DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS

REPORT TO THE COMMISSIONER
ON THE AUGUSTA MENTAL HEALTH INSTITUTE
AND SELECTED REPRESENTATIVE COMMUNITY MENTAL HEALTH CENTERS

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PART I

AUGUSTA MENTAL HEALTH INSTITUTE - February 1974

This report contains findings and tentative suggestions resulting from my visit to the Augusta Mental Health Institute in December, 1973. It is not an in-depth evaluation of everything I saw; rather it focuses on areas where improvement may be needed.

Contents:

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I. PATIENT ADVOCATE PROGRAM

In general, I was impressed that the DMHC has created a patient advocate program and, in particular, with the quality and dedication of the two advocates I met. However, I question the purpose of the program, the advocate's position within the official administrative structure of the hospital, potential conflicts of interest, and the specific duties and powers of advocates.

To begin with, I am confused as to the primary purpose of the patient advocate program. Does the advocate serve primarily a monitoring function on behalf of the superintendent or does he serve primarily an adversary function on behalf of the individual patient? (It should be noted that in either function the advocates serve a particular party. Therefore, the advocate is quite different from a traditional ombudsman, whose primary attributes are impartiality and independence from the administration.) It would seem to me that the ideological thrust of the notion of a patient advocate is partiality of the advocate for the patient. In accordance with this function the advocate acts on behalf and in the interests of the individual patient. He places the patient's interests above other interests.

The patient advocate at Augusta Mental Health Institute is currently a DMHC staff member directly responsible to the Superintendent. Anyone in this position within the hospital hierarchy is likely to have some concern for his own job and salary, problems caused for his superiors, problems caused for his fellow staff members, and the ability of the hospital to provide the best treatment for the greatest number of patients. These interests are not always compatible, and frequently at odds, with the interests of the individual patient. It would seem that the advocate is faced with an inherent conflict between his advocacy for individual patients and his concerns generated by his position within the hospital administration.

If the primary purpose of the patient advocate program is to provide an adversary acting for individual patients, the possibility of establishing the patient advocacy program independent of the hospital and DMHC should be explored.

A possible funding mechanism could be a federal, state, DMHC, or private foundation grant. The patient advocates themselves could be made responsible to the Mental Health Advisory Board, or perhaps a new Citizens and Consumers Advocacy Board. Whatever path is followed, the two essential elements for the new program would be the authority of the head patient advocate to appoint his own staff and his independence from the DMHC ordinary chain of command.

I also suggest that the responsibilities and powers of patient advocates be explicitly spelled out as soon as possible. They may be broken down into at least four categories. First, a patient advocate shall function as an information source for both patients and DMHC personnel. His duties should require him to be kept informed of all current policies and practices of the department and institution as well as relevant developments in other parts of the country. Second, the patient advocate program shall primarily serve as a grievance-response mechanism. To this end, patient advocates should be given authority to receive complaints by patient, intercede with hospital officials on behalf of a patient, refer complaints, or assist patients in advancing formal grievance proceedings. (see the section on Patients' Grievance Mechanism for how this would work.) It may also be desirable to give the advocate sole discretion to refuse to accept complaints where there is clearly "another remedy available," where the complaint is "trivial or frivolous," or where the complaint is "too stale to justify an investigation." Third, patient advocates may initiate their own investigations. It is likely that some patients will fear reprisals for raising complaints. It is important for the advocate to have the capacity to minimize this inevitable reluctance on the part of some patients. This he can do by raising complaints on his own initiative. The advocate should also have authority to publicize his general findings and recommendations, and where appropriate to publicize a patient's complaint, where written authorization has been given by the patient. Fourth, the patient advocate should have a reporting function. He shall compile, maintain, and prepare statistical information regarding complaints and their resolution for periodic submission, together with appropriate recommendations for administrative changes which are based thereon, if any, to the commissioner, superintendents, advisory board, governor, general court, the public or any of these.

It is also vital that all patient communications to the advocate made within the scope of his duties, together with written records or accounts thereof, shall be confidential and not subject to disclosure by any process or authority of the department or its employees.

Furthermore, the patient advocate should be granted access to department and institution files, records and personnel and to patients as may be necessary to the proper conduct of his duties. Such access shall be limited only as may be required by orderly administrative practices or prohibitions of law. Where access is denied, the advocate may petition the commissioner in writing for a favorable ruling. Within 24 hours, the commissioner shall grant or deny the petition in writing, stating the reasons for his actions.

Explicit criteria for the selection of patient advocates should be developed. These criteria could be developed by the funding agency, in conjunction with the commissioner, superintendents, and mental health advisory board or other designated board.

The DMHC may also want to issue a policy statement that the patient advocate program should not and cannot be regarded as a substitute for competent administration, for conscientious personnel, for adequate supervision of public employees by superiors, for administrative appeals, and for judicial review of administrative action. A

patient advocate program is only an additional safeguard for patients.

II. PATIENTS' RIGHTS AND RESPONSIBILITIES

Although the current statement of patient rights and responsibilities is concise (which is quite a virtue in and of itself) it includes some things you may not want and fails to include other things that you may very well want. For example, it is written that "any of these rights, however, may be denied for the welfare of the patient only by the superintendent, or his designees (unit chief or O.D.)." This "loophole" would permit the superintendent or his designees to open sealed mail sent to patients from their attorneys, private physicians and other mental health personnel, courts, and government officials. I do not think that is desirable. On the other hand, the present statement contains no provision that the patient has the right to be treated with respect and dignity. The following are some suggestions about some rights and duties that the Patient Council and superintendent may want to adopt or think about. They are self-explanatory.

