a biological mental illness. Patients will be admitted to the intermediate care unit on a voluntary or involuntary basis.

- High Security Forensic Unit: A 20-bed unit will provide the initial placement for all forensic patients admitted to the hospital. NCR patients and IST patients will be transferred to the intermediate care forensic unit subsequent to treatment team recommendations. Forensic patients admitted to the hospital from jails or prisons will be maintained on the high security forensic unit for their entire hospitalization. The design of this unit will allow six beds to flex from high security to intermediate care if required.

- Intermediate Care Forensic Unit: A 24-bed unit will provide extended treatment for male and female patients who have been admitted to the hospital as NCR or IST and whose functioning has permitted treatment team approval of reduced security requirements.

The provision of a high security unit will minimize the security concerns involved when housing inmate patients. The provision of a dedicated clinical staff will also permit intensive acute psychiatric treatment and the cooperative discharge planning with jail and prison staff that will optimize an inmate's potential for maintaining stability after return to the correctional setting. These are areas now frustrating the relationship between corrections and the AMHI forensic unit.

The recommendation to provide 24 male and female intermediate care forensic beds was based on factoring the information gained about current Maine treatment and management of these patients with the population forecast. In many states, the forensic patients of this unit would have been transferred from high security forensic settings to less secure civil settings. Maine's practice of retaining all NCR and IST patients on a forensic unit requires the development of a less restrictive environment for long-term treatment and maintenance.

The Psychiatric Treatment Center has been designed to provide maximum flexibility to meet evolving system needs. Six beds of the high security forensic unit are designed to allow for use either as high security or intermediate care beds. Thus, the high security forensic unit could be reduced to 14 beds and the intermediate care forensic unit increased to 30 beds if needed.

The infrastructure of Psychiatric Treatment Center will be built to enable the addition of two 24-bed units (civil or forensic) without significant change to the core structure, in the event that additional beds are required as a result of changing demographics or policy change. This expansion will not be needed if the requisite community resources are established.

An essential component of the recommendation for the construction of the Psychiatric Treatment Center is the creation of two stand-alone eight bed intensely supervised residential facilities. The Supportive Living Centers will provide safe living environments for persons with serious and persistent mental illness who no longer require hospital-level treatment, but whose needs cannot now be adequately met in the community. The Supportive Living Centers will also provide a training setting for individuals throughout the state to develop skills to effectively treat and support this challenging population. This training will permit the sharing of best practices that will facilitate the subsequent development of similar placements in other locations within Maine.

A chart comparing the bed capacity of the current AMHI patient units with the bed capacity of the proposed units of the Psychiatric Treatment Center and the Supportive Living Centers is provided in Table 35 on page 75.

Table 35
Comparison of Existing and Proposed Civil and Forensic Beds

CURRENT AMHI UNITS	LICENSED BED CAPACITY		PROPOSED PSYCHIATRIC TREATMENT CENTER	BED CAPACITY
Region I-Civil	25		Acute Care-Civil	24
Region II-Civil	25		Intermediate Care-Civil	24
Region II-Civil	26			
Civil Subtotal	76		Civil Subtotal	48
Forensic-Maximum	6		Forensic-High Security	20
Forensic-Medium	21		Forensic-Intermediate	24
Forensic Subtotal	27		Forensic Subtotal	44
AMHI Total	103		Center Total	92
Residential Beds	0		Supportive Living Centers	16
TOTAL BEDS	**103**		**TOTAL BEDS**	**108**

System Recommendations: DMHMRSAS is working and will continue to work on resolving system issues impacting the need for inpatient psychiatric treatment. It is strongly recommended that DMHMRSAS accomplish improvements in the following areas during the transition construction period to ensure optimal system functioning and utilization of the new inpatient beds.

- Continuing development of the partnership between DMHMRSAS and community hospitals and community psychiatric hospitals through agreement on the most clinically effective roles for community and state-operated beds and the establishment and monitoring of performance standards. As noted previously, there appears to be general agreement about the following hospital roles:

  - Optimally, community hospitals would serve only the patients residing within their geographic area.

  - Psychiatric units of community acute care hospitals may be unable to effectively provide the level of treatment required by some patients. These patients should be served by the community psychiatric hospitals and the state-operated hospitals.

  - State-operated hospitals should serve two functions: the "safety net" for patients needing acute treatment, and a treatment center for patients who meet the criteria for intensive and extended treatment.

  - Clearly defined criteria must be established to determine when transfers from community to state-operated beds are appropriate.

  - Patients admitted to community hospitals requiring extended care and substantial psychosocial rehabilitation would be best served by state-operated hospitals with extensive treatment resources.

- Continued efforts to integrate community and hospital mental health providers in developing inpatient treatment plans and discharge plans when a patient is hospitalized in a state-operated or community facility.

- Development of state-of-the-art treatment tracks and programming for inpatients with multiple needs related to persistent and serious mental illness, substance abuse and/or histories of trauma.

- Establishment of a centralized clearing-house process for hospital admissions to address the serious problems with the current psychiatric hospitalization pre-screening process.

- Refinement of community crisis services to maximize the effectiveness of outpatient services and limit the use of hospitalization to instances in which hospital-level care is clinically appropriate. These refinements include:

  - Development of 23-hour assessment beds and the provision of psychiatric support and adequate staff for the community crisis beds that would enable safe and effective options to hospitalization.

  - Refinement of use of in-home support staff to enable consumers experiencing psychiatric crises to be safely treated in the least restrictive environment.

  - Development and monitoring of performance standards for crisis services.

- Staff development and training opportunities for hospital-based mental health staff to enhance their skills in providing state of the art treatment. Staff development and training activities for community crisis workers and case managers to enhance skills in providing crisis interventions.

- Increased university affiliations to provide additional clinical resources for inpatient and community mental health services as well as provide training opportunities that would attract additional skilled clinicians to the State of Maine.

- Development of a peer support system.

- Development of a second secure forensic halfway house located in an appropriate location to address the needs of current forensic unit patients requiring supervision but no longer requiring inpatient treatment.

- Increasing mental health support to local jails through establishment and monitoring of performance standards for community agencies responsible for these services.

- Development of an admission protocol that would permit direct dialogue and acceptance/refusal of admissions between the forensic unit and jail staff.

- Training of law enforcement officers regarding mental health issues to facilitate the appropriate disposition when mental health issues may have contributed to minor law infractions.

- Training of correctional officers in identifying the signs of serious mental illness and appropriate interventions to facilitate effectiveness of mental health services within the jails and prisons.

- Development of partnership between the Maine Department of Correction and community psychiatric hospitals to provide inpatient treatment for adolescent forensic patients.

III. OPERATIONAL & ARCHITECTURAL PROGRAM

INTRODUCTION

The Psychiatric Treatment Center is designed to provide an environment that promotes normalcy while ensuring patient safety and space for treatment consistent with current best clinical practices. Since psychiatric treatment is constantly evolving, the building's design will provide maximum flexibility to allow for changes in treatment and programming over time.

The hospital is designed to accommodate an initial population of 92 patients. In the event that additional patient beds may be required in the future, the program spaces, support services, and utility infrastructure of the hospital are sized to accommodate a future expansion of up to 140 beds. Economies of scale in construction and operating costs will be realized if additional housing is needed in the future as a result of changing demographics, service delivery practices and/or changes in policy.

The facility design is based on a cluster concept. Patient units are designed with two to three clusters, each cluster providing bedroom and leisure space for four to sixteen patients, and shared treatment space to serve a maximum of 24 patients. Each patient unit will have multipurpose rooms for program activities and offices for treatment team staff to facilitate an integrated program of activities and treatment.

The four patient units of the Psychiatric Treatment Unit will provide space to conduct varying levels of treatment in order to address the individual needs of each patient. Intensive care and crisis care beds will provide the interventions and staff supervision required when a patient is experiencing the acute phase of mental illness or is behaving in a manner that presents a risk of harm to self or others. The treatment areas, programming space and indoor/outdoor leisure space will facilitate the recovery process.

An extensive Treatment Mall will provide the multifaceted programming proven most beneficial for persons with serious mental illness. Programming will address issues related to mental illness, including specialized treatment for patients dually diagnosed with substance abuse and/or histories of trauma.

Administrative areas are designed to facilitate the efficient processing of facility and patient based documentation. Sufficient training space has been included to promote the clinical skills of Psychiatric Treatment Center staff and the development of university affiliations. These affiliations will enhance patient treatment and offer clinical training opportunities for Maine residents.

The Psychiatric Treatment Center will provide 48 civil patient beds. A 24-bed acute care unit will focus on the treatment of patients involuntarily committed for acute psychiatric distress. The acute unit will not compete with the community hospitals

for these patients but will serve as the "safety net" for acute patients who are unable to be served within their community due to lack of bed availability or threat of dangerousness.

A 24-bed intermediate care unit will provide extended treatment for patients with the severe and persistent mental illnesses often inadequately addressed in brief hospitalizations and without access to significant involvement in programming opportunities. This unit will be subdivided into three patient clusters to permit the focusing of treatment for patients identified as experiencing problems related to substance abuse and trauma.

Forensic patient services within the Psychiatric Treatment Center will be provided in two distinct units. A 20-bed high security forensic unit will provide living areas and on-unit treatment for patients admitted from jails and prisons throughout the State of Maine. The high security unit will also be the initial treatment area for patients admitted after being judged not criminally responsible (NCR) or incompetent to stand trial (IST). The high security forensic unit will permit the separation of patients with high security concerns from those without such concerns. Six beds of this unit will be located to permit these beds to be flexibly included in the intermediate care forensic unit when needed.

A 24-bed intermediate care forensic unit will provide the long-term care of NCR and IST patients after treatment staff judge a patient to be capable of safely participating in a staff-supervised medium security environment.

The Psychiatric Treatment Center will be both a physically and staff secure facility. The building perimeter (exterior walls and windows) will be designed and constructed to meet the highest levels of security in conformance with industry standards and will also serve as the primary line of security for the facility. Architectural fencing will be used to define property line demarcations.

Fixed glazed panels will be used in appropriate locations to provide visibility into a room or in the secure exterior perimeter of the structure to admit in natural light wherever possible. Glazing materials will range from tempered glass in interior partition walls, to laminated glass or a polycarbonate product such as MR-5, where vandalism is a concern. The Building Access Center requires a higher level of security, and its glazing will be glass-clad polycarbonate. As the exterior skin of the facility is secure, glazing will be security grade, either polycarbonate or glass-clad polycarbonate.

Where prescribed, the glazed panels will have an internal blind system, which consists of micro-blinds sandwiched between two layers of glazing. The blinds are contained between the two layers to make them tamper-proof. Controls for the blinds will be located in a convenient location inside or outside the room. The blinds may be opened or closed by a patient whenever privacy is required or the blinds

may be controlled by staff when clinically indicated. Alternatively, the glazing can have an inner core of liquid crystals. An electrical switch, placed at a convenient location inside or outside the room, controls the polarity of the liquid crystals. When they are polarized so that they are perpendicular to the glazing, they are completely invisible to the eye, and the glazing is clear. When they are polarized so that they are parallel to the glazing, they form an opaque screen, thereby providing the room with privacy.

A state of the art security electronics system will be utilized to allow staff to safely supervise patient movement and provide for personal safety. All security features will be sensitively designed so as to be unobtrusive and blend in with the normative and therapeutic environment of the facility.

While in some instances electronic technology will be used to enhance the security of the hospital, in no instance will the use of electronic surveillance substitute for staff supervision and interaction. Closed-circuit television (CCTV) will monitor vehicle and pedestrian entrances/exits from the hospital and conduct intermittent surveillance of certain hallways and other areas that do not need continual staff surveillance.

Electronic technology will be used to ensure the safety of staff and patients within the hospital. The life-safety system within the patient units and other selected areas of the hospital will include various electronic components, including sprinkler and smoke alarm monitoring at the Security Center. The emergency doors of the hospital will have remote unlocking capability through the Security Center.

A programmable card access system will allow certain staff access to selected areas of the facility without a key or Building Access Center intervention. The card access system also provides a management tool by developing a computerized memory of when and by whom each designated door was used.

On-line computer terminals will be placed in appropriate areas to ensure that needed information is readily available to staff involved in the decision-making and treatment processes.

DESIGN CONSIDERATIONS

In accordance with the Uniform Federal Accessibility Standards (UFAS) and the Americans with Disabilities Act (ADA), handicapped access is provided throughout the Psychiatric Treatment Center. This meets the UFAS requirement for accessibility in all areas for common use, visitor use, and possible use by handicapped employees. Every patient unit will have handicapped accessible bedrooms, showers and restrooms in accordance with code requirements. All

common areas will meet all accessibility requirements. Furthermore, all doors in the patient units will be of sufficient width to accommodate a stretcher or gurney.

ARCHITECT'S RESPONSIBILITY

The architect of record is ultimately responsible for satisfying all applicable codes, regulations, and laws including, but not limited to, building codes, life safety codes, OSHA regulations, Maine environmental laws, and the Americans with Disabilities Act. While the Operational and Architectural Programs may address some, or even a substantial portion, of these requirements, these programs are in no way intended as an exhaustive identification of code and regulation issues. The architect of record is required to ensure that all legal design requirements are met.

METHODOLOGY

The operational and architectural programs that follow are intended to be a guide to the architect with respect to the various rooms and spaces within the hospital. This document outlines the specific square footage and general equipment requirements for each functional component.

The operational and architectural programs of the Psychiatric Treatment Center have been organized into 13 functional components as illustrated below, and the Supportive Living Centers comprise the fourteenth functional area.

1.000	Public Lobby/Administration
2.000	Staff Support
3.000	Patient Units: Civil
4.000	Patient Units: Forensic
5.000	Centralized Programming Services
6.000	Admission/Discharge Area
7.000	Visitation
8.000	Medical Support Services
9.000	State Forensic Services
10.000	Food and Laundry Services
11.000	Building Access and Patient Safety Services
12.000	Facility Management Services
13.000	Site
14.000	Supportive Living Centers

The space standards of the Operational and Architectural Programs are derived from the *Design Considerations for Mental Health Facilities* by the American Institute of Architects Committee on Architecture for Health, the *1996-97 Guidelines for Design and Construction of Hospital and Health Care Facilities* by the American

Institute of Architects Academy of Architecture for Health, and the consultant team's professional experience in programming similar facilities. Furthermore, the JCAHO Regulations, and the *Regulations for the Licensure of General and Specialty Hospitals in the State of Maine* (July 1972 with amendments through January 1997) were consulted to verify compliance with all applicable requirements.

The operational program describes in detail how each component is to function as well as the hours of operation, staffing and security requirements.

The architectural program describes each space and its associated net usable or assignable area (net square footage). A departmental grossing factor was applied to the total net square footage of each component to accommodate necessary circulation space within functions, mechanical shafts, and other unassigned areas that are part of the component.

In any facility, additional square footage is also needed to accommodate major enclosed circulation and mechanical rooms that relate to the overall facility rather than individual components, as well as the building structure and exterior "skin." This space was computed by applying a building gross factor to the sum of the individual building component gross square footage.

The architectural program summary sheet that follows summarizes all the functional component net and gross square footages as well as the overall building gross square feet. In addition, the square footage of all exterior spaces is delineated. The full operational and architectural program follows the program summary. For each component, the operational description precedes the detailed space list.

It is important to note that, because the architectural program is considered an essential element of the operational program, the architectural program forms have not been given individual table designations.

Supportive Living Centers

The proposal includes the development of two residential placements providing intensive support and supervision. Two 8-bed Supportive Living Centers will provide a safe residential placement for persons transitioning to less secure community placements.

An operational and architectural program for the Supportive Living Centers is provided in Section 14.000.

SUMMARY SHEET: PSYCHIATRIC TREATMENT CENTER

Number	Functional Area	NSF	GSF	Notes
	INDOOR SPACES - PSYCHIATRIC TREATMENT CENTER			
1.000	ADMINISTRATION/PUBLIC LOBBY	8,885	11,176	
2.000	STAFF SUPPORT	600	750	
3.000	PATIENT UNITS: CIVIL	17,915	26,873	
4.000	PATIENT UNITS: FORENSIC	18,180	27,270	
5.000	CENTRALIZED PROGRAMMING SERVICES	9,610	13,454	
6.000	ADMISSION/DISCHARGE AREA	2,045	2,659	
7.000	VISITATION	1,669	2,100	
8.000	MEDICAL SUPPORT SERVICES	3,160	4,108	
9.000	STATE FORENSIC SERVICES	1,585	1,981	
10.000	LAUNDRY AND FOOD SERVICES	3,810	4,897	
11.000	BUILDING ACCESS AND PATIENT SAFETY SERVICES	380	503	
12.000	FACILITY MANAGEMENT	7,900	9,225	
13.000	SITE	0	0	
	SUBTOTAL	**75,739**	**104,994**	
	Building Gross Factor (10%)	7,574	10,499	Includes Mechanical/Electrical, Building Gross, and Major Circulation
	TOTAL	**83,313**	**115,493**	

	OUTDOOR SPACES - PSYCHIATRIC TREATMENT CENTER			
3.216	Outdoor Leisure Area	3,000	3,000	
4.122	Outdoor Leisure Area	3,000	3,000	
4.216	Outdoor Leisure Area	3,000	3,000	
5.204	Outdoor Relaxation Area	3,000	3,000	
5.222	Outdoor Exercise Yard	5,000	5,000	
10.227	Dumpster/Compactor	250	250	
10.228	Container (Trash) Store	100	100	
10.229	Recycling	50	50	
12.111	Truck Loading/Staging Area	400	400	
12.112	Staging Area/Loading Dock	200	200	
13.101	Public Parking	18,000	18,000	
13.102	Staff Parking	76,500	76,500	
	TOTAL	**112,500**	**112,500**	

Note: NSF is the net usable or assignable area. GSF includes a departmental grossing factor to accommodate necessary circulation space within functions, mechanical shafts, and other unassigned areas that are part of the component.

SUMMARY SHEET: SUPPORTIVE LIVING CENTERS

Number	Functional Area	NSF	GSF	Notes
	INDOOR SPACES: SUPPORTIVE LIVING CENTERS			
14.100	INDIVIDUAL LIVING SPACES	2,560	3,456	
14.200	CLUSTER AREAS (2 GROUPS OF INDIVIDUAL LIVING SPACES)	540	729	
14.300	COMMON AREAS	1,850	2,498	
14.400	STAFF OFFICE AREA	430	538	
14.500	FACILITY MAINTENANCE AND SUPPORT AREAS	580	696	
	SUBTOTAL	**5,960**	**7,916**	
	Gross Factor (10%)	596	792	Includes Mechanical/Electrical, Building Gross, and Major Circulation
	TOTAL	**6,556**	**8,708**	**Total interior square footage for 1 facility**
	x 2 FACILITIES	**13,112**	**17,415**	**Total interior square footage for 2 facilities**

	OUTDOOR SPACES: SUPPORTIVE LIVING CENTERS			
14.204	Outdoor Leisure Area	2,000	2,000	
	TOTAL	**2,000**	**2,000**	**Total exterior square footage for 1 facility**
	x 2 FACILITIES	**4,000**	**4,000**	**Total exterior square footage for 2 facilities**

Note: NSF is the net usable or assignable area. GSF includes a departmental grossing factor to accommodate necessary circulation space within functions, mechanical shafts, and other unassigned areas that are part of the component.

1.000
Administration/Public Lobby

1.000 ADMINISTRATION/PUBLIC LOBBY

A. Hours of Operation

The administration area will be open from 8:00 AM to 4:00 PM, Monday through Friday. The public lobby will be open from 7:00 AM to 8:30 PM. Administrative, clinical and support staff will enter and exit the Psychiatric Treatment Center through the public lobby 24-hours a day via a card access entry system.

B. Operational Description

The public lobby provides the entrance into the Psychiatric Treatment Center. The administrative offices are the areas in which day-to-day administration, clinical oversight, business and personnel activities occur.

Public Lobby

The public lobby will be the primary access point into the Psychiatric Treatment Center. All staff and visitors will enter through this area. Patients with grounds or off-grounds privileges will also leave and enter the hospital through the public lobby.

The main door of the hospital will open into a weather vestibule through which all staff, visitors and patients with grounds or community privileges will pass. From 8:30 PM until 7:00 AM, the internal door of the weather vestibule will be locked. A closed-circuit camera and intercom located in the weather vestibule will allow persons needing to access the lobby during these hours to communicate with staff in the Building Access Center. Should entry be necessary, the Building Access Center Supervisor will dispatch the Area Supervisor to the lobby to meet the individual. Hospital staff will be able to enter the Psychiatric Treatment Center at any time via a card access entry system.

A receptionist will be present in the public lobby from 7:00 AM to 8:30 PM every day. The receptionist will greet, process and direct visitors to the administrative offices or the visitation area. The receptionist will maintain a log indicating the departure and re-entry of patients leaving the hospital as approved by treatment teams.

The receptionist will also accept funds brought to the patient by visitors. The funds will be accepted and placed in a small vault. A receipt for the funds will be generated and the patient's account will be updated to reflect the additional funds. Funds will be transferred by the receptionist from the vault to the patient units each afternoon.

The public lobby will be divided into two zones. The first zone will have seating areas for visitors waiting to be processed by the receptionist into the hospital. The second zone, which will be separated by a physical barrier, will provide a circulation area for persons who have been processed for entry into the hospital and have been properly screened.

All persons entering the Psychiatric Treatment Center through the public lobby will pass through an architecturally concealed metal detector. Should further security screening be required, a small search room will be located adjacent to the metal detector for persons visiting or meeting with forensic patients. The receptionist will oversee this process from 7:00 AM to 8:30 PM. A designated staff member will oversee the monitoring process from 8:30 PM until 7:00 AM and assist the receptionist in expediting the screening process during peak movement times. This assistance will be critical during staff shift changes.

After passing through the metal detector, all persons entering the facility will pass through a vestibule controlled by the Building Access Center. Surveillance, access and control of the doors into and out of the vestibule will be accomplished through visual surveillance from the adjacent Building Access Center.

The vestibule will be large enough to differentiate patient-focused and administrative-focused circulation into the secure areas of the hospital. One door of the vestibule controlled by the Building Access Center will permit entrance into patient treatment areas. A second door controlled by the Building Access Center will permit entrance into the administrative area. A third door will permit visitor access to the corridor leading to the patient visiting area. A scanner for recording staff time and attendance will be located in the vestibule.

Consistent with the processes outlined, the public lobby will include the following components:

- A weather vestibule large enough to comfortably accommodate four persons. Operation of the inner doors of the vestibule will be controlled by the Building Access Center. Surveillance of the weather vestibule will be accomplished through a closed-circuit camera and intercom connected to the Building Access Center.

- The first area of the public lobby encountered when entering the hospital will be large enough to contain seating for 25 persons in several furniture groupings. The groupings will include comfortable lounge seating and end tables. A display rack will offer visitors the opportunity to obtain brochures and newsletters about mental health issues, and display boards will provide information about mental health issues and functions. Rules regarding visitation will be posted prominently.

- This area of the public lobby will also include 12 coin, token or credit card activated lockers for the secure storage of items not permitted within the hospital. The lockers will be large enough to accommodate coats and large items. Upon activation, visitors will remove the key from a locker and maintain it in their possession until they leave the hospital. When items are retrieved from the lockers, the key will remain in a fixed position in the lock so that it cannot be once again removed.

- A non-obtrusive physical barrier will be provided to separate the pre- and post-security screening zones of the lobby. This barrier will be adjacent to and/or may incorporate the metal detector. A small search room will be provided adjacent to the metal detector. Sufficient space will be available for wheelchair and pedestrian circulation though the metal detector.

- The receptionist area will include an open counter where the receptionist will greet visitors and complete the processing of their requests. The open counter will be large enough to allow visitors and patients to simultaneously record their movement in the designated logs. The receptionist area will also include protected desktop space for a computer and printer, a phone console, and built-in storage for forms and documentation related to the receptionist's duties.

- An x-ray machine will be located in the receptionist area to enable the receptionist and designated staff to screen briefcases and packages. This x-ray machine will also be used to scan mail and packages received by patients in the high security forensic unit. A small vault to maintain incoming patient funds until distribution to the patient living units will also be located in the receptionist area.

- The post-security screening area will be sized to permit ten people to wait prior to entering the vestibule.

- Staff and visitors entering the administrative, visitation and patient areas will enter a vestibule after passing through the post-security screening area. The vestibule will be sized to accommodate 20 standing people. Since this is the area where staff will record time and attendance through an electronic scanner, the area will be crowded before and after shift change times. The doors leading into the vestibule and leading out to visitation, administration and patient areas are controlled by the Building Access Center and will be interlocked.

- The Building Access Center, described in further detail in Section 11.000, will be located adjacent to the lobby and vestibule to facilitate observation of these areas. To permit the transfer of emergency keys between the Building Access Center and authorized staff, a pass through will be provided between the vestibule and the Building Access Center. The perimeter of the Building Access Center will be constructed so as to provide for the protection of both staff and security electronics. However, the security will be unobtrusive and materials such as glass-clad

polycarbonate will be utilized to provide security and unobstructed views from within the Building Access Center.

- A room that will serve as the centralized hub for the telephone system as well as the ATM lines will be located in the pre-security area of the public lobby. Having the telephone room outside of the security perimeter will facilitate access by TELCO and Bell Atlantic for servicing and repairs while maintaining the security integrity of the hospital.

- Male and female public restrooms, water fountain, public telephones, janitor closet.

Administration

Administrative operations of the Psychiatric Treatment Center will be organized to ensure the maintenance of quality patient care as well as the most effective and efficient use of staff resources. While administrative personnel will be located in a centralized area, the location of specific departments will be based on their primary functions. The administration area will be divided into the following sub-areas:

- Superintendent's Office
- Mailroom/Switchboard
- Administrative Services
- Operational Services
- Clinical Services
- Clinical Support Services
- Patient Records
- Administrative Support

- The Superintendent's Office provides space for the complex duties of the chief administrator of the Psychiatric Treatment Center. The superintendent's secretary will be located in a reception area to greet visitors and to coordinate the various meetings conducted here. Private office space for the superintendent will be located adjacent to the reception area. A conference room for administrative and clinical meetings will be accessed from the reception area.

- The Mailroom/Switchboard area coordinates the hospital's communication with other agencies and the public. Incoming hospital, staff and patient mail will be sorted in this area and placed in designated mail slots able to be accessed by staff at all times. Internal hospital mail and outgoing mail will also be processed in this area. When a package arrives, mailroom/switchboard staff will document the arrival with a note in the appropriate mail slot, and retain the package until pick-up. Staff retrieving packages for patients will scan the packages using the x-ray located by the receptionist's desk in the public lobby. All mail received by patients on the high security forensic unit will be scanned. Unit staff will deliver

patient outgoing mail to the mailroom for processing, ensuring that postage has been provided.

The switchboard will be operational from 8:00 AM to 4:00 PM, Monday through Friday. Switchboard responsibilities will be assumed by the public lobby receptionist on weekdays from 4:00 PM and 8:30 PM, and on weekends and holidays from 7:30 AM to 8:30 PM. Security staff will assume switchboard responsibilities during the periods not covered by the switchboard/mailroom staff or the public lobby receptionist.

- Administrative Services conducts the human resources, payroll, information management, teleconferencing, staff development, and staff coordination (scheduling) functions for the Psychiatric Treatment Center. The area will include a reception area for shared secretarial support, a private office for the director of administrative services, an interview office to permit confidential human resource discussions, and office groupings for human resources, management information systems and staff coordination staff. The human resources space will provide a cashier's window for the distribution of staff paychecks, as well as significant file storage space to comply with personnel record retention requirements.

- Operational Services includes the functions of facility management, business management and security. The area will include a reception area for shared secretarial support; private offices for the chief operating officer, the director of institutional maintenance and safety, and the director of security and safety compliance; and an office grouping for the business staff. Office space for the building maintenance supervisor, the executive housekeeper, and the dietetic services manager will be located in their operational areas.

- Clinical Services provides the clinical leadership for patient treatment at the Psychiatric Treatment Center as well as the disciplinary-specific oversight and supervision of clinical staff. The proximity of the office space of the clinical leadership of the various disciplines will foster a multidisciplinary approach to patient care. Staff dedicated to continuous performance improvement activities will also be located in the clinical services area. Although the nursing supervisors providing leadership for the three shifts are important members of the clinical services staff, their offices will be located near the patient treatment areas to facilitate access.

- Clinical Support functions include the medical records operations; staff development; audiovisual support services; and the staff library. While these functions will be administratively responsible to the director of administrative services, their spaces will be located to facilitate efficient staff access.

- The Patient Records area will provide a centralized location for the retention of archival patient files and the processing of patient documentation. The patient records area will be located adjacent to the patient units, the admission/ discharge area, and the medical clinic. In addition to maintaining the records of patient treatment, the records staff will monitor the timely receipt of transcriptions and assist in patient admissions.

- An Administrative Support area will provide shared copy/fax/storage rooms, meeting space, a pantry/break room, coat closet, restrooms, and a janitor closet. The administrative support areas may not be co-located, but may be located throughout the hospital's administrative area at various locations to maximize their convenience and accessibility to all administrative staff.

Consistent with the processes outlined, the administrative area will include the following components:

Superintendent's Office: The Superintendent's Office will be entered from an administrative corridor through a door that will be locked when staff are not present.

- The reception area of the superintendent's office will accommodate working space for the superintendent's secretary as well as space for six people waiting for the superintendent or meetings. The reception area will be furnished with two small sofas, two side chairs, end tables, coffee table, and lamps. Working space for the secretary will be furnished with a desk and desk chair, and equipped with a computer and printer. A coat closet will also be provided.

- A secure room adjacent to the secretary's area will provide a work counter, a copying machine, fax machine and cabinets for storage of supplies. This room will also include six file cabinets for retention of hospital administrative documentation.

- The superintendent's office will be sized to permit a desk area and small conference area. The office will be furnished with a large lockable desk, chair, computer table, two side chairs, credenza, bookcases, and a conference table with six chairs. The office will be equipped with a computer and printer and phone console.

- A conference room capable of seating 20 persons will be accessed from the reception area. The room will be furnished with a large conference table and 20 side chairs. A wall unit will provide a dry marker board and charting capabilities.

- An alcove adjacent to the conference room will provide a sink, refrigerator, coffee maker, counter and cabinet space. This alcove will have a door permitting closure when not in use.

Mailroom/Switchboard: The mailroom/switchboard room will be located adjacent to the staff support area to facilitate access by all staff. The room will be divided into a work area and general access area.

- The work area for the mailroom/switchboard room will be sized to permit the central management of hospital telephone calls. The switchboard work area will be equipped with a switchboard with headset capabilities, a chair for switchboard operations, display space to facilitate access to frequently requested information, and a staff paging system.

- A long counter will be provided for sorting incoming mail, packages, periodicals and the hospital's internal mail; a counter with a postage machine for processing outgoing mail and packages; deep shelves for storage of incoming mail and newspapers prior to sorting; deep shelves for storing packages until staff pick-up; space for storing outgoing mail until postal pick-up; and cabinets for supply storage.

- The work area will be separated from the general access area by counter space and a wall unit with mail slots. The mail slots for the patient units and hospital departments will be large enough to accommodate legal sized envelopes, periodicals and newspapers. Staff not assigned to specific areas will be assigned individual mail slots. Approximately 20 large, 20 medium and 40 small mail slots will be required. Two large slots in tne area beneath the counter space will enable staff to separate posted patient mail from internal mail and mail requiring postage. Bins will be located under the slots to facilitate mail collection.

- The general access space of this area will accommodate three people, and will have a work counter for staff retrieving mail. The walls will have several dry marker and corkboards to facilitate hospital-wide communication. Job postings and other related employment information will be prominently posted in this area.

Administrative Services: This area will be sized to accommodate ten staff in private or shared office space. The area will be located off the administrative corridor. A cashier's window from the human resources space to the administrative corridor will facilitate the distribution of staff paychecks.

- The reception area will be sized to accommodate workstations for the two clerk typists who will provide support to the staff in the administrative services area. The workstations will be separated by four foot high acoustical partitions with overhead cabinets, desktop, counter, drawer and file space. The workstations will be equipped with chairs, a computer and printer.

- The office of the director of administrative services will be accessed through the reception area, and will be sized to accommodate a desk, chair, two side chairs, a credenza, two file cabinets, and a small conference table with four chairs. The office will be equipped with a computer and printer.

- An interview room sized for three people will be accessed through the reception area. The room will permit staff having shared space to conduct confidential meetings, and will be important when employee benefits, employee performance or workers compensation issues need to be discussed. The room will be furnished with a small table and three chairs.

- Space for human resource functions will include shared office space for a human resources technician, a personnel assistant, and a workers' compensation technician. The shared space will be divided by four foot high acoustical partitions that will provide overhead cabinets, desktop, counter, file and drawer space for each workstation. Each workstation will be equipped with a desk chair, computer and printer. A centralized workspace will include a large table for reviewing and collating records.

- A cashier's window from this office will open to the administrative corridor to permit staff receipt of paychecks. Time and attendance monitoring will be completed by a vendor, with the support of human resources staff. Payroll processing will be completed on-site, and the checks distributed by human resources staff. The cashier's window area will include a sliding window with counter space, a stool, a computer terminal for accessing account information, and a secure vault.

- Archival files will be maintained in a room that is accessed from the shared office and able to accommodate the equivalent of 32 file cabinets. The consultant team recommends the use of a Space Saver or similar type filing system to facilitate file retrieval and mitigate the amount of space required by the storage of paper files. The consultant team further recommends the use of microfiche and/or scanner/disk storage of inactive files. The file room will include a table and two chairs to facilitate record review and shelving for the storage of forms related to personnel functions and office supplies.

- The management information systems area will include shared office space for a systems information specialist, a staff support technician and a systems information technician. The shared office space will accommodate three workstations and centralized workspace. The workstations will be separated by four foot high acoustical partitions that will provide overhead cabinets, desktop, counter, file and drawer space. Each of the workstations will be equipped with a desk chair, computer and printer. A central workspace will provide a large table and four chairs to permit small group problem resolution.

- Access to the room containing the computer servers for the local area network system and the teleconferencing links equipment will be through the shared MIS office space. This room will have adequate ventilation and humidity control. Cabinets to maintain replacement parts and office supplies will be provided, as well as a workspace for minor repairs to information processing equipment.

- A large lockable closet will have shelving to permit the storage of large computer and printer boxes. This closet will be accessible from the shared MIS office.

- The staff coordination (scheduling) area will include shared office space for the four staffing coordinators who perform scheduling responsibilities from 6 AM to 9 PM, 7 days a week. Although staff coordination is supervised by the director of administrative services, the office space will be located to facilitate staff access and interface with the nursing shift coordinators. The shared office space will accommodate four workstations and a centralized workspace. The workstations will be separated by four foot high acoustical partitions that provide overhead cabinets, desktop, counter, file and drawer space, and individual lockable cabinets. Each of the workstations will be equipped with a desk chair, computer and printer. A central workspace will provide a large table and four chairs to facilitate work projects requiring two or more staff.

- A room off the shared office space will provide filing space for the storage of staff scheduling and assignment records. This room will be kept locked, with limited card access.

Operational Services: This area will be sized to accommodate ten staff in private or shared spaces, and will be located off the administrative corridor.

- The reception area will be sized to accommodate the workstation for the clerk typist who will provide support to staff of operational services. The workstation will be defined by four foot high acoustical partitions that provide overhead cabinets, desktop, counter, file and drawer space. The workstation will be equipped with a desk chair, computer and printer.

- The private office of the chief operating officer will be accessed through the reception area, and will be sized to accommodate a desk, chair, two side chairs, a credenza, two file cabinets, and a small conference table with four chairs. The office will be equipped with a computer and printer.

- Private offices for the institutional maintenance/safety director and the security/safety compliance director will be accessed through the reception area, and will be sized to accommodate a desk, chair, two side chairs, and two file cabinets. The offices will be equipped with a computer and printer.

- The business office will include a private office for a financial analyst and shared office space for an accountant and an accountant clerk. The private office of the financial analyst will be sized to accommodate a desk, chair, two side chairs, and two file cabinets. The office will be equipped with a computer and printer. The shared office space will accommodate two workstations, centralized workspace, and an alcove for record storage. The workstations will be separated by four foot high acoustical partitions that provide overhead cabinets, desktop, counter, file and drawer space. Each of the workstations will be equipped with a desk chair, computer and printer. The centralized workspace will include a large table and four chairs for compiling and reconciling data.

- A room off the shared office space will provide filing space for the storage of financial records. This room should be kept locked, with limited card access.

- A cashier's window from the shared business office space will open to the administrative corridor to permit staff to submit requests for or obtain reimbursement for authorized expenditures. The cashier's window area will include window counter space, a staff stool, a computer terminal for accessing account information, and a secure vault.

Clinical Operations: This area will be sized to accommodate 14 staff in private or shared space. The area will be located off the administrative corridor but near patient areas. A central office area for clinical leadership staff will be complemented by office groupings for nursing support and quality assurance activities.

- The reception area will be sized to accommodate the workstations for the two clerk typists who will provide support to the staff of the central clinical services area. The workstations will be separated by four foot high acoustical partitions that provide overhead cabinets, desktop, counter, file and drawer space. The workstations will be equipped with desk chairs, computer and printer.

- Private offices for the clinical director, director of nursing, psychology director, social work director and therapeutic rehabilitation director will be entered through the reception area and will be sized to accommodate a desk, chair, two side chairs, and two file cabinets. The offices will be equipped with a computer and printer.

- The office grouping for nursing support services will include shared office space for an assistant director of nursing and a clinical nurse specialist, and a small interview room for confidential staff supervision and counseling. The shared office space will be sized to accommodate two workstations separated by four foot acoustical partitions that will provide overhead cabinets, desktop, counter, file and drawer space. The workstations will be equipped with chairs and a computer. A printer and four file cabinets will be shared.

- The interview room will be sized for discussions between three people, and will be furnished with a small conference table and three chairs.

- The office grouping for quality assurance activities will include a private office for the director of quality assurance and shared office space for staff responsible for infection control, utilization review, risk management, and the maintenance of data required for licensure and certification. The private office for the director of quality assurance will be sized to accommodate a desk, chair, two side chairs, and two file cabinets. The office will be equipped with a computer and printer. The shared office space will be sized to accommodate four workstations separated by four foot high acoustical partitions that provide overhead cabinets, desktop, counter, file and drawer space. The workstations will be equipped with chairs, computer and printer. A centralized workspace with a table and six chairs will facilitate staff meetings and completion of work projects.

- The shared office space for the nursing shift coordinators will be located adjacent to the patient units. The shared space will accommodate four workstations separated by four foot high acoustical partitions that provide overhead cabinets, desktop, counter, file and drawer space and individual lockable cabinets. Each of the workstations will be equipped with a desk chair, computer and printer. A cabinet for the storage of office supplies will be provided.

Clinical Support: Space for clinical support functions will be located to facilitate efficient staff access. Staff development services, audiovisual support services and the staff library will be located off the administrative corridor.

- The staff development area will include a training room able to accommodate 25 people, adjacent office space for a staff development coordinator and an audiovisual specialist, secure space for the storage of training materials, and secure space for the storage of audiovisual equipment. The training room will be equipped with a folding room partition, so that the room can be subdivided into two smaller simultaneous training or meeting areas. For training purposes, this room will have appropriate facilities for ICN teleconferencing, multiple audiovisual connections including fiber optics and wall-mounted monitors, as well as marker boards. Long tables with comfortable chairs for trainees, a lectern for instructors and a projection screen will be provided.

- Private offices for the staff development coordinator and audiovisual specialist will be located off the training area, and sized to accommodate a desk, chair, two side chairs, a cabinet for storage, and two file cabinets. Each office will be equipped with a computer and printer.

- The storage closets for training materials and audiovisual equipment will be located immediately adjacent to the training room.

- The staff library will be sized to accommodate 120 linear foot of six-foot high book shelving for clinical references and journals, a periodical display rack, cabinets for storage of videotapes, two small worktables each with four chairs, librarian counter for processing staff requests, cabinets for supply storage, and a workstation for the research specialist. The workstation will be separated from the central library area by a four foot high partition that will provide overhead cabinets, desktop, counter, file and drawer space. The workstation will be equipped with a desk chair, computer and printer.

Patient Records: Space for the secure storage and ready access by authorized staff of archival patient records will be located to facilitate efficient staff access. The patient records area will include a private office for the medical records director, centralized workspace for three medical records clerks, filing cabinets, an alcove with a copy machine and fax machine, and cabinets and shelving for the storage of medical record forms and supplies. The consultant team recommends the use of a Space Saver or similar type filing system to facilitate file retrieval and mitigate the amount of space required by the storage of paper files. The consultant team further recommends the use of microfiche and/or scanner/disk storage of inactive files.

- A private office for the director of medical records will be sized to accommodate a desk, chair, two side chairs, and two file cabinets. The office will be equipped with a computer and printer.

- The three workstations for the medical records clerks will be separated by four foot high acoustical partitions that will provide overhead cabinets, desktop, counter, file and drawer space. The workstations will be equipped with desk chairs, computers and printers. The central workspace will be furnished with two long tables for the processing and review of medical record documentation.

- A work counter with a computer with a pull down shutter will face onto the admissions/discharge area to allow medical records clerks to interview new admissions and verify that records are in order prior to discharging patients. The pull down shutter will secure the counter area and medical records area after hours.

Shared Administrative Support: The following spaces will be located within the administrative area:

- A copy/file/work room will be equipped with a copier, a fax machine, a paper shredder, work tables and a supply cabinet.

- A pantry alcove with a refrigerator, microwave, coffee maker, countertop, sink, and cabinets will be located adjacent to the workroom.

- A conference room to accommodate 12 people will be utilized for processing new employees and for the conducting of staff meetings and work sessions. The room will be furnished with movable conference tables capable of reconfiguration, 12 chairs, and display and dry marker boards and equipped with tele-conferencing capabilities. The conference room will also be accessible from the patient corridor.

- Coat closet, located in close proximity to staff entrance to the administrative area.

- Male and female staff restrooms, water fountain, and janitor closet.

C. Staffing

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
PUBLIC LOBBY							
Receptionist: 7:00 AM–3:30 PM	X	X	X	X	X	X	X
Receptionist: 12:30 PM-9:00 PM	X	X	X	X	X	X	X
SUPERINTENDENT OFFICE							
Superintendent	X	X	X	X	X		
Secretary	X	X	X	X	X		
MAIL/SWITCHBOARD							
Mail/Switchboard Operator	X	X	X	X	X		
ADMINISTRATIVE SERVICES							
Director	X	X	X	X	X		
Clerk Typist	X	X	X	X	X		
Clerk Typist	X	X	X	X	X		
Personnel Assistant	X	X	X	X	X		
Human Resources Technician	X	X	X	X	X		
Workers Compensation Technician	X	X	X	X	X		
Systems Information Specialist	X	X	X	X	X		
Staff Support Technician	X	X	X	X	X		
Systems Information Technician	X	X	X	X	X		
Staffing Coordinator 6:00 AM – 2:30 PM	X	X	X	X	X	X	X
Staffing Coordinator 12:30 PM – 9:00 PM	X	X	X	X	X	X	X

OPERATIONAL SERVICES							
Chief Operating Officer	X	X	X	X	X		
Institutional Maintenance/ Safety Director	X	X	X	X	X		
Security/Safety Compliance Director	X	X	X	X	X		
Clerk Typist	X	X	X	X	X		
Financial Analyst	X	X	X	X	X		
Accountant	X	X	X	X	X		
Account Clerk	X	X	X	X	X		
CLINICAL OPERATIONS							
Clinical Director	X	X	X	X	X		
Director of Nursing	X	X	X	X	X		
Psychology Director	X	X	X	X	X		
Social Work Director	X	X	X	X	X		
Therapeutic Recreation Director	X	X	X	X	X		
Clerk Typist	X	X	X	X	X		
Clerk Typist	X	X	X	X	X		
Assistant Director of Nursing	X	X	X	X	X		
Clinical Nurse Specialist	X	X	X	X	X		
Director of Quality Assurance	X	X	X	X	X		
Infection Control/Utilization Review Nurse	X	X	X	X	X		
Risk Management Nurse	X	X	X	X	X		
Compliance Assistant	X	X	X	X	X		
Nursing Shift Coordinator: Day	X	X	X	X	X	X	X
Nursing Shift Coordinator: Eve	X	X	X	X	X	X	X
Nursing Shift Coordinator: Night	X	X	X	X	X	X	X
CLINICAL SUPPORT							
Staff Development Coordinator	X	X	X	X	X		
Audio Visual Specialist	X	X	X	X	X		
PATIENT RECORDS							
Director of Medical Records	X	X	X	X	X		
Medical Records Clerk 8:00 AM – 4:30 PM	X	X	X	X	X		
Medical Records Clerk 1:30 PM – 10:00 PM		X	X	X	X	X	
Medical Records Clerk 1:30 PM – 10:00 PM	X	X	X	X			X

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
1.000	**ADMINISTRATION/PUBLIC LOBBY**							
1.100	PUBLIC LOBBY							
1.101	Weather Vestibule	1-4	1	50 /area	50			Includes CCTV and intercom to the Building Access Center, shared by staff and public
1.102	Reception Desk	2	1	60 /person	120			Includes briefcase x-ray machine, small vault, desk area, chairs, countertop, wall-mounted forms rack
1.103	Metal Detector	1	1	50 /area	50			Pass-thru metal detector; architecturally concealed, includes sufficient space for the passage of a wheel chair around the outside of the metal detector
1.104	Visitor Search/Interview Room	1-2	1	60 /area	60			Table and loose chairs
1.105	Visitor Pre-Screening/Waiting	25	1	15 /person	375			Comfortable seating, display racks; awaiting screening
1.106	Public Lockers	1	12	2.5 /locker	30			Half-height lockers sized to accommodate coats
1.107	Telecommunications & Data Equipment Room	1	1	200 /area	200			Fiber optics telephone equipment, accessible to telephone company
1.108	Visitor Post-Screening Waiting	10	1	15 /person	150			Post-screening area, separated from pre-screening area by physical barrier
1.109	Public Restroom - Men	1	1	50 /area	50			ADA accessible, number of fixtures per code
1.110	Public Restroom - Women	1	1	50 /area	50			ADA accessible, number of fixtures per code
1.111	Water Fountain Alcove	2	1	6 /area	6			Locate near restrooms, 2 water fountains, 1 at ADA height
1.112	Public Telephones	1	2	7 /phone	14			ADA accessible
1.113	Vestibule	20	1	10 /person	200			Separate exit doors differentiate access to administrative, patient and visitation areas
1.114	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
Subtotal	1.100				1,395	1.30	1,814	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
1.000	**ADMINISTRATION/PUBLIC LOBBY - cont'd**							
1.200	SUPERINTENDENT'S OFFICE							
1.201	Superintendent's Office	1	1	200 /office	200			Desk, chair, credenza, file cabinet, phone, computer, printer, bookshelves, small conference table with seating for 6
1.202	Reception/Waiting	6	1	15 /person	90			Comfortable seating, side table, coffee table
1.203	Secretary Workstation	1	1	60 /worksta.	60			Desk, chair, phone, computer; within reception/waiting area
1.204	Copy/Fax/File Room	-	1	100 /area	100			Work table, copy machine, fax machine, printer, shredder, shelving, supply cabinet, file cabinets
1.205	Conference Room	20	1	20 /person	400			Conference table, 20 chairs, side table, wall-mounted white board, lockable cabinets for A/V equipment
1.206	Coat Closet	-	1	20 /area	20			
1.207	Pantry Alcove	-	1	20 /area	20			Adjacent to conference room; cabinets, small refrigerator, microwave, coffee-maker, sink, countertop
Subtotal	1.200				890	1.25	1,113	
1.300	MAILROOM/SWITCHBOARD							
1.301	Switchboard	1	1	80 /area	80			Work area with switchboard and headset, chair, display area for materials, staff paging system; within mailroom area
1.302	Mailroom	3	1	200 /area	200			Work table, sorting bins, 20 large, 20 medium and 40 small mail slots, countertop for sorting incoming mail and packages, postage machine for outgoing mail, deep shelving, undercounter bins and slots
1.303	Staff Access Area	3	1	50 /area	50			Work counter, outgoing mail slot, staff side of mail slots, wall-mounted whiteboards and corkboards
Subtotal	1.300				330	1.25	413	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
1.000	**ADMINISTRATION/PUBLIC LOBBY - cont'd**							
1.400	ADMINISTRATIVE SERVICES							
1.401	Reception/Clerical Workstations	1	2	80 /worksta.	160			Desk with return for computer, printer, chair, phone, 1 visitor chair, acoustical partitions, cabinets
1.402	Director of Administrative Services' Office	1	1	160 /office	160			Desk, chair, credenza, file cabinet, phone, computer, printer, bookshelves, small conference table with seating for 4
1.403	Interview Room	3	1	100 /room	100			Table, loose chairs, acoustical privacy
1.404	Human Resource Workstations	1	3	80 /worksta.	240			Desk with return for computer, printer, chair, phone, 1 visitor chair, acoustical partitions, cabinets, common worktable
1.405	Cashier's Window	1	1	40 /worksta.	40			Window with counter space, stool, computer, secure vault; window opens to administrative corridor
1.406	Archival File Room	-	1	150 /area	150			Space Saver file system, table, 2 chairs, shelving
1.407	MIS Workstations	1	3	80 /worksta.	240			Desk with return for computer, printer, chair, phone, 1 visitor chair, acoustical partitions, cabinets, common worktable with 4 chairs
1.408	Computer Equipment Room	-	1	100 /area	100			Computer equipment, servers, UPS, etc.; temperature & humidity control, surge suppression; computer repair desk; limited card access only
1.409	Storage Closet	-	1	60 /area	60			Shelving for computer equipment; lockable; accessible from MIS workstations
1.410	Staff Coordination Workstations	1	4	60 /worksta.	240			Desk with return for computer, printer, chair, phone, 1 visitor chair, acoustical partitions, cabinets, common worktable with 4 chairs
1.411	Staff Coordination File Room	-	1	80 /area	80			Lockable; file cabinets for staff scheduling records
Subtotal	1.400				1,570	1.25	1,963	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
1.000	**ADMINISTRATION/PUBLIC LOBBY - cont'd**							
1.500	OPERATIONAL SERVICES							
1.501	Reception/Clerical Workstations	1	1	100 /area	100			Desk with return for computer, printer, chair, phone, acoustical partitions, cabinets
1.502	Chief Operating Officer's Office	1	1	160 /office	160			Desk, chair, credenza, file cabinet, phone, computer, printer, bookshelves, small conference table with seating for 4
1.503	Institutional Maintenance/Safety Director's Office	1	1	100 /office	100			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.504	Security/Safety ComplianceDirector's Office	1	1	100 /office	100			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.505	Financial Analyst's Office	1	1	100 /office	100			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.506	Accountant Workstations	1	2	80 /worksta.	160			Desk with return for computer, printer, chair, phone, 1 visitor chair, acoustical partitions, cabinets, common worktable with 4 chairs
1.507	Financial Files Room	-	1	80 /area	80			Lockable; file cabinets for financial records
1.508	Cashier's Window	1	1	40 /worksta.	40			Window with counter space, stool, computer, secure vault; window opens to administrative corridor
Subtotal	1.500				840	1.25	1,050	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
1.000	**ADMINISTRATION/PUBLIC LOBBY - cont'd**							
1.600	CLINICAL OPERATIONS							
1.601	Reception/Clerical Workstations	1	2	60 /worksta.	120			Desk with return for computer, printer, chair, phone, acoustical partitions, cabinets
1.602	Clinical Director's Office	1	1	120 /office	120			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.603	Director of Nursing Office	1	1	100 /office	100			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.604	Psychology Director's Office	1	1	100 /office	100			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.605	Social Work Director's Office	1	1	100 /office	100			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.606	Therapeutic Rehabilitation Director's Office	1	1	100 /office	100			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.607	Nursing Support Services Workstations	1	2	60 /worksta.	120			Desk with return for computer, printer, chair, phone, 1 visitor chair, acoustical partitions, cabinets, common worktable with 4 chairs
1.608	Interview Room	3	1	100 /area	100			Table and 3 chairs, acoustical privacy
1.609	Quality Assurance Director's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.610	Quality Assurance Services Workstations	1	4	60 /worksta.	240			Desk with return for computer, printer, chair, phone, 1 visitor chair, acoustical partitions, cabinets, common worktable with 6 chairs
1.611	Nursing Shift Coordination Workstations	1	4	60 /worksta.	240			Desk with return for computer, printer, chair, phone, 1 visitor chair, acoustical partitions, cabinets
Subtotal	1.600				1,420	1.25	1,775	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
1.000	**ADMINISTRATION/PUBLIC LOBBY - cont'd**							
1.700	CLINICAL SUPPORT							
1.701	Training Room	25	1	20 /person	500			Long tables and chairs, A/V capability, teleconferencing capability, wall-mounted monitors, lectern, projection screen, markerboards, moveable partition
1.702	Secure Storage Closets	-	2	60 /area	120			Shelving, lockable
1.703	Staff Development Coordinator's Office	1	1	100 /office	100			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 2 visitor chairs
1.704	Audiovisual Specialist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 1 visitor chair
1.705	Staff Library	up to 6	1	300 /area	300			Shelving, periodical rack, cabinets, 2 worktables with 4 chairs each, librarian counter, librarian workstation with acoustical partition and desk, chair, computer, printer, phone
Subtotal	1.700				1,100	1.25	1,375	
1.800	PATIENT RECORDS							
1.801	Patient Records & Archives	3	1	220 /area	220			Space Saver file system, 2 long tables, chairs, shelving
1.802	Medical Records Director's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, 1 visitor chair
1.803	Records Clerks' Workstations	1	3	60 /worksta.	180			Desk with return for computer, printer, chair, phone, acoustical partitions, cabinets
1.804	Copier Alcove	-	1	40 /area	40			Copier, fax, shredder; within medical records room
1.805	Window to Admissions Area	1	1	40 /worksta.	40			Work counter, computer, printer, window with pull-down shutter facing into Admissions/Discharge area (6.000)
Subtotal	1.800				560	1.25	700	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
1.000	**ADMINISTRATION/PUBLIC LOBBY - cont'd**							
1.900	ADMINISTRATIVE SUPPORT AREA							
1.901	Copy/Fax/Work Room	-	1	100 /area	100			Work table, copy machine, fax machine, printer, shredder, shelving, supply cabinet
1.902	Pantry Alcove	10	1	20 /area	20			Refrigerator, microwave, coffee maker, sink, countertop, cabinets; adjacent to the workroom
1.903	Conference Room	12	1	20 /person	240			Conference table, 12 chairs, side table, wall-mounted white board, lockable cabinets for A/V equipment, teleconferencing capability adjacent to patient corridor
1.904	Coat Closet	-	1	20 /area	20			Located in close proximity to staff entrance
1.905	Staff Restroom (M/F)	5	2	180 /area	360			ADA accessible, number of fixtures per code, wall-mounted water fountain outside
1.906	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
Subtotal	1.900				780	1.25	975	
Total	**1.000**				**8,885**		**11,176**	

2.000
Staff Support

2.000 STAFF SUPPORT

A. Hours of Operation

The spaces that comprise this area will generally be accessible to staff on all three shifts, 7 days a week.

B. Operational Description

Staff support areas include a staff break room and male and female staff shower and dressing rooms.

A centralized break area will provide staff a pleasant space in which they can take a meal break. The break room will have a refrigerator, vending machines, microwave, cabinets, counter space, sink with instant hot water, and tables and chairs for up to 16 staff. The break room will be open 24 hours a day.

A centralized male and female changing area with shower and bathroom facilities will be provided for hospital staff near the patient gym. The showers and dressing rooms will be essential when weather emergencies require staff presence for extended periods. For physical fitness, exercise, and stress reduction, staff will be permitted to utilize the hospital's gymnasium and exercise equipment, when it is not in use by patients, before and after their work shifts.

C. Staffing

There are no staff assigned to work in this area.

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
2.000	**STAFF SUPPORT**							
2.100	STAFF BREAK AREA							
2.101	Shower/Restroom (M/F)	1-3	2	150 /area	300			Shower stall with drying area; ADA accessible, number of fixtures per code
2.102	Staff Break Room	20	1	15 /person	300			4 tables w/ 4 chairs each, countertop, cabinets, vending machines, coffee maker, sink with instant hot water, refrigerator, microwave, shelving for resource materials
Subtotal	2.100				600	1.25	750	
Total	**2.000**				**600**		**750**	

3.000
Patient Units: Civil

3.000 PATIENT UNITS: CIVIL

Introduction

The Psychiatric Treatment Center's patient units will be designed to provide comfort and safety for persons in need of inpatient psychiatric treatment. Services will be provided in a milieu that promotes patient dignity and independence. The patient will be afforded staff supervision and personal privacy based on his/her current mental status.

The Psychiatric Treatment Center will provide two patient units for civil patients, and is designed to facilitate future expansion if required. Each civil unit will have the capacity to provide appropriate treatment for patients in various phases of recovery.

Based upon the current needs within the AMHI service area, the civil units are designated as follows. The units are being designed with maximum flexibility to allow for future change.

- Acute Care Unit: This 24-bed unit will provide the "safety net" beds for patients who are in need of psychiatric hospitalization but who are unable to be served within the community due to risk issues or lack of available community hospital bed space within the patient's catchment area. These patients will typically enter the Psychiatric Treatment Center on an emergency involuntary order. While the average length of stay on the acute care unit will be less than 30 days, decisions to discharge or transfer a patient will be based on the judgement of the treatment team and the patient.

