STATE OF MAINE

DRUG ABUSE PREVENTION PLAN

1973-1974

STATE OF MAINE
DEPARTMENT OF HEALTH AND WELFARE
AUGUSTA

ADDRESS REPLY TO:

DEAN FISHER, M. D.
COMMISSIONER

Bureau of Rehabilitation
32 Winthrop Street

November 8, 1973

Mr. Karst Besterman
Acting Director
Division of Narcotic Addiction & Drug Abuse
National Institute of Mental Health
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852

Dear Mr. Besterman:

The attached document is the completed version of the Maine State Drug Abuse Plan as required under the Drug Abuse Office and Treatment Act of 1972.

The Plan reflects the changes recommended in your letter of October 5, 1973, which were based upon the results of the Review Committee.

We appreciated the technical assistance provided by the National Institute of Mental Health State Program Development team and the central office drug abuse staff. Much of this revised version is based upon their thoughtful and candid suggestions.

On behalf of the Office of Alcoholism and Drug Abuse Prevention I herewith submit the Maine State Drug Abuse Plan.

Sincerely,

Marilyn McInnis

(Mrs.) Marilyn McInnis
Acting Director
Office of Alcoholism and Drug
Abuse Prevention

MM:wc
Attachment

MAINE COMMISSION ON DRUG ABUSE
411 STATE OFFICE BUILDING
AUGUSTA, MAINE 04330

TELEPHONE (207) 289-3161

STATE OF MAINE

STEPHEN P. SIMONDS
CHAIRMAN

R. W. CARBONNEAU
EXECUTIVE DIRECTOR

August, 1973

William E. Bunney, Jr., M.D.
Director
Division of Narcotic Addiction &
Drug Abuse
National Institute of Mental Health
Parklawn Building, 5600 Fishers Lane
Rockville, Maryland 20852

Dear Dr. Bunney:

On behalf of the Maine Commission on Drug Abuse, I am transmitting the 1973-74 Maine State Drug Abuse Plan. This Plan was prepared to comply with Section 409 of the Drug Abuse Office and Treatment Act of 1972 (86 Stat 80, 21 USC 1176).

The Plan examines the incidence of drug abuse, existing resources and proposes specific policy, program and legislative action for the coming year.

The Plan reflects a cooperative effort by many individuals and agencies. Without their generous help and assistance, this Plan could never have been produced.

The Drug Abuse Office and Treatment Act of 1972 at this stage requires a heavy emphasis on planning and coordinating. For the future, we have much to accomplish towards better educating the general public about drug abusers developing greater concern about their needs and eliminating the scarcity of preventive services available for those at risk within our State.

The limited amount of time available (March 8, 1973 to June 30, 1973) to the State and its regional drug abuse prevention planning agencies to complete comprehensive planning required this State agency to request a 60-day delay which was approved. Still, the six-month planning period did not allow us to submit a fully-developed plan at this time. However, the extent and varied scope of activities represented by this planning effort fully demonstrates our sole state agency's capacity with

respect to program management and our coordinative capabilities have become better developed.

The plan, as a documentary process, gives full evidence that the Single State Agency is competent in the areas of responsibilities assigned by the Drug Abuse Office and Treatment Act of 1972 (86 Stat 80, 21 U.S.C. 1176.

We are convinced that, with the provision of an adequate Federal response, success in drug abuse prevention can be attained.

Sincerely,

Richard W. Carbonneau
EXECUTIVE DIRECTOR

RWC/pic

The following legal advertisement publicizing the State Drug Abuse Plan appeared in the Kennebec Journal, a newspaper with statewide distribution, on Tuesday, Wednesday and Thursday November 6, 7 and 8, 1973:

LEGAL ADVERTISEMENT

The 1973 State Plan for comprehensive drug abuse treatment and prevention services as provided for under Section 407 of the federal Drug Abuse Office and Treatment Act PL 92-255 has been prepared. Upon approval of the Plan, fiscal year 1973 funds in the amount of $119,787 will be allocated to the State for the implementation of the State Plan.

Recommendations and Action Priorities include:

1. Services pertaining to drug abuse education, training, prevention and early intervention.
2. Residential and out-patient diagnostic and counseling services.
3. Increased use of existing vocational rehabilitation and social service agencies.
4. Increased drug abuse treatment and rehabilitation services in Maine's correctional institutions.
5. Administration of an orderly, integralde planning and services network available to all without discrimination and in all areas of the State.
6. Achievement of objectives through an ongoing regional and statewide mechanism that promotes the integration of drug-related programs with all other appropriate community services.
7. Preparation of a Uniform Controlled Substance Act for Maine.
8. Adequate community participation, e.g., concerned citizens, employees, consumers of service and their families, in the development of drug abuse services.

A copy of the State Plan is available for examination at the Maine State Library in Augusta.

State of Maine
Executive Department
State Planning Office
189 State Street, Augusta, Maine 04330

KENNETH M. CURTIS
GOVERNOR

PHILIP M. SAVAGE
STATE PLANNING DIRECTOR

TEL. (207) 289-3261

FEB 27 1974

STATE APPLICATION IDENTIFIER
74060010

COMPLETION OF STATE CLEARINGHOUSE REVIEW

The Maine State Planning Office, designated by the Governor as the State Clearinghouse, has satisfactorily completed its review of the project described in the attached FORM 189. No further State Clearinghouse action will be necessary.

Please review the attached FORM 189 for correctness of the information submitted, notifying us of any changes which should be made to this form to reflect changes made in the proposal since submission of the initial "Notification of Intent." Unless the changes are material in nature, a corrected FORM 189 will be supplied without further Clearinghouse review.

If State Clearinghouse or Governor's Review of this project is required by the Grantor Agency, the attached FORM 189, this letter, and the attachments listed below (if any), must accompany your formal application to indicate that this Review Requirement has been satisfactorily met. This FORM 189, completed thru PART 3, completely replaces PART 1 of your application form, if application is made using any one of the following new standardized "APPLICATION FOR FEDERAL ASSISTANCE" forms:

Form 186	(Nonconstruction Programs)	OMB No. 80-R0186
Form 184	(For Construction Programs)	OMB No. 80-R0184
Form 185	(Short Form)	OMB No. 80-R0185

Upon submission of the Final Application to the Grantor Agency, please return the enclosed copy of this form with items 41 & 42 completed, to the State Clearinghouse. A self addressed envelope is enclosed for your convenience.

(___) If checked, the below listed agencies have submitted the attached final comments concerning this project:

(___) If checked, this project must also be reviewed by the follow Areawide Clearinghouse(s):

COVER SHEET for FEDERAL GRANT APPLICATION/AWARD NOTIFICATION

yr mo day: 19 73 12 04

ITEMS 1-31 TO BE COMPLETED BY APPLICANT OR CLEARINGHOUSE DEPENDING UPON STATE PROCEDURES

3. APPLICANT – Organizational Unit	4. ADDRESS – Street or P. O. Box	2 FEDERAL EMPLOYER ID No.
ME HLTH & WELF DEPT	ST HSE	016000001

5. CITY	6. COUNTY	7. STATE	8. ZIP CODE	9. PROG NO. (Catalog of Fed Domestic Assistance)
AUGUSTA	KENNEBEC	ME	04330	13269

10. TYPE OF ACTION: a ☐ New c ☒ Modification b ☐ Continuation

TYPE OF CHANGE (Complete if 10b or 10c was checked)
11. a ☐ Increased Dollars b ☐ Decreased Dollars
12. a ☐ Increased Duration b ☐ Decreased Duration
13. a ☒ Other Scope Change b ☐ Cancellation

14. EXISTING FED GRANT

15. REQUESTED FUND START: yr mo: 19 74 03
16. FUNDS DURATION: 015 (Months)
17. EST. PROJECT START: yr mo: 19 73 03
18. EST. PROJECT DURATION: 036 (Months)

19. APPLICANT TYPE — Enter Letter [A]
A. State; B. Interstate; C. Sub State Dist; D. County; E. City; F. School District; G. Community Action Agency; H. Sponsored Organization; I. Indian; J. Other (Specify in Remarks)

FUNDS REQUESTED (For Changes Show Only Amt. of Inc.(+) or Dec.(-))

20. FEDERAL	( ) $ 133,000
21. STATE	( ) $
22. LOCAL	( ) $
23. OTHER	( ) $
24. TOTAL (20, 21, 22, 23)	( ) $ 133,000

25. BRIEF TITLE OF APPLICANT'S PROJECT: DRUG ABUSE STATE PLAN

26. DESCRIPTION OF APPLICANT'S PROJECT (Purpose)

PLAN PREPARED IN COMPLIANCE WITH SECT 409 - DRUG ABUSE OFFICE & TREATMENT ACT OF 1972 (68 STAT. 80,21USE1176). CONTAINS ASSESSMENT OF DRUG ABUSE PROBLEM, EXISTING RESOURCES, GAPS IN SERVICES, RECOMMENDATIONS & ACTION AGENDA.

27. AREA OF PROJECT IMPACT (Indicate City, County, State, etc.): STATEWIDE

28. CONGRESSIONAL DISTRICT — Of Applicant: [01] Districts Impacted By Project: [01, 02]

29. Environmental Assessment Required By State/Federal Agency? ☐ Yes ☒ No

30. CLEARINGHOUSE(S) TO WHICH SUBMITTED: a ☒ State b ☐ Area Wide c ☐ None

31. a NAME OF CONTACT PERSON	b ADDRESS – Street or P. O. Box	c TELEPHONE NO.
Michael D. Fulton	Bureau of Rehabilitation	207-289-21

ITEMS 32-38 TO BE COMPLETED BY CLEARINGHOUSE

32. CLEARINGHOUSE ID: 001 — MULTIPLE CLEARINGHOUSE ☐

33. a ACTION BASED ON REVIEW OF: a ☐ Notification b ☒ Application
33. b ACTION TAKEN: a ☐ With Comment b ☒ Without Comment c ☐ Waived d ☐ Unfavorable

34. STATE APPLICATION IDENTIFIER (SAI): ME (State) 74060010 (Number)

35. CLEARINGHOUSE IMPACT CODE — STATE WIDE: ☒ Yes ☐ No; County/City Plng Area

36. STATE PLAN REQUIRED: ☒ Yes ☐ No

37. RECEIVING DATE AT CLEARINGHOUSE: yr mo day: 19 74 02 04

38. FINAL CLEARINGHOUSE ACTION DATE: yr mo d: 19 74 02 2

ITEMS 39-42 TO BE COMPLETED BY APPLICANT BEFORE SENDING FORM TO FEDERAL AGENCY

39. CERTIFICATION – The applicant certifies that to the best of his knowledge and belief the above data are true and correct and filing of this form has been duly authorized by the governing body of the applicant. Check box if no clearinghouse response was received in 30 days ☐

40. a NAME (Print or Type)	b TITLE	c SIGNATURE of Authorized Representative	d TELEPHONE NUMBER

41. DATE MAILED TO FEDERAL/STATE AGENCY: yr mo day: 19 ___ ___ ___

42. NAME OF FEDERAL / STATE AGENCY TO WHICH THIS APPLICATION SUBMITTED

ITEMS 43-54 TO BE COMPLETED BY FEDERAL OFFICE EVALUATING AND RECOMMENDING ACTION ON THE APPLICATION

43. GRANT APPLICATION ID (Assigned by Federal Agency)

52. Application Rec'd. yr mo day: 19 ___ ___ ___

53.a Exp. Action Date yr mo day: 19 ___ ___ ___

Always Complete 53.a OR b

53.b Rec. to Applicant yr mo day: 19 ___ ___ ___

44. GRANTOR AGENCY

45. ORGANIZATIONAL UNIT

46. ADMINISTERING OFFICE

REVISIONS

Amended Applic. Received (yr mo day)	Rev. Expected Action Date (yr mo day)	54. Exp. Action Revised As Of (yr mo day)	Subsequent Rec. Applicant (yr mo da)
19 ___ ___ ___	19 ___ ___ ___	19 ___ ___ ___	19 ___ ___ ___
19 ___ ___ ___	19 ___ ___ ___	19 ___ ___ ___	19 ___ ___ ___
19 ___ ___ ___	19 ___ ___ ___	19 ___ ___ ___	19 ___ ___ ___

47. ADDRESS – Street or P. O. Box	48. CITY	49. STATE	50. ZIP CODE	51. TELEPHONE NUMBER

ITEMS 55-65 TO BE COMPLETED BY THE FEDERAL OFFICE APPROVING THE GRANT APPLICATION

FINAL ACTION — FINAL DATES (yr mo day)
55. ☐ Awarded ☐ Rejected ☐ Withdrawn — 19 ___ ___ ___
56. FUNDS AVAILABLE — 19 ___ ___ ___
57. ENDING DATE — 19 ___ ___ ___
FEDERAL GRANT ID

FUNDS APPROVED (For Changes Show Only Amt. of Inc. (+) or Dec. (-).)

60. FEDERAL AMOUNT (F Y ___ funds)	( ) $ .00
61. STATE SHARE	( ) $ .00
62. LOCAL SHARE	( ) $ .00
63. OTHER	( ) $ .00
64. TOTAL (60, 61, 62, 63)	( ) $ .00

59. FEDERAL FUND ACCOUNT NUMBER

65. MULTIPLE PROGRAM - LINK

66. REMARKS: FEDERALLY REQUIRED STATE PLAN

DEFINITIONS & ABBREVIATIONS

Act means the Drug Abuse Office and Treatment Act of 1972 (86 Stat. 80, 21 USC 1176).

Secretary means the Secretary of the Department of Health, Education & Welfare and any other office of that department to whom the secretary has delegated authority.

State means the State of Maine.

Commission means Maine Commission on Drug Abuse (MCDA)

Single State Agency means Maine Commission on Drug Abuse. As of January 1, 1974 the single state agency will be the Office of Alcoholism and Drug Abuse in the Bureau of Rehabilitation of the Department of Health & Welfare.

State Advisory Council means the Maine Commission on Drug Abuse. On January 1, 1974 the Maine Council on Alcohol and Drug Abuse Prevention and Treatment will become the State Advisory Council.

Office means the Office of Alcoholism and Drug Abuse in the Department of Health & Welfare

NIMH means National Institute of Mental Health

SAODAP means President's Special Action Office for Drug Abuse Prevention

OUTLINE OF STATE PLAN

I. INTRODUCTION

- A. Drug Problems Summary
- B. Summary of Needs, Priorities and Plans
- C. The State Planning Process
- D. Description of the State
  1. Population Distribution
  2. Economic Base
  3. Unique Points of Vulnerability or Resistance to Drug Abuse
  4. Political Description
  5. Maps

II. PROBLEM DEFINITION

- A. Narrative Description
- B. Quantification of Drug Abuse Problems
  1. Comprehensive Problem Description
     - a. Law Enforcement
     - b. Education
     - c. Public Health Laboratory
     - d. Deaths
     - e. Human Service Agencies
     - f. Physicians
     - g. Mental Health
     - h. Hospitals
     - i. Health Care Comparison Data
     - j. Conclusions

III. RESOURCE IDENTIFICATION

- A. Existing Resources (Public and Private)
  1. Legal and Legislative
  2. Treatment/Rehabilitation
  3. Prevention/Crisis Intervention
  4. Education and Training
  5. Criminal Justice System
  6. Public and Private Employee Programs
  7. Program Management and Coordination

General Data

On November 14, 1972 Governor Kenneth M. Curtis designated the Maine Commission on Drug Abuse as the single State Agency to administer and/or supervise the administration of the State Plan under the Drug Abuse Office and Treatment Act of 1972. At that time the Maine Commission on Drug Abuse was located in the Executive Department.

As of October 3, 1973, legislative action transfered the Maine Commission to the Department of Health and Welfare. Further legislation (appendix) created a combined alcoholism and drug abuse unit, designated as the Office of Alcoholism and Drug Abuse Prevention, and placed it in the Bureau of Rehabilitation, Department of Health and Welfare. As of January 1, 1974, the Office of Alcoholism and Drug Abuse Prevention will be the single state agency to administer both the Drug Abuse Office and Treatment Act of 1972 and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. (Reference to this authority is in PL566, section 7106, subsection 6, in appendix) Section 7106, subsection 6, of PL566 further authorizes the Office of Alcoholism and Drug Abuse Prevention to apply on behalf of the State for grants authorized under Section 409, and to carry out all duties and responsibilities required by the Federal Act and the Regulations.

Until January 1, 1974, Mr. Richard Carbonneau, Executive Director, Maine Commission on Drug Abuse is the responsible official heading the drug abuse area of responsibility. By January 1, however, a director of the Office of Alcoholism and Drug Abuse Prevention, and a Drug Program Specialist will be appointed. Identification of those officials will, therefore, await their permanent appointment, although Mrs. Marilyn McInnis is currently Acting Director of the Office.

Sections 7107, 7108, and 7109 of PL566 (appendix) outline the establishment, structure, and operation of a combined alcoholism and drug abuse advisory council to the Office of Alcoholism and Drug Abuse Prevention. At minimum these sections mandate a state advisory council representative of public and private organizations, individuals, groups, and of agencies concerned with drug abuse prevention functions to be appointed by the Governor and approved by his Executive Council. They further mandate that as a dual council both the interests of alcoholism and drug abuse are held equally. The provision for split agendas and balanced membership exist, although the specific procedures of council operation will be vested with the council with respect to insuring the interests of both alcoholism and drug abuse. Provisions such as maintaining records of recommendations, within reasons for non-acceptance of recommendations, and public availability of such records for inspection will definitely be established within the by-laws of the advisory council. Specifics in terms of meeting at least five times a year, compensation, and staff assistance are also provided for in State legislation.

I. Introduction

A. Drug Abuse Problems Summary

The traditionalism that is so often associated with New England is especially apparent in Maine. The subject of drug use and abuse is a topic not well received by Mainers and it may well be that the conservative estimates of drug abuse reflect the State's generally conservative stance.

The Plan has objectively identified the problem only to the extent that agencies responding to the State Plan survey reported contact with drug abusers. A more accurate, objective assessment was inhibited by the lack of standardized reporting to central data retrieval sources. However, even these conservative estimates indicate a substantial poly drug abusing population. Although the using population is concentrated in urban areas; considerable poly drug use, frequently in combination with alcohol, was reported for the rural areas.

The data also indicates that traditional agencies are not reaching drug abusers who are potential clients. Lack of awareness of the needs of drug abusers, a reluctance to work with drug abusers and a lack of resources all hamper motivation to broaden the scope of services. Traditional human service agencies are vital to Maine's drug abuse prevention efforts because the State's specialized drug abuse prevention and treatment resources are wholly inadequate to meet emerging needs. The treatment system in Maine consists of three programs all located in the urban areas of southern Maine. There are not drug treatment services north of Augusta. Programs of prevention and education are also concentrated in southern Maine, ~~although~~ with the exception of the MDEP which conducts teacher training workshops throughout the State.

Attached are a list of Maine's drug problems in priority order and a summary of existing resources.

B. Summary of Needs, Priorities and Plans

The Office of Alcoholism and Drug Abuse Prevention, the single State agency, is committed to the development of community based services that will provide continuity of care through integration of services and the use of multifunding mechanisms.

Priorities for the first action year will be the development of statewide systems of management, information, coordination and on-going planning. Direct Services to drug abusing clients are critically dependent on the ability of the single State agency to effectively respond to demonstrated needs.

The following tables outline Maine's priority management and service needs and, also, propose an action agenda for implementation.

SUMMARY
EXISTING RESOURCES

Agency	Sponsor	Service	Modality	Budget (FY 73) Federal	Budget (FY 73) State/Local	Client Capacity	*Staff
Maine Commission on Drug Abuse	Public	Single State Agency	Administration	$119,781	$76,000		3
Maine Drug Education Program	Public	Teacher Training	Education	23,200	30,000		3
Augusta Rap & Rescue	Private, non-profit	24-hour crisis intervention	Treatment	71,775	2,400	77 Outpat.	7
Brunswick Drug Abuse Center	Private, non-profit	Out-patient counseling	Treatment	68,946	2,500	88 Outpat.	4½
Rap Place, Lewiston	Private, non-profit	Alternatives activities	Prevention Education	32,000	2,800		6
York County Counseling Service (AIDE Center)	Private, non-profit (CMHC)	Training & Education	Counseling		30,000		2
Drug Rehabilitation, Inc.	Private, non-profit	Residential & Out-patient	Treatment	107,810	2,500	15 Resid. 25 Outpat.	7
Southern Regional Drug Council	Southern Maine Comprehensive Health Asso.	Regional Coordination	Coordination	4,800			1
Kinsman Hall	Private	Residential	Treatment	N.A.	N.A.	N.A.	N.A.
Elan I	Private	Residential	Treatment	N.A.	N.A.	N.A.	N.A.