1) You have a right to be treated with dignity and respect. (You should be called Mr. Green or Mrs. Green or Miss Green or Ms. Green, not Green or John or Mary, unless you prefer to be called by any other name.)

2) You have a right to consent to or to refuse any treatment. You have a right to have things explained clearly. (For example, any possible side effects of medicines.) You have a right to refuse treatment by any physician or other mental health staff member and to request a different doctor or mental health staff member.

3) You have a right to the least restrictive conditions necessary to achieve the purposes of treatment.

4) You have the right to be free from any unnecessary or excessive medication. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with your individualized treatment program.

5) You have a right to refuse to participate in or be interviewed for research purposes. You have the right to full explanation of the purposes and potential hazards of the research and uses of the research results if you do participate. Unless you give your express and informed consent, you shall not be subjected to experimental research.

6) You have a right to privacy.

   a. No employee should talk to you about your problems in the day room or halls or where others, whether patients or staff, may hear.

   b. No one should call across the room for personal information. For example, "Are you married?" or "Do you have Medicaid?"

c. It shall be the duty of the hospital to provide one room on each ward, in addition to the day room, furnished with comfortable chairs, standing lamps, and rug where patients may exercise their right to privacy without intrusion by staff, except where absolutely necessary. Whenever a staff member enters this room, he shall be required to knock first and request entrance.

7) You have a right to have all information regarding you to be held in strict confidence by the hospital staff and patient advocate.

8) You have a right to know about all conferences concerning you, the decisions that were made, and on what basis they were made.

9) You have a right to know what's going on. You have a right to question anything you do not understand or that is worrying you. The employee to whom you address your question has the duty to respond to you promptly and courteously.

10) You have an unrestricted right to receive sealed mail from your attorney, private physician, or other mental health worker, from courts, and government officials. You have a right to mail and receive unopened correspondence.

11) (I would explicitly include in the present right number 5 the additional rights to register to vote and to marry and obtain a divorce.)

12) The hospital has a duty to supply an adequate allowance of clothing to any patients who do not have suitable clothing. You have the right to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered yours throughout your stay at the hospital.

13) You have a right to regular physical exercise several times a week. It shall be the duty of the hospital to provide space and equipment for such exercise.

14) You have a right to be outdoors at regular and frequent intervals, in the absence of medical considerations.

15) You shall not be required to perform labor which involves the operation and maintenance of the hospital or for which the facility is under contract with an outside organization. Your privileges or release from the hospital shall not be conditioned upon the performance of such labor. You may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. §206 as amended, 1966.

16) You may be required to perform therapeutic tasks which do not involve the operation of the facility, provided the specific task or any change in assignment is:

a. An integrated part of your individual treatment plan and as approved as a therapeutic activity by a mental health professional responsible for supervising your treatment and;

b. Supervised by a staff member to oversee the therapeutic aspects of the activity.

17) You have the right to make any complaint concerning policy, practice, rule, treatment, condition or exercise of authority by the Department of Mental Health and Corrections, its constituent institutions, or employees. You have the right to have the patient advocate formulate and facilitate your complaint. It is the duty of the patient advocate to treat all communication with you as confidential.

III. PATIENTS' GRIEVANCE MECHANISM

Rights are no good unless there is some mechanism for enforcing them when they are abridged. For example, in my rounds with the patient advocate we learned that several patients were being denied prompt access to a telephone. Other patients complained to me about grievances of a more serious nature (i.e. harassment by a staff member). The following is a set of rules which define the structure and functioning of one kind of patient grievance mechanism. Major attention is paid to the categories of grievants, due process, and final appeal to an outside Board. An explanation follows each rule:

1. Grievance and Grievant.

a. Grievance

(1) Any complaint concerning policy, practice, rule, treatment condition or exercise of authority by the Department of Mental Health and Corrections, its constituent institutions or employees may constitute a grievance.

(2) These shall include:

(a) Matters wherein the means and authority for proper review, adjudication, and relief reside within Augusta Mental Health Institute (institutional grievances).

(b) Matters wherein the means and authority for proper review, adjudication and relief reside at the departmental level (departmental grievances); and

(c) Matters of either category which may also give rise to a legal claim for which appropriate remedies are also available in a court of law.

b. Grievant.

(1) Any patient, group or association of patients who are in the Augusta Mental Health Institute and assert a grievance.

(2) Any person, group or association of persons having substantial interests (by virtue of their relationship with a patient) who assert a grievance relating to the exercise of those interests.

(3) A grievant may act in his own behalf in asserting a grievance or may act through the patient advocate or another person who is also a grievant in the same proceeding.

Explanation: It would be wise to distinguish between those grievances under the jurisdiction of the hospital and those under the jurisdiction of the department. The following discussion will pertain only to grievances under the jurisdiction of the hospital, but the possibility for asserting a broader range of grievances should be kept in mind if the grievance mechanism is extended to other institutions in the DMHC.

The term grievant is defined to indicate who may initiate grievances. In addition to patients and their advocates, I would suggest that grievances may be brought by members of the immediate family, the patient's attorney, or his clergyman whose interests may be aggrieved by the conduct of hospital personnel or adversely affected by a particular policy, rule or regulation. It should not be intended that an individual in this category may present a complaint that may be ordinarily raised by a patient. Instead, for persons to be aggrieved they must show that the conduct of an official or the application of a rule or regulation directly interferes with their access to the patient. For example, parents who are not permitted to visit their daughter during regular visiting hours and are given no reasons for this refusal would come within the scope of this rule.

2. Hospital Grievance Officer.

(1) The superintendent, acting through his appointed officers, shall have authority to receive, review, investigate, adjudicate, grant and implement relief with respect to any grievance of an institutional nature.

(2) The hospital grievance officer shall be a person holding the position of deputy superintendent.