- Intermediate Care Unit: This 24-bed unit will provide extended treatment for patients whose severity of mental illness requires extended inpatient treatment for therapeutic effect. Many of these patients are multiply diagnosed with mental illness and histories of substance abuse and/or trauma. Patients will be admitted to the intermediate care unit on a voluntary or involuntary basis directly from the community, by transfer from a community hospital bed or from the acute care unit. The decision to transfer a patient from a community hospital will be based on the potential need for extended inpatient treatment only when the transfer will not have a negative impact on the patient's continued recovery.

While the focus of the treatment on the acute and intermediate care units will differ based on the needs of the patients being served, the treatment principles will be the same. Both units will provide multidisciplinary treatment in the least restrictive environment that is consistent with the patient's current mental status. All patients will be engaged in active treatment focused on the reduction or management of symptoms and behaviors that led to the admission and the development of skills that will promote enhanced functioning over a sustained period.

Upon admission to the Psychiatric Treatment Center, the patient will be assigned to the patient unit consistent with his/her current clinical status. The units will provide private or semi-private bedrooms and shared living space and will also include specialized beds where intensive intervention and staff supervision may be provided. A physician or physician extender will determine the patient's unit assignment at admission and subsequent modifications will be based on physician order.

The patient's treatment will be guided by a treatment plan that is developed by a multidisciplinary clinical team and the patient. The plan will be based on an integrated multidisciplinary assessment completed within four days of the patient's admission. This assessment will include the integration of the patient's Individualized Support Plan (ISP) whenever an ISP exists. The treatment plan will be reviewed and updated to reflect changes in the patient's functioning and goals.

All doors in the patient units will be of sufficient width to allow for the passage of a stretcher or gurney, with staff accompaniment. A portion of the rooms in each patient unit and all common spaces will be handicapped accessible, in accordance with ADA guidelines and code requirements.

Glazing, which is the use of see-through non-breakable wall areas, will be utilized throughout the units to facilitate staff observation and a feeling of openness while moderating the noise from one area to another.

Offices for members of a patient's treatment team will be located within the patient's unit to facilitate staff-patient interaction, staff-staff interaction and consistency in treatment team conduct.

Although the Treatment Mall will provide extensive programming opportunities, each patient unit will provide areas for on-unit treatment and programming. These on-unit treatment areas will be available for all patients; however, their use will be essential for patients whose mental status precludes participation in the Treatment Mall even with staff supervision. Programming and treatment space on the patient units will also permit these activities during hours when the Treatment Mall is not available for patient access.

The patient units will have immediate access to the Treatment Mall and be in close proximity to the admission/discharge area, the visitation area and the administrative area. Locked and secured access to the units will be controlled by unit staff or the Building Access Center. Each patient unit will access a secure outdoor leisure time area.

The patient units will be designed to permit the zoning and closure of staff office and programming areas when these areas are not in use. This will limit the space requiring staff supervision to areas where the patients are present. The units will

also allow the flexible separation of bed space to meet the clinical needs of specific patient groups.

Staffing levels of the patient units will meet or exceed those required by the *Bates v. Duby* Consent Decree. The staff mix on each shift will be adequate to address the clinical needs of the patients currently residing on the unit.

ACUTE CARE UNIT

A. Hours of Operation

24 hours a day, 7 days a week.

B. Operational Description

The acute care unit will be sized to provide treatment based on individual need for 24 male and female adult patients. The unit will consist of an intensive treatment area, two areas of patient single and double occupancy bedrooms, leisure and treatment area, nursing and clinical support area and a staff office area. Each area will be accessed from an entrance foyer housing a nursing station and a quiet area for patients desiring close proximity to staff. Each area will be totally compliant with ADA and applicable handicap accessibility codes.

Intensive Care Area: The intensive care area will provide two high observation private bedrooms for patients in acute psychiatric distress. Two non-assigned rooms for intensive patient supervision and monitoring during times when seclusion or the use of restraints is clinically necessary will also be located in this area. The intensive care area will be adjacent to the nursing station and outside of the general patient circulation area. Access to the area will be from the nursing station and entrance foyer.

Components of the intensive care area will include:

- An intensive care corridor wide enough to facilitate the patient movement and pacing often experienced during acute psychiatric episodes.

- Two private patient bedrooms with glazing of the walls adjacent to the intensive care corridor and visible from the nursing station. Each bedroom will be sized to accommodate a bed, a small cabinet for the storage of the patient belongings approved by the psychiatrist, and a patient chair. Lighting for the patient bedrooms will be controlled by staff from outside the room.

- A patient restroom with a sink, toilet, shower and privacy screen or curtain and space for non-intrusive staff supervision when the patient's clinical status requires intensive monitoring will be located off the corridor near the patient bedrooms.

- A treatment room sized to permit individual patient assessment and treatment will be furnished with a small table and three comfortable chairs. The wall adjacent to the intensive care corridor will be glazed.

- A multipurpose room for patient dining, small activities and patient relaxation will accommodate two small tables, each with four chairs, a small sofa, three side chairs, a cabinet for supply storage, and a secured television.

- A small pantry containing a sink, refrigerator; microwave, coffeemaker, water cooler, cabinets and counter space will be located off the multipurpose room. Access to the pantry area will be controlled by staff.

- Two crisis care rooms will be sized to provide patient time-out, seclusion and restraint application in a safe manner. The location and acoustics of these rooms will optimize staff observation while minimizing patient stimulation and potential disruptions to the unit's therapeutic milieu. Each crisis care room will be furnished with a bed capable of restraint application, although the bed may be removed when the patient would benefit most from only a mattress and bedding.

- The crisis care rooms will be accessed through a shared anteroom large enough to accommodate staff conducting constant observation as well as safe patient and furniture movement. A patient restroom and shower large enough to accommodate unobtrusive staff monitoring will be located off the anteroom. The walls and doors of the crisis care rooms and anteroom facing the nursing station will be glazed to ensure optimal staff observation.

- A closet large enough to accommodate the storage of clean linen, supplies, restraints and furniture that must be removed from the intensive care bedrooms and crisis care rooms from time to time due to the patient's clinical condition will be provided.

- Staff restroom.

- Janitor's closet.

Acute Care Patient Bedroom Area: The patient bedroom area will provide space for two patient groupings. One grouping will include two single and three double patient bedrooms. The second grouping will include two single and six double patient bedrooms. Circulation between the grouping areas will normally be opened but may be restricted via a movable partition or door based on patient need. The

bedroom areas will be located within sight of the nursing station and will provide patient leisure space as well as bedroom space. Patients will be assigned to either private or shared bedroom space based on clinical need. A small bench will be constructed outside each bedroom door to facilitate the transition of patients tentative about leaving their bedrooms.

Components of the two patient bedroom groupings will include:

- Four private patient bedrooms will be sized to accommodate one bed, end table, small desk, and comfortable chair. A closet will house a wardrobe insert with drawers, shelving and clothing hanging space for the storage of patient belongings. The fixtures and mirror will be designed to reduce risk for self-harm. A small glazed area in the bedroom wall will facilitate unobtrusive staff observation; however, integral blinds will permit patient privacy when clinically appropriate.

- Nine double patient bedrooms will be sized to accommodate two beds, two end tables, a small desk, and two comfortable chairs. Two closets will each house a wardrobe insert with drawers, shelving and clothing hanging space for the storage of patient belongings. The fixtures and mirror will be designed to reduce risk for self-harm. A small glazed area in the bedroom wall will facilitate unobtrusive staff observation; however, integral blinds will permit patient privacy when clinically appropriate.

- Seven patient restrooms, each providing a toilet, sink and shower, will be located adjacent to the bedrooms. Each restroom is designed to serve two patient bedrooms. Two restrooms will be ADA accessible.

- A tub room will be provided with an outer changing area, and privacy screen. The tub room will be ADA accessible.

- A large closet with shelving for the storage of patient hygiene supplies and clean linen.

- A closet for the collection of soiled linen. Soiled linens will be sent to a commercial laundry for cleaning.

- The patient grouping area with five patient bedrooms will include a leisure space able to accommodate eight patients and two staff persons socializing, reading or watching television. The leisure space will be furnished with a sofa, three side chairs, end tables, a small table and four chairs, a bookcase for reading material, a lockable cabinet for the storage of leisure supplies and games, and a secured television. The space will be partitioned with glazing and furniture, and will be arranged to facilitate the use of the space for several simultaneous leisure activities. A small space will be provided for patients choosing personal time and

will be furnished with a comfortable chair, an end table and lamp. Shelving for plants around the window areas will facilitate patient involvement in horticulture activities, as well as enhance the therapeutic environment. A glazed booth with acoustical sound privacy will provide a counter, chair and telephone for patient use.

- The patient grouping area with eight patient bedrooms will include a leisure area able to accommodate 14 patients and two staff socializing, reading or watching television. The leisure area will be furnished with three sofas, six side chairs, end tables, two small tables each with four chairs, a bookcase for reading material, a lockable cabinet for the storage of leisure supplies and games, and a secured television. The space will be partitioned with glazing, and furniture will be arranged to facilitate the use of the space for several simultaneous leisure activities. Small spaces will be provided for patients choosing personal time. Each of these areas will be furnished with a comfortable chair, an end table and lamp. Shelving for plants around the window areas will facilitate patient involvement in horticulture activities as well as enhance the therapeutic environment. A glazed booth with acoustical sound privacy will provide a counter, chair and telephone for patient use.

- An outdoor leisure area will be accessed from both patient groupings and will be sized to accommodate 20 persons engaged in quiet recreation. Four park benches, four picnic tables, and a small garden will provide an area for unstructured patient leisure as well as unit activities. An awning will be constructed over a portion of the outdoor recreation area to provide protection for patients who desire fresh air during inclement weather or protection from the sun when patients have been prescribed certain medications.

- A glazed area from the indoor leisure areas to the outdoor area will include vending machines for patient snack periods. All items from the vending machines will be provided in plastic or paper containers. The space will also contain individual patient lockers for storage of outdoor wear. Access to the snack/vending area from the indoor leisure areas will be controlled by staff and visible from the nursing station.

- A large room adjacent to the snack/vending area will provide space for the unit vault containing patient cash and valuables and space for the storage of patient belongings not permitted in the patient bedrooms due to clinical concerns or space limitations. This room will include hanging bags for the storage of clothing as well as large cubicles and shelving to accommodate other patient belongings. This room will be subdivided by a counter to limit patient access to an area accommodating four persons for the staff distribution of cash and personal belongings to the patient. This area will be equipped with a computer for updating patient accounts.

Treatment Area: While the treatment area of the acute care patient unit will provide treatment and recreational space for all unit patients, use of this area will be primarily by patients whose mental status precludes participation on the Treatment Mall or during hours when the Treatment Mall is not operational.

Components of the treatment area will include:

- Two treatment rooms for patient assessment and treatment as well as discharge planning with community providers will accommodate a small table and three comfortable chairs. The wall adjacent to the corridor will be glazed.

- A group treatment room that is able to accommodate eight persons either seated in a circle or comfortably seated around group tables will be utilized for psychotherapy and psychoeducational groups, as well as small arts and crafts activities. The group treatment room will be furnished with movable tables that can be reconfigured, eight comfortable chairs, and dry marker boards and magnet boards. The room will be designed to facilitate the use of audiovisual equipment and will include cabinets for the storage of arts and crafts supplies and a sink.

- A multipurpose room sized to accommodate 20 seated persons will be utilized for unit community meetings and activities, additional treatment space, and on-unit dining when needed for specific patients. The space will enable the provision of holiday parties, bingo games and large group events such as movies as well as provide space for staff meetings. The multipurpose room will be furnished with five small tables, each with four chairs, and a lockable cabinet for storage of games and recreational items. The room will be designed to facilitate the use of audiovisual equipment and will have a closet for the storage of a large screen TV and VCR on a movable stand. The multipurpose room will have direct staff controlled access to the snack/vending room leading to the outdoor area.

- A small pantry providing a sink, refrigerator, microwave, coffee maker, ice maker, counter space, and cabinets will be located off the multipurpose room for use during patient dining and social activities. The pantry will be large enough to accommodate the distribution of patient meal trays received from the central kitchen. The pantry will have lockable doors to ensure security when the area is not being used.

- A quiet room able to accommodate a comfortable chair for patients requiring a brief time-out period will be provided proximate to the treatment area. The quiet room walls will have glazed areas to facilitate staff observation.

- A laundry room, to be utilized simultaneously by two patients, includes ironing space for patient personal clothing, a commercial-grade washer and dryer, and

two counter spaces for laundry sorting and folding. A lockable closet will store an iron and ironing board as well as provide shelving for laundry supplies.

- Janitor's closet and trash room.

Staff Office Area: This area will provide staff offices for members of the patient unit's treatment team as well as provide on-unit staff restrooms and a staff break area. The area will be accessed from the entrance foyer and adjacent to the nursing and clinical support area. Office walls adjacent to the corridor will be glazed to facilitate observation.

Components of the staff office area will include:

- An on-unit staff break area will complement the centralized staff break area and provide a pleasant space for meals and snacks for staff unable to leave the unit. The break room will be equipped with a refrigerator, microwave, sink, small cabinet for supply storage, countertop, and a dining table able to accommodate four persons. The break room will include personal locker space for staff assigned to the unit. The break room will be located adjacent to the entrance foyer and glazed to allow visibility from the nursing and clinical support area.

- Male and female staff restrooms, ADA accessible.

- A private office for a program services director will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Two private offices for psychiatrists will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The offices will be equipped with a computer, printer and dictation equipment.

- A private office for a psychologist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Private offices for two social workers will each be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The offices will be equipped with computers and printers.

- A private office for the recreational therapist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared open office area will be sized to provide three unassigned workstations for use by the treatment plan scribe, habilitation aides, students and staff not

assigned to the unit. The workstations will be divided by a four foot high acoustical partition. Each workstation will be equipped with a desk chair, desktop and drawer/file space, and a computer. The workstations will share a printer.

Nursing and Clinical Support Area: This area will provide the space for unit treatment planning and medical activities, as well as include the centralized nursing station facilitating routine staff monitoring of unit activities. Patient access to this area will be limited to the treatment planning room and medical treatment room. The medical treatment room and treatment planning room will be accessed from the nursing station and the entrance foyer. Access into the nursing and clinical support area will be controlled by staff within the nursing station or by the Building Access Center.

Components of the nursing and clinical support area will include:

- A nursing station sized to accommodate two workstations and the presence of two additional staff will be located to maximize observation of unit patient bedroom and leisure areas as well as to provide optimal monitoring of the intensive care area. The nursing station will be defined by a raised counter that will provide open and protected work space. The area will be equipped with three staff chairs, a Kardex documenting individual patient care plans, storage cabinets, and a computer.

- A treatment planning room will be sized to accommodate eight persons seated around a conference table and will be located adjacent to the entrance foyer and the unit's medical records room. Glazing between the treatment planning room and the nursing station will facilitate staff observation into this area. The treatment planning room will be furnished with a conference table, eight chairs and a computer on a movable stand. The room will be used for patient-staff interactions and staff meetings when not needed for treatment planning. When more than eight people are required at a treatment team meeting, use of the large multipurpose room in the visiting area may be scheduled.

- A medical records and charting room will provide space for the updating and maintenance of patient medical records and for facilitating staff communication. One area of the medical records room will provide lateral files to accommodate patient current and prior records, and counter space for interim placement of records requiring processing or signatures. A table with four chairs will afford staff space to record patient progress and activities in the medical records. Wall cubicles will provide ready access to medical record and patient care forms and bins for the routing of documentation to the appropriate staff or department. Dry marker boards and magnet boards will be available in the medical records room for the recording of patient census information and posting of official notices. The second area of the medical records room will include a workstation and a shared work area. The workstation and shared work space will be separated by

a four foot high acoustical partition. The workstation for the ward clerk will provide counter and desktop space, overhead cabinets, and drawer space. This workstation will be equipped with a chair, telephone console and a computer. Transcription equipment will not be necessary since this is a contracted service. The shared work space will house a copy machine, fax machine, and counter space; printer for the computers of the ward clerk, nursing station and treatment planning room; and storage for office supplies.

- A private office for the unit's nursing supervisor will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared office space will be sized to provide two unassigned workstations for use by nursing staff, particularly the nurse providing unit oversight when the nursing supervisor is not present. The workstations will be divided by a four foot high acoustical partition that will provide desktop and drawer space. Each workstation will be equipped with a chair and a computer.

- A medication administration room will be located adjacent to the entrance foyer. Access to this room will be from the nursing station or through a dutch door between the medication administration room and the entrance foyer. The half door will provide the secure administration of medications to patients. The medication administration room will be sized to accommodate one nurse administering medication or seated at a counter transcribing physician orders and preparing medication administration records. The room will include a large medication cart, a refrigerator for the storage of medications, a lockable cabinet for the storage of controlled medication and sharps, cabinets for the storage of non-controlled medications and related supplies, a water cooler to provide water to patients during medication administration, and a sink for handwashing.

- The medical treatment room will include an anteroom furnished with a desk, chair, and a side chair for the completion of nursing assessments and individual patient health education that will include medication education and oral hygiene teaching. The side chair will be adaptable to permit the safe drawing of blood for laboratory testing. A container for the safe disposal of sharps will be provided.

- The medical treatment room will be utilized for medical assessments and treatments as well as the administration of injectible medications. The room will provide an exam table and physical examination equipment, a desk and chair for the physician or physician extender, a sink, cabinets for medical supplies, containers for the disposal of sharps and medical waste, and a small refrigerator for the storage of laboratory specimens awaiting pick-up.

C. Acute Care Unit Staffing

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
DAY SHIFT							
Psychiatrist	X	X	X	X	X		
Psychiatrist	X	X	X	X	X		
Program Services Director	X	X	X	X	X		
Psychologist	X	X	X	X	X		
Social Worker	X	X	X	X	X		
Social Worker	X	X	X	X	X		
Recreational Therapist	X	X	X	X	X		
Habilitation Aide		X	X	X	X	X	
Habilitation Aide	X	X	X	X			X
Ward Clerk	X	X	X	X	X		
Nursing Supervisor	X	X	X	X	X		
Registered Nurse	X	X	X	X	X	X	X
Registered Nurse	X	X	X	X	X	X	X
Treatment Plan Scribe	X	X	X	X	X		
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
EVENING SHIFT							
Registered Nurse	X	X	X	X	X	X	X
Registered Nurse	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
NIGHT SHIFT							
Registered Nurse	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X

INTERMEDIATE CARE UNIT

A. Hours of Operation

24 hours a day, 7 days a week.

B. Operational Description

The intermediate care unit will be sized to provide treatment based on individual need for 24 male and female adult patients. This unit will consist of a crisis care area, three areas of patient private bedrooms, leisure and treatment area, nursing and clinical support area, and a staff office area. Each area will be accessed from an entrance foyer housing a nursing station and a quiet area for patients desiring close proximity to staff.

All patients of the intermediate care unit will have private bedrooms to provide a more normal living environment since these patients will typically experience more extended hospital stays than patients of the acute care unit. The intermediate care patient bedrooms will also provide additional space for personal belongings and will be wired for cable access.

Crisis Care Area: The crisis care area will provide two unassigned crisis care rooms to provide intensive patient supervision and monitoring when seclusion or the use of restraints is clinically necessary. The crisis care area will be located adjacent to the nursing station and outside of the general patient circulation area.

Components of the crisis care area will include:

- Two crisis care rooms will be sized to provide patient time-out, seclusion and restraint application in a safe manner. The location and acoustics of these rooms will optimize staff observation while minimizing patient stimulation and potential disruption to the unit's therapeutic milieu. Each crisis care room will be furnished with a bed capable of restraint application, although the bed may be removed when the patient would benefit most from only a mattress and bedding. Room lighting will be controlled by staff from outside the rooms.

- The crisis care rooms will be accessed through a shared anteroom large enough to accommodate staff constant observation as well as safe patient and furniture movement. A patient restroom and shower large enough to accommodate unobtrusive staff monitoring will be located off the anteroom. A closet large enough to accommodate the storage of clean linen, personal hygiene supplies, mattresses, restraints and beds that must be removed from the crisis care rooms

due to the patient's clinical condition will be accessed from the anteroom. The walls of the crisis care rooms and anteroom facing the nursing station will be glazed to ensure optimal staff observation.

- Janitor's closet.

Intermediate Care Patient Bedroom Area: The patient bedroom area of the intermediate care unit will provide space for three patient groupings. Two of the three groupings will provide four private patient bedrooms. The third grouping will provide 16 private patient bedrooms. Circulation between the three areas will normally be open, but may be restricted through movable partitions or doors based on patient need. The patient bedroom areas will be located within sight of the nursing station and will provide leisure as well as bedroom space. A small bench-like area will be constructed outside bedroom doors to accommodate patients tentative about moving from their bedroom to other areas of the unit.

Components of the three patient bedroom groupings will include:

- Twenty-four individual patient bedrooms will be sized to accommodate one bed, a wall unit containing shelving, counter and desk space, and a comfortable chair. A closet will house a wardrobe insert with drawers, shelving and clothing hanging space for the storage of patient belongings. The fixtures and mirror will be designed to reduce risk for self-harm. A small glazed area in the bedroom wall will facilitate unobtrusive staff observation; however, integral blinds will permit patient privacy when clinically appropriate.

- Twelve patient restrooms, each providing a toilet, sink and shower, will be shared by two patients and located adjacent to the patient bedrooms. Two restrooms will be ADA accessible.

- A tub room will be provided with an outer changing area, and privacy screen. The tub room will be ADA accessible.

- Each of the two smaller patient bedroom groupings will each include a leisure area able to accommodate four patients and two staff socializing, reading, or watching television. The leisure space will be furnished with one sofa, two side chairs, end tables, a small table and four chairs, a bookcase for reading material, a lockable cabinet for the storage of leisure supplies and games, and a secured television. The space will be partitioned with glazing and furniture, and will be arranged to facilitate the use of the area for different simultaneous leisure activities. A small space will be provided for patients choosing personal time, and will be furnished with a comfortable chair, an end table and lamp. Shelving for plants around the window areas will facilitate patient involvement in horticulture activities as well as enhance the therapeutic environment. A glazed

booth with acoustical sound privacy will provide a counter, chair and telephone for patient use.

- The large patient bedroom grouping will include a leisure space able to accommodate 16 patients and two staff socializing, reading or watching television. The leisure space will be furnished with two sofas, four side chairs, end tables, three small tables each with four chairs, a bookcase for reading material, a lockable cabinet for the storage of leisure supplies and games, and a secure television. The space will be partitioned with glazing and furniture, and will be arranged to facilitate the use of the area for different simultaneous leisure activities. Two small spaces will be provided for patients choosing personal time. Each of these areas will be furnished with a comfortable chair, an end table and lamp. Shelving for plants around the window areas will facilitate patient involvement in horticulture activities as well as enhance the therapeutic environment. A glazed booth with acoustical sound privacy will provide a counter, chair and telephone for patient use.

- A large closet with shelving for the storage of patient hygiene supplies, unit supplies, and clean linen.

- A closet for the collection of soiled linen.

- An outdoor leisure area will be accessed from each of the patient bedroom groupings. The leisure area will be sized to accommodate 26 persons engaged in quiet recreation. Four park benches, five picnic tables, and a small garden will provide space for unstructured patient leisure as well as such unit activities and picnics. An awning will be constructed over a portion of the outdoor recreation area to provide protection for patients who desire fresh air during inclement weather or protection from the sun when patients have been prescribed certain medications.

- A glazed room leading from the indoor leisure areas to the outdoor leisure area will include vending machines for patient snack periods. All items from the vending machines will be provided in plastic or paper containers. The space will also contain individual patient lockers for storage of outdoor wear. Access to this room from the indoor leisure areas will be controlled by staff and visible to the nursing station.

- A large room adjacent to the leisure areas will provide secure space for the unit vault containing patient cash and valuables and space for the storage of patient belongings not permitted in the patient bedrooms due to clinical concerns or space limitations. This room will include hanging bags for the storage of clothing as well as large cubicles and shelving to accommodate other patient belongings. This room will be subdivided by a counter to limit patient access to an area accommodating four persons for staff distribution of cash and personal

belongings to the patients. This area will be equipped with a computer for updating patient accounts.

Treatment Area: While the treatment area of the intermediate care patient unit will provide treatment and recreational space for all unit patients, use of this area will be primarily by patients whose mental status precludes participation on the Treatment Mall or during hours when the Treatment Mall is not operational.

Components of the treatment area will include:

- Two treatment rooms for individual patient assessment and treatment as well as discharge planning with community providers will be sized to accommodate a small table and three comfortable chairs, and will have glazing of the wall adjacent to the corridor.

- A group treatment room that is able to accommodate eight persons either seated in a circle or comfortably seated around group tables will be utilized for psychotherapy and psychoeducational groups, as well as small arts and crafts activities. The room will be furnished with movable tables that can be reconfigured, eight comfortable chairs, a dry marker board and magnet boards. The room will be designed to facilitate the use of audiovisual equipment, and will include cabinets for the storage of arts and crafts supplies and a sink.

- A multipurpose room sized to accommodate 24 seated persons will be utilized for unit community meetings and activities, additional treatment space, and on-unit dining when needed for specific patients. The space will enable the provision of holiday parties, bingo games and large group movies as well as provide space for staff meetings. The multipurpose room will be furnished with six small tables, each with four chairs, and a lockable cabinet for storage of games and recreational items. The room will be designed to facilitate the use of audiovisual equipment and will have a closet for the storage of a large screen TV and VCR on a movable stand. The multipurpose room will have direct staff controlled access to the snack/vending room leading to the outdoor area.

- A small pantry providing a sink, refrigerator, microwave, coffee maker, ice maker, counter space, and cabinets will be located off the multipurpose room for use during patient dining and social activities. The pantry will be large enough to accommodate the distribution of patient meal trays received from the central kitchen when a patient is unable to attend meals in the centralized dining area. The pantry will have lockable doors to ensure security when area is not in use.

- A quiet room able to accommodate a comfortable chair for patients requiring a brief time-out period will be provided. The wall of this room adjacent to the corridor will be glazed to facilitate staff observation.

- A laundry room sized to be utilized simultaneously by two patients and with ironing space for patient personal use, a commercial-grade washer and dryer, and two counter spaces for laundry sorting and folding will be provided. A lockable closet will store an iron and ironing board as well as provide shelving for laundry supplies.

- Janitor's closet and trash room.

Staff Office Area: This area will provide staff offices for the unit's treatment team, as well as provide on-unit staff restrooms and staff break areas. Office walls adjacent to the corridor will be glazed to facilitate observation. The area will be accessed from the entrance foyer adjacent to the nursing and clinical support area.

Components of the staff office area will include:

- An on-unit staff break area will complement the centralized staff break area and provide a pleasant space for meals and snacks for staff unable to leave the unit. The break room will be equipped with a refrigerator, microwave, sink, small cabinet for supply storage, a countertop, and a dining table able to accommodate four persons. The break room will also include personal locker space for staff assigned to the unit. The break room will be located adjacent to the entrance foyer and glazed to allow visibility from the nursing and clinical support area.

- Male and female staff restrooms, ADA accessible.

- A private office for a program services director will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- A private office for a psychiatrist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer, printer and dictation equipment.

- A private office for a psychologist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Private offices for two social workers will each be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The offices will be equipped with a computer and printer.

- A private office for the recreational therapist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared open office area will be sized to provide three unassigned workstations for use by habilitation aides, students and staff not assigned to the unit. The workstations will be divided by a four foot high acoustical partition. Each workstation will be equipped with a desk, chair, file and drawer space, and a computer. The workstations will share a printer.

Nursing and Clinical Support Area: This area will provide the area for unit treatment planning and medical activities, and will include the centralized nursing station that will facilitate routine staff monitoring of unit activities. Patient access to this area will be limited to the treatment planning room and medical treatment room. The medical treatment room and treatment planning room will be accessed from the nursing station and the entrance foyer. Access into the nursing and clinical support area will be controlled by staff within the nursing station or by the Building Access Center.

Components of the nursing and clinical support area will include:

- A nursing station sized to accommodate two workstations and the presence of two additional staff will be located to maximize observation of unit patient bedroom and leisure areas as well as to provide optimal monitoring of the crisis care area. The nursing station will be defined by a raised counter that will provide open and protected work space. The area will be equipped with three staff chairs, a Kardex documenting individual patient care plans, storage cabinets, and a computer.

- A treatment planning room will be sized to accommodate eight persons seated around a conference table, and will be located adjacent to the entrance foyer and the unit's medical records room. Glazing between the treatment planning room and the nursing station will facilitate staff observation into this area. The treatment planning room will be furnished with a conference table, eight chairs and a computer on a movable stand. The room will be used for patient-staff interactions and staff meetings when not needed for treatment planning. When more than eight persons are required at a treatment team meeting, use of the large multipurpose room in the visiting area may be scheduled.

- A medical records/charting room will provide space for the updating and maintenance of patient medical records and for enabling staff communication. One area of the medical records room will provide lateral files to accommodate patient current and prior records, and counter space for interim placement of records requiring signatures. A table with four chairs will afford staff space to

record patient progress and activities in the medical records. Wall cubicles will provide ready access to medical record and patient care forms and bins to route documentation to the appropriate staff or department. Dry marker boards and corkboards will be available for the recording of patient census information and posting of official notices.

The second area of the medical records room will include a workstation for the medical records clerk and a shared work space. The workstation and shared work space will be separated by a four foot high acoustical partition. The workstation for the ward clerk will provide counter and desktop space, overhead cabinets, and drawer space. This workstation will be equipped with a chair, telephone console and a computer. Transcription equipment will not be necessary since this is a contracted service. The shared work space will house a copy machine, fax machine, counter space, printer for the computers of the ward clerk, nursing station and treatment planning room; and storage for office supplies.

- A private office for the unit's nursing supervisor will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared office space will be sized to provide two unassigned workstations for use by nursing staff, particularly the nurses providing unit oversight when the nursing supervisor is not present. The workstations will be divided by a four foot high acoustical partition that will provide desktop and drawer space. Each workstation will be equipped with a chair and a computer.

- A medication administration room will be located adjacent to the entrance foyer. Access to this room will be through the nursing station or through a dutch door from the entrance foyer. The half door will provide the secure administration of medications to patients. The room will be sized for one nurse to administer medication or to be seated at a counter for transcribing physician orders or preparing medication administration records. The room will include a large medication cart, a refrigerator for the storage of medications and sharps, a lockable cabinet for the storage of controlled medication, cabinets for the storage of non-controlled medications and related supplies, a water cooler to provide water to patients during medication administration, and a sink for handwashing.

- The medical treatment room will include an anteroom furnished with a desk, chair, and a side chair for the completion of nursing assessments and individual patient health education that will include medication education and oral hygiene teaching. The side chair will be adaptable to permit the safe drawing of blood for laboratory testing. A container for the safe disposal of sharps will be provided.

- The medical treatment room will be utilized for medical assessments and treatments, as well as the administration of injectible medications. The room will provide an exam table and the medical equipment necessary for physical evaluations, a desk and chair for the physician or physician extender, a sink, cabinets for medical supplies, and containers for the disposal of sharps and medical waste. A small refrigerator for the storage of laboratory specimens awaiting pick-up will be located in the treatment room.

C. Intermediate Care Unit Staffing

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
DAY SHIFT							
Psychiatrist	X	X	X	X	X		
Program Services Director	X	X	X	X	X		
Psychologist	X	X	X	X	X		
Social Worker	X	X	X	X	X		
Social Worker	X	X	X	X	X		
Recreational Therapist	X	X	X	X	X		
Habilitation Aide		X	X	X	X	X	
Habilitation Aide	X	X	X	X			X
Ward Clerk	X	X	X	X	X		
Nursing Supervisor	X	X	X	X	X		
Registered Nurse	X	X	X	X	X	X	X
Registered Nurse	X					X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
EVENING SHIFT							
Registered Nurse	X	X	X	X	X	X	X
Registered Nurse	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
NIGHT SHIFT							
Registered Nurse	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
3.000	**PATIENT UNITS: CIVIL**							
3.100	ACUTE CARE (24 PATIENTS)							
	INTENSIVE ACUTE CARE (2 PATIENTS)							
3.101	Intensive Care Bedrooms	1	2	120 /room	240			Glazing on wall adjacent to corridor, visible from nursing station, bed, storage cabinet, chair; 1 ADA
3.102	ADA Patient Restroom/Shower	1	1	100 /room	100			Toilet with privacy screen, sink, shower with outer changing area, privacy screen, double shower head; ADA accessible
3.103	Treatment Room	3	1	100 /area	100			Table and 3 comfortable chairs, glazing of wall adjacent to corridor
3.104	Activity/Multipurpose/Dining	4	1	150 /area	150			Tables and chairs, sofa and side chairs, storage cabinet, television
3.105	Pantry	-	1	60 /area	60			Adjacent to multipurpose room; lockable; cabinets, small refrigerator, microwave, coffee-maker, sink, water cooler, countertop
3.106	Crisis Care Rooms	1	2	100 /area	200			Bed adapted for restraint application, acoustical attenuation
3.107	Crisis Care Ante-Room/ Restroom/Shower	1	1	120 /area	120			Space for staff observation, patient restroom, shower
3.108	Crisis Care Room Storage Closet	-	1	120 /area	120			Storage area for clean linen, supplies, restraints, and furniture storage; adjacent to anteroom
3.109	Staff Restroom	1	1	50 /area	50			ADA accessible
3.110	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
3.000	**PATIENT UNITS: CIVIL - cont'd**							
	ACUTE CARE (22 PATIENTS)							
3.111	Single Occupancy Bedrooms	1	4	120 /room	480			Bed, end table, desk, comfortable chair, closet with wardrobe insert, shelving; glazing with integral blinds on wall adjacent to corridor
3.112	Double Occupancy Bedrooms	2	9	200 /room	1,800			Two each of: bed, end table, desk, comfortable chair, closet with wardrobe insert, shelving; glazing with integral blinds on wall adjacent to corridor
3.113	Patient Restrooms/Showers	1	5	85 /room	425			Toilet with privacy screen, sink, shower with outer changing area, privacy screen
3.114	ADA Patient Restrooms/Showers	1	2	100 /room	200			Toilet with privacy screen, sink, shower with outer changing area, privacy screen, double shower head; ADA accessible
3.115	Tub Room	1	1	60 /area	60			Tub with privacy screen & screened changing, ADA accessible
3.116	Storage - Clean Linens	-	1	60 /area	60			Shelving for clean linens & personal hygiene items
3.117	Storage - Soiled Linens	-	1	60 /area	60			Cart storage for soiled linens
3.118	Leisure Room	8	1	30 /person	240			Table and 4 chairs, sofa and side chairs, shelving around windows, storage cabinet, television with a glazed barrier for acoustical separation
3.119	Telephone Booth	1	1	5 /area	5			Alcove within leisure room with acoustical privacy; ADA accessible
3.120	Leisure Room	16	1	30 /person	480			Table and 4 chairs, sofas and side chairs, shelving around windows, storage cabinet, television with a glazed barrier for acoustical separation
3.121	Telephone Booth	1	1	5 /area	5			Alcove within leisure room with acoustical privacy; ADA accessible
3.122	Snack/Vending Room	1-4	1	160 /area	160			Glazed room adjacent to indoor leisure rooms, vending machines, lockers for outdoor wear
3.123	Outdoor Leisure Area	20	1	3000 /area	(3,000)			Picnic tables, park benches, small garden, partially covered (awning) for weather protection; accessed from snack/vending area
3.124	Patient Clothing/Vault	4	1	300 /area	300			Hanging bags for patient clothing, large cubicles and shelving for patient belongings, secure storage for valuables and cash, countertop separating patient access area, computer; accessible from snack/vending area

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
3.000	**PATIENT UNITS: CIVIL - cont'd**							
	TREATMENT AREA							
3.125	Treatment Room	3	2	100 /area	200			Table and 3 comfortable chairs, glazing of wall adjacent to corridor
3.126	Group Treatment Room	8	1	25 /person	200			Moveable tables, comfortable chairs, whiteboard, magnet boards, storage cabinets, A/V capable, sink
3.127	Activity/Multipurpose	20	1	25 /person	500			5 small tables with 4 chairs each, storage cabinets, A/V capable, large screen TV and VCR and moveable stand
3.128	Storage Closet	-	1	40 /area	40			Lockable, within activity/multipurpose room
3.129	Pantry	-	1	80 /area	80			Adjacent to multipurpose room; lockable; cabinets, small refrigerator, microwave, coffee-maker, sink, water cooler, countertop, tray distribution area
3.130	Quiet Room	1	1	80 /area	80			Comfortable chair, glazed wall
3.131	Laundry Room	1-2	1	100 /area	100			Commercial quality washer & dryer, 2 work counters, slop sink, closet for ironing board, iron & supplies
3.132	Janitor Closet	-	2	40 /area	80			Slop sink, mop racks, ventilation
3.133	Trash Room	-	1	20 /area	20			
	STAFF OFFICE AREA							
3.134	Staff Break Room	4	1	150 /area	150			instant hot water, refrigerator, microwave, shelving; 35 staff lockers
3.135	Staff Restroom (M/F)	1	2	50 /area	100			ADA accessible
3.136	Program Services Director's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.137	Psychiatrist's Office	1	2	80 /office	160			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.138	Psychologist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.139	Social Workers' Office	1	2	80 /office	160			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.140	Recreational Therapist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.141	Shared Staff Workstations	1	3	60 /worksta.	180			Desktop space, chairs, computers, phones, half-height partitions, shared printer and lockable cabinet

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
3.000	**PATIENT UNITS: CIVIL - cont'd**							
	NURSING AND CLINICAL SUPPORT AREA							
3.142	Nursing Station	4	1	200 /area	200			2 work stations, raised counter, 3 chairs, Kardex, storage cabinets, computer
3.143	Treatment Planning Room	8	1	20 /person	160			Conference table with 8 chairs, computer on movable stand, glazing of walls adjacent to nursing station, adjacent to medical records room & entrance foyer
3.144	Medical Records/Charting Room	-	1	200 /area	200			Lateral files, table with 4 chairs, wall cubicles, whiteboard and corkboards; workstation with half-height partition, counter and desktop, overhead cabinets, chair, telephone console, computer; copier, fax, work counter, printer, supply cabinet
3.145	Nursing Supervisor's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.146	Shared Workspace	1	2	60 /worksta.	120			2 unassigned work stations with desk, chair, computer, phone, half-height partitions
3.147	Medication Administration Room	1	1	80 /area	80			Dutch door to nursing station, small refrigerator, automated pharmaceutical dispensing machine, lockable cabinets, water cooler, sink, work counter, medication cart
3.148	Medical Treatment Anteroom	2	1	60 /area	60			Desk, chair, side chair equipped for blood draw, sharps disposal
3.149	Medical Treatment Room	2	1	100 /area	100			Exam table, examination equipment, small desk, chair, sink, cabinets, sharps disposal, medical waste disposal, small refrigerator
Subtotal	3.100				8,745	1.50	13,118	
Subtotal	Outdoor Space				3,000			

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
3.000	**PATIENT UNITS: CIVIL - cont'd**							
3.200	INTERMEDIATE CARE (24 PATIENTS)							
	CRISIS CARE							
3.201	Crisis Care Rooms	1	2	100 /area	200			Bed adapted for restraint application, acoustical attenuation
3.202	Restroom/Shower	1	1	120 /area	120			Space for staff observation, patient restroom, shower
3.203	Closet	-	1	60 /area	60			storage; adjacent to anteroom
3.204	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
3.205	Single Occupancy Bedrooms	1	24	120 /room	2,880			Bed, end table, desk, comfortable chair, closet with wardrobe insert, shelving; glazing with integral blinds in bedroom wall adjacent to corridor
3.206	Patient Restrooms/Showers	1	10	85 /room	850			Toilet with privacy screen, sink, shower with outer changing area, privacy screen
3.207	ADA Patient Restrooms/Showers	1	2	100 /room	200			Toilet with privacy screen, sink, shower with outer changing area, privacy screen, double shower head; ADA accessible
3.208	Tub Room	1	1	60 /area	60			Tub with privacy screen & screened changing, ADA accessible
3.209	Storage - Clean Linens	-	1	60 /area	60			Shelving for clean linens & personal hygiene items
3.210	Storage - Soiled Linens	-	1	60 /area	60			Cart storage for soiled linens
3.211	Leisure Room	6	2	30 /person	360			Table and 4 chairs, sofa and side chairs, shelving around windows, storage cabinet, television with a glazed barrier for acoustical separation
3.212	Telephone Booth	1	1	5 /area	5			Alcove within leisure room with acoustical privacy; ADA accessible
3.213	Leisure Room	18	1	30 /person	540			3 tables each with 4 chairs, sofas and side chairs, shelving around windows, storage cabinet, television with a glazed barrier for acoustical separation
3.214	Telephone Booth	1	1	5 /area	5			Alcove within leisure room with acoustical privacy; ADA accessible
3.215	Snack/Vending Room	1-4	1	160 /area	160			Glazed room adjacent to indoor leisure rooms, vending machines, 24 patient lockers for outdoor wear
3.216	Outdoor Leisure Area	26	1	3000 /area	(3,000)			Picnic tables, benches, small garden, partially covered (awning) for weather protection; accessed from snack/vending area
3.217	Patient Clothing/Vault	4	1	300 /area	300			Hanging bags for patient clothing, large cubicles and shelving for patient belongings, secure storage for valuables and cash, countertop separating patient access area, computer; accessible from snack/vending area

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
3.000	**PATIENT UNITS: CIVIL - cont'd**							
	TREATMENT AREA							
3.218	Treatment Room	3	2	100 /area	200			Table and 3 comfortable chairs, glazing of wall adjacent to corridor
3.219	Group Treatment Room	8	1	25 /person	200			Moveable tables, comfortable chairs, whiteboard, magnet boards, storage cabinets, A/V capable, sink
3.220	Activity/Multipurpose	24	1	25 /person	600			6 small tables with 4 chairs each, storage cabinets, A/V capable, large screen TV and VCR and moveable stand
3.221	Storage Closet	-	1	40 /area	40			Lockable, within activity/multipurpose room
3.222	Pantry	-	1	80 /area	80			Adjacent to multipurpose room; lockable; cabinets, small refrigerator, microwave, coffee-maker, sink, water cooler, countertop, tray distribution area
3.223	Quiet Room	1	1	80 /area	80			Comfortable chair, glazed wall
3.224	Laundry Room	1-2	1	100 /area	100			Commercial quality washer & dryer, 2 work counters, slop sink, closet for ironing board, iron & supplies
3.225	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
3.226	Trash Room	-	1	20 /area	20			
	STAFF OFFICE AREA							
3.227	Staff Break Room	4	1	150 /area	150			instant hot water, refrigerator, microwave, shelving; 35 staff lockers
3.228	Staff Restroom (M/F)	1	2	50 /area	100			ADA accessible
3.229	Program Services Director's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.230	Psychiatrist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.231	Psychologist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.232	Social Workers' Office	1	2	80 /office	160			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.233	Recreational Therapist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.234	Shared Staff Workstations	1	3	60 /worksta.	180			Desktop space, chairs, computers, phones, half-height partitions, shared printer and lockable cabinet

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
3.000	**PATIENT UNITS: CIVIL - cont'd**							
	NURSING AND CLINICAL SUPPORT AREA							
3.235	Nursing Station	4	1	200 /area	200			2 work stations, raised counter, 3 chairs, Kardex, storage cabinets, computer
3.236	Treatment Planning Room	8	1	20 /person	160			Conference table with 8 chairs, computer on movable stand, glazing of walls adjacent to nursing station, adjacent to medical records room & entrance foyer
3.237	Medical Records/Charting Room	-	1	200 /area	200			Lateral files, table with 4 chairs, wall cubicles, whiteboard and corkboards; workstation with half-height partition, counter and desktop, overhead cabinets, chair, telephone console, computer; copier, fax, work counter, printer, supply cabinet
3.238	Nursing Supervisor's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
3.239	Shared Workspace	1	2	60 /worksta.	120			2 unassigned work stations with desk, chair, computer, phone, half-height partitions
3.240	Medication Administration Room	1	1	80 /area	80			Dutch door to nursing station, small refrigerator, automated pharmaceutical dispensing machine, lockable cabinets, water cooler, sink, work counter, medication cart
3.241	Medical Treatment Anteroom	2	1	60 /area	60			Desk, chair, side chair equipped for blood draw, sharps disposal
3.242	Medical Treatment Room	2	1	100 /area	100			Exam table, examination equipment, small desk, chair, sink, cabinets, sharps disposal, medical waste disposal, small refrigerator
Subtotal	3.200				9,170	1.50	13,755	
Subtotal	Outdoor Space				3,000			
Total	**3.000**				**17,915**		**26,873**	

4.000
Patient Units: Forensic

4.000 PATIENT UNITS: FORENSIC

Introduction

The Psychiatric Treatment Center will provide two forensic units for the inpatient treatment of adult males and females meeting the following criteria:

- Patients judged Not Criminally Responsible (NCR).
- Patients judged Incompetent to Stand Trial (IST).
- Patients for whom court-ordered evaluations are being conducted in an inpatient setting.
- Patients transferred from jails of the State of Maine.
- Patients transferred from prisons of the Maine Department of Correction.

The forensic patient areas will be designed to provide the same comfort and safety as provided in the hospital's civil units. Treatment will be provided in a milieu that promotes patient dignity and independence. The patient will be afforded staff supervision and personal privacy based on his/her current mental status. However, the forensic patient areas will provide the enhanced attention to security required for the safety of patients, staff and the community.

The Psychiatric Treatment Unit will provide two patient units for forensic patients, and is designed to facilitate future expansion if required. Each unit will have the capacity to provide appropriate treatment for patients in various phases of recovery. The patient units to be provided for forensic patients are as follows:

- High Security Forensic Unit: This 20-bed unit will provide the initial placement and acute care for all forensic patients admitted to the Psychiatric Treatment Center. NCR patients and IST patients will be transferred from the high security forensic unit to the intermediate care forensic unit subsequent to a treatment team recommendation that the high security environment is no longer required. Forensic patients admitted to the hospital from jails or prisons will generally remain on the high security forensic unit for their entire hospitalization. Six beds of this unit will be located to permit these beds to be flexibly included in the intermediate care forensic unit when needed.

- Intermediate Care Forensic Unit: This 24-bed unit will provide extended care for patients who have been admitted to the hospital as NCR or IST, and whose functioning has permitted treatment team recommendation and/or judicial approval of reduced security requirements. Most of these patients will have lengths of stay in excess of a year. Some patients may be hospitalized for decades due to the severity of their mental illness and/or history of dangerous behavior. NCR and IST patients must secure court approval to move from the hospital.

While the focus of the treatment on the high security and intermediate care forensic units will differ based on the patients being served, the principles of care will be the same. Both units will provide multidisciplinary treatment in the least restrictive environment that is consistent with the patient's current mental and security status. All patients will be engaged in active treatment focused on the reduction or management of symptoms and behaviors that led to the admission and the development of skills that will promote enhanced functioning over a sustained period.

All forensic patients will be provided private bedrooms. Private bedrooms on the high security forensic unit will ensure patient safety for a population in which there may be security as well as clinical risks. Patients on the intermediate care forensic unit will be provided private bedrooms to provide a more normal living environment during their extended hospital stays. Both units will include specialized beds where intensive intervention and supervision will be provided.

A patient's treatment will be guided by a treatment plan that is developed by a multidisciplinary clinical team and the patient. The plan will be based on an integrated multidisciplinary assessment completed within four days of the patient's admission. This assessment will include the integration of the patient's Individualized Support Plan (ISP) whenever an ISP exists. The treatment plan will be reviewed and updated to reflect changes in the patient's functioning and goals.

Offices of clinical staff of the patient's treatment team will be located within the unit to facilitate staff-patient interaction, staff-staff interaction and consistency in treatment team conduct.

Patients of the high security forensic unit will remain on the unit unless escorted by staff to the visitation area or medical clinic. These patients will receive treatment and dining within the secure unit. Patients of the high security forensic unit will not interact with patients of the intermediate care forensic unit or the civil patient units. As noted previously, a section of the high security forensic unit will be designed to flexibly provide additional housing of intermediate care forensic patients if needed.

Patients of the intermediate care forensic unit will be permitted access to the Treatment Mall based on treatment team approval. Thus, treatment and dining for these patients will occur both on the unit and on the Treatment Mall.

The forensic patient units will access the Treatment Mall, the admission/ discharge area, the visitation area and the administrative area through a major corridor. Access to the intermediate care forensic unit will be secured by locks controlled by unit staff or the Building Access Center. Access to the high security forensic unit will be controlled by the Building Access Center. Each forensic unit will have access to an outdoor recreation area.

The forensic patient units will be designed to permit the zoning and closure of treatment and staff office areas when these areas are not in use. This will facilitate the provision of staff supervision to areas where patients are present. The units will also allow the separation of living space to meet the clinical needs of specific patient groups.

Staffing levels of the forensic patient units will meet or exceed those required by the *Bates v. Duby* Consent Decree. The staff mix of each shift will be adequate to address the clinical needs of the patients currently residing on a unit.

HIGH SECURITY FORENSIC UNIT

A. Hours of Operation

24 hours a day, 7 days a week.

B. Operational Description

The high security forensic unit will be sized to provide treatment for 20 male and female adult patients. The unit will consist of an intensive care area for male patients, an area for the treatment of male patients requiring continued placement on the high security forensic unit, an intensive care area for female patients, an area for the treatment of female patients requiring continued placement on the high security forensic unit, nursing and clinical support area, and a staff office area. Each area will be accessed from an entrance foyer housing a nursing station. Six beds of the male treatment area will be located to permit flexible use by intermediate forensic care patients if needed.

Male and female patients of the high security forensic unit will not interact unless participating in therapeutic activities when recommended by the treatment team and closely supervised by staff.

Male Intensive Care Area: The male intensive care area will provide four high observation private bedrooms for male patients when admitted to the forensic unit or when exhibiting acute psychiatric distress. Two non-assigned rooms will permit intensive patient supervision and staff monitoring when seclusion or the use of restraints is clinically necessary. The intensive care area will be located adjacent to the nursing station and outside of the general patient circulation area. The area will be accessed from the nursing station and the entrance foyer.

Components of the male intensive care area will include:

- An intensive care corridor wide enough to facilitate the patient movement and pacing often experienced during acute psychiatric episodes.

- Four private patient bedrooms with glazing of the walls adjacent to the intensive care corridor and visible from the nursing station. Each bedroom will be sized to accommodate a bed, a small cabinet for the storage of the patient belongings approved by the psychiatrist, and a patient chair. Bedroom lighting will be controlled by staff from outside the room.

- Two patient restrooms with a sink, toilet, shower, a privacy screen or curtain, and space for non-intrusive staff supervision when the patient's status requires intensive monitoring will be located off the corridor near the patient bedrooms. One restroom will be ADA accessible.

- A treatment room for individual patient assessment and treatment will be sized to accommodate a small table and three comfortable chairs and will have glazing of the wall adjacent to the intensive care corridor.

- A multipurpose space for four patients and two staff will be provided for patient dining, small activities and patient relaxation will accommodate two small tables each with four chairs, a small sofa, three side chairs, a cabinet for supply storage, and a secured television.

- An area off the multipurpose space will include a small pantry containing a sink, refrigerator, microwave, coffee maker, water cooler, cabinets and counter space. Access to the pantry will be staff controlled.

- Two crisis care rooms will be sized to provide patient time-out, seclusion and restraint application in a safe manner. The location and acoustics of these rooms will optimize staff observation while minimizing patient stimulation and potential disruptions to the unit's therapeutic milieu. Each crisis care room will be furnished with a bed capable of restraint application although the bed may be removed when the patient would benefit most from only a mattress and bedding.

- The crisis care rooms will be accessed through a shared anteroom large enough to accommodate staff constant observation as well as safe patient and furniture movement. A patient restroom and shower large enough to accommodate unobtrusive staff monitoring will be located off the anteroom. The walls of the crisis care rooms and anteroom facing the nursing station will be glazed to ensure optimal staff observation.

- A closet large enough to accommodate the storage of clean linen, supplies, restraints and the furniture that must be removed from the intensive care bedrooms and crisis care rooms from time to time due to the patient's clinical condition will be located adjacent to the crisis care anteroom.

- Staff restroom.

- Janitor's closet.

High Security Forensic Male Patient Bedroom and Treatment Area: The male patient area will provide 12 private patient bedrooms and treatment space. The space will be designed to permit the flexible division of six of the bedrooms from the others when needed. A small bench-like area will be constructed outside bedroom doors to accommodate patients who are tentative about leaving their bedrooms.

Components of the male patient bedroom and treatment area will include:

- Twelve private patient bedrooms will be sized to accommodate one bed, a small desk and comfortable chair. A closet will house a wardrobe insert with drawers, shelving and clothing hanging space for the storage of patient belongings. The fixtures and mirror will be designed to reduce risk for self-harm. A small glazed area in the bedroom wall will facilitate unobtrusive staff observation; however, integral blinds will permit patient privacy when clinically appropriate. Bedroom doors will be double hinged to facilitate staff access when patients attempt to block entry.

- Six patient restrooms, each providing a toilet, sink and shower to be shared by two patients, will be located adjacent to the patient bedrooms. Two restrooms will be ADA accessible.

- A tub room will be provided with an outer changing area, and privacy screen.

- A large closet with shelving for the storage of patient hygiene supplies and clean linen.

- A closet for the collection of soiled linen.

- A leisure area able to accommodate 12 patients and two staff socializing, reading or watching television will be furnished with two sofas, three side chairs, end tables, a small table and four chairs, a bookcase for reading material, a lockable cabinet for the storage of leisure supplies, and a secured television. The area will be partitioned with glazing and furniture arranged to facilitate the use of the space for different simultaneous leisure activities. A small space for patients choosing personal time will be furnished with a comfortable chair and end table. A glazed booth with acoustical sound privacy will provide a counter, chair and telephone for patient use.

- A small recreation room with an exercise bike, treadmill and exercise mat will be provided for patient indoor exercise. Glazing of the wall adjacent to the common

area will ensure staff observation of patient use. Access to the exercise room will be controlled by staff.

- An outdoor leisure and recreation area will be accessed from the male patient living and treatment area. This area will be sized to accommodate 20 people for outdoor recreation. Three park benches, three picnic tables, and a small garden will provide an area for unstructured patient leisure and unit activities. An awning will be constructed over a portion of the outdoor recreation area to provide protection for patients who desire fresh air during inclement weather or protection from the sun when patients have been prescribed certain medications.

  The outdoor recreation area will include a half basketball court, since patients of the high security forensic unit will not have access to the Treatment Mall gym and recreation yard.

- A glazed area from the indoor leisure area to the outdoor area will include vending machines for patient snack periods. All items from the vending machines will be provided in plastic or paper containers. The space will also contain individual patient lockers for storage of outdoor wear. Access to this room from the indoor leisure areas will be controlled by staff and visible from the nursing station.

- A room adjacent to the indoor leisure rooms will provide space for the unit vault containing patient cash and valuables, and space for the storage of patient belongings not permitted in the patient bedrooms due to clinical concerns or space limitations. This room will include hanging bags for the storage of clothing as well as large cubicles and shelving to accommodate other patient belongings. The room will be subdivided by a counter to limit patient access to an area accommodating four persons for the staff distribution of cash and personal belongings to the patients. This area will be equipped with a computer for updating patient accounts.

- A quiet room furnished with a comfortable chair will be available for patients requiring a brief time-out period. The quiet room will have glazing to facilitate staff observation and will be located proximate to the nursing station.

- Two treatment rooms for individual patient assessment and treatment as well as discharge planning will be sized to accommodate a small table and three comfortable chairs, and will have glazing of the wall adjacent to the corridor. Access to these rooms will be controlled by staff.

- A group treatment room that is able to accommodate eight people either seated in a circle or comfortably seated around group tables will be utilized for psychotherapy and psychoeducational groups, as well as small arts and crafts groups. The group treatment room will be furnished with movable tables that can

be reconfigured, eight comfortable chairs, and dry marker and magnet boards. The room will be designed to facilitate the use of audiovisual equipment, and will include cabinets for the storage of arts and crafts supplies and a sink. Access to this room will be controlled by staff.

- A multipurpose room sized to accommodate 12 patients and two staff will be utilized for patient dining, unit community meetings, and additional treatment space. The multipurpose room will be furnished with four small tables each with four chairs, and a lockable cabinet for the storage of games and recreational items. The room will be designed to facilitate the use of audiovisual equipment. A closet will store a large screen TV and VCR on a movable stand. The multipurpose room will have staff controlled access to the room leading to the outdoor area.

  Dining for all patients of the high security forensic unit will occur in the multipurpose room. Dining will be accomplished by delivery of patient trays through a corridor between the multipurpose room and the hospital's main patient corridor. Meals will be served from a tray cart located in a pantry off the multipurpose room. The pantry will provide a sink, refrigerator, microwave, coffee maker, icemaker, counter space, cabinets, and adequate space for the placement of the meal tray cart and a second cart for the retrieval of trays after patients have completed their meals. A dutch door between the multipurpose room and pantry will enable patient receipt of trays without access to the pantry area. The pantry will be secured when not in use. The pantry will be located adjacent to the multipurpose rooms of both the male and female high security forensic living units to minimize the duplication of resources and the effort required to transfers trays to patient units.