*Aggregate figure reflecting total full time staff

The following Community Mental Health Centers provide limited drug abuse services within their catchment areas:

Aroostook Mental Health Clinic
The Counseling Center
Kennebec Valley Mental Health Center
Tri-County Mental Health Services
Maine Medical Center Community Mental Health Center
Mid-Coast Mental Health Clinic
Bath-Brunswick Mental Health Association
York County Counseling Services

B Analysis of Problems, Present Responses and Identified Gaps in Services

PROBLEM	RESOURCES	GAPS	NEEDS
Incidence of drug abuse is not reported in any consistent, usable fashion; incidence is often under reported or not reported	Limited hospital, health care, mental health and criminal justice data systems	No statewide management information and evaluation system	Management information system Prevalence and incidence survey Educate reporting agencies to use management information system
No statewide development and coordination of drug abuse programs	OADAP SPD State Planning Office	System for development and coordination of drug programs No mechanism for long-range planning	Sufficient staff, resources, local committment & input, effective managment information and evaluation system
Large at risk population in both rural and urban areas	Drug Rehabilitation, Inc. Brunswick Drug Center Augusta Rap & Rescue CMHC	No services north of Augusta No awareness by CMHC of at risk population among their clients	Prevention & Treatment in areas without services, subject to need educate CMHC staff to be more aware
Urban: use of amphetamines, barbiturates, marijuana and some narcotics	DRI Brunswick Augusta Rap & Rescue Limited detoxification services CMHC	No services in urban areas north of Augusta	Prevention and outpatient treatment services in Bangor, Presque Isle, Caribou, Rockland Develop detoxification services where appropriate Educate staff of ancillary services to relate needs of drug abusers, e.g., health, mental health, social, crimina justic agencies
Rural: use of inhalants, pills, and marijuana frequently in combination with alcohol	CMHC	Trained staff and resources to address needs of rural drug abusing population	Staff trained in youthful drug abuse Additional outreach counselors in each mental health region (6)
Increasing poly drug abuse among Indian	none	Accurate information regarding prevalence and incidence of drug abuse Capability to respond to needs of this population	Special Study to assess extent of problems Indigenous drug abuse prevention education and treatment services

PROBLEM	RESOURCES	GAPS	NEED
Traditional services are not reaching potential clients who are drug abusers	OADAP SPD	Awareness of needs of drug abusing population and ready willingness to serve this population	Effective use of OADAP enabling legislation Additional staff and resources, using multi-funding mechanisms Agency education & training
Lack of drug education and discipline policies in local schools	MDEP "Guide for Adminstrators: Developing School Drug Policy."	Technical assistance in development of school drug policy	Educate school adminstrators to use MDEP Guide and to assist them in development of policy suited to local needs
Increasing numbers of drug offenders in State correctional facilities	Self-help group at Maine State Prison limited alternatives to incarceration	No services in four out of five correctional institutions No professional services at Maine State Prison	Correctional personnel trained in working with drug abusers Mechanisms for pre-trial diversion Drug Counselor at Maine State Prison
Negative public attitudes toward drug abusers	Media National Drug Abuse Information Clearinghouse	Mechanism for using existing resources	OADAP and State Advisory Council given resources to increase capability to use existing resources to better inform public

V. Action Agenda

Objective	Need	Action Resource	Annual Cost	Local/State	Federal	Source	Deadline for Implementation
Establish management, coordination and support services -assure continued funding and operation of existing services -regional coordination in southern Maine -effective utilization of SPO, State Planning Office -secure necessary resources to carry out OADAP responsibilities	Effective system for development and coordination of drug programs	OADAP Southern Me.Comprehensive Health Association via Southern Regional Drug Abuse Council	$43,000.	$10,000.	$33,000.	409	1/1/74 (4/1/74 r coordina
-management information system	Statewide management information system Prevalence & incidence survey	OADAP via contract	$50,000.		$50,000	409	1/1/75 m informat system 7/1/74 s
Provide additional resources in areas with fewest services and/or highest incidence of drug abuse	Prevention and out-patient services in Bangor, Rockland, Presque Isle, Caribou	Counseling Center Mid-Coast M.H. Clinic Community Action Aroostook M.H. Clinic	$75,000.	$25,000.	$50,000.	409 410 H-80	9/1/74
	Prevention and outreach counseling for users in rural areas	Extension Service	$45,000.	$15,000.	$30,000.	409 410 H-80	9/1/74
	Educational vocational and recreational alternatives to drugs for at risk population in orban and rural Maine	MDEP Rap Place, Lewiston AIDE Center, Sanford Community Action groups	$45,000	$10,000.	$35,000.	409 U.S.O.	7/1/74 E.

V. Action Agenda (continued)

Objective	Need	Action Resource	Annual Cost	Local/State	Federal	Source	Deadline for Implemen
	Study incidence & prevalence of drug abuse in Indian communities and respond according to need	Maine Dept. of Indian Affairs	$40,000	$10,000	$30,000	409 410 Bur. of Indian Affairs	9/1/74
	Drug abuse prevention and treatment services at Maine State Prison	Bureau of Corrections	$15,000	$ 3,000	$12,000	LEAA	7/1/74
Augment prevention treatment and education resources of existing service delivery system	Drug abuse training for school, cmhc, hospital, health care, criminal justice personnel and staff of ancillary services	OADAP via MDEP University of Maine Bureau of Health Southern Regional Drug Abuse Council Criminal Justice Academy	$50,000	$10,000	$40,000	410 USOE H-80 LEAA	1/1/75
	Technical assistance for school administrators in development of school drug education and discipline policy	OADAP via MDEP Southern Regional Drug Abuse Council State Superintendents Assoc.	$10,000	$ 5,000	$ 5,000	410 H-80	1/1/75
	Effective programs of public information	OADAP State Advisory Council	$22,000	$10,000	$12,000	H-80 USOE	1/1/75

C. State Planning Process

The Maine Commission on Drug Abuse was established by the Legislature in September 1971 to coordinate the planning and implementation of a drug abuse prevention program for Maine. The MCDA was not given the mandate or the resources to provide direct services; and therefore looked to the development of community-base programs for drug abusers. Support of local programs was consistent with a general trend in Maine toward the decentralization of social, health, mental health and correctional services. The Commission sought a delivery system that would include a lead agency in each region responsible for coordinating drug abuse services. Because community mental health centers (CMHC) were generally the dominant treatment agency in a region and because there was a CMHC in each of the regions, they were viewed as appropriate lead agencies.

The U.S. Congress also recognized the responsibility of the CMHC system when they passed the Drug Abuse Office and Treatment Act of 1972. The Act includes a provision amending the CMHC Act (42 USC 2688a) to require CMHC to conduct treatment and rehabilitation programs for drug abusers, or, to document why such services were not needed in their catchment area. Because of difficulties in documenting the extent of the drug problem, all of Maine's six federally funded CMHC requested a waiver of this requirement. Many felt that drug treatment services were needed in their catchment area, but they were not certain that the CMHC was the most appropriate agency to provide these services. In view of the currently long waiting lists for services, the CMHC were not anxious to take on yet another community problem.

State Program Development (SPD) is a partnership between the Maine Department of Mental Health & Corrections and the National Institute of Mental Health which is intended to "facilitate the development of a delivery system of mental health services, training and evaluation as part of a coordinated human services network making maximum use of existing agency resources," and, to "result in a greater relevance and responsiveness of NIMH and the Regional Office in meeting the State mental health needs." (Memo of Understanding - appendix) ← Footnote bottom / page

Through membership on the State SPD Steering Committee, the MCDA was able to play an active role in the development of mutually agreeable goals and objectives for implementing drug abuse services. Drug abuse was included as one of the ten SPD service objectives:

> "Development of a collaborative on-going relationship between the Department of Mental Health & Corrections and the Drug Abuse Commission in the formulation of a State Plan for the prevention and treatment of drug abuse and for the initiation of needed services in selected areas on a demonstration basis." (Memo of Understanding - appendix)

As part of the SPD process, CMHC were asked to sponsor regional workshops focusing on SPD goals and objectives. Drug Abuse prevention and treatment emerged as areas of particular concern for the participants. Again, the CMHC questioned their own potential for effectiveness in dealing with drug abusers. This marked reluctance on the part of CMHC to recognize and deal with drug abuse is indicative of the attitude of most of the State's health, mental health and social service agencies. The MCDA recognized that this attitude would have to be changed in order to develop

effective services. The MCDA deliberately selected CMHCs to coordinate the development of the State Drug Abuse Plan with the thought that if CMHCs had a highly respnsible role in developing the Plan, they might also have a greater investment in its implementation.

Contracts were signed with CMHC in each of the State's four northern planning districts. Since the four CMHCs in southern Maine coordinate their planning through the Southern Maine Comprehensive Health Association, SMACHA was selected to develop the drug abuse plan for the southern Maine region. The Maine Drug Education Program, State Department of Educational & Cultural Services, was chosen to develop the Education/Training component of the Plan. One person from each region was designated as the Planning Coordinator and was responsible for:

- Assessment of drug abuse problem in the area.
- Inventory of existing services and gaps in services.
- Detailed description of programs proposed to fill gaps, expand existing services and achieve goals.
- Action plan for implementation which accomodates priorities and funding resources.
- System for administering services and assuring coordination with allied human service agencies.

At the State level, Commission members provided the necessary coordination with other State agencies. A subcommittee of the Commission, representing Bureau of Mental Health, Law Enforcement Planning & Assistance Agency, Rehabilitation, State Planning Office, and Bureau of Health, was named to oversee the development of the Plan and to assure consistency and coordination with other State plans.

In order to maximize community participation in the planning process, six of the eight planning regions established regional drug councils or planning groups to monitor the development of the Plan. Representation on the Regional Councils included consumers, providers and regional Alcoholism and LEAA coordinators.

In July 1973 after the regional reports were submitted, planning coordinators met in Augusta for a two-day workshop. Participants presented the findings of the regional reports. Together, the findings of the Commission subcommittee and the regional planners served as the basis for the formulation of Statewide goals and objectives.

The full membership of the MCDA met on August 7th to review the Plan. Commission members had received a draft copy of the Plan one week prior to the meeting. After recommending certain changes in the draft, the Plan was approved by the Commission members.

The Plan was then submitted to the State Planning Office for review through the A-95 process. A-95 affords all agencies of State and local government an opportunity to review and comment upon the Plan. Notice of A-95 approval was received on September 6, 1973. A copy of the approval is included. ~~in the Appendix.~~

PLANNING AGENCIES

Agency	Region	Planning Coordinator
Aroostook Mental Health Clinic	I	Walter Cogswell
Counseling Center	II	Tony Birckhead
Kennebec Valley Mental Health Center	III	John Doherty
Tri-County Mental Health Services	IV	Christos Gianopoulos
Southern Maine Comprehensive Health Association	V, VI, VII, VIII	Ronald Welch Penny Davis
Maine Drug Education Program	Education/Training	Susan Scanlan

C. Description of the State

"The fine house, the beautiful harbors and islands, yes. But Maine is a museum of another kind, a collection of the deserted and abandoned, a preservation of the feel of long, catatonic winters. Its exhibitions tell of no money and nothing to do and no place to go. It preserves the face of lack, of minimum, the bottom -- the pure, lost negative... With the poor, and all of us, the truth is found in the rusting, immovable car."

Elizabeth Hardwick
"In Maine"
A Maine Manifest
by Richard Barringer and Others
Published by the Allagash Group, Bath, Maine

Maine is the hinterland of the northeast and, as such, has always been somewhat cut off from events elsewhere in the nation. However, in the past twenty years the influence of the media, superhighway and tourism have drawn Maine closer to its neighbors.

With the decline of traditional industries, manufacturing and the independent rural way of life have given way to the prospect of suburbia and employment in the new industries: tourism, real estate, banking and social services. As Maine entered the 70's, its chronically-decreasing rate of population growth reversed. In 1971, for the first time, Maine population grew faster than the national average to pass the one million mark. In the past, young people left the state in large numbers -- for factory jobs in Massachusetts or white-collar jobs in the nation's large cities. During the decade 1960-1970, 100,000 of Maine's citizens, many of them young, left the state seeking opportunities not available at home.

1. Population Distribution

The Maine population is about equally divided between urban and rural. This pattern has remained constant since World War II. A rapid shift toward urban concentration is expected during the next decade.

The term "urban" means largely medium-sized communities separated by undeveloped areas. The urban-suburban-exurban sprawl has yet to affect Maine. Approximately 70% of the population lives in communities of 10,000 or less. The two largest population centers are Greater Portland (141,626) and Lewiston-Auburn (73,000).

URBAN-RURAL POPULATION
1970

	Size of Place	% of Total Population
Urban	50,000-100,000	6.6
	25,000- 50,000	7.6
	10,000- 25,000	31.8
	5,000- 10,000	11.1
	2,500- 5,000	8.0
	TOTAL URBAN	50.8%

URBAN-RURAL POPULATION (cont.)
1970

	Size of Place	% of Total Population
Rural	1,000- 2,500	8.6
	0- 1,000	40.6
	TOTAL RURAL	49.2%

It is important to note the highly uneven population distribution within the state. Approximately two thirds of the state's population lives in a 20-mile "corridor" along the Maine Turnpike, the state's only interstate route. Similarly, three fourths of all new jobs and plant expansions occur within this corridor.

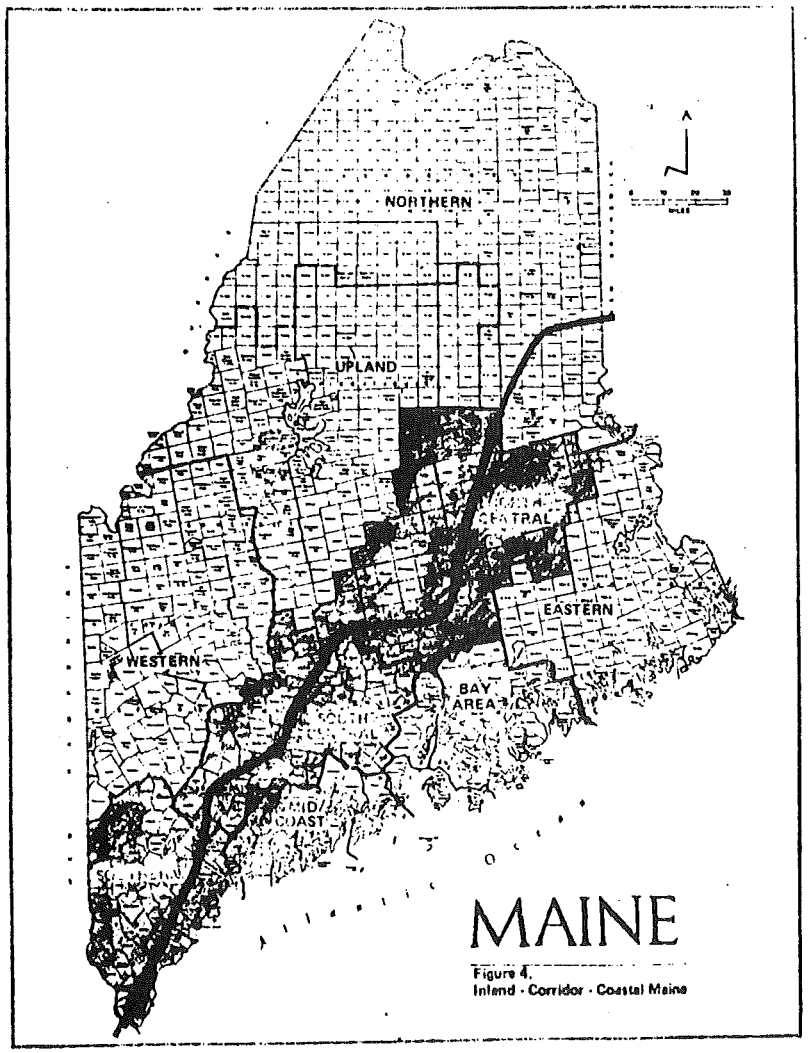


Figure 4.
Inland - Corridor - Coastal Maine

From 1960 to 1970 there were significant changes in the age trends of the population which may impact on future incidence of drug abuse within the state. In the ten-year period, the number of children in the 0-4 age range decreased 22%; there was less than a 1% increase in the 5-9 group and the 15-24 year age group increased 25%, confirming a reversal in the pattern of outmigration. Employment opportunities, housing, transportation and social services will have to expand to meet the demands of this age group.

AGE, RACE AND SEX DISTRIBUTION

		Male		Female	
Age	Total	White	Non-White	White	Non-white
Under 15	285,981	144,814	1,141	138,866	1,160
15-24	168,391	82,877	952	84,037	525
25-34	109,710	53,745	568	54,867	530
35-64	313,374	150,382	764	161,497	731
65+	114,592	47,423	199	66,768	202
Totals	992,048	479,241	3,624	506,035	3,148
		(482,865)		(509,183)	
Median Age	28.6	27.1	22.7	30.2	23.0
		(27.0)		(30.1)	

2. Economic Base

Manufacturing, government, trade and services employ 68% of Maine's workers. Between 1960 and 1970 the fastest growing sectors were services (+45%) and government (+43%).

MAINE EMPLOYMENT 1971
Annual Average

	Workers (1,000's)	Percent
Major Sources		
Manufacturing	102.8	24.8
Trade	67.5	16.3
Services	44.0	10.6
Government	69.0	16.7
Total	283.3	68.5
Minor Sources		
Construction	16.9	4.1
Finance	12.6	3.0
Transportation	17.5	4.2
All Other	38.1	9.2
Total	85.1	20.6
Agriculture	13.1	3.2
Unemployed	31.8	7.7
In Dispute	0.5	0.1
Total Maine Work Force	413.8	100.0

Maine employment trends can be seen in changes in sources of personal income during the period 1940-1970. Maine's traditional textile and leather industries have declined as the mills moved south or closed in the face of foreign competition. Re-training and re-employment programs have had little effect on the unemployment rate among workers laid off by these industries.

Total Personal Income: * Percentage by Source†	MAINE				NEW ENGLAND		UNITED STATES		PERCENTAGE CHANGE, 1950 - 1970		
	1940	1950	1960	1970	1950	1970	1950	1970	U.S.	N.E.	Me.
farm	7.7	8.0	5.4	3.0	2.2	0.6	7.1	2.4	-.66	-.73	-.63
mining	0.1	0.2	0.1	0.06	0.1	0.06	1.4	0.7	-.50	-.40	-.70
contract construction	1.6	2.4	3.5	4.1	3.1	4.2	3.5	4.0	+.14	+.35	+.71
manufacturing	22.7	26.7	22.8	21.1	29.8	23.0	21.9	19.8	-.10	-.23	-.21
trade (wholesale & retail)	10.4	10.9	10.9	10.3	11.7	10.9	12.1	11.1	-.08	-.07	-.06
finance, insurance & real estate	2.0	1.7	2.1	2.5	3.0	3.8	2.6	3.4	+.31	+.27	+.47
transport, communications & utilities	5.4	5.2	4.9	4.0	4.6	3.9	6.2	5.0	-.19	-.15	-.23
services	5.6	4.7	5.3	6.9	6.1	9.9	6.1	8.7	+.43	+.62	+.47
government	9.9	7.9	13.4	13.5	8.1	11.0	9.2	13.8	+.50	+.36	+.71
other industries	0.22	0.36	0.49	0.21	0.24	0.17	0.14	0.13	-.07	-.29	-.42
proprietor's income (non farm)2	10.4	10.2	9.2	7.4	8.4	6.2	10.1	6.4	-.37	-.26	-.27
property income3	19.6	14.2	13.1	13.8	15.4	15.5	12.6	14.1	+.12	+.01	-.03
transfer payments4	4.5	7.5	9.1		6.9	10.1	6.6	9.9	+.50	+.45	+.71

Note: 1. Total personal income is that received from all sources before direct personal taxes. Columns do not add to 100% as they include worker's contributions to social insurance programs, and exclude supplementary labor income such as contributions to pensions and group insurance programs.
2. Proprietor's income measures the earnings of unincorporated business enterprises, professional practitioners, partnerships, producer cooperatives, and others in self-employment.
3. Property income consists of dividends, rental income, and personal interest income.
4. Transfer payments are income not resulting from current production, as retirement and social security benefits and military pensions.
Source: U.S. Department of Commerce

*Barringer and Others, A Maine Manifest, Published by the Allagash Group.

Maine is a trading economy, sensitive to the vagaries of the national economy. The state's manufacturing and tourist industries are especially dependent on outsiders to buy products/services. Maine's license plates advertise "Vacationland" and as tourism becomes more important to Maine, Maine's prosperity becomes more closely tied to the nation's economic health.

Maine's deepwater ports, ideal for oil tankers and the refineries the tankers supply, may hold the key to a degree of economic revitalization. Conservationists oppose oil refineries because of the potential for spills which would threaten another important natural resource, the Maine coast. Others, painfully aware of the state's 9% unemployment rate, are willing to take the risk.

Mainers used to think that in politics, "as Maine goes, so goes the nation," but the reverse applies to Maine's economy.

3. Unique Points of Vulnerability/Resistance to Drug Abuse

While Maine may be a "backwater" of the national economy, it is important to note that Maine's young people are no longer divorced from the national scene. Somewhat like every other young person born after World War II, their lifetime corresponds directly with an unprecedented period of economic growth and change. Even though most have not been able to directly witness some of the more telling events of the past decade, their lives are deeply affected, nevertheless. More significantly, youth in Maine are much like their contemporaries elsewhere in the nation in that their expectations exceed the traditional aspirations of their parents. Not even the more remote areas of the State are immune from the influences of television, the superhighway and tourism.

Maine's unique points of vulnerability to drug abuse can be summarized as follows:

1. Tourism

Tourism is one of Maine's most important industries--millions of people visit Maine each year to enjoy the State's lakes, ocean coastline and fine ski areas. In many coastal towns, the population doubles or triples in the summer months. Considerable numbers of tourists pass through Maine on their way to the Canadian vacation areas of New Brunswick and Nova Scotia. The tourists' impact on the extent of the drug abuse problem in Maine is attested to by the fact that during the past two years more that 250 individuals have been arrested on drug charges in Baxter State Park, only one of the many parks and camping areas in Maine.

2. Long Border with Canada

Although no hard data was available, the Maine State Police and Bureau of Customs officials contend that Maine's long border with Canada makes the State a logical pass-through for the considerable drug traffic moving from points in Canada to the northeastern U.S., including Maine.

3. Geographic and Social Isolation

In the past, small communities in Maine had little tolerance for deviant lifestyles or social conflict. A young person who wished to live by a different value system was subtly pressured to do it elsewhere. Today, however, the traditional institutions that upheld community norms are breaking down; drugs are available even in Maine's smallest and most isolated communities.

Maine has never been able to adequately provide much in the way of employment opportunities for its young. In the past, Maine educated its young people only to see large numbers of them leave the State for employment elsewhere. Today young people in Maine are not as anxious to leave the State to seek "fame and fortune"; they are staying, with the hope of doing better than their parents. These rising expectations not only manifest themselves in the form of demand for material gain; they also take form in increased pressure for social and political change.