(3) The superintendent and hospital grievance officer shall also have authority to commence an investigation on their own initiative and to grant and implement such relief as may be warranted.

Explanation: You may or may not want to create the position of a hospital grievance officer. Depending upon the number of complaints and their seriousness it may be possible to designate a part-time grievance officer. The primary virtue of such a position would be the centralization of the grievance process. Making the grievance officer responsible to the superintendent only would also minimize the problems of peer group pressure

and command influence. It is also expected that the hospital grievance officer would take over the monitoring function on behalf of the superintendent, which is now played by the patient advocate.

3. Informal Grievance Proceedings.

Complaints that lend themselves to quick investigations and immediate resolution should be resolved informally at the mental health team level among the grievant, the patient advocate, and the appropriate team staff members.

Explanation: The formal grievance process should not be invoked nor the intervention of the hospital grievance officer required for complaints that can be easily resolved. For example, complaints about canteen privileges could be easily resolved informally. The formal grievance process would be invoked for complaints that have not been resolved in the informal grievance process, or grievances, that because of their nature, may require more extensive investigation. Examples are repeated denials to revise treatment, unanswered complaints about sanitary conditions, harassment by staff member or patient, or alleged unfair disciplinary sanction.

4. Formal Grievance Proceedings.

(1) The formal grievance process shall be commenced at the unit level by submitting a written complaint to the unit chief through the hospital grievance officer. The complaint shall bear the grievant's name, signature, and shall set forth the nature of the grievance (including information necessary to verify factual allegations) in a plain and concise statement, and the relief requested.

(2) A complaint may be submitted by a grievant acting in his/her own behalf or by a patient's advocate or other duly constituted representative acting in the grievant's behalf.

(3) No patient, group, association, or class of patients shall be barred from filing a complaint or pursuing any of the remedies set forth in these rules. No prejudicial action whatever shall be taken against any patient on account of his/her filing a complaint or giving evidence in connection therewith.

(4) The hospital grievance officer shall have authority as may be necessary to make determinations of fact.

(5) The decision of the unit chief on a complaint shall set forth in writing and notification thereof shall be given to the grievant or his representative, and to any hospital employees as may be required.

(6) Where the unit chief rejects the complaint for lack of jurisdiction or authority over the subject matter, the complaint shall be immediately directed to the superintendent.

Explanation: In addition to the above, specific review procedures of how these proceedings are to be conducted on the unit level must be worked out.

5. Appeals.

(1) A grievant may appeal an adverse decision of the unit chief to the superintendent, through the hospital grievance officer, within seven days for a de novo review. The appeal shall be in writing and shall conform to the requirement for filing a complaint.

(2) Where an appeal is taken, the unit chief shall be given notice thereof, together with a copy of the appeal and an opportunity to present a summary of his position.

(3) Upon due consideration, including additional investigation if warranted, the superintendent may grant or deny the appeal. Notification of the superintendent's decision on the appeal shall be given to the unit chief, the grievant(s), and his representative and shall be in writing.

Possible additional requirements:

(4) A grievant may appeal an adverse decision of the superintendent to the Outside Advisory Board within seven days for a de novo review. The appeal shall be in writing and shall conform to the requirements for filing a complaint.

(5) Where an appeal is taken the superintendent shall be given notice thereof, together with a copy of the appeal, and an opportunity to present a summary of his position.

(6) Upon due consideration, including additional investigation if warranted, the Outside Advisory Board may grant or deny the appeal. Notice of the Board's decision on the appeal shall be given to the superintendent, the grievant(s), and his representative and shall be in writing.

Explanation: This rule sets forth the procedures for appeal. It provides for de novo review of an appeal by the superintendent and gives him authority to consider evidence outside the recommendations and findings of the unit chief and hospital grievance officer. It also provides an additional de novo review by an Outside Advisory Board and gives it the authority to consider evidence outside the findings of the superintendent. It provides that ultimate disposition of a grievant's complaint rests in a body outside the ordinary command structure of the hospital.

6. Petition for Reconsideration

(1) The grievant or superintendent may within three days file a petition for reconsideration of an adverse decision on an appeal. The petition shall be in writing. It shall bear the petitioner's name and signature and set forth reasons for petitioning for reconsideration in a plain and concise statement.

(2) Where a petition for reconsideration is filed, the grievant or superintendent shall be given notice, together with a copy of the petition for reconsideration. In addition, the grievant or superintendent shall have an opportunity to reply.

(3) Upon due consideration, including additional investigation if warranted, the Outside Board may grant or deny the petition. Notification of the Outside Board's decision shall be in writing to the grievant and the superintendent.

Explanation: Petitions for reconsideration should be limited to those situations where a party to the grievance believes that the Outside Board has overlooked certain important aspects of the grievance or new information, not able to be presented during earlier review procedures, should be brought to the attention of the Outside Board.

IV. STAFF DISCRETIONARY POWER

Perhaps the most striking impression of my 24 hour patient experience was the tremendous discretionary power the ward staff had over every aspect of my life. This discretion is frequently not properly confined, structured, and checked. For example, patient representative Paul Pierce found in his November 19, 1973 site visit to BMHI that a "resident can be placed in the cooler (seclusion) without a physician having any input or knowledge of that decision." During my patient experience and visits around the hospital, I received that distinct impression that rules were often selectively and arbitrarily enforced.