- A laundry room to be used by one patient will include ironing space for patient personal clothing, and will be equipped with a commercial-grade washer and dryer, and counter space for laundry sorting and folding. A lockable closet will store an iron and ironing board as well as provide shelving for laundry supplies.

- Janitor's closet and trash room.

Female Intensive Care Area: The female intensive care area will provide two high observation private bedrooms for the initial placement of female forensic patients, female forensic patients experiencing acute psychiatric distress, and those requiring intensive supervision and staff monitoring when seclusion or use of restraints is clinically necessary. The intensive care area will be located adjacent to the nursing station.

Since the number of female forensic patients is limited and there will be fluctuations in need, the female intensive care area will be designed to permit its flexible use for

male intensive care or for female patient bedrooms via the locking or unlocking of doors accessing the male intensive care unit or female forensic patient bedroom unit. The female intensive care area will be accessed from the nursing station and from the entrance foyer.

Components of the female intensive care area will include:

- Two private patient bedrooms with glazing of the wall adjacent to the corridor and visible from the nursing station will be sized to accommodate a bed, a small cabinet for the storage of the patient belongings approved by the psychiatrist, and a patient chair. The beds will be capable of restraint application, although the bed and other furniture may be removed when the patient would benefit most from only a mattress and bedding. Bedroom lighting will be controlled by staff from outside the room.

- A patient restroom with sink, toilet, shower, and a privacy screen or curtain and space for non-intrusive staff supervision will be located near the patient bedrooms. The restroom will be ADA accessible.

- A multipurpose room for patients and two staff will be provided for patient dining, treatment, small activities and patient relaxation. The area will accommodate one small table with four chairs, a small sofa, one side chair, a cabinet for supply storage, and a secured television.

- An alcove off the multipurpose space will include a small pantry containing a sink, refrigerator, microwave, coffee maker, water cooler, cabinets, and counter space.

- A closet large enough to accommodate the storage of restraints; and furniture that must be removed from the intensive care bedrooms from time to time due to the patient's clinical condition. Clean linen and soiled linen storage will be provided by closets on the male intensive care unit.

High Security Forensic Female Patient Living and Treatment Area: The female patient living and treatment area will provide two private patient bedrooms and treatment space.

Components of the female patient living and treatment area will include:

- Two private patient bedrooms will be sized to accommodate one bed, a small desk, and a comfortable chair. A closet will house a wardrobe insert with drawers, shelving and clothing hanging space for the storage of patient belongings. The fixtures and mirror will be designed to reduce risk for self-harm. A small glazed area in the bedroom wall will facilitate unobtrusive staff

observation; however, integral blinds will permit patient privacy when clinically appropriate. Bedroom doors will be double hinged to facilitate staff access when patients attempt to block entry.

- One patient restroom providing a toilet, sink and shower will be shared by the two patients and located adjacent to the patient bedrooms. The restroom will be ADA accessible.

- A tub room will be provided with an outer changing area, and privacy screen. The tub room will be ADA accessible.

- A closet with shelving for the storage of patient hygiene supplies and clean linen.

- A closet for the collection of soiled linen.

- A leisure space able to accommodate two patients and two staff socializing, reading or watching television will be provided. The leisure space will be furnished with a sofa, one side chair, a small table and four chairs, a bookcase for reading material, a lockable cabinet for the storage of leisure supplies, and a secured television. A glazed booth with acoustical sound privacy will provide a counter, chair and telephone for patient use.

- The outdoor leisure/recreation area and exercise room provided for the male forensic patients will be utilized by the female forensic patients at designated times. Access from the female area to the outdoor recreation area will be through the glazed snack/vending room. This will permit female patient access to the vending machines and the room for the storage of patient cash and belongings. The exercise room will be located to facilitate female patient access with staff supervision.

- A. multipurpose room sized to accommodate three patients and two staff will be utilized for dining, unit community meetings, and treatment space. The multipurpose room will be furnished with two small tables each with three chairs, and a lockable cabinet for storage of games and arts and crafts supplies. The female multipurpose room will be adjacent to the male multipurpose room to facilitate staff of the female area access to the pantry for the distribution of female meal trays.

- A laundry room to be used by one patient will include ironing space for patient personal clothing, and will be equipped with a commercial-grade washer and dryer. The room will also provide counter space for laundry sorting and folding. A lockable closet will store an iron and ironing board, as well as provide shelving for laundry supplies.

- Janitor's closet and trash room.

Staff Office Area: This area will provide staff offices for the high security forensic unit's treatment team members as well as provide on-unit staff restrooms and a break area. The walls adjacent to the corridor will be glazed to facilitate observation. The area will be accessed from the entrance foyer adjacent to the nursing and clinical support area.

Components of the staff office area will include:

- An on-unit staff break area that will complement the centralized staff break area and provided a pleasant space for meals and snacks for staff unable to leave the unit. The break room will be equipped with a refrigerator, microwave, sink, small cabinet for supply storage, and a countertop, and will be furnished with a dining table able to accommodate four persons. The break room will include personal locker space for staff assigned to the unit. The break room will be located adjacent to the entrance foyer and glazed to allow visibility from the nursing station and medical support area.

- Male and female staff restrooms, ADA accessible.

- A private office for a program services director will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- A private office for a psychiatrist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- A private office for a psychologist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- A private office for a social worker will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- A private office for the recreational therapist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared open office area will be sized to provide three unassigned workstations for use by the treatment plan scribe, habilitation aides, students and staff not assigned to the unit. The workstations will be divided by a four foot high acoustical partition. Each workstation will be equipped with a desk chair,

desktop, file and drawer space, and a computer. The workstations will share a printer.

Nursing and Clinical Support Area: This area will provide the space for unit treatment planning and medical activities, and will include the centralized nursing station facilitating routine staff monitoring of unit activities. Patient access to this area will be limited to the treatment planning room and medical treatment room. The medical treatment room and treatment planning room will be accessed from the nursing station and the entrance foyer. Access into the nursing and clinical support area will be controlled by staff within the nursing station or by the Building Access Center.

Components of the nursing and clinical support area will include:

- A nursing station sized to accommodate two workstations, and the presence of two additional staff will be located to maximize observation of unit patient bedroom and leisure areas, as well as to provide optimal monitoring of the male and female intensive care areas. The nursing station will be defined by a raised counter that will provide open and protected workspace. The area will be equipped with three staff chairs, a Kardex documenting individual patient care plans, storage cabinets, and a computer. Access into the nursing and clinical support area will be controlled by staff within the nursing station or by the Building Access Center.

- A treatment planning room will be sized to accommodate eight people seated around a conference table, and will be located adjacent to the entrance foyer and the unit's medical records room. Glazing between the treatment planning room and the nursing station will facilitate staff observation into this area. The treatment planning room will be furnished with a conference table, eight chairs, and a computer on a movable stand. The room will be used for patient-staff interactions and staff meetings when not needed for treatment planning. When more than eight people are required at a treatment team meeting, use of the large multipurpose room may be scheduled.

- A medical records/charting room will provide space for the updating and maintenance of patient medical records and for enabling staff communication. One area of the medical records room will provide lateral files to accommodate patient current and prior records, and counter space for interim placement of records requiring signatures. A table with four chairs will afford staff space to record patient progress and activities in the medical records. Wall cubicles will provide ready access to medical record and patient care forms, and bins to route documentation to the appropriate staff or department. Dry marker and corkboards will be available for recording of patient census information and posting of official notices.

The second area of the medical records room will include a workstation for the medical records clerk and a shared work space. The workstation and shared workspace will be separated by a four foot high acoustical partition. The workstation for the ward clerk will provide counter and desktop space, overhead cabinets, and drawer space. This workstation will be equipped with a chair, telephone console and a computer. Transcription equipment will not be necessary since this is a contracted service. The shared work space will house a copy machine; fax machine; counter space; printer for the computers of the ward clerk, nursing station and treatment planning room; and storage for office supplies.

- A private office for the unit's nursing supervisor will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared office space will be sized to provide two unassigned workstations for use by nursing staff, particularly the nurse providing unit oversight when the nursing supervisor is not present. The workstations will be separated by a four foot high acoustical partition that will provide desktop and drawer space. Each workstation will be equipped with a desk chair and computer.

- A medication administration room will be located adjacent to the entrance vestibule. Access to this room will be through the nursing station or through a dutch door from the entrance foyer. The half door will provide the secure administration of medications to patients. The room will be sized for one nurse to administer medication or to be seated at a counter for transcribing physician orders or preparing medication administration records. The room will include a large medication cart, a refrigerator for the storage of medications, a lockable cabinet for the storage of controlled medication and sharps, cabinets for the storage of non-controlled medications and related supplies, a water cooler to provide water to patients during medication administration, and a sink for handwashing.

- The medical treatment room will include an anteroom furnished with a desk, chair, and a side chair for the completion of nursing assessments and individual patient health education that will include medication education and oral hygiene teaching. The side chair will be adaptable to permit the safe drawing of blood for laboratory testing. A container for the safe disposal of sharps will be provided.

- The medical treatment room will be utilized for medical assessments and treatments, as well as the administration of injectible medications. The room will provide an exam table and the medical equipment necessary for physical evaluations, a desk and chair for the physician or physician extender, a sink, cabinets for medical supplies, and containers for the disposal of sharps and

medical waste. A small refrigerator for the storage of laboratory specimens awaiting pick-up will be located in the treatment room.

C. High Security Forensic Unit Staffing:

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
DAY SHIFT							
Psychiatrist	X	X	X	X	X		
Program Services Director	X	X	X	X	X		
Psychologist	X	X	X	X	X		
Social Worker	X	X	X	X	X		
Recreational Therapist	X	X	X	X	X		
Habilitation Aide		X	X	X	X	X	
Habilitation Aide	X	X	X	X			X
Ward Clerk	X	X	X	X	X		
Nursing Supervisor	X	X	X	X	X		
Registered Nurse	X	X	X	X	X	X	X
Registered Nurse	X	X			X	X	X
Treatment Plan Scribe	X	X	X	X	X		
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
EVENING SHIFT							
Registered Nurse	X	X	X	X	X	X	X
Registered Nurse	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
NIGHT SHIFT							
Registered Nurse	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X

INTERMEDIATE CARE FORENSIC UNIT

A. Hours of Operation

24 hours a day, 7 days a week.

B. Operational Description

The intermediate care forensic unit will be sized to provide treatment for 24 male and female adult patients. This unit will be similar to the intermediate care unit for civil patients and thus will consist of a crisis care area, two groups of patient private bedrooms, leisure and treatment area, nursing and clinical support area, and a staff office area. Each area will be accessed from an entrance foyer housing a nursing station and a quiet area for patients desiring close proximity to staff.

Patients of the intermediate care forensic unit will be provided more personal belonging space than patients of the high security forensic unit, since the intermediate care patients will experience more extended hospital stays. The intermediate care forensic patient bedrooms will be wired for cable access. Each area will be totally compliant with ADA and applicable handicap accessibility codes.

Crisis Care Area: The crisis care area will provide two unassigned crisis care rooms to provide intensive patient supervision and monitoring during crisis episodes. The crisis care area will be located adjacent to the nursing station and outside of the general patient circulation area.

Components of the crisis care area will include:

- Two crisis care rooms will be sized to provide patient time-out, seclusion and restraint application in a safe manner. The location and acoustics of these rooms will optimize staff observation while minimizing patient stimulation and potential disruption to the unit's therapeutic milieu. Each crisis care room will be furnished with a bed capable of restraint application, although the bed may be removed when the patient would benefit most from only a mattress and bedding. Room lighting will be controlled by staff from outside the rooms.

- The crisis care rooms will be accessed through a shared anteroom large enough to accommodate staff constant observation as well as safe patient and furniture movement. A patient restroom and shower large enough to accommodate unobtrusive staff monitoring will be located off the anteroom. The walls of the crisis care rooms and anteroom facing the nursing station will be glazed to ensure optimal staff observation.

- A closet large enough to accommodate the storage of clean linen, supplies, restraints and the furniture that must be removed from the intensive care bedrooms and crisis care rooms from time to time due to the patient's clinical condition will be adjacent to the crisis care anteroom. A closet sized to accommodate shelving for the storage of clean linen, supply storage, and the storage of beds when removed from the crisis care rooms due to the patient's clinical condition.

- Janitor's closet.

Intermediate Care Forensic Patient Bedroom Area: The patient bedroom area of the intermediate care forensic unit will provide space for two patient groupings. One grouping will provide eight private patient bedrooms. The second grouping will provide 16 private patient bedrooms. Circulation between the two areas will normally be open, but may be restricted through movable partitions or doors based on patient need. The patient bedroom areas will be located within sight of the nursing station and will provide leisure as well as bedroom space. A small bench-like area will be constructed outside bedroom doors to accommodate patients tentative about moving from their bedroom to other areas of the unit.

Components of the two patient bedroom groupings will include:

- Twenty-four private patient bedrooms will be sized to accommodate one bed, a comfortable chair, and a wall unit containing shelving, counter and desk space. A closet will house a wardrobe insert with drawers, shelving and clothing hanging space for the storage of patient belongings. The fixtures and mirror will be designed to reduce risk for self-harm. A small glazed area in the bedroom wall will facilitate unobtrusive staff observation; nowever, integral blinds will permit patient privacy when clinically appropriate.

- Twelve patient restrooms, each providing a toilet, sink and shower to be shared by two patients, will be located adjacent to the patient bedrooms. Two restrooms will be ADA accessible.

- A tub room will provide an outer changing area and privacy screen. The tub room will be ADA accessible.

- The patient bedroom area for eight patients will include a leisure area able to accommodate eight patients and two staff socializing, reading or watching television. The leisure space will be furnished with one sofa, three side chairs, a small table and four chairs, a bookcase for reading material, a lockable cabinet for the storage of leisure supplies and games, and a secured television. The space will be partitioned with glazing and the furniture will be arranged to facilitate the use of the area for different simultaneous leisure activities. A small

space will be provided for patients choosing personal time, and will be furnished with a comfortable chair, an end table and lamp. Shelving for plants around the window areas will facilitate patient involvement in horticulture activities, as well as enhance the therapeutic environment. A glazed booth with acoustical sound privacy will provide a counter, chair and telephone for patient use.

- The patient bedroom grouping for 16 patients will include a leisure space able to accommodate 16 patients and two staff socializing, reading or watching television. The leisure space will be furnished with four sofas, six side chairs, end tables, two small tables each with four chairs, a bookcase for reading material, a lockable cabinet for the storage of leisure supplies and games, and a secured television. The space will be partitioned with glazing and the furniture will be arranged to facilitate the use of the area for different simultaneous leisure activities. Two small spaces will be provided for patients choosing personal time. Each of these areas will be furnished with a comfortable chair, an end table and lamp. Shelving for plants around the window areas will facilitate patient involvement in horticulture activities, as well as enhance the therapeutic environment. A glazed booth with acoustical sound privacy will provide a counter, chair and telephone for patient use.

- A large closet with shelving for the storage of patient hygiene supplies, unit supplies, and clean linen.

- A closet for the collection of soiled linen.

- An outdoor leisure area will be accessed from the two patient bedroom groupings. The outdoor area will be sized to accommodate 26 persons engaged in quiet recreation. Four park benches, five picnic tables, and a small garden will provide space for unstructured patient leisure as well as such unit activities as picnics. An awning will be constructed over a portion of the outdoor recreation area to provide protection for patients who desire fresh air during inclement weather or protection from the sun for patients prescribed certain medications.

- A glazed snack/vending area providing access from the indoor leisure areas to the outdoor area will include vending machines for patient snack periods. All items from the vending machines will be provided in plastic or paper containers. The space will also contain individual patient lockers for storage of outdoor wear. Access to this room from the indoor leisure areas will be controlled by staff and visible from the nursing station.

- A large room adjacent to the snack/vending area will provide secure space for the unit vault containing patient cash and valuables and space for the storage of patient belongings not permitted in the patient bedrooms due to clinical concerns or space limitations. This room will include hanging bags for the storage of clothing as well as large cubicles and shelving to accommodate other patient

belongings. This room will be subdivided by a counter to limit patient access to an area accommodating four persons for staff distribution of cash and personal belongings to the patients. This area will be equipped with a computer for updating patient accounts.

- A quiet room able to accommodate a comfortable chair for patients requiring a brief time-out period will have a glazed wall to facilitate staff observation.

Treatment Area: While the treatment area of the intermediate care forensic unit will provide treatment and recreational space for all unit patients, use of this area will be primarily by patients whose current mental status precludes participation on the Treatment Mall or during hours when the Treatment Mall is not operational.

Components of the treatment area will include:

- Two treatment rooms for individual patient assessment and treatment as well as discharge planning with community providers will be sized to accommodate a small table and three comfortable chairs, and will have glazing of the wall adjacent to the corridor.

- A group treatment room that is able to accommodate eight people either seated in a circle or comfortably seated around group tables will be utilized for psychotherapy and psychoeducational groups, as well as small arts and crafts activities. The room will be furnished with movable tables that can be reconfigured, eight comfortable chairs, and dry marker and magnet boards. The room will be designed to facilitate the use of audiovisual equipment, and will include cabinets for the storage of arts and crafts supplies and a sink.

- A multipurpose room sized to accommodate 24 seated persons and two staff will be utilized for unit community meetings and activities, additional treatment space, and on-unit dining when needed for specific patients. The space will enable the provision of holiday parties, bingo games and large group events such as movies, as well as provide space for staff meetings. The multipurpose room will be furnished with six small tables each with four chairs, and a lockable cabinet for storage of games and recreational items. The room will be designed to facilitate the use of audiovisual equipment and will have a closet for the storage of a large screen TV and VCR on a movable stand. The multipurpose room will have staff controlled access to the snack/vending room, which provides entry to the outdoor leisure area.

- A small pantry providing a sink, refrigerator, microwave, coffee maker, icemaker, counter space and cabinets will be located off the multipurpose room for use during patient dining and social activities. The pantry will be large enough to accommodate the distribution of meal trays received from the central kitchen for

patients not able to access the centralized dining area. The pantry will have lockable doors to ensure security when the area is not being used.

- A laundry room sized to be used simultaneously by two patients will include ironing space for patient personal clothing and will be equipped with a commercial-grade washer and dryer. The room will also provide two counter spaces for laundry sorting and folding. A lockable closet will store an iron and ironing board as well as provide shelving for laundry supplies.

- Janitor's closet and trash room.

Staff Office Area: This area will provide staff offices for the unit's treatment team members as well as provide on-unit staff restrooms and staff break areas. Office walls adjacent to the corridor will be glazed to facilitate observation. The area will be accessed from the entrance foyer adjacent to the nursing and clinical support area.

Components of the staff office area will include:

- An on-unit staff break area that will complement the centralized staff break area and provided a pleasant space for meals and snacks for staff unable to leave the unit. The break room will be equipped with a refrigerator, microwave, sink, small cabinet for supply storage, a countertop, and a table able to accommodate four persons. The break room will include personal locker space for staff assigned to the unit. The break room will be located adjacent to the entrance foyer and glazed to allow visibility from the nursing and clinical support area.

- Male and female staff restrooms, ADA accessible.

- A private office for a program services director will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- A private office for a psychiatrist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer, printer and dictation equipment.

- A private office for a psychologist will be sized to will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Private offices for two social workers will each be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The offices will be equipped with a computer and printer.

- A private office for the recreational therapist will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared open office area will be sized to provide three unassigned workstations for use by habilitation aides, students and staff not assigned to the unit. The workstations will be divided by a four foot high acoustical partition. Each workstation will be equipped with a desk chair, desktop, file and drawer space, and a computer. The workstations will share a printer.

Nursing and Clinical Support Area: This area will provide the space for unit treatment planning and medical activities, and will include the centralized nursing station that will facilitate routine staff monitoring of unit activities. Patient access to this area will be limited to the treatment planning room and medical treatment room. The medical treatment room and treatment planning room will be accessed from the nursing station and the entrance foyer.

Components of the nursing and clinical support area will include:

- A nursing station sized to accommodate two workstations and the presence of two additional staff will be located to maximize observation of unit patient bedroom and leisure areas as well as to provide optimal monitoring of the crisis care area. The nursing station will be defined by a raised counter that will provide open and protected work space. The area will be equipped with three staff chairs, a Kardex documenting individual patient care plans, storage cabinets, and a computer. Access into the nursing and clinical support area will be controlled by staff within the nursing station or by the Building Access Center.

- A treatment planning room will be sized to accommodate eight people seated around a conference table and will be located adjacent to the entrance foyer and the unit's medical records room. Glazing between the treatment planning room and the nursing station will facilitate staff observation into this area. The treatment planning room will be furnished with a conference table, eight chairs and a computer on a movable stand. The room will be used for patient-staff interactions and staff meetings when not needed for treatment planning. When more than eight persons are required at a treatment team meeting, use of the large multipurpose room in the visiting area may be scheduled.

- A medical records room will provide space for the updating and maintenance of patient medical records and for enabling staff communication. One area of the medical records room will provide lateral files to accommodate patient current and prior records and counter space for interim placement of records requiring signatures. A table with four chairs will afford staff space to record patient progress and activities in the medical records. Wall cubicles will provide ready

access to medical record and patient care forms and bins to route documentation to the appropriate staff or department. Dry marker and corkboards will permit the recording of patient census information and posting of official notices.

The second area of the medical records room will include a workstation for the medical records clerk and a shared work space. The workstation and shared work space will be separated by a four foot high acoustical partition. The ward clerk's workstation will provide counter and desktop space, overhead cabinets, and drawer space. This workstation will be equipped with a chair, telephone console and a computer. Transcription equipment will not be necessary since this is a contracted service. The shared work space will house a copy machine, fax machine, counter space, printer for computers of the ward clerk, nursing station and treatment planning room, and storage for office supplies.

- A private office for the unit's nursing supervisor will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared office space will be sized to provide two unassigned workstations for use by nursing staff, particularly the nurse providing unit oversight when the nursing supervisor is not present. The workstations will be divided by a four foot high acoustical partition. Each workstation will be equipped with a desk chair, desktop, file and drawer space, and a computer.

- A medication administration room will be located adjacent to the entrance foyer. Access to this room will be through the nursing station or through a dutch door from the entrance foyer. The half door will provide the secure administration of medications to patients. The room will be sized for one nurse to administer medication or to be seated at a counter for transcribing physician orders or preparing medication administration records. The room will include a large medication cart, a refrigerator for the storage of medications, a lockable cabinet for the storage of controlled medication and sharps, cabinets for the storage of non-controlled medications and related supplies, a water cooler to provide water to patients during medication administration, and a sink for handwashing.

- The medical treatment room will be utilized for medical assessments and treatments as well as the administration of injectible medications. The room will provide an exam table and the medical equipment necessary for physical evaluations, a desk and chair for the physician or physician extender, a sink, cabinets for medical supplies, and containers for the disposal of sharps and medical waste. A small refrigerator for the storage of laboratory specimens awaiting pick-up will be located in the treatment room.

- The medical treatment room will include an anteroom furnished with a desk, chair, and a side chair for the completion of nursing assessments and individual

patient health education that will include medication education and oral hygiene teaching. The side chair will be adaptable to permit the safe drawing of blood for laboratory testing. A container for the safe disposal of sharps will be provided.

C. Intermediate Care Forensic Unit Staffing:

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
DAY SHIFT							
Psychiatrist	X	X	X	X	X		
Program Services Director	X	X	X	X	X		
Psychologist	X	X	X	X	X		
Social Worker	X	X	X	X	X		
Social Worker	X	X	X	X	X		
Recreational Therapist	X	X	X	X	X		
Habilitation Aide		X	X	X	X	X	
Habilitation Aide	X	X	X	X			X
Ward Clerk	X	X	X	X	X		
Nursing Supervisor	X	X	X	X	X		
Registered Nurse	X	X	X	X	X	X	X
Registered Nurse	X					X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
EVENING SHIFT							
Registered Nurse	X	X	X	X	X	X	X
Registered Nurse	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
NIGHT SHIFT							
Registered Nurse	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X
Mental Health Worker	X	X	X	X	X	X	X

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
4.000	**PATIENT UNITS: FORENSIC**							
4.100	HIGH SECURITY FORENSIC (20 PATIENTS)							
	MALE INTENSIVE CARE (4 PATIENTS)							
4.101	Intensive Care Bedrooms	1	4	120 /room	480			Glazing on walls adjacent to corridor, visible from nursing station, bed, storage cabinet, chair; 1 ADA
4.102	Patient Restroom/Shower	1	1	85 /room	85			Toilet with privacy screen, sink, shower with outer changing area, privacy screen
4.103	ADA Patient Restroom/Shower	1	1	100 /room	100			Toilet with privacy screen, sink, shower with outer changing area, privacy screen, double shower head; ADA accessible
4.104	Treatment Room	3	1	100 /area	100			Table and 3 comfortable chairs, glazing of wall adjacent to corridor
4.105	Activity/Multipurpose/Dining	1	6	25 /person	150			Tables and chairs, sofa and side chairs, storage cabinet, television
4.106	Pantry	-	1	80 /area	80			Adjacent to multipurpose room; lockable; cabinets, small refrigerator, microwave, coffee-maker, sink, water cooler, countertop, staging area for tray distribution
4.107	Crisis Care Rooms	1	2	100 /area	200			Bed adapted for restraint application, acoustical attenuation
4.108	Crisis Care Ante-Room/ Restroom/Shower	1	1	120 /area	120			Space for staff observation, patient restroom, shower
4.109	Crisis Care Room Storage Closet	-	1	120 /area	120			Storage area for clean linen, supplies, restraints, and furniture storage; adjacent to anteroom
4.110	Staff Restroom	1	1	50 /area	50			ADA accessible
4.111	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
4.000	**PATIENT UNITS: FORENSIC - cont'd**							
	MALE HIGH SECURITY (12 PATIENTS)							
4.112	Single Occupancy Bedrooms	1	12	120 /room	1,440			Bed, desk, comfortable chair, closet with wardrobe insert, shelving; glazing with integral blinds in bedroom wall adjacent to corridor, double hinged doors
4.113	Patient Restrooms/Showers	1	4	85 /room	340			Toilet with privacy screen, sink, shower with outer changing area, privacy screen
4.114	ADA Patient Restrooms/Showers	1	2	100 /room	200			Toilet with privacy screen, sink, shower with outer changing area, privacy screen, double shower head; ADA accessible
4.115	Tub Room	1	1	60 /area	60			Tub with privacy screen & screened changing, ADA accessible
4.116	Storage - Clean Linens	-	1	60 /area	60			Shelving for clean linens & personal hygiene items
4.117	Storage - Soiled Linens	-	1	60 /area	60			Cart storage for soiled linens
4.118	Leisure Room	14	1	30 /person	420			Table and 4 chairs, sofa and side chairs, shelving around windows, storage cabinet, television with a glazed barrier for acoustical separation
4.119	Telephone Booth	1	1	5 /area	5			Alcove within leisure room with acoustical privacy; ADA accessible
4.120	Exercise Room	2	1	80 /area	80			Exercise bike and exercise mat; lockable
4.121	Snack/Vending Room	1-4	1	100 /area	100			Glazed room adjacent to indoor leisure rooms, vending machines, lockers for outdoor wear
4.122	Outdoor Leisure Area	12	1	3000 /area	(3,000)			Picnic tables, park benches, small garden, partially covered (awning) for weather protection, half basketball court (50'x50'); accessed from snack/vending area
4.123	Patient Clothing/Vault	2	1	200 /area	200			Hanging bags for patient clothing, large cubicles and shelving for patient belongings, secure storage for valuables and cash, countertop separating patient access area, computer; accessible from snack/vending area

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
4.000	**PATIENT UNITS: FORENSIC - cont'd**							
	TREATMENT AREA							
4.124	Treatment Room	3	2	100 /area	200			Table and 3 comfortable chairs, glazing of wall adjacent to corridor
4.125	Group Treatment Room	8	1	25 /person	200			Moveable tables, comfortable chairs, whiteboard, magnet boards, storage cabinets, A/V capable, sink
4.126	Activity/Multipurpose/Dining	14	1	25 /person	350			4 small tables with 4 chairs each, storage cabinets, A/V capable, large screen TV and VCR and moveable stand
4.127	Storage Closet	-	1	40 /area	40			Lockable, within activity/multi-purpose room
4.128	Pantry	-	1	140 /area	140			Adjacent to multipurpose rooms of both male and female forensic units; lockable; cabinets, small refrigerator, microwave, coffee-maker, sink, water cooler, countertop, staging area for meal carts/food tray distribution, dutch door
4.129	Quiet Room	1	1	80 /area	80			Comfortable chair, glazed wall
4.130	Laundry Room	1	1	100 /area	100			Commercial quality washer & dryer, work counter, slop sink, closet for ironing board, iron & supplies
4.131	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
4.132	Trash Room	-	1	20 /area	20			
	FEMALE INTENSIVE CARE (2 PATIENTS)							
4.133	Intensive Care Bedrooms	1	2	120 /room	240			Glazing on wall adjacent to corridor, visible from nursing station, bed, storage cabinet, chair
4.134	ADA Patient Restroom/Shower	1	1	100 /room	100			Toilet with privacy screen, sink, shower with outer changing area, privacy screen, double shower head; ADA accessible
4.135	Activity/Multipurpose/Dining	4	1	150 /area	150			Table and chairs, sofa and side chairs, storage cabinet, television
4.136	Pantry	-	1	40 /area	40			Adjacent to multipurpose room; lockable; cabinets, small refrigerator, microwave, coffee-maker, sink, water cooler, countertop

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
4.000	**PATIENT UNITS: FORENSIC - cont'd**							
	FEMALE HIGH SECURITY (2 PATIENTS)							
4.137	Single Occupancy Bedrooms	1	2	120 /room	240			Bed, desk, comfortable chair, closet with wardrobe insert, shelving; glazing with integral blinds on wall adjacent to corridor, double hinged doors
4.138	ADA Patient Restroom/Shower	1	1	100 /room	100			Toilet with privacy screen, sink, shower with outer changing area, privacy screen, double shower head; ADA accessible
4.139	Tub Room	1	1	60 /area	60			Tub with privacy screen & screened changing, ADA accessible
4.140	Storage - Clean Linens	-	1	25 /area	25			Shelving for clean linens and supplies
4.141	Storage - Soiled Linens	-	1	40 /area	40			Cart storage for soiled linens
4.142	Leisure Room	4	1	30 /person	120			Table and 4 chairs, sofa and side chairs, shelving around windows, storage cabinet, television with a glazed barrier for acoustical separation
4.143	Telephone Booth	1	1	5 /area	5			Alcove within leisure room with acoustical privacy; ADA accessible
4.144	Activity/Multipurpose/Dining	4	1	150 /area	150			3 small tables with 4 chairs each, storage cabinets, A/V capable, large screen TV and VCR and moveable stand
4.145	Laundry Room	1	1	100 /area	100			Commercial quality washer & dryer, work counter, slop sink, closet for ironing board, iron & supplies
4.146	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
4.147	Trash Room	-	1	10 /area	10			
	STAFF OFFICE AREA							
4.148	Staff Break Room	4	1	150 /area	150			instant hot water, refrigerator, microwave, shelving; 35 staff lockers
4.149	Staff Restroom (M/F)	1	2	50 /area	100			ADA accessible
4.150	Program Services Director's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.151	Psychiatrist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.152	Psychologist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
4.000	**PATIENT UNITS: FORENSIC - cont'd**							
4.153	Social Workers' Office	1	2	80 /office	160			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.154	Recreational Therapist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.155	Shared Staff Workstations	1	3	60 /worksta.	180			Desktop space, chairs, computers, phones, half-height partitions, shared printer and lockable cabinet
	NURSING AND CLINICAL SUPPORT AREA							
4.156	Nursing Station	4	1	200 /area	200			2 work stations, raised counter, 3 chairs, Kardex, storage cabinets, computer
4.157	Treatment Planning Room	8	1	20 /person	160			Conference table with 8 chairs, computer on movable stand, glazing of walls adjacent to nursing station, adjacent to medical records room & entrance foyer
4.158	Medical Records/Charting Room	-	1	200 /area	200			Lateral files, table with 4 chairs, wall cubicles, whiteboard and corkboards; workstation with half-height partition, counter and desktop, overhead cabinets, chair, telephone console, computer; copier, fax, work counter, printer, supply cabinet
4.159	Nursing Supervisor's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.160	Shared Workspace	1	2	60 /worksta.	120			2 unassigned work stations with desk, chair, computer, phone, half-height partitions
4.161	Medication Administration Room	1	1	80 /area	80			Dutch door to nursing station, small refrigerator, automated pharmaceutical dispensing machine, lockable cabinets, water cooler, sink, work counter, medication cart
4.162	Medical Treatment Anteroom	2	1	60 /area	60			Desk, chair, side chair equipped for blood draw, sharps disposal
4.163	Medical Treatment Room	2	1	100 /area	100			Exam table, examination equipment, small desk, chair, sink, cabinets, sharps disposal, medical waste disposal, small refrigerator
Subtotal	4.100				8,990	1.50	13,485	
Subtotal	Outdoor Space				3,000			

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
4.000	**PATIENT UNITS: FORENSIC - cont'd**							
4.200	INTERMEDIATE CARE FORENSIC (24 PATIENTS)							
	CRISIS CARE							
4.201	Crisis Care Rooms	1	2	100 /area	200			Bed adapted for restraint application, acoustical attenuation
4.202	Restroom/Shower	1	1	120 /area	120			Space for staff observation, patient restroom, shower
4.203	Closet	-	1	100 /area	100			storage; adjacent to anteroom
4.204	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
4.205	Single Occupancy Bedrooms	1	24	120 /room	2,880			Bed, end table, wall unit with desktop space comfortable chair, closet with wardrobe insert, shelving; glazing with integral blinds on wall adjacent to corridor
4.206	Patient Restroom/Shower	1	10	85 /room	850			Toilet with privacy screen, sink, shower with outer changing area, privacy screen
4.207	ADA Patient Restroom/Shower	1	2	100 /room	200			Toilet with privacy screen, sink, shower with outer changing area, privacy screen, double shower head; ADA accessible
4.208	Tub Room	1	1	60 /area	60			Tub with privacy screen & screened changing, ADA accessible
4.209	Storage - Clean Linens	-	1	60 /area	60			Shelving for clean linens & personal hygiene items
4.210	Storage - Soiled Linens	-	1	60 /area	60			Cart storage for soiled linens
4.211	Leisure Room	15	1	30 /person	450			Table and 4 chairs, sofa and side chairs, shelving around windows, storage cabinet, television with a glazed barrier for acoustical separation
4.212	Telephone Booth	1	1	5 /area	5			Alcove within leisure room with acoustical privacy; ADA accessible
4.213	Leisure Room	15	1	30 /person	450			2 tables with 4 chairs, sofas and side chairs, shelving around windows, storage cabinet, television with a glazed barrier for acoustical separation
4.214	Telephone Booth	1	1	5 /area	5			Alcove within leisure room with acoustical privacy; ADA accessible
4.215	Snack/Vending Room	1-4	1	120 /area	120			Glazed room adjacent to indoor leisure rooms, vending machines, lockers for outdoor wear
4.216	Outdoor Leisure Area	26	1	3000 /area	(3,000)			Picnic tables, benches, small garden, partially covered (awning) for weather protection; accessed from snack/vending area
4.217	Patient Clothing/Vault	4	1	300 /area	300			Hanging bags for patient clothing, large cubicles and shelving for patient belongings, secure storage for valuables and cash, countertop separating patient access area, computer; accessible from snack/vending area

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
4.000	**PATIENT UNITS: FORENSIC - cont'd**							
	TREATMENT AREA							
4.218	Treatment Room	3	2	100 /area	200			Table and 3 comfortable chairs, glazing of wall adjacent to corridor
4.219	Group Treatment Room	8	1	25 /person	200			Moveable tables, comfortable chairs, whiteboard, magnet boards, storage cabinets, A/V capable, sink
4.220	Activity/Multipurpose	24	1	25 /person	600			6 small tables with 4 chairs each, storage cabinets, A/V capable, large screen TV and VCR and moveable stand
4.221	Storage Closet	-	1	40 /area	40			Lockable, within activity/multipurpose room
4.222	Pantry	-	1	100 /area	100			Adjacent to multipurpose room; lockable; cabinets, small refrigerator, microwave, coffee-maker, sink, water cooler, countertop, staging area for tray distribution
4.223	Quiet Room	1	1	80 /area	80			Comfortable chair, glazed wall adjacent to corridor
4.224	Laundry Room	1-2	1	100 /area	100			Commercial quality washer & dryer, 2 work counters, slop sink, closet for ironing board, iron & supplies
4.225	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
4.226	Trash Room	-	1	20 /area	20			
	STAFF OFFICE AREA							
4.227	Staff Break Room	4	1	150 /area	150			instant hot water, refrigerator, microwave, shelving; 35 staff lockers
4.228	Staff Restroom (M/F)	1	2	50 /area	100			ADA accessible
4.229	Program Services Director's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.230	Psychiatrist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.231	Psychologist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.232	Social Workers' Office	1	2	80 /office	160			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.233	Recreational Therapist's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.234	Shared Staff Workstations	1	3	60 /worksta.	180			Desktop space, chairs, computers, phones, half-height partitions, shared printer and lockable cabinet

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
4.000	**PATIENT UNITS: FORENSIC - cont'd**							
	NURSING AND CLINICAL SUPPORT AREA							
4.235	Nursing Station	4	1	200 /area	200			2 work stations, raised counter, 3 chairs, Kardex, storage cabinets, computer
4.236	Treatment Planning Room	8	1	20 /person	160			Conference table with 8 chairs, computer on movable stand, glazing of walls adjacent to nursing station, adjacent to medical records room & entrance foyer
4.237	Medical Records/Charting Room	-	1	200 /area	200			Lateral files, table with 4 chairs, wall cubicles, whiteboard and corkboards; workstation with half-height partition, counter and desktop, overhead cabinets, chair, telephone console, computer; copier, fax, work counter, printer, supply cabinet
4.238	Nursing Supervisor's Office	1	1	80 /office	80			Desk, chair, phone, file cabinet, computer, printer, bookshelves, visitor chair
4.239	Shared Workspace	1	2	60 /worksta.	120			2 unassigned work stations with desk, chair, computer, phone, half-height partitions
4.240	Medication Administration Room	1	1	80 /area	80			Dutch door to nursing station, small refrigerator, automated pharmaceutical dispensing machine, lockable cabinets, water cooler, sink, work counter, medication cart
4.241	Medical Treatment Anteroom	2	1	60 /area	60			Desk, chair, side chair equipped for blood draw, sharps disposal
4.242	Medical Treatment Room	2	1	100 /area	100			Exam table, examination equipment, small desk, chair, sink, cabinets, sharps disposal, medical waste disposal, small refrigerator
Subtotal	4.200				9,190	1.50	13,785	
Subtotal	Outdoor Space				3,000			
Total	**4.000**				**18,180**		**27,270**	

5.000
Centralized Program Services

5.000 CENTRALIZED PROGRAMMING SERVICES

A. Hours of Operation

While patient programming will be provided on the centralized Treatment Mall between the hours of 8:00 AM and 8:00 PM every day, the major programming in this area will occur between the hours of 8:00 AM and 4:00 PM, Monday through Friday.

B. Operational Description

Treatment and programming will be provided on each patient unit. However, programming efforts will be focused within a centralized Treatment Mall for patients who have recovered from the most acute phase of psychiatric disturbance. The centralized area will provide the patient services and programs required for therapeutic benefits and enhanced quality of life. The area will also provide patients with ready access to peer support and advocacy services.

Best clinical practices indicate that patient participation in Treatment Mall activities will also provide patients and staff an opportunity to evaluate the patient's ability to cope with group situations in a community-like environment. Since the Treatment Mall will be located within the secure perimeter, patients will be afforded freedom of movement and choice of program involvement without risk to the safety of the patient or community.

Treatment Mall programming will include educational and recreational activities as well as traditional psychotherapies. Clinically-driven programming will offer patients the maximum opportunity to achieve their treatment goals and gain the social and coping skills necessary for successful reintegration into the community.

The patient's multidisciplinary team will determine when a patient is able to safely participate in Treatment Mall activities with or without individual staff supervision. The treatment team will cooperate with the patient in developing a schedule of activities within the Treatment Mall that are consistent with the patient's interests and treatment needs. While a patient's initial participation may be limited in time and variety due to his/her clinical condition, this participation will be designed to foster patient motivation for continued recovery and additional involvement in therapeutic programming.

Developing and maintaining Treatment Mall programming that engages patients is essential from a clinical and staff perspective. While eleven staff will be assigned to the Treatment Mall, unit-based hospital staff will also be providing treatment and monitoring within this area. To ensure adequate staff presence on the Treatment

Mall, the number of patients present on the mall must be great enough to permit unit-based staff to leave the patient units without compromising the unit's safety.

Programming options to be offered on the Treatment Mall include the following: psychotherapeutic groups, psychoeducational groups focused on understanding mental illness and activities of daily living, substance abuse treatment, academic training, vocational rehabilitation, art and music therapy, pottery, cooking groups, horticulture groups, structured leisure activities, and therapeutic exercise.

Space for religious services, unstructured leisure activities, indoor and outdoor recreation, and large group activities will also be provided. The patient library, barber/beauty shop, patient meditation room, and gymnasium will also be located on the Treatment Mall.

Offices for the chaplain, patient advocate and peer specialists will be located in this area, thereby facilitating patient access to these important resources. Finally, the Treatment Mall will provide access to the centralized patient dining rooms and the patient medical clinic, discussed in Sections 10.000 and 8.000, respectively.

The Treatment Mall will be designed to permit programming in two distinct areas. The areas for recreational and leisure activities and a large multipurpose room will be available for patient use everyday from 8:00 AM until 8:00 PM. Access to staff offices and clinical treatment areas will be limited to 8:00 AM until 4:00 PM, Mondays through Fridays. This organization of space will ensure optimal patient utilization of the Treatment Mall while reducing the area requiring staff supervision when staff presence is limited.

The walls of all rooms on the Treatment Mall will be glazed to facilitate staff observation of patient activities and interactions. Each room and specific location on the Treatment Mall will be lockable, with the keys provided to designated clinical and security staff. Rooms will be locked when not in use.

Daytime Treatment Mall Programming Spaces: The following is an outline of the Treatment Mall programming spaces that will be operational from 8:00 AM to 4:00 PM, Monday through Friday:

- A group treatment room that is able to accommodate eight patients and two staff either seated in a circle or comfortably seated around group tables will be utilized for psychotherapy and psychoeducational groups. While the groups offered to a specific patient will be determined by his/her treatment plan, the focus of the groups provided will include: symptom management, stress reduction, assertiveness training, substance abuse treatment, relapse prevention techniques, trauma survivors, interpersonal relationship skills, and parenting skills. The group treatment room will be furnished with movable tables that can

be reconfigured, ten comfortable chairs, and dry marker and magnet boards. The room will be designed to facilitate the use of audiovisual equipment.

- One educational room will provide an adult educational environment for ten patients. While this room will be primarily used for education, the room will also be available for psychoeducational groups when academic activities are not occurring. The type of academic instruction provided (Adult Basic Education, GED preparation or remedial reading) will be determined by the patient's treatment plan. The educational room will be furnished with a desk and chair for the teacher, movable tables able to be reconfigured, and ten chairs. The room will also be equipped with a computer and printer, lockable cabinets for the storage of educational workbooks and reference materials, a lockable file cabinet for storage of confidential patient educational files (e.g., test scores, etc.), and dry marker and magnet boards. The room will be designed to facilitate the use of audiovisual equipment.

- A computer lab sized to accommodate eight patients will be located adjacent to the educational room with a connecting door to permit the teacher to provide instruction simultaneously in both areas when patient groups are small. The computer lab will be equipped with eight workstations. Each workstation will include desktop space, a computer and chair. The computer lab will also have two printers, a lockable cabinet for supply storage and dry marker and magnet boards.

- Office space for the vocational rehabilitation counselor who provides assistance to patients in securing employment and then facilitates the coaching and support required for successful completion of job duties. The office space will be sized to accommodate three people, and will be furnished with a desk and two chairs, a computer, a printer, and two file cabinets.

- Office space for the dual diagnosis counselor will be sized to accommodate a desk, chair, one side chair, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- An area off the Treatment Mall's main corridor will house two treatment rooms able to accommodate a patient and staff member for individual assessments or therapy. These rooms will be furnished with a small table and two comfortable chairs. The table will routinely be used as a side table, but can also be used as a working table when clinical assessments are being conducted.

- The area off the main corridor will also include a room for the conduct of neuropsychological assessments and the provision of group therapy for small patient groups. The psychology lab will be furnished with a table and six chairs, a desk and chair, a computer and printer, and a lockable cabinet for the storage of testing equipment.

- In addition, a training area able to accommodate four staff and trainees will be located between the psychology lab and one of the individual treatment rooms. The training area will be furnished with a small table and four comfortable chairs. One-way mirrors and sound transmitting capabilities will be located in the wall between the training area and one treatment room and in the wall between the training area and the psychology lab. These adaptations will permit student supervision and training. Such training resources will facilitate achievement of the goal of attracting university affiliations for the Psychiatric Treatment Center. Patients will provide informed consent before participating in treatment or assessment sessions which will be viewed by trainees through the one-way mirrors.

- Another area off the main corridor will provide space for the patient advocate. This area will include a reception area with two comfortable chairs, a side table, a bookshelf, and magnet board for displaying material related to the advocacy function. Connected to the reception area will be an office for the patient advocate. This office will be furnished with a desk, desk chair, one side chair, a computer and printer, and two file cabinets.

- Office space for staff from community providers will be provided to facilitate patient discharge planning. While the space will not provide community staff with designated office space, each of two non-assigned workstations will provide a writing shelf, computer and two chairs. One printer will be shared.

Daytime and Evening Treatment Mall Programming Spaces: The following outlines the area of the Treatment Mall that will be available for patient use from 8:00 AM to 8:00 PM, 7 days a week:

- A multipurpose room designed for patient unstructured recreation will also accommodate 25 patients for holiday parties, bingo games and large group movies. Pet therapy may also occur in this area. The multipurpose room will be furnished with five small game tables, each with four chairs, two small sofas and comfortable chair groupings, and a lockable cabinet for storage of board games and reading material. Additional tables and chairs and a collapsible ping pong table will be stored in a large lockable closet. The room will be designed to facilitate the use of audiovisual equipment.

- A sink, small refrigerator, microwave, coffee maker, counter space and cabinets will be located in a small pantry alcove off the multipurpose room for use during patient social activities. This area will have lockable doors to ensure security when the area is not being used.

- A patient break and snack area will be located adjacent to the multipurpose room. This area will be furnished with three small tables, each with four chairs.

Snack and drink vending machines will also be located in this area. All items from the vending machines will be provided in plastic or paper containers. Access to this patient relaxation area will limited to scheduled break periods.

- A small outdoor relaxation area with four park benches and three picnic tables will be accessed from the break area. A protective awning will be constructed over part of the outdoor recreation area to provide patients who desire fresh air protection during inclement weather or protection from the sun when patients have been prescribed certain medications.

- A large group room that will accommodate 25 patients will be equipped with a movable divider that will permit the space to be divided into two small areas. The large space will be utilized for religious services and large group activities. When divided, the smaller rooms may be used for activities and programming for patient groups of less than ten. The large group room will be furnished with two large tables and 25 comfortable chairs. A large closet will provide storage for a small altar, podium and other religious supplies. Another closet will store a large TV and VCR on a movable stand. The room will be designed to facilitate the use of audiovisual equipment. Acoustics of this room will be designed to accommodate music therapy and activities involving music such as Karaoke.

- Adjacent to the large group room will be an office for the chaplain and a small chapel or meditation room. The chaplain's office will be furnished with a desk, chair, one side chair, a computer and printer, a bookshelf, and a file cabinet. The meditation room will provide six comfortable chairs and subdued lighting to facilitate chaplain-patient interactions and small Bible study groups as well as provide patients a place for quiet reflection. The chaplain will monitor patient access to the meditation room.

- A room accommodating eight patients and two peer counselors will serve as the resource center for the peer support activities that will occur throughout the Psychiatric Treatment Center. The room will provide two workstations for the peer specialists. Each workstation will have desktop space, a computer and chair. The workstations will share a printer and file cabinet. Additional furnishings for the peer support resource center will include two small group tables, ten comfortable chairs, shelving, and display boards for presentation of resource material.

- The patient library will accommodate 50 linear feet of four-foot high book shelves, two small work tables, each with three chairs, two reading chairs, a counter for processing book requests and returns, and a workstation for the library aide. The workstation will include desktop space, a computer, a printer, and a chair. A lockable cabinet and file cabinet will permit documentation and supply storage. Display boards will be available for the presentation of themes and reading

suggestions. An alcove will provide a table for book preparation and repair, and shelves for book storage.

- Two arts and crafts rooms will provide space for patients to participate in painting, sewing, craft activities, horticulture, and such groups as current events and travel. Each room will be furnished with three long tables, 12 chairs, a large sink to facilitate clean-up, and large lockable cabinets for supply storage. One cabinet will be assigned for the storage of the Clinical Dietician training supplies.

- An area offering patients the opportunity to practice meal planning and food preparation will be located behind lockable double doors in one of the arts and crafts rooms. The space will accommodate six patients and include a refrigerator, sink, counter space, stove, microwave, and cabinet space for food preparation supplies. An exhaust system will be provided for the cooking area. The space and furnishings of the arts and crafts room will be utilized for meal planning and patient socialization while enjoying the meals prepared.

- A third arts and crafts room will provide patients the opportunity to work with clay and produce ceramic art. The room will contain four large counter areas each capable of accommodating two patients working with clay. The room will be equipped with two large sinks, shelving for storage of "works in progress," lockable cabinets for the storage of paint and other supplies, and a kiln.

- An area adjacent to the arts and crafts rooms will provide private office space for the recreational therapist supervising the Treatment Mall leisure and recreation activities, and shared office space for the five habilitation aides assigned to the area. The recreational therapist office will include a desk, chair, one side chair, a computer and printer, a file cabinet, and a display board. The shared office space of the habilitation aides will contain five workstations, two computers, one printer, a copying machine, and two file cabinets. A large lockable closet will store musical instruments and large supply containers. Another lockable closet will store a TV and VCR and a sound system on movable stands.

- A gym large enough to accommodate a volley ball court that is encircled by a four foot wide marked walking track will provide patients the opportunity for recreation during inclement weather. A half basketball court will be located at one end of the gym. One large storage closet will contain such recreational equipment as basketballs, volleyballs and net, aerobic step-stairs, and floor mats. Another large closet will store 100 folding chairs and a portable stage. The stage will facilitate volunteer group and patient presentations.

- A room equipped with treadmills, stationary bikes, a stair master, and universal weights will be located adjacent to the gym. The room will include a water fountain, cabinets for the storage of clean towels, and a container for soiled linen.

- An outdoor recreation yard including a basketball court, space fcr a volley ball court and a small walking track will be accessed through a door near the gym. A restroom that can be accessed form the yard will be provided.

- Shared office space will be provided in the vicinity of the recreation areas for the two habilitation aides responsible for therapeutic exercise, sports and outdoor recreational programs. The shared office space of the habilitation aides will contain two workstations, one computer and printer, and a file cabinet.

- The barber/beauty shop will provide space to accommodate a barber/beautician, the patient being served, a waiting patient, and staff providing patient supervision. The room will include a barber chair, a barber's sink and counter, lockable cabinets for storage of supplies/equipment, and three waiting chairs.

- An area off the Treatment Mall's main corridor will provide two small respite rooms for patients who become agitated or fearful while in the area. The rooms will provide staff the opportunity for timely crisis intervention and permit a brief time-out period for patients. The respite rooms will be furnished with three comfortable chairs and a side table. Items that could be dangerous if a patient was to lose control will not be placed in the respite rooms.

The following areas will be provided throughout the Treatment Mall:

- Patient/staff restrooms, male and female, number of fixtures per code requirements, ADA accessible.

- Water fountains.

- Janitor's closets.

C. Staffing

While unit-based staff will provide much of the clinically-focused treatment on the Treatment Mall, the following staff positions will be dedicated to the Treatment Mall's educational, activities and recreational programs or will have their office space located in this area.

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
Academic Teacher	X	X	X	X	X		
Research Specialist	X		X		X		
Patient Advocate	X	X	X	X	X		
Chaplain	X	X	X	X	X		
Vocational Counselor	X	X	X	X	X		
Dual Diagnosis Counselor	X	X	X	X	X		
Peer Specialist	X	X	X	X	X		
Peer Specialist (11:30 AM- 8:00 PM)	X	X	X	X	X		
Recreational Therapist	X	X	X	X	X		
Habilitation Aide-Arts & Crafts	X	X	X	X	X	X	X
Habilitation Aide-Arts & Crafts (11:30 AM – 8:00 PM)	X	X	X	X	X	X	X
Habilitation Aide-Float (11:30 AM – 8:00 PM)	X	X	X	X	X		
Habilitation Aide-Library (11:30 AM – 8:00 PM)	X	X	X	X	X		
Habilitation Aide-Recreation	X	X	X	X	X	X	X
Barber/ Beautician		X		X		X	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
5.000	**CENTRALIZED PROGRAMMING SERVICES**							
5.100	DAYTIME TREATMENT MALL PROGRAMMING SPACES							
5.101	Group Treatment Room	10	1	20 /person	200			Tables and loose chairs, whiteboard, magnet boards, equipped for A/V use
5.102	Classroom	10	1	20 /person	200			Moveable tables and chairs, teacher's desk, computer, printer, lockable cabinets, lockable file cabinet, whiteboard, magnet boards, equipped for A/V use
5.103	Computer Lab	8	1	35 /person	280			Eight workstations each with desktop, computer, chair, 2 shared printers, lockable cabinet, whiteboard, magnet boards
5.104	Voc/Rehab Counselor Office	1	1	100 /office	100			Desk, chair, computer, phone, file cabinets, visitor chair
5.105	Substance Abuse Counselor Office	1	1	80 /office	80			Desk, chair, computer, phone, file cabinets, visitor chair
5.106	Individual Treatment Room	2	1	100 /room	100			Table and comfortable chairs; one room with one-way mirror to Training Room
5.107	Psychology Lab	6	1	180 /area	180			Table and 6 chairs, desk, chair, computer, printer, lockable cabinet, one-way mirror to Training Room
5.108	Training Room	4	1	100 /area	100			Table and 4 comfortable chairs, one-way mirror to one Individual Treatment Room and the Psychology Lab, with sound transmitting capability
5.109	Patient Advocate Reception Area	2	1	15 /person	30			2 comfortable chairs, side table, bookshelf, magnet board
5.110	Patient Advocate Office	1	1	80 /office	80			Desk, chair, computer, phone, file cabinets, visitor chair
5.111	Unassigned/Community Providers Workstations	1	2	60 /worksta.	120			Each with writing surface, chair, computer, phone, shared printer
Subtotal	5.100				1,470	1.40	2,058	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
5.000	**CENTRALIZED PROGRAMMING SERVICES - cont'd**							
5.200	DAYTIME & EVENING TREATMENT MALL PROGRAMMING SPACES							
5.201	Multipurpose/Game Room	25	1	25 /person	625			Five small game tables, each with 4 loose chairs, 2 sofa and comfortable chair groupings, lockable storage cabinet, collapsible tables and chairs, equipped for A/V use
5.202	Pantry Alcove	-	1	20 /area	20			Adjacent to multipurpose room; lockable; cabinets, small refrigerator, microwave, coffee-maker, sink, countertop
5.203	Patient Break Room	12	1	20 /person	240			3 tables w/ 4 chairs each, vending machines
5.204	Outdoor Relaxation Area	20	1	3000 /area	(3,000)			4 park benches, 3 picnic tables, garden for horticulture, partially covered for weather protection; accessible from Patient Break Room
5.205	Group Activity Room	25	1	300 /area	300			Two large tables, 25 comfortable chairs, moveable partition for room division capability; equipped for A/V use
5.206	Small Storage Closet	-	1	25 /area	25			Shelving, lockable; sized for storage of A/V equipment and supplies, within Large Group Activity Room
5.207	Large Storage Closet	-	1	50 /area	50			Shelving, lockable; sized for storage of religious articles, altar, podium and supplies; within Large Group Activity Room
5.208	Chaplain's Office	1	1	80 /office	80			Desk, chair, computer, phone, file cabinets, visitor chair
5.209	Meditation Room	6	1	100 /area	100			6 comfortable chairs, subdued lighting, adjacent to Chaplain's office
5.210	Peer Counseling Room	12	1	250 /area	250			2 small tables and 10 comfortable chairs, shelving, display boards; 2 staff workstations with desktop, chair, computer, phone, shared printer
5.211	Library	up to 10	1	400 /area	400			Appropriate shelving, 2 tables with 3 chairs each; 2 reading chairs, book processing counter, workstation with desktop, chair, computer, printer; alcove with work table
5.212	Arts and Crafts Room	10	2	25 /person	500			3 long tables, 12 chairs, sink, lockable storage cabinets
5.213	Patient Meal Planning and Food Preparation Area	6	1	20 /person	120			Countertops, sink, refrigerator, microwave, stove/oven; exhaust vent over cooking area; adjacent to one Arts & Crafts Room
5.214	Ceramics Arts Room	8	1	250 /area	250			Table, chairs, potter's wheels, 2 large sinks, kiln, lockable storage cabinets, shelving

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
5.000	**CENTRALIZED PROGRAMMING SERVICES - cont'd**							
5.215	Recreational Therapist's Office	1	1	80 /office	80			Desk, chair, computer, phone, file cabinet, bookshelf, visitor chair, display board
5.216	Habilitation Aide Workstations	1	4	60 /worksta.	240			Desktop space, chair, computer, phone, shared printer
5.217	Copy/File/Fax Alcove	-	1	80 /area	80			Copier, counter space, office supply cabinet, file cabinets
5.218	Recreational Supply Closets	-	2	80 /area	160			Lockable; one for musical instruments and large supply containers, one for TV/VCR and other electronic equipment
5.219	Indoor Gymnasium	up to 20	1	3,200 /area	3,200			Volleyball court, Jr. High-sized basketball half court, walking track, water fountain
5.220	Gymnasium Storage Closets	-	2	120 /area	240			Lockable, some shelving; one for storage of recreation equipment, one for storage of 100 folding or stackable chairs & portable stage
5.221	Exercise Room	up to 5	1	250 /area	250			Treadmill, stationary bike, universal weights, water fountain, cabinet for clean towels, rolling cart for soiled towels
5.222	Outdoor Exercise Yard	32	1	5,000 /area	(5,000)			Handball wall, non-regulation basketball court (50' x 25'), volleyball court, walking track; accessed through indoor gymnasium
5.223	Outdoor Restroom	1	1	50 /area	50			ADA accessible
5.224	Shared Staff Workstations	1	2	60 /worksta.	120			Desktop space, chair, computer, phone, shared printer and file cabinet; adjacent to recreation areas
5.225	Barber/Beauty Shop	4	1	120 /area	120			1 barber chair, hairwashing sink, counter, lockable storage cabinets, 3 waiting chairs
5.226	Respite Rooms	3	2	80 /area	160			3 comfortable chairs, side table
5.227	Patient Rest rooms (M/F)	1	6	50 /area	300			ADA accessible, located throughout Treatment Mall at convenient locations, pair 1 male and 1 female rest room in same location, wall-hung water fountain outside, number of fixtures per code
5.228	Staff Rest rooms (M/F)	1	2	50 /area	100			ADA accessible, number of fixtures per code
5.229	Janitor Closet	-	2	40 /area	80			Slop sink, mop racks, ventilation
Subtotal	5.200				8,140	1.40	11,396	
Subtotal	Outdoor Spaces				8,000	1.00	8,000	
Total	**5.000**				**9,610**		**13,454**	

6.000
Admissions/Discharge Area

6.000 ADMISSION/DISCHARGE AREA

A. Hours of Operation

The Psychiatric Treatment Center must be able to accept admissions 24 hours a day, 7 days a week to ensure immediate access for patients in need of acute psychiatric care. Admissions related to non-acute care and discharges will be conducted between 8:00 AM and 4:00 PM, Monday through Friday whenever possible.