Services for the individuals and communities are few and far between. Existing services usually cover vast areas and are overextended, providing care to those most in need. This leaves little or no manpower or funds to deal with the needs of the young - recreation, alternative schooling, job employment development, mental health and other services.

4. Political Description

There are two significant levels of government in Maine: State and municipal. In the absence of a strong county government structure, the State assumes the coordinating functions normally performed by county governments in other states.

Social services in Maine are delivered by the State, larger municipalities and private agencies. The State Department of Health & Welfare operates through a system of regional offices.

Maine does not rank high among the states in expenditures for social services. The table below compares Maine's per capita expenditures on selected items with the 50 state average.

Per Capita Amounts of Selected Financial Items 1971

	Total Expenditures	Education	Highways
50 State Average	433.64	170.75	72.06
Median State	440.77	170.10	80.90
Maine	442.03	159.13	91.01

	Public Welfare	Hospitals	Health
50 State Average	79.21	22.60	7.33
Median State	62.64	19.43	5.66
Maine	80.95	19.54	5.66

	Corrections	Natural Resources	Employment Security Administration
50 State Average	6.12	12.40	4.58
Median State	5.24	13.49	4.42
Maine	6.31	19.71	6.32

In January, 1972 Governor Curtis issued an Executive Order establishing a system of Official Planning and Development Districts for the entire state. Economic considerations, environmental factors, land and water use controls along with management implication were the basic consideration in the designation of these districts.

These sub-state districts are designed to serve as the framework for coordination and integration of local, state and federal activities, focusing on these major objectives:

1. Coordination of local government planning and programs.

2. Uniform Districts for the planning, programming and delivery of state services.

3. Uniform alignment with federal programs and administrative districts. (OMB Circular A-95 Review).

REGIONAL PLANNING COMMISSIONS IN MAINE - SEPTEMBER, 1972

ANDROSCOGGIN VALLEY REGIONAL PLANNING COMMISSION
James O. Nesbitt, Executive Director
181 Russell Street
Lewiston, Maine 04240 — Tel. 784-0151
Clyde Pulsifer, Jr.
Chairman

BATH-BRUNSWICK REGIONAL PLANNING COMMISSION
Dana A. Little, Executive Director
98 Maine Street
Brunswick, Maine 04011 — Tel. 725-4233
George E. Stimpson
Chairman

GREATER PORTLAND COUNCIL OF GOVERNMENTS
William Rogers, Jr., Executive Director
169A Ocean Street
South Portland, Maine 04106 — Tel. 799-8523
Richard Boyman
Chairman

HANCOCK COUNTY REGIONAL PLANNING COMMISSION
Robert Cossette, Acting Director
County Court House - Room 202
P.O. Box 608
Ellsworth, Maine 04605 — Tel. 667-5729
Raymond Gross
Chairman

KNOX COUNTY REGIONAL PLANNING COMMISSION
Mrs. Pauline Fay, Executive Director
P.O. Box 664
Rockland, Maine 04841 — Tel. 594-5693
Earl D. Paxman
Chairman

NORTH KENNEBEC REGIONAL PLANNING COMMISSION
Elery Keene, Planning Director
16½ Benton Avenue
Winslow, Maine 04902 — Tel. 873-0711
Clifford A. Manchester
Chairman

NORTHERN MAINE REGIONAL PLANNING COMMISSION
James A. Barresi, Executive Director
P.O. Box 911
Presque Isle, Maine 04769 — Tel. 768-5511
Robert G. Soucy
Chairman

PENOBSCOT VALLEY REGIONAL PLANNING COMMISSION
Talbot Averill, Planning Director
Bangor City Hall
Bangor, Maine 04401 — Tel. 945-5769
Richard Stratton
Chairman

SOUTHERN KENNEBEC VALLEY REGIONAL PLANNING COMMISSION
John B. Forster, Planner-Administrator
154 State Street
Augusta, Maine 04330 — Tel 622-7146
Roland Whittier, Jr.
Chairman

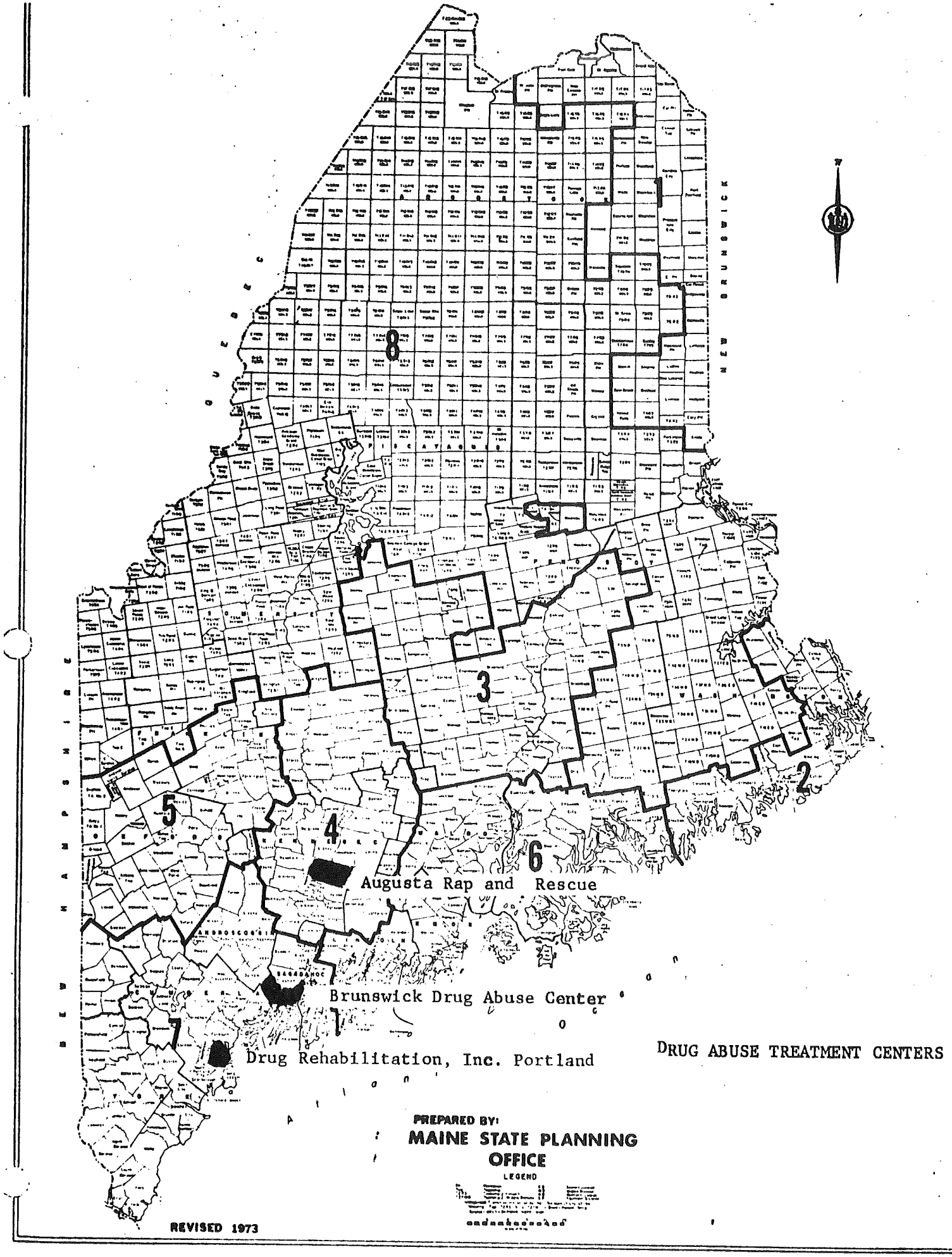
SOUTHERN MAINE REGIONAL PLANNING COMMISSION
Arthur T. Lougee, Executive Director
County Court House
Alfred, Maine 04002 — Tel. 324-5780
Fred R. Lane
Chairman

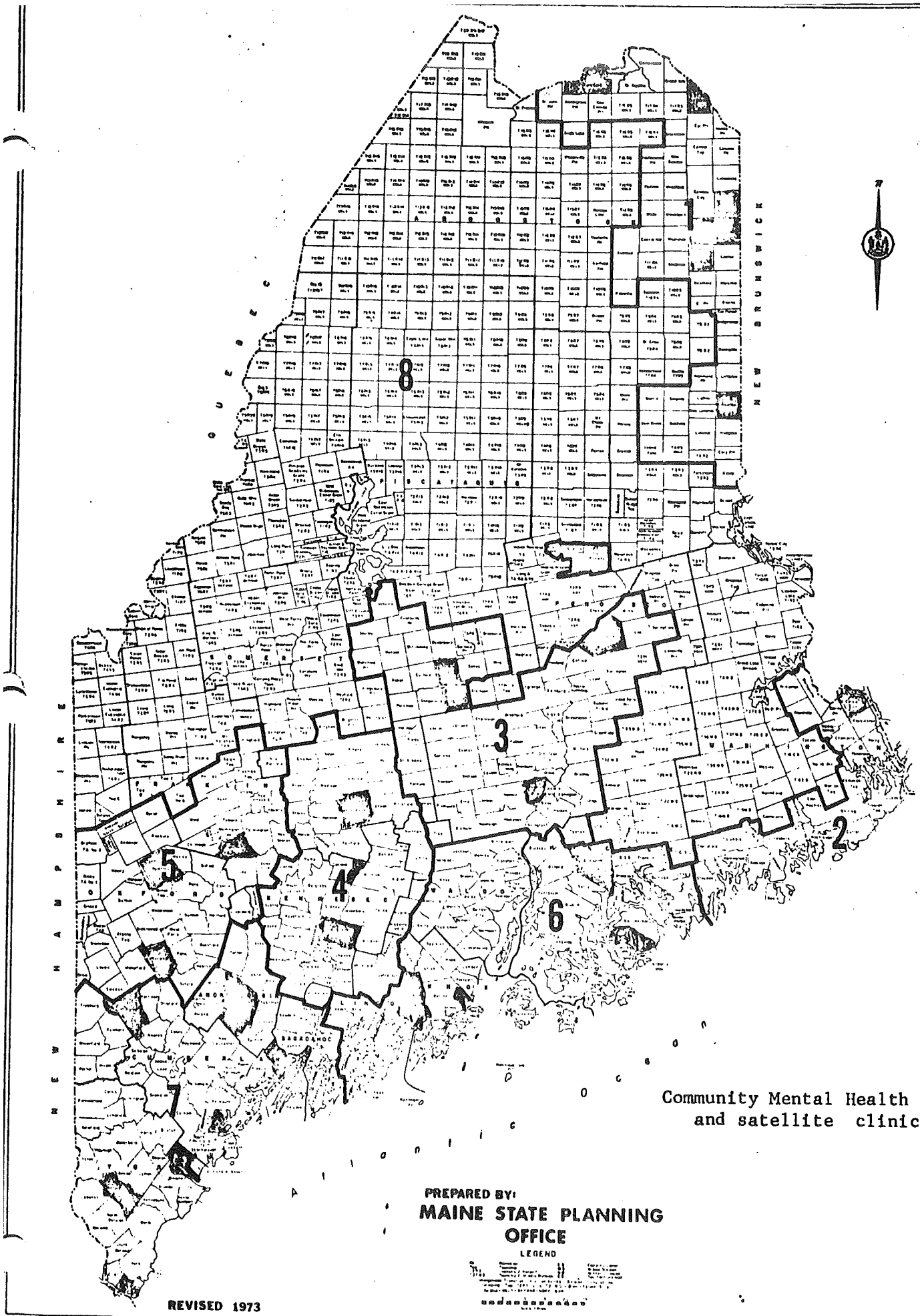
WASHINGTON COUNTY REGIONAL PLANNING COMMISSION
Donald J. Bushey, Director
P.O. Box 273
Machias, Maine 04654 — Tel. 255-3971
Arlo Bates
Chairman

The eleven Regional Planning Commissions only have review and comment authority. They do not have the power to tax, nor can they distribute funds, as a viable county government does.

There is a strong tradition of local government. Maine's 496 municipal governments (includes villages, towns and cities) raise revenues from property taxes and allocate the major portion for maintenance of school and roads. Occassionally modest amounts are set aside from "social services." It was expected that revenue sharing funds would be used to support the development of community-based social services. Instead, most towns chose either to use revenue sharing for capital expenditures or to stabilize their existing tax rate.

Maine's Congressional delegation includes two Representatives (one Democrat and one Republican) and two Democratic U.S. Senators.


QUEBEC
NEW BRUNSWICK
NEW HAMPSHIRE
8
3
2
5
4
6
7
1
Augusta Rap and Rescue
Brunswick Drug Abuse Center
Drug Rehabilitation, Inc. Portland
DRUG ABUSE TREATMENT CENTERS
PREPARED BY:
MAINE STATE PLANNING OFFICE
LEGEND
REVISED 1973



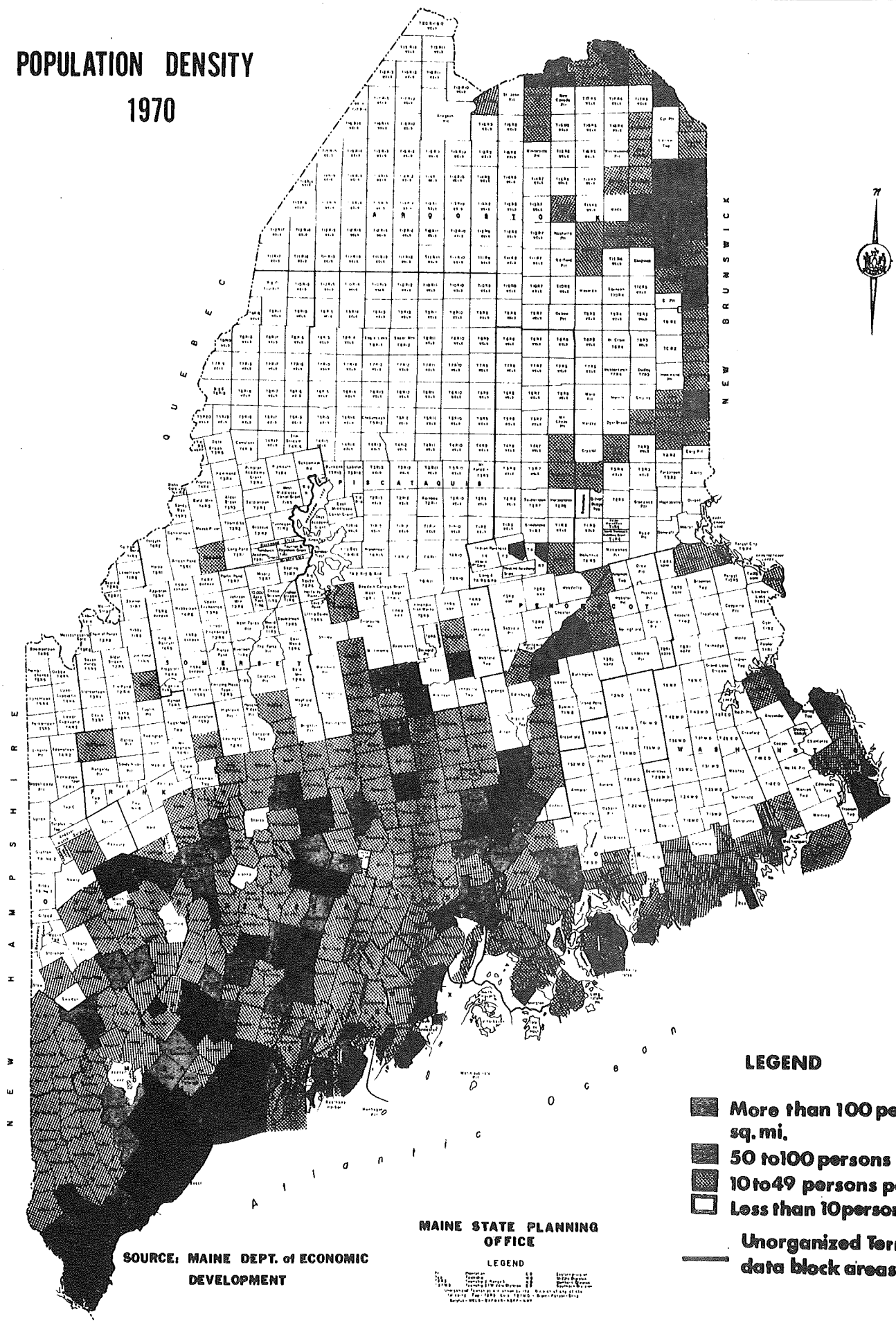
Community Mental Health Centers
and satellite clinics

PREPARED BY:
MAINE STATE PLANNING
OFFICE

LEGEND

REVISED 1973

POPULATION DENSITY
1970



LEGEND

- More than 100 persons per sq. mi.
- 50 to 100 persons per sq. mi.
- 10 to 49 persons per sq. mi.
- Less than 10 persons per sq. mi.
- Unorganized Territory data block areas

SOURCE: MAINE DEPT. of ECONOMIC DEVELOPMENT

MAINE STATE PLANNING OFFICE

LEGEND

II. Problem Definition

A. Narrative Description - Regional

The State of Maine has a total population of 993,663 and, by virtue of its geographic location, is somewhat cut off from the rest of the nation. The traditionalism that is so often associated with New England is especially apparent in Maine. The subject of drug use and abuse is a topic not well received by Mainers, and it may well be that the conservative estimates of drug abuse incidence gleaned from the present survey reflect the conservation so prevalent in the state. Unquestionably, the traditional values have contributed to the quality of Maine life, but they have also hindered in some ways. Innovations are often suspect or even disdained, and the striving for independence and individual problem-solving often means that the recognition of pressing ills, let alone outside help may be denied. Like any ill not addressed head-on, economic and social difficulties in Maine fester and worsen until often the individual's or his community's response is pathological. The "Downeast" nature construes reliance on outside sources for the solution of personal problems as weakness and the heritage of "rugged individualism" dies hard.

The State of Maine has as its highest priority the planning and development of a uniform data retrieval system. The lack of such resulted in conservative estimates of drug use and abuse baseline information although there were indicators of extent and descriptors of problem type which argue the need for a comprehensive coordination of effort and development of new facilities. A refined management information system would assess the extent of drug use and abuse among the general population and meet state and federal reporting needs on clients entering into drug treatment programs.

A comprehensive statement regarding drug abuse in the State of Maine includes the following:

1. The use of marijuana was substantiated in quantity, being the most prevalent in the below 24 age group. There appears to be significant numbers of young people being introduced into the drug culture via experimentation with marijuana. The abuse of amphetamines, barbiturates and hallucinogens also occurred primarily within the 15-24 age group. The abuse of amphetamines, barbiturates and hallucinogens are well documented in all ages up to 35 when the emphasis narrows to barbituates.

2. Since so few of the forms received specified sex of abusers, the differences in drug abuse patterns by sex could not be determined. When a sex breakdown was available, the majority of abuse cases reported were male. Aside from inadequate records, it may be that female abusers did not actively seek help in great numbers from the agencies surveyed, that their problems were not diagnosed as drug related, or that they were not abusing illicit drugs.

3. The drug abuse problem was concentrated in Southern Maine, the most populated area of the state. There were fewer drug problems reported in Regions I and II than in Regions III and IV, a result which correponds with the distribution of population.

4. The respondents to the questionnaire indicated that they believe Maine has a substantial "at risk" population. The risk of becoming abusers appears especially high for the youth of both rural and urban Maine because of high unemployment rates, low incomes, and a general lack of opportunities evident in the state.

5. Staff of existing drug treatment programs indicated a prevalent pattern of combined alcohol/drug abuse among young people. This is almost expected because the culture condones, even encourages the use of alcohol.

Maine's Drug Problem in Priority Order

Drug of Abuse	Age of population At Risk	Age of Population Most Affected	Geographic Distribution
1. Marijuana	13-25	14-25	Statewide
2. Amphetamines	15-35+	15-25 } Drug of preference 25 and older	Statewide non-prescription use concentrated in Urban Areas
3. Barbiturates/ Depressants	15-35+	18-25	Statewide non-prescription use concentrated in Urban Areas
4. Poly drug	15-30	17-25	Statewide mixing with alcohol predominately
5. Hallucinogens	15-25	15-25	Statewide use declining - remaining concentration in the University areas
6. Inhalents	9-17	9-15	Statewide - especially in the rural areas
7. Narcotics	15-35+	18-25	Portland and Bangor - no evidence of presence in other areas.

Estimates derived from available data including arrests and hospital admissions as well as subjective reports.

Region I, the Aroostook county area, is a rather isolated region of the state, bordered on three sides by Canada. The area is primarily rural and comparatively under-populated. Schools in the region experience a 4.1% drop-out rate and unemployment statistics reveal a rate of 11.4%. Census data suggests a heavy out-migration of young adults who are unable to obtain employment locally.

"Hard" data regarding drug abuse in Region I is limited, although many respondents believe that there is extensive use and abuse of drugs by youths. Law enforcement statistics indicate that the primary at-risk population is the junior high through college age group. It appears that possession and sale of illicit drugs or even knowledge of such is a closely guarded secret. Physicians and hospitals keep no records which might bring offenders to the attention of authorities, and the criminal justice system likely intercepts only those offenders who draw attention to themselves through excessive or flagrant drug use. Based on data received from this Region, some assumptions might be made: 1) there appears to be a significant amount of covert drug use, 2) there is no existing system for uniformly gathering data regarding drug use and abuse.

Region II is a large geographic area comprised of Hancock, Washington, Penobscot, and Piscataguis Counties. The population numbers approximately 215,000 with the largest concentration residing near Bangor, Region II's largest city. The population is largely white but includes an American Indian population of 1,308. The economy is primarily dependent on pulp and paper manufacture, agriculture and small industry. Although the main campus of the University of Maine is located in Region II, the area has a high school drop-out rate. 23% of the adults over 25 have eight years or less of education and only 4.7% of this same age group have one to three years of college.