The grievance mechanism suggested above should help to check the abuse of discretionary power in the hospital but it is not enough. (In fact, you might want to consider doing a study of the exercise of discretion in the hospital and its effect on patients.) For the present, I offer one suggestion for your consideration. Rules and policy statements need not be "generalizable." They need not apply to large classes of activities, people or situations. When the superintendent or unit chief knows the answer to a hypothetical case, he should issue a rule, stating the case, his position, and his reasons, without generalization. When further hypothetical cases can be added, they should be. Since this kind of rule-making interacts with decisions in particular cases, generalizations will usually emerge in due course. In other words, I suggest that the hospital administrators formulate some of their rules in the form of:

1. Hypothetical set of facts;

2. A statement of the problem raised by the facts;

3. An indication of the hospital's answer to the problem and when appropriate;

4. A statement of the hospital's reasons for its position.

In this regard, decisions resulting from the grievance mechanism may provide some valuable input for these rules. The idea is that what happened to one patient should not be repeated to another patient and the discretionary power that permitted such an abuse either eliminated or properly confined and structured.

V. AFTERCARE PROGRAMS

Though I will devote much more attention to aftercare in a subsequent report, I do want to give some of my impressions of the day I spent with two mental health workers from the Ken-Som Unit at the Arsenault's. Batchelder's and Willowcrest Boarding Homes.

While efforts to move patients from the hospital to the community should be continued and probably increased, efforts should also be taken to keep expatients away from boarding homes like the ones I visited. Those homes represent a very effective way of shutting up patients in the community. Indeed, the Willowcrest Home is a mini state hospital with day rooms, nurses with white uniforms, and rows of beds amidst drab, crowded, and dirty conditions. The patients seemed forlorn, lost, and without a sense of hope. At the Arsenault Home residents are treated with little dignity and respect. They complained of having their mail opened by the operator and inadequate and poor quality food. In one case, the operator's family ate the ice cream one of the boarders had bought for herself. Batchelder's Home was the most depressing and disheartening of the three. Residents are confined to one room which serves as living, dining, and recreation room. The door to the kitchen is latched and off limits to the residents. They must be in bed by 9 P.M. and turn in their cigarettes and lighters every night. The operator, who is a very nervous woman, is totally incompetent. She reinforces the boarders' fantasies, and on her own initiative cut down a patient's medication according to the report of the two mental health workers. The week before my visit the two mental health workers spent two hours cutting the toe nails of the residents after they complained that they couldn't walk properly because of ingrown nails. One resident had been at this home for one and a half years and never had her toe nails cut. Her feet were crusted with filth and it was learned that none of the residents took tub baths; they all took sponge baths because the operator found it impossible to help them in and out of the tub.

In none of the three homes were the patients encouraged to interact in any way with other people in the community. The rights of the residents were often ignored and thought should be given as to whether the patient advocacy program might be extended to foster and boarding homes. Followup of patients in the community is crucial and requires friendly cooperation and coordination with a wide range of community organizations and agencies. From the little I've seen so far, Maine has a long way to go in this area.

VI. MISCELLANEOUS SUGGESTIONS

1. The provision of a gymnasium for patients and athletic equipment.

2. The current privilege card system should be reversed. A patient should be entitled to all privileges unless he/she shows that he/she should be denied certain privileges. The staff member who makes this determination should make this denial in writing, state the reasons for the denial and the time period the denial is to remain in effect. A copy of the denial of privilege shall be given to the patient and the patient advocate responsible for the particular team or ward.

3. The ability of a staff member to relate to patients and the quality, warmth, and depth of his/her relationships with patients should be considered in promotion.

4. A far greater concern should be exhibited for the privacy of patients. A room should be set aside on each ward as a place of quiet and retreat for patients. The room should be furnished with comfortable chairs, a rug, and standing lamps and contain no television or radio. Any staff member should be required to knock and ask permission to enter before entering this room.

5. The dining halls should remain continuously open from breakfast to a few hours after dinner so that residents may sit around the tables, smoke, or chat. Coffee, tea, and hot chocolate should be made available during all these hours to patients.

6. Patients should be allowed a leisurely amount of time to finish their meals.

7. During intake only one staff member should ask questions. Needless repetition of questions should be avoided by staff members.

8. Specific procedures should be set up for a patient to play a meaningful role in devising his programs of treatment and release as soon as he enters the hospital.

PART II

COMMUNITY MENTAL HEALTH CENTERS - June 1974

This is a report of my visits to Tri-County Mental Health Services (March 18 to March 22 and on May 20), Aroostook Mental Health Center (May 21 to May 24), and the Maine Medical Community Mental Health Center (May 27 to May 31).

The report is divided into two parts. The first section contains general observations on each of these centers and discusses their positive aspects and areas where improvement is needed. The second section discusses the future of the mental health program in Maine and suggests possible roles for the State and local areas.

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I. CRITIQUE OF THE THREE CENTERS

A. SUMMARY

The three community mental health centers visited in Maine share many of the same problems that beset community mental health nationwide. There lacks real planning, assessment of community and often individual client needs, setting of specific objectives and priorities, coordination with other human services agencies, program evaluation, accountability to clients, and involvement of a broad range of community groups. Though resident patient populations have dropped at both state hospitals, centers have been extremely slow in assuming responsibility for released patients and thus far have failed to provide adequate community alternatives. Present arrangements between centers and state hospitals lack specific procedures and guidelines for transfer of patients as well as an over-all guiding philosophy and objective. Furthermore, many staff members often at the same center have markedly different perceptions of the role of state hospitals. When mental health staff members fail to share consensus on the role of state hospitals or even to be aware of current DMHC policy regarding state hospitals, the public can hardly be expected to lend its support to current and future mental health programs.