B. Operational Description

This area is the central admission and discharge point for all forensic and civilly committed patients entering and leaving the Psychiatric Treatment Center. Patients admitted on a voluntary basis will enter the hospital through the public lobby and then be escorted by staff to the admission/discharge area.

Civil patients admitted on the basis of an emergency involuntary or commitment order will be transferred to the Psychiatric Treatment Center from community crisis services, hospital emergency rooms or community hospital psychiatric units by secure law enforcement vehicles or ambulance. These patients will be released as determined by the discharge recommendations of their treatment plan.

Forensic patients will be transferred to the Psychiatric Treatment Center from the sending court, from local jails and from state prisons by secure law enforcement vehicles or correctional vans. Patients returning to correctional facilities after discharge will be released to transport officers of the correctional facility through the admission/discharge area. Forensic patients returning to the community after discharge will be released as determined by the discharge recommendations of their treatment plan.

The admission/discharge area will serve as the point where the transport of patients to off-site medical care or appointments is initiated and will be the point of exit and entry for forensic patients requiring transport to court hearings. The admission/ discharge area will also serve as the entry and exit point for individuals brought to the Psychiatric Treatment Center from correctional facilities for the completion of court-ordered evaluations by State Forensic Services staff.

All patient admissions to the civil units will require prior approval from the Psychiatric Treatment Center admissions staff and the Medical Director or designee. Forensic patient admissions will be approved by the Forensic Unit psychiatrist or designee. Off-site medical care and appointments will be scheduled by the Nursing Office. The Forensic Unit will coordinate patient appearance at required court hearings with the

court of jurisdiction. Appointments for forensic evaluations will be scheduled by State Forensic Services staff. All staff scheduling patient movement or forensic evaluations will advise designated Psychiatric Treatment Center staff of the activity no less than 24 hours before the scheduled activity. Designated hospital staff will be advised of patient admissions as soon as the admission is approved by the civil or forensic staff.

Admissions Process

Voluntary patients for admission will be escorted from the public lobby to the admission/discharge area by unit clinical staff and a designated staff member. Involuntary and forensic patients will be admitted through a secure garage that will provide a vehicular sallyport to the admission/discharge area. The garage will permit a controlled environment as well as an area protected from inclement weather. After entering the garage and prior to entering the pedestrian vestibule to the admission/discharge area, law enforcement officers conducting the transport will place their weapons into a secure gun drop box. The garage and pedestrian vestibule will have interlocking doors controlled remotely by the Building Access Center.

The admissions process will begin once the patient and transport officers have entered the pedestrian vestibule. A member of the hospital staff will be present to welcome the patient and the transport officers. It is the responsibility of the transporting officers to ensure the patient does not have dangerous items on his/her person prior to exiting the pedestrian vestibule and entering the admission/discharge area. All persons, except transporting law enforcement officers, will pass through an unobtrusive metal detector prior to entering the secured area of the Psychiatric Treatment Center.

Only one admission will be permitted in the pedestrian vestibule at any time. When there are multiple admissions pending, patients exhibiting the most acute symptoms or out-of-control behavior will be admitted first. Other patients will wait in the transport vehicle with transporting officers until their access can be safely managed.

A waiting room will be available for patients and accompanying transport officers. Forensic patients and civil patients demonstrating out-of-control behavior during the waiting period will remain in the restraints used during transport. Other patients will have the transporting restraints removed while in the waiting room.

When alerted that an anticipated admission has arrived at the hospital, the nursing supervisor and a mental health worker of the unit expecting the admission will come to the admission/discharge area to initiate the admission process. During the hours when present, a medical records clerk assist in the preparation of documentation related to the admission through the window between the medical records room and

the central admissions office. The on-site physician or physician extender and the unit's psychiatrist, when on site, will be alerted to the need to assist in the admissions process as soon as possible.

The nursing supervisor will review the paperwork accompanying the patient to ensure all legal requirements for the patient's admission have been accomplished. Part 1 of the Pre-Admission Screening Forms will be reviewed or initiated, if not previously completed.

The patient will be interviewed by the nursing supervisor, who will advise the patient of his/her placement in the Psychiatric Treatment Center and the components of the admissions process. The nurse will attempt to determine if the patient has a guardian, named representative or is receiving services from a psychiatrist, an ACT team, ICM or case manager. The patient will also be asked if there are persons who should be notified about the patient's admission. The nurse will attempt to contact the identified people while the admission process is conducted. If unable to reach the patient's ACT team, ICM or case manager, the community agency providing these services will be informed of the admission to facilitate timely involvement of the community staff and availability of the patient's ISP.

The mental health worker will then begin the cataloging of the cash, valuables, jewelry, medications, clothing and belongings brought to the hospital. The patient will acknowledge in writing the accuracy of the cash and valuables listed prior to their placement in a heat-sealed bag, and subsequent placement in a small vault in a secure area. Patients transferred to the Forensic Unit from jails and prisons will be permitted to maintain only minimal amounts of clothing and belongings. Excess property will be given to the jail or prison's transport officers for return to the sending facility.

If clinically required, the mental health worker will accompany the patient to the shower room, where the patient will shower and dress in appropriate hospital attire. The mental health worker will provide the greatest privacy possible given the patient's mental status while assessing the patient for signs of physical trauma. Transport officers will be available to assist with ensuring the safety of the patient and staff when needed. The clothing and belongings inventory will be completed when the clothing the patient had been wearing has been added. The patient will acknowledge in writing the accuracy of the inventory. Two staff members will also acknowledge in writing the accuracy of the inventory.

The patient interview will continue with the nursing supervisor's explanation of the rights afforded to patients using the *Patient's Rights Summary*, which is a synopsis of the *Rights of Recipients of Mental Health Services.* The treatment offered by the Psychiatric Treatment Center and the expectations for patient behavior will be reviewed using the *Patient Information Booklet.* The patient will be given a copy of the *Patient's Rights Summary* and the *Patient Information Booklet.*

The nurse will complete the Nursing Intake Assessment, Pre-Admission Screening Forms, Part II.

The patient will be escorted to a medical examination room where the psychiatrist, or physician extender when the psychiatrist is not on site, will complete the Physician Intake Assessment, Part III of the Pre-Admission Screening Forms, and conduct a current risk assessment. The psychiatrist or physician extender will inform the patient of his/her right to refuse treatment. This notification and the patient's response will be documented on an Informed Consent to Treatment form.

If the psychiatrist or physician extender has agreed with the need for the patient's admission and the patient's behavior permits, the transport officers will be allowed to leave. Designated hospital staff will observe and control the departure of the transport officers through the vehicular garage via camera and intercom.

While the patient is in the medical examination room, a physician or physician extender will conduct an initial medical examination, completing those portions of the Universal Assessment related to physical history and examination that can be comfortably tolerated by the patient. Tuberculosis testing will be initiated by the nurse if the patient is able to tolerate the procedure.

The mental health worker and nurse will assist the patient in providing a shoulder and head photograph for the medical record.

When a medical records clerk is present, the clerk will initiate the patient's medical record and ancillary hospital documentation. The clerk will determine if the patient has previously been a patient of the hospital and, if so, will incorporate available prior records into the new record. If the prior records are not immediately available, a note indicating the existence of the records will be placed in the new medical record for subsequent unit staff follow-up.

If prior records are available, the medical records clerk will determine the presence of Advanced Directives (Living Will Declarations and Durable Power of Attorney). If there are Advanced Directives, the clerk will copy the directives and include in the new medical record. The clerk will complete documentation reflecting the review of the presence of Advanced Directives for the unit social worker's follow-up within one working day of the patient's admission.

When a medical records clerk is not present, the nursing supervisor and mental health worker will initiate the medical record, complete the required sections of documentation and submit notification to medical records staff of the need to complete the documentation process as soon as possible.

After completion of the initial components of the admission process, the patient will be escorted to the assigned living unit by the nursing supervisor, mental health worker and a designated staff member. Staff will ensure that the patient has been issued adequate hygiene supplies. The patient will not be restrained unless that is the only safe way to accomplish the movement. Completion of the Universal Assessment will be conducted by unit staff in accordance with the Psychiatric Treatment Center's policies and procedures.

After the patient is safely transferred to his/her assigned living unit, the mental health worker will return to the admission/discharge area to retrieve the patient's clothing and belongings. The mental health worker will ensure that clothing is searched before taking the articles to the unit. The mental health worker will also assess the cleanliness of the patient's clothing and belongings, and ensure that steps are taken to clean the items if needed. When the patient is stable, he/she will be given the opportunity to select the items to be maintained on the unit and those that must be stored because of insufficient space in the patient's room.

Cash, valuables and jewelry obtained from patients during the admission process will be transferred to the unit's vault each morning Monday through Friday.

Discharge Process

All patients being discharged from the Psychiatric Treatment Center will be brought to the central admissions office by unit staff. Paperwork will be reviewed to ensure that legal issues related to the discharge have been addressed. Discharge plans will be reviewed with the patient and discharge medications provided to the patient as ordered by the psychiatrist or physician. Documentation related to the release will be completed.

The patient's cash, valuables and jewelry maintained in the patient unit's vault and the patient's clothing and belongings will be brought to the admission/discharge area prior to unit staff bringing the patient. The cash, valuables, jewelry, clothing and belongings will be reviewed by the patient and staff to ensure consistency with the inventory completed at the time of admission and subsequent changes.

If the patient is being discharged to a community placement or to family or friends, the patient will be escorted by unit staff to the public lobby and released. If the patient is being discharged to a jail or prison, the patient will be released to the transport officers of the jail or prison through the vehicular garage. A hospital staff member will be present during the release.

Patient Transport

Patients requiring transport for off-site medical care or other appointments will be escorted by the unit staff providing the transportation through the central hall of the admission/discharge area to the pedestrian vestibule. Staff will ensure that the vehicle to be used for the transportation is available in the garage prior to bringing the patient to the admission/discharge area. A designated staff member will be present while the patient and transporting staff move through the pedestrian vestibule and the garage. The transporting unit staff will note the patient and staff departure and later return times on the log in the vestibule.

State Forensic Services Appointments

Individuals transported from correctional facilities to the Psychiatric Treatment Center for the completion of court-ordered evaluations by State Forensic Services will enter the hospital through the vehicular garage and pedestrian vestibule of the admission/discharge area. A designated hospital staff member will be present while the individual and the transporting officers move through the pedestrian vestibule. The transporting officers will note their entrance time on the log in the vestibule. The designated hospital staff member will escort the group through the admission/ discharge area to the State Forensic Services Department.

When the evaluation appointment has been concluded, State Forensics Services staff will contact the Building Access Center for an escort of the individual and the transport officers to the admission/discharge area. The departing transport officers will note their departure time on the log in the vestibule. The designated staff member will remain present while the individual and transporting officers exit through the pedestrian vestibule.

Consistent with the above processes, the admission/discharge area will include the following components:

- Vehicular garage large enough to accommodate two large vans and the safe movement of patients who may be out-of-control. A secure gun drop box will be located in this area.

- Pedestrian vestibule large enough to accommodate the patient and four staff. The vestibule will access the entrance hall to the waiting room and admission area. The vestibule will be large enough to accommodate a metal detector.

- Entrance hall from which the waiting room and central admissions office and patient areas of the Psychiatric Treatment Center can be accessed. The hall will accommodate a small counter on which visitors and staff will log their arrival at and departure from the Psychiatric Treatment Center.

- Waiting room large enough to accommodate the patient, three transport officers and one designated hospital staff member. The space will be pleasant but free from items that could be used in patient outbursts. The waiting room will be furnished with comfortable seating, a secured television and a water fountain.

- The central admissions area will be located adjacent to the medical records office to facilitate this department's assistance in the admissions process. The area will be large enough to accommodate two workstations, each with a desk, computer terminal, a side chair, a table for inventorying patient property, and a small vault for temporary storage of patient cash and valuables. An alcove off the central admissions area will provide space with a chair and camera to comfortably photograph the patient during the admissions process.

- An area inaccessible by patients will include a copying machine, a fax machine, a listing of certified sign language senders/receivers and translators for access when a patient has a hearing impairment or limited English speaking ability, a forms and medical record jacket supply unit, and a coffee maker for waiting transport staff. File cabinets will be provided for copies of patient property inventory records.

- The medical examination room will be directly accessible from the admissions area, and will include an examination table, scale, medical equipment necessary to conduct a physical examination or provide first aid and a container to handle medical waste. A desk and side chair will permit the psychiatrist to conduct the initial psychiatric assessment. The room will have a sink and locked cabinets for securing medical equipment.

- Entrance to the admission shower room will be through the central admission area. The admission shower room will be large enough to safely accommodate four people, and will include a shower large enough to facilitate patient privacy while permitting staff observation when necessary. A toilet stall and sink will be included for patient use.

- A large storage closet will accommodate the storage of patient hospital attire in various sizes, basic patient hygiene supplies, clean linen, and supplies for the medical examination room.

- A large storage closet will accommodate the interim storage of patient belongings unable to be immediately transferred to the patient unit.

- Visitor bathroom adjacent to the waiting room.

- Staff bathroom adjacent to the office area.

- Janitor's closet.
- Closet for collection of soiled linen.

C. Staffing

No staff will be dedicated to the admission/discharge area. Staff will come to this area when required by admission, discharge or patient transport. Designated hospital staff will be responsible to ensure the security of the admission/discharge area before and after and in between uses. Doors to the waiting room, central admissions office and medical examination room will remain locked except when a patient admission or discharge is being processed.

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
6.000	**ADMISSION/DISCHARGE AREA**							
6.100	ADMISSION/DISCHARGE/PROPERTY STORAGE							
6.101	Vehicular Garage	-	1	800 /area	800			Parking for 2 vans; emergency exit door from garage; recessed gun lockers, CCTV cameras; 14 ft. height clearance; covered for weather protection
6.102	Pedestrian Vestibule	5	1	100 /area	100			Adjacent to vehicular garage, metal detector
6.103	Entrance Hall	1	1	60 /area	60			Counter space
6.104	Waiting Area	5	1	125 /area	125			Adjacent to entrance hall, comfortable seating, secured television, water fountain, glazing for ready visibility
6.105	Central Admissions Office	2	1	200 /area	200			Two work stations with desk, chair, computer, patient chair; table for sorting patient belongings, vault; includes window to medical records area
6.106	Photo/ID Alcove	2	1	20 /area	20			Chair and camera equipment, adjacent to admissions office
6.107	Copier/Forms/Files/Coffee	2	1	80 /area	80			Copier, fax machine, forms storage rack, file cabinets, coffee maker; adjacent to admissions office
6.108	Shower/Changing/Patient Toilet	up to 3	1	100 /area	100			Shower stall with separate changing area, toilet, sink, ADA accessible; designed to permit patient privacy while permitting observation when necessary
6.109	Medical Screening Room	2	1	100 /area	100			Desk, chair, computer, charting area, phone, 2 chairs, medical examination equipment, scale, sink
6.110	Supply Storage	-	1	100 /area	100			Clean linen, hygiene supplies, documentation supplies, shelving
6.111	Staff/Visitor Restrooms	1	2	50 /area	100			ADA accessible
6.112	Trash Room	-	1	10 /area	10			Adjacent to entrance hall
6.113	Soiled Linens	-	1	60 /area	60			Closet for laundry cart for soiled linens
6.114	Temporary Storage	-	1	150 /area	150			Lockable area for interim storage of excess patient property
6.115	Janitor's Closet	-	1	40 /area	40			Slop sink, mop rack, ventilation
Subtotal	6.100				2,045	1.30	2,659	
Total	**6.000**				**2,045**		**2,659**	

7.000
Visitation

7.000 VISITATION

A. Hours of Operation

Visitation hours for most patients of the Psychiatric Treatment Center will be from 10:00 AM to 8:00 PM on weekdays and from 8:00 AM to 8:00 PM on weekends and holidays. Visitation hours for patients housed on the high security forensic unit will be limited to designated periods in order to ensure that safety issues may be adequately addressed. All patients will be provided unrestricted visitation from their attorney, clergy or members of a rights protection or advocacy service.

B. Operational Description

Since visitation of the patient by family and friends often serves to promote a patient's mental health, the Psychiatric Treatment Center will provide optimal opportunities for visitation. Visitation rules will be posted in the public lobby and on each of the patient units. Visitors will be encouraged to consider the patient's involvement in therapeutic programming when scheduling their visits.

Visits by a group of more than five people for a specific patient will be discouraged, due to the confusion often generated by too many visitors and the size of the visiting rooms. Visits by children under the age of 12 will require pre-arrangements with the unit's Program Services Director or designee.

The duration of visits will not be restricted, especially when the visitors have traveled a long distance. However, when several visitor groups are waiting, visitors will be requested to limit their visit to a reasonable amount of time. Visitors will also be encouraged to consider the impact of lengthy visits on the patient's participation in scheduled therapeutic activities.

Visitation for all patients of the Psychiatric Treatment Center will be conducted in individual rooms in a centralized visitation area. Visitor access to the visitation area will be from the public lobby, and patient access will be from corridors in the hospital's secure area.

Upon arrival at the public lobby, visitors will inform the receptionist of their intent to visit a specific patient. Visitors unknown to the receptionist will be required to provide a photo identification prior to the visit. Visitors will document their presence by signing in and signing out on an electronic Visitation Log that will electronically track entrance and exit times and visit duration.

The receptionist will verify the availability of a visiting room, and then notify staff in the patient's unit of the identity of the visitors present. Unit staff will confirm that

there are no pending physician orders related to the patient's visitation and then advise the patient of the visitors. Patients retain the right to refuse or terminate visits from specific or all visitors.

If the patient agrees to the visit, unit staff will assist the patient in preparing for the visit and then escort the patient to the visitation area. A staff member from the patient's unit will remain outside of the visiting room during the visit unless other staff are present to provide observation and supervision.

Visitors will enter the visitation area after passing though a metal detector in the public lobby. Visitors who refuse to be screened will not be allowed entrance to the hospital. Visitors to the forensic unit may be subject to additional security screening, which will occur in the search room adjacent to the metal detector. Visitors who refuse this additional screening will not be allowed entrance to the hospital. Lockers will be located in the lobby for the secure storage of visitor property that will not be permitted within the hospital. Such property includes weapons, pocket knives and other sharp instruments, and medications.

Packages brought by visitors will be scanned by a package x-ray in the public lobby. If the security screening indicates the package may contain metal objects, the package must be opened by the visitor and approved by staff before being taken into the visitation area. Packages not identified as possibly containing metal objects by the security screening will be opened by the patient or visitors in the presence of the unit staff escorting the patient to the visitation area.

Visits will usually be conducted without staff present. However, activities in the visiting rooms will be monitored by staff located outside the rooms to ensure a safe setting for the patient and visitors. When inappropriate behavior is observed in a visiting room, staff will remind the patient and visitors of visitation rules. If the inappropriate behavior continues, the staff member will request the assistance of designated staff in terminating the visit.

If a staff member observes a potentially dangerous or escalating situation in a visiting room, the staff member will activate an alarm system to call for designated staff assistance in intervening. Staff will intervene in the least intrusive manner while ensuring the safety of all.

When a patient's mental status is fragile or the patient has been agitated prior to the visit, unit staff may remain in the room during the visit. Staff will explain this precaution to the patient and visitors in a respectful and therapeutic manner at the beginning of the visit.

When the visit is completed, unit staff will escort the patient back to the unit. During the escort, staff will assess the patient in order to prepare staff for any potential consequences of a visit that may have had a negative impact on the patient.

The visitation area will provide a multipurpose space for court commitment and other administrative hearings related to a patient's hospitalization. The visitation rooms will provide space for the patient to privately confer with his/her representative during the hearing process if necessary. This multipurpose room will also be used by for group meetings that will include both patients and persons from the community. Such groups include the National Alliance for the Mentally Ill, Alcoholics Anonymous and peer support groups.

Consistent with the above processes, the visitation area will include the following components:

- A central visitation support area will provide visitor access to the individual visiting rooms and an area for staff to conduct observation and supervision of visiting activities. This area will be large enough to facilitate staff observation of all visiting rooms while minimizing disruptions related to visitors concerned with their observation by other visitors. This area will be furnished with two small desks and chairs to facilitate unobtrusive staff observation. A lockable closet will contain toys for children and paper supplies that would be useful when visitors bring food or snacks to the patient. Vending machines, restrooms (one with a baby changing station), a water fountain and a public telephone will be provided for the convenience of visitors.

- Four visiting rooms, each able to accommodate a patient and five visitors, will provide a pleasant, home-like environment. Walls between the visiting rooms and the central visitation support area will be glazed to facilitate staff observation. The doors providing access to the patient corridors will remain locked unless a patient is entering or leaving a visiting room. The visiting rooms will be furnished with comfortable seating and residential-type furnishings. While all visiting rooms will be glazed, the glazing in two visiting rooms will be equipped with integral blinds to permit privacy when the visiting room is used for family therapy or family involvement in treatment planning.

- Two small visiting rooms will provide space for patient meetings with an attorney, clergy member or other professional. Walls from the visiting rooms to the central visitation support area will be glazed to facilitate staff observation. The doors providing access to the patient corridors will remain locked unless a patient is entering or leaving the visiting room. The small visiting rooms will be furnished with a small table and three chairs. These rooms may also be used for small visitor groups when the larger visiting rooms are occupied. The rooms will also be used to conduct outpatient follow-up for patients discharged from the hospital and requiring such monitoring. The glazing in these rooms will be equipped with integral blinds to permit privacy when used for outpatient services.

- A multipurpose room that will accommodate 25 persons will be accessed through the central visitation support area. This room will be used for administrative hearings and groups involving both patients and people from the community. Since staff will be present during the meetings planned for the multipurpose room, only the doors from the room to the patient corridor and the central support area will be glazed. This will maximize the privacy afforded legal proceedings, self-help group and staff meetings. The door providing access to the patient corridors will remain locked unless a patient is entering or leaving the multipurpose room. The multipurpose room will be furnished with a conference table suitable for use in court proceedings and 12 chairs. A lockable closet will store additional chairs for group use. The multipurpose room will be designed to facilitate the use of audiovisual equipment.

- A small pantry providing a sink, small refrigerator and coffee maker will facilitate refreshments for group meetings. The pantry will be secured by a lockable door when not in use and will be immediately adjacent to the multipurpose room.

- Janitor's closet

C. Staffing

Staff will not be assigned to the visitation area. Unit staff will provide observation and supervision during visitations. Designated staff will be available for assistance and will be responsible to ensure that the area is locked when not in use.

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
7.000	**VISITATION**							
7.100	PATIENT VISITING CENTRAL SUPPORT							
7.101	Central Visitation Staff Support Area	1-2	1	150 /area	150			Immediately adjacent to visiting rooms with good visibility into each room, 2 desks and chairs for staff, vending machines
7.102	Storage Closet	-	1	10 /area	10			Within central support area; shelving for forms, paper goods, toys for children, etc.
7.103	Public Rest rooms (M/F)	1	2	50 /area	100			Within central support area; ADA accessible, baby changing station; exterior wall-hung water fountain
7.104	Public Telephone	1	1	7 /booth	7			Booth with glazing or half-height acoustical partition for privacy
Subtotal	7.100				267	1.30	347	
7.200	PATIENT VISITING							
7.201	Visiting Rooms	6	4	150 /room	600			Each room with comfortable seating and residential-type furniture, door to patient corridor, glazed wall to central area, acoustical attenuation for privacy, 2 rooms with integral blinds
7.202	Small/Official Visiting Rooms	3	2	75 /area	150			Each room with table and loose chairs, door to patient corridor, sufficient wall glazing (with integral blinds) for ready observation, acoustical attenuation for privacy
7.203	Multipurpose Room	25	1	20 /person	500			Adjacent to central area; conference table with 12 loose chairs, white board, A/V capability
7.204	Storage Closet	-	1	100 /area	100			Within multipurpose room; shelving, storage for additional chairs, A/V equipment, etc.
7.205	Pantry Alcove	-	1	12 /area	12			Adjacent to multipurpose room; cabinets, small refrigerator, microwave, coffee-maker, sink, countertop
7.206	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
Subtotal	7.200				1,402	1.25	1,753	
Total	**7.000**				**1,669**		**2,100**	

8.000
Medical Support Services

8.000 MEDICAL SUPPORT SERVICES

A. Hours of Operation

Physicians or physician extenders will be on site 24 hours a day, seven days a week. Dental staff will be present from 8:00 AM to 4:00 PM, Monday through Friday. Pharmacy technicians will also be present from 8:00 AM to 4:00 PM, Monday through Friday. Routine patient access to the medical area will be determined by scheduled appointment or staff referral. Emergency treatment will be determined by staff referral.

B. Operational Description

Medical Support Services will provide patients of the Psychiatric Treatment Center with medical and dental care, as well as initiate and track the processing of non-psychiatric laboratory testing. The medical area will also house the pharmacy area and provide sleeping accommodations for physicians or physician extenders providing night coverage. The provision of medical and dental services will be restricted to current hospital patients. Patients discharged form the hospital with pending medical or dental issues will be referred to appropriate providers in the community.

The medical clinic will remain accessible to patients at all times. The medical clinic will be located adjacent to the Treatment Mall and the high security forensic unit to facilitate access for the two distinct patient groups. Since these groups are not to interact, their visits will be scheduled at different times. The medical clinic will be located in the vicinity of the admission/discharge area to facilitate the presence of the physician or physician extender for conducting admission physical evaluations.

Physician or physician extenders will complete admission physical assessments, routine medical examinations, the assessment and treatment of emergency and non-emergency medical problems emerging subsequent to a patient's admission as well as provide treatment for pre-existing medical conditions. Treatment will include referral for specialty consults and treatment when required. Such consults may be conducted within the hospital or within the community depending upon the availability of services.

The physicians and physician extenders will provide initial psychiatric evaluations for patients admitted to the hospital when psychiatrists are not present. The physicians and physician extenders will also provide medical coverage for psychiatric crises and the use of seclusion or restraint when psychiatrists are not present. The psychiatrists will be available for consultation with the physicians and physician extenders 24 hours a day.

Whenever the patient's mental status permits, the admissions physical assessment will be completed during the admissions process. If this does not occur, the assessment will be completed within 24 hours of admission. The medical clinic nurse will ensure that the TB testing and laboratory testing required for patients admitted to the hospital has been ordered and completed. Blood draws for non-psychiatric laboratory testing will routinely be completed in the medical clinic, but may be conducted on the patient units when clinically indicated. Laboratory testing for the Psychiatric Treatment Center will be completed off-site by a contract provider.

Patients reporting or exhibiting medical problems will be referred to the medical clinic by unit staff. The patients will be seen and triaged on the unit for minor ailments or problems requiring immediate attention, and will be scheduled for a medical clinic appointment for routine care. An emergency crash cart will be maintained in the medical clinic for use in the clinic or patient areas when required.

The medical clinic clerk will maintain a schedule for patient appointments and notify unit staff of the pending appointment 24 hours prior to the appointment. Patients with chronic health conditions such as hypertension, cardiac problems or diabetes will be assigned to chronic care clinics to facilitate routine nursing and physician review, and the provision of ongoing patient education about chronic medical conditions.

Patients admitted to the Psychiatric Treatment Center will be assessed for the need for dental services by a physician or physician extender during the admission physical assessment. All patients will receive treatment for emergency dental conditions as indicated by the dental assessment or by the patient's self-report. Patients who remain in the hospital for six months will receive a dental examination that will be repeated every six months. Dental services to be provided include preventive services, emergency restorative services and periodontal care.

While pharmacy services are provided through a contract with a community provider, the medical clinic will provide space for the receipt and return of medications, as well as the point of medication preparation and distribution to the patient units.

Consistent with the above processes, the medical support services area will include the following components:

- An entranceway permitting the access of patients from the Treatment Mall and the high security forensic unit. Access to the clinic will be controlled by medical clinic staff or the Building Access Center.

- A reception area sized for six persons awaiting scheduled appointments and providing a protected workstation for the medical clinic clerk. The waiting area

will serve patients waiting for medical or dental appointments and will be furnished with comfortable seating for six.

- The medical clinic clerk's workstation will face the reception waiting area and be defined by a partition providing open and protected counter space. The workstation will be equipped with desktop and counter space, a staff chair, cubicles to manage the medical records for scheduled appointments, two file cabinets, and storage cabinets. The workstation will be equipped with a telephone, a computer, printer and fax machine. Access into the treatment areas will be controlled by the medical clinic clerk or by the Building Access Center.

- A nursing assessment area will be furnished with a desk, chair, and a side chair, and will provide office space for the medical nurse and for the conducting of nursing assessments and individual patient health education. The side chair will be adaptable to permit the safe drawing of blood for laboratory testing. A small refrigerator for the storage of laboratory specimens awaiting pick-up will be provided. A container for the safe disposable of sharps will also be provided. The space will be large enough to complete the assessment of visual functioning. If physical assessment by the nurse is required, the patient will be transferred to a medical treatment room.

- Two medical treatment rooms will be utilized for medical assessments and treatments. Each treatment room will provide an exam table and the medical equipment necessary for physical evaluations; a writing surface and chair for the nurse, physician or physician extender; a sink; cabinets for medical supplies; and containers for the disposal of sharps and medical waste. One medical treatment room will include EKG equipment.

- A tub room will be provided with a whirlpool tub, an outer changing area, and a privacy screen

- A medical supply area including the shelving for the storage of clean linen and medical supplies and a work station for the medical services technician. The workstation will be equipped with desktop and counter space, a staff chair, and two file cabinets. The workstation will be equipped with a computer and printer.

- A closet for the collection of soiled linen.

- An area for the maintenance of an emergency crash cart to ensure ready availability when needed as well as facilitate the routine staff monitoring of the integrity of the cart's contents.

- A closet for the storage of wheel chairs and other equipment that may be required by the hospital patients with physical disabilities.

- Two private offices for the physicians sized to accommodate a desk, chair, two side chairs, bookcase, and file cabinet. The offices will be equipped with computers, printers and dictation equipment.

- Two private offices for the physician extenders sized to accommodate a desk, chair, one side chairs, bookcase, and file cabinet. The offices will be equipped with computers and printers.

- An unassigned office space for physicians and physician extenders not employed full-time by the hospital but providing part-time or contractual services. The space will be sized to accommodate a desk, chair, and one side chair. The office will be equipped with a computer and printer.

- Shared office space for the dentist and dental hygienist contracted for these services sized to provide two workstations. The workstations will be equipped with a chair, desktop space, and locked drawer and cabinet space. A computer and printer will be shared.

- Two dental examination and treatment rooms will be equipped to provide routine and emergency dental care. One treatment room will include a panorex x-ray machine.

- A dental workroom with a counter, sink, and cabinet for the storage of dental supplies and equipment for x-ray development and viewing.

- A staff break room equipped with a refrigerator, microwave, sink, small cabinet for supply storage, a countertop, and a table able to accommodate four people. The break room will be located adjacent to the rest area provided for physicians and physician extenders providing night and 24 hour weekend medical coverage.

- A rest area for physicians and physician extenders providing night medical coverage for the hospital will include a bedroom and restroom with shower. The rest area will be furnished with a bed, bureau, comfortable chair and television. A small closet for hanging clothes will also be provided.

- One pharmacy room for the receipt and return of medications to the contracted vendor and for the distribution of medications to the patient units. The room will include workstations for the pharmacy technicians, counter space for the sorting and distribution of medications, cabinets for the storage of stock non-controlled medications, refrigerator for the storage of medications, space for medication carts, and, a lockable cabinet for the storage of stock controlled medication. The pharmacy area will be equipped with a fax machine to ensure the timely processing of medication orders. The pharmacy technician workstations will be equipped with desktop and counter space, a chair, drawers and cabinet space, and computers. The technicians will share a printer.

- A second pharmacy room will be provided for preparation of medications for outpatients. The room will include counter space for the sorting and distribution of medications, cabinets for the storage of stock non-controlled medications, refrigerator for the storage of medications, space for medication carts, and a lockable cabinet for the storage of stock controlled medication.

- Office space for the Director of Pharmacy will accommodate a desk, chair, side chair, bookcase and file cabinet. A computer and printer will be provided.

- Staff restrooms, ADA accessible.

- Patient restroom, ADA accessible.

- Water fountain.

- Janitor's closet.

C. Staffing

The staffing listed below does not reflect the pharmacist contracted to provide on-site services and supervision as required by state pharmacy guidelines.

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
DAY SHIFT							
Physician	X	X	X	X	X		
Physician			X	X	X	X	X
Medical Nurse	X	X	X	X	X		
Medical Clinic Clerk	X	X	X	X	X		
Medical Services Technician	X	X	X	X	X		
Dentist	X	X	X	X	X		
Dental Hygienist	X	X	X	X	X		
Pharmacy Technician	X	X	X	X	X		
Pharmacy Technician	X	X	X	X	X		
EVENING SHIFT							
Physician Extender	X	X	X	X	X	X	X
NIGHT SHIFT							
Physician Extender	X	X	X	X	X	X	X

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
8.000	**MEDICAL SUPPORT SERVICES**							
8.100	MEDICAL CLINIC							
8.101	Reception/Waiting Area	10	1	15 /person	150			Seating; drinking fountain
8.102	Medical Clinic Clerk Workstation	1	1	80 /person	80			Separated from reception/waiting by half-height partition with countertop; computer workstation, work counter, stools, charting
8.103	Medical Records	1	1	100 /area	100			File cabinets, adjacent to medical clerk workstation
8.104	Nursing Assessment Area	1	1	100 /area	100			Desk, chair, computer, phone, file cabinet, chair for blood drawing, sink, work counter, cabinet storage, locked specimen storage, refrigerator, sharps disposal, sized for vision testing
8.105	Medical Treatment Rooms	2-3	2	120 /area	240			Includes exam table, stool, writing surface, privacy screen, blood pressure devices and other exam equipment, sink; one with EKG equipment
8.106	Tub Room	1	1	50 /area	50			Whirlpool tub with privacy screen & screened changing, ADA accessible
8.107	Medical Supply Room	-	1	120 /area	120			Shelving for the storage of clean linens and supplies; workstation with computer and printer
8.108	Storage - Soiled Linens	-	1	60 /area	60			Cart storage for soiled linens
8.109	Crash Cart Maintenance Area	-	1	40 /area	40			Cart storage area, lockable
8.110	Storage - Equipment	-	1	120 /area	120			Sized for wheelchair storage, shelving for equipment and supplies
8.111	Physicians' Office	1	2	100 /area	200			Desk, chair, computer, phone, dictation machine, file cabinet, bookcase, 2 visitors' chairs
8.112	Physician Extenders' Office	1	2	80 /area	160			Desk, chair, computer, phone, file cabinet, bookcase, visitor chair
8.113	Unassigned Office	1	1	80 /area	80			Desk, chair, computer, phone, file cabinet, bookcase, visitor chair

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
8.000	**MEDICAL SUPPORT SERVICES - cont'd**							
8.100	MEDICAL CLINIC - cont'd							
8.114	Dental Office	1	2	60 /worksta.	120			Shared office with 2 workstations, each with desk, chair, phone, cabinets; one with computer and printer
8.115	Dental Operatory	2-3	2	120 /area	240			Dental chair, sink, work cart, cabinet storage, one with panorex x-ray
8.116	Dental Supply/Work Room	1	1	100 /area	100			Includes sink, x-ray development and viewing, shelving and cabinets for supplies, work surface, chair
8.117	Staff Break Room	4	1	25 /person	100			Table w/ 4 chairs, countertop, cabinets, coffee maker, sink with instant hot water, refrigerator, microwave, shelving
8.118	Physician Rest Area	1	1	150 /area	150			Bed, bureau, comfortable chair, television, small closet, restroom, shower
8.119	In-Patient Pharmacy	3	1	250 /area	250			Sink, shelving, computer, printer, fax machine, counter space, narcotics cabinet, cabinets, cart storage and staging area, refrigerator; includes pharmacist workstation with desk, chair, computer, printer
8.120	Out-Patient Pharmacy	3	1	350 /area	350			Counter space, sink, shelving, cabinets, cart storage and staging area, refrigerator
8.121	Director of Pharmacy Office	1	2	80 /area	160			Desk, chair, computer, phone, file cabinet, bookcase, visitor chair
8.122	Staff Restroom (M/F)	1	2	50 /area	100			ADA accessible, wall-mounted waterfountain outside
8.123	Patient Restroom	1	1	50 /area	50			ADA accessible
8.124	Janitor's Closet	-	1	40 /area	40			Ventilation, slop sink, mop rack
Subtotal	8.100				3,160	1.30	4,108	
Total	**8.000**				**3,160**		**4,108**	

9.000
State Forensic Services

9.000 STATE FORENSIC SERVICES

A. Hours of Operation

State Forensic Services offices are operational from 8:00 AM to 4:00 PM, Monday through Friday.

B. Operational Description

State Forensic Services coordinates and performs such court-ordered forensic evaluations as: competency to stand trial evaluations, criminal responsibility evaluations, pre-sentencing reports, periodic assessments of the mental functioning and prognosis of individuals previously determined to be incompetent to stand trial (IST) or not criminally responsible (NCR), and evaluations regarding child abuse and neglect.

State Forensic Services staff arrange for the completion of forensic evaluations through contract community providers as well as conduct the evaluations. State Forensic Services also establishes the standards for the forensic evaluation process for the State of Maine. The staff conduct quality assurance reviews and provide training in the completion of court-ordered evaluations.

Although State Forensic Services will not be funded through the Psychiatric Treatment Center, its locations within the hospital will facilitate the completion of court-ordered evaluations for patients of the forensic units, particularly patients who have been found IST or NCR. The location will also provide a secure environment for the evaluation of individuals who are transported from jails or prisons for court-ordered evaluations.

Patients of the Psychiatric Treatment Center requiring evaluation by State Forensic Services staff will be evaluated on the patient units whenever possible. If a patient must be evaluated in the State Forensic Services offices, one or two unit staff will accompany the patient. Designated hospital staff may assist in ensuring safety if there is a high level of risk.

Individuals transported from correctional facilities for the completion of court-ordered evaluations by State Forensic Services staff will enter the Psychiatric Treatment Center through the vehicular and pedestrian sallyport of the admission/discharge area. Designated hospital staff will escort the individual and transporting officers through the admission/discharge area to the State Forensic Services department.

The transporting officers will remain in the State Forensics Service area while the evaluation is being conducted. Evaluations will be completed in interview rooms by

one or two clinical staff. The evaluations will be videotaped to provide confirmation of the process.

When an evaluation appointment has been concluded, State Forensics Services staff will contact designated hospital staff for an escort of the individual and the transporting officers to the admission/discharge area where they will exit through the pedestrian vestibule and vehicular garage.

When the forensic evaluation has been documented, State Forensic Services staff will complete distribution as required by the court order. Copies of the evaluations and supporting data will be retained by State Forensic Services.

The area will be located in the secure area of the hospital adjacent to the admission/discharge area. Entrance to the area will be monitored by the Building Access Center via intercom and camera.

Consistent with the processes outlined, the State Forensic Services area will include the following components:

- The reception area of State Forensics Services will accommodate working space for the secretary as well as a waiting room for five people. The working space for the secretary will include a desk, desk chair, and two side chairs. The working space will be equipped with a computer and printer. An alcove in the reception area will provide a sink, refrigerator, microwave, coffee maker, counter and cabinet space for the use of transport offices and staff. This alcove will have a door permitting closure when not in use. A coat closet for ten people will also be provided.

- A room adjacent to the secretary's area will provide a work counter, a copying machine, fax machine, scanner and cabinets for storage of supplies. This room will also include four file cabinets for pending evaluation material.

- A waiting area large enough to accommodate five people will be part of the reception area and located adjacent to the interview room. The waiting room will be pleasant but free from items that could be used in patient outbursts. The space will be furnished with a sofa, four side chairs, and a secure television. Glazing of the wall between the waiting room and interview room will permit observation of the evaluation process by the transporting officers. Integral blinds within the glazing will permit privacy in the interview room when indicated.

- A records room accessible from the reception area will be sized to accommodate ten file cabinets, 14 linear feet of six foot shelving for archival documents, and shelving for retention of video tapes. A counter and chair will be located in the room to facilitate staff review of archival records.

- Another room with space for office supply storage, testing equipment storage, and video equipment.

- An interview room able to accommodate four persons and the videotaping process will be the primary site for conducting evaluations. The room will be adjacent to the waiting area with glazing to permit observation. The interview room will be designed to facilitate videotaping. Cabinets will provide storage for videotaping equipment and a folding table used when conducting structured psychological assessments. Shelving for the storage of interview forms will be provided. The room will be furnished with four comfortable chairs and a table suitable for psychometric testing.

- A multipurpose room sized to accommodate 15 people for staff meetings and training will be used to conduct evaluations when needed. The room will be furnished with three tables able to be reconfigured and 15 chairs. Two side chairs and end table at one end of the room will facilitate clinical interviews when evaluations are conducted. The room will be designed to permit videotaping. A wall unit will provide a dry marker board and charting capabilities.

- A private office for the director of State Forensic Services will be sized to permit a desk area and small conference area. The office will be furnished with a desk, chair, two side chairs, file cabinet, conference table with six chairs, and bookcases. The office will be equipped with a computer and printer.

- A private office for a psychologist will be sized for a desk area and space for individual interviews. The office will be furnished with a desk, chair, cabinet for storage of testing equipment, bookcase, and two side chairs. The office will be equipped with a computer and printer.

- A private office for a program manager will accommodate a desk area and additional workspace. The office will be furnished with a desk, desk chair, side working table, file cabinet, bookcase, and one side chair. The office will be equipped with a computer and printer.

- A resource room capable of accommodating 20 linear feet of book shelving will house the Forensic Services library. This room will also provide two workstations to be used for students, visiting clinicians and individuals completing self-report assessments. The workstations will be divided by four foot high acoustical partitions. Each workstation will be equipped with desktop space and a chair. One workstation will be equipped with a computer for staff use and for completion of self-report assessments. The resource room will be furnished with a small table and four chairs to facilitate its use for staff break periods.

- Visitor/patient restroom adjacent to the waiting and interview room, ADA accessible, with a wall-mounted water fountain outside.

- Staff restroom, ADA accessible.
- Janitor's closet.

C. Staffing

While State Forensic Services is staffed as follows, the Psychiatric Treatment Center budget will not include the Forensic Services staff. The hospital will assume financial responsibility for the facility maintenance and utility expenses of State Forensic Services. However, staff compensation and operational expenses of this department will be the responsibility of DMHMRSAS Central Office.

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
Director	X	X	X	X	X		
Program Manager	X	X	X	X	X		
Psychologist	X	X	X	X	X		
Secretary	X	X	X	X	X		

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
9.000	**STATE FORENSIC SERVICES**							
9.100	FORENSIC SERVICES							
9.101	Reception/Waiting	5	1	20 /person	100			Comfortable seating, side table, television
9.102	Secretary Workstation	1	1	60 /worksta.	60			Desk, chair, phone, computer; within reception/waiting area
9.103	Pantry Alcove	-	1	20 /area	20			Adjacent to reception/waiting area; cabinets, small refrigerator, microwave, coffee-maker, sink, countertop
9.104	Copy/Fax/File Room	-	1	100 /area	100			Work table, copy machine, fax machine, shelving, 4 file cabinets
9.105	Records Room	-	1	120 /area	120			10 file cabinets, shelving, countertop and chair
9.106	Storage	-	1	60 /area	60			Shelving for testing and video equipment, supply cabinet, folding table
9.107	Interview Room	4	1	100 /area	100			Comfortable seating, table, videotaping capability, storage cabinets for videotape equipment, shelving, wall glazing with integral blinds
9.108	Multipurpose/ Conference Room	15	1	20 /person	300			3 tables, 15 chairs, side table with 4 chairs, wall-mounted white board
9.109	Director's Office	1	1	160 /area	160			Desk, chair, file cabinet, phone, computer, printer, bookshelves, small conference table with seating for 6
9.110	Psychologist's Office	1	1	100 /area	100			Desk, chair, storage cabinet, phone, computer, printer, bookshelves, 2 visitor chairs
9.111	Program Manager's Office	1	1	100 /area	100			Desk, chair, work table, phone, computer, printer, bookshelves, visitor chair, file cabinet
9.112	Resource Room	6	1	200 /area	200			2 workstations with desk, chair, half-height partitions, one with computer; table and four chairs for staff breaks, 20 feet of shelving
9.113	Coat Closet	-	1	25 /area	25			Adjacent to waiting room
9.114	Staff Restroom	1	1	50 /area	50			ADA accessible, adjacent to waiting room
9.115	Visitor Restroom	1	1	50 /area	50			ADA accessible, adjacent to waiting room, wall-mounted water fountain outside
9.116	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
Subtotal	9.100				1,585	1.25	1,981	
Total	**9.000**				**1,585**		**1,981**	

10.000
Laundry and Food Services

10.000 LAUNDRY AND FOOD SERVICES

The laundry and food services areas incorporate the following components:

- A laundry pick-up and distribution system for institutional laundry (linens). Institutional laundry will be cleaned by a private provider. The patients will clean their personal clothing and items in laundry rooms provided on the patient units.

- A production kitchen for the preparation of three meals per day for patients and staff. The production kitchen includes areas for meal planning, preparation, cooking, serving, cleaning, and storage.

- A dining area for those patients able to leave their patient units for dining. The dining area will be located on the Treatment Mall.

Laundry Services

A. Hours of Operation

16 hours a day, 7 days a week in the patient units for patient personal laundry.
8 hours a day, 5 days a week for collection/distribution of institutional laundry.

B. Operational Description

All bulk institutional laundry such as sheets, towels, and blankets will be cleaned by a private provider. All personal items and clothing will be washed by the patients in the patient laundry rooms available on each patient unit.

For personal laundry, each patient will be responsible for laundering his or her own clothes and personal items. Unit staff will provide support when needed. Each patient unit will contain a commercial-grade washing machine and dryer. The washing machine will be equipped with an automatic soap dispenser, to dispense a pre-measured amount of soap per load. The laundry room will also contain a dryer and folding table. The laundry rooms will be available during patient waking hours although patient access to the laundry room will be controlled by staff to ensure safety issues are appropriately addressed.

Institutional laundry services will be provided via a contract with a private provider. Institutional custodial workers will distribute clean linen to the patient units and other designated hospital areas on a scheduled basis. A supply of clean linen will be

maintained on each of the patient units for use between regularly scheduled laundry distribution times. Unit staff will distribute the clean linen to patients as required. Unit staff, with patient assistance, will collect soiled institutional laundry on a scheduled basis. Staff will inspect the soiled laundry as it is collected to ensure that contaminated clothing is placed in a melt away bag. The soiled linen will be collected in authorized laundry bags and stored in a soiled linen closet until transfer to a centralized area for soiled laundry collection. Institutional custodial staff will collect soiled laundry from patient units on a daily basis, and will transfer it to the centralized storage area on a soiled laundry cart.

All biologically contaminated laundry will be handled following the special handling mandates of the Center for Disease Control (CDC) Guideline for Isolation Precautions in Hospitals, the CDC "What Employees Should Know About Universal Precautions," and the Occupational Safety and Health Administration (OSHA) regulation 29CFR1910.1030 for Blood Borne Pathogens.

Institutional custodial staff will distribute clean linen to the patient units on a clean linen cart on a scheduled basis. While soiled laundry may be collected at the same time clean linen is distributed, the linens will be kept separate. The designated clean linen cart will be used for distribution only. At no time will the clean linen cart be utilized for soiled laundry.

The private provider will deliver clean linen, sorted and sealed in plastic. The clean linen will be transferred to a centralized area for clean linen temporary storage. The linen will be stored on protected shelves for easy retrieval and subsequent distribution to the patient units. The shelves will be equipped with plastic covers to keep dust and other particulates from settling on the clean linen. The clean linen storage room will contain a sorting table and a clean linen cart storage area.

Consistent with the above processes, laundry services will include the following components:

- A soiled linen storage area, with a table for sorting and bagging of soiled linen, shelving, and a cart storage area.

- A room or closet for the storage of the soiled linen carts. The soiled linen carts must only be used for the collection of soiled linens, never for the distribution of clean linens, and must be stored in a separate area from the clean linen carts. Color coding of the carts would assist in maintaining the separation of the carts.

- A room for the temporary storage of clean linens. Most of the clean linens will be stored on the patient units.

- A room for the storage of the clean linen carts.

- A cart washing area to facilitate the routine cleaning of linen carts.

- A laundry loading/staging area for the transfer of the bagged soiled laundry to the private provider's truck. This staging area is adjacent to the truck loading dock, and is shared by the kitchen and facility management components of the hospital. The staging area is described in further detail in Section 12.000.

- The patients' personal items and clothing will be cleaned by the patients themselves in the laundry rooms provided in each patient unit. These laundry areas are described in further detail in Sections 3.000 and 4.000.

C. Staffing

No staffing will be specifically assigned to laundry functions. These duties will be provided by institutional custodial staff under the supervision of the executive housekeeper.

Food Service: Production Kitchen

A. Hours of Operation

The production kitchen will operate from 6:00 AM to 7:00 PM daily, with three meals served between 7:30 AM and 6:00 PM.

B. Operational Description

The meal service mission is to provide three hot and/or cold meals each day at appropriate times. Meals will be produced in accordance with a three-week cycle menu (with seasonal variations). Menus will be developed by a registered dietitian, and will meet or exceed the allowances of the Recommended Dietary Requirements as set forth by the U.S. Federal Government, as well as the guidelines set forth in the Regulations for the Licensure of General and Specialty Hospitals in the State of Maine, July 1972, with amendments through January 1997, Section XI.C. Special therapeutic diets, when ordered by the physician, will be served, in addition to religious meals when endorsed by the chaplain or the administration.

Equipment will be initially purchased to serve the patient population and staff being planned for the initial phase of construction. The kitchen, however, will be sized for potential future hospital expansion.

Meals will be served at typical meal times. Food will be served cafeteria-style from steam tables (in service lines) in two dining rooms located off the Treatment Mall. Special diets will be marked by the food service staff and handed out to the patient during mealtime. The number of special diets in the future will be kept to a minimum, since most of the food being prepared will conform to the typical special diet requirements.

Meals will be served on-unit in pre-portioned thermal trays for patients housed in the high security forensic unit. Patients from other units may also be served meals in pre-proportioned trays in their patient units based on physician orders. The trays will be portioned uniformly and speedily in the production kitchen to maintain temperature, portion and cost control capability. The thermal trays will be shipped in thick wall, highly insulated boxes, and transported on wheeled or non-mechanical conveyance carts. This will allow food temperature in the trays to be maintained at 140 degrees. Each food box will be sized to hold the number of trays to remotely serve an entire patient unit. This will allow the patient unit staff to distribute the trays and allow the remaining food box to stay sealed, keeping the food at the desired temperature. The production kitchen will be sized and organized to dispense dining room meals and carted patient trays within a two-hour scheduled meal period.

Food product will be requisitioned weekly for delivery to the production kitchen storerooms, which shall have a capacity of seven to ten days. Food will be delivered, on average, twice a week for fresh foods such as breads, fruits and vegetables; once a week for dry and frozen goods; and three times a week for rapid spoil items such as milk.

Areas for the storage of cold and frozen foods, dry storage, cooking, baking of sheet goods, food preparation, meal assembly, scullery (pot and dishwashing), offices, and support space will be provided. Additionally, external areas will be established for waste collection and compactors, and recycling.

The design of the kitchen will facilitate the one way movement of product from one end of the kitchen (incoming) to the other (outgoing) end of the production process. Separate cooking areas will be provided for food preparation, baking, broiling, and cooking.

Consistent with the above processes, the production kitchen area will include the following components:

- A small ingredient room adjacent to a cook's cooler will permit the accurate portioning and staging of raw ingredients for the upcoming meal production.

- The food preparation area will include areas for cleaning vegetable and produce, opening canned goods and frozen or dry boxes. A hot food preparation area with

cooktops will be provided, as well as ovens for baking and roasting. A beverage and ice area will also be provided in the food production kitchen.

- The cleaning and sanitizing of all soiled trays and delivery equipment will be processed in a separate, designated area of the production kitchen. The kitchen design must be carefully laid out so that returning soiled trays and boxes do not cross the paths of outgoing clean trays and food boxes.

- Two sanitation areas will be provided in the kitchen: one with industrial-grade dishwashers for the sanitizing of dishes, pots, containers, cutlery and trays; and a second area with a spray hose and floor drain for the sanitizing of the food carts.

- The production kitchen storerooms will include a dry goods and canned goods storeroom, two walk-in refrigerators, two walk-in freezers, and a baked goods storeroom. The production kitchen storerooms will be supplemented by a food storage room in the central warehouse, which will have the capacity to store canned and some dry goods for up to 30 days (see Section 12.000).

- Three offices are provided in close proximity to the production kitchen: an office for the dietetic services manager, an office for the assistant dietetic manager, and shared office space with three workstations for the clinical dietician and two diet coordinators. The private offices and one workstation will be equipped with a computer and printer. A copy machine will be located in the shared office space.

- A walk-in closet will be provided for the maintenance of manuals and books required for food production.

- The production kitchen will be equipped with male and female locker rooms/ changing areas for cooks and food service workers to change into uniforms upon arrival at work. Staff restrooms will be provided in this area.

- Janitor's closet and trash room.

C. Staffing

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
Dietetic Services Manager		X	X	X	X	X	
Assistant Dietetic Services Mgr	X	X	X	X			X
Clinical Dietician	X		X				
Diet Coordinator (Swing)		X	X	X	X	X	
Diet Coordinator (Swing)	X	X	X	X			X
Cook (6:00 AM – 2:30 PM)	X	X	X	X	X	X	X
Cook (10:30 AM – 7:00 PM)	X	X	X	X	X		

Food Service Worker (6:00 AM – 2:30 PM)	X	X	X	X	X	X	X
Food Service Worker (6:00 AM – 2:30 PM)	X	X	X	X	X	X	X
Food Service Worker (6:00 AM – 2:30 PM)	X	X	X	X	X	X	X
Food Service Worker (10:30 AM – 7:00 PM)	X	X	X	X	X	X	X
Food Service Worker (10:30 AM – 7:00 PM)	X	X	X	X	X	X	X
Food Service Worker (10:30 AM – 7:00 PM)	X	X	X	X	X	X	X

Dining

A. Hours of Operation

7:30 AM to 6:00 PM seven days a week.

B. Operational Description

Two dining rooms each with seating for up to 32 will be located directly off the Treatment Mall. Patients will be able to access the dining rooms from the program areas without having to return to their patient units first.

Patients will be scheduled for meals for one of two shifts. Two patient units and staff may be scheduled to eat at one time in the separate dining rooms during the two shifts. Every effort will be made to arrange the scheduling for the appropriateness of the patients dining simultaneously.