As in most areas of the country, hallucinogens, marijuana, amphetamines and other drugs are available in this area. School officials estimate that well over half of high school students have experimented with drugs. The Department of Indian Affairs report use of drugs on this area's Indian reservation as high with a large number of drug users among the population of students and returned veterans. A 1970 Drug Use Study at the University of Maine indicated drug use matching national levels. Law enforcement agencies in the Bangor area alone estimate, on the basis of police and ambulance calls, an incidence of 2-4 drug overdoses per month. Law enforcement agencies appear well coordinated having either a special division or one officer who devotes full time to drug abuse enforcement and education. The most recent drug raid in Region II involved 105 secret grand jury indictments for alleged sales violations with 139 counts and 40-50 individuals apprehended. Local Bangor hospitals could give little drug abuse information, claiming that they did not compile such information or were not permitted to release it. The general impression is that medical staffs have placed little emphasis on diagnosis and management of drug problems.

Based on data received from this region, the following impressions are made: 1) there appears to be some increase in drug usage, particularly among the adolescent and college age groups, 2) there is a great deal of misinformation and ignorance regarding drug abuse and its treatment, and 3) there is a lack of coordination in record keeping in most agencies who come into contact with drug abusers.

Region III is comprised of Kennebec and Somerset Counties and encompasses approximately 4,780 square miles with the greatest concentration of population residing in southern urban area. The northern region is primarily rural with much of the area uninhabited. There is a differing set of economic conditions existing between the southern and northern sections of the region. While the southern area has a higher rate of employment and income, the northern area is poor and plagued by the highest unemployment rate in the State.

Identification of individuals in Region III who are using drugs is considered by many as impossible and possibly irrelevant. The data collected would lead one to believe that for the most part those using drugs use them with sophistication and secrecy, an assumption verified in the small numbers of persons exposed as drug abusers through established agencies. Physicians reported recognizing a drug problem, but did not feel they were the ones to whom drug abusers turned for assistance. Law enforcement reports that the number of arrests in no way reflects the actual incidence of drug use in their area. For example, the low number of arrests compared to the actual amount of marijuana available indicates that most policemen are not interested in "busting kids for grass". It appears that law enforcement personnel are included in the social rehabilitation aspect of drug abuse. There is great pressure in this area to stop drugs and to "get" the suppliers.

The Veterans Administration Hospital is located in this Region and statistics show significant numbers of veterans to be drug abusers. It may be that this is a high risk group in Region III.

Data obtained from this area suggests the following: 1) there is an undue concern with guarding information regarding drug use and abuse, 2) law enforcement and other community agencies appear unclear as to their role in dealing with drug abusers, and 3) any uniform data collection system is non-existent.

Region IV, the Tri-County District, is composed of Androscoggin, Franklin, and Oxford Counties, and is located in the south-central quadrant of the State, reaching north to Canada. The major population center is in the Lewiston-Auburn twin city area. Androscoggin County is a waning industrial area past its heyday of textile industry while Oxford and Franklin Counties depend largely on the paper industry for their economic base. This area has significant economic problems. It has been designated a poverty area by the Department of Health, Education, and Welfare and had a 1971 unemployment rate of 9.6%. Additional data indicates that 10% of all families live in poverty earning less than $3,745 per year. Approximately 40% of all families represent the "working poor" earning less than $7,000 per annum. The social consequences of such economic conditions are serious and include a 6% school dropout rate and a high percentage of people leaving the area to find employment elsewhere.

The social problems in this area are many and hierarchical in nature. The poverty and the frustrations of eking out a living are primary problems. There exists a documented alcohol abuse problem that has become almost endemic. Although it is difficult to secure hard data on drug abuse, reliable sources point out that many who use drugs heavily often mix drugs with alcohol.

People who were called together from the corners of the Region to discuss the drug problem felt that a central need was to concentrate on integrating service efforts toward young people, the at-risk group for both alcohol and drug abuse. Since mental health systems and rap centers appeared to be those resources most frequently utilized by youth, it might be appropriate if those organizations joined forces with quite different organizations (e.g. law enforcement and schools) to discuss doing more together to prevent and treat abuse problems.

Region V, the Southern Maine District, encompasses the Cumberland, York, Southern Mid-Coast and Penobscot Bay Sub-regions.

The Cumberland Sub-region has a total population of 171,899 with 27% identified as being in the high risk age category in terms of incidence of drug abuse, i.e., between 14-34 years of age. Although the region is 37% rural, it contains the Greater Portland Area with 102,827 people, the largest metropolitan area in Maine. Employment opportunities are quite diversified with manufacturing leading the way, but approximately 10% of all residents are living at or below poverty level.

There are several factors which make for high vulnerability to drug abuse in the Cumberland Subregion, including: 1) the concentration of youth in the Portland area, the influx of summer visitors, the port, the four area colleges, and for some, the lack of alternatives. However, it is difficult to assess the feelings people have regarding drug abuse let alone actual incidence figures. The United Drug Abuse Council recently decided to hold a 14 week In-Service Drug Education course for teachers in the Cumberland subregion. Preliminary inquiries to school administrators indicated that there was not drug problem and that few teachers would be interested in the program. Nevertheless, the program was initiated, 100 teachers registered and paid the $25 fee, and attendance the first night was significant. Questionnaire data from these educators indicated that they had dealt with over a hundred cases of drug related problems and many reported an increase in drug usage.

The Neighborhood Youth Corps (NYC) of Cumberland County conducts an active work and skill training program for low income school dropouts. Early in 1970 NYC became concerned about the increased drug use by youths who were prospective enrollees. Probing into the situation resulted in the following: it is estimated that 60% of NYC enrollees had had contact with drugs, the drug of preference being speed which was often injected.

Although law enforcement figures regarding drug abuse are conservative indicators of actual use, there is data that points to a high proportion of drug related felony convictions in Southern Maine. The Maine Commission on Drug Abuse retained an attorney to research each of 204 felony convictions for the year 1972 in Cumberland. Through his efforts, it was determined that 61% of felony convictions involved drugs (sales or possession) or persons using illegal drugs (refer to Table FC-1 for detailed report).

Additional data indicate that most of the 321 drug-related arrests (possession or sale) were males between the ages of 19-21. Marijuana arrests were most frequent, followed by arrests for illegal use of amphetamines, hallucinogens and other "dangerous" drugs. (See Table CJ-1 for detailed presentation).

The York subregion is the southernmost section of the planning area and has a total population of 111,576, 43% rural. A large percentage of the work force is in manufacturing. Among the factors which contribute to high vulnerability to drug abuse in York are: 1) 28% of the population falling between the ages of 15-34, 2) the presence of two colleges in the area, 3) the lack of recreational alternatives, 4) heavy influx of tourism during the summer, and 5) 12,568 family units defined as living below poverty level. The Division

of Vocational Rehabilitation serving York and Cumberland reports the following information regarding their clients in 1972: drug use was notable and primarily within the 15-25 age group with marijuana the first drug of choice followed by significant use of hallucinogens and amphetamines.

The Southern Mid-Coast subregion encompasses 575 square miles including a coastal section just north of Portland, Maine's largest urban area. The area has a characteristic population which is archtypical of the commonly perceived "downeasterner" of Maine. The citizens of outlying towns are extremely individualistic and are not prone to cooperate with regional and state planning efforts. Drug abuse is viewed by many as an underground type of activity brought into the area by city hippies and transients. The area has a year round population of 58,721 with an annual summer influx of over 40,000. The total population at peak season approaches 100,000. The economic base is centered primarily around a local shipbuilding industry, tourism, fishing and agriculture. Much of the economic activity is seasonal and consequently unemployment is high during the long "off" season. The vulnerability of this area to drug abuse is brought to light by several factors including: 1) 29% of the population falling within the high risk age range of 14-35 including students at Bowdoin College and personnel associated with the Naval Air Station, 2) a significant concentration of youth within urban areas, 3) a lack of year-round recreational activities, and 4) high unemployment rate (7.4%). From data received, primary needs appear to be education regarding drug use and abuse and development of a data collection system to report information on drug contacts to concerned agencies.

Special Populations: Indians

Maine's Indians are a distinct minority group within the State's predominantly Anglo and Franco-American population. The Indian population is approximately 2600, and of this population, about 75% live in the northeastern area of the State.

Aroostook County	
Houlton area	250
Caribou area	250
Washington County	
Pleasant Point Reservation	400
Indian Township Reservation	300
Penobscot County	
Indian Island Reservation	350
Bangor Area	150

Penobscots, Passamaquoddy and MicMac are the three major tribes represented within the population.

Although alcoholism has traditionally been a problem among native Americans, poly drug abuse appears to be increasing, especially among the young. The State's Commissioner of Indian Affairs, cited drug use by Vietnam era veterans and by students attending college off the reservation as particular problems. He and many other tribal leaders are concerned about the influence that these two groups have on younger Indians.

Maine Indians have long been a neglected population. The Penobscots, Passamaquoddies and MicMac tribes are not under federal control and therefore are not eligible for many of the services accorded Indians in other areas of the United States. Because Maine Indians are disinclined to avail themselves of community programs designed to meet the health and welfare needs of the white man, most Indian families are without access to the most basic human services.

The development of indigenous drug abuse prevention and treatment resources in Indian communities must begin with a clear assessment of the scope of the drug abuse problem among Maine native Americans. The Commissioner of Indian Affairs has indicated his willingness to cooperate in planning for needed services.

B. Quantification of Drug Abuse Problem Indicators

Because of the dearth of definitive information concerning drug abuse in the state, the Maine Commission on Drug Abuse sought data on abuse problems by surveying a variety of community indicators: Law Enforcement, Schools, Human Service Agencies, Physicians, Mental Health Centers, and Hospitals. Additional data was acquired from the State Public Health laboratory and the Department of Health and Welfare, Division of Vital Statistics. The information that has been collected and analyzed is by no means complete, nor does it assume a complete understanding of the scope of Maine's drug abuse problem. However, from the extent of drug abuse incidence reported along with the fact that this is at best a conservative estimate of the extent and type of drug abuse in Maine, the existence of a large, poly-drug abusing population can be strongly inferred.

Law Enforcement

Data describing arrests for drug abuse was gathered primarily from the Maine State Police. In a majority of cases, local police and county sheriffs did not respond to the survey citing the following reasons: they did not have time to respond, difficulty in establishing the existence of a drug offense, other data was not transferable, they preferred not to respond to a Maine Commission on Drug Abuse survey because it was not being conducted by a law enforcement agency, and, they perceived the drug problem as being low profile and did not want to inflame the situation.

The reliance on State Police data to indicate a pattern of drug use or abuse is extremely misleading for several reasons. Since State Police largely confine their jurisdiction to State highways, the vast percentage of arrests are for traffic related offenses. No test is made to determine if the intoxicated driver is under the influence of a drug other than alcohol. Complaints are issued for possession only if drugs are found at the time a driver is stopped for a driving offense. Finally, their arrest data do not specify the drug involved is a drug arrest. Hence the data collected are lacking in the following areas: 1) failure to show arrests for illegal sales of drugs, 2) failure to show illegal use of drugs, and 3) showing possession of drugs only when another offense is involved. However, the number of non-alcohol drug arrests made when, for the most part, they are not actively sought indicates a drug problem exists.

Table LE-1 presents the data collected from State Police records and local police and county sheriff surveys.

Table LE-1 Arrests reported by local Police, Sheriffs, and State Police for specific* drug abuse offenses in Maine during 1972.

Drug	Juveniles		Adults		Total	
	#	%	#	%	#	%
Narcotics	2	1%	19	1%	21	2%
Barbiturates	1	.4%	19	1%	20	2%
Amphetamines	0	0	68	5%	68	5%
Hallucenogens	0	0	38	3%	38	3%
Marijuana	42	33%	399	34%	441	34%
*Other	84	65%	642	54%	726	55%
	129		1185		1314	

*All State Police drug arrests are grouped under the "other" category.

Marijuana arrests are the most common identifiable arrests for both juveniles and adults. The majority of drug arrests occur in the 18-24 age group, a figure which conforms to national patterns showing that use of illicit drugs is most frequent within this age group. Police and courts exercise more discretion in dealing with juvenile drug offenders, thus reducing arrests in that category.

Table SP-1 Indicates State Police arrests for drug offenses by offense and age.

	0-17	18-24	25-34	35+	Total
OUI Drugs	10% (8)	2% (12)	5% (2)	0% (6)	4% (22)
Sale	2% (2)	8% (41)	8% (3)	7% (1)	7% (41)
Possession	82% (69)	88% (423)	85% (34)	93% (14)	87% (540)
Other	6% (5)	1% (7)	2% (1)	0% (0)	2% (13)
	N = 84	N = 483	N = 40	N = 15	N = 622

Juveniles arrested for drug offenses are most frequently apprehended for possession of paraphanalia incidental to drug use ("other" category) and secondarily for operation of a vehicle while under the influence of a drug. Possession and sale of drugs account for a very small percentage of drug arrests, reflecting the previously mentioned bias in State Police arrests.

Among adults, the most outstanding percentages of drug arrests are for sale and possession. The percentages of operation under the influence of drugs and drug use arrests are very low.

Conviction data indicates that of those arrested for drug offenses by State Police, 57.9% are convicted, the remainder dismissed, continued, suspended or filed. Among those arrested on drug charges, 10.5% were placed on parole or probation.

Although comprehensive statewide data is not available on drug arrests due to the lack of a uniform reporting code, data was obtained on incarcerations in the Cumberland County jail to indicate the incidence of such arrests in Region V, the most populated area in the State. Table CJ-1 presents the results of this record search.

Table CJ-1 Commitments to Cumberland County jail for drug offenses for persons 17 and over in 1972

Drug	Commitment Category	Number of Commitments	Total Commitments per drug
Marijuana	Possession	112	181
	Sale	12	
	Being in Presence	57	
Amphetamines	Possession	35	71
	Sale	36	
Heroin	Possession	7	9
	Sale	2	
Hallucinogins	Possession	4	16
	Sale	12	
Dangerous Drugs	Possession	12	44
	Sale	2	
	Possession of Hypodermic	30	
Total			321

Of the above commitments 12% were female. The 19-21 age group represented the largest number of commitments in all commitment categories.

A second research effort in Region V revealed a relationship between drug use and felonies committed in that region.

A lawyer was retained to research each of the 204 felony convictions for the year 1972. Using court records, interviews with the county prosecutor, and in many cases personal knowledge, it was determined that 125 or 61% of the felony convictions involved non-alcohol drugs (sale, possession) or persons using illegal drugs. Table FC-1 presents these findings.

Table FC-1 Felony convictions in Cumberland County for 1972

Type of Offense	No. of convictions or guilty pleas	%
1. Felony drug convictions and pleas	70	34
2. Crimes against property by drug users	43	21
3. Crimes against persons by drug users	12	5.8
4. Total drug felony convictions	125	61
5. Property crimes not involving drug users	50	24
6. Crimes against persons by non-drug users	29	14.2
7. Total non-drug felony convictions	79	39
8. Total felony convictions	204	100

The above data reveals that a high proportion of people convicted of felonies in the southern Maine region are drug users. The percentage of drug users in the assaultive and non-assaultive categories are similar to those reported by Tinklenberg in his study of incarcerated offenders in California for the National Commission on Marijuana and Drug Abuse in 1972. The study was conducted in California because a wide variety of drugs have been available and used by young people in California for several years.

If one assumed that the heavy drug users in the California study are equivalent to the unspecified drug users in this Maine sample, the above statistics reveal that in the Cumberland County area the incidence of drug use among felons is similar to that in California.

It cannot be emphasized too strongly that the figures in this section are conservative indicators of the drug use actually encountered by law enforcement personnel. In 1974 the Management Information System will provide a more comprehensive view of drug users in trouble with the law.

Correctional System

Maine has five correctional facilities, two juvenile training centers, a men's reformatory, a women's reformatory, and a maximum security facility. The majority of drug offenders are sentenced to the Men's Correctional Center and Maine State Prison, the maximum security facility.

The Warden of the Maine State Prison supplied the following information on the number of inmates charged with drug offenses for the years 1971, 1972 and through June 30, 1973.

Table CS-1 Drug offenders in Maine State Prison 1971-73

Charge	1971	1972	1973	Total
Possession of amphetamine	2	3	1	6
Possession of heroin	1	13	1	15
Possession of hypodermic needle	0	0	2	2
Importing hashish	0	0	1	1
Furnishing amphetamine	0	0	8	8
Sale of Marijuana	0	8	3	11
Sale of Narcotic Drugs	3	11	2	16
Sale of Hallucinogenic Drugs	0	0	2	2
Unlawful Sale of Drugs	0	0	1	1
Sale of amphetamine	0	0	1	1
Sale of Methamphetamine	0	0	6	6

Impressionistic data on inmates convicted of other felonies indicates that more than 70% of the approximately 370 inmates have been involved in the illegal use of drugs.

Although the number of inmates incarcerated for drug offenses has increased six-fold since 1971, there are no professional drug abuse treatment services available for inmates of the Maine State Prison. Drug-involved inmates have organized a self-help group but lack of professional supervision and support is hampering the group's efforts.

The Men's Correctional Center, a reformatory, receives persons convicted of misdemeanor and first offenders. In most cases, first time drug offenders are sentenced to the Men's Correctional Center. No "hard data" was available concerning the number of inmates sentenced on drug related offenses. The Superintendent and staff of Men's Correctional Center indicated that since the majority of drug abusers at Men's Correctional Center are sentenced for other crimes, an indication of the number of drug offenders would provide an accurate picture of drug use among the Men's Correctional Center population. The Superintendent estimated that more than 80% of the inmates use illegal drugs.

The correctional program at Men's Correctional Center emphasizes educational rehabilitation, work release and heavy reliance on community based services. The staff at Men's Correctional Center would like to see an upgrading of the quality and scope of existing community health, mental health and social services in a way that would make these services more available and accessible to the drug offender.

Education

The information provided by 51 school systems (62% of those surveyed) indicates that many of the schools feel they are facing a drug problem but do not know how to deal with it. Although most of the public school systems provide an educational program designed to affect the student's attitudes toward drug use and abuse, the administrators who answered the questionnaire considered neither the program nor the method of presentation adequate or successful. A most frequent response was that the schools need guidelines on what to do for drug abuse education and how to do it. The primary orientation of schools in their current drug education program is informational with the responsibility falling most often on the classroom teacher and/or the health or physical education teacher. The schools utilized a variety of methods of presentation, however, lectures, group discussions and films were most often used. When the schools used outside agencies for drug education programs, they turned to the police most often, but also used counseling centers, rap centers and churches.

School administrators felt that the legal aspects of drug abuse limited the responsiveness of the schools to students' drug problems. Teachers were allowed the privilege of confidentiality with students in the majority of school systems, so it would not be necessary to report drug abusers if the teacher could be of some help to the student. It is questionable whether any drug abuse counseling could be carried on by guidance counselors since there is a scarcity of counselors within the schools. The majority

of schools reporting did not have a uniform policy for the discipline of drug abusers. When a policy was cited, it was most often that recommended by the State but individual policies included calling the police.

In 1971 a study was conducted in twelve Maine communities to assess the drug use practices of students, ages 11 through 18. The following results were derived:

Table PS-1 Incidence of drug used and type of drug preferred

Marijuana	20%	(3176)
Hallucinogens	6%	(873)
Stimulants and Depressants	16%	(2604)
Narcotic Cough Syrup	7%	(1143)
Opiates	1%	(222)
Inhalants	6%	(921)
		8939

Based on a total subject sample of 15,880, the above results indicated that over half of the students used drugs, with stimulants/depressants and marijuana being the major drugs of choice. These results corroborate the school system administrators' feeling that the schools are facing a drug problem.

A drug use study was conducted at the University of Maine at Orono in 1970. The Orono campus is the largest in the University system. Figures from this study indicated that the incidence of illicit drug use was approaching or exceeding the national college average in 1970 as reported by the National Commission on Marijuana and Drug Abuse. This is illustrated in Table UM-1.

Table UM-1 Percent of students ever using drugs as reported in 1970.

Drug	University of Maine	National Average
Marijuana	33%	36%
Stimulants and Depressants	31%	31%
Hallucinogens	8%	9%
Opiates	6%	4%

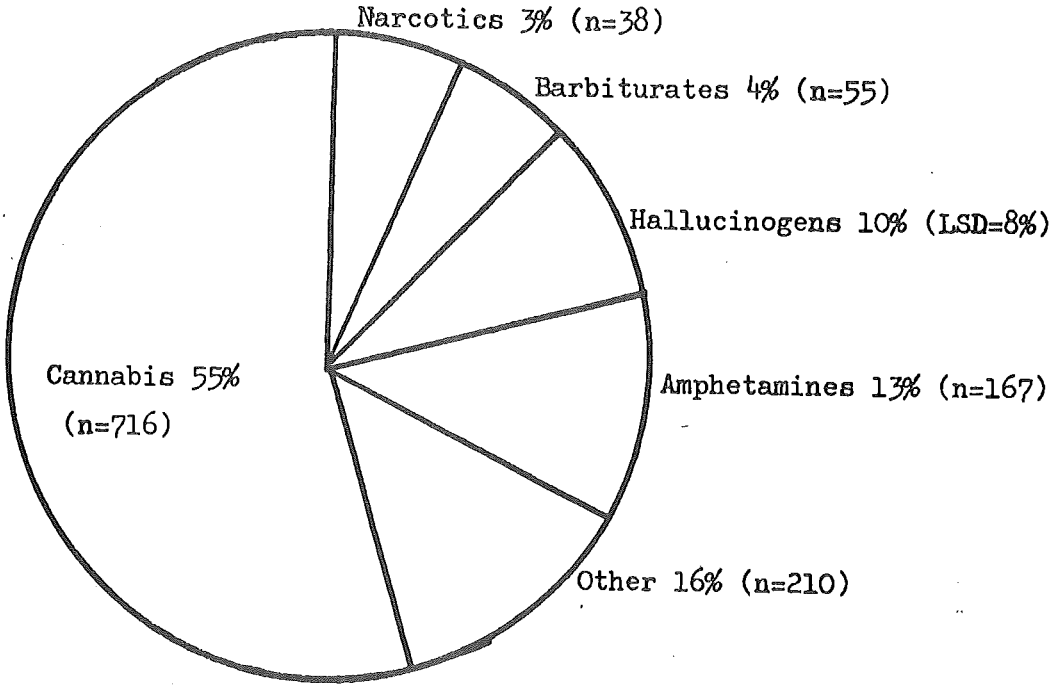
The National Commission's nationwide composite study of college drug use in 1972 indicates a rise in marijuana use to 50%, stimulants and depressants to 39%, hallucinogens to 14% and opiates to 6%. Because drug use at the University of Maine at Orono matched national figures so closely in 1970, it is most likely that a corresponding increase in drug use has also occurred at the Orono Campus.