B. TRI-COUNTY MENTAL HEALTH SERVICES

TCMHS is the first community mental health center to be established in Maine. Yet of the three centers visited, it is the most uncertain of its future, programatically as well as financially. A few Tri-County staff and officials in other areas of the state attribute TCMHS's difficulties to a well-meaning, but futile attempt to provide all things to all people. I do not share this observation. While the center has undoubtedly aided a number of clients, it also has taken no initiative to establish a program for alcoholics, provides few programs that are relevant to the needs of the rural poor and lower-income French Canadians in Lewiston, does not have an active children's program, and until very recently had no real aftercare program. Rather, TCMHS like many other centers across the country suffers from a lack of

consensus among staff of why the center exists, what it is trying to accomplish, and how it should operate. Fattened for a number of years by federal funds, the center expanded rapidly with little or no planning. Policy was not consciously formulated; rather it happened as the result of ad-hoc decisions. Now that federal dollars have decreased, crisis management is the order of the day. The objective is to save existing programs, not to question their relevance or effectiveness. There are some excellent programs and individual staff members at this center, but they are not coordinated by either a guiding philosophy or an active administration. At present, the center appears to be a collection of semi-independent baronies tied together by a letterhead and a common thirst for funds. Preoccupied with its own internal crises, the center is failing to give sufficient consideration to the responsiveness of its program to the needs of the Tri-County area.

Positive Aspects:

1. The most impressive program of TCMHS that I saw is clearly the Depot, a program geared towards lower income children and their parents. Located in a renovated train depot in the midst of the population it is designed to serve, the program has an energetic and enthusiastic staff with a common understanding of their objectives. The staff seem to have made a real effort to assess the needs of their clients and to structure their program according to those needs. For example, their survey to determine the hours the community deemed most convenient to have the clinic open should be repeated throughout the state. Also laudatory are their followup studies on the Intensive Group Program and their continual evaluation of the Parent Education workshops. Such on-going evaluations should be implemented in other TCMHS programs. Finally, the informal, friendly atmosphere of the Depot seems more attractive to many clients than the more formal, bureaucratic atmosphere of the main office on Campus Avenue.

2. There are several outstanding staff members at TCMHS who would be an asset to any center in the country. The problem is that their talents are not being utilized to the fullest extent. Indeed, many of them are frustrated in their attempts to bring about program changes.

Areas for Improvement:

1. No real assessment of community needs. TCMHS has no formal and on-going mechanism to identify the mental health needs of its catchment area. I did not receive the impression that the center has structured its five essential services and other programs to meet the particular problems of Lewiston or Oxford and Franklin counties.

2. Lack of coordination with other human services agencies. While there are informal contacts between center staff and other agencies, there does not appear to be continuous on-going relationships. For example, the local director of Health and Welfare stated that he and his staff have little contact with center staff. The different roles and responsibilities of these agencies for the center's clients need to be spelled out and their efforts coordinated.

3. Lack of staff consensus on the purposes and goals of the center. I received the impression that staff members often work at cross purposes because they fail to have commonly established goals and objectives. They are uncertain of each other's roles and responsibilities. Neither do they successfully resolve differences of opinion and conflicts. For example, there existed some markedly different perceptions of the center's relationship to AMHI. Some staff members thought that the center should take over responsibility of the state hospital for all patients from the Tri-County area. Others thought that AMHI must always remain as a backstop for the center and expressed anger and frustration that Augusta would not take more patients from the center.

4. Lack of program and financial planning. Though the center hired a mental health planner a couple of years ago to head its Developmental Services Branch, there seems little commitment to any real planning. The planner is excluded from Policy Council meetings, he makes little input in formulating the programs of unit directors, and has been assigned a number of ad-hoc projects that have little impact on the operation of the center. Furthermore, few unit directors seem to have either the interest or time to formulate plans for their own programs.

5. Lack of vigorous outreach and casefinding. The basic thrust of the center is to react to the problems and people who come through the door. Typically, they are depressed individuals who need someone to talk to. While the center may serve this function quite well, it is questionable whether this should be the principle focus of a community mental health center and whether $1.5 million might not be spent a good deal more effectively.

6. Lack of evaluation and accountability. At present there is no real evaluation of the relevance, quality, and effectiveness of programs. Neither is there adequate evaluation of staff performance. What few evaluative efforts that have been made appear to have slight impact on program development. For example, a Consumer Evaluation Survey was completed in March, 1973 but it has not been followed up and its findings (i.e., the center's limited effectiveness with rural clients and lack of knowledge of consumers of what the center does) do not seem to have affected any change in the center's programs. In addition, there is no mechanism to resolve the complaints of individual clients nor specific standards and guidelines for accountability.

7. Lack of consumer involvement. Until recently, the Board of Directors does not seem to have played an active role in policy formulation. The composition of the Board also fails to reflect the socio-economic makeup of the Tri-County area. There is a need for increased input of lower socio-economic class consumers through either a change in the composition of the Board or other mechanisms.

8. Lack of a comprehensive followup and aftercare program. There has been some improvement in this program since it started, but aftercare remains one of the most serious weaknesses of this center. Problems include:

(a) lack of coordination and mutual suspicion between center staff and state hospital staff. There is considerable need for more staff interaction on levels below the superintendent and the center director.

(b) lack of vigorous followup of all patients. Some patients continue to be seen only once every three months for routine medication.

(c) lack of adequate record keeping of patients returning to the Lewiston area. Some patients are literally lost in the transfer.

(d) lack of day care and recreation for many expatients. There is considerable need for more mobile teams and activity therapists.

(e) lack of home visiting.

(f) a total lack of real alternatives to hospitalization and transitional facilities. There exists one therapeutic boarding home, no half-way houses, no group living arrangements, no patient apartments, and no sheltered workshops.