Patients will eat meals cafeteria style after being served along a food line by food service workers behind the counter. A self-service beverage bar will be provided with individual containers of milk or juice and self-serve water and drink dispensers. Patients that receive special dietary meals will be identified by staff by reviewing a special diet log prior to serving the patient. Food service workers will make every effort to recognize the patients and be familiar with their dietary needs and restrictions.

The dining room environment will be bright with pleasing colors, with non-fixed tables and comfortable dining chairs. Patients will drop off their dirty trays as they exit the dining room. Ideally, this drop off area will be immediately adjacent to the scullery area within the production kitchen. Alternatively, patients may place their dirty trays in a cart prior to exiting the dining room.

Staff will eat with the patients of their assigned living units. Other staff may eat during or immediate following the patients' scheduled meals. A debit card reader will be located by the serving line to facilitate the process of charging staff for the cost of meals they choose to purchase.

C. Staffing

Since staff will eat meals with their assigned living unit, there will be no dedicated staff in the dining area. Food will be served by food service workers and mental health workers, and the dining rooms will be cleaned by institutional custodial staff. Porters supervised by the executive housekeeper will assist in delivering the pre-portioned thermal meal trays to patients on the high security forensic unit and to patients on other patient units when ordered by the physician.

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
Porter (Food Delivery)		X	X	X	X	X	
Porter (Food Delivery)	X	X	X	X			X

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
10.000	**LAUNDRY AND FOOD SERVICES**							
10.100	LAUNDRY							
10.101	Soiled Linen Storage Area	1-2	1	100 /area	100			Bag racks/holders, shelving
10.102	Soiled Linen Cart Storage	-	1	60 /area	60			
10.103	Clean Linen Storage Room	1-2	1	100 /area	100			Covered shelving
10.104	Clean Linen Cart Storage	-	1	60 /area	60			
10.105	Cart Washing Area	-	1	60 /area	60			Sink, hose, floor drain
10.106	Truck Loading/Staging Area	-	-	- -	-			Shelving, cart staging; adjacent to truck loading dock; shared by laundry, kitchen, and facility maintenance functions; see 12.117
10.107	Truck Loading/Receiving Dock	-	-	- -	-			Truck loading dock, shared by kitchen, laundry, and facility maintenance functions, sized for the loading/unloading of one tractor trailer, covered, raised platform for truck unloading; see 12.118
Subtotal	10.100				380	1.25	475	
10.200	PRODUCTION KITCHEN							
10.201	Hot Food Prep/Cooking	-	1	100 /area	100			Kettles, ovens, tables
10.202	Cold Food Preparation	-	1	100 /area	100			Mixer, cutter, tables, sinks
10.203	Baking/Roasting	-	1	60 /area	60			Ovens, racks
10.204	Beverage Production & Ice	-	1	40 /area	40			Instant/freeze dry products
10.205	Ingredient Room Issue	-	1	50 /area	50			Bins, shelving tables
10.206	Tray Assem. & Temp. Holding	-	1	150 /area	150			Carts, assembly line
10.207	Cart & Tray Clean Staging	-	1	80 /area	80			
10.208	Pan & Container Clean Staging	-	1	30 /area	30			
10.209	Utensil, Pan, Container, Tray	-	1	40 /area	40			Reserve and issue items
10.210	Tray Washing	-	1	100 /area	100			Tray washer/dryer 2-3; access to each dining room
10.211	Cart Wash	-	1	80 /area	80			

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
10.000	**LAUNDRY AND FOOD SERVICES - cont'd**							
10.212	Cold Storage	-	1	80 /area	80			Shelving and dunnage racks
10.213	Frozen	-	1	80 /area	80			Dry stores, shelving
10.214	Dry Storage - General	-	1	200 /area	200			Pallet shelving
10.215	Dry Storage/Paper Goods	-	1	100 /area	100			Shelving and dunnage racks
10.216	Kitchen Equipment/Utensils	-	1	40 /area	40			Shelving, casters, conveyor parts; locked knife storage
10.217	General Storage	-	1	60 /area	60			Spare parts, special occasions storage, etc.
10.218	Dietetic Services Manager's Office	1	1	80 /office	80			Computer equipped
10.219	Assistant Dietetic Manager's Office	1	1	80 /office	80			Computer equipped
10.220	Shared Office Space	1	4	60 /worksta.	240			Computer equipped, copier; work stations include desktop space, chair, drawers and file storage
10.221	Walk-In Closet	-	1	40 /area	40			Shelving for manuals, books, CPI binders, etc.
10.222	Food Service Staff Locker/ Changing/Restroom (M/F)	1-3	2	80 /area	160			Lockers for food services staff; ADA accessible
10.223	Janitor Closet/Mop Area	-	1	40 /area	40			Slop sink, mop racks, ventilation, floor drain
10.224	Trash Room	-	1	60 /area	60			Trash cans (sufficient for 2 day storage), recycling bins, temperature controlled
10.225	Truck Loading/Staging Area	-	-	- -	-			Shelving, cart staging; adjacent to truck loading dock; shared by laundry, kitchen, and facility maintenance functions; see 12.117
10.226	Truck Loading/Receiving Dock	-	-	- -	-			Truck loading dock, shared by kitchen, laundry, and facility maintenance functions, sized for the loading/unloading of one tractor trailer, covered, raised platform for truck unloading; see 12.118
10.227	Dumpster/Compactor	-	1	250 /area	(250)			Not included in total net sq. ft.
10.228	Container (Trash) Store	-	1	100 /area	(100)			Not included in total net sq. ft.
10.229	Recycling	-	1	50 /area	(50)			Not included in total net sq. ft.; includes recycling bins
Subtotal	10.200				2,090	1.25	2,613	
Subtotal	Outdoor Spaces				400	1.00	400	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
10.000	**LAUNDRY AND FOOD SERVICES - cont'd**							
10.300	PATIENT DINING							
10.301	Dining Rooms	32	2	15 /person	960			Small tables and comfortable dining chairs
10.302	Serving Line	-	2	150 /area	300			Includes debit card readers for staff
10.303	Dirty Tray/Utensil Return	-	2	40 /area	80			
Subtotal	10.300				1,340	1.35	1,809	
Total	**10.000**				**3,810**		**4,897**	

11.000
Building Access and Patient Safety Services

11.000 BUILDING ACCESS AND PATIENT SAFETY SERVICES

A. Hours of Operation

24 hours a day, 7 days a week.

B. Operational Description

The Building Access Center is the focal point of the Psychiatric Treatment Center's safety operations. It operates on a 24 hour basis for monitoring and coordinating the hospital's access, safety and communications systems. Building Access Center activities include observing and controlling the hospital's entrance and exit traffic; monitoring the institution's communication, fire alarm/detection and personal alarm systems; issuing emergency keys and monitoring the issuance of all facility keys; monitoring and operating electronically controlled doors; and monitoring CCTV operations and perimeter security.

A personal alarm system will be installed to further ensure patient and staff safety. With this system, a need for assistance is indicated when the staff member presses a button on a pager-type device or when the device is no longer in an upright position. The personal alarm system precludes the need for emergency response systems mounted throughout the hospital.

The Building Access Center will be located adjacent to the public lobby to facilitate observation of the entrance area, lobby and main vestibule. The Building Access Center will be accessed through an electronically controlled door leading out of the main vestibule to prevent unauthorized access into this area. This measure is necessary to ensure the safety and privacy of staff and patients throughout the facility. The walls and doors of the Building Access Center will be enclosed with fully grouted walls with both vertical and horizontal reinforcement. In addition, ample security glazing will be provided above the height of the console equipment to permit clear observation of all persons conducting business at the Building Access Center window, the public lobby and entrance vestibule, and staff and visitors passing through the vestibule to gain access to various locations within the facility.

An automated time and attendance and staff identifier system will identify when staff enter and leave the facility. In addition, an automated key control box will be located in the vestibule to allow staff to access those keys not kept on the patient units. The key control box will be activated by card access and a personal identification number. The system will also automatically log in and out all keys.

A staff member will staff the Building Access Center at all times. Redundant touch screen door control and communication capabilities will allow one person to operate all necessary equipment and systems.

The Building Access Center will have excellent direct visibility of the entrance vestibule into the public lobby so that positive identification of all persons entering and exiting can be made. All other visual observation will be by event-activated CCTV (staff or patients pressing a door intercom will activate a camera at that location and the resulting image will be cued into the monitor in the Building Access Center). Cameras and monitors will be in color, and care will be taken to avoid creating banks of monitors that are difficult to observe properly. Use of CCTV cameras will be kept to a minimum throughout the facility. They will be used only where absolutely necessary, and will not be utilized to replace a staff position when that position is necessary for appropriate patient care.

The Building Access Center will encompass the following areas:

- The Building Access Center will include the monitoring consoles for security monitoring systems, life safety monitoring equipment (fire and smoke alarms), door controls, personal alarm systems, and CCTVs monitors. Secure pass-throughs and talk-throughs will facilitate communication between persons inside and outside the Building Access Center, as well as allow for the passage of papers, keys, radios, alarms and other items to persons in the vestibule. The vestibule will also contain the key box for staff daily use keys; either a chit board or electronic "Key Watcher" system will be employed.

- An equipment room immediately adjacent to the Building Access Center will house the equipment for the monitoring equipment as well as communication and intercom equipment. The equipment room will also have a copier and fax machine.

- Staff will oversee the issuance and maintenance of the staff card access system. A computer designated for programming access cards will be located in a small room off the Building Access Center. Documentation of staff receipt of access cards or keys will be maintained. This area will also contain a lockable cabinet with a chit board for the storage of emergency keys.

- Storage room with space for outdoor weather gear and shelving for office supplies.

- Coffee maker/water cooler, beverage counter.

- Staff restroom, ADA accessible.

C. Staffing

Security operations will be managed by the Director of Security and Safety Compliance. The following positions will be allocated to conduct the described security functions.

POSITION	*MON*	*TUE*	WED	THU	FRI	SAT	SUN
Building Access Center Supervisor (Days)	X	X	X	X	X	X	X
Area Supervisor (Days)	X	X	X	X	X	X	X
Building Access Center Supervisor (Evenings)	X	X	X	X	X	X	X
Area Security Supervisor (Evenings)	X	X	X	X	X	X	X
Building Access Center Supervisor (Nights)	X	X	X	X	X	X	X
Area Supervisor (Nights)	X	X	X	X	X	X	X

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
11.000	**BUILDING ACCESS AND PATIENT SAFETY SERVICES**							
11.100	BUILDING ACCESS AND PATIENT SAFETY CENTER							
11.101	Building Access Center	1	1	150 /area	150			Includes security monitoring systems, alarm centers, door controls, etc., countertop for radio chargers, pass-throughs, emergency key cabinet, daily use keys stored in chit system or electronic "Key Watcher" system; adjacent to Public Lobby
11.102	Building Access Center Equi	1-2	1	75 /area	75			Includes communications equipment, CCTV & intercom equipment, copier, fax
11.103	Storage Room	1	1	60 /area	60			Lockable, shelving
11.104	Key Closet/Key Card Computer	1	1	40 /area	40			Lockable, chit board for storage and immediate availability of emergency keys, computer for programming staff card access cards
11.105	Staff Restroom	1	1	50 /area	50			ADA accessible
11.106	Beverage Station	-	1	5 /area	5			Coffee maker, water cooler, countertop
Subtotal	11.100				380	1.32	503	
Total	**11.000**				**380**		**503**	

12.000
Facility Management

12.000 FACILITY MANAGEMENT

A. Hours of Operation

Authorized staff have access to these areas on an as-needed basis for all three shifts.

B. Operational Description

The facility management functional spaces are comprised of the following areas:

- Central storage
- Maintenance/housekeeping
- Central mechanical

Supervisory staff will be provided centralized office space within the warehouse/ maintenance areas.

Central Storage

The warehouse component will be located in close proximity to the vehicle entrance to the facility and outside of the security perimeter. The warehouse will have both a vehicle entrance, and share the loading dock/staging area with other secure receiving and shipping operations, such as the kitchen and laundry components. There will be a separate pedestrian entrance for vendors. Storage areas will be in close proximity to the vehicle loading lock. The administrative area of the warehouse function will be closely associated with the loading dock, so that careful monitoring and inventory of goods movement can occur.

Warehouse spaces will be ventilated to assure the proper storage of all items to be maintained. The warehouse requires special provisions for temperature and humidity regulation, smoke and fire suppression, contamination protection, and vermin control. While the warehouse is intended to provide up to a 30-day retention time for institutional supplies, some goods may be stored for longer periods of time. Special equipment may include a battery operated forklift and pallet jacks. All storage will be palletized with an appropriate rack storage system, three pallets high. Aisle widths will be wide enough for a forklift. The receiving/loading dock area will provide adequate space for a tractor-trailer truck to unload goods.

Consistent with the above processes, the central storage area will include the following components:

- A warehouse area will be divided into several storage sub-components that will be separately secured and alarmed to assure controlled and supervised access. These areas include:

  - Central storage, for the storage of bulk items.

  - Institutional supplies, for the storage of paper products, cleaning materials and housekeeping supplies/equipment and other supplies necessary for the operation of the center.

  - Short-term storage for miscellaneous storage of short-term items, such as crafts items.

- An office for the storekeeper will be located adjacent to an office of the building engineer but with a view of the receiving loading dock. The office will include a desk, chair, one side chair, and file cabinets. The office will be equipped with a computer and printer.

- Janitor's closet.

- External areas will be established for waste collection and recycling with bailing machines and compactors, and biohazard storage for subsequent pick-up at the loading dock.

- Exterior areas will include a trash compaction/bailing area, and a staging area/loading area sized for a tractor-trailer truck.

Maintenance/Housekeeping

The Psychiatric Treatment Center will maintain a housekeeping and maintenance plan to ensure that the hospital is maintained in good repair. While DMHMRSAS may choose to outsource major repairs, the hospital's maintenance staff will perform routine and preventive maintenance to ensure that all building systems are functioning properly.

The Psychiatric Treatment Center will include a small area for minor repairs, but the majority of these activities will occur within the maintenance shop area currently available on the AMHI campus. Space for the long-term storage of toxic and caustic materials such as paints, cleaning supplies, and other potentially hazardous or combustible materials will be provided in the current shop areas. Lawn maintenance and snow removal equipment will also be maintained in the current shop areas.

Consistent with the above processes, the maintenance/housekeeping area will include the following components:

- The Psychiatric Treatment Center maintenance shop will include space for minor repairs. Maximum use will be made of wall spaces for workbenches and peg boards for tools that are most frequently used in the maintenance function. Shadow boards will be used for tool control and storage.

- A storage room will be provided for the temporary storage of broken furniture. The broken furniture will be brought to the carpentry or other applicable shop for repair, or sent out to a private provider for repair. Every effort will be made to deal with broken furniture as quickly as possible, and either fix and return the furniture into use, or discard furniture that is not considered repairable.

- An office area will provide private office space for the building engineer (the storekeeper is included above in the central storage area), and an executive housekeeper. The offices will have a desk, chair, one side chair, and file cabinets. The offices will be equipped with computers and printers.

- A copy/fax/file room with a copier, fax machine, shredder, office supply cabinet and file cabinets. This area will be shared with warehouse staff.

- A multipurpose room for contract negotiations and planning as well as staff meetings and staff breaks. Shelving will be provided for the storage of documentation and technical manuals. An alcove will provide a beverage counter, a sink, small refrigerator, a microwave, and coffee maker.

- Female and male staff locker areas including a shower/changing room, and staff restrooms.

Central Mechanical

The central mechanical plant houses the central heating plant and centralized chillers for the hospital, as well as an area for the emergency generators. If the design incorporates separate buildings for one or more of the functions of the facility, then these buildings will all be tied to the central mechanical plant. A life cycle analysis will need to be performed to determine whether or not to construct and equip a central plant versus rooftop units.

C. Staffing

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
Building Engineer	X	X	X	X	X		
Storekeeper	X	X	X	X	X		
Executive Housekeeper	X	X	X	X	X		
Maintenance Mechanic (Days)		X	X	X	X	X	
Maintenance Mechanic (Days)	X	X	X	X			X
Maintenance Mechanic (Evenings)	X	X	X	X	X		
Institutional Custodial Work (Days)	X	X	X	X			X
Institutional Custodial Work (Days)	X	X	X	X			X
Institutional Custodial Work (Days)		X	X	X	X	X	
Institutional Custodial Work (Days)		X	X	X	X	X	
Institutional Custodial Work-Laundry (Days)	X	X	X	X	X		
Institutional Custodial Work (Evenings)	X	X	X	X	X	X	X
Institutional Custodial Work (Evenings)	X	X	X	X	X	X	X

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
12.000	**FACILITY MANAGEMENT**							
12.100	WAREHOUSE							
12.101	Storekeeper's Office	1	1	80 /office	80			Desk, chair, filing cabinets, phone, computer, printer, visitor chair, view of loading dock
12.102	Central Storage	-	1	600 /area	600			General facility storage for bulk items
12.103	Supply Storage	-	1	350 /area	350			Storage of paper products, cleaning supplies, etc.
12.104	Short Term Storage	-	1	400 /area	400			Easy access short term storage, craft items, etc.
12.105	Forklift Staging/Charging	-	1	60 /area	60			
12.106	Shipping Staging	-	1	120 /area	120			
12.107	Food Storage - Dry	4	1	800 /area	800			Pallet racks 3 high
12.108	Food Storage - Cold/Frozen	-	1	200 /area	200			Freezers and coolers
12.109	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
12.110	Truck Loading/Staging Area	-	1	150 /area	150			Shelving, cart staging; adjacent to truck loading dock; shared with laundry and kitchen
12.111	Staging Area/Loading Dock	-	1	400 /area	(400)			1 loading bay, sized for tractor-trailer, weather protection, separate ground-level pedestrian entrance, loading platform; shared with kitchen and laundry; not included sf
12.112	External Trash Compaction/Bailing	-	1	200 /area	(200)			Exterior space, truck access, recycling bins; not counted in total sf
Subtotal	12.100				2,800	1.20	3,360	
Subtotal	Outdoor Spaces				600	1.00	600	
12.200	MAINTENANCE							
12.201	Building Engineer's Office	1	1	80 /office	80			Desk, chair, filing cabinets, phone, computer, printer, visitor chair
12.202	Executive Housekeeper's Office	1	1	80 /office	80			Desk, chair, filing cabinets, phone, computer, printer, visitor chair
12.203	Records/File/Copy/Fax Room	1	1	100 /area	100			Includes file storage; shared with Maintenance/Housekeeping

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
12.000	**FACILITY MANAGEMENT - cont'd**							
12.204	Multipurpose/Break Room	8	1	160 /area	160			Tables, chairs, phone, white board, shelving for manuals, alcove with small refrigerator, microwave, coffee maker, sink, counter top, cabinets; shared
12.205	Locker/Shower/Changing/ Restroom (M/F)	8	2	100 /area	200			18 full length lockers; changing space, benches, toilet room, shower area; shared
12.206	Broken Furniture Storage	-	1	100 /area	100			Shelving, temporary storage
12.207	Workshop for Minor Repairs/Tools & Parts Storage	1-2	1	150 /area	150			Located within security perimeter; adjacent to Dietary Services
12.208	Bio-Hazard Storage	-	1	40 /area	40			Temperature controlled, ventilate directly to exterior, shelving, lockable
12.209	Janitor Closet	-	1	40 /area	40			Ventilation, slop sink, mop rack; shared with warehouse
Subtotal	12.200				950	1.15	1,093	
12.300	CENTRAL MECHANICAL PLANT							
12.301	Chillers	-	1	1,000 /area	1,000			Air handlers elsewhere
12.302	Boiler	-	1	1,000 /area	1,000			Air handlers elsewhere
12.303	Emergency Generators	-	1	1,200 /area	1,200			
12.304	Electrical Services/Panels	-	1	800 /area	800			Includes electrical service and telephone relay panels
12.305	Sprinkler Systems	-	1	150 /area	150			Includes pressure tanks and electronic controls
Subtotal	12.300				4,150	1.15	4,773	
Total	**12.000**				**7,900**		**9,225**	

13.000
Site

13.000 SITE

A. Hours of Operation

Monday through Friday, day shift plus additional times as required.

B. Operational Description

The site issues outline those site design details that are essential to the efficient and effective operation of the hospital. The site issues include access, parking and security.

Appropriate signage throughout the public areas of the hospital's grounds will be utilized to direct both pedestrian and vehicular traffic to the appropriate locations, such as parking areas, the public lobby, and vehicular access/egress locations. Signage and pavement markings will be utilized to regulate traffic direction and flow.

The site design will prevent public vehicles from driving up close to the hospital. This can be accomplished through the use of architectural elements, landscaping, bollards, concrete planters, and other attractive and dignified exterior treatments that will keep vehicles an acceptable distance from the facility.

It is important to note that vehicular access to all areas of the grounds must be provided for fire department access. Included in the accessibility requirements for the fire department is one (or more, if necessary) turn-around area adequately sized for a ladder truck. Local codes and the fire marshall will provide the necessary specifications for fire department access.

Parking

Two separate parking areas will provide adequate space for staff, official visitors, and the general public. Visitor parking will be located adjacent to the entrance into the public lobby. At least ten official parking spaces will be located in this area. Approximately 30 additional spaces should be provided in the visitor parking area.

A separate parking area, designated for staff only, will be located beyond but adjacent to the visitor parking lot. If desired by DMHMRSAS, the staff parking will have assigned parking spots for certain staff members (e.g., facility director, doctors, etc.). Given the various shifts and work hours, 170 spaces will provide adequate parking for all staff.

Handicapped parking spaces will be provided in all lots in accordance with ADA requirements.

A parking area next to the warehouse/facility maintenance building will provide staff parking as well as parking for hospital vehicles.

Perimeter Security

The use of fencing at the Psychiatric Treatment Center will be unobtrusive to ensure the hospital has a residential appearance and that the exterior reflects the hospital's mission of treatment for persons with mental illness. The design and physical structure of the hospital will provide the primary perimeter security. When fencing is used, estate fencing will be primarily utilized. The use of estate fencing and appropriate landscaping will provide a visual perimeter of the hospital grounds.

C. Staffing

There will be no designated staff for the parking areas and the site. However, designated hospital staff will patrol the parking areas and the grounds on a regular basis.

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
13.000	**SITE**							
13.100	PARKING							
13.101	Public Parking	40	1	450 /space	(18,000)			Provide handicap spaces in accordance with ADA regulations
13.102	Staff Parking	170	1	450 /space	(76,500)			Provide handicap spaces in accordance with ADA regulations
Subtotal	13.100				94,500	1.00	94,500	Outdoor space
Total	**13.000**				**94,500**		**94,500**	**Outdoor space**

14.000
Supportive Living Centers

14.000 SUPPORTIVE LIVING CENTERS

A. Hours of Operation

24 hours a day, 7 days a week.

B. Operational Description

The Supportive Living Centers will provide a staff-secure and safe home environments for persons with serious and persistent mental illness for whom psychiatric hospital-level care is no longer required, but for whom community placement has been precluded due to the need for a structured living environment and intensive support.

Existing houses or similar structures will be rehabilitated for use as Supportive Living Centers. The Supportive Living Centers will provide mini-apartments with adequate supervision and a high level of support for persons with serious mental illness for whom community placements have proved unsuccessful. The Supportive Living Centers are not designed to mirror a hospital environment, but to provide a home-like setting for residents. Each Center will function independently to provide services for eight residents, and will not require co-location with each other or the Psychiatric Treatment Center.

While opportunities for psychosocial rehabilitation and psychiatric treatment will be provided within each Supportive Living Center, their primary function will be to provide a supervised living environment from which residents may safely access community resources. Unobtrusive measures such as security windows and estate fencing of outdoor areas will ensure resident safety while facilitating free movement within the facilities. Staff will monitor the departure and return of residents at all times, with staff controlling movement in and out of the facility between the hours of 8:00 PM and 8:00 AM.

Each Supportive Living Center will include eight private living areas configured in two clusters around common leisure, dining, treatment and recreation space. The individual living areas will include a sitting area and bedroom area as well as a private restroom and shower. The sitting area will provide space for personal activities and quiet time and will be equipped to permit a personal television, computer and/or telephone. Residents may use Center-provided furniture or their personal furniture. The individual areas will provide ample storage and display space for personal belongings.

Although part-time staff will be present to assist with food preparation and house maintenance, residents will be encouraged and expected to participate in these activities with staff support at a level consistent with their clinical status. Consistent with the description of the Supportive Living Centers, each of the facilities will include the following components:

Individual Living Areas: Each resident will have a private living area large enough to accommodate a sitting area, a bedroom area and a private restroom and shower. Residents will be permitted to use their personal furniture if they choose in order to facilitate the establishment of individualized personal space.

Space within the eight individual living areas includes:

- Bedroom space will accommodate a bed, end table, and side chair.

- A double closet will include a wardrobe insert with drawers, shelving and clothing hanging space for the storage of personal belongings. A lockable drawer will permit residents to safely maintain valuable personal items.

- A sitting area will accommodate a comfortable sitting chair, end table, a wall unit to provide desk space, shelving, placement of television with cable hook-up and counter space for placement of personal items, a desk chair, and display boards for personal items. The sitting area will also have a telephone jack for residents who choose to have a personal phone.

- A private restroom will provide a toilet, sink, counter space, and shower. A call-button to access staff assistance will be provided.

Cluster Areas: The eight individual living areas will be divided into two clusters to minimize the perception of a crowded institutional setting. The clusters will also permit residents the choice of with whom they would prefer to socialize at a specific point in time. Each cluster will include the following:

- A leisure area will accommodate four residents socializing, reading or playing games. The leisure area may also be used when residents have visitors. Each leisure area will be furnished with one sofa, two side chairs, end tables, a small table and four chairs, a bookcase for reading material, and a cabinet for the storage of leisure supplies and games. A phone will be available in this area for resident use.

- A small television room will permit residents to watch television without disturbing other residents using the leisure space. The television room will be furnished with a sofa, two comfortable chairs and a television. Walls adjacent to the common area will be glazed to maximize the feeling of open space while attenuating the television noise.

- An outdoor leisure area will be accessed from each cluster. The outdoor leisure courtyards will be sized to accommodate six persons engaged in quiet recreation. Two park benches, a picnic table, and a small garden will be provided.

- A tub room with a changing area will be shared by the clusters to offer residents the opportunity for tub bathing when requested.

- One janitor's closet will serve both clusters.

Common Areas: These areas will be available for all residents.

- The entry foyer into the Supportive Living Center will permit staff observation while providing an inviting entrance into the facility for residents and visitors. Glazing and high ceilings will complement a furniture arrangement of a sofa and chair. The foyer will also provide residents with a comfortable place to wait for visitors or transportation to community activities. A small staff desk in this area will permit unobtrusive staff observation of activities in the foyer when needed.

- A small room accessed from the entry foyer will provide residents a private space for visits and meetings with persons from the community when the resident prefers that the meeting not take place in the living areas. The room will be furnished with a sofa and comfortable chairs and side tables.

- Public restroom, ADA accessible.

- Water fountain.

- A kitchen able to accommodate food storage and preparation for 12 persons and sized to facilitate the participation of residents in food preparation with staff supervision will be provided.

- A dining room accommodating 12 persons served buffet style will be partitioned by glazing into two distinct areas to facilitate resident choice of with whom they would like to share a meal. The dining room will be furnished with four small tables, each accommodating four people. The dining room will be utilized by residents and staff.

- A multipurpose room sized for 12 seated persons will be utilized for community meetings, psychosocial rehabilitation activities, and arts and crafts. The space will enable the provision of holiday parties, bingo games and large group movies. The multipurpose room will be furnished with three small tables, each with four chairs, and a lockable cabinet for storage of programming supplies. The room

will be designed to facilitate the use of audiovisual equipment and will have a closet for the storage of a large screen TV and VCR on a movable stand.

- A small pantry alcove providing a sink, refrigerator, microwave, coffee maker, ice maker, counter space, and cabinets will be located off the multipurpose room for resident use during activities. The pantry will have lockable doors to ensure safety when the area is not being used.

- A vending machine area will be located adjacent to the multipurpose area for resident and staff use.

- A laundry room will include ironing space, a commercial-grade washer and dryer, and counter space for laundry sorting and folding. A lockable closet will store an iron and ironing board as well as provide shelving for laundry supplies. Closets for clean linen and soiled linen storage will be adjacent to the laundry room.

- A storage closet with shelving for equipment and supplies will be provided.

- Janitor's closet.

Treatment Areas:

- One consultation/treatment room for individual resident counseling, assessment and meetings with community providers will be sized to accommodate a small table and three comfortable chairs.

- One group room accommodating eight people seated at two long tables will be available for psychoeducational/support groups and treatment planning. The room will also be used for staff meetings.

- A medication room sized for three standing persons will be provided adjacent to the common area to safely secure resident medications. This room will not be designed for nurse administered medication but will provide space for residents to administer their own medications with staff supervision and monitoring. The medication room will include locked cabinets to maintain resident medications, a sink for handwashing, a small refrigerator for medications requiring refrigeration and a small refrigerator for the maintenance of laboratory specimens awaiting pick-up. The medication room will also include a closet for the storage of hygiene and medical supplies.

- Adjacent to the medication room will be a small office for nursing staff to provide health education, evaluate resident physical complaints, complete blood draws for laboratory testing, and administer injectible medications. The room will include a small desk, desk chair, a side chair adaptable for the safe drawing of

blood for laboratory testing, and an exam table. Containers for the safe disposal of sharps and medical waste will be provided.

Staff Office Area: Since Supportive Living Center staff will be expected to be actively involved with the residents at all times, the space allocated for staff offices is minimal. The office area will be accessed from the entry foyer.

Components of the staff office area will include:

- A private office for the Supportive Living Center registered nurse/director will be sized to accommodate a desk, chair, two side chairs, bookcase, and file cabinet. The office will be equipped with a computer and printer.

- Shared open office area will provide two unassigned workstations for use by Center staff, consultants and community providers when completing documentation. The workstations will be divided by a four-foot high acoustical partition that will provide desktop and drawer space. Each workstation will be equipped with a desk chair, file and drawer storage, and a computer. The workstations will share a printer. The shared office space will include a copier, fax machine, and counter space. Resident records will also be maintained in this area.

- Staff locker room with individual lockers for each staff member and cabinet and refrigerator space for storing staff lunches.

- Staff restroom, ADA accessible.

Facility Maintenance and Support Areas:

- Furnace and air conditioning space.

- Electrical and water heating space.

- Garage space for program van.

- Storage space for indoor and outdoor maintenance equipment.

C. Supportive Living Center Staffing

Each Supportive Living Center will be staffed as follows:

POSITION	MON	TUE	WED	THU	FRI	SAT	SUN
DAY SHIFT							
Registered Nurse/Director	X	X	X	X	X		
Licensed Practical Nurse						X	X
Residential Counselor	X	X	X	X	X	X	X
Residential Counselor	X	X	X	X	X	X	X
EVENING SHIFT							
Licensed Practical Nurse	X	X	X	X	X	X	X
Peer Specialist	X	X	X	X	X		
Residential Counselor	X	X	X	X	X	X	X
NIGHT SHIFT							
Licensed Practical Nurse	X	X	X	X	X	X	X
Residential Counselor	X	X	X	X	X	X	X
CONSULTING STAFF							
Psychiatrist	4 hours per week						
Psychologist	4 hours per week						
Social Worker	8 hours per week						
Recreational Therapist	8 hours per week						
Meal Preparation Assistant	20 hours per week						
Custodial Assistant	20 hours per week						

This staffing pattern assumes that community mental health service providers will provide the supervision required for individual residents to participate in such community-based programs as day treatment programs and job opportunities.

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
14.000	**SUPPORTIVE LIVING CENTERS**							
14.100	INDIVIDUAL LIVING SPACES							
14.101	Bedrooms	1	8	160 /area	1,280			Bed, end table, side chair, double closet with wardrobe insert, 2 ADA accessible
14.102	Private Bathrooms	1	8	80 /area	640			Toilet, sink, shower, 2 ADA accessible
14.103	Private Sitting Areas	1	8	80 /area	640			Comfortable sitting chair, end table, wall unit with desk, shelving, TV stand, chair, display boards, telephone jack, cable hookup
Subtotal	14.100				2,560	1.35	3,456	
14.200	CLUSTER AREAS (2 GROUPS OF INDIVIDUAL LIVING SPACES)							
14.201	Leisure Room	4	2	30 /person	240			Sofa, 2 side chairs, end tables, small table with 4 chairs, bookcase, storage cabinet, telephone
14.202	Television Room	4	2	100 /area	200			Sofa, 2 comfortable chairs, TV, glazed walls providing acoustical privacy
14.203	Tub Room	1	1	60 /area	60			Tub with outer changing area, ADA accessible
14.204	Outdoor Leisure Area	6	2	1000 /area	(2,000)			2 park benches, 1 picnic table, garden
14.205	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
Subtotal	14.200				540	1.35	729	
Subtotal	Outdoor Space				2,000			
14.300	COMMON AREAS							
14.301	Entry Foyer	4	1	100 /area	100			Glazed walls, high ceiling, sofa, chair, small staff desk
14.302	Visiting/Meeting Room	6	1	120 /area	120			Sofa, comfortable chairs, side tables
14.303	Public Restroom (M/F)	1	2	50 /area	100			ADA accessible, exterior wall-hung water fountain
14.304	Kitchen	4	1	200 /area	200			1 large capacity refrigerator, 1 large capacity freezer, double oven, 2 stove tops, 2 sinks, 2 large capacity dishwashers, countertops, wall-mounted storage cabinets, food storage pantry for dry and canned goods
14.305	Dining	12	1	15 /person	180			6 small tables with 4 chairs each
14.306	Buffet Line	4	1	50 /area	50			On common wall between kitchen and dining areas
14.307	Multipurpose Room	12	1	300 /area	300			Six small tables with 4 chairs each, storage cabinet, closet for large screen TV and VCR, A/V capability

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
14.000	**SUPPORTIVE LIVING CENTERS - cont'd**							
14.308	Pantry Alcove	1	1	40 /area	40			Refrigerator, sink, microwave, coffee maker, ice maker, counter space, cabinets, lockable doors
14.309	Vending Area	-	1	40 /area	40			Vending machines
14.310	Storage Closet	-	1	20 /area	20			Shelving for equipment and supplies
14.311	Laundry Room	1	1	80 /area	80			Commercial quality washer & dryer, work counter, slop sink, closet for ironing board, iron & supplies
14.312	Storage - Clean Linens	-	1	40 /area	40			Shelving for clean linens & personal hygiene items
14.313	Storage - Soiled Linens	-	1	60 /area	60			Cart storage for soiled linens
14.314	Janitor Closet	-	1	40 /area	40			Slop sink, mop racks, ventilation
14.315	Consultation/Treatment Room	3	1	100 /area	100			Small table and 3 comfortable chairs
14.316	Group Treatment Room	8	1	25 /person	200			2 tables and 8 comfortable chairs
14.317	Medication Room	1-2	1	100 /area	100			2 refrigerators, lockable cabinets, water cooler, sink, work counter, closet for storage of hygiene and medical supplies
14.318	Medical Evaluation Room	2	1	80 /area	80			Desk, chair, side chair equipped for blood draw, exam table, containers for sharps and medical waste disposal
Subtotal	14.300				1,850	1.35	2,498	
14.400	STAFF OFFICE AREA							
14.401	RN/Director's Office	1	1	100 /office	100			Desk, chair, file cabinet, phone, computer, printer, bookshelves, 2 visitor chairs
14.402	Unassigned Workstations	1	2	60 /worksta.	120			Desk with return for computer, chair, phone, acoustical partitions, cabinets, shared printer
14.403	Copy/Fax/File Area	-	1	80 /area	80			Lockable; file cabinets, copier, fax machine, shredder, printer, counter space; co-located with unassigned workstations
14.404	Staff Lockers/Storage	1-4	1	80 /area	80			Full-size lockers for staff, storage cabinets, refrigerator
14.405	Staff Restrooms (M/F)	1	1	50 /area	50			ADA accessible
Subtotal	14.400				430	1.25	538	

Number	Component	Persons/Units Per Area	Number of Areas	Space Standard	NSF	Gross Factor	GSF	Notes
14.000	**SUPPORTIVE LIVING CENTERS - cont'd**							
14.500	FACILITY MAINTENANCE AND SUPPORT AREAS							
14.501	Furnace/Electrical/ Equipment Room	-	1	200 /area	200			Furnace, hot water heater, fuse box, etc. - air handlers in attic or on roof, air conditioning units outside
14.502	Vehicle Garage	-	1	300 /area	300			Garage space for van
14.503	Equipment Garage	-	1	80 /area	80			Maintenance equipment storage; shelving for gardening tools, etc.
Subtotal	14.500				580	1.20	696	
Total	**14.000**				**5,960**		**7,916**	

IV. STAFFING RECOMMENDATIONS

IV. STAFFING RECOMMENDATIONS

Introduction/Overview

The staffing tables included in this chapter represent the staffing recommendations for the Psychiatric Treatment Center and the Supportive Living Centers. The staffing recommendations are based on the facilities proposed by the architectural and operational programs, a review of current AMHI staffing, and discussions with DMHMRSAS staff. The recommendations reflect the numbers of personnel required to operate at a clinically sound and safe level - this will not result in a "bare bones" operation, nor will it represent an overly generous and wasteful level of service.

Staffing is often an ongoing activity that evolves throughout the facility design and construction process. Schematic design and design development will allow for an additional level of confirmation or modification as the design of the building becomes more developed. In fact, in many cases, the "final" staffing requirements will not be known until after the buildings are opened and operational, at which point DMHMRSAS will have the benefit of experience regarding how the buildings truly work and function.

Staffing levels for the Psychiatric Treatment Center were developed to meet or exceed those required by the *Bates v. Duby* Consent Decree. The staff mix on each unit will be adequate to address the clinical needs of the patients.

Since the implementation of the Supportive Living Centers is a critical component of the overall plan, staffing of the residential settings is required in addition to staffing the Psychiatric Treatment Center.

Relief Factor Assumptions

Calculation of correct relief factors is essential in determining staff requirements. A relief factor is analogous to a budget document; it is a plan, based on a series of assumptions and historical data, for how many personnel are required for agreed upon positions requiring 24 hours a day, 7 days a week coverage.

Based on discussion with AMHI administrative and personnel staff, the recommended staffing plan was developed using a relief factor of 1.7. Thus, the staffing plan minimally provides 1.7 employees for each position requiring coverage at all times.

- It was assumed that nursing and mental health worker staff might provide relief services on one or more units, but these staff would not be required to provide relief on different shifts.

- When a specific position requires one or two staff 24 hours a day, 7 days a week, the relief factor was increased to full-time employee relief. For example, the public lobby receptionist position requires 7 day a week coverage for two swing shifts daily in order to have staff present 7:00 AM through 8:30 PM. Four staff positions, not the 3.4 calculated by applying a relief factor of 1.7, are included in the staffing plan to ensure coverage by trained staff at all times

Salary and Benefit Assumptions

The estimated salary for each staff position was based on review of current AMHI personnel costs to ensure that the presence of staff with extended years of service and higher compensation levels were accurately represented. Salaries are based on 1999 compensation costs and, thus, will require updating based on modifications in state salaries between 1999 and the year when the new facilities become operational.

Benefit costs were estimated to be 40% of salaries, based on discussions with AMHI administrative and personnel staff.

Presentation of the Proposed Staffing Plan

Two tables are provided to assist the review of the proposed staffing plan.

- Table 36 on page 235 outlines the staffing levels by profession and/or discipline and shift.

- Tables 37 on pages 236 to 244 and Tables 38 and 39 on pages 245 to 254 summarize the staffing recommendations and the related costs. The tables are organized by the functional components described in the Operational and Architectural Program. The 12 columns of this table represent the following:

  - Position Title – identification of the responsibilities of the staff position.
  - Day Shift - the number of personnel required in the particular functional location during the hours of 7 AM to 3:30 PM or 8 AM to 4:30 PM.
  - Swing Shift - the number of personnel required in the particular functional location during a flexible, 8 hour period overlapping the day and evening shifts, evening and night, or night and day shifts.
  - Evening Shift - the number of personnel required in the particular functional location during the hours of 3 PM to 11:30 PM.
  - Night Shift - the number of personnel required in the particular functional location during the hours of 11 PM to 7:30 AM.
  - Sub-total - the sum of the number of personnel required to staff the location, without accounting for days off, vacations, sick leave, etc.

- Days Covered - the number of days each week that the location is open and must be staffed.
- Relief Factor - the personnel multiplier required to ensure that adequate personnel are available to maintain services the requisite number of hours, days, and weeks each year.
- Total - the number of personnel, including relief factor, required to operate each positions the requisite days and shifts.
- Total Staff - the number of personnel, including relief factor, required to operate each functional area the requisite days and shifts.
- Annual Salary and Benefits - the estimated salary for the position based on review of current AMHI personnel costs with 40% added for the cost of benefits.
- Total Salary and Benefits – the estimated salary and benefit cost times the total number of staff.

STAFFING SUMMARY

Staffing for both the Psychiatric Treatment Center and the two Supportive Living Centers for enhanced treatment and programming for 108 persons with serious mental illness is the same as is now provided at AMHI for 103 licensed patient beds.

While the staffing levels of the Psychiatric Treatment Center will not exceed those currently at AMHI, the enhanced physical plant will permit greater staff investment in programming and treatment activities. The physical limitations of AMHI that compromise patient treatment opportunities will no longer exist. The significant staff time now spent to ensure adequate patient safety and security and provide custodial care due to the physical plant will no longer be required. Thus, staff of the Psychiatric Treatment Center will have the space and additional time to devote to patient treatment and activities.

The new construction will result in a significant reduction in the need for facility maintenance staff. Eight of the current positions are being transferred to the Bureau of General Services to provide ongoing maintenance for the state office buildings on the AMHI campus.

The total staffing for the Psychiatric Treatment Center and Supportive Living Centers is 311.9, as compared to the current AMHI staffing of 327.5. However, staffing for the proposed facilities does not include the ten member Reintegration Team now in AMHI's budget but proposed for transfer to the Central Office budget, and the eight maintenance positions being transferred from AMHI's budget to the Bureau of General Services. The increase of 2.4 positions in the proposed staffing is related to additional clinical coverage, which may be provided through professional service contracts.

Even though the number of direct care positions will not change with implementation of the proposed staffing plan, the plan will provide enhanced services through:

- Addition of 11.6 staff dedicated to patient programming.
- Provision of 28.4 staff to operate Supportive Living Centers.
- Staff dedicated building access and patient safety.

While the proposed staffing reflects changes in some current staff roles and functions, all current AMHI staff whose job functions change as a result of the proposed staffing plan will be provided training and reassignment to new positions.

A comparison of the current staffing of AMHI with the proposed staffing for the new facilities is provided in Table 36.

Table 36
Staffing Comparison

	CURRENT AMHI STAFFING	PROPOSED STAFFING FOR NEW FACILITIES	POSITION TRANSFERS
Administrative Positions	43	42	0
Direct Care Positions	223	223	0
Support Positions	51.5	46.9	8*
Reintegration Team	10	0	10**
TOTAL	327.5	311.9	18

* Maintenance positions transferred to Bureau of General Services
** Reintegration Team positions transferred to DMHMRSAS Central Office

Note: *All AMHI staff whose job functions may change as a result of the proposed staffing plan will be provided the opportunity, through training, to be reassigned to a new position.*

TABLE 37
Psychiatric Treatment Center/Supportive Living Centers
Staffing by Discipline/Shift

Functions	*Location*	*Number Required*	*Shift*
ADMINSTRATION			
Superintendent	Administration	1	Days
Administrative Services, Director	Admin Services	1	Days
Chief Operating Officer	Operations	1	Days
ADMINISTRATIVE SERVICES			
Personnel Assistant	Admin Services	1	Days
Human Resources Technician	Admin Services	1	Days
Workers Compensation Technician	Admin Services	1	Days
Systems Information Specialist	Admin Services	1	Days
Systems Support Technician	Admin Services	1	Days
Systems Information Technician	Admin Services	1	Days
Staffing Coordinator	Admin Services	1.7 (2)	Swing
Staffing Coordinator	Admin Services	1.7 (2)	Swing
Staff Development Coordinator	Admin Services	1	Days
Audio Visual Specialist	Admin Services	1	Days
Medical Records Director	Admin Services	1	Days
OPERATIONAL SERVICES			
Institutional Safety/Maintenance, Director	Operations	1	Days
Financial Analyst	Operations	1	Days
Accountant	Operations	1	Days
CLERICAL			
Receptionist	Public Lobby	1.7 (2)	Days
Receptionist	Public Lobby	1.7 (2)	Swing
Secretary	Superintendent	1	Days
Mail/Switchboard Operator	Mailroom	1	Days
Clerk Typist	Admin Services	1	Days
Clerk Typist	Admin Services	1	Days
Clerk Typist	Operations	1	Days
Account Clerk	Operations	1	Days
Clerk Typist	Clinical	1	Days

Functions	***Location***	***Number Required***	***Shift***
Clerk Typist	Clinical	1	Days
Medical Records Clerk	Admin Services	1	Days
Medical Records Clerk	Admin Services	1.7 (2)	Swing
Ward Clerk	Acute Unit	1	Days
Ward Clerk	Intermediate Care	1	Days
Ward Clerk	High Secure	1	Days
Ward Clerk	Intermediate Forensic	1	Days
Medical Clinic Clerk	Medical Support	1	Days
Pharmacy Technician	Medical Support	1	Days
Pharmacy Technician	Medical Support	1	Days
Medical Services Technician	Medical Support	1	Days
PROGRAM SERVICES			
Program Services Director	Acute Unit	1	Days
Program Services Director	Intermediate Care	1	Days
Program Services Director	High Secure	1	Days
Program Services Director	Intermediate Forensic	1	Days
PROGRAMMING			
Therapeutic Recreation Director (Occupational Therapist)	Clinical	1	Days
Recreational Therapist	Treatment Mall	1	Days
Recreational Therapist	Acute Unit	1	Days
Recreational Therapist	Intermediate Care	1	Days
Recreational Therapist	High Secure	1	Days
Recreational Therapist	Intermediate Forensic	1	Days
Academic Teacher	Treatment Mall	1	Days

Functions	***Location***	***Number Required***	***Shift***
Resource Specialist	Library	.6	Days
Chaplain	Treatment Mall	1	Days
Dual Diagnosis Counselor	Treatment Mall	1	Days
Vocational Counselor	Treatment Mall	1	Days
Peer Specialist	Treatment Mall	1	Days
Peer Specialist	Treatment Mall	1	Swing
Habilitation Aide-Arts & Crafts	Treatment Mall	1.7	Days
Habilitation Aide-Arts & Crafts	Treatment Mall	1.7	Swing
Habilitation Aide-Flexible	Treatment Mall	1	Swing
Habilitation Aide-Library	Treatment Mall	1	Swing
Habilitation Aide-Recreation	Treatment Mall	1.7	Swing
Habilitation Aide	Acute Unit	1.7 (2)	Days
Habilitation Aide	Intermediate Care	1.7 (2)	Days
Habilitation Aide	High Secure	1.7 (2)	Days
Habilitation Aide	Intermediate Forensic	1.7 (2)	Days
Barber/Beautician	Treatment Mall	.5	Swing
PHYSICIANS			
Clinical Director	Clinical	1	Days
Psychiatrist	Acute Unit	1	Days
Psychiatrist	Acute Unit	1	Days
Psychiatrist	Intermediate Care	1	Days
Psychiatrist	High Secure	1	Days
Psychiatrist	Intermediate Forensic	1	Days
Physician	Medical Support	1	Days
Physician	Medical Support	1	Days
Physician Extender	Medical Support	1.7	Evenings
Physician Extender	Medical Support	1.7	Nights
Dentist	Medical Support	1	Days
Dental Hygienist	Medical Support	1	Days
PSYCHOLOGY			
Psychology Director	Clinical	1	Days
Psychologist	Acute Unit	1	Days
Psychologist	Intermediate Care	1	Days
Psychologist	High Secure	1	Days
Psychologist	Intermediate Forensic	1	Days

Functions	*Location*	*Number Required*	*Shift*
SOCIAL WORK			
Social Work Director	Clinical	1	Days
Social Worker	Acute Unit	1	Days
Social Worker	Acute Unit	1	Days
Social Worker	Intermediate Care	1	Days
Social Worker	Intermediate Care	1	Days
Social Worker	High Secure	1	Days
Social Worker	Intermediate Forensic	1	Days
Social Worker	Intermediate Forensic	1	Days
REGISTERED NURSES			
Director of Nursing	Clinical	1	Days
Assistant Director of Nursing	Clinical	1	Days
Clinical Nurse Specialist	Clinical	1	Days
Quality Assurance, Director	Clinical	1	Days
Infection Control/Utiliz Review Nurse	Clinical	1	Days
Risk Management Nurse	Clinical	1	Days
Medical Nurse	Medical Support	1	Days

Functions	***Location***	***Number Required***	***Shift***
Nursing Shift Coordinator	Clinical	1.7	Days
Nursing Supervisor	Acute Unit	1	Days
Nursing Supervisor	Intermediate Care	1	Days
Nursing Supervisor	High Secure	1	Days
Nursing Supervisor	Intermediate Forensic	1	Days
Nurse	Acute Unit	1.7	Days
Nurse	Acute Unit	1.7	Days
Nurse	Intermediate Care	1.7	Days
Nurse (Coverage for Supervisor)	Intermediate Care	.7	Days
Nurse	High Secure	1.7	Days
Nurse	High Secure	1	Days
Nurse	Intermediate Forensic	1.7	Days
Nurse (Coverage for Supervisor)	Intermediate Forensic	.7	Days
Registered Nurse Rotating Relief	Patient Units	1	Days
Nursing Shift Coordinator	Clinical	1.7	Evenings
Nurse	Acute Unit	1.7	Evenings
Nurse	Acute Unit	1.7	Evenings
Nurse	Intermediate Care	1.7	Evenings
Nurse	Intermediate Care	1.7	Evenings
Nurse	High Secure	1.7	Evenings
Nurse	High Secure	1.7	Evenings
Nurse	Intermediate Forensic	1.7	Evenings
Nurse	Intermediate Forensic	1.7	Evenings
Registered Nurse Rotating Relief	Patient Units	1	Evenings
Nursing Shift Coordinator	Clinical	1.7	Nights
Nurse	Acute Unit	1.7	Nights
Nurse	Intermediate Care	1.7	Nights
Nurse	High Secure	1.7	Nights
Nurse	Intermediate Forensic	1.7	Nights
Registered Nurse Rotating Relief	Patient Units	1	Nights
MENTAL HEALTH WORKERS			
QA Compliance Assistant	Clinical	1	Days
Treatment Plan Scribe	Acute	1	Days
Mental Health Worker	Acute Unit	1.7	Days

Functions	***Location***	***Number Required***	***Shift***
Mental Health Worker	Acute Unit	1.7	Days
Mental Health Worker	Acute Unit	1.7	Days
Mental Health Worker	Acute Unit	1.7	Days
Mental Health Worker (Intensive)	Acute Unit	1.7	Days
Mental Health Worker	Intermediate Care	1.7	Days
Mental Health Worker	Intermediate Care	1.7	Days
Mental Health Worker	Intermediate Care	1.7	Days
Mental Health Worker	Intermediate Care	1.7	Days
Treatment Plan Scribe	High Secure	1	Days
Mental Health Worker	High Secure	1.7	Days
Mental Health Worker	High Secure	1.7	Days
Mental Health Worker	High Secure	1.7	Days
Mental Health Worker	High Secure	1.7	Days
Mental Health Worker (Intensive)	High Secure	1.7	Days
Mental Health Worker	Intermediate Forensic	1.7	Days
Mental Health Worker	Intermediate Forensic	1.7	Days
Mental Health Worker	Intermediate Forensic	1.7	Days
Mental Health Worker	Intermediate Forensic	1.7	Days
MH Worker Rotating Relief	Patient Units	1	Days
Mental Health Worker	Acute Unit	1.7	Evenings
Mental Health Worker	Acute Unit	1.7	Evenings
Mental Health Worker	Acute Unit	1.7	Evenings
Mental Health Worker	Acute Unit	1.7	Evenings
Mental Health Worker (Intensive)	Acute Unit	1.7	Evenings
Mental Health Worker	Intermediate Care	1.7	Evenings
Mental Health Worker	Intermediate Care	1.7	Evenings
Mental Health Worker	Intermediate Care	1.7	Evenings
Mental Health Worker	High Secure	1.7	Evenings
Mental Health Worker	High Secure	1.7	Evenings
Mental Health Worker	High Secure	1.7	Evenings
Mental Health Worker	High Secure	1.7	Evenings
Mental Health Worker (Intensive)	High Secure	1.7	Evenings
Mental Health Worker	Intermediate Forensic	1.7	Evenings
Mental Health Worker	Intermediate Forensic	1.7	Evenings

Functions	*Location*	*Number Required*	*Shift*
Mental Health Worker	Intermediate Forensic	1.7	Evenings
MH Worker Rotating Relief	Patient Units	1	Evenings
Mental Health Worker	Acute Unit	1.7	Nights
Mental Health Worker	Acute Unit	1.7	Nights
Mental Health Worker	Acute Unit	1.7	Nights
Mental Health Worker	Acute Unit	1.7	Nights
Mental Health Worker	Intermediate Care	1.7	Nights
Mental Health Worker	Intermediate Care	1.7	Nights
Mental Health Worker	Intermediate Care	1.7	Nights
Mental Health Worker	High Secure	1.7	Nights
Mental Health Worker	High Secure	1.7	Nights
Mental Health Worker	High Secure	1.7	Nights
Mental Health Worker	High Secure	1.7	Nights
Mental Health Worker	Intermediate Forensic	1.7	Nights
Mental Health Worker	Intermediate Forensic	1.7	Nights
Mental Health Worker	Intermediate Forensic	1.7	Nights
MH Worker Rotating Relief	Patient Units	1	Nights
BUILDING ACCESS AND PATIENT SAFETY			
Building Access and Patient Safety Compliance Director	Security	1	Days
Building Access Center Supervisor	Security	1.7	Days
Area Supervisor	Security	1.7	Days
Building Access Center Supervisor	Security	1.7	Evenings
Area Supervisor	Security	1.7	Evenings
Building Access Center Supervisor	Security	1.7	Nights
Area Supervisor	Security	1.7	Nights
FOOD SERVICES			
Dietetic Services Manager	Production Kitchen	1	Swing
Assistant Dietetic Services Manager	Production Kitchen	1	Swing
Clinical Dietitian	Production Kitchen	.4	Days

Functions	***Location***	***Number Required***	***Shift***
Diet Coordinator	Production Kitchen	1.7 (2)	Swing
Cook (5:00 AM – 1:30 PM)	Production Kitchen	1	Swing
Cook (12:30 PM – 8:00 PM)	Production Kitchen	1.7	Swing
Food Services Worker (5:00 AM – 1:30 PM)	Production Kitchen	1.7	Swing
Food Services Worker (5:00 AM – 1:30 PM)	Production Kitchen	1.7	Swing
Food Services Worker (5:00 AM – 1:30 PM)	Production Kitchen	1.7	Swing
Food Services Worker (10:00 AM – 6:30 PM)	Production Kitchen	1.7	Swing
Food Services Worker (10:00 AM – 6:30 PM)	Production Kitchen	1.7	Swing
Food Services Worker (10:00 AM – 6:30 PM)	Production Kitchen	1.7	Swing
FACILITY MANAGEMENT			
Building Engineer	Facility Maintenance	1	Days
Storekeeper	Facility Maintenance	1	Days
Maintenance Mechanic	Facility Maintenance	1.7 (2)	Days
Maintenance Mechanic	Facility Maintenance	1	Days
Executive Housekeeper	Facility Maintenance	1	Days
Institutional Custodial Worker	Facility Maintenance	1	Days
Institutional Custodial Worker	Facility Maintenance	1	Days
Institutional Custodial Worker	Facility Maintenance	1	Days
Institutional Custodial Worker	Facility Maintenance	1	Days
Institut Custodial Worker (Laundry)	Facility Maintenance	1	Days
Institutional Custodial Worker	Facility Maintenance	1.7	Evenings
Institutional Custodial Worker	Facility Maintenance	1.7	Evenings
Porter (Food Delivery)	Facility Maintenance	1.7 (2)	Swing

POSITION	*Number Required*	*Shift*
SUPPORTIVE LIVING CENTER "A"		
Registered Nurse	1	Day
Licensed Practical Nurse	.7	Day
Licensed Practical Nurse	1.7	Evenings
Licensed Practical Nurse	1.7	Nights
Residential Counselor	1.7	Days
Residential Counselor	1.7	Days
Residential Counselor	1.7	Evenings
Residential Counselor	1.7	Nights
Peer Specialist	1	Evenings
Meal Preparations Assistant	.5	Swing
Custodial Assistant	.5	Swing
Psychiatrist	.1	Days
Psychologist	.1	Days
Social Worker	.2	Days
Recreational Therapist	.2	Days
SUPPORTIVE LIVING CENTER "B"		
Registered Nurse	1	Day
Licensed Practical Nurse	.7	Day
Licensed Practical Nurse	1.7	Evenings
Licensed Practical Nurse	1.7	Nights
Residential Counselor	1.7	Days
Residential Counselor	1.7	Days
Residential Counselor	1.7	Evenings
Residential Counselor	1.7	Nights
Peer Specialist	1	Evenings
Meal Preparations Assistant	.5	Swing
Custodial Assistant	.5	Swing
Psychiatrist	.1	Days
Psychologist	.1	Days
Social Worker	.2	Days
Recreational Therapist	.2	Days