While the data indicate that a drug problem definitely exists the responses of school systems indicated that they do not feel adequately prepared for either education regarding drug abuse or dealing with students who are involved in drug abuse. Because the schools are in a position to influence children from an early age, one area needing concentration for combatting drug abuse is the development of a good drug education package and training of counselors and educators in how best to use it.

Public Health Laboratory

The State's Public Health Laboratory is a public, self-supporting agency. Samples of drugs, plan material, organs, food and other substances are mailed or delivered to the lab for content analysis. Public health care agencies, private citizens, physicians, law enforcement officials and others with the required fee utilize the services. The great majority of the samples are forwarded by police and thus reflect illegal use of the drug being analyzed.

Figure PH-1 Drug Specimens Analyzed by the Public Health Lab in 1972



This data source indicates the statewide drug of preference to be cannabis, followed by amphetamines and hallucinogens.

The Public Health Laboratory recommends that an anonymous statewide substance testing service be instituted in cooperation with those agencies concerned with drug use within the State. This service would allow substances with an abuse potential to be identified and the general public and individual submitting the sample to be aware of the potential problems associated with the use of a given drug. Several state models are available for modified use here in Maine.

Deaths

Drug related death data was drawn from the 1972 statistics collected by the Deaprtment of Health and Welfare, Division of Vital Statistics.

In 1972 Maine had 34 drug related deaths. Suicides accounted for 13 of these deaths. The remaining 21 were either accidental or it could not be determined whether or not ehy were suicides. The drug involved could be identified or classified within the given drug categories in only seven cases. The remaining 27 cases fell within the "other/unknown" category. Males were involved in 16 cases and females in 18 cases. Two deaths fell in the age group 0-17, four at 18-24, seven at 25-34 and twenty-one at 35+. Five of these deaths were due to barbiturates and two to tranquilizers; the remainder were due to other unknown drugs.

The Chief Medical Examiner for the State of Maine has provided death and autopsy data for fiscal year 1969 through 1971. This data describes natural and traumatic deaths. Within these broad categories, the number of autopsied deaths is reported. Deaths by overdose of drugs and alcoholism are reported under the traumatic deaths category. The projections for 1972 are based upon the average percent of change in each category over 1969-1971 (see Table D-1).

Table D-1

Reported Drug Deaths

Year	Total natural & traumatic deaths	Total traumatic		Autopsied traumatic	Drug deaths		Alcohol deaths		Drug + Alcohol deaths	
	#	#	%	#	#	%	#	%	#	%
1969	1662	651	39.1	185	8	.5	24	1.4	32	1.9
1970	1797	552	30.7	183	10	.6	15	.8	25	1.4
1971	1932	629	32.6	210	12	.6	27	1.4	39	2.0
3 year total	5391	1832	33.9	578	30	.5	66	1.2	96	1.8
projected 1972	1962	603	30.7	220	12	.6	31	1.6	44	2.2

It can be seen that traumatic deaths have shown a slight decrease in the past four years while the percentage of drug and alcohol deaths has very slightly increased. Given the tendency to misreport drug and alcohol deaths it is expected that the actual percentage increase in drug and alcohol deaths in recent years is higher than show in Table D-1.

Caution must be exercised in the interpretation of both Division of Vital Statistics and Chief Medical Examiner's drug related death data because within the State of Maine there are limited requirements for a body fluids analysis or autopsy. Therefore, incidence of drug deaths is under reported. The only method of determining a drug related death is if the above analysis or autopsy is requested, pr physical evidence present at the scene of the death indicates drug involvement as the primary cause. However, this evidence is frequently unreported or disregarded to protect the families to those involved. Therefore, this data probably represents only a portion of the total drug involved deaths in the State of Maine.

Human Service Agencies

Data describing human service agencies' contact with drug abusers was gathered primarily through the use of the Human Services Supplement. This supplement was mailed or delivered in person by the regional planning coordinators to the administrators of human service agencies listed in the Maine Human Resources Index or as yet unlisted programs within their catchment areas which had a potential to or served drug abusers. Data was reported by level of contact, treatment and age of a particular type of abuser. Half of the human service agencies in the State responded.

Human service agencies' data indicated the majority of those contacting them for an abuse problem were seen on a one time basis. The remainder were regularly counseled (38%) or referred (7%) to a more appropriate agency for treatment.

Table HSA-1

Human Service Agency
Drug Abuse Contacts by Age

Drug	Age 0-14		15-17		18-25		26-35		35+	
	#	%	#	%	#	%	#	%	#	%
Narcotics	0	0	12	4	42	7	5	7	1	4
Barbiturates	24	39	53	16	120	21	18	24	10	22
Amphetamines	12	20	100	31	132	23	19	26	5	21
Hallucinogens	8	13	76	24	122	21	14	19	1	4
Marijuana	12	20	76	24	148	26	12	16	7	29
Cocaine	0	0	0	0	2	-1	1	1	0	0
Other	5	8	5	1	9	2	5	7	0	0
	61		322		575		74		24	

Table HSA-1 illustrates the percentages of each drug abuse within given age groups who contacted human service agencies. Within the 0-14 age grouping, the drugs of choice in order of preference are barbiturates, amphetamines, and marijuana. A shift occurs in the 15-17 age group with amphetamines emerging as the most preferred drug while hallucinogens and marijuana are equally preferred as second choices. The 18-25 age group evidences a fairly equal preference among barbiturates, amphetamines, hallucinogens and marijuana and the preference for marijuana drops significantly in the 26-35 age group. Within the over 35 group, barbiturates emerge as the drug of choice and far surpass other drugs in order of preference.

Physicians

A majority (68%) of the 227 physicians who returned the survey felt that drug abuse has become a problem in the community they serve. A number of doctors noted that they had seen an increase in drug use in the last two years.

When physicians were asked what drugs they felt were a problem in their community, a significant proportion felt that "hard drugs" were as much of a problem as alcohol and marijuana. As Table P-1 below indicates, they saw problems with narcotics, barbiturates, amphetamines and hallucinogens.

Table P-1

Drug Problems by Age Group

Drug	School Age	Young Adult	45-65	65+	Total
Narcotics	5% (8)	11% (41)	11% (8)	0	9% (58)
Barbiturates	11% (23)	16% (60)	63% (44)	74% (14)	21% (141)
Amphetamines	21% (44)	25% (89)	21% (15)	16% (3)	23% (151)
Hallucinogens	17% (36)	16% (59)	1% (1)	5% (1)	15% (97)
Inhalants	8% (17)	2% (9)	0	0	4% (26)
Marijuana	37% (77)	28% (103)	1% (1)	0	27% (180)
Other	1% (3)	1% (5)	1% (1)	5% (1)	1% (9)
	N=208	N=366	N=70	N=19	N=662

The physicians felt that school age children were abusing narcotics, barbiturates, amphetamines, hallucinogens, and inhalants. Drugs abused by persons over 45 years of age included narcotics, barbiturates, and amphetamines. Marijuana abuse occurred only among school age persons and young adults.

Although most physicians felt that there were specific drug problems in their communities, most thought that few of the persons with thos problems seek help from physicians. Almost half of the physicians felt that the State laws relating to the treatment of minors limited their effectiveness in treating youthful drug abusers. Another 20% did not know if the laws hampered their effectiveness with youth because they had no way of knowing how many youths were kept away by the laws. Those doctors who felt limited by the regulations considered them too restrictive and felt that reporting procedures kept patients away.

The physicians most often used an outpatient method of treatment. When hospitalization was used, it was primarily used for persons in the 35+ age group. Only 8% of the doctors had ever prescribed treatment in a halfway house. Over half of the physicians felt that drug abusers needed more than medical attention and that good treatment included the use of community resources such as drug rescue centers. However, when asked what community resources they referred patients to, Mental Health Centers headed the list, rap and rescue centers and AA being the

other major recipients of referrals. This indicates a lack of drug rescue centers to refer to.

Physicians seemed to question if anyone knows how to prevent or deal with drug abuse. Half of them considered the existing educational programs inadequate, but several questioned the effectiveness of any education program. Several physicians considered drug abuse the problem of an emotionally immature culture. Several others felt that Maine needs a rehabilitation center for drug abusers.

Mental Health

One or more mental health centers in each of the eight regions returned the mental health supplement which requested information on the number of drug cases diagnosed in 1972. The data received are only estimates and may not reflect either actual drug abuse among clients or the actual number of clients. As Table MH-1 indicates, the mental health centers report fewer contacts with drug abusers than did human service agencies. The total number of clients with any type of drug abuse problem was 1,156 for the State.

Table MH-1

Mental Health Centers
Number of Drug Related Diagnoses by Age

	Juvenile		18 and Over	
	%	#	%	#
Narcotics	2%	8	1%	7
Barbiturates	11%	45	4%	31
Amphetamines	16%	64	5%	39
Hallucinogens	16%	64	2%	15
Marijuana	26%	105	9%	69
Alcohol	24%	96	74%	559
Other	5%	20	4%	31
		402		754

The above table shows that most juvenile mental health center clients who have problems centering around or including drug abuse abuse marijuana, alcohol, hallucinogens and amphetamines, and barbiturates in that order of frequency. Adults with drug problems are most often treated for problems relating to the abuse of alcohol. Women reported abusing drugs more frequently than alcohol while men reported abusing alcohol most frequently.

The mental health figures for the State support the national trend that juveniles and adult women are the primary drug abusers. However, Mental health centers reported that most of their contact clients were actually adult men. This partially accounts for the center's lack of contact with drug abuse. Mental health centers do not consider it their function to serve as drug treatment facilities and people with drug problems are not likely to seek help from them. When Mental Health Centers do treat drug abusers they most frequently treat them in relation to another problem which results in a further under reporting of drug abuse.

abused drug followed by marijuana, other drugs, and hallucinogens. Tranquilizers begin to show up as a sizeable problem in this group. At age 35 and above, abuse of barbiturates occurs most frequently followed by abuse of other and unknown drugs and tranquilizers. For all ages combined, hospitals most frequently treat patients for abuse or misuse of "other" or unknown drugs, barbiturates, amphetamines and hallucinogens.

Because the previously presented data did not take into account the six large hospitals not on BCDS, an additional set of statistics on emergency room treatment for drug abuse is included from one of these hospitals. Table H-2 describes number of drug abuse cases received by the largest hospital in Maine.

Table H-2 Number of Drug Abuse Cases Received during May, July, and September of 1972 by Maine Medical Center Emergency Room

Drug Problem	# of cases received
Barbiturates and Tranquilizers	39
Amphetamines	18
Hallucinogens	12
Narcotics	2
Over the counter drugs	17
Alcohol and Barbituates	39
Alcohol (under age 25)	15
Ups and Downs	7
Other combinations	8
Drug related illnesses	17
To see a psychiatrist	14
Suicide	3
Total Drug Related	216
Total Emergency Room Cases Received	13,839

A drug case incidence rate of 15.4 per thousand emergency room cases summarizes the above table. Also, of the above cases 111 were female and 105 were male. This reflects a good size drug abuse problem for Portland, Maine's largest city where in a population of 65,116 there are approximately 70 drug abuse cases a month in only one of the city's three major hospitals.

Hospitals

Data describing hospitals' contact with drug users was gathered primarily through the Blue Cross Data System (BCDS). This was necessary because of a poor response to the hospital survey. The following reasons were given for not responding to the survey: they did not have the time; their records were not kept in a manner which lent itself to this type of a report; physicians usually disguised drug abuse cases; hospital records were confidential and not open for review by non-medical personnel; and they saw no resulting benefit to themselves or their hospital if they replied.

The BCDS is a pilot project of the Blue Cross Medical Insurance System. Although the majority of Maine hospitals are included, six of the larger hospitals including the largest hospital in Maine do not subscribe to this reporting system. Thus again the cases of drug abuse will be under recorded. Data is displayed by diagnosis and the system has voluntary reporting requirements. Data could not be presented by individual hospitals because waivers were not granted. However, data for the hospitals within an entire planning region could be presented. Most member hospitals responded well to this service. The longer a hospital responded to this data service, the more likely the hospital was to report drug abuse cases. Data from State hospitals and the VA Hospital have been summed with general hospital data.

Table H-1 indicates the percentages of drug abuse and age groupings of abusers reported by 79% of Maine's hospitals for 1972.

Table H-1

Hospital Reporting of Drug Abuse by Age for 1972

Drug	0-17		18-24		25-34		35+		Total	
	#	%	#	%	#	%	#	%	#	%
Narcotics	0	0	24	16	6	9	3	3	33	9
Barbiturates	11	22	16	10	6	9	38	38	71	20
Tranquilizers	4	8	4	3	8	12	15	15	31	9
Amphetamines	4	8	29	19	15	24	5	5	53	14
Cannabis	3	6	21	14	9	14	1	1	34	9
Hallucinogens	6	12	27	18	8	12	4	4	45	12
Volatile Substance	2	4	3	2	2	3	0	0	7	2
Other	19	39	29	19	9	14	32	33	89	25
	49		153		63		98		363	

As Table H-1 illustrates, the 0-17 age group is treated most frequently at hospitals for problems with unknown drugs or combinations of drugs ("other"), barbiturates and hallucinogens. In the 18-24 age group, the distribution is fairly even among abuse of amphetamines, unknown drugs or combination of drugs, hallucinogens, and narcotics. In the 25-34 age category, amphetamines take the lead as the most often

abused drug followed by marijuana, other drugs, and hallucinogens. Tranquilizers begin to show up as a sizeable problem in this group. At age 35 and above, abuse of barbiturates occurs most frequently followed by abuse of other and unknown drugs and tranquilizers. For all ages combined, hospitals most frequently treat patients for abuse or misuse of "other" or unknown drugs, barbiturates, amphetamines and hallucinogens.

Because the previously presented data did not take into account the six large hospitals not on BCDS, an additional set of statistics on emergency room treatment for drug abuse is included from one of these hospitals. Table H-2 describes number of drug abuse cases received by the largest hospital in Maine.

Table H-2 Number of Drug Abuse Cases Received during May, July, and September of 1972 by Maine Medical Center Emergency Room

Drug Problem	# of cases received
Barbiturates and Tranquilizers	39
Amphetamines	18
Hallucinogens	12
Narcotics	2
Over the counter drugs	17
Alcohol and Barbituates	39
Alcohol (under age 25)	15
Ups and Downs	7
Other combinations	8
Drug related illnesses	17
To see a psychiatrist	14
Suicide	3
Total Drug Related	216
Total Emergency Room Cases Received	13,839

A drug case incidence rate of 15.4 per thousand emergency room cases summarizes the above table. Also, of the above cases 111 were female and 105 were male. This reflects a good size drug abuse problem for Portland, Maine's largest city where in a population of 65,116 there are approximately 70 drug abuse cases a month in only one of the city's three major hospitals.

III Resource Identification

This section describes the services in Maine that address the issue of drug dependence through prevention, education, treatment, and/or rehabilitation. Also included in this section are the enforcement and correctional resources of the criminal justice system.

As this section vividly demonstrates, Maine's drug abuse prevention and treatment resources are wholly inadequate when it comes to meeting Maine's needs. It is startling when one realizes that the treatment system in Maine consists of three programs, and only one of these programs is designed to provide residential treatment. It is also obvious that the services that do exist, exist for only those residents that live in Southern Maine, as there are no treatment services north of Augusta (Augusta being 300 miles from the northern border). Residents north of Augusta must rely on poorly developed services offered through traditional treatment helping services.

SUMMARY
EXISTING RESOURCES

Agency	Sponsor	Service	Modality	Budget (FY 73) Federal	Budget (FY 73) State/Local	Client Capacity	*Staff
Maine Commission on Drug Abuse	Public	Single State Agency	Administration	$119,781	$76,000		3
Maine Drug Education Program	Public	Teacher Training	Education	23,200	30,000		3
Augusta Rap & Rescue	Private, non-profit	24-hour crisis intervention	Treatment	71,775	2,400	77 Outpat.	7
Brunswick Drug Abuse Center	Private, non-profit	Out-patient counseling	Treatment	68,946	2,500	88 Outpat.	4½
Rap Place, Lewiston	Private, non-profit	Alternatives activities	Prevention Education	32,000	2,800		6
York County Counseling Service (AIDE Center)	Private, non-profit (CMHC)	Training & Education	Counseling		30,000		2
Drug Rehabilitation, Inc.	Private, non-profit	Residential & Out-patient	Treatment	107,810	2,500	15 Resid. 25 Outpat.	7
Southern Regional Drug Council	Southern Maine Comprehensive Health Asso.	Regional Coordination	Coordination	4,800			1
Kinsman Hall	Private	Residential	Treatment	N.A.	N.A.	N.A.	N.A.
Elan I	Private	Residential	Treatment	N.A.	N.A.	N.A.	N.A.

*Aggregate figure reflecting total full time staff

The following Community Mental Health Centers provide limited drug abuse services within their catchment areas:

Aroostook Mental Health Clinic
The Counseling Center
Kennebec Valley Mental Health Center
Tri-County Mental Health Services
Maine Medical Center Community Mental Health Center
Mid-Coast Mental Health Clinic
Bath-Brunswick Mental Health Association
York County Counseling Services

A. Existing Resources

1. Legal and Legislative

In 1971 the Legislature responded to Maine's increasing concern about the problems of drug abuse by establishing the Maine Commission on Drug Abuse within the Executive Department. The legislation provided representation on the Commission from ten State Departments and agencies having drug abuse prevention, treatment, or regulatory interests; and from five citizen members, including the Commission Chairman.

The Commission was given the responsibility of coordinating all drug abuse efforts of local government and private groups. In carrying out its responsibilities the Commission was authorized to:

> Examine all requests for appropriations or program grants relating to drug abuse made by state agencies, and supervise the disbursement of all state funds appropriated for the purpose of helping local and regional governments and agencies and private groups deal with drug abuse.

All local and regional agencies and groups seeking state assistance were required to file applications with the Commission and no grants of state funds could be made without Commission approval.

In addition to its coordinative responsibilities, the Commission has functioned as a resource to the Legislature, other State Departments, local agencies and private groups.

Under the recently enacted legislation, the Maine Commission on Drug Abuse and the Division of Alcoholism Services will merge to become the Office of Alcoholism and Drug Abuse Prevention in the Bureau of Rehabilitation. Although the Office does not officially become effective until January 1, 1974, preparation for the merger began in August 1973 when the MCDA moved into the Bureau of Rehabilitation. An Acting Director has been appointed and given full authority to implement the merger.

A full description of the broad organizational and functional responsibilities of the Office of Alcoholism and Drug Abuse Prevention (OADAP) is included in the Plan's introductory section.

MEMBERS OF THE MAINE COMMISSION ON DRUG ABUSE

Mr. Stephen Simonds, Chairman of the Maine Commission on Drug Abuse
Human Services Development Center
University of Maine
Portland, Maine

Mr. Gary Cook
Livermore Falls, Maine

Ms. Pauline Gingras
Augusta, Maine

Departmental Representative

Health and Welfare
Dean Fisher, M.D., Commissioner
Representative: Owen Pollard

Mental Health and Corrections
William Kearns, Commissioner

Education & Cultural Services
Carroll McGary, Commissioner
Representative: Carl Mowatt

Public Safety
Parker Hennessey, Commissioner
Representative: Millard Nickerson

Manpower Affairs
Representative: Stan Jones

Attorney General
Jon Lund, Attorney General
Representative: John Atwood

State Youth Coordinator
George Ezzy

State Planning Office
Philip Savage, Director
Representative: Carolyn Manson

Executive
Representative: Dennis Violette

Division of Economic Opportunity
Herbert Sperry, Director

Law Enforcement Planning and
Assistant Agency
Jack Leet, Executive Director

University of Maine
Donald MacNeil, Chancellor
Representative: Ira Hymoff

Comprehensive Health Planning
Mark Knowles, Director
Representative: John Supranovich

Community Mental Health Centers

There are eight community mental health centers in Maine, one in each of the mental health catchment areas. Most centers provide a minimum of five essential services: 24 hour telephone coverage, inpatient, day care, outpatient and educational consultation. The level and quality of service varies from region to region, but as a minimum outpatient care is available through each center. Mental Health Centers do not usually identify and treat drug abusers *per se* but prefer to apply more traditional mental health labels in dealing with drug involved individuals. This philosophy stems partly from an admitted ignorance of the problems of drug abuse and, also, prior negative experiences in handling drug cases. None of the centers conducts specialized drug abuse treatment programs and only one center, York County Counseling Services, has a Drug Specialist on staff.

Although drug abusers are admitted to mental health centers inpatient units for detoxification and short-term psychiatric care, the majority of drug cases are seen on an outpatient basis.

Drug Rehabilitation, Inc.