9. Lack of initiative in establishing alcoholism programs and programs for adolescents.

C. AROOSTOOK MENTAL HEALTH CENTER

Of the three centers visited, AMHC is by far the most community-oriented and the most dedicated to providing a range of human services. In part this orientation is explained by the center's responsiveness to the needs of the area itself. Unlike Portland or Lewiston, Aroostook County has little in the way of social services outside its comunity mental health center, which has had to fill in many of the service gaps. AMHC also comes the closest of the three centers in embodying the familiar, though frequently ignored objectives of personal self-maximization and maintenance of the patient in the community whenever possible.

This is not to say that AMHC provides the best possible mental health services or that it is able to adequately respond to the needs of all its clients. The center has neither the staff nor the money to accomplish this and, in addition, its existing programs are not as flexible as they should be because of funding restrictions largely beyond the center's control. But the center does about as well as one might hope for given these constraints. The future effectiveness of AMHC will largely depend upon the transfer of funds and personnel from Bangor Mental Health Institute.

Positive Aspects:

1. A largely self-propelled and enthusiastic staff. I have seen few other centers in the country with a staff that seems to enjoy working with each other so much.

2. Good communication among staff and between professionals and nonprofessionals. In general I saw none of the friction between different professional groups and between professionals and nonprofessionals here that was quite noticeable

at Tri-County. Staff seemed to know what each other were doing and were quite supportive of each other's efforts. The only example of a major breakdown in communication was in regards to the new alcoholism program. Here the center director and one of the program workers had very different ideas about target groups of the new program.

3. Good Administration. The center director received plaudits for his administrative ability from everyone I interviewed.

4. Excellent relations between center staff and the Board of Directors. All important policy decisions are brought before the board which makes the ultimate determinations. Several board members praised the extensive briefings they received at meetings and the preparatory information sent to them before meetings. The Board members I spoke to expressed great confidence in the center director.

5. Positive Expressions of Client Satisfaction. I spoke individually with every client in the day care program at Fort Fairfield without the presence of staff, with several clients in the day care program at Fort Kent, and a class of seventh and eighth graders at the Stockholm Elementary School who had participated in the center's school consultation program. All the day care clients were very positive about the services provided by the center. Their complaints centered around the lack of group living arrangements, sheltered workshops, and jobs. (My experience at AMHC should be contrasted to my visit to the day care program in Lewiston, where the unit director refused to let me speak with her clients. She explained that her patients were too frequently bothered by visitors. It would seem, however, that the patients themselves have the right to see or or refuse to see visitors. Sheltering them from visitors hardly contributes to getting them back into the community.) My discussion with the school children was very enjoyable. There was no center staff member present, but all the kids said they had gained new insight about themselves, their classmates, and their families.

6. Extensive use of school contracts. AMHC is the only center to make extensive use of contracts to provide consultation services to local schools.

7. Warm, informal atmosphere for clients. Though the central office is located in the general hospital, it presents an informal, warm atmosphere to clients. Day care clients wander freely about the center. This is a considerable change from only a year ago when the day care patients stayed in one room and rarely communicated with visitors.

Areas for Improvement:

1. Poor relations with Bangor Mental Health Institute. The center director freely admits that his center's relations with BMHI are "terrible." As a result some Aroostook residents are admitted to BMHI without prior screening by the AMHC and others released from BMHI without followup by AMHC. Some of these problems have been alleviated by the assignment of an AMHC MSW to Bangor, but definite guidelines and procedures must be worked out for the transfer of patients and the responsibilities of each facility spelled out. In addition, there seems to be a definite need for unitization of BMHI.

2. Inadequate aftercare program. While the director of the aftercare program and his staff seem to be very able and dedicated, their program cannot meet the range of human needs of their clients. Expatients have few alternatives in Aroostook County. They go back either to their families or to foster homes. There are no half-way houses, no extended care facilities, and no group living arrangements. Neither are there sheltered workshops or many jobs available. Other problems of the aftercare program include:

   (a) The program fails to pick up people who are not on public assistance. The director of aftercare explained that the Department of Health and Welfare restricts certain aftercare services to those on public assistance. This regulation works as a disincentive to expatients to find a job. A number of expatients want to work but fear that if they do they will no longer be able to participate in the aftercare program.

   (b) Better coordination between aftercare staff and BMHI staff.

   (c) More home visiting and crisis intervention outside the day care programs.

   (d) Training programs for foster-care parents and activities for residents in foster care homes are needed.

3. Lack of a solid information base to evaluate program effectiveness. While subjectively AMHC seems to be doing a very good job there lacks data to conclusively establish this. The center is just beginning to set up an evaluation system and procedures need to be developed to insure that the evaluation results influence decision-making.

4. Lack of input from all segments of the community. While the staff is very conscious of gearing the center's programs to the needs of the community, there currently exists no formal mechanism to tap all segments of the community. The Board of Directors is not representative of the socio-economic makeup of the area, though some board members told me that they are attempting to broaden the composition of the board. Regardless of the future board makeup, it is necessary for the center to develop other mechanisms to insure that all groups have input into center policy-making.

5. Better use of the inpatient facility. At present the inpatient facility is rarely more than half full. This suggests that some residents at BMHI might be transferred to this inpatient facility.

6. Expansion of the alcoholism program. According to almost everyone I interviewed alcoholism is one of the most pressing problems of Aroostook.

D. MAINE MEDICAL COMMUNITY MENTAL HEALTH CENTER

The basic orientation of this center is a traditional medical approach and the basic policy question it raises is whether medical intervention is that alternative which produces the most benefit for patients at least cost. The

center director, who is as open and forthright as he is competent, argues that there is little evidence that psychiatrists can effectively prevent mental illness and that psychiatrists should therefore restrict themselves to providing what they know best how to do -- namely, the maintenance of a medical inpatient facility. This reasoning neglects two considerations. First, a psychiatric orientation is not necessarily a community mental health orientation. Other mental health professionals and nonprofessionals may very effectively perform tasks that are inappropriate for psychiatric intervention. Second, and more important, there is no conclusive evidence that the medical orientation of P-6 is truly effective in helping patients. Beyond personal beliefs and clinical observations, there is no conclusive evidence, admits the center director, that P-6 is doing patients any good. (Of course, neither does any other center director in Maine have conclusive evidence that his center's programs are effective.)