TABLE 38
Psychiatric Treatment Center/Supportive Living Centers
Staffing Plan

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
1.000 ADMINISTRATION/PUBLIC LOBBY													
	Superintendent	1	0	0	0	1	5	1	1		120260	$120,260	
	Secretary	1	0	0	0	1	5	1	1		32340	$32,340	
	Receptionist	1	1	0	0	2	7	1.7	4		33600	$134,400	
	Mail Switchboard Operator	1	0	0	0	1	5	1	1		33320	$33,320	
	Director, Admin. Services	1	0	0	0	1	5	1	1		75600	$75,600	
	Clerk Typist	2	0	0	0	2	5	1	2		34860	$69,720	
	Personnel Assistant	1	0	0	0	1	5	1	1		42420	$42,420	
	H.R. Technician	1	0	0	0	1	5	1	1		32340	$32,340	
	Workers Comp. Technician	1	0	0	0	1	5	1	1		26180	$26,180	
	Systems Information Spec.	1	0	0	0	1	5	1	1		52360	$52,360	
	Staff Support Technician	1	0	0	0	1	5	1	1		33600	$33,600	
	Systems Information Technician	1	0	0	0	1	5	1	1		43960	$43,960	
	Staffing Coordinator	1	0	1	0	2	7	1.7	4		43960	$175,840	
	Chief Operating Officer	1	0	0	0	1	5	1	1		84000	$84,000	

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
	Instit. Maint./Safety Director	1	0	0	0	1	5	1	1		53760	$53,760	
	Security/Safety Compliance Director	1	0	0	0	1	5	1	1		43960	$43,960	
	Clerk Typist	1	0	0	0	1	5	1	1		32340	$32,340	
	Financial Analyst	1	0	0	0	1	5	1	1		67200	$67,200	
	Accountant	1	0	0	0	1	5	1	1		40390	$40,390	
	Account Clerk	1	0	0	0	1	5	1	1		33950	$33,950	
	Clinical Director	1	0	0	0	1	5	1	1		0	$0	Contractor
	Director of Nursing	1	0	0	0	1	5	1	1		86800	$86,800	
	Psychology Director	1	0	0	0	1	5	1	1		78680	$78,680	
	Social Work Director	1	0	0	0	1	5	1	1		72300	$72,300	
	Therapy Rec. Director (OT)	1	0	0	0	1	5	1	1		64820	$64,820	
	Clerk Typist	2	0	0	0	2	5	1	2		31220	$62,440	
	Assistant Directpr Nursing	1	0	0	0	1	5	1	1		83160	$83,160	
	Clinical Nurse Specialist	1	0	0	0	1	5	1	1		75320	$75,320	
	Director Quality Assurance	1	0	0	0	1	5	1	1		68880	$68,880	
	Infect.Control/Util. Rev. Nurse	1	0	0	0	1	5	1	1		56000	$56,000	
	Risk Mgmt Nurse	1	0	0	0	1	5	1	1		56000	$56,000	
	Compliance Assistant	1	0	0	0	1	5	1	1		56000	$56,000	
	Nursing Shift Coord.	1	0	1	1	3	7	1.7	5.1		69720	$355,572	

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
	Registered Nursing Relief	1	0	1	1	3	5	1	3		56000	$168,000	
	Mental Health Worker Relief	1	0	1	1	3	1	1	3		31220	$93,660	
	Medical Records Director	1	0	0	0	1	5	1	1		59500	$59,500	
	Medical Records Clerk	1	0	0	0	1	5	1	1		33320	$33,320	
	Medical Records Clerk	0	1	0	0	1	7	1.7	2		33320	$66,640	
	Staff Development Coord	1	0	0	0	1	5	1	1		56000	$56,000	
	Audio Visual Specialist	1	0	0	0	1	5	1	1		38850	$38,850	
								Subtotal		**57.1**		$2,859,882	
2.000 STAFF SUPPORT													
	NO STAFF											$0	
								Subtotal		**0**		$0	
3.000 PATIENT UNITS: CIVIL													
Acute	Psychiatrist	2	0	0	0	2	5	1	2		0	$0	Contractor
	Program Services Director	1	0	0	0	1	5	1	1		71400	$71,400	
	Psychologist	1	0	0	0	1	5	1	1		71680	$71,680	
	Social Worker	2	0	0	0	2	5	1	2		50400	$100,800	
	Recreation Therapist	1	0	0	0	1	5	1	1		49280	$49,280	

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
	Habilitation Aide	1	0	0	0	1	7	1.7	2		32900	$65,800	
	Ward Clerk	1	0	0	0	1	5	1	1		30240	$30,240	
	Nursing Supervisor	1	0	0	0	1	5	1	1		58380	$58,380	
	Registered Nurse	2	0	2	1	5	7	1.7	8.5		56000	$476,000	
	Treatment Plan Scribe	1	0	0	0	0	5	1	1		36400	$36,400	
	Mental Health Worker	5	0	5	4	14	7	1.7	23.8		31220	$743,036	
Interm.	Psychiatrist	1	0	0	0	1	5	1	1		0	$0	Contractor
	Program Services Director	1	0	0	0	1	5	1	1		71400	$71,400	
	Psychologist	1	0	0	0	1	5	1	1		71680	$71,680	
	Social Worker	2	0	0	0	2	5	1	2		50400	$100,800	
	Recreation Therapist	1	0	0	0	1	5	1	1		49280	$49,280	
	Habilitation Aide	1	0	0	0	1	7	1.7	2		32900	$65,800	
	Ward Clerk	1	0	0	0	1	5	1	1		30240	$30,240	
	Nursing Supervisor	1	0	0	0	1	5	1	1		58380	$58,380	
	Registered Nurse	1	0	2	1	4	7	1.7	6.8		56000	$380,800	
	Registered Nurse	1	0	0	0	1	2	0.7	0.7		56000	$39,200	
	Mental Health Worker	4	0	3	3	10	7	1.7	17		31220	$530,740	
								Subtotal	**78.8**			$3,101,336	
4.000 PATIENT UNITS: FORENSIC													
High	Psychiatrist	1	0	0	0	1	5	1	1		0	$0	Contractor
	Program Services Director	1	0	0	0	1	5	1	1		71400	$71,400	

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
	Psychologist	1	0	0	0	1	5	1	1		71680	$71,680	
	Social Worker	1	0	0	0	1	5	1	1		50400	$50,400	
	Recreation Therapist	1	0	0	0	1	5	1	1		49280	$49,280	
	Habilitation Aide	1	0	0	0	1	7	1.7	2		32900	$65,800	
	Ward Clerk	1	0	0	0	1	5	1	1		30240	$30,240	
	Nursing Supervisor	1	0	0	0	1	5	1	1		58380	$58,380	
	Registered Nurse	1	0	2	1	4	7	1.7	6.8		56000	$380,800	
	Registered Nurse	1	0	0	0	1	5	1	1		56000	$56,000	
	Treatment Plan Scribe	1	0	0	0	1	5	1	1		36,400	$36,400	
	Mental Health Worker	5	0	5	4	14	7	1.7	23.8		31220	$743,036	
Interm.	Psychiatrist	1	0	0	0	1	5	1	1		0	$0	Contractor
	Program Services Director	1	0	0	0	1	5	1	1		71400	$71,400	
	Psychologist	1	0	0	0	1	5	1	1		71680	$71,680	
	Social Worker	2	0	0	0	2	5	1	2		50400	$100,800	
	Recreation Therapist	1	0	0	0	1	5	1	1		49280	$49,280	
	Habilitation Aide	1	0	0	0	1	7	1.7	2		32900	$65,800	
	Ward Clerk	1	0	0	0	1	5	1	1		30240	$30,240	
	Nursing Supervisor	1	0	0	0	1	5	1	1		58380	$58,380	
	Registered Nurse	1	0	2	1	4	5	1.7	6.8		56000	$380,800	
	Registered Nurse	1	0	0	0	1	3	0.7	0.7		56000	$39,200	
	Mental Health Worker	4	0	3	3	10	7	1.7	17		31220	$530,740	
								Subtotal		**76.1**		$3,011,736	

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
5.000 CENTRALIZED PROGRAM SERVICES													
	Academic Teacher	1	0	0	0	1	5	1	1		56000	$56,000	
	Research Specialist	1	0	0	0	1	3	1	0.6		56000	$33,600	
	Chaplain	1	0	0	0	1	5	1	1		58660	$58,660	
	Peer Specialist	1	1	0	0	2	5	1	2		39200	$78,400	
	Recreational Therapist	1	0	0	0	1	5	1	1		49280	$49,280	
	Vocational Counselor	1	0	0	0	1	5	1	1		43960	$43,960	
	Dual Diagnosis Counselor	1	0	0	0	1	5	1	1		47000	$47,000	
	Habilitation Aide	1	1	0	0	2	7	1.7	3.4		32900	$111,860	
	Habilitation Aide	0	2	0	0	2	5	1	2		32900	$65,800	
	Habilitation Aide-Recreation	0	1	0	0	1	7	1.7	1.7		32900	$55,930	
	Barber/Beautician	0.5	0	0	0	0.5	5	1	0.5		30800	$15,400	
								Subtotal		**15.2**		$615,890	
6.000 ADMISSION/DISCHARGE AREA													
	NO STAFF											$0	
								Subtotal		**0**		$0	
7.000 VISITATION													
	NO STAFF											$0	

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
8.000 MEDICAL SUPPORT SERVICES													
	Physician	2	0	0	0	2	5	1	2		183260	$366,520	
	Medical Nurse	1	0	0	0	1	5	1	1		56000	$56,000	
	Medical Clinic Clerk	1	0	0	0	1	5	1	1		35000	$35,000	
	Pharmacy Technician	2	0	0	0	2	5	1	2		36260	$72,520	
	Medical Services Technician	1	0	0	0	1	5	1	1		37660	$37,660	
	Dentist	1	0	0	0	1	5	1	1		0	$0	Contractor
	Dental Hygienist	1	0	0	0	1	5	1	1		0	$0	Contractor
	Physician Extender	0	0	1	1	2	7	1.7	3.4		72660	$247,044	
								Subtotal		**12.4**		$814,744	
9.000 STATE FORENSIC SERVICES													
	NO STAFF											$0	
								Subtotal		**0**		$0	
10.000 FOOD AND LAUNDRY SERVICES													
	Dietetic Services Manager	0	1	0	0	1	5	1	1		48440	$48,440	
	Asst. Diet Service Manager	0	1	0	0	1	5	1	1		46200	$46,200	
	Clinical Dietitian	1	0	0	0	1	2	0.4	0.4		70000	$28,000	
	Diet Coordinator	0	1	0	0	1	7	1.7	2		30940	$61,880	
	Cook	0	1	0	0	1	7	1.7	1.7		31220	$53,074	
	Cook	0	1	0	0	1	5	1	1		31220	$31,220	
	Food Services	0	6	0	0	6	7	1.7	10.2		27300	$278,460	

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
	Worker												
								Subtotal		**17.3**		$547,274	
11.000 BUILDING ACCESS AND PATIENT SAFETY SERVICES													
	Building Access Center Supervisor	1	0	1	1	3	7	1.7	5.1		35000	$178,500	
	Area Supervisor	1	0	1	1	3	7	1.7	5.1		35000	$178,500	
								Subtotal		**10.2**		$357,000	
12.000 FACILITY MAINTENANCE													
	Building Engineer	1	0	0	0	1	5	1	1		51100	$51,100	
	Maintenance Mechanic	1	0	0	0	1	7	1.7	2		34020	$68,040	
	Maintenance Mechanic	0	0	1	0	0	5	1	1		34020	$34,020	
	Executive Housekeeper	1	0	0	0	0	5	1	1		34860	$34,860	
	Institutional Custodial Worker	5	0	0	0	5	5	1	5		28420	$142,100	
	Institutional Custodial Worker	0	0	2	0	2	7	1.7	3.4		28420	$96,628	
	Porter (Food Delivery)	0	1	0	0	0	7	1.7	2		26420	$52,840	
	Storekeeper	1	0	0	0	1	5	1	1		30800	$30,800	
								Subtotal		**16.4**		$510,388	

	Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits	Notes
	Employee Totals								**284**			$11,818,250	
	# Licensed Beds								**92**				
	# Staff/100 Patients								**308**				
CONTRACT POSITIONS													
	Clinical Director	1	0	0	0	1	5	1			200845	$200,845	
	Psychiatrist	5	0	0	0	5	5	5			174000	$870,000	
	Dentist	1	0	0	0	1	5	1			119300	$119,300	
	Dental Hygienist	1	0	0	0	1	5	1			41310	$41,310	
	Management Fee/On-Call/Benefits/Peer Review											$560,000	
							Sub-total	*				$1,791,455	

Contract staff positions counted with employee positions.

TABLE 39
Supportive Living Centers Staffing Plan

Position Title	Day Shift	Swing Shift	Evng Shift	Night Shift	Sub-total	Days Covered	Relief Factor	Total	TOTAL Staff	Annual Salary & Benefits	Total Salary & Benefits
Registered Nurse/Director	2	0	0	0	2	5	1	2		55000	$110,000
Licensed Practical Nurse	0	0	2	2	4	7	1.7	6.8		40600	$276,080
LPN/RN Weekend Relief	2	0	0	0	2	2	1	0.8		40600	$32,480
Residential Counselor	4	0	2	2	8	7	1.7	13.6		31220	$424,592
Peer Specialist	0	0	2	0	2	5	1	2		39200	$78,400
Psychiatrist-Consulting	1	0	0	0	1	1	1	0.2		220000	$44,000
Psychologist-Consulting	1	0	0	0	1	1	1	0.2		71680	$14,336
Social Worker-Consulting	1	0	0	0	1	2	1	0.4		50400	$20,160
Recreation Therapist	0	1	0	0	1	2	1	0.4		49280	$19,712
Meal Preparation Assistant	0	1	0	0	1	5	1	1		31220	$31,220
Custodial Assistant	1	0	0	0	1	5	1	1		28000	$28,000
						Subtotal			**28.4**		$1,078,980

Staff Totals	**12**	**2**	**6**	**4**				**28.4**			
# Residents								**16**			
# Staff/100 Residents								**177.5**			

V. SITE ANALYSIS

V. SITE ANALYSIS

Sire Selection Process

Site selection for any facility usually begins with the owner and/or user defining the key selection criteria that are specific to the particular project needs. In this case, the Project Team worked closely with DMHMRSAS to establish key custom criteria. Following that, several more site specific and development cost related criteria were added to identify available sites that fundamentally meet the selection criteria.

A first-cut assessment of the sites was then performed to narrow the field. As a final step, the Project Team worked closely with various stakeholder groups and City officials in the Augusta area, and came to recommend the AMHI site as the best available, all things considered. The narrative that follows briefly describes the site selection process for the new Psychiatric Treatment Center.

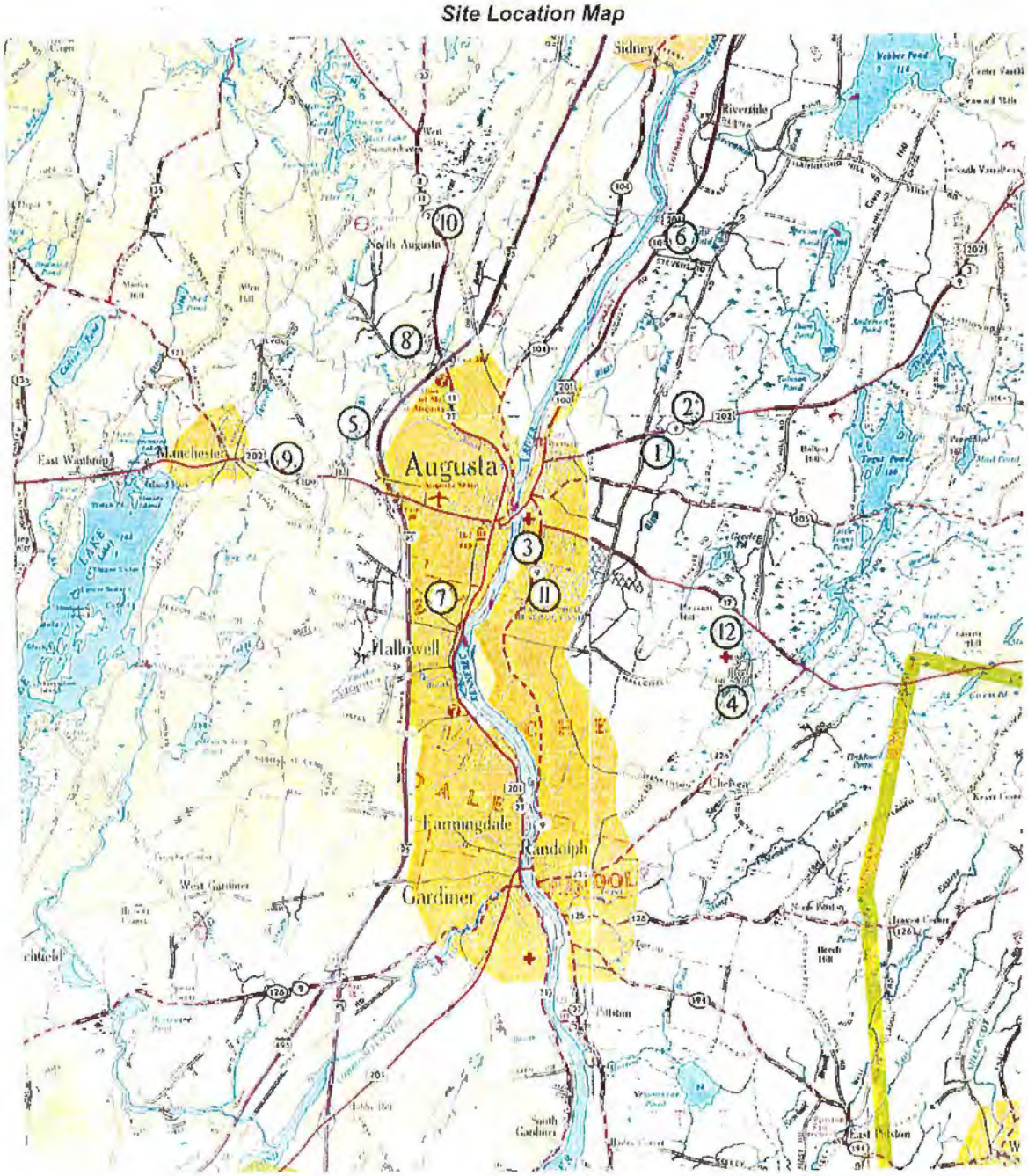
Beginning in September 1999, the Project Team met with representatives of DMHMRSAS to establish the most critical characteristics of a site in order for that site to be considered as suitable for the intended uses. These custom criteria included such considerations as location with respect to clients and existing workforce, distance from an acute care hospital, and distance from an interstate highway. More specifically, the list of custom criteria is as follows:

- Parcel of sufficient size and configuration to support the program needs, both now and for future expansion
- Proximity to an existing acute care medical hospital
- Proximity to existing workforce
- Proximity to civil client base (based on needs assessment)
- Proximity to interstate access point
- Proximity to locations offering "independent services" (convenience stores, etc.)
- Proximity to existing transportation services
- Physical buffer to achieve patient privacy
- Federal funding opportunities/constraints

A list of more general criteria includes cost to purchase, cost to develop, soils, wetlands, topography, regulatory issues, availability of utilities, zoning issues, encumbrances, hazardous materials impact, etc.

Two basic categories of sites were considered likely candidate sites. They included land already owned by the state or other government entity, and land currently for sale. The state/federal government-owned sites include the AMHI campus, Togus and the Stevens School in Hallowell. Other available land included nine sites in the Augusta area that were of a sufficient size and within the threshold "proximity" range to be considered viable. These sites are illustrated in the Site Location Map in Figure B on page 256.

Figure B
Site Location Map



Members of the Project Team visited the 12 sites, took photographs, reviewed secondary data (USGS maps, zoning maps, etc.), and evaluated them against the criteria. The analysis of the site evaluation process is presented below.

Site Evaluation Process

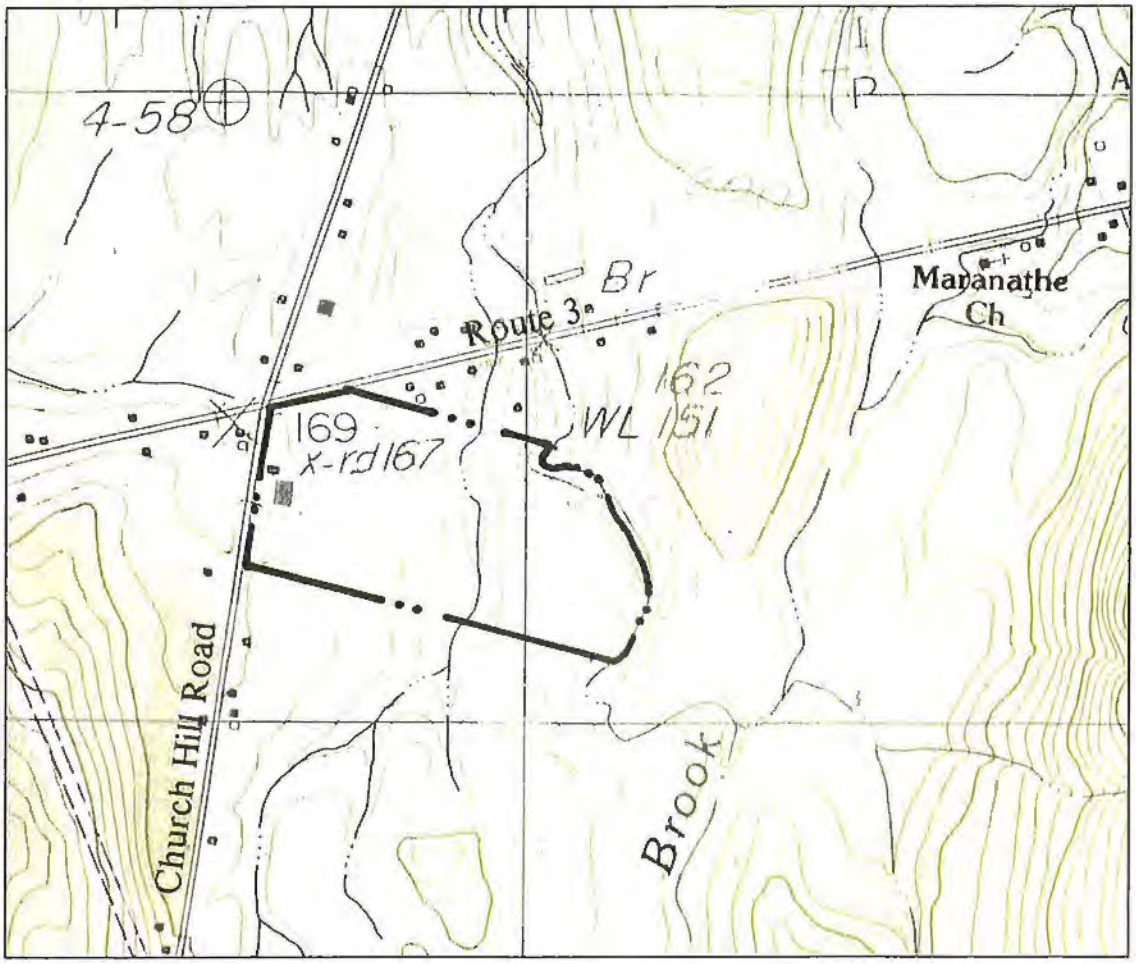
The following pages include a series of plans showing each site that the Site Selection Team evaluated. Each sheet also indicates the comments related to that site. These twelve sites were identified by various means, including land already owned by the state or federal government, parcels listed for sale and brought to our attention by a local real estate agent, and parcels brought to our attention by the seller. These are listed as follows, with the number of each site correlated to the site numbering in Figure B:

1. Route 3 at Church Hill Road, Augusta; approximately 51 acres.
2. Route 3, west of the Church Hill Road intersection, Augusta; approximately 70 acres.
3. AMHI, southwest portion, Augusta; approximately 20 acres.
4. Togus, southerly portion, Chelsea; approximately 20 acres.
5. Leighton Road, Augusta; up to 90 acres.
6. Riverside Drive at the Vassalboro Line, Augusta; approximately 44 acres.
7. Stevens School, Hallowell; approximately 60 acres.
8. Oakland Road, Augusta; approximately 28 acres.
9. Route 202, Manchester, approximately 28 acres.
10. Outer Civic Center Drive, Augusta; approximately 23 acres.
11. Hospital Street, Augusta, approximately 58 acres
12. Route 17, adjacent to Togus, Augusta; approximately 119 acres.

Detailed Site Analyses

Presented below, for each of the 12 sites, are site identification maps and some bullet points detailing each site's critical evaluation. For ease of presentation, each site is presented on a separate page.

Figure C
Location Map: Site 1



Site #1 - Partial Site Plan (from USGS)

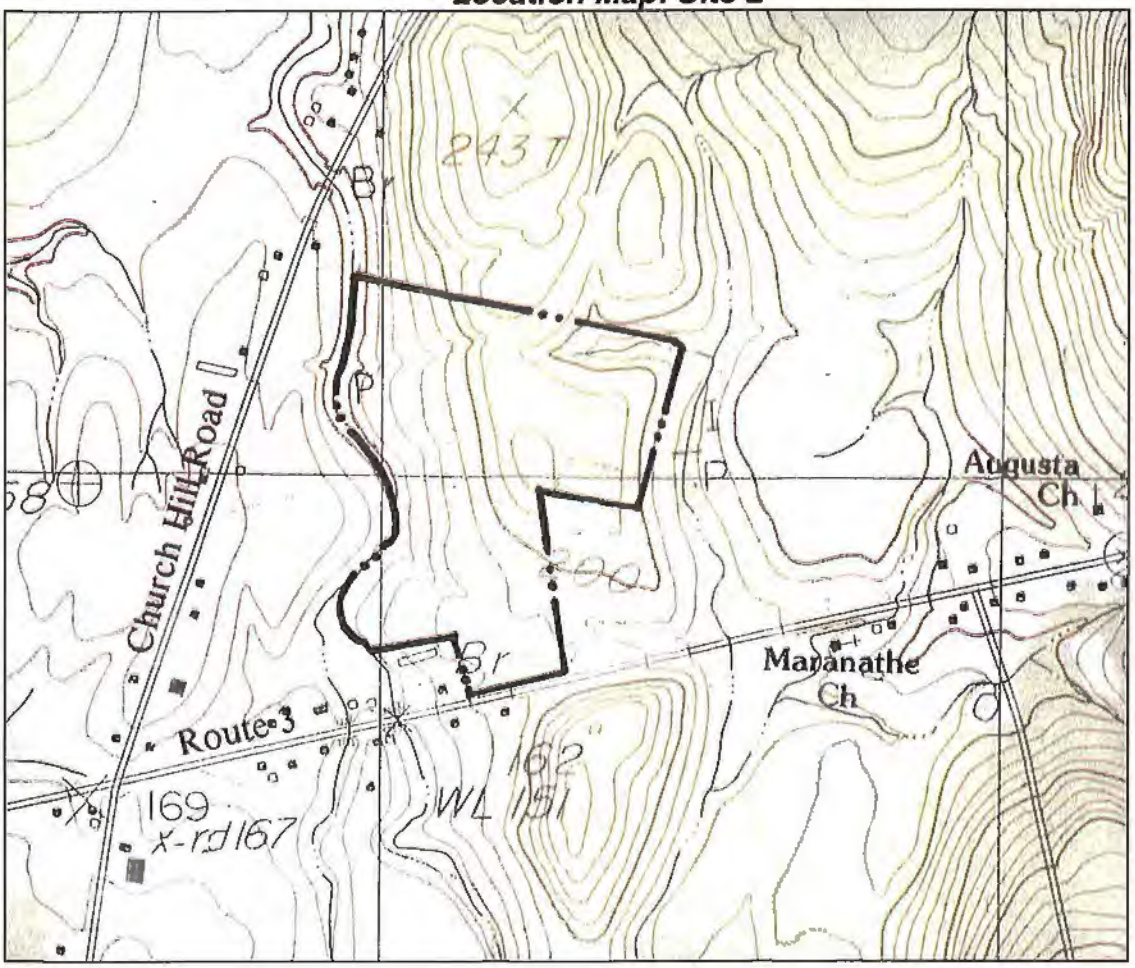
Scale: 1" = 1000'

Site #1 – Routes 3/9/202 at Church Hill Rd.
51 Acres, >20 Acres Buildable

- Approximately 5 minutes to Maine General
- Approximately 9 minutes to I-95
- Convenience store at intersection, across Church Hill Rd.
- Gently rolling farmland
- Would need to extend water and sewer
- Corner of non-signaled intersection; access onto Route 3 or Church Hill Rd.
- Stream and some wetlands
- Site Character: attractive on site; average off site

When new bridge is constructed, access to I-95 will be very direct.

Figure D
Location Map: Site 2



Site #2 - Partial Site Plan (from USGS)

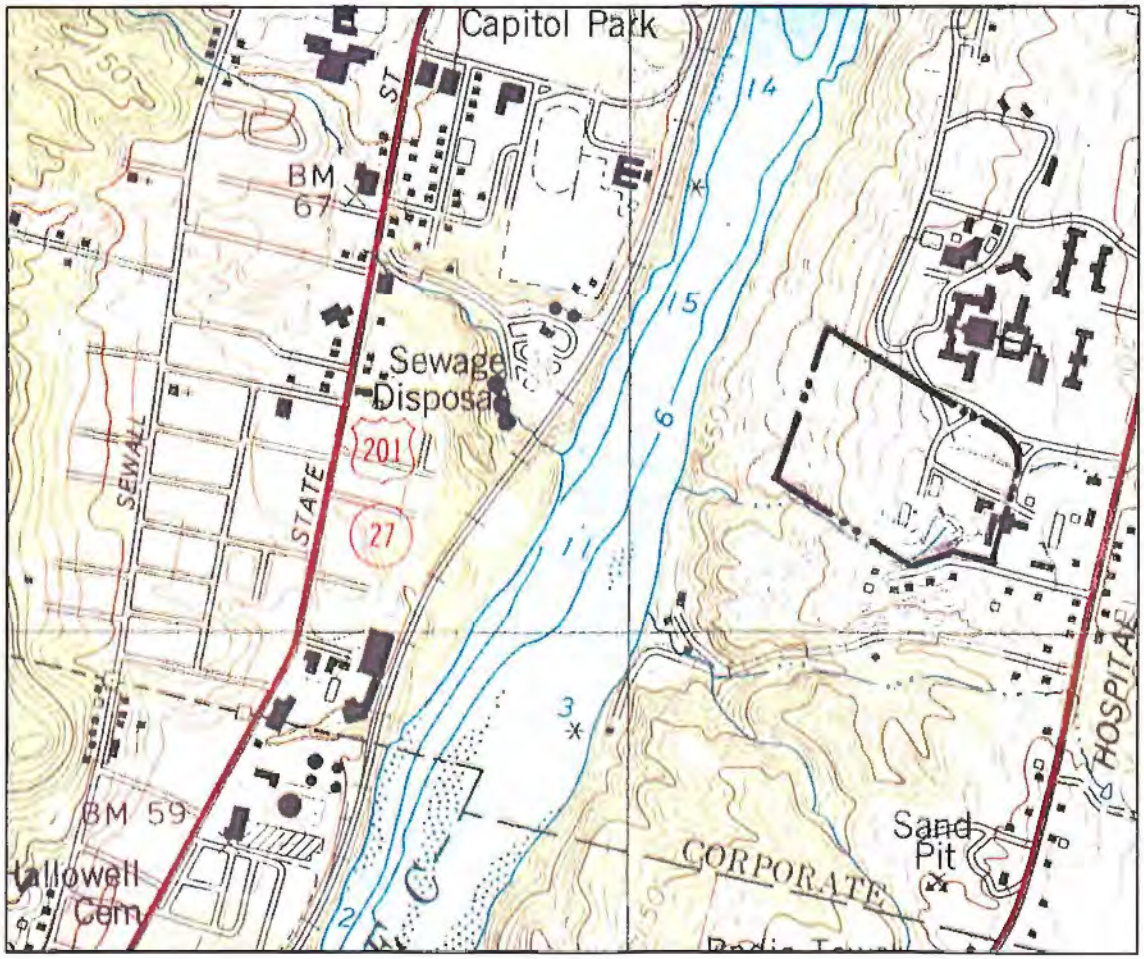
SCALE: 1" = 1000'

Site #2 – Routes 3/9/202 @ Church Hill Road, just east of Site #1
70 Acres, >20 Acres buildable

- Approximately 5 minutes to Maine General
- Approximately 9 minutes to I-95
- Convenience store at far side of intersection, .5 mile from closest corner
- Gently rolling farmland; attractive existing vegetation
- Water and sewer not available; could be extended
- Near corner of non-signaled intersection; access onto Route 3 only
- Few natural resources constraints apparent; stream at western edge
- Site Character: Very attractive on site; average off site

When new bridge is constructed, access to I-95 will be very direct.

Figure E
Location Map: Site 3



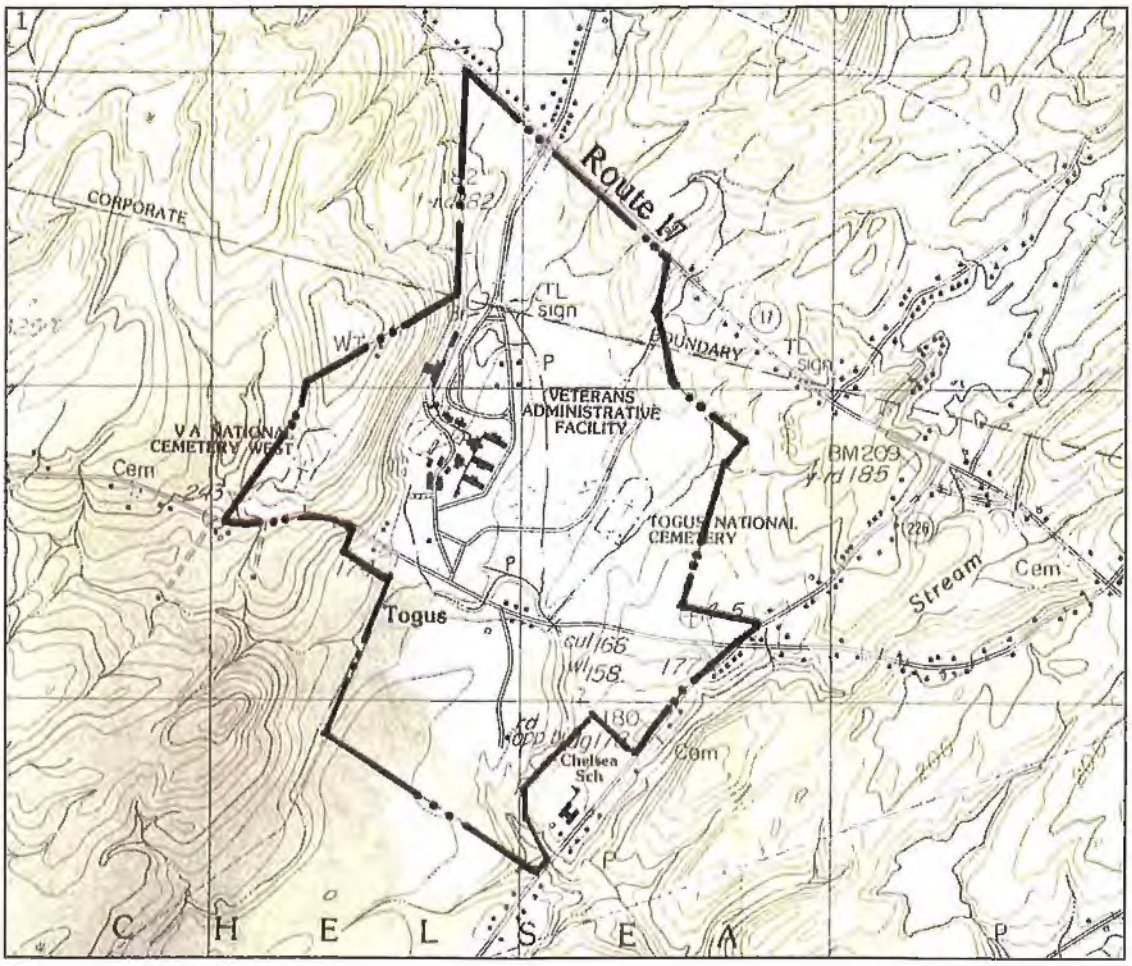
Site #3 - Partial Site Plan (from USGS)

SCALE: 1" = 1000'

Site #3 – AMHI
20+/- Acres, <20 Acres buildable

- Immediate access to Maine General
- Approximately 5 minutes to I-95
- "Independent services" available nearby, with sidewalks
- Topography will require terraced site construction; over 60 feet elevation change across site
- New utility infrastructure required
- Good visibility to and from site
- Existing uses would be displaced
- Natural buffers will need to be supplemented
- Exposed site up/down river corridor

Figure F
Location Map: Site 4



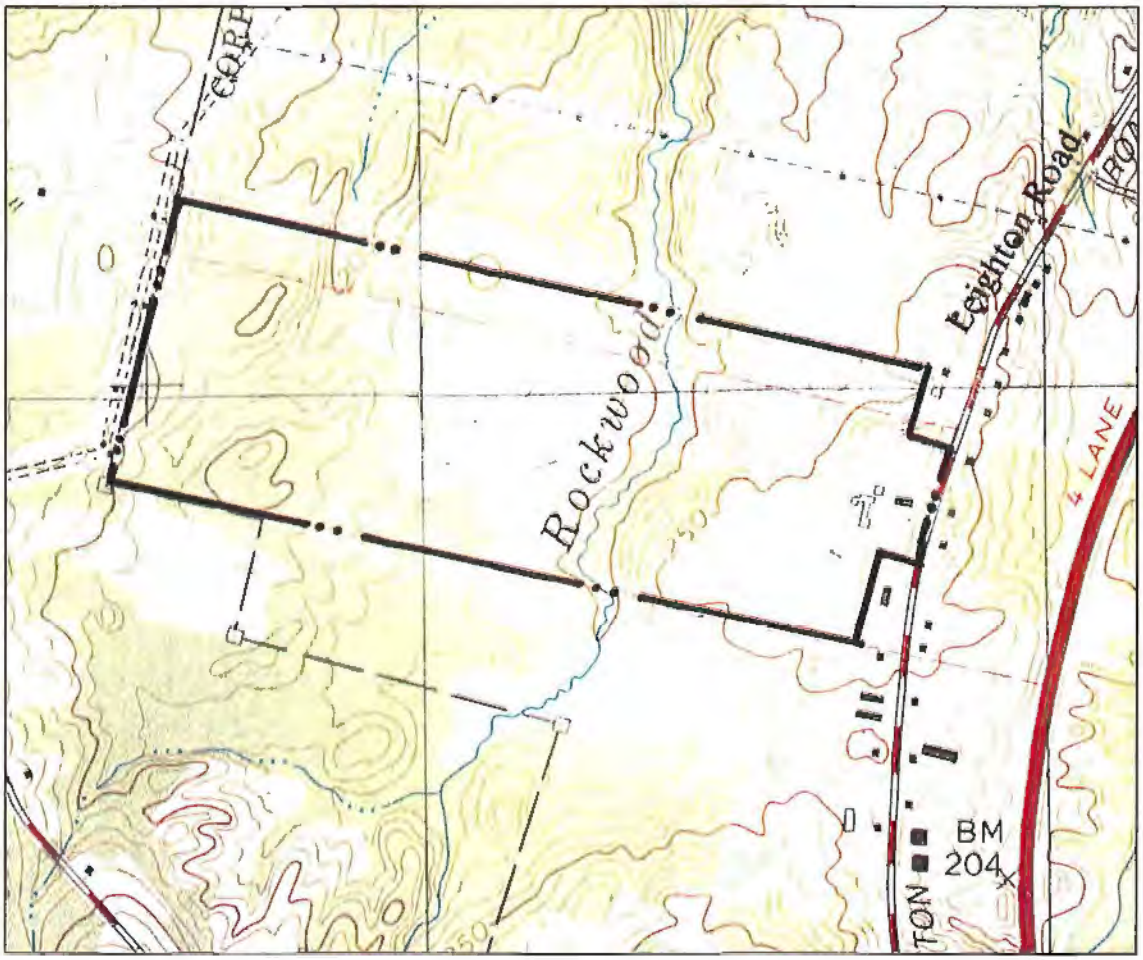
Site #4 - Partial Site Plan (from USGS)

SCALE: 1" = 2000'

Site #4 – Togus
508 Acres overall, 20 buildable acres available

- Approximately 10 minutes to Maine General
- Approximately 14 minutes to I-95
- No off-site "independent services" available
- Sufficient utility capacity to support additional development
- Over 40 acres of site used for sludge spreading
- Geology requires building on piles; extensive clay; peat in lowlands
- Streams and wetlands in much of the currently unbuilt areas
- East and West Cemeteries and steep slopes consume much otherwise developable area

Figure G
Location Map: Site 5



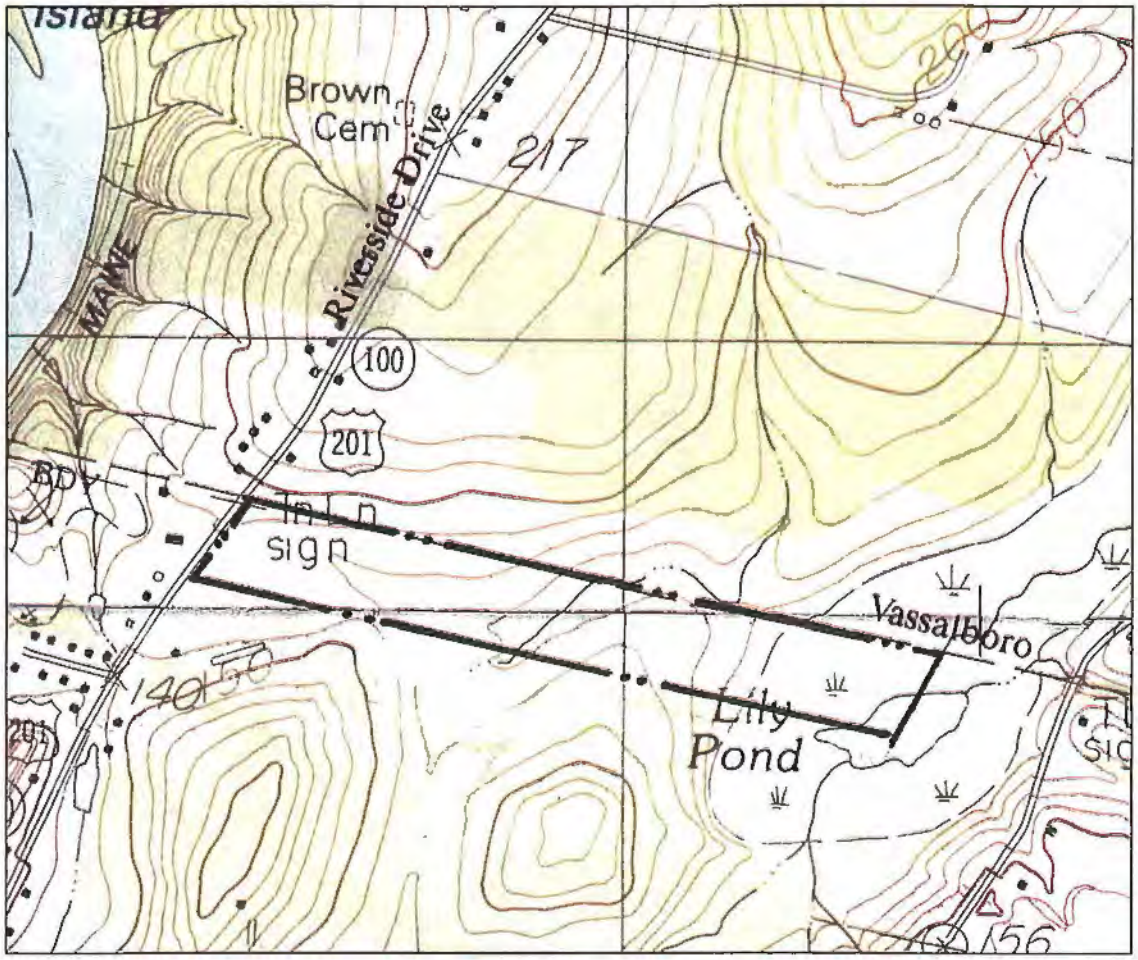
Site #5 - Partial Site Plan (from USGS)

SCALE: 1" = 1000'

Site #5 – Leighton Road, Augusta
Up to 90 Acres

- Approximately 6 minutes to Maine General
- Approximately 2 minutes to I-95
- No convenience within reasonable walking distance
- Secluded site, rolling over high ground to lower land in back.
- Sewer not available; water nearby; sewer could be extended
- Stream crosses site about a third of the way back: Regulatory issues.
- On site character very good; off site residential
- Sufficient buildable area in back; barely 20 in "front"

Figure H
Location Map: Site 6



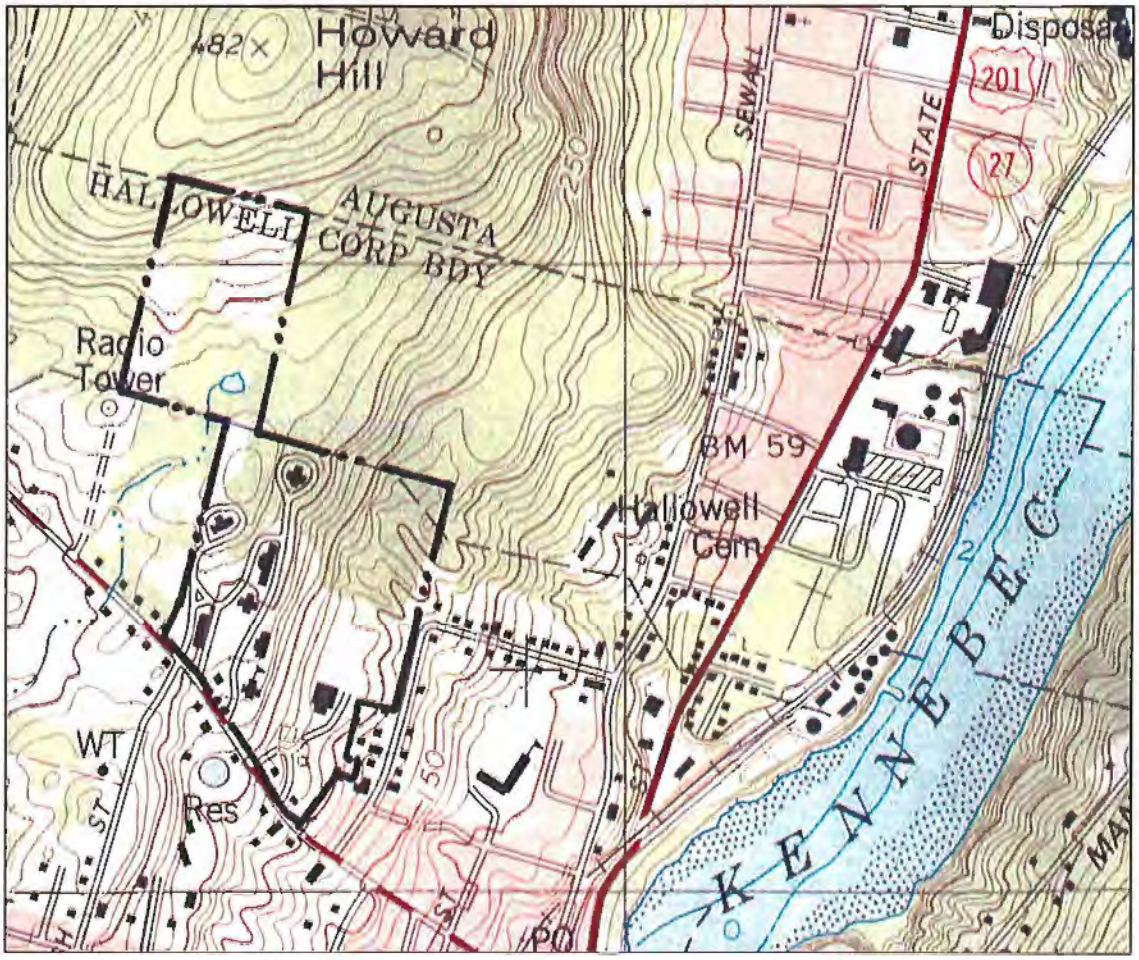
Site #6 - Partial Site Plan (from USGS)

SCALE: 1" = 1000'

Site #6 – Riverside Drive, Augusta City line at Vassalboro
44 Acres

- Approximately 7 minutes to Maine General
- Approximately 11 minutes to I-95
- No "independent services" within reasonable walking distance
- Flat site; poor configuration
- Sewer not available; water in Riverside Drive
- Low site character
- Apparent dump site
- Apparent wetland pockets

Figure I
Location Map: Site 7



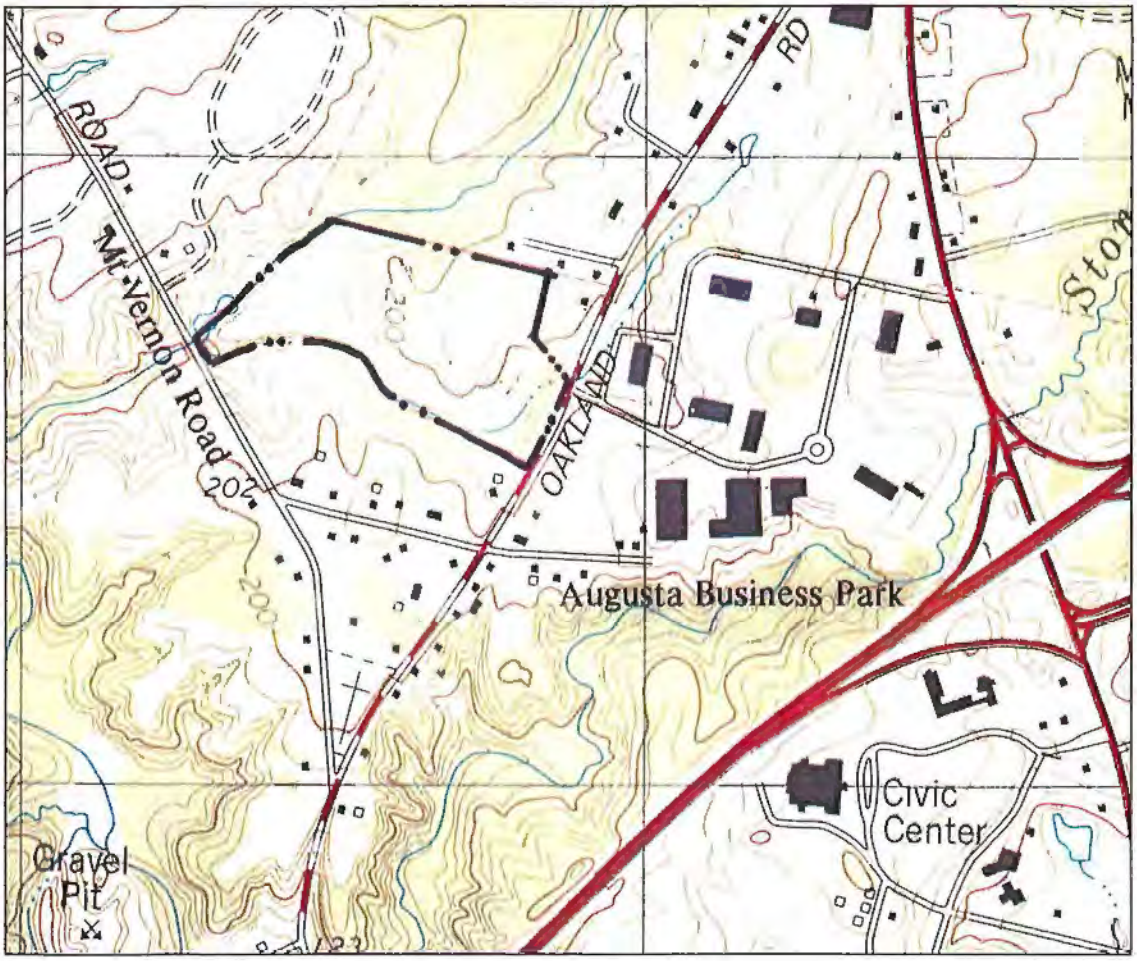
Site #7 - Partial Site Plan (from USGS)

SCALE: 1" = 1000'

Site #7 – Stevens School Site, Hallowell
58± Acres, < 20 Acres buildable

- Approximately 5 minutes to Maine General
- Approximately 9 minutes to I-95
- "Independent services" nearby in town.
- Utilities available
- Insufficient sized building area available, without demolition of many existing buildings
- Steep slopes in otherwise developable areas

Figure J
Location Map: Site 8



Site #8 - Partial Site Plan (from USGS)

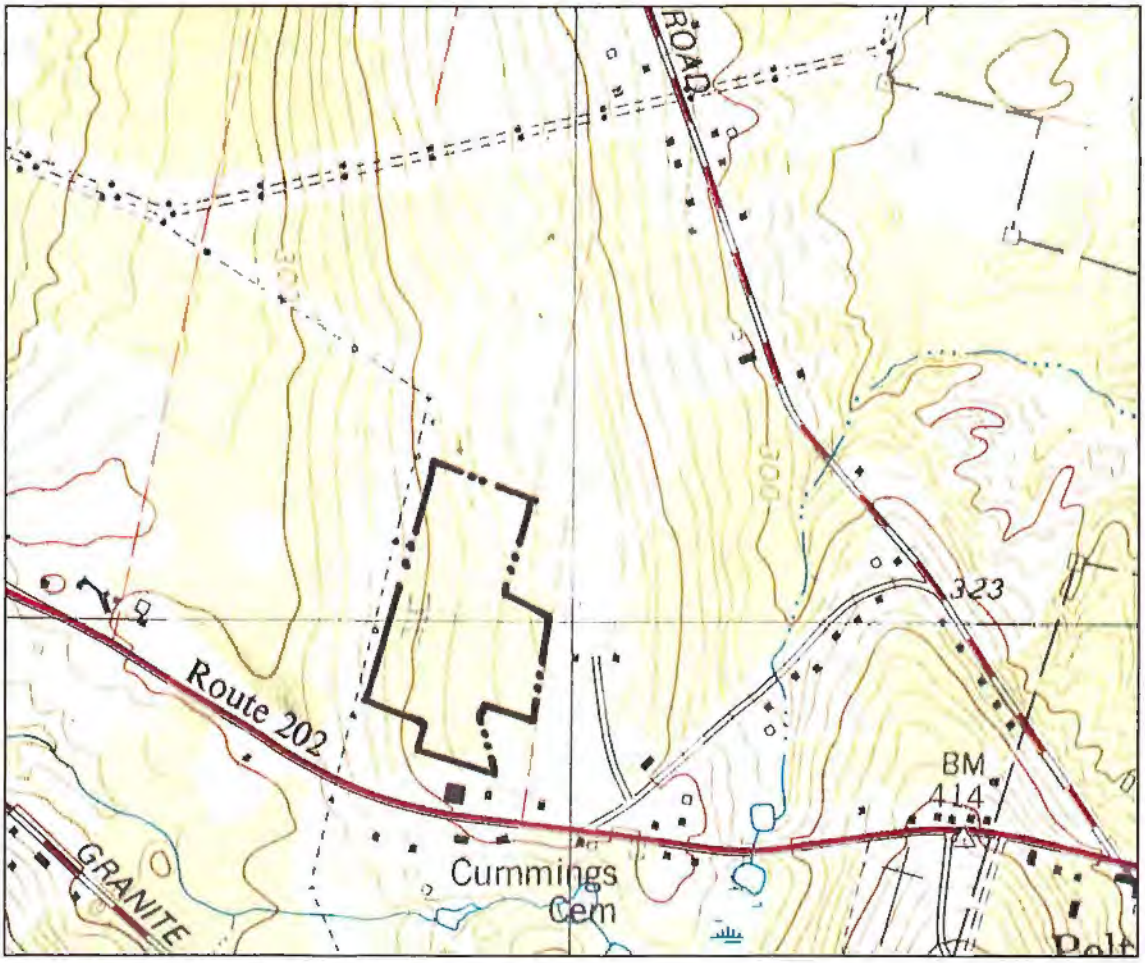
SCALE: 1" = 1000'

Site #8 – Oakland Road, behind Augusta Business Park
28 Acres; < 20 buildable

- Approximately 10 minutes to Maine General
- Approximately 6 minutes to I-95
- Inadequate "independent services" available (Irving Gas/Mainway on Routes 8/11/27) .6 mile walk through Augusta Business Park
- Gently rolling in central section, dropping at side and back of site
- Sewer and water nearby
- Attractive site, constrained regarding developable area

Natural resources constraints around periphery

Figure K
Location Map: Site 9



Site #9 - Partial Site Plan (from USGS)

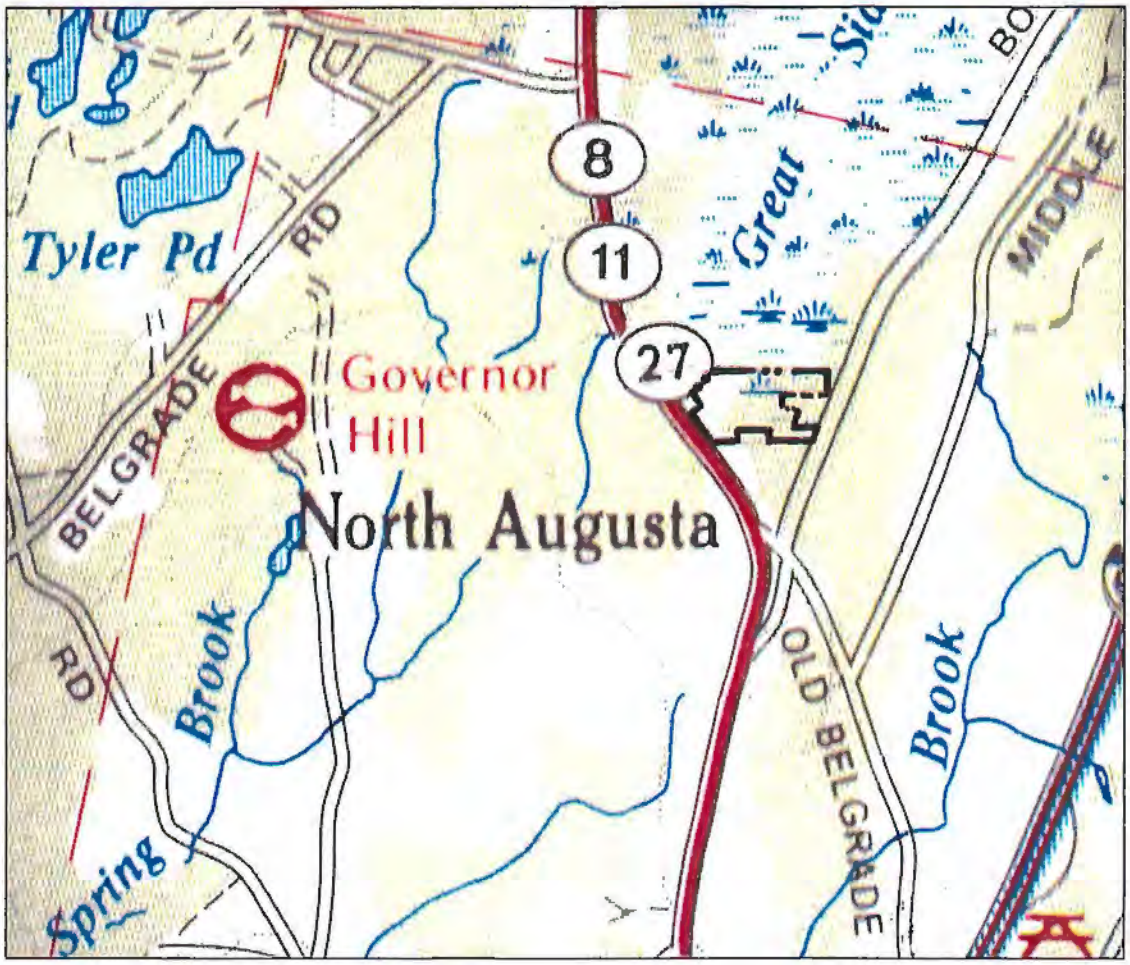
SCALE: 1" = 1000'

Site #9 – Western Ave., Manchester
28 Acres

- Approximately 9 minutes to Maine General
- Approximately 5 minutes to I-95
- Inadequate "independent services" opportunities (adjacent Irving Gas/Mainway store)
- Low site character
- NW exposure; potentially windy and cold
- High traffic volumes make it difficult to exit site heading easterly
- Side slope of hill (4%+/-), developable
- Business area, non-residential

Figure L
Location Map: Site 10

Site 10:



Site #10 - Partial Site Plan (from The Maine Atlas & Gazetteer)

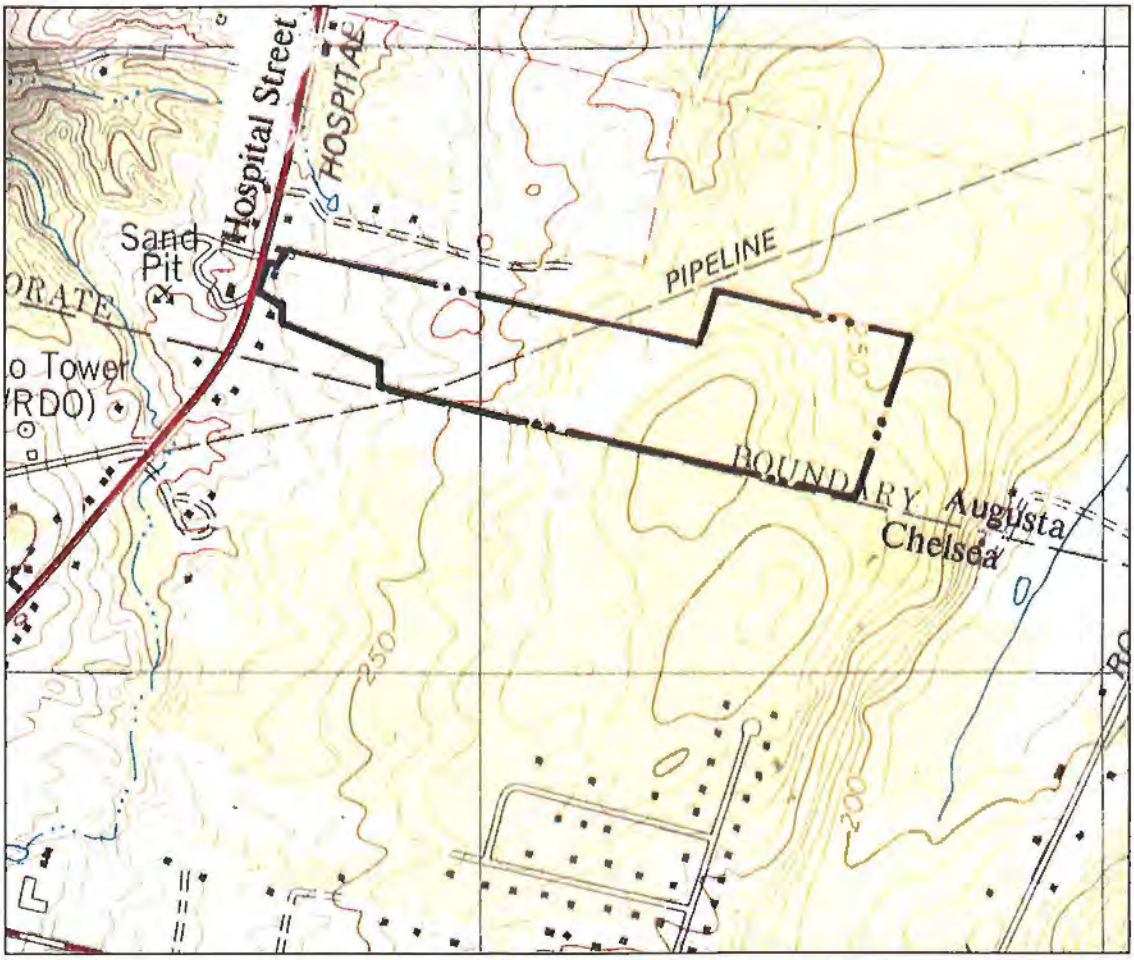
SCALE: 1" = 2640'

Site #10 Outer Civic Center Drive
23 Acres

- Approximately 8 minutes to Mainel-95
- Approximately 12 minutes to Maine General
- Removed from "independent services" opportunities
- Flat site, adjacent to large, protected wetland system
- Sewer not available; water is nearby
- Constrained by natural resources occurrences.