Of Maine's three drug treatment programs only Drug Rehabilitation, Inc. (DRI), located in Portland, will offer both residential and day care services. DRI is the first residential drug treatment facility in the Sttate designed to serve Maine clients. The program, funxed by LEAA and an NIMH rapid expansion contract, will work with drug dependent individuals between the ages of 15 and 26. Priority will be given to referrals from police and courts in the southern Maine region.

DRI's proposed treatment program is a departure from the traditional therapeutic community approach which emphasized the use of ex-addicts and a long term (18-24 month) treatment program. The treatment program at DRI is intended to be short (3-6 months) and the emphasis will be on getting the client back into the community as soon as possible. Vocational and educational rehabilitation and intensive follow-up are important components of the program. Through its store front on Pine Street (opened 10/15/73) and residence on Danforth Street, DRI can work with up to 15 clients in residence and 25 clients in day care. Under its present contract DRI has begun accepting clients for day care and expects to open the residence by early December. The program staff is composed of three professionals, including the director, a half-time nurse, a part-time social work student and two resident counselors.

DRI will have 24 hour medical and psychiatric coverage through a contract with the Maine Medical Center's Community Mental Health Center.

DRI is attempting to meet a growing need in Southern Maine for day care drug free treatment. Referrals are coming from Community Mental Health Centers, Health and Welfare, individuals and the courts. It appears that this long awaited resource will be fully utilized within a very short time.

Treatment Legislation

Maine law provides three different mechanisms for the treatment of drug abusers.

First, as in most states, a person may be voluntarily admitted to a hospital for treatment for drug abuse (M.R.S.A. 34 § 2291 et. seq.).

Secondly, M.R.S.A. 22 § 1353 provides that "a person suffering from the effects of the use of an opiate, cocaine, chloral hydrate, other narcotic barbiturate or the excessive use of alcohol may be committed to the care of any hospital, including state hospital for the mentally ill, or any legally qualified physician of not less than five years actual practice for treatment..." The actual procedure for such involuntary hospitalization is tightly regulated by M.R.S.A. 34 § 2331 et. seq., as amended by Public Laws of 1973, Chapter 547.

The statutory avenue of treatment (Public Law of 1973, Chapter 566) was recently enacted by the Maine Legislature and will become effective on January 1, 1974. The newest mechanism allows a defendant convicted of any drug offense to be placed on probation if he agrees to undergo treatment in a state-approved residential or non-residential treatment and rehabilitation program. Under Chapter 566 the defendant may be placed on probation for a period of not more than two years. A decision to terminate treatment before the expiration of the probationary period may be made, subject to court approval, by the professional staff of the treatment facility. It should be noted that Chapter 566 provides a mechanism to circumvent the stringent mandatory minimum sentencing provisions contained in many of Maine's drug statutes.

Brunswick Area Drug Abuse Center

The Brunswick Area Drug Abuse Center (BADAC) was established in 1970 through local funding. In July, 1972 BADAC was awarded an eight year NIMH Drug Abuse Service Project Grant. With the award of the federal grant, BACDAC initiated five service components:

1. 24 hour walk-in crisis clinic
2. Alternative programs
3. Referral resource for courts and police
4. Group and individual counseling
5. Confidential drug analysis and identification

The Alternative Program, begun in January of 1973, is the major and most visible thrust of the BADAC prevention program. The Alternative Program is modeled after already successful programs in Connecticut and California. The Center now maintains the Wick Coffee House in Brunswick and The Bridge in Bath. Both coffee houses offer film making, pottery, theatre and dance to adolescents and young adults in the Bath-Brunswick area. The Wick Coffee

House is staffed by one paraprofessional and/or one volunteer, while The Bridge is manned solely by volunteers.

Group and individual counseling is another component of the BADAC program. One part-time professional and four full time paraprofessionals offer counseling services to drug users and their parents. Ther is a therapy group for 14-17 year olds in Brunswick, a group for 16-18 in Bath and a parents group. The parents group is led by a psychiatric social worker whose time is donated by the Bath-Brunswick Mental Health Association.

Information and referral is another component of the Brunswick Drug Abuse Center program. A manual for referral has been put together by the staff and volunteers of BADAC. The referral systerm has resulted in formal and informal agreements with other agencies such as town welfare offices, Odyssey House in New Hampshire, Bath Memorial Hospital, The Bath-Brunswick Mental Health Association, Augusta State Hospital and the Togus Veterans Administration Hospital.

Apart from a paid staff of four full time paraprofessionals and one part-time professional, the BADAC works with thirty plus volunteers, a good indicator of the degree of community support for the program.

Rap and Rescue, Inc.

Augusta Rap and Rescue, Inc. serves eight towns in the Southern Kennebec Valley with a total population of 42,530 (1970 census). This figure increases by 10,000 during the summer months. Rap and Rescue, Inc. in its services deals with both the problems of an urban environment and those problems associated with rural America. The 1970 census indicated that there were 5,001 young people between the ages of 14 and 20 years in this area.

Most of the problems that Rap and Rescue deals with fall into the following categories: suicidal preoccupation, depression, alcohol or drug abuse, domestic conflicts, and law enforcement difficulties. The Center consists of several loosely-organized branches which relate to one another when they coordinate in providing help for the client. The major thrust of Rap and Rescue is:

1. Crisis intervention
2. Alternate activities
3. Follow-up
4. Community outreach programs

The crisis portion of the Center consists of a twenty-four hour facility with telephone and staff support. The operation requires trained staff in the elements of first aid and general counseling. During the course of 1972-1973, more than ten staff members completed American Red Cross Training and participate presently in training sessions on counseling techniques offered by the Kennebec Valley Mental Health Center. Crisis staff receives

training in pharmacology (how to use the PDR), telephone counseling techniques, and emergency crisis procedures. Most of Rap and Rescue's paid staff serves in volunteer positions until they acquire competence in the above areas.

The crisis portion of Rap and Rescue also can provide emergency food and housing for limited time periods, and can dispense drug and health information. Often the Augusta Police Department will bring a case (LSD bummer, alcoholic, speed freak) there rather than incarcerate that individual. Often, Rap and Rescue gets referrals from Augusta General Hospital, in cases who have received emergency aid at the hospital and now must be discharged, but whose recuperation is not complete, are homeless, or have an intolerable home life.

The Alternate Activity Program of Rap and Rescue has set the following objectives:

1. To provide through the availability of a craft workshop, writing classes, rap sessions, etc., a vehicle to combat apathy, boredom, and restlessness, thus stimulating within the individual a sense of worth and accomplishment, an awareness of his or her creativity,

2. To provide contact with peers and staff in the form of games, music, and rap sessions. Here is an opportunity to develop a mutual trust and a place to find help in dealing with day-to-day problems, such as staying in school, seeking employment, or just plain getting one's head straight.

To fill these needs, the Alternate Activities Program was developed in a vacant Augusta State Hospital building known as the Burleigh Building. Here recreational and craft facilities exist as well as meeting area where group sessions and staff meetings are held. Currently, several crafts are being taught.

Groups that are offered include one open to anyone, one for women only, and one for adults and non-related children. It is felt that these groups serve the above objectives by providing peer contact, developing interpersonal relationships, educating participants as to varying life philosophies, and offering participants a forum to discuss their problems openly.

During the week the Burleigh Building is open to the public from 5:00 P.M. until 11:00 P.M. On weekends the facilities open at 12 Noon and close at 11:00 P.M. Although attendance fluctuates from night to night, it has been increasing and attracting new people since the opening of the Burleigh Building in March 1973. Average attendance would probably fall between 20 and 25 people per night.

The staff of Alternate Activities Program consists of a director/coordinator, an assistant, several part-time staff members who may also serve as crisis or follow-up staff as well, and craft instructors.

Follow-up Services:

Because practically all crisis cases handled by Rap and Rescue indicate personal problems beyond the emergency situation, those clients need a continuity of care mechanism to insure that they receive the best services available to them. To accomplish this goal, it is necessary to carefully identify a client's problems and set goals once the client has emerged from his or her "crisis". This task is given to the follow-up portion of Rap and Rescue.

Each client is assigned to a staff worker who will serve as the counselor. Together with the Follow-up Coordinator and his assistant, they discuss the client's problems in terms of the services Rap and Rescue can provide. If Rap and Rescue services cannot solve the immediate problem, a referral is made.

The community outreach programs of Rap and Rescue have existed for several years, but in the past year have formalized and now serve a specific need in the catchment area. Rap and Rescue runs a program at the Kennebec County Jail which is a thorough success both from the standpoint of being accepted positively by the Sheriff's Department and the use prisoners have made of the leather-craft programs.

The basic objectives of the Jail Programs are several fold. Ideally, it is to provide prisoners with any of the services that the Center has available. They cannot come to Rap and Rescue, so Rap and Rescue goes to them. This is based on the assumption that has been verified that many of the prisoners had a history of drug use and abuse and that they would be returning to the community.

The program has been reasonably successful in attracting ex-prisoners to the Center once thy are out on the street. The biggest difficulty, since this is a county jail, is that the Center can only make contacts with men who are in close proximity. An additional success is the willingness of the Sheriff's Department to bring some people to the Center as an alternative to arrest. This newly-developed credibility is a beneficial side effect of the program.

Another component of the Center is the speakers bureau. Information is disseminated and speakers respond to service clubs and groups of adults and schools who seek information or guidance in the subject area of youth problems and drug abuse. This portion of the Center operation has expanded in the past year and will continue to do so as the community learns that drugs are only symptomatic of a myriad of other social and individual problems.

Residential Programs

Kinsman Hall

Kinsman Hall is a private residential treatment center located in Jackmam, Maine. The program was moved to this relatively remote site in northern Maine after experiencing zoning difficulties in New York, the program's original location.

Kinsman Hall houses 80± residents between the ages of 15 and 26. The overwhelming majority of the residents come from outside Maine; many are referred by the courts as a condition of probation. The State Bureau of Corrections has sponsored about 15 clients at Kinsman Hall, through a special arrangement under which Maine clients are accepted at a lower rate of payment. However, the normally high cost of treatment ($1200/month) and the intensive nature of the program make it unsuitable for all but a few Maine referrals.

The 18-24 month treatment program is patterned on the Synanon and Daytop drug-free therapeutic community approach. Residents are exposed to a rigorous regimen of peer group pressure and behavior modification techniques aimed at re-socializing the individual to a more adaptive made of behavior. The marathon group session, lasting from three to seven days, is the core of the program.

Elan I

Elan I is a private residential treatment facility that moved to southern Maine from Massachusetts in 1970. Like Kinsman Hall, Elan I also experienced zoning difficulties in its original location.

Elan I began as a drug treatment facility, but now claims to be a therapeutic private school and is seeking licensing as such. Elan's mode of treatment is a variation on the standard therapeutic community model; residents must earn privileges, are responsible for the maintenance of the house and are exposed to continual peer influence. The two directors of Elan I, a psychiatrist and a graduate of Daytop, feel that Elan I differs from other therapeutic communities in its attempt to build on a resident's strengths, rather than restructure his entire personality.

Residents of Elan I are between the ages of 15 and 26 and are a combination of committed offenders and young people voluntarily admitted by their parents. All but two or three of the 70+ residents come from out of state, the majority referred by the Massachusetts Division of Youth Service. Because the program is oriented toward clients from urban areas, and because the cost of treatment is so high ($1200/month) Elan I is not viewed as a treatment resource, by the State of Maine.

Methadone Treatment Programs

In Maine methadone is used primarily for analgesia in severe pain and short term detoxification. There are no approved treatment programs using methadone nor are there any treatment programs using narcotic antagonists.

In June 1972 the MCDA, in collaboration with the Bureau of Health, surveyed all physicians and drug abuse programs to assess the need for methadone treatment. Most physicians were opposed to methadone treatment, feeling that the scope of the heroin problem did not warrant programs at this time. Staff of the various drug treatment programs concurred in this judgment.

Since all available data indicates that heroin is not a serious problem, the MCDA has not encouraged the establishment of methadone maintenance treatment programs. Programs of treatement for poly drug abuser, who constitute the majority of the drug abusing population in Maine, were seen as a greater priority.

When the new Food and Drug Administration methadone regulations were published in 1973, the MCDA, as the State's methadone authority, notified physicians, hospitals, and pharmacies of the revised application and approval procedures. Fifteen hospitals applied and were approved to use methadone for analgesia in severe pain, for detoxification and for temporary maintenance treatment. Although fifteen hospitals are approved to provide detoxification, the Maine Medical Center located in Portland and the Eastern Maine Medical Center in Bangor are, in pr;ctice, the only hospitals in Maine that routinely provide detoxification services.

State Hospitals

The Maine Department of Mental Health and Corrections administers three psychiatric hospitals; Bangor Mental Health Institute, Augusta Mental Health Institute and the Children's Psychiatric Hospital.

It is the policy of these hospitals to admit persons for treatment whose use of drugs is primarily rooted in the type of psychiatric or psycho-social problems the hospital is equipped to handle. None of the institutions has specialized programs for drug abusers. The hospital administrators, reflecting the policy of the state mental health agency, are engaged in an effort to reduce the population of the State Hospitals by placing more emphasis on community-based care. In facit, the CPH is in process of phasing out of operation completely. Like other hospitals in Maine, the state hospitals are often cited as existing resources in theory, but in practice, they are not.

Veterans Administration Center at Togus

Togus Veterans Administration Hospital operates a limited drug treatment program for inactive service connected drug users. Patients with any other medical or psychiatric problems are not admitted to the program. The treatment program utilizes a combination of psychoanalytic and group therapy techniques. The program treated a total of 56 patients in 1972; the majority of patients were poly drug abusers.

Maine's drug dependent Viet Nam era veterans do not view the VA Hospital as a "place to turn." They feel that the VA program is traditionally oriented toward the treatment of alcoholics, is irrelevant and unresponsive to their needs.

Vocational

Neighborhood Youth Corps

The Neighborhood Youth Corps, a federally funded, statewide program, provides job training, education and skill development for school age drop-outs between

the ages of sixteen and eighteen. It appears that a relatively high percentage of New York City clients are either involved in drugs or are exposed to drug abuse on a regular basis. New York City directors who were polled as part of the planning process, cited a lack of treatment resources for their clients. It was the concenus of the group that New York City could function most effectively as an ancillary service within a system of comprehensive drug abuse prevention and treatment services.

Division of Vocational Rehabilitation

The Division of Vocational Rehabilitation, part of the State Bureau of Rehabilitation, provides traditional vocational rehabilitation services to alcoholics, drug abusers and others who are vocationally disabled. Services include diagnostic evaluation, counseling, physical restoration, individual or group therapy, training and job placement. The Division has offices in all of the State's major population centers. Like the Neighborhood Youth Corps and othe job training programs, the services of the Division of Vocational Rehabilitation are best categorized as ancillary services.

3. Prevention/Crisis Intervention

Community Mental Health Centers

Community Mental Health Centers (CMHC) in York County, Portland, Lewiston, Waterville, Bangor and Ft. Fairfield maintain 24 hour telephone emergency coverage. In cases involving drug abuse, the staff person on duty talks with the individual and attempts to resolve the situation over the telephone. If this is not satisfactory, the staff member may arrange for the individual to be seen by an out-patient counselor, treated in the emergency room or admitted to the CMHC's in-patient unit. In Brunswick and Augusta, mental health center staff usually refer cases involving drug abuse to the drug treatment center.

AIDE Center

The AIDE Center, in York County, is a program sponsored by the York County Extension Service and staffed by volunteers trained at the Drug Dependence Institute, Yale University. Services include counseling, referral and drug information for residents of York County. The program, started several months ago, hopes to expand in order to provide full time counseling services.

Rap Place, Inc.

Rap Place is a crisis intervention, outreach and community education program serving the Lewiston-Auburn area. Funded through the U.S. Office of Education and the MCDA, Rap Place operates a 24 hour hotline; a walk-in clinic for counseling, information and referral; a food co-op; and alternative activities. Rap Place is funded from the U.S. Office of Education for the community education and training components of its program. Rap Place maintains a good working relationship with Tri-County Mental Health Services, and uses the CMHC as a referral for individuals requiring hospitalization or professional counseling. In addition to its activities in the Lewiston-Auburn area, Rap Place has conducted drug information programs at Augusta State Hospital, Maine State Prison and the Men's Correctional Center.

4. Education and Training

Maine Drug Education Program

The Maine Drug Education Program, a part of the State Department of Education and Cultural Services, has been in operation for three years. Throughout this time, the MDEP has developed a comprehensive training program in drug abuse prevention.

The MDEP recognized the futility of trying to scare young people into acceptable behavior, and has developed and promoted programs which affect the self-concept and problem solving abilities of youth. The National Drug Education Program of the U.S. Office of Education has published management objectives for FY '73 programs which reflect the philosophy the State of Maine has been operating from for three years. The MDEP is funded, in part, through a grant from the U.S. Office of Education.

> "The program purpose of the National Drug Education Program of the U.S. Office of Education is to bring about certain conditions in communities which are thought to relate to a reduction in drug abuse:
>
> Open communication among youth, parents and teachers.
>
> An availability of meaningful alternatives to the abuse of drugs.
>
> Potential abusers having a purpose in living and a feeling of control over their own lives.
>
> A willingness on the part of people to accept the validity of experimenting with alternative life styles not involving the abuse of drugs.
>
> A shift in immature individuals' value structures away from placing immediate gratification first and foremost.
>
> An improved perception of what the consequences of drug abuse are -- physiological, psychological, social and legal."

During the first two years, the MDEP training program consisted of one week, live-in Leadership Training Institutes for community teams. Six workshops trained 66 community teams and a total of 450 people. One result of this training was a multiplier effect, whereby the teams, trained by the MDEP in skills for diagnosing problems and planning community action, trained additional community people who in turn created action programs.

During the past year the MDEP has concentrated its efforts on teacher training and curriculum development. MDEP conducts workshops for elementary teachers in the use of Human Development programs. These programs focus on children's skills in the areas of awareness, self-concept, and social interaction. Two workshops will be financed by local school districts and

will be for all the elementary teachers in those districts. The others will be conducted in five different regions of the state and will be attended by teachers from a large number of school districts. Approximately 580 teachers and administrators will receive training.

The MDEP also sponsors workshops at which trainers from NIMH train school/community teams in the use of the Social Seminar Series.

Last year MDEP produced Maine's first drug policy manual for school administrators. "Developing School Drug Policy: A Guide for Administrators" - was distributed to all superintendents as an aid in the formulation of school drug policy. Rather than putting forward a model policy, the manual suggests alternatives that school's might consider in developing the policy best suited to their needs.

The MDEP maintains a close working relationship with the Maine Commission on Drug Abuse. The Director of the MDEP is a member of the Commission and chairman of the Commission's Education Subcommittee. The Commission performs a review and comment on all MDEP budget requests and grant proposals. In addition, the Commission receives a copy of the MDEP's quarterly report to the U.S. Office of Education.

Drug Dependence Institute

Teams from eight Maine communities have been trained at the U.S. Office of Education Drug Dependence Insitute at Yale University. The teams, representing a cross section of the community, attend Yale University for two weeks of training in drug education and community organization. Due to a lack of effective follow-up, these community teams are, for the most part, underutilized community education resources. There are a few outstanding exceptions such as the York County group responsible for the A.I.O.E. Center in Sanford.

The following is a list of teams from Maine that have attended the Drug Dependence Institute during 1973:

Roland Beaulieu
Van Buren Drug Education and
Prevention, Inc.
P.O. Box 5
Van Buren, Maine 04785
207/868-2855 Project Number: 1124

Earl M. Redwine, Jr.
Aroostook County Action Program
P.O. Box 1116
Presque Isle, Maine 04769

Rufus Bernard
City of Caribou, Police Department
25 High Street
Caribou, Maine 04736
207/493-3301 Project Number: 1011

Donald R. Clavette
Madawaska Jaycees
P.O. Box 70
Madawaska, Maine 04756
207/728-7186 Project Number: 1006

Dana R. Lear
Knox County Community Action
431 Maine Street
P.O. Box 808
Rockland, Maine 04841
207/596-6601 Project Number: 1002

Local School Programs

More than eighty per cent of Maine's school districts provide educational programs designed to affect student attitudes toward drug use and abuse. Most oftern the classroom teacher and/or the health education teacher are responsible for drug education programs. The State Department of Educational and Cultural Services has not developed a uniform statewide drug education curriculum, although most schools indicated that they feel this would be helpful.

The State Department of Education and Cultural Services recognized this problem, but given its limited resources, has had to concentrate its efforts on drug education in-service training programs for teachers.

DRUG EDUCATION CURRENTLY USED IN SCHOOLS

Educational Approach			Program Responsibility		
Information	41	80.3%	Classroom Teacher	27	52.9%
Value-Orientation	19	37.3%	Health/Phys.Ed.Teacher	21	41.2%
Decision Making	16	31.4%	Program is integrated	20	39.2%
Psycho-Social Orientation	9	17.6%	Guidance Counselor	11	21.5%
Problem Solving	8	15.7%	None	3	5.8%
			Principal	1	2.0%
Presentation			**Source of Material**		
Lectures	31	60.7%	State Dept. of Education	32	62.7%
Group Discussions	26	50.9%	Commercial	24	47.0%
Films	23	45.0%	Teachers	23	45.0%
Standard Curriculum	18	35.4%	Publisher	19	37.3%
Assemblies	17	33.3%			
Student Research	14	27.3%			
Ex-Addict Talks	12	23.6¢			

University of Maine

a. Teacher Education

A summer course dealing with drugs, alcohol and tobacco was offered at the Orono Campus during the summers of 1971-1972 but it has been discontinued. Drug related information is included in Health Education courses; however, these courses are not a requirement for individuals preparing to be teachers. CSS.01 Drugs: Attitudes and Behavior.

The University of Maine Portland-Gorham is offering a 45 hour program for teachers and others confronted with drug abuse and its related problems. The program is taught by a team of four professionals and stresses factual information, attitude identification, causes of drug abuse and individual and community response to the drug problem. The program incorporates a variety of teaching methods and group dynamic techniques in order to allow the participants both the informational and experiential background needed to understand the nature of the drug problem and what can be done about it.