There is, however, persuasive evidence that strongly indicates that many patients admitted to P-6 need not be hospitalized and that they can often be treated more effectively and far less expensively through another alternative. A pilot study conducted recently at Maine Medical Center, where a Psychiatric Home Treatment Program team treated patients in their homes in lieu of inpatient care, showed that a patient can be effectively treated at home for an average cost of $379.00 in contrast to a cost of $948.35 for an average ten-day inpatient stay with a four week outpatient followup. If resources were transferred from the P-6 program or perhaps other programs, a far greater number of patients could be kept in the community. This could also lead to a reduction of the number of beds on P-6 or at least result in the transfer of far fewer patients to AMHI.

At present Maine Medical CMHC provides services that psychiatrists want to provide rather than the kinds of services that clients may need. It was suggested by a number of clients and staff members that the "white coat" orientation of the center turns away many potential consumers, particularly those from the lower socio-economic classes. The emphasis on a medical approach has undoubtedly impeded the development of broader based community services. Furthermore, the authoritarian structure characteristic of the medical model has made it difficult for client complaints to be acted upon or even registered.

Positive Aspects:

1. In Portland's confusing tangle of ineffective bureaucracies and uncoordinated service agencies, Maine Medical stands out in providing a large amount of direct service. And despite numerous patient complaints (see below), P-6 provides much better care and attention than does AMHI.

2. A good therapeutic nursery. The most impressive component of the center's program is the therapeutic nursery which is directed towards Model Cities children. The program attempts to integrate children in day care centers and schools while refusing to act as a dumping ground for problem children, works with parents on an on-going basis, and includes an evaluation component.

3. The existence of Help in the catchment area. The only expatient's group in the state, Help is becoming increasingly active in promoting patients' rights and changes in the mental health system. The center and in particular its executive director have shown increasing responsiveness to Help.

Areas for Improvement:

1. The need for more community-based services.

2. Lack of a mechanism to register and act upon client complaints. Clients and exclients, while appreciative of the food and other aspects of P-6, also expressed considerable dissatisfaction with their lack of rights and the manner in which some staff treated them. Among the numerous complaints were:

   (a) Patients are inadequately informed of their rights. When I visited P-6, a list of patient rights was posted nowhere on the ward.

   (b) Counsel for one patient was denied access to his client and the patient was not told that her lawyer had come to see her.

   (c) Staff do not readily answer questions about treatment, diagnosis, and test results.

   (d) The use of security rooms as punishment.

   (e) Constant surveillance and lack of privacy. When I attended a Help meeting on P-6, the charge nurse insisted that a staff member be present contrary to the wishes of the Help group.

   (f) Compulsory attendance of OT and community meetings. These are considered an integral part of the therapy on P-6, but there is no evidence that shows that compulsory attendance of OT and community meetings is more effective therapeutically than voluntary attendance.

   (g) Incidences of inhumane treatment. According to several sources, one patient was about to be released and was told by his doctor that his unmarried twin sister with whom he was extremely close was pregnant. Later the doctor told the patient that this was untrue and that he just wanted to test the patient's strength before he was released.

   (h) The existence of a locked ward, though few patients need to be locked in.

   (i) Strict enforcement of a curfew.

   (j) Pressure and coercion to sign voluntary commitment papers.

   (k) Condescending attitude of some staff members and their lack of respect for the dignity of the patients.

(l) No call button in the seclusion rooms. One patient screamed all night for water but no staff member came to her assistance.

(m) Overmedication of patients for transfer to AMHI. The existence of these numerous complaints suggests that a patient advocate program might well be needed at this community mental health center.

3. Inadequate aftercare program.

In operation for only two months, the present aftercare program performs more a referral function than anything else. There are no present plans for establishing alternative living arrangements or sheltered workshops and the staff has not developed an on-going relationship with the Help group. Furthermore, this program apparently neglected to give sufficient consideration to the hiring of expatient patients as aftercare workers. According to the director of the aftercare program a number of qualified expatients were passed over in the selection of mental health workers because other non-patient candidates seemed more qualified. In the future priority should be given to expatients in filling staff positions.

4. Lack of an independent Board of Directors with full authority and responsibility to make program and financial decisions for the catchment area. The present Area Five Board is purely advisory and has been more preoccupied with asking what it is than making policy. The Board needs to incorporate and to spell out specific goals and objectives. The Board also needs to delineate its relationships with other human service agencies in the community and to specify the areas where joint cooperation is possible. The Board should also take responsibility for evaluating the effectiveness of present service components so that its future resource allocation and program decisions can be made on the basis of adequate data.

5. Questionable transfer of patients to AMHI I was not able to obtain solid information on patient transfer policies, but I suggest that a study be made to ascertain the criteria for transfer and to make sure that certain patients are not being transferred to AMHI for lack of insurance or money or that patients who have been previously sent to Augusta are not automatically sent back.

6. Possible overuse of medication in the outpatient clinic. A study should be conducted to determine if medication is dispensed too frequently and indiscriminately in the outpatient services. In 1973, almost half of the total clinic visits were for medication (5093 out of 11,006).

7. Resolution of conflicts between service needs and residency training needs. At present there is no formal mechanism to identify and resolve the conflicting needs of clients for services and those of residents for training.