Figure M
Location Map: Site 11

Site 11:



Site #11 - Partial Site Plan (from USGS)
SCALE: 1" = 1000'

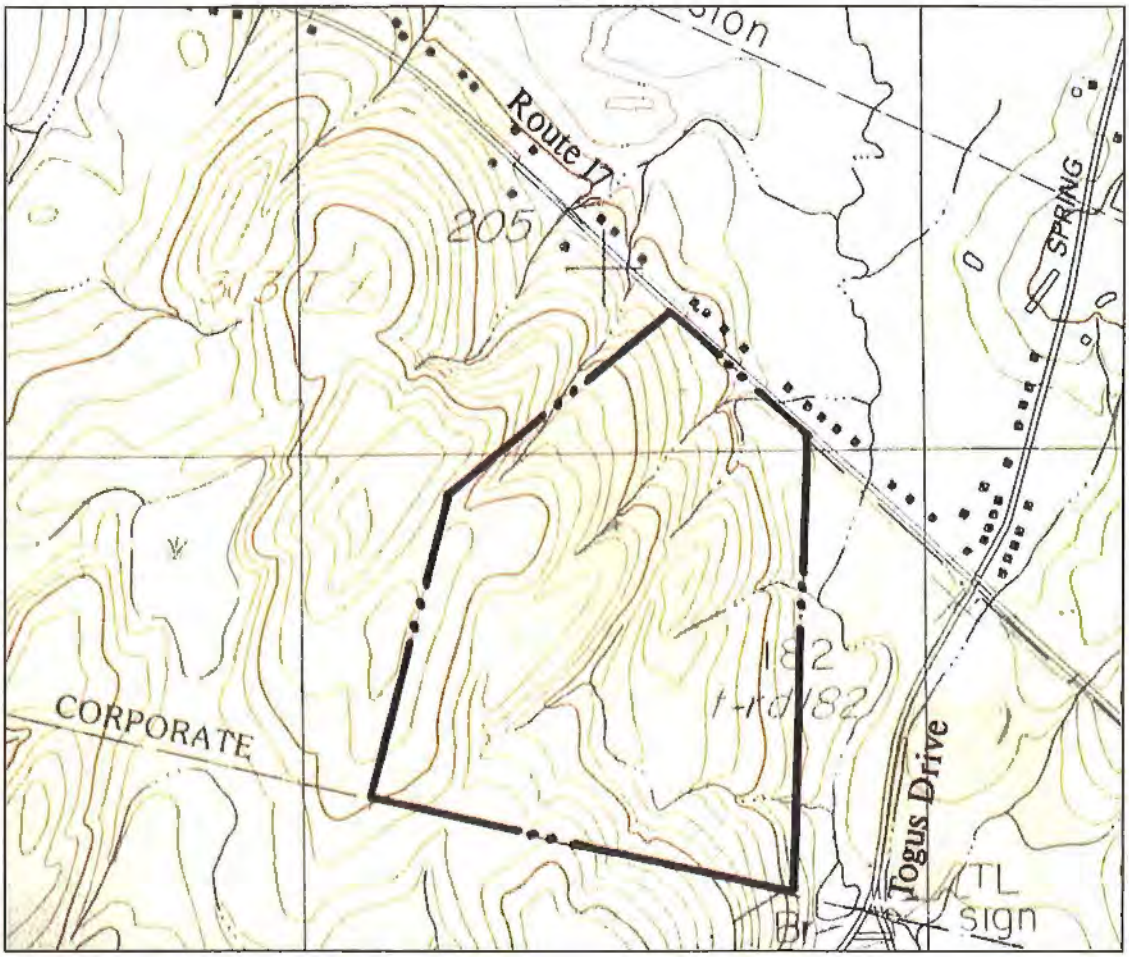
Site #11 – Hospital Street
XX Acres, > 20 Acres buildable

- Approximately 2 minutes to Maine General
- Approximately 6 minutes to I-95
- "Independent services" nearby
- Gently rolling farmland
- Water and Sewer available in Hospital Street
- Site character moderate to high

TAKEN OFF MARKET

Figure N
Location Map: Site 12

Site 12:



Site #12 - Partial Site Plan (from USGS)

SCALE: 1" = 1000'

Site #12 – Adjacent to Togus
119 Acres; >20 buildable

- Approximately 8 minutes to Maine General
- Approximately 12 minutes to I-95
- No off-site "independent services" available
- Steep slopes restricting developable areas on hill tops
- No sewer available
- Water is available in Route 17

Site Evaluation

Upon completion of the analysis of the 12 sites, the evaluation narrowed the finalists to four sites:

- A 51 acre site on the corner of Route 3 and Church Hill Road
- A 70 acre site on Route 3, just east of the Church Hill Road intersection
- An approximately 20 acre developable area on the AMHI campus.
- An approximately 20 acre developable area on the Togus campus

The other eight sites did not make the first cut for various reasons, including remoteness, natural resources issues, utilities, configuration, absence of suitable independent services, traffic concerns and time/distance to Maine General Hospital (the acute care hospital identified in the custom criteria).

Throughout the site selection process and more aggressively as evaluation of the four finalist sites began, DMHMRSAS solicited comments from the key stakeholder and community groups involved. These included the DMHMRSAS Stakeholders Group, the Augusta City Manager, the Capitol Planning Commission, the Augusta City Council, the Augusta State Facilities Master Planning Committee, and the Capitol Riverfront Improvement District Commission. Once it was established that each of the four sites satisfied to relative degrees such criteria as size, configuration, proximity to existing workforce and civil client base, it became clear that two criteria emerged as critical to the final selection. Those were relative distance to Maine General and place in the community.

With regard to proximity to an existing acute care facility, the criterion is defined simply as "the closer the better." With all other things being equal, it is critically important that a client be transported in the shortest possible time to the hospital.

The notion of independent services was clarified to include more than the ability to walk to the store and get a pack of candy or other personal items. It must offer a client the opportunity to become part of the community: to observe it, to reacquaint oneself with it, and to participate in it to increasing degrees as individual health was restored.

Noting that the two Route 3/Church Hill Road sites offer a degree of opportunity to walk to a convenience store, they both failed to provide the richness and diversity of opportunity that a more in-town location could offer. Similarly, the Togus site, aside from its being the furthest from Maine General of the four finalists, also lacked any real opportunity to reestablish personal connections with the larger community. In the final analysis, of the 12 sites assessed, the AMHI site emerged as the preferred site that best meets the defined needs of the proposed Psychiatric Treatment Center.

While implementation of the Supportive Living Centers is fundamental to this project, the Centers are not designed to be co-located with the Psychiatric Treatment Center. Indeed, from the perspective of many consumers of mental health services and interested Maine citizens, the location of the Supportive Living Centers in separate locales is essential.

VI. CONCEPT DESIGN

VI. CONCEPT DESIGN

Site Planning

The proposed location for the new facility is at the southernmost end of the existing Augusta Mental Health Institute (AMHI) campus.

The site comprises approximately 20 acres and is bounded by the Kennebec River on the west, Hospital Drive on the north, and the Campbell barn – an historic part of the original agricultural support complex for the Institute – on the east. The AMHI property line forms the southern boundary of the site, past which the land drops into a deeply wooded swale. The neighboring land use to the south consists of scattered, low-density residential development. The central portion of the site is relatively flat. The western side slopes towards the river. Several structures exist on the site and are used primarily for storage. DEP Response, and a maintenance facility including a vehicle storage lot, are also present. The structures range from former outbuildings to relatively new pre-engineered, and block and frame construction. All existing structures will be removed and their functions relocated to accommodate placement of the new facility.

The proposed building and site development will be placed to take best advantage of the flat upper portion of the site. The long, two story residential portion of the building will follow the crest of the slope, following the contour, and taking advantage of panoramic views to the river and Capitol building to the west. The remainder of the building extends to the east, giving way to a passenger drop off, parking (210 spaces total), and service access. The location of the parking and service areas between the proposed building and the existing Campbell Barn will minimize their visual impact on Hospital Street to the east and the Capitol Hill area across the river to the west. Pedestrian connections will be extended to Hospital Street and the AMHI campus.

The site will be served by all new utilities. Water service is available from nearby Hospital Street. A major sanitary line is available at the lower end of the AMHI campus. A proposed electrical service upgrade planned for the AMHI campus will be available for tie-in by the new facility. All electrical and communications lines will be placed underground.

New landscape planting will be provided that will unify the facility with the campus setting, provide shade and visual interest, and soften the visual impact of parking, drives, and other vehicle areas.

Design Objectives

The conceptual design included in this report is a first literal representation of the rooms, departments, functions and inter-relationships described in the operational and architectural programs. The development of this design has also been guided by a review of applicable codes, standards and national guidelines for freestanding inpatient psychiatric hospitals. The guidance and insights gained from stakeholders, staff, and State officials during on-site hands-on design charettes and design reviews during December and January have had significant additional influence on the resulting conceptual design. The resulting design demonstrates how the program might be accommodated on the selected site while meeting five overarching objectives:

- Optimize the use of staffing resources by the design of a facility that operates efficiently.
- Provide an environment that supports patient dignity, autonomy and privacy.
- Protect patients, staff and citizens with a facility that achieves a high degree of security.
- Achieve outcome objectives through a facility that facilitates therapeutic efficacy.
- Develop a building that is comfortable within its physical context and that presents a non-threatening non-institutional expression.

The design presented with this report is intended to be a conceptual design that tests and articulates the program so that the project can be understood and reacted to, and so that reliable construction and operating budgets can be developed. In articulating this design, we have found it helpful to work at a level of detail that goes beyond conceptual design as a means of demonstrating the possibilities inherent in the plan. The sketch elevations and the more detailed plans included in the report should be understood and viewed as a demonstration of the promise inherent in the conceptual plan.

Components and Locations

Departmental program components have been arranged on the site, and within the building, to take advantage of important relationships with both external points of site access and views across the river. More public program elements (and support elements requiring truck access) are located towards the front of the site, facilitating public access and simplifying internal security zoning. More private residential elements are located at the back of the site, allowing them to capitalize on the lovely views into the woods and across the Kennebec Valley. (Natural views can be an important adjunct to the therapeutic milieu.) This general zoning also allows for greater security within the residential and treatment areas by minimizing cross-traffic among patient, support and public circulation routes.

Residential units are directly connected to a treatment mall, facilitating access during day and evening hours without security compromise. The treatment mall is itself designed so that differing patient cohorts can occupy it simultaneously. Civil patients are expected to make the greatest use of the treatment mall and, accordingly, are located on the ground floor in close proximity to the major treatment program elements, so that portions of the mall are accessible to patient programs during evening hours without requiring supervision of the entire mall.

Program elements are organized around a series of defined outdoor courtyards: the entry court, a service courtyard, a visitor's patio, and three residential courtyards. These courtyards provide secure outdoor areas for patient recreation and therapeutic programs. By using building elements as security barriers around all or parts of these courts, the need for expensive fencing that might have an objectionable appearance is minimized. The forensic courtyard is completely surrounded by building elements, eliminating the need for unappealing institutional high security fencing typically associated with recreational areas at forensic hospitals.

The organization of the building into clear sub-elements linked at three major circulation nodes (akin to the role that public squares play in an urban plan) and organized around exterior courtyards makes it easy for a patient or visitor to understand how the building is organized, and facilitates the development of a clear way-finding program.

Flexibility and Growth

The conceptual plan and program are developed to permit a high degree of flexibility to accommodate future changes in census, patient type and treatment modalities. If population demands sometime in the future require additional bed space, the building and site plans have been designed to accommodate a two story, 48-bed addition adjacent to the second residential circulation node at the end of the treatment mall opposite the building's support wing. The core administrative, support and treatment facilities provide sufficient capacity to support these two additional residential units.

Program elements like the Pharmacy and Medical Clinics that have historically provided services to outpatients as well as inpatients have been strategically located so that future access to outpatients might be accommodated with minimum impacts on inpatient access or facility security.

While each residential unit is unique and has been designed to accommodate the specific patient mix for which it has been programmed, the design of the units is organized using the same principles, and this internal "design DNA" allows any unit to be easily transformed to accommodate a different patient cohort. In addition, five

beds in each adjoining unit have been designed so that they can re-aggregate to adjacent nursing units in order to accommodate temporary or permanent census conditions. Sub-specialty units within each nursing unit are further arranged to allow relatively easy reallocation or reclassification as a reaction to changes in patient census.

Building Access and Patient Safety

The building is designed as an important contributor to the facility's security program. External access is localized and controlled. Ordinary vertical circulation is concentrated in three easily supervised and monitored nodes. Emergency egress is organized so that patient discharge flows into secured outdoor areas.

The internal zoning of the facility is designed to minimize cross-circulation patterns between differing categories of users, and to provide internal circulation patterns that become defined and concentrated during evening and night hours to smaller and more easily supervised zones. The location of program elements within the building is designed to enhance both passive and active staff supervision.

Appearance

This design commission was originally undertaken to explore the organization and operation of a psychiatric treatment center for the State of Maine. Comments from staff and stakeholders during the course of our work underscored the additional importance that the appearance of the building would have for users, staff and the public. How it looks, they said, is as important as how it works. Time and again we heard the worry that such a large building would inevitably be institutional in character, and were asked to heed cautions that an institutional appearance was to be avoided at all costs.

While the organizational pattern that we selected for this project is responsive to a series of programmatic considerations as outlined above, this pattern is also one that facilitates the development of a building massing and appearance that will be appropriate both on the site and as an expression of the State's attitude towards those for whom it cares. The use of a series of courtyards around which the program develops allows the large undifferentiated mass of the building to be allocated among a series of smaller, more human-scaled building elements. The facility is easier to know and understand because each element has an identity and a character that springs from its use. The resulting massing is more consistent with existing buildings on the campus than the appearance that results from a large, undifferentiated mega-hospital. The use of narrower wing elements around these courtyards provides significant amounts of natural light and views within all treatment

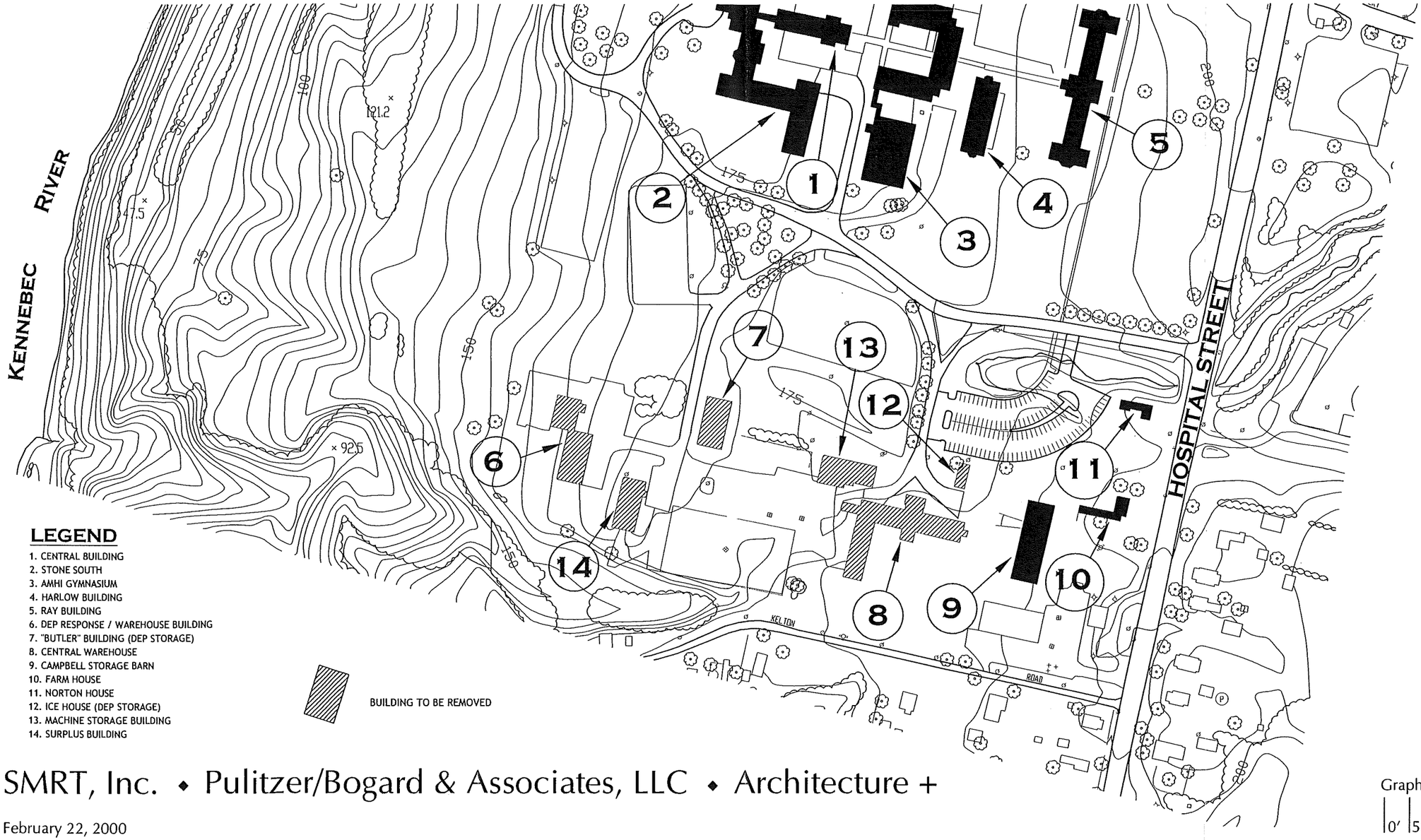
areas and provides roof spans that can reasonably accommodate the sloping roofs that will assist in the development of a non-institutional character.

Some simple preliminary sketches have been included as a demonstration of the promise inherent in the plan for its future development as a building that has a human scale, picturesque qualities, and the appearance of a farmstead that has grown over the years, or of a small village.

FIGURE 0

Existing Conditions Plan

Maine Psychiatric Treatment Center - Site



LEGEND

1. CENTRAL BUILDING
2. STONE SOUTH
3. AMHI GYMNASIUM
4. HARLOW BUILDING
5. RAY BUILDING
6. DEP RESPONSE / WAREHOUSE BUILDING
7. "BUTLER" BUILDING (DEP STORAGE)
8. CENTRAL WAREHOUSE
9. CAMPBELL STORAGE BARN
10. FARM HOUSE
11. NORTON HOUSE
12. ICE HOUSE (DEP STORAGE)
13. MACHINE STORAGE BUILDING
14. SURPLUS BUILDING

BUILDING TO BE REMOVED

NORTH

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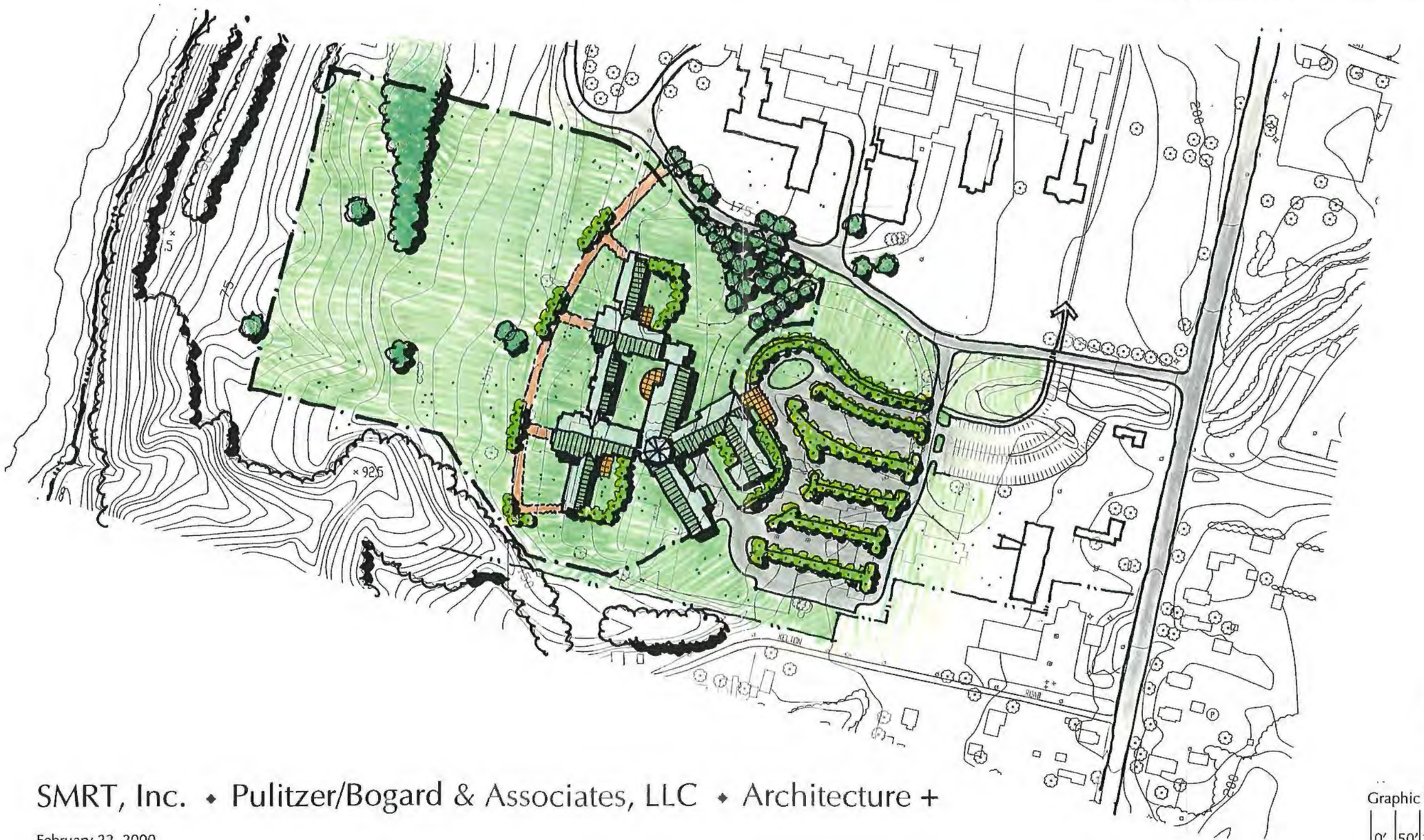
Graphic Scale