The University offers a variety of courses in group dynamics, group interaction in the classroom and group counseling. These hum relations courses are optional, and are probably not taken by a majority of teachers.

Each campus seems to have counselors or other personnel who run various kinds of personal growth groups. These are very informal and not a part of the University program of studies and not necessarily viewed as an integral part of its counseling services. These groups would not be participated in by a majority of teachers.

b. University Counselor Training Program

There are no programs in the counseling curriculum which prepare counselors for dealing with drug abusing individuals.

The University of Maine's Counselor Education Programs at the Portland-Gorham and Orono Campuses have a number of group guidance, group counseling and other courses which are human relations studies. These courses are required for counselors who are seeking a Master's Degree in Guidance or a Certificate of Advanced Study in Guidance. The courses stress a balanced approach to using group work in the schools. This is particularly valuable in Maine, since few school systems permit personal growth sessions that are intensive or seen as sensitivity training to operate. Counselors themselves are exposed to a number of group experiences in human relations training. The Maine Personnel and Guidance Association has sponsored a number of workshops in psychodrama, group dynamics and other human relations concepts for counselors.

5. Criminal Justice System

The drug traffic prevention resources of Maine's criminal justice system are concentrated in five of the State's larger communities: Portland, Lewiston, Bangor, Waterville and Rockland. Police in these communities have a special unit or at least one officer who devotes full or part-time to drug abuse law enforcement. Local law enforcement agencies in Portland, Bangor and Lewiston alsohave Metropolitan Enforcement Groups (MEG Units) which are undercover investigative units specializing in drug law inforcement. The MEG Units are partially funded through grants from the Maine Law Enforcement Planning and Assistance Administration (MLEPAA).

In June 1973 the Maine Commission on Drug Abuse was awarded a grant from LEAA to study drug abuse and the Maine criminal justice system. The study report is based on an attitude and opinion survey of Maine Police Chiefs, County Sheriffs, County Attorneys and District Court Judges. This study provides a good picture of drug abuse law enforcement practice and policy.

The following tables, taken from the study report, reflect law enforcement priorities, prosecutorial policies and attitudes toward treatment and rehabilitation for drug offenders.

LAW ENFORCEMENT PRIORITIES

	Police Chiefs	Sheriffs
High investigative priority given to:		
Possession:		
Marijuana	34%	28%
Other drugs	44%	50%
Sale:		
Marijuana	46%	35%
Other drugs	58%	64%
Percent who present every drug arrest for prosecution . . .	70%	64%

Prosecutorial Policy

	Maine County Attorneys	National* District Attorneys
Routine prosecution of individuals charged with:		
Possession:		
Marijuana	67%	60%
Other drugs	94%	60%
Sale:		
Marijuana	94%	60%
Other drugs	94%	N.A.

* From a 50 state survey of District Attorneys conducted in August 1971 by National Commission on Marijuana and Drug Abuse.

Treatment and Rehabilitation

	Police Chiefs	County Sheriffs	County Attorneys	Judges
Percent who favor:				
1. Voluntary treatment	98%	93%	100%	100%
2. Use of public funds for treatment programs	92%	93%	100%	100%
3. Treatment in lieu of prosecution	52	57%	67%	58%
4. Treatment as a condition of probation	90%	86%	100%	100%
5. Treatment while sentenced to correctional facility	88%	86%	94%	92%
6. Treatment as a condition of parole	90%	64%	94%	92%

The criminal justice system provides only minimal evaluative and treatment services at the law enforcement, court and county jail level. There are no specialized services for drug offenders at the level of the criminal justice system.

Somewhat better treatment services are available at State Correctional facilities, but, again, these are limited. The correctional institutions generally have ratios of 70-100 inmates per full time psychologist or social worker.

Maine has five correctional institutions: Maine State Prison, Men's Correctional Center, Women's Correctional Center, Boys Training Center and Stevens School for Girls. These institutions are administered by the Bureau of Corrections which is part of the State Department of Mental Health and Corrections.

Maine State Prison

Maine State Prison (MSP) is the State's maximum security facility and with a daily population of 373, is the state's largest penal facility. The prison psychologist estimates that 10% of the prison population is incarcerated on drug offenses and that more than 70% of the population are drug users. With the exception of Congenial House, a self help group directed by inmates with drug abuse problems, there are no specialized services for drug dependent inmates.

Men's Correctional Center

Men's Correctional Center in South Windham is a reformatory for offenders sentenced for under one year. The daily populations averages 103, with an estimated 80% of the inmates having used drugs. The institution has no drug treatment program, although several MCC staff have been trained at Maine Drug Education Program Workshops.

Women's Correctional Center
Boys Training Center
Stevens School for Girls

During 1972 the Bureau of Corrections employed a part-time (4 hours/week) consultant to conduct a drug abuse in-service training program for staff of Women's Correctional Center, Stevens School and Boys Training Center. Within the limited time available, this counselor also attempted to do some drug counseling with residents of these institutions.

Each of the five institutions provides services intended to better prepare the inmate for life outside the institution. Because many of the inmates have low socio-economic and educational attainment, treatment and rehabilitation programs are aimed at improving the inmates's potential in these areas.

Drug offenders consitute a different type of inmate. Often they are more motivated and have higher educational attainment. Staff of the institutions feel that existing institutional treatment and rehabilitation programs do not "reach" the drug abusing inmate, and indicated a need for more counseling services for the drug involved offender, in addition, to more training for themselves.

Probation and Parole

The State Bureau of Corrections also includes the Division of Probation and Parole. Large caseloads and inadequate back-up services in the community limit the Division's role as a treatment resource.

Thirty one of Maine's forty Probation and Parole officers were surveyed to elicit their perceptions of the extent of drug abuse in their regions. They were also asked to indicate the number of clients in their caseload who might benefit from residential treatment, day care, counseling and/or after care. The table below represents the results of that survey:

PROBATION AND PAROLE

Residential	Day Care	Counseling	Aftercare
15	6	20	19
43	30	65	0
47	10	118	2
0	0	34	5
105	46	237	26

Education and Training

The Maine Criminal Justice Academy offers two week and three day Drug Schools for law enforcement personnel taught by agents of the Federal Bureau of Narcotics and Dangerous Drugs. The courses focus on drug identification, laws of search and seizure, undercover techniques, and other enforcement related areas, and are offered throughout the nation.

In addition to the training resources of the Maine Criminal Justice Academy, The MLEPAA has awarded numerous small grants to local law enforcement agencies for drug abuse education and training. A list of all such grants awards since 1969 is attached.

LEAA GRANTS: DRUG ABUSE EDUCATION AND TRAINING

1969 - Auburn, Narcotics training for one officer. Surveillance of drug activity to result. $1,747.

1969 - Drug Abuse Seminar for 200 officers. Maine Law Enforcement Council. Exposed officers to nature and scope of drug scene they must curtail. $446.

1970 - South Portland. Pamphlets and other materials for drug education presentation. 2500 sets distributed at series of meetings directed at school age persons. $1,098.

1970 - Brunswick. Public information on Dangerous Drugs. $308.

1970 - Bath. Purchase materials and equipment to conduct drug education program. (over 1600 persons attended) $775).

1970 - Portland Council of Governments. Narcotics Law seminar for 70 police and prosecutive officers. $869.

1970 - Maine JC's. Purchase and use of 25 Smart-Teens Drug Education Kits. $312.

1970 - Department of Health and Welfare. Drug materials for distribution, and films. $5000.

1970 - Brunswick, Bangor and Auburn. Three officers to attend BNDD training progra;. $3,360.

1970 - LEAA Central Office - 4 week workshop in alcohol, tobacco and dangerous drugs with the Regional Medical Program for 3 police officers and 6 coorectional personnel. $2,409.

1970 - Cumberland County Sheriff Department. Drug Education Program. $3,900.

1971 - Maine Commission on Drug Abuse. Project to expand the resources of the MCDA by staff person attending the District Attorneys Drug Workshop. $470.

1971 - South Portland Youth Services Bureau to curb youth problems, one of which is drug abuse. $13,516.

1972 - (April) Bangor PD. Attendance at BNDD training course. $1,862.

1972 - (April) LEAA Central Office. Attendance at N.E. School of Alcohol Studies. $1,375.

1972 - (September) American Bar Association National Institute for Prosecution and Defense of Drug Cases. Cumberland County Attorney. $1.193.00.

Same institute. Hancock County Attorney. $543.

LEAA Grants - continued -

1972 - (September) Maine State Prison. Drug Counselor. $1,717.

1972 - (November) Lewiston/Auburn PD. Regional Service Unit for Narcotics and Organized Crime. $46,975.

1973 - (February) Cumberland County Sheriff. Residential treatment center for drug abusers in a highly structured, drug free environment. $36,225.

1973 - (February) BNDD Workshop. Calais PD. - $427, Rumford PD. - $577.

6. Public and Private Employer Programs

A questionnaire was distributed to personnel managers of Maine businesses. Twenty-three businesses replied to the questionnaire. In 1972 the personnel managers estimated that a total of seventy-one full-time employees in their businesses had a drug problem which came to their attention. These incidences were handled in various ways; eight were handled by in-house counseling, eight by referring to a helping agency, four by referral to clergy, and one by referral to a physician. In only four of the seventy-one incidents were the employees dismissed. It was also stated that sixteen of the individuals who had alcohol or other drug problems were no longer employed as a result of their problem.

Seventeen employers indicated an interest in drug education, six indicated they did not know if drug education should be presented. Ten of the employers indicated they provided a drug education program. These programs varied from distribution of pamphlets, to workshops given by a trained team. It is interesting to note that only one employer felt his business definitely did not need a drug education program.

DRUGS USED IN PROBLEM INCIDENTS

Alcohol	42
Drug Unknown	18
Marijuana	9
Narcotics	2
Total	71

7. Program Management and Coordination Resources

Overall coordination of the development, administration and evaluation of drug abuse services is the responsibility of the Office of Alcoholism and Drug Abuse Prevention. The Drug Program Specialist on the staff of OADAP is responsible for maintaining effective liaison with state and federal agencies, regional coordinating councils and drug abuse programs.

The Drug Program Specialist assists with communities and state agencies in the development of program proposals. All requests for state or federal funds are reviewed by the staff of OADAP and then by the Review and Comment Committee. The OADAP staff performs a similar review and comment function on all State Plans which impact on the Drug Abuse Plan.

Proposals for state funding are evaluated by the Review and Comment Committee to assure consistency with the OADAP Grant Guidelines. Recommendations of the Review and Comment Committee are submitted for consideration by the full Advisory Council.

The Southern Regional Drug Abuse Council effects coordination in Southern Maine through technical assistance in proposal development and through its review and comment function.

The Regional Coordinator, as representative of the Council, works with local groups in designing new components of existing programs, or in designing new community-based services. The Regional Coordinator reviews the program to insure consistency with the area's total delivery system, including the functions of the CMHC, hospitals, schools and other drug abuse services. Proposals are also expected to conform with the goals and objectives outlines in the Southern Regional component of the State Drug Abuse Prevention Plan.

Review and comment is a joint function of the Southern Regional Drug Council and Southern Maine Comprehensive Health Association, the area's "b" agency. Both of these groups are made up of consumers and providers of service and are an excellent means of coordinating service as their representation is extremely broad. The Review and Comment Committee of the SRDAC evaluates all program proposals to assess the extent to which the proposal will duplicate or supplement existing services. The recommendations of this Review Committee are voted on by the full membership of the Regional Drug Abuse Council, which is made up of consumers and providers of drug services. The review and accompanying comments are then sent to SMACHA, which reviews the proposal from a health planning perspective. Proposals approved at the regional level are forwarded to the OADAP, where the second level of coordination takes place.

IV Needs and Gaps in Services

A. Objectives

Maine has developed immediate and long-range objectives for implementing the State's overall goal of reducing the incidence of drug abuse. These objectives are based on available data indicating the extent of the drug abuse problem and on an assessment from existing resources. The first objective is related to resolving problems of information management and program administration. The second and third objective relate to expanding existing services and developing additional resources.

Objectives FY 1974-75

1. Establish management, coordination and support services.
   a. implement a statewide management information system
   b. assure continued funding and operation of existing drug abuse services
   c. secure necessary resources to carry out OADAP responsibilities
   d. regional coordination in Southern Maine
   e. effective utilization of SPD process
   f. establish mechanism for ongoing planning that will insure adequate community input

2. Augment prevention, treatment and education resources of existing service delivery system.
   a. improve coordination between drug treatment services and criminal justice system
   b. train physicians and appropriate hospital personnel in management of acute drug cases, including detoxification procedures
   c. train school, CMHC, social welfare and law enforcement, professionals and paraprofessionals to recognize and deal with drug-related problems
   d. Assist local schools in development of school drug education and discipline policy

3. Provide additional resources in areas with fewest services and/or highest incidence of drug abuse
   a. outreach counseling and referral services for youth in Northern Maine
   b. prevention and treatment services available to all Indian communities
   c. drug abuse education and treatment resource for staff and inmates of Maine State Prison and Men's Correctional Center

d. implement alternative sentencing provisions of Public Laws of 1973 Chapter 566 - begin work on additional legal mechanisms, including pre-trial division

e. Sponsor innovative educational, recreational and vocational alternatives to drug abuse

Long-Range Objectives

1. Develop a coordinated system of comprehensive services that will be available and accessible to all drug abusers.

2. Keep existing services relevant to changing needs through:

   a. staff training

   b. statewide management information system

   c. ongoing evaluation

3. Cooperate in the development of coordinated youth services using multi-funding mechanisms.

4. A Uniform Controlled Substance Act for Maine that will include provisions for pre-trial diversion of drug-involved offenders and realistic penalties for drug offenses.

5. Identify common needs and resources applicable to both alcohol and drug programs.

B. Analysis of Problems, Present Responses and Identified Gaps in Service

The following analysis looks at the problems identified during the planning process, relates them to existing resources capable of addressing the problem and indicates areas where there are gaps in services. Some of the identified gaps in service are due to the fact that existing health, mental health, social welfare and criminal justice agencies do not have adequate training, staff or resources to address the needs of the drug abusing population. In other areas where gaps in service occur, there simply are no existing resources to build on and new responses will be needed.

C. Identification of Response Areas to be Increased or Reduced

The analysis of problems, present responses and identified needs and gaps in service indicates a need for increased responses in the areas of data collection and retrieval, program management and coordination, prevention, treatment, training and legislation. Agencies responsible for the State's current data collection efforts must be asked to add appropriate drug abuse categories to existing systems. Also, they must be educated in the use of the proposed management information system.

The basic framework for overall program managment and coordination exists in the legislation establishing the single State drug abuse authority. However, inadequate staff and resource prevent the single State agency from increasing its program management and coordination capability to meet the growing need for coordination.

Agencies currently involved in meeting the health, mental health and social welfare needs of the general population must be given the mandate and sufficient resources to address the needs of the drug abusers among their target population.

Recently enacted legislation, PL of 1973, Chapter 566 provides the foundation for legal alternatives to incarceration. This initial legislative response must be expanded to include additional alternatives such as pre-trial diversion programs.

D. Identification of New Responses

An increase in poly drug abuse in all regions of the State, combined with a paucity of existing drug abuse resources argue the need for new responses in almost every area of drug abuse prevention. Additional resources in the form of funding, trained manpower and local commitment are necessary if Maine is to implement a managment information system; design a system for statewide development and coordination of drug programs; conduct effective long-range planning; provide client services in areas where these are lacking; and conduct effective programs of public information for the people of Maine.

E. Constraints

A reluctance to report instances of drug abuse and inadequate resources are the principal constraints which hamper the planning process.

The difficulty in obtaining drug related data from social welfare and criminal justice systems impeded a clear assessment of the nature and extent of the drug abuse problem. It is impossible to plan needed services when the agencies upon whom one relies for information do not keep adequate records or, if they do, will not report them. There is, for example, no uniform criminal justice reporting system and no accurate method for recording drug related deaths. This aversion to reporting data stems, in part, from Maine's traditional reticence about individual or family problems.

Some data was available from the three drug treatment programs through the CODAP and NIMH reporting systems. However, the three programs are not broad enough in scope to give us management information on which to plan for additional services.

The lack of data compounds the existing problem of inadequate funding for drug services, as funding at both the state and federal level is linked to the ability to document the drug abuse problem. Lack of funds inhibits our ability to take decisive action in areas where there are service needs and hampers the establishment of a management information system which is vital to effective long-range planning.

While the lack of an adequate data retrieval system results in a conservative baseline estimate of drug use and abuse, the indicators do arue the need for a comprehensive coordination of effort and for the development of additional services.

F. Consistency and Coordination with Other Plans

Review of and consistency with other state plans is maintained formally through the A-95 review process within the State Planning Office. The State Planning Office, with eight regional planning offices, is mandated to coordinate the flow of federal funds assuring maximization of those resources and an appropriate, non-duplicative development of federally funded activities. In addition to its own central office and regional office assessment of funding proposals, the State Planning Office has representatives in each agency of state government who receives weekly listings of funding proposals.

The Office of Alcoholism and Drug Abuse Prevention receives and reviews these weekly listings. When these contain something relevant to drug abuse activities OADAP staff contacts the applicant agency for in-depth review of those provisions related to drug abuse. Inconsistancies with or duplication of parts of the drug abuse state plan can then be arbitrated between the parties directly concerned. Should this effort not result in acceptable conformance to the drug abuse state plan, then a formal review system is maintained by the State Planning Office.

Coordination of state planning efforts, in order to be effective over time, must be maintained through the cooperation and good will of those individuals having responsibility for such activities. This informal, though critical, process is fostered by having Office of Alcoholism and Drug Abuse Prevention staff sitting on various advisory boards and assigned as liaison with specific agencies. In these ways relationships are developed that open communication and foster a sense of cooperation.

It is through the above processes and a direct review while compiling data for this plan that a review of various state plans was conducted. Consistency with the several plans cited in the regulations was not a problem. Drug abuse, despite objective and subjective documentation, is not admitted as being a problem of concern, if it is mentioned directly in those plans. Broadly speaking two trends come out of the state plans as a group. Either minimal reference is made to a willingness to treat the drug abuser in conformity to a regulation (e.g. Vocational Rehabilitation) or the drug abuser is ignored while a general effort is to provide generic services across the board (e.g. Mental Health Centers).

More specifically Section 314(a) and 314(b) plans indicate little or no concern for drug abuse. Activities with respect to drug abuse vary from place to place with Portland showing the highest concern. Planning, though not extensive, is coordinated and a staff person is funded by the Single State Agency through the local agency.

The Mental Health Center Plan is largely concerned with the administrative objectives of decentralization into local communities with increased autonomy for planning and service development and delivery. Since treatment is emphasized in terms of developing comprehensive care, drug abuse is not a priority per se.

The Alcoholism and Alcohol Abuse Plan makes no mention whatsoever of drug abuse, except to note that alcohol is considered to be a drug.

Vocational Rehabiliation and Social Welfare plans refer to drug abuse as an

allowable disability subject to the operating procedures governing treatment in thos agencies. No special emphasis is made toward serving the drug abusing population or pursuing anything other than a passive role in treatment.

LEAA is taking an indirect approach to drug abuse by emphasizing training and education for juvenile justice personnel and by fostering general rehabilitation and treatment for the public offender population. Again, we see the trend toward generic services for broadly defined populations in need.

The Education Plan does contain specific reference to drug abuse trainings directed toward public school teachers, guidance counselors, and administrators. Although a visible emphasis is made within the plan, the unit assigned to carry out training and curriculum development has only two staff members. We consider, however, that the specific reference to drug abuse in the plan is at least a fair acknowledgement that a problem exists and is worthy of being dealt with.

Duplication of services with respect to drug abuse specifically does not seem to be a problem given the general tone and direction of the various state plans. Consistency with the Drug Abuse State Plan, on the other hand, is a marked problem because only minimal reference to and activity for the drug abusing population is evident. Initial consistency with our State Plan, then, becomes a matter of focusing the activities of other agencies upon drug abuse as a problem requiring action. The Office of Alcoholism and Drug Abuse Prevention also recognizes its responsibility to assure that specific efforts in drug abuse are made by governmental and non-governmental agencies, organizations, and groups and that these efforts are non-duplicative and consistent with the overall, statewide drug abuse strategy.

The Federal regulations are explicit with respect to activities which will assure the capability of the state agency to carry out its coordinating function. The activities prescribed by regulation are sufficient in specific terms to allow the state agency to fulfil its responsibility. In addition, the Office of Alcoholism and Drug Abuse Prevention has direct access to the A-95 review procedure through a cooperative State Planning Office, to help assure coordination. We also have the benefit of the agreement between NIMH and the State of Maine for technical assistance through the State Program Development process. We have an interdepartmental coordinating committee established by P.L. 566 (appendix) to assure the cooperation of governmental agencies in the drug abuse effort. We also have a stipulation that OADAP's recommendations in its annual report will be binding upon operating agencies of state government. These and other mechanisms, such as the State Advisory Council, regional advisory councils, and a competent staff, assure that the Office of Alcoholism and Drug Abuse Prevention has the support and capability to effectively deal with the drug abuse problem in the State of Maine.

More specifically the State Agency is mandated by state law to provide consultation to other state and local agencies with respect to the planning, development, and implementation of drug abuse efforts. The State Program Development agreement assures the cooperation and coordination of drug abuse efforts within the mental health community. Mutually agreeable goals and objectives are being jointly developed at this time in an effort to specify activities subsumed under the drug abuse priority item in the NIMH/Maine SPD contract.

Since the single state agency for drug abuse is now part of the Department of Health and Welfare a closer relationship to health planning should become evident. Although being in the same umbrella agency does not necessarily insure cooperation and communication, reasonable proximity does assure the possibility of interaction. We are confident that our staff coupled with both state and federal mandates will be able to successfully coordinate health services planning with respect to drug abuse efforts.