8. Inadequate provision of services to the rural areas of Cumberland County.

9. Expansion of partial hospitalization and day care.

II. A PERSPECTIVE FOR THE FUTURE

A. The Options

The major policy question facing Maine is how it should allocate its scarce resources for mental health among different service delivery systems to achieve the greatest benefit for clients of those services. This is a difficult political, economic, clinical, administrative, and moral decision and its effective resolution requires the involvement of consumers, voters, community mental health workers, and educators as well as the Department of Mental Health and Corrections, the State Legislature, and the State Employees Association. There is a choice of at least three options:

1. Maintain the present allocation of state resources with the great bulk of funds going to two state hospitals and a small portion to the centers. With decreasing federal funds most of the centers would have to cut back their present level of services and a few might have to fold. And even if National Health Insurance is passed quickly, it is likely that the centers will have to follow a basic medical orientation to qualify for those funds.

2. Transfer of a portion of state hospital funds to local centers to pick up the deficit from federal monies. The operation of the state hospitals would be scaled down, but they would remain for the foreseeable future as a backstop for the centers for certain kinds of patients.

3. The establishment of real alternatives to hospitalization and transitional facilities in local areas which would assume total responsibility for all local patients. This would require the phasing out of the two state hospitals and the redistribution of mental hospital resources to local areas.

   It is strongly recommended that the DMHC support the third option. There are a variety of reasons for this but they can be simplified into two propositions. First, locally based alternatives to hospitalization and transitional facilities are more effective, more humane, more appropriate, and possibly less expensive than institutionalization. Second, these alternatives will not be established in Maine in the foreseeable future unless the State redistributes the great bulk of its funds to local areas to pay for them.

B. STATEWIDE PLAN

With this perspective it is strongly recommended that the DMHC establish a broad based task force (or if this is not possible at present to assign some top level staff) to prepare a detained statewide plan written in plain English for the genuine decentralization of mental health services. Such a statewide plan might very well adopt some of the following recommendations and principles.

C. Specific Proposals

DMHC and State Responsibility

1. Development of flexible formulas for the transfer of resources to local areas.

2. Development of guidelines and procedures to be used by local area planners and consumer groups in formulating area plans premised on total local responsibility.

3. Development of effective mechanisms of accountability including:

   (a) Standards for alternative community services.

   (b) Establishment of a patient advocate in each local area.

   (c) A change in the composition of site visit teams to include expatients, citizens, and other outsiders.

   (d) Small unrestricted grants to expatients groups and consumer organizations to monitor the quality of services.

   (e) Appropriate penalties for non-compliance.

4. Devemopment of legal mechanisms to require local areas to develop plans and assume total responsibility within a specified period of time.

5. Designation of review committees for area plans.

6. Provisions for the protection of the rights and job security of hospital employees. Strenuous efforts should be made to relocate and retrain employees.

7. Determination of the future of state hospital buildings and property. The buildings may be demolished and the grounds turned into a park, some buildings may be saved and used as retreats or camps, etc.

8. Revision of existing codes for foster care homes.

9. Establishment of specific areas of coordination and specific responsibilities of other state human service agencies and determination of how this coordination and responsibility will be carried out.

10. Development of a public education program to explain in plain English what is intended and why.

Center and Local Area Responsibility

1. Formulation of specific area plans. These plans should include:

   (a) Specific provisions for the placement of all currently institutionalized patients and those released since present center aftercare programs were begun.

   (b) Specific provisions for the establishment of half-way houses, group living arrangements, patient apartments, extended care homes, sheltered workshops, and job retraining. Where these facilities are to be located, who will run them, how they will operate, what they will cost, and why should be specified.

(c) What staff will be used, what they will do, and why.

(d) Specific provisions for day care programs, recreation, counseling, home visiting, and mobile teams.

(e) Specific provisions for the monitoring of foster care homes, nursing homes, and other patient residences.

(f) Training programs for foster parents, nursing home operators, half-way house staff, and other residential staff.

(g) Public education about the decentralization of mental health services and preparation of the community to accept expatients.

(h) Built-in evaluation component.

2. Provisions to include a wide range of consumers, citizens, professionals, nonprofessionals, local legislators, and others in the area planning effort.

D. Additional Observations.

1. While the above recommendations are far-reaching and perhaps not all are feasible at present, a number seem relatively easy to implement at this time. For example, the expansion of the patient advocate program to centers (Maine Medical would be a good place to start), training programs for foster care parents, change in the composition of site visit teams, small unrestricted grants to groups like Help, and education to prepare communities to accept expatients. Furthermore, unitization of Bangor Mental Health Institute should be implemented immediately.

2. All distinctions between "after-care" and "pre-care" and so forth should be dropped. Indeed, if deinstitutionalization is successful the term "half-way house" will become a misnomer since there will be no more state hospitals. All these services and programs should be viewed as a continuum of social supports for individuals who may need help from time to time during their lives. The limited adaptation of some individuals must be recognized by all staff.

3. For the foreseeable future there will be a small group of individuals who need long-term supervision. Such individuals often do not need to be placed in a medical inpatient facility and local areas should establish long-term non-medical facilities with a warm, homelike atmosphere for them. Good food and freedom may not cure these individuals, but they may make life better.

4. The DMHC should establish a policy to give priority to qualified expatients for department and center jobs. Perhaps the most frequent complaint I heard from clients is the lack of job opportunities.

5. A strenuous attempt should be made in the planning process and public education programs to keep professional and bureaucratic jargon to an absolute minimum. Consumers and citizens are immediately deterred and confused by esoteric (and often meaningless) language. Mental health issues are complex but they are not inscrutable. For example, I attended a meeting of a health planning group in Portland and half the time I had no idea what they were talking about.