0′ 50′ 100′ 200′

FIGURE P

Conceptual Site Plan

Maine Psychiatric Treatment Center - Site



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Graphic Scale

0′ 50′ 100′ 200′

FIGURE Q

First Floor Plan

Maine Psychiatric Treatment Center

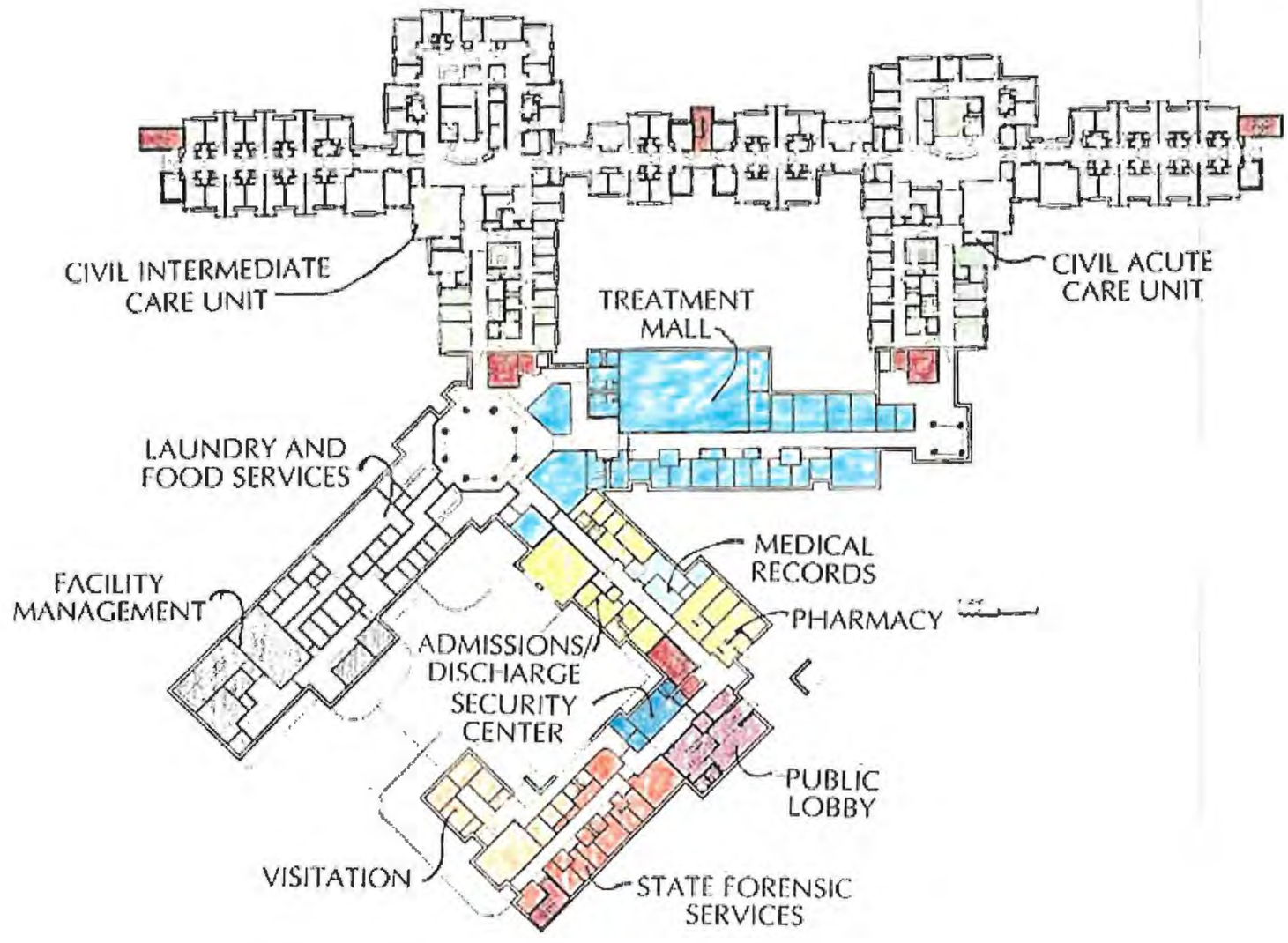

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FIGURE R

Second Floor Plan

Maine Psychiatric Treatment Center

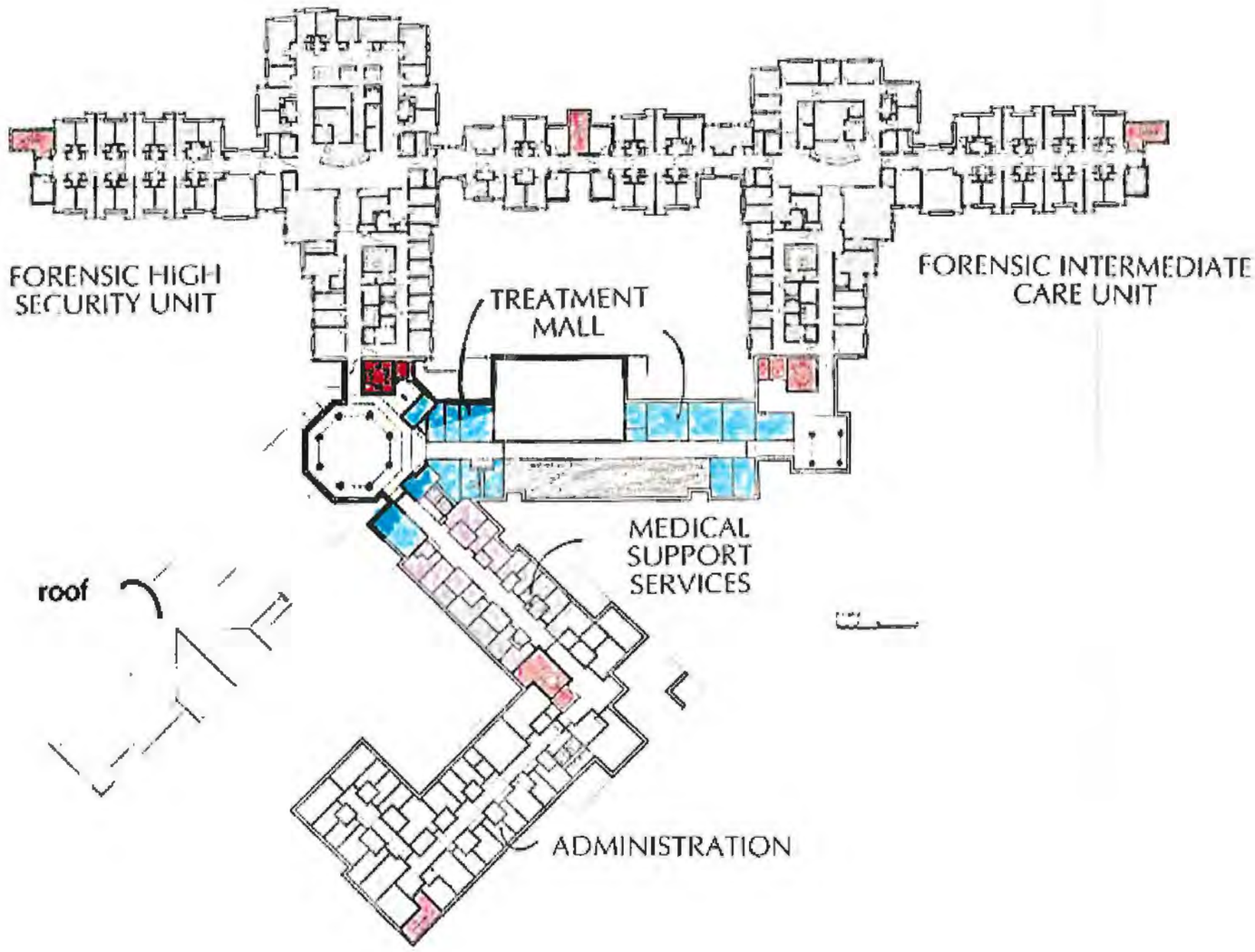

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FIGURE S

Roof Plan

Maine Psychiatric Treatment Center

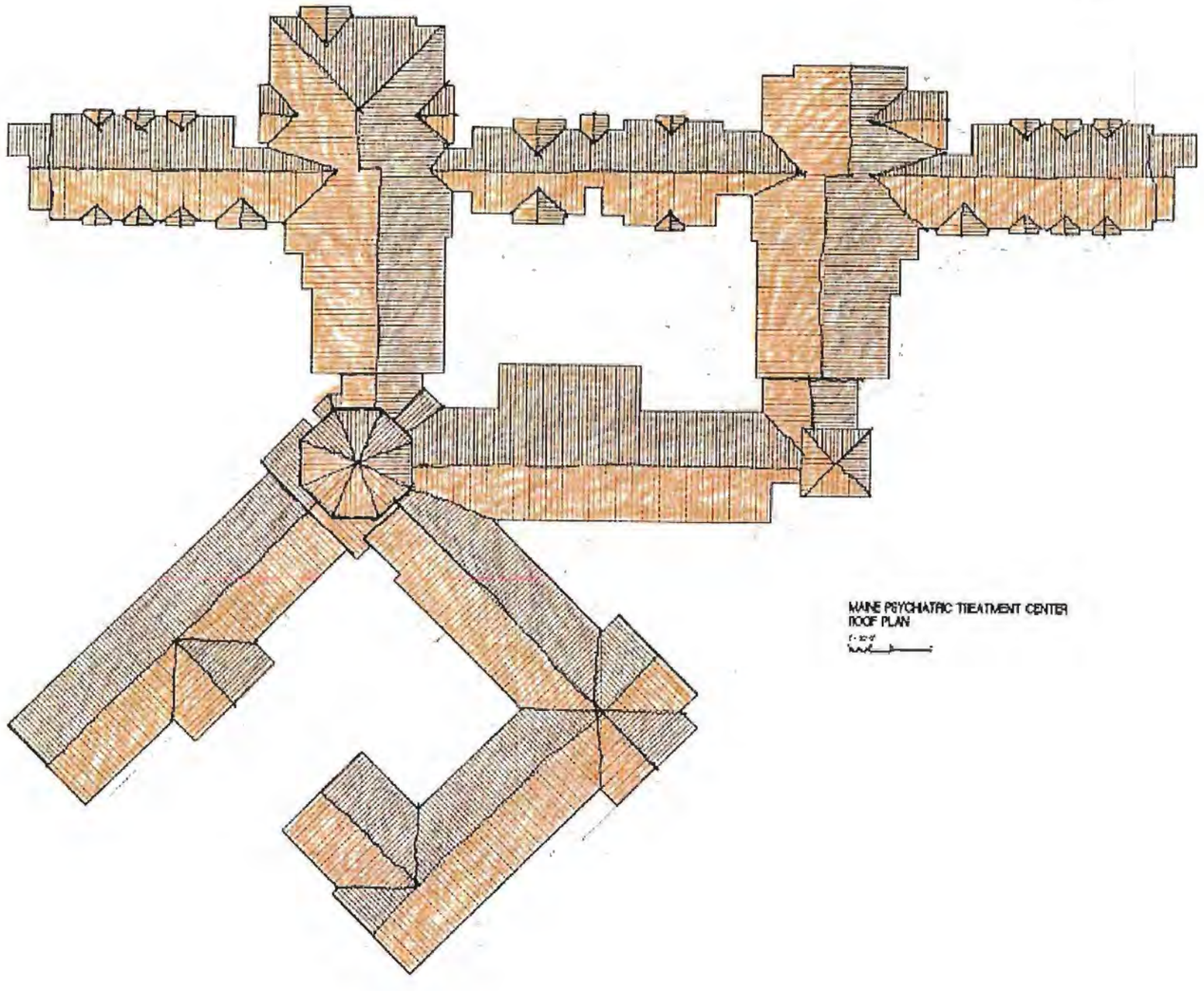

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FIGURE T

Administration

Maine Psychiatric Treatment Center - First Floor

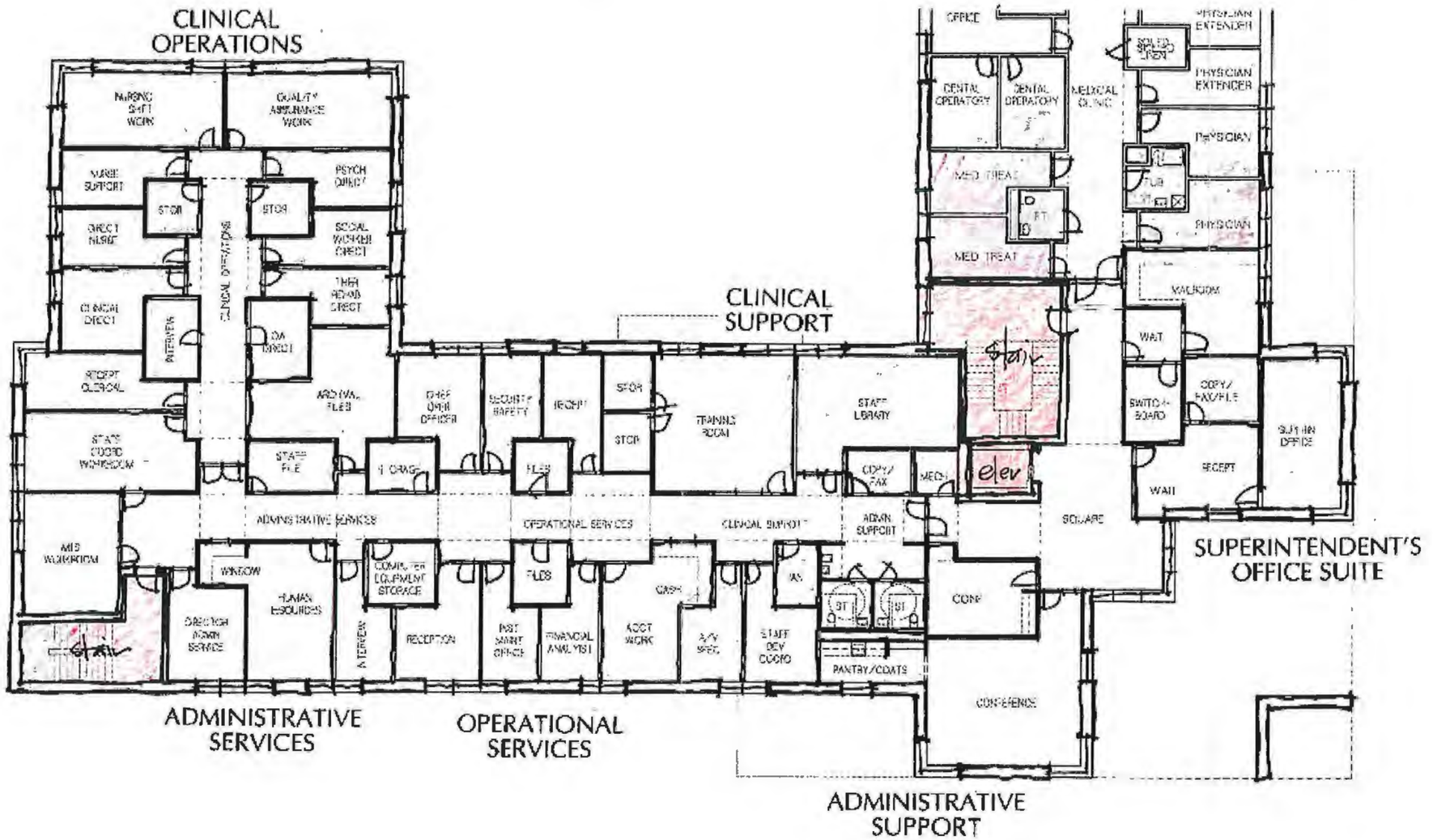

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FIGURE U

Civil Acute Care Unit

Maine Psychiatric Treatment Center - First Floor

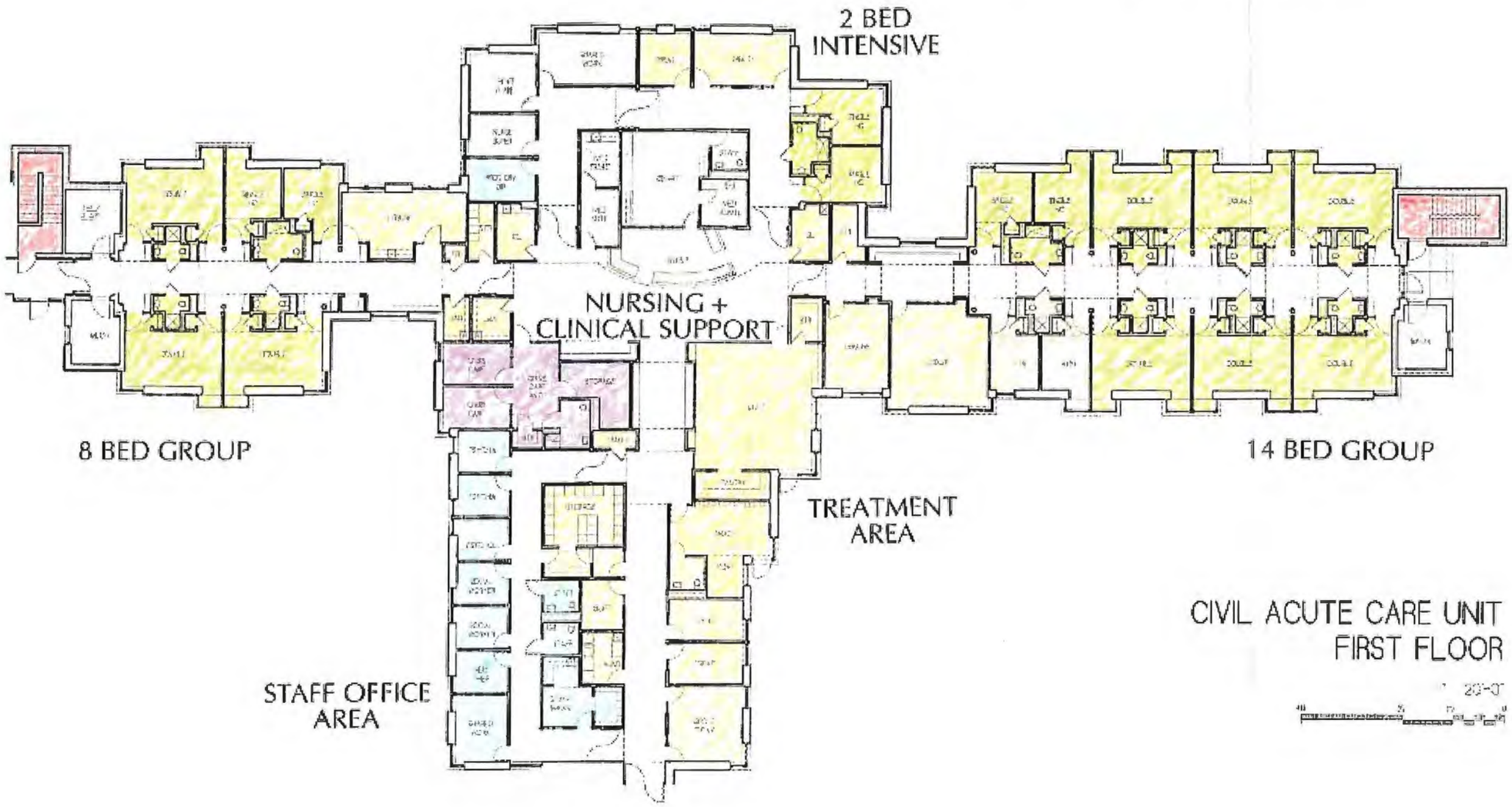

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FIGURE V

Civil Intermediate Care Unit

Maine Psychiatric Treatment Center - First Floor

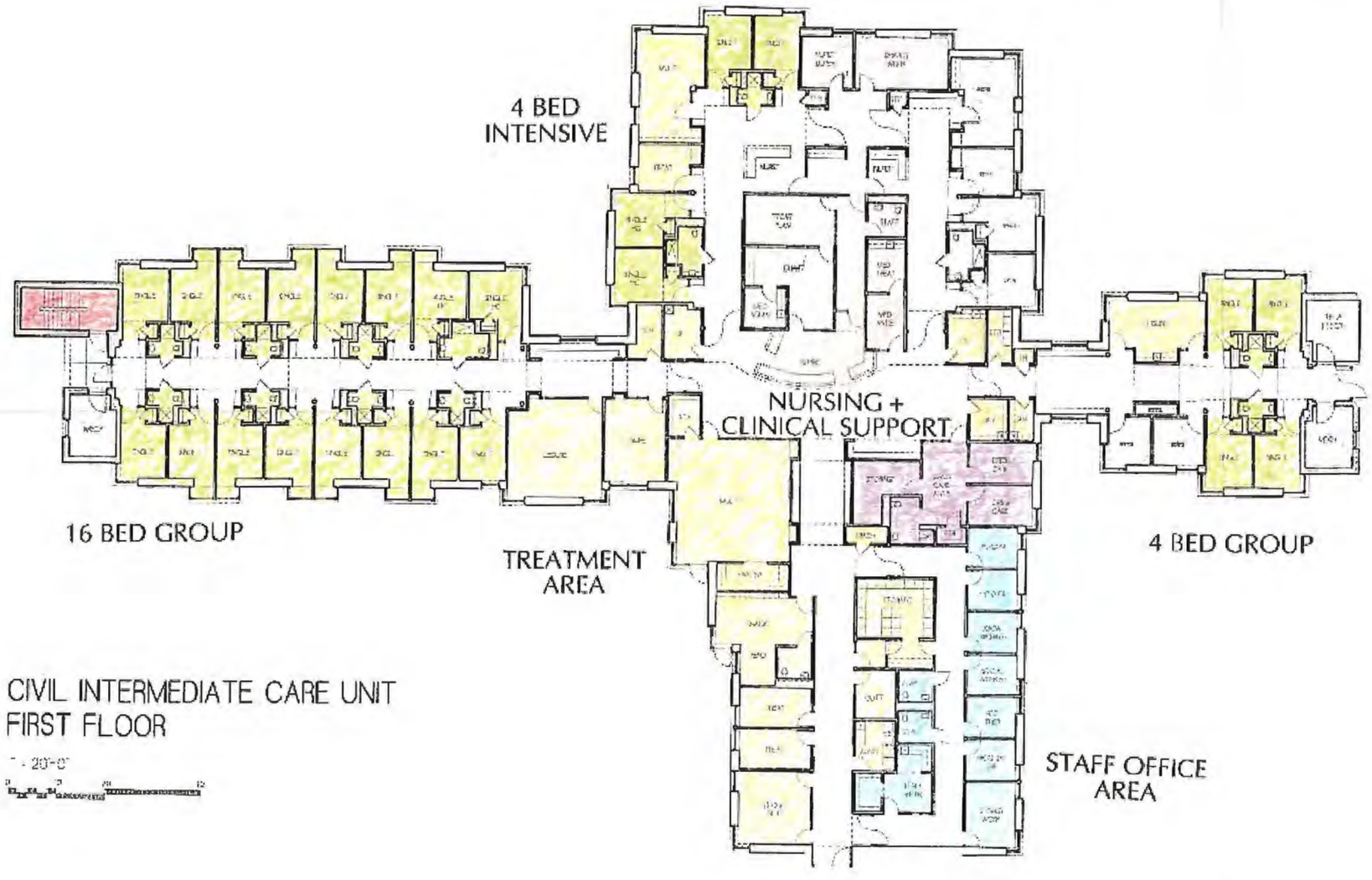

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FIGURE W

Forensic High Security Unit

Maine Psychiatric Treatment Center - Second Floor

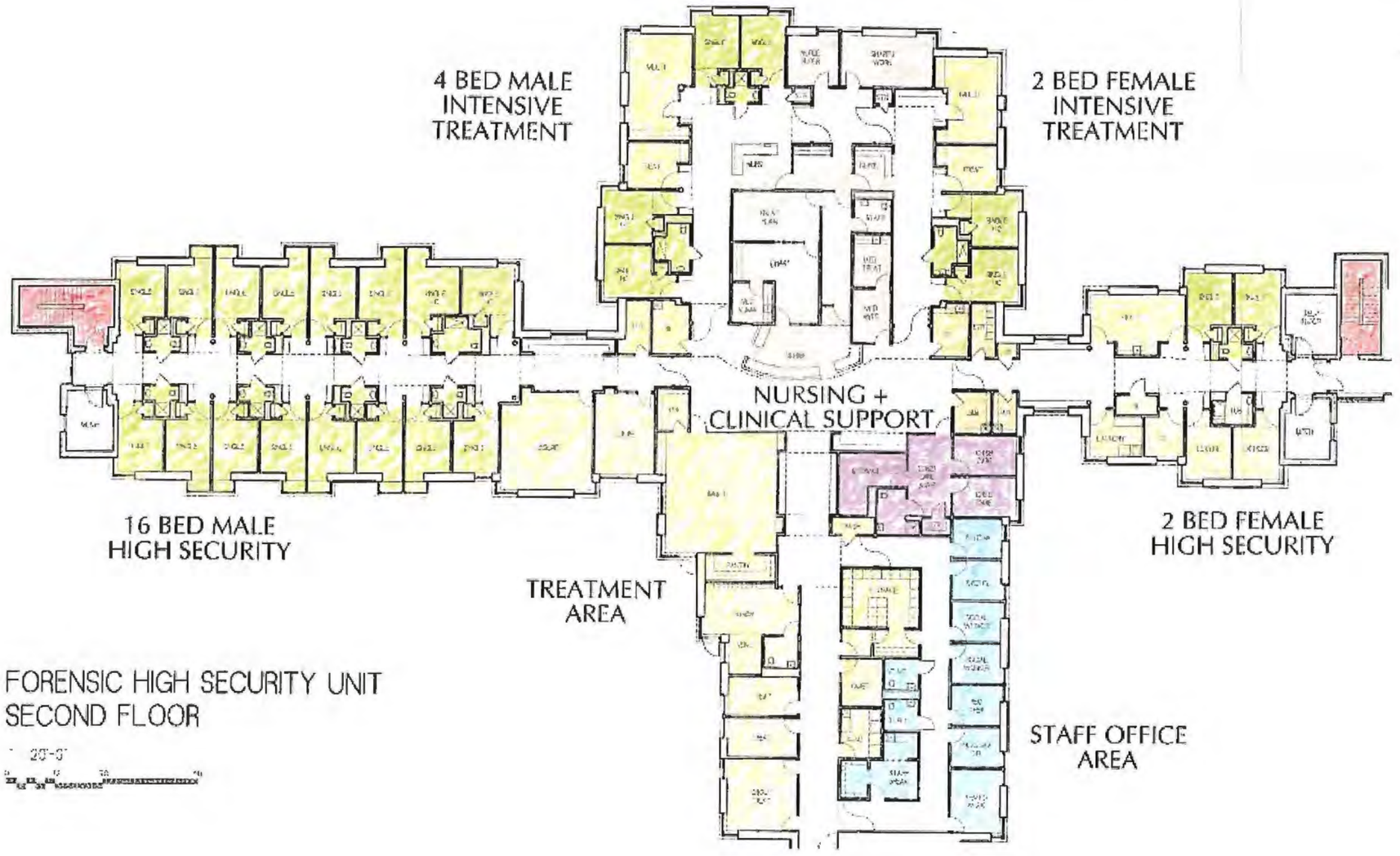

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FIGURE X

Forensic Intermediate Care Unit

Maine Psychiatric Treatment Center - Second Floor

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FIGURE Y

Treatment Mall

Maine Psychiatric Treatment Center - First Floor

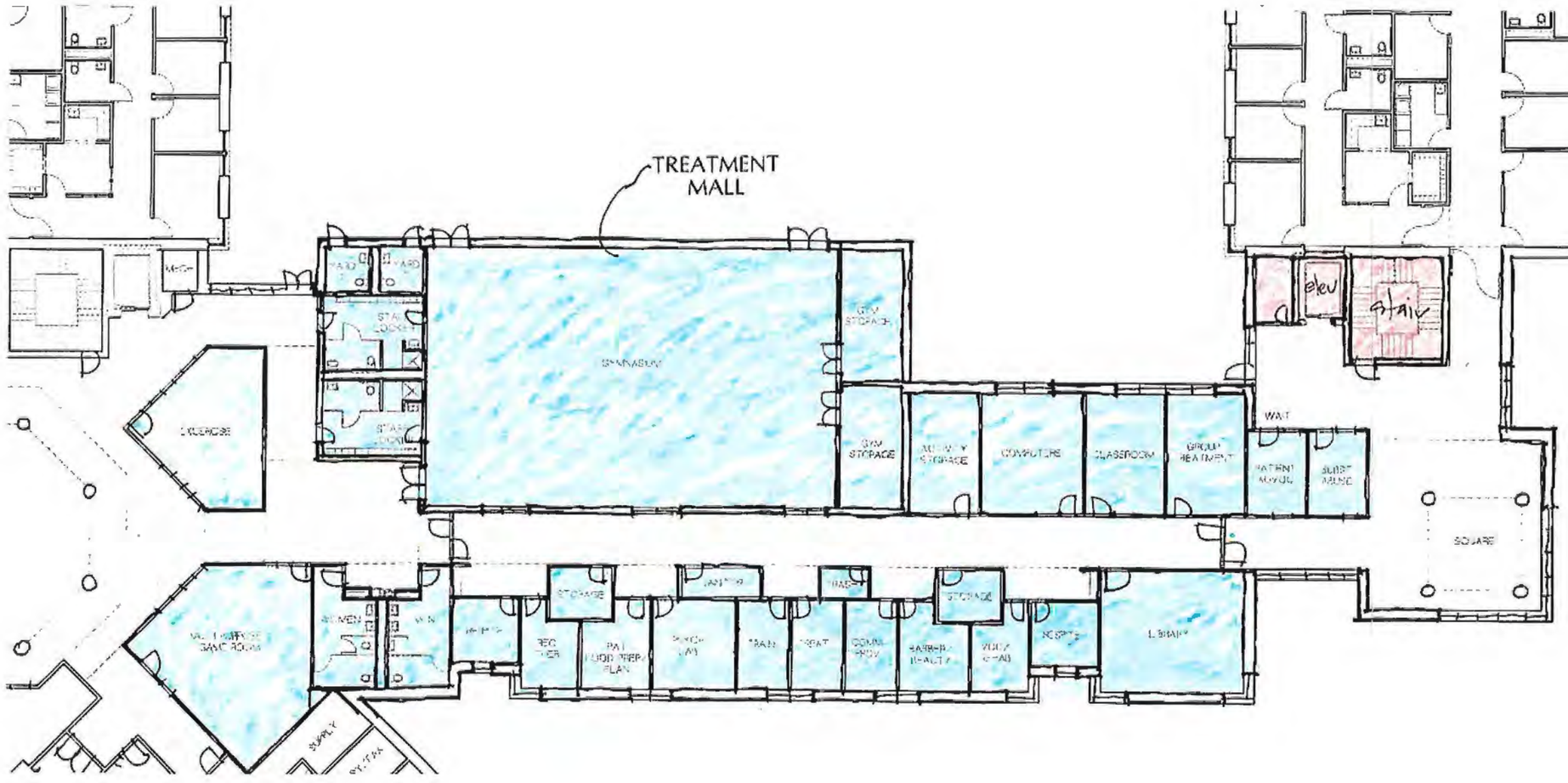

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FIGURE Z

Treatment Mall

Maine Psychiatric Treatment Center - Second Floor

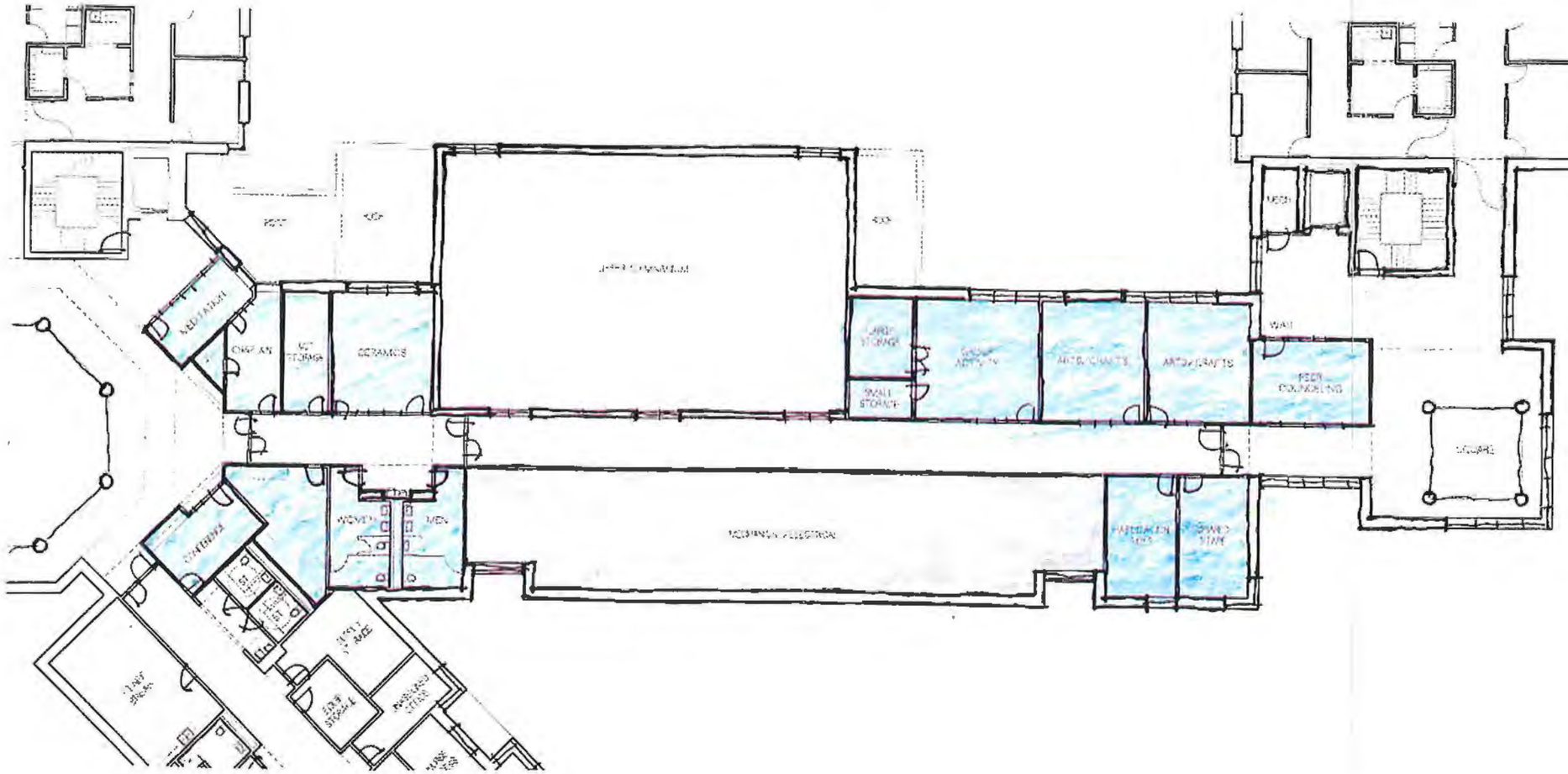

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FIGURE AA

Admissions/Discharge
Medical Records/Pharmacy

Maine Psychiatric Treatment Center - First Floor

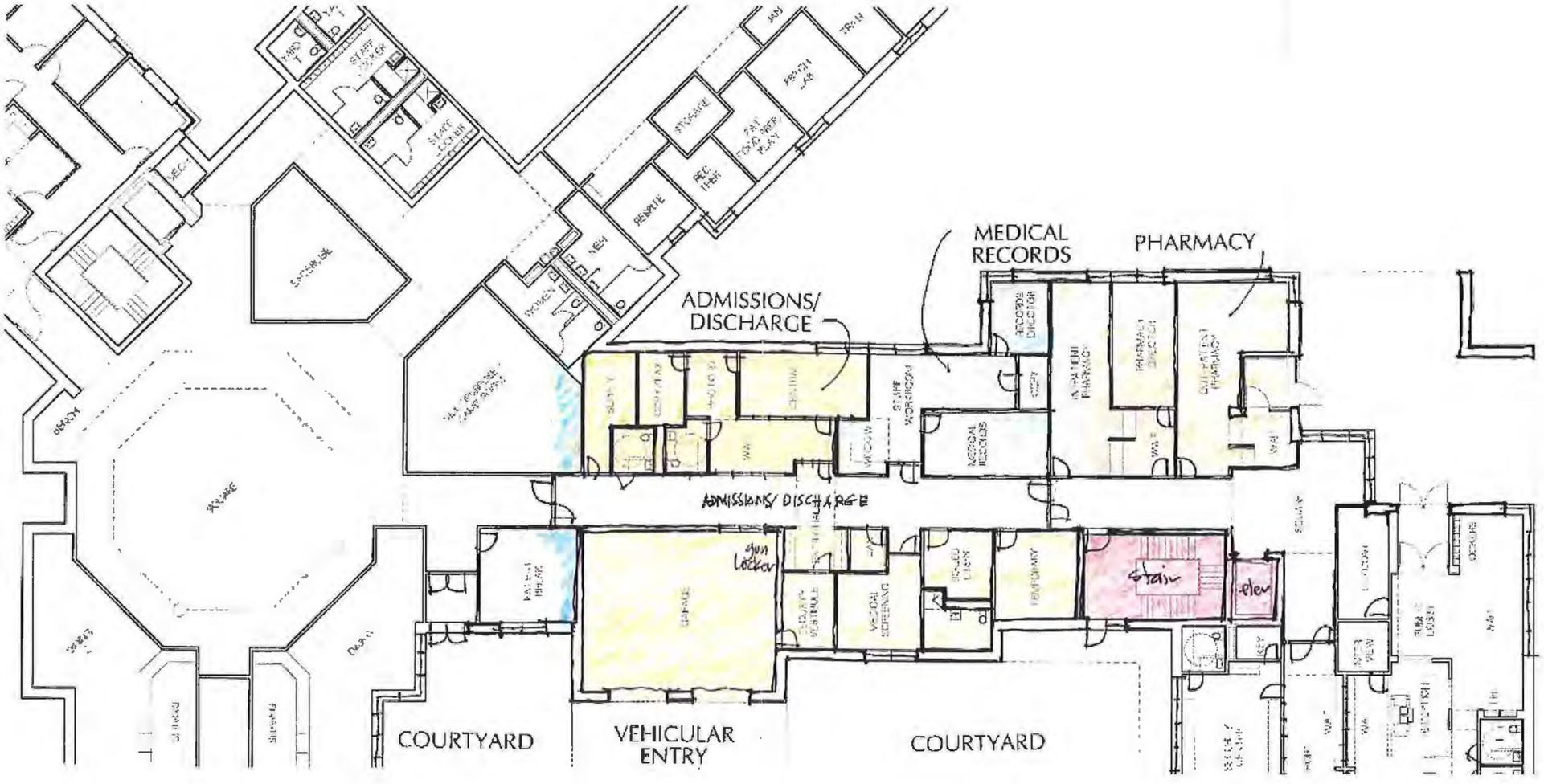

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FIGURE BB

Medical Support Services

Maine Psychiatric Treatment Center - Second Floor

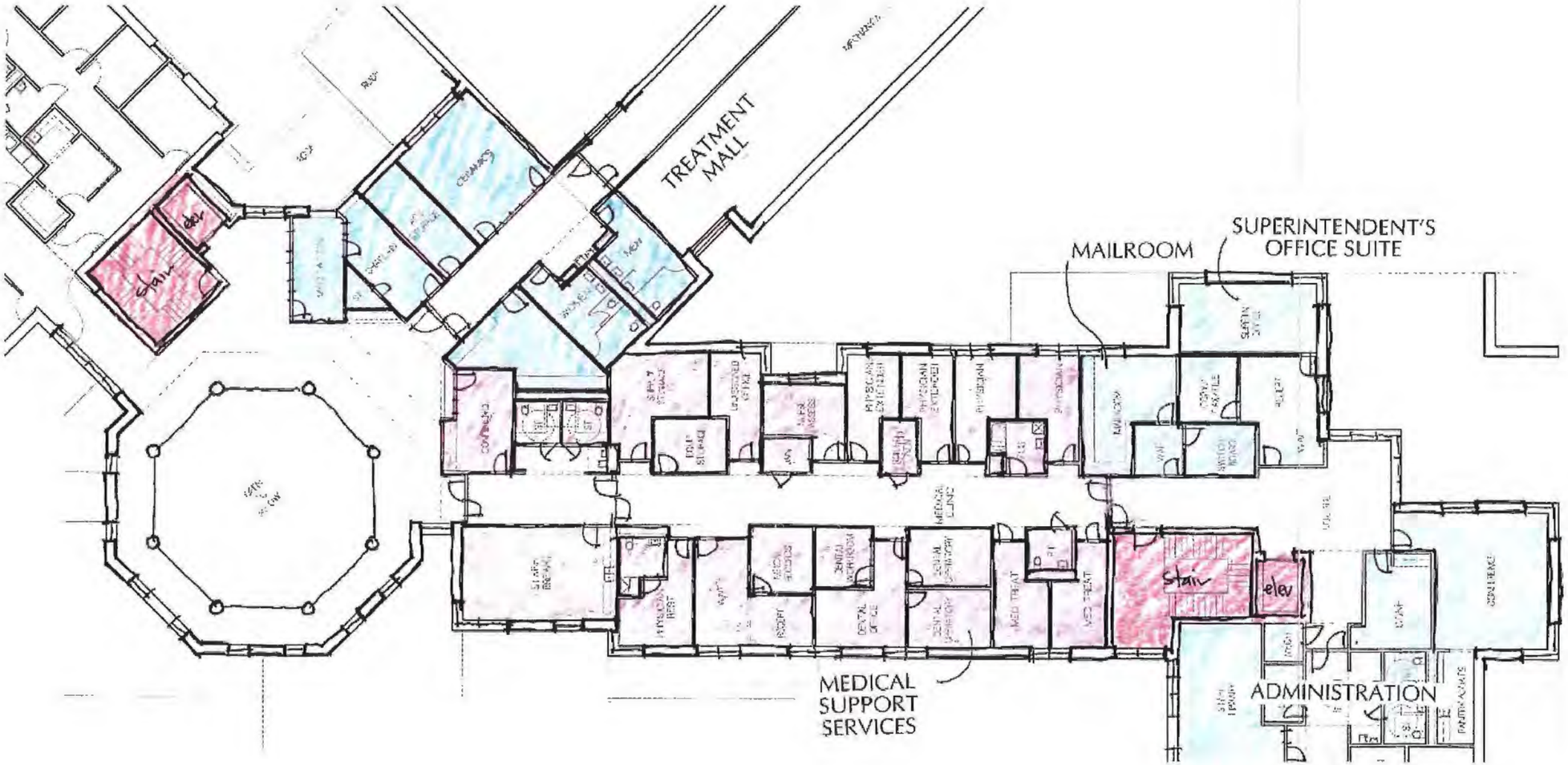

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FIGURE CC

Public Lobby/Security Center/ Visitation/State Forensic Services

Maine Psychiatric Treatment Center - First Floor

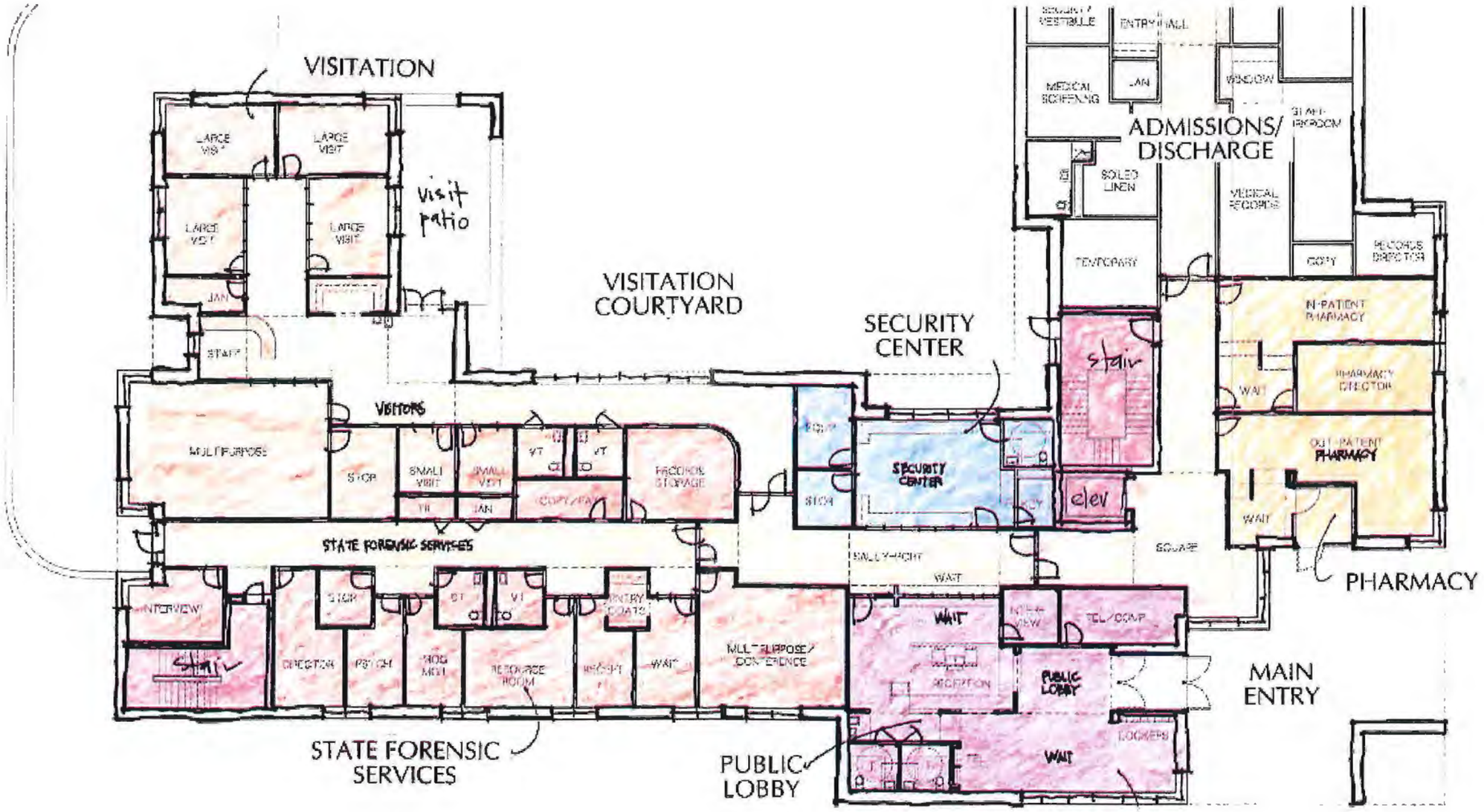

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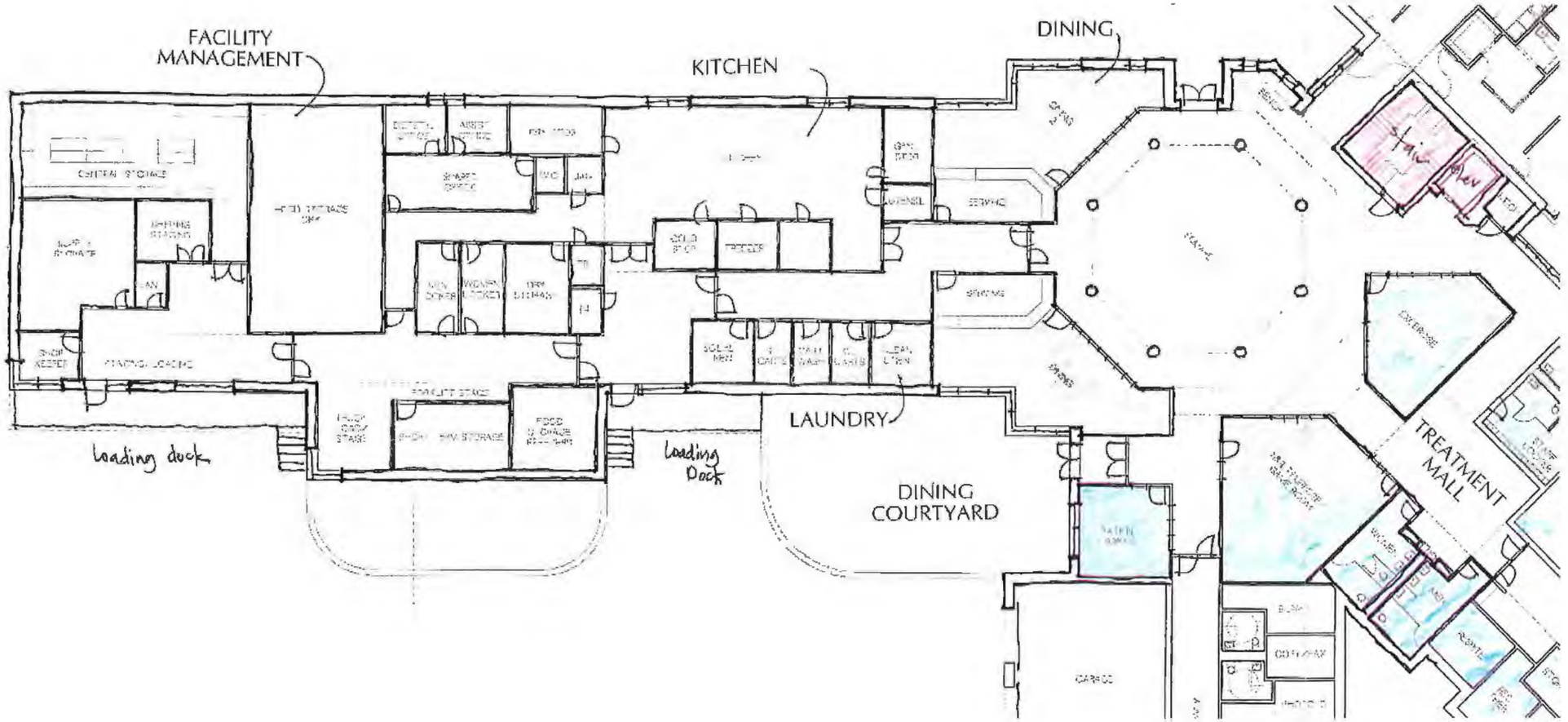
FIGURE DD

Food and Laundry Services Facilities Management

Maine Psychiatric Treatment Center - First Floor



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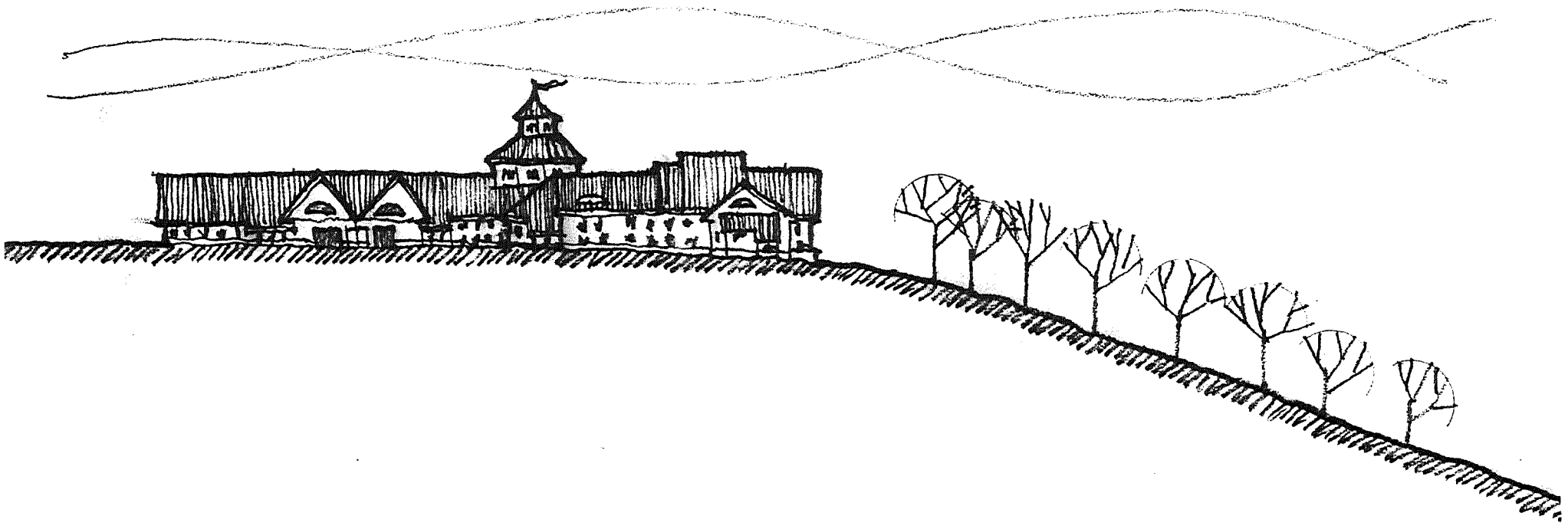

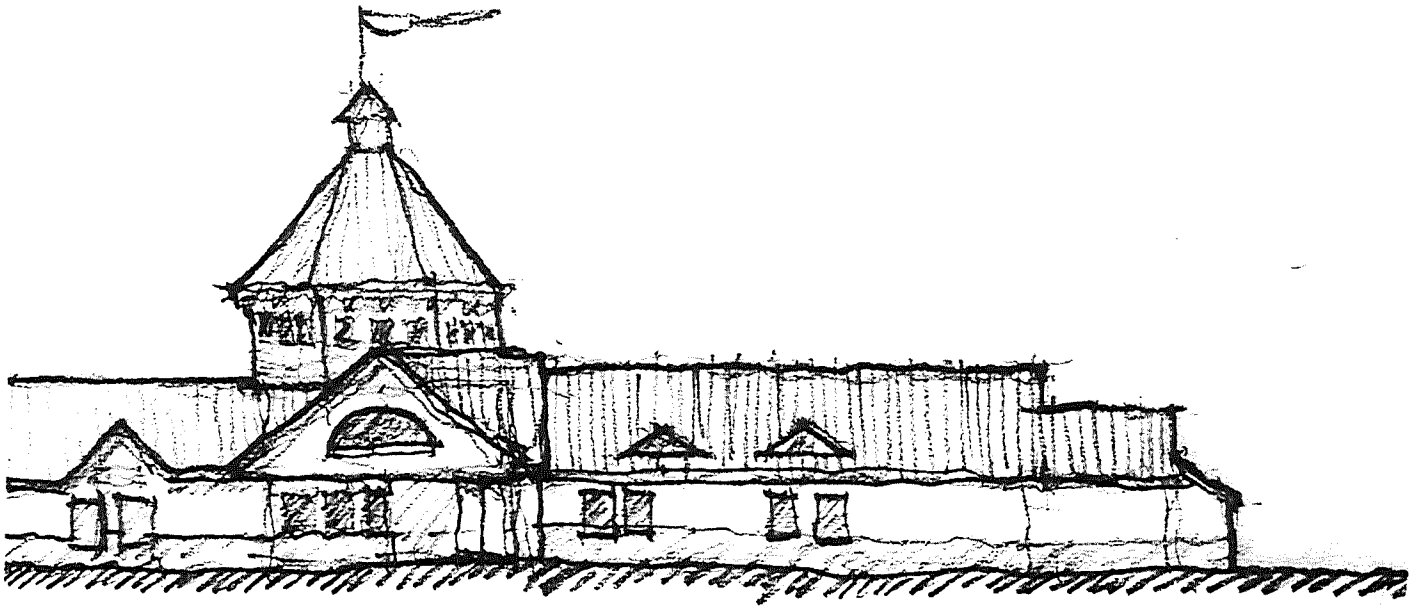

VII. COST ESTIMATES

VII. COST ESTIMATES

OPERATING COSTS

The annual operational costs for the Psychiatric Treatment Center and the two Supportive Living Centers were estimated based on an analysis of the current AMHI expenditures, review of the compensation for Maine state employees, and consultant estimates of utility costs for the new facilities.

The annual operational costs of the new facilities were based on the FY2000 dollars to facilitate a comparison with current AMHI operations. Thus, the operational cost estimates for the new facilities reflect current dollars, and will need updating based on the year that the facilities become operational.

Current AMHI Expenditures: The FY2000 AMHI expenditures were determined through discussion with DMHMRSAS financial staff to ensure that supplemental fund requests and transfers as well as the existing budget were accurately reflected. For example, utility costs reflected in the AMHI budget are actually offset by credits from state office buildings on the AMHI campus. Further, while funds for overtime expenses are not budgeted for AMHI, the funds required are obtained by annual transfers of funds from other DMHMRSAS accounts.

Personal Services (Employee) Costs: The salary for each staff position of the new facilities was based on an analysis of current AMHI personnel costs to ensure that the presence of staff with extended years of service and higher compensation levels were accurately represented. Benefit costs were estimated to be 40% of salaries based on discussions with AMHI administrative and personnel staff.

Reintegration Team: The Reintegration Team includes physicians, clinicians and administrative positions now included in the AMHI budget ,but whose primary function is to assist in the transition of patients to the community. DMHMRSAS has determined that this team will not be included in the budgeting for inpatient treatment in the future, but will be included in the Central Office budget; thus, the Reintegration Team was not included in the operational costs for the new facilities.

Professional Services (Contract Staff) Costs: Since DMHMRSAS has relied on contracts to ensure adequate psychiatric coverage for AMHI, these positions were continued as contract positions for the Psychiatric Treatment Center.

Professional Services (Non Staff) Costs: These costs include numerous contracts with community providers for such necessary operational services as laundry, phlebotomy and specialized consultations. These costs fluctuate based on the patient population being served. The estimates for these costs for the new facilities were developed by multiplying the current AMHI annual per patient cost of $3,229 by the number of individuals to be served by the new facilities.

Miscellaneous Non-Personnel Costs: These costs include the provision of food, medication, and treatment supplies. These costs fluctuate based on the patient population being served. The estimates for these costs for the new facilities were developed by multiplying the current AMHI annual per patient cost of $22,557 by the number of individuals to be served by the new facilities.

Utility/Repair and Maintenance Costs: The utility/repair and maintenance costs for the new facilities were developed based on an engineering analysis of the new facilities.

Table 40
Operating Cost Analysis: Comparison of AMHI to New Facilities

Augusta Mental Health Institute FY 2000			**NOTES:**
Number of Licensed Beds		103	
Number of Staff		318	Excludes positions proposed for transfer to Central Office Budget
Staff/100 Patients		308.25	
Total Personal Services (AMHI Employee) Costs		$ 13,149,452.00	
Reintegration Team		$ 859,397.00	
Overtime Costs		$ 175,000.00	Funds not budgeted; annual Transfer from other DMHMRSAS Accounts
Professional Services Costs-Contract Staff		$ 1,827,124.00	
Professional Services Costs-Non Staff		$ 332,611.00	Includes community contracts (laundry, phlebotomy)
Repairs and Equipment		$ 284,086.00	For entire AMHI campus
Utility Costs (Utilities and Fuel oil)		$ 1,019,754.00	
Misc. Non-Personnel Costs		$ 2,323,420.00	Includes food, medication, Supplies, operations
Credit for Non- Hospital Utilities on AMHI Campus		$ (500,000.00)	
Total Estimated Expenditures		**$ 19,470,844.00**	Includes budget plus transfers/ Requests of $975,000

Projected Psychiatric Treatment Center (FY2000 dollars)			**NOTES:**
Number of Licensed Beds		92	
Number of Staff		283.5	
Staff/100 Patients		308.15	
Total Personal Services (Employee) Costs		$ 11,818,250.00	
Reintegration Team		0	
Overtime Costs		$ 100,000.00	
Professional Services Costs-Contract Staff		$ 1,791,455.00	
Professional Services Costs-Non Staff		$ 297,068.00	Includes community contracts (laundry, phlebotomy)*
Repairs and Equipment		$ 50,000.00	Estimated figure based on new building
Utility Costs		$ 400,000.00	Estimated by SMRT for new building only
Misc. Non-Personnel Costs @ $22,557/patient		$ 2,075,244.00	Includes food, medication, supplies, operations **
Total Estimated Operating Expenditures		**$ 16,532,017.00**	

* Professional Services Costs-Non Staff estimated at current AMHI annual per patient cost of $3,229.
** Miscellaneous Non-Personnel Costs estimates at current AMHI annual per patient cost of $22,557.

Projected Supportive Living Centers (FY2000 dollars)			**NOTES:**
Number of Residents		16	
Number of Staff		28.4	
Staff/100 Residents		177.50	
Total Personal Services (Employee) Costs		$ 1,078,980.00	
Overtime Costs		$ 12,000.00	
Professional Services Costs-Non Staff		$ 51,664.00	Includes community contracts (laundry, phlebotomy)*
Repairs and Equipment		$ 10,000.00	Estimated
Utility Costs		$ 34,000.00 -	Estimated by SMRT
Misc. Non-Personnel Costs @ $22,557/resident		$ 360,912.00	Includes food, medication, supplies, operations **
Total Estimated Operating Expenditures		**$ 1,547,556.00**	

* Professional Services Costs-Non Staff estimated at current AMHI annual per patient cost of $3,229.
** Miscellaneous Non-Personnel Costs estimates at current AMHI annual per patient cost of $22,557.

Analysis of Operational Costs

Providing state of the art treatment for 108 individuals in the new Psychiatric Treatment Center and two Supportive Living Centers will cost the state **$18,079,573** (in current dollars). In comparison, the FY 2000 costs for the operation of the 103 licensed AMHI beds is **$18,611,447**, which excludes the costs for the Reintegration Team. Translating this differential into the cost per patient day results in the following efficiencies:

- AMHI: 37,595 patient days at **$495.05** per day
- New Facilities: 39,420 patient days at **$458.64** per day

This translates into a **3%** decrease in daily operating costs, while actually increasing the overall number of positions working in the new facilities. This is achievable, as the new facilities will be more efficient to maintain and operate. For example, maintaining security within the new treatment center will become more efficient when aided by the proposed state of the art facility design and security electronics. This

will enable the eventual reassignment of positions, upon completion of a transition process, into direct patient treatment and services.

CAPITAL COSTS

Table 41
Capital Cost Analysis by Component

A. Construction		$23,098,600.
B. Administrative Cost and Reserve		$ 3,414,360.
C. Fees and Services		$ 2,987,040.
D. Supportive Living Center		$ 1,000,000.
	Total Project Cost	**$30,500,000.**

The $30,500,000 capital budget for the project includes both the Psychiatric Treatment Center (92 beds) and the Supportive Living Centers (16 beds).

The budget presented reflects the standard Bureau of General Services Budget format, which includes construction, administrative cost and reserve and fees and services.

The construction cost per square foot of $200 is estimated for the Psychiatric Treatment Center, and includes projected site development costs. This cost per square foot is based on comparisons with similar facilities; it also reflects the current construction climate in the State of Maine.

Administrative cost and reserve includes furniture and equipment, legal and insurance costs as well as project contingency. The contingencies are based on percentage of construction cost. At this point, a 5% bidding contingency and a 5% program and design contingency are being carried.

Fees and services include architect/engineer fees based on the BGS standard fee schedule, specialty consultants, regulatory approval fees and consultants, transition costs, life cycle analysis, clerk of the works, special inspections and reimbursables.

The project budget also includes $1,000,000 dedicated to the development of Supportive Living Center projects. Funds would go toward the purchase, renovation and expansion of existing residences.

The site selected for the project is a parcel on the existing Augusta Mental Health Institute property. There are a number of buildings on this parcel, of no historic significance, which must be removed prior to start of construction. The cost of removal and replacement of these structures is not included in the budget.

VIII. APPENDICES

APPENDIX A

MAINE INPATIENT TREATMENT INITIATIVE: CIVIL & FORENSIC STAKEHOLDERS GROUP

Chair	Lynn Duby, Commissioner, DMHMRSAS
Project Manager, Site Selection	Elaine Clark, Bureau of General Services
Project Manager, Program	Katie Fullam Harris, DMHMRSAS
Consumers	Liz Carignan Eileen Wilkins Mark Cadrette
AFSCME	Beverly Minor Hathaway
AMHI Quality Improvement Council	Joan Detel
Citizen's Advisory Group on Mental Health	Reverend David Glusker
City of Augusta	Bill Bridgeo
Courtmaster, AMHI Consent Decree	Gerald Rodman
Disabilities Rights Center/Plaintiffs' Counsel	Helen Bailey
Joint Standing Committee on HHS	Representative Tom Kane, represented by Elaine Fuller
Maine Association of Chiefs of Police	Dick Mears
Maine Association of Emergency Room Physicians	Harry Grimnitz, MD
Maine Association of Mental Health Services	Jane Morrison
Maine Hospital Association	Kathleen Stuchiner
Maine Jail Association	Captain Catherine Mesaric
Maine Psychological Association	Sheila Comerford
Maine Psychiatric Association	Lawrence Mutty, MD
Maine Sheriffs' Association	Sheriff Bryan Lamoreau
MSEA	Mary Ann Turowski
National Alliance for the Mentally Ill, Maine	Carol Carothers
Office of Advocacy	Richard Estabrook
Statewide Quality Improvement Council	Pat Hunt/Phil Monaco
DAFS/BGS	William Stoddard
Department of Corrections	Ralph Nichols Mary Ann Saar
DMHMRSAS	Sawin Millet Susan Wygal Ann LeBlanc, Ph.D.
DMHMRSAS Regional Office	Holly Stover

APPENDIX B

PROPHET SIMULATION MODEL
GEORGE WASHINGTON UNIVERSITY

The Prophet Simulation model is an example of what is called a stochastic entity simulation model. It is stochastic in the sense that the model is conceptually designed around the movement of individual cases into, through, and out of a distinct population defined by the user. The model also makes use of the Monte Carlo simulation techniques by adding an element of randomness to the simulation model. The model generates random numbers to use in the simulation process during the group composition and lengths of stay associated with a system. Individual cases are processed by the model through a series of probability distribution arrays or matrices, which allow for computations of specific cases. When loaded with accurate data, the model will mimic the flow of cases through any given population.

Patient populations at any point in future time are composed of: (1) persons hospitalized at the beginning of the simulation, and (2) patients admitted to the population at any point after the start of the simulation. The existing and new patient admissions are modeled separately. By disaggregating a system in this manner, one can make adjustments in some sub-populations without altering the process of other sub-groups. This is particularly significant for completing "what-if" simulations on the forecasted population.

For the needs assessment, two projections were produced by the Prophet simulation model: one each for the civil and forensic populations. However, the model also projects movements into and out of various statuses, and produced a number of admission and release projections. The computer program produced these outputs in the form of vectors, which represent a ten-year time span.

The process can be described as follows: First, the existing patient populations were disaggregated. This was done for several populations in a process that involves several steps. For example, the existing patient population groups were each assigned to a length of stay category using Monte Carlo techniques. Time remaining in the hospital was then determined for each member of that length of stay category. Through this process, hospital time (or number of bed days) was calculated for each patient of the current population. The presence of each case was then marked on the trace vector. Additionally, when a patient was discharged from the hospital, a mark was made on the exit movement trace vector. The patients may return to the hospital again, eventually exiting the system or exceeding the maximum length of the projection. At each stage of the person's progress, and for each movement, appropriate trace vectors were updated. The result was a set of fully updated trace vectors, which comprised the population and movement projections.

The movements and outputs were especially useful in terms of monitoring how well the model is replicating the actual flow of cases through the system. The basic building blocks of the model were:

- *ID Groups* - Case identities which are meaningful within the context of the system's record keeping, and similar to the way patients currently are treated within the mental health system (i.e., male civil cases, female forensic, etc.).

- *Statuses* - Stages or conditions associated with the operation of the system (i.e., hospitalized, released, etc.).

- *Flow* - Connections between statuses, which represent the paths or flows a patient could take through the system, and the length of stay (or lag) in each status (i.e., confinement to release, blue paper to formal admission).

These basic building blocks -- ID groups, statuses and flows -- make up the set of attributes tailored to the specific needs of the State of Maine. ID groups, status and flow descriptions were set up for each of the Maine civil and forensic, male and female populations. Summary data were generated from the three data sources, and were used in building the simulation models.

The forecasted growth in patient admissions used in the models was based on the Maine state demographic population forecasts as provided form the Maine State Planning Office. Demographic growth for the state is projected to average 0.54% per year from the year 2000 to 2005, and 0.57% per year from the year 2005 to 2010.

APPENDIX C

MAINE INPATIENT TREATMENT INITIATVE: CIVIL & FORENSIC COMMENTS RECEIVED ON DRAFT DOCUMENTS

Comments on Needs Assessment:

Davis – 12/02/99
State Quality Improvement Council – Monaco, 12/10/99
Bailey, Estabrook, DeSisto – 12/21/99
Citizens Advisory Group – Glusker, 12/21/99, 1/20/2000
MSEA, Local 1989 – Turwoski, 12/22/99
Maine Psychiatric Association – Overstreet, 12/22/99
Maine Association of Mental Health Services – Shea, 12/22/99
NAMI, Maine - Carruthers, 12/28/99
Maine Hospital Association – Stuchiner, 12/29/99
Courtmaster – Rodman, 12/29/99
Maine Medical Association – Smith, 12/29/99
Eileen Wilkins – 12/29/99
Maine Chapter of American College of Emergency Physicians – Grimnitz, 12/29/99
Western Quality Council - McAuliffe & Copeland, 1/13/2000
Coastal Quality Improvement Children's Committee – Swasey-Ballou, 1/13/2000
Spring Harbor Hospital – King, 1/14/2000
Mal Wilson, 1/16/2000
Disability Rights Center – Bailey, 1/18/2000
Western Area Quality Council – Copeland, 1/19/2000

Comments on Site Selection

Courtmaster - Rodman, 1/10/2000

Comments on Program

Faust, 12/6/99
LaBlanc, 12/6/99; 1/13/2000
Wygal, 12/7/99
Bustin-Baker – 12/6/99
Wisch, 1/18/2000

APPENDIX D

DOCUMENTATION REVIEWED

Rights of Recipients of Mental Health Services, DMHMRSAS, amended January, 1995.

Augusta Mental Health Institute Unit Continuous Quality Improvement Plans, 1999-2000.

Review of Maine Mental Health System by Ronald J. Diamond, M.D., July 29, 1999.

DMHMRSAS Plan of Correction for Medicare Conditions of Participation (AMHI); memo dated July 23, 1999.

Reduced Scope Proposed Renovation of Existing Forensic Facilities at AMHI, Revised February 10, 1999.

DMHMRSAS Update to the Joint Standing Committee on Health and Human Services, January, 1999.

Annual Report on Services Contacted with Community Based Agencies Fiscal Year Ending June 30, 1998, dated January 31, 1999.

Plan for Mental Health Safety Net Services for Regions I and II, March, 1999.

1998 Patient Profiles, Augusta Mental Health Institute.

Cost of New Forensic Hospital vs. Renovation to Existing AMHI Forensic Hospital, memo dated November 5, 1998.

Development of Facility Based Outpatient/Day Treatment Services, memo dated October 23, 1998.

Forensic Treatment Unit Program Description, revised April, 1998.

Strategic Plan for Adult Mental Health Services in Region III, December, 1998.

Funding Sources and Expenditures of State Mental Health Agencies Fiscal Year 1997, National Association of State Mental Health Program Directors Research Institute, Inc.

More...and More Needy, A Study of Maine's Homeless Population, dated November 1997.

Augusta Mental Health Institute Policy and Procedure Manual, November 10, 1997.

Consultant Report by Joel Dvoskin, Ph.D., October 20, 1997.

Letter to the Editor from Anne B. Pringle, dated March 31, 1997.

Review of the Forensic Mental Health Evaluation Process for the State of Maine; Kenneth Appelbaum, M.D.; Joel Dvoskin, Ph.D.; and Thomas Grisso, Ph.D., March 7, 1997.

Reinvesting in Mental Health Care by DMHMR, 1997.

Task Force to Review Maine's Laws Concerning Involuntary Commitment, January 30, 1997.

Readmission Rate Analysis, memo dated January 3, 1997.

DMHMRSAS FY 1997 Department Update.

Governor's Task Force on Mental Health Recommendations, October 22, 1996

Report to Commissioner Melodie Peet, Commissioner, DMHMRSAS, regarding the Review of the Death of Wrendy Hayne, June, 1996.

Final Consolidated Plan for Implementing Settlement Agreement to AMHI Consent Decree, May 3, 1996.

Changes Taking Place at AMHI, memo dated June 21, 1996.

Special Directive: Patient Levels, memo dated May 8, 1996.

Consortium of Southern Maine General Hospitals, Study to Determine Feasibility for Development of Acute Psychiatric Inpatient Care, November, 1992.

State of Maine Contract with Community Mental Health Provider for Crisis Care, Fiscal Year 2000.

State of Maine Contract with Community Mental Health Provider for Residential Housing services and Community Support Services, Fiscal Year 2000.

State of Maine Contract with Community Hospital, Fiscal Year 1998.

Regulations for the Licensure of General and Specialty Hospitals in the State of Maine, July, 1992 with amendments through January, 1997.

Bates vs. Duby Consent Decree, dated July 31, 1990 and subsequent orders.

Maine Regulations related to Forensic Services.

Using Artificial Neural Networks and the Gutenberg-Richter Power Law to "Rightsize" a Behavioral Health Care System, article in American Journal of Medical Quality by George E. Davis, MD, and Walter E. Lowell, Ed D, September/October 1999.

Position Descriptions, State of Maine.

AMHI Budget and Staffing Plans, FY1999 and FY2000.

Website Information from the National Association of State Mental Health Program Directors Research Institute, Inc.

Design Considerations for Mental Health Facilities by the American Institute of Architects Committee on Architecture for Health

1996-97 Guidelines for Design and Construction of Hospital and Health Care Facilities by the American Institute of Architects Academy of Architecture for Health

JCAHO Regulations

APPENDIX E

DATA ANALYSIS & POPULATION FORECASTING TABLES

State Of Maine: Discharges By Hospital, 1996 – 1998 *

Hospital	1996		1997		1998	
	N	%	N	%	N	%
The Acadia Hospital	1,008	14.7%	934	13.9%	998	15.5%
Augusta Mental Health Institute	N/A	----	N/A	----	N/A	----
AR Gould TAMC	9	.1%	11	.2%	15	.2%
Bangor Mental Health Institute	N/A	----	N/A	----	N/A	----
Blue Hill Memorial	27	.4%	27	0.4%	17	0.3%
Brighton Medical Center	7	.1%	N/A	----	N/A	----
CA Dean Memorial	8	.1%	8	.1%	6	.1%
Calais Regional	17	.2%	23	.3%	14	.2%
Cary Medical Center	3	.0%	11	.2%	7	.1%
Central Maine Medical Center	42	.6%	31	.5%	32	.5%
Community General and Rehabilitation	310	4.5%	319	4.8%	315	4.9%
Down East Community	18	.3%	10	.1%	5	.1%
Eastern Maine Medical Center	71	1.0%	59	.9%	52	.8%
Franklin Memorial	12	.2%	11	.2%	12	.2%
HD Goodall	9	.1%	6	.1%	14	.2%
Houlton Regional	12	.2%	10	.1%	5	.1%
Inland Hospital	16	.2%	16	.2%	19	.3%
Maine Coast Memorial	20	.3%	14	.2%	19	.3%
Maine General Augusta	438	6.4%	544	8.1%	437	6.8%
Maine General Waterville	607	8.8%	553	8.3%	547	8.5%
Maine Medical Center	776	11.3%	743	11.1%	704	11.0%
Mayo Regional	18	.3%	16	.2%	13	.2%
Mercy	51	.7%	46	.7%	39	.6%
Mid-Coast Bath	8	.1%	2	.0	N/A	----

Hospital	1996		1997		1998	
	N	%	N	%	N	%
Mid-Coast Brunswick	318	4.6%	332	5.0%	262	4.1%
Miles Memorial	26	.4%	26	.4%	14	.2%
Millinocket Regional	11	.2%	8	.1%	5	.1%
Mt. Desert Island	30	.4%	35	.5%	28	.4%
New England Rehabilitation	1	.0%	N/A	----	N/A	----
Northern Cumberland Memorial	19	.3%	40	.6%	30	.5%
Northern Maine Medical Center	128	1.9%	111	1.7%	114	1.8%
Parkview Memorial	9	.1%	5	.1%	6	.1%
Penobscot Bay Medical Center	244	3.5%	331	4.9%	421	6.6%
Penobscot Valley	13	.2%	12	.2%	4	.1%
Redington Fairview General	16	.2%	11	.2%	13	.2%
Rumford Community	27	.4%	17	.3%	19	.3%
Sebasticcok Valley	41	.6%	34	.5%	33	.5%
Spring Harbor Hospital	1,352	19.7%	1,123	16.8%	981	15.3%
Southern Maine Medical Center General	329	4.8%	365	5.4%	362	5.6%
St. Andrew's	8	.1%	4	.1%	8	.1%
St. Joseph	23	.3%	35	.5%	30	.5%
St. Mary's Regional Medical Center	714	10.4%	707	10.5%	756	11.8%
Stephen's Memorial	10	.1%	3	.0%	6	.1%
Waldo County General	13	.2%	10	.1%	16	.2%
Westbrook Community	25	.4%	72	1.1%	23	.4%
York	33	.5%	28	.4%	24	.4%
Total	6,877	100.0%	6,703	100.0%	6,425	100.0%

** Data from Maine Mental Health Data Organization*
Only hospitalizations coded 19 (psychiatric) were included.

State of Maine: Mental Health Discharge Characteristics, 1996 – 1998 *

Characteristic	1996		1997		1998	
	N	%	N	%	N	%
Age						
Under 25	954	13.9%	841	12.5%	839	13.1%
26-35	1,833	26.7%	1,594	23.8%	1,527	23.8%
36-45	1,747	25.4%	1,877	28.0%	1,875	29.2%
46-55	926	13.5%	964	14.4%	881	13.7%
56 and Over	1,417	20.6%	1,427	21.3%	1,303	20.3%
Missing	0	0%	0	0%	0	0%
Average Age	43.3		44.2		43.3	
Total	6,877	100.0%	6,703	100.0%	6,425	100.0%
Length of Stay						
1 day	613	8.9%	598	8.9%	560	8.7%
2-5 days	2,006	29.2%	2,024	30.2%	1,992	31.0%
6-10 days	2,118	30.8%	1,905	28.4%	1,937	30.1%
11-15 days	1,016	14.8%	1,045	15.6%	821	12.8%`
16-20 days	439	6.4%	440	6.65	390	6.1%
21-30	376	5.5%	402	6.0%	395	6.1%
31-60	253	3.7%	238	3.6%	270	4.2%
61-120	48	.7%	48	.7%	53	.8%
121+	8	.1%	3	.0%	7	.1%
Average LOS	10.1		10.0		10.2	
Total	6,877	100.0%	6,703	100.0%	6,425	100.0%

** Data from Maine Mental Health Data Organization*
Only hospitalizations coded 19 (psychiatric) were included.

State & Community Hospital Data Comparison

	County of Residence 1998					ALOS 1998 (Civil Patients)
	Androscoggin	**Cumberland**	**Kennebec**	**York**	**All Other**	
State Hospital: AMHI [1]	9.05%	38.6%	27.1%	6.6%	18.7%	56.2 Days
Community Hospitals [2]	9.0%	22.0%	13.4%	9.4%	46.2%	10.2 Days

[1] Source: AMHI Hospital

[2] Source: Maine Health Data Organization

State of Maine: Discharges by Patient County of Residence, 1996 – 1998 *

County of Residence	1996		1997		1998	
	Number	Percent	Number	Percent	Number	Percent
Androscoggin	649	9.4%	593	8.8%	577	9.0%
Aroostook	432	6.3%	441	6.6%	440	6.8%
Cumberland	1,655	24.2%	1,666	24.9%	1,411	22.0%
Franklin	129	1.9%	99	1.5%	102	1.6%
Hancock	249	3.6%	235	3.5%	212	3.3%
Kennebec	939	13.7%	869	13.0%	858	13.4%
Knox	158	2.3%	219	3.3%	231	3.6%
Lincoln	123	1.8%	111	1.7%	105	1.6%
Oxford	243	3.5%	199	3.0%	196	3.1%
Penobscot	815	11.9%	837	12.5%	861	13.4%
Piscataquis	92	1.3%	98	1.4%	74	1.2%
Sagadahoc	161	2.3%	144	2.1%	124	1.9%
Somerset	256	3.7%	242	3.6%	240	3.7%
Waldo	155	2.3%	164	2.4%	204	3.2%
Washington	140	2.0%	124	1.8%	108	1.7%
York	600	8.7%	568	8.5%	606	9.4%
New Hampshire	23	.3%	17	.3%	12	.2%
Other United States	57	.8%	76	1.1%	60	.9%
Canada	1	.0%	1	.0%	1	.0%
Total	6,877	100.0%	6,703	100.0%	6,425	100.0%

Note: For 1998, there are 6 missing cases

** Data from Maine Mental Health Data Organization*
Only hospitalizations coded 19 (psychiatric) were included.

Augusta Mental Health Institute
FY 1998-1999 Admissions Characteristics

Characteristic	1998		1999	
	Number	Percent	Number	Percent
Sex				
Male	220	60.3%	208	63.0%
Female	145	39.7%	122	37.0%
Age				
25 and Under	61	16.7%	66	20.0%
26-35	105	28.8%	91	27.6%
36-45	109	29.9%	98	29.7%
46-55	56	15.3%	40	12.1%
56 and Over	34	9.3%	35	10.6%
Marital Status				
Married	34	9.3%	23	7.0%
Divorced	106	29.0%	77	23.3%
Single	196	53.7%	200	60.6%
Other	27	7.4%	30	9.1%
Forensic Unit				
Yes	38	10.4%	54	16.4%
No	327	89.6%	276	83.6%

FY 1998-1999 Length of Stay of Discharged AMHI Patients

	Civil Patients		Forensic Patients	
Length of Stay (days)	1998	1999	1998	1999
Minimum	1	1	4	1
Average	56.2	46.3	54.0	26.2
Maximum	706	330	217	227

Augusta Mental Health Institute
FY 1998-1999 Admissions Characteristics

Committing County	1998		1999	
	Number	Percent	Number	Percent
Androscoggin	33	9.0%	38	11.5%
Aroostook	0	0.0%	2	0.6%
Cumberland	141	38.6%	86	26.1%
Franklin	5	1.4%	6	1.8%
Hancock	2	0.5%	0	0.0%
Kennebec	99	27.1%	85	25.8%
Knox	9	2.5%	14	4.2%
Lincoln	2	0.5%	1	0.3%
Out of State	6	1.6%	11	3.3%
Oxford	12	3.3%	16	4.8%
Penobscot	1	0.3%	1	0.3%
Piscataquis	0	0.0%	1	0.3%
Sagadahoc	9	2.5%	7	2.1%
Somerset	15	4.1%	12	3.6%
Waldo	7	1.9%	9	2.7%
Washington	0	0.0%	1	0.3%
York	24	6.6%	40	12.1%
Total	365	100.0%	330	100.0%

APPENDIX F

MAINE COMMUNITY HOSPITAL ANALYSIS
ONLY ADULT PSYCHIATRIC PATIENTS

January 1, 1999 – June 30, 1999

Region	Counties Served By Community Hospitals within the Region	Average Daily Census 1/99-6/99	Number of Licensed Beds	Number of Operational Beds
Region I	Cumberland York	70.85	84	83
Region II	Androscoggin, Franklin Oxford, Kennebec Somerset, Knox Lincoln, Waldo Cumberland, Sagadahoc	69.2	88	83
Region III	Washington, Aroostook Penobscot, Piscataquis, Hancock	61	71	70

Maine Community Hospital Analysis
Only Adult Psychiatric Patients
January 1, 1999 – June 30, 1999

Region	Average Monthly Admissions 1/99-6/99	Average Monthly Involuntary Admissions 1/99-6/99	Average Monthly Voluntary Admissions 1/99-6/99	Percentage Of Involuntary Admissions from Catchment 1/99-6/99	Percentage of Voluntary Admissions from Catchment 1/99-6/99	Average Monthly Referrals to other Acute Hospitals 1/99-6/99	Average Monthly Referrals due to Capabilities (Risk) 1/99-6/99	Average Monthly Referrals due to Capacity 1/99-6/99
I	192	63	129	12% – 38%	20% – 95%	47	N/A – 0	N/A – 37
II	223	31	192	N/A – 85%	60% - 90%	127	41	76
III	173	25	149	11% - 60%	N/A – 89%	34	4	30

Region	Average Monthly Number of Patient LOS Under 30 days 1/99-6/99	Average Monthly Number of Patient LOS Over 30 days 1/99-6/99	Average Monthly Number of Patient LOS Over 90 days 1/99-6/99	ALOS Patients Under 30 days 1/99-6/99
Region I	179	9	1.5	7.6; 9.2; 9.38
Region II	183	10	2	7; 8; 8.3; 17.9
Region III	144	9	4	9; 10.9