Project applications coming from the major federally funded governmental agencies, including Section 410 application, will be reviewed according to drug abuse regulations. The Office of Alcoholism and Drug Abuse Prevention will prepare a written evaluation of 410 project applications including comments on the relationship of the project to other projects pending and approved and to the State Plan. This evaluation will be submitted to the Secretary within 30 days of receipt of application with a copy furnished to the applicant. Community Mental Health Center 256 applications will be reviewed and commented upon within 30 days of receipt.

In addition to OADAP staff evaluation all proposals for federal funding will be submitted to a review and comment committee of the state advisory council when this procedure can be carried out without undue delay. Review by the state advisory council should help assure the input of approriate segments of the community into the funding process.

The A-95 review mechanism, with its weekly notices and with responsible officials identified in various agencies as primary reviewers, will be a final assurance that agencies and authorities having interests or responsibilities related to project and program proposals will have reasonable opportunity to review such proposals.

Although such mechanisms as A-95, SPD, Interdepartmental Coordinating Committee, etc., are useful in information exchange and coordination, other sources for information gathering and dissemination are necessary. For example, specific program data must be gathered from treatment agencies even though they rarely use drug abuse as a primary diagnosis or problem and may not be receiving specifically earmarked federal or state money. We anticipate having to sell treatment agencies the value of participating in a statewide information system consistent with federal information systems. Selling should become easier as data from an incidence and prevelance study becomes available and as more money for treatment begins to funnel to the community. (A full discussion of our management information system is contained in Section of this Plan.)

Incidence and prevalance data, social indicators of drug abuse, and treatment specific information are all necessary, but begs the question of using and disseminating results. We, therefore, anticipate building upon an at least annual report of the Office of Alcoholism and Drug Abuse Prevention's activities. This document can be used by the advisory council in public information efforts and by agency staff for political and consultative efforts. The annual report and any interim reports must, therefore, serve a number of functions. Analysises of objective data from our information system must be used not only descriptively, but as a basis for providing advice and guidance to state and local governmental officials and our legislators.

It is necessary for OADAP to intervene in the policy and planning functions of this state in order to insure the effective resolution of our durg abuse problems. The stipulation that the Office's report and recommendations are advisory to the Governor and Legislature and binding upon the operating agencies gives us the basis for redirecting public policy on all matters pertaining to drug abuse prevention functions. The catalyst of public dissemination of information through the media will at least insure that our voice is heard.

G. Ranked and Priced List of Needs in Priority Order

NEED	PRICE
Effective system for development and coordination of drug abuse programs	$43,000
Statewide management info rmation and evaluation system, including incidence and prevalence survey	$50,000
Programs of prevention and outpatient treatment in Bangor, Rockland, Presque Isle and Caribou	$75,000
Programs of prevention and outreach counseling for users in rural areas	$45,000
Education, vocational and recreational alternatives to drugs for at risk population in urban and rural areas	$45,000
Special study to asses incidence of drug abuse among Indians and development of programs in response to need	$40,000
Training for school, CMHC, hospital, health care and criminal justice personnel in needs of drug abusing population	$50,000
Drug abuse treatment services at Maine State Prison	$15,000
Technical assistance for school administrators in the development of school drug policy	$10,000
Effective program of public information	$22,000

B. Analysis of Problems, Present Responses and Identified Gaps in Services

PROBLEM	RESOURCES	GAPS	NEEDS
Incidence of drug abuse is not reported in any consistent, usable fashion; incidence is often under reported or not reported	Limited hospital, health care, mental health and criminal justice data systems	No statewide management information and evaluation system	Management information system Prevalence and incidence survey Educate reporting agencies to use management information system
No statewide development and coordination of drug abuse programs	OADAP SPD State Planning Office	System for development and coordination of drug programs No mechanism for long-range planning	Sufficient staff, resources, local committment & input, effective managment information and evaluation system
Large at risk population in both rural and urban areas	Drug Rehabilitation, Inc. Brunswick Drug Center Augusta Rap & Rescue CMHC	No services north of Augusta No awareness by CMHC of at risk population among their clients	Prevention & Treatment in areas without services, subject to need educate CMHC staff to be more aware
Urban: use of amphetamines, barbiturates, marijuana and some narcotics	DRI Brunswick Augusta Rap & Rescue Limited detoxification services CMHC	No services in urban areas north of Augusta	Prevention and outpatient treatment services in Bangor, Presque Isle, Caribou, Rockland Develop detoxification services where appropriate Educate staff of ancillary services to relate needs of drug abusers, e.g., health, mental health, social, crimina justic agencies
Rural: use of inhalants, pills, and marijuana frequently in combination with alcohol	CMHC	Trained staff and resources to address needs of rural drug abusing population	Staff trained in youthful drug abuse Additional outreach counselors in each mental health region (8)
Increasing poly drug abuse among Indian	none	Accurate information regarding prevalence and incidence of drug abuse Capability to respond to needs of this population	Special Study to assess extent of problems Indigenous drug abuse prevention education and treatment services

PROBLEM	RESOURCES	GAPS	NEED
Traditional services are not reaching potential clients who are drug abusers	OADAP SPD	Awareness of needs of drug abusing population and ready willingness to serve this population	Effective use of OADAP enabling legislation Additional staff and resources, using multi-funding mechanisms Agency education & training
Lack of drug education and discipline policies in local schools	MDEP "Guide for Adminstrators: Developing School Drug Policy."	Technical assistance in development of school drug policy	Educate school adminstrators to use MDEP Guide and to assist them in development of policy suited to local needs
Increasing numbers of drug offenders in state correctional facilities	Self-help group at Maine State Prison limited alternatives to incarceration	No services in four out of five correctional institutions No professional services at Maine State Prison	Correctional personnel trained in working with drug abusers Mechanisms for pre-trial diversion Drug Counselor at Maine State Prison
Negative public attitudes toward drug abusers	Media National Drug Abuse Information Clearinghouse	Mechanism for using existing resources	OADAP and State Advisory Council given resources to increase capability to use existing resources to better inform public

V. Action Agenda

This section outlines the needs identified through the planning process, indicates action resources and potential sources of implementation funding.

OADAP, the single state agency, will assume primary responsibility for carrying out the Action Agenda. Since OADAP Was such an important role in organizing an effective statewide drug abuse prevention effort, the action agenda for the first year places heavy emphasis on obtaining the resources required for statewide systems of management, information, coordination and planning. The implementation of the needs outlined in Section IV are critically dependent on the development of an effective single state agency, capable of responding to demonstrated needs.

The agencies listed in the Action Agenda are all potential mechanisms for implementation. Allocation of resources will be contingent upon the ability of the OADAP to work with these groups in developing program and funding proposals capable of meeting state and federal guidelines.

V. Action Agenda

Objective	Need	Action Resource	Annual Cost	Local/State	Federal	Source	Deadline for Implementation
Establish management, coordination and support services -assure continued funding and operation of existing services -regional coordination in southern Maine -effective utilization of SPD, State Planning Office -secure necessary resources to carry out OADAP responsibilities	Effective system for development and coordination of drug programs	OADAP Southern Me.Comprehensive Health Association via Southern Regional Drug Abuse Council	$43,000.	$10,000.	$33,000.	409	1/1/74 OAD 4/1/74 reg coordinati
-management information system	Statewide management information system Prevalence & incidence survey	OADAP via contract	$50,000.		$50,000	409	1/1/75 mgt information system 7/1/74 sur
Provide additional resources in areas with fewest services and/or highest incidence of drug abuse	Prevention and out-patient services in Bangor, Rockland, Presque Isle, Caribou	Counseling Center Mid-Coast M.H. Clinic Community Action Aroostook M.H. Clinic	$75,000.	$25,000.	$50,000.	409 410 H-80	9/1/74
	Prevention and outreach counseling for users in rural areas	Extension Service	$45,000.	$15,000.	$30,000.	409 410 H-80	9/1/74
	Educational vocational and recreational alternatives to drugs for at risk population in orban and rural Maine	MDEP Rap Place, Lewiston AIDE Center, Sanford Community Action groups	$45,000	$10,000.	$35,000.	409 U.S.O.	7/1/74 E.

V. Action Agenda (continued)

Objective	Need	Action Resource	Annual Cost	Local/State	Federal	Source	Deadline for Implementat
	Study incidence & prevalence of drug abuse in Indian communities and respond according to need	Maine Dept. of Indian Affairs	$40,000	$10,000	$30,000	409 410 Bur. of Indian Affairs	9/1/74
	Drug abuse prevention and treatment services at Maine State Prison	Bureau of Corrections	$15,000	$ 3,000	$12,000	LEAA	7/1/74
Augment prevention treatment and education resources of existing service delivery system	Drug abuse training for school, cmhc, hospital, health care, criminal justice personnel and staff of ancillary services	OADAP via MDEP University of Maine Bureau of Health Southern Regional Drug Abuse Council Criminal Justice Academy	$50,000	$10,000	$40,000	410 USOE H-80 LEAA	1/1/75
	Technical assistance for school administrators in development of school drug education and discipline policy	OADAP via MDEP Southern Regional Drug Abuse Council State Superintendents Assoc.	$10,000	$ 5,000	$ 5,000	410 H-80	1/1/75
	Effective programs of public information	OADAP State Advisory Council	$22,000	$10,000	$12,000	H-80 USOE	1/1/75

V. Action Agenda

B. Proposed Budget for Allocation of 409 Funds

Project	Cost
Statewide and regional system for management, information, for coordination and planning for drug abuse prevention	$33,000
Management information and evaluation system	$30,000
Incidence and Prevalence Survey (general population and Indians)	$25,000
Direct client services in rural and urban areas and on Indian reservations	$40,000
Programs of prevention for at risk population (training, alternatives)	$15,000

Ten percent of all Section 409 funds will be withheld by the Bureau of Rehabilitation to cover administrative overhead incident to OADAP's supervision of the implementation of Section 409 funded projects. All projects identified for proposed funding are consistent with the problems and needs identified in the Plan and are allocated to areas with fewest services and/or highest incidence of drug abuse.

VI. Program Management

On June 28, 1973 Governor Curtis signed into law (Chapter 566) An Act Reconstituting and More Effectively Coordinating the Maine Commission on Drug Abuse and the Division of Alcoholism and Providing an Alternative for Violators of Drug Laws. (appendix) This Law establishes a combined alcohol and drug abuse agency called the Office of Alcoholism and Drug Abuse Prevention (OADAP) with the general charge of establishing the overall planning, policy, objectives and priorities for all alcoholism and drug abuse control, education, rehabilitation, research, training, and treatment functions within the State. Specifically, the Office is designated as the single State agency of Maine State Government solely responsible for administering the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, as amended, and the Drug Abuse Office and Treatment Act of 1972, as amended. The OADAP among other things is empowered to review all proposed legislation, fiscal activities, plans, policies, and other administrative functions relating to drug abuse and alcoholism activities made by or requested of all state agencies. The Office has the authority to submit to these bodies findings, comments and recommendations, which in the case of the Judicial Council, Legislature, Governor and Commissioner shall be advisory; and which in the case of other state agencies shall be binding. The tone and explicit enumeration of OADAP's authority, powers and duties, and responsibility contained in Chapter 566 assures the legal basis for effective management, coordination, program design, implementation and control and evaluation of all alcoholism and drug abuse activities within the State. Clear responsibility is therefore vested with the Director, Office of Alcoholism and Drug Abuse Prevention for program management and coordination.

A. Organization and Function Responsibility

With the implementation of the Office of Alcoholism and Drug Abuse Prevention, the Maine Commission on Drug Abuse and the Division of Alcoholism Services are abolished and their functions assimilated into the new combined Office. The process of bringing the Maine Commission and the Alcoholism division into a unified unit is progressing smoothly. The on-going functions of both units are being incorporated into the daily operations of the Office without difficulty largely due to the cooperation which existed between the units and among their individual members prior to the inception of the new Office.

The internal organizational structure of OADAP will have an overall director with a Drug Program Specialist and an Alcoholism Program Specialist responsible to the Director. The Personnel classification statements contained in appendix indicate the nature of the functions of these OADAP personnel. Basicly the division of labor for the three top positions falls within textbook prescriptions. The Director of OADAP is responsible for the overall management of the Office and is informally accountable to the major systems of state government, as implied by the tone of PL 566 and the history of OADAP's development in our past legislative session. Formally, however, the OADAP director is responsible to the Director, Bureau of Rehabilitation. Given the extensive nature of OADAP's power and duties, the director position is highly sensitive and political, playing much of his activity in the external environment.

The daily operation of the two programs in the Office vests with the two program

specialists. Their functions are directly related to program development, implementation, and accountability and are, therefore, directed toward specific day-to-day activities of making alcoholism and drug abuse related services work well in the local communities and within the state agencies.

Professional support services for OADAP will for the time being consist of legal, regional planning and coordination, research and evaluation, and fiscal capabilities. A lawyer, funded through an LEAA grant, will be responsible to the OADAP director. His responsibility is to prepare a Uniform Controlled Substances Act in conjunction with the Attorney General. Additional, he has assumed responsibility for coordinating OADAP's activities with the criminal justice system and acting as an advocate for OADAP within administrative law governing its practices. He has, for example, been able to unravel some legal entanglements in PL 566 and in the development and implementation of licensing and certification procedures. He will also review and write legislation relating to drug abuse efforts coming before our Special Legislative Session this January.

Regional planning and coordination is necessary to deal with the community organization, data generation, local planning, agency coordination, and accountability enforcement at the local level for drug abuse interests. These functions will rest largely with the Drug Abuse Program Specialist until sufficient experience is gained to determine the need for local planning coordinators for drug abuse. Local planning and coordination in the Portland area has been contracted with the state agency planning grant and will be continued.

Research and evaluation services to OADAP and specifically the drug abuse effort will be provided by the Bureau of Rehabilitation's Research, Evaluation, and Planning unit. Staff of this unit, taking direction from the Drug Program Specialist, will assure that a management information system is established and maintained. (A detailed description of this system is under Section VI B. Management Information.) It is through the REP unit that the data base and data analysis for controlling the developmental, and program monitoring aspects of the drug abuse responsibility of the single State agency will be provided.

Fiscal control and monitoring for OADAP and the drug abuse effort will be integrated into the existing fiscal machinery of the Bureau of Rehabilitation. This unit, working closely with the Drug Program Specialist, will handle the day-to-day operational aspects of fiscal management and provide adequate assurance that all Federal regulations relating to its functions with respect to the drug abuse effort are fulfilled.

As an overview, we can see that the major components of the single State agency's capability to function effectively are present. The legal basis is outlined specifically in PL 566 in the appendix and structurally individuals and component support units are visable. It should be noted that when the Maine Commission on Drug Abuse was located in the Executive Department support services and legislative mandate were minimal. Lack of staff to carry out support functions hampered much much of the Commission's effort despite its location at a high government level. It was in essence a step-child operation. The line on Organization Chart B running from the Governor into the operating structure of the Department of Health & Welfare affords the opportunity for the drug abuse effort to gain legitimate status as a functional unit of State Government.

B. Management Information

1. Introduction

Responsibility for developing and maintaining the management information system detailed below rests with the Research, Evaluation, and Planning unit of the Bureau of Rehabilitation under the guidance of the Drug Program Specialist. Data collection, "selling" agencies on the importance of input through our format, day-to-day maintenance of information flow, and analysis of reports will be the conjoint responsibility of REP and the Drug Program Specialist.

We anticipate that the development of the system design and the technical aspects of data manipulation and reporting will be contracted out to an appropriate firm. The use of processed information coming from the system, however, will rest with the Drug Program Specialist and the OADAP Director in terms of concluding recommendations, policy change and development, licensing and accreditation, funding projects, modifying programs, etc.

2. System

The Management Information System described in this section conforms as much as possible to the Alcohol Abuse Management Information System currently under development for the Office of Alcoholism and Drug Abuse Prevention. The two systems are alike in both intent and design. This similarity between the dual systems allows maximum coordination of drug and alcohol planning and evaluation effort at the administrative level.

The intent of the Drug Abuse Management Information System is to determine the scope and regional configurations of drug use and abuse and problems related to both as a basis for providing relevant action programs and defining the effort and effectiveness of such programs.

The design of the Drug Abuse Management Information System will follow that developed for alcohol abuse. Three interdependent system which include Federal reporting requirements (CODAP) will be developed to compose the main system. These components are:

1. Community Monitoring System
2. Program Monitoring System (CODAP)
3. Assessment of Treatment Effectiveness

The functional relationships of these three systems is diagramed on the last page of this section.

3. Methodology

The development of each of the three systems follows the general procedural outline of:

1. Identification of the relevant variables
2. Location and/or creation of data sources for identified variables
3. Collection capability

4. Storage and retrieval procedures

5. Generation of reports

6. Statistical analysis

4. Community Monitoring System

1. Identification of variables: The procedure here will be to work with personnel in the Office of Alcoholism and Drug Abuse Prevention, consultants in the area of drug research, and knowledgeable laymen, to identify in measurable terms community indicators of drug abuse and drug use. Examples of such variables are presented in Table 1.

Table 1

Examples of variables which could be included in the Community Monitoring System

1. Hospital admissions
2. Causes of death
3. High school dropout rate
4. Drug related arrests and convictions
*5. Type and number of drug treatment facilities
6. Socio-economic characteristics related to drug abuse compiled for each Region

*This information will follow the format of the State and Local Treatment Survey required by the NIMH.

Some of the data on the above variables has already been collected for the Alcohol Abuse Management Information System and is readily available.

Since the extend of the problem is partly determined by attitudes toward drug use and abuse a mail survey to influential groups in the community at large will be regularly conducted if funds are available. Also if funds are available a household survey similar to that used by the National Commission on Marijuana and Drug Abuse is planned to give data on youth and adult drug use throughout Maine. It will also provide a comparison of Maine's drug use with nation-wide drug use.

2. Location of variables: Once a variable has been decided upon for inclusion in the system a source of the variable must be found. As much as possible these sources will be centralized at the state level or from private organizations. Experience in developing the State Plan has shown that many of the variables must be gathered from local sources.

3. Collection capability: Data from centralized sources will be collected by the Director of the Office of Alcoholism and Drug Abuse Prevention. Data that

exists only at local levels will be collected by the Regional Coordinators. Alternate arrangements will be made for those regions without coordinators.

4. Storage and retrieval: Community Monitoring System data will be transcribed from computer printouts, court records or other sources by the collection agent onto specially designed tables. This tabular data will then by key punched onto cards. The punched cards will be used in the annual computer analysis of the data.

5. Generation of Reports: Reports of quarterly or annual totals will be obtained from the special data tables. These reports will also be available to the public. A survey consultatnt will provide the reports based on the surveys of community groups and the household survey.

6. Statistical analysis: Special computer manipulations of all collected data relating the findings of each of the tripartite systems to one another will be conducted on a regular basis. Statistical consultants will assist the Director in determining the kinds of analyses that are desirable and necessary and the personnel or consultation services required for actual performance of the analyses. It is expected that such analyses will answer questions related to the increase or decrease of durg use and abuse in each region and determination of the most effective treatment for each type of drug abuser entering into the Program Monitoring System.

5) Program Monitoring System - Client Oriented Data Acquisition Process

1. Identification of variables: Variables of value to the SAODAP have already been developed and are included in the "Client Oriented Data Acquisition Process" (CODAP) data forms and National Management Handbook. Since these forms do not provide adequate treatment assessment items and other items of interest to the State Agency a special State specific short form will be designed to provide this additional information. Only the clinic facilities receiving federal NIMH money for treating drug problems will be required to supply the three CODAP data forms plus the State specific form. Other state supported facilities will supply information on each drug user treated using only the CODAP Admission and Case Sample Report and the State specific form.

The identification items used to track clients will be carefully studied before they are accepted to insure that State confidentiality requirements have been met.

2. Location and/or creation of data sources: The data source will be the data forms provided by CODAP and the additional State specific form. These will comprise the state reporting requirements for all clinics licensed and accredited by the state.

3. Collection capability: Data from each treatment/referral facility will be forwarded to the State Agency by the 12th of the month following the previous quarterly reporting period. The State Agency will forward all required coded

forms to NIMH based on the following quarterly schedule unless otherwise notified:

Report	Period Covered	Date Due at NIMH
1	January 1 - March 31	April 21
2	April 1 - June 30	July 21
3	July 1 - September 30	October 21
4	October 1 - December 31	January 21

4. Storage and Retrieval: CODAP data forms will be forwarded to NIMH. Non-CODAP data will be processed onto punched cards and retained by the Office of Alcoholism and Drug Abuse Prevention. Items of value from the CODAP forms will also be punched onto cards and retained.

5. Generation of Reports: Computer programs will be developed to generate reports based on non-CODAP data. Additional programing will be developed to relate CODAP and non-CODAP data. Complete reports will be retained by the Office of Alcoholism and Drug Abuse Prevention. Thse reports (less any confidential information) will be made available to the Legislature and any other State Agency. Summaries of these reports will be made available to the public. Participating programs will receive quarterly reports on their individual programs by NIMH and the Office of Alcoholism and Drug Abuse Prevention.

6) Assessment of Treatment Effectiveness

1. Identification of relevant variables: Variables which assess treatment effectiveness that are not included on CODAP forms will be developed for the State specific form. Table 2 presents a list of possible assessment variables not included in CODAP.

Table 2

Examples of variables which could be included in the Assessment of Treatment Effectiveness

For each individual -

1. Additional ethnic information such as Franco-American, or American Indian tribe
2. Behavioral indicators of extent of abuse before treatment:
   - amount of school missed
   - job time lost
   - description of emotions
   - description of appearance
3. The same behavioral indicators during and after treatment
4. Treatment model
5. Types of treatment given
6. Therapist rating of treatment outcome

2. Location and/or creation of data source: The data source will be the CODAP and state specific data forms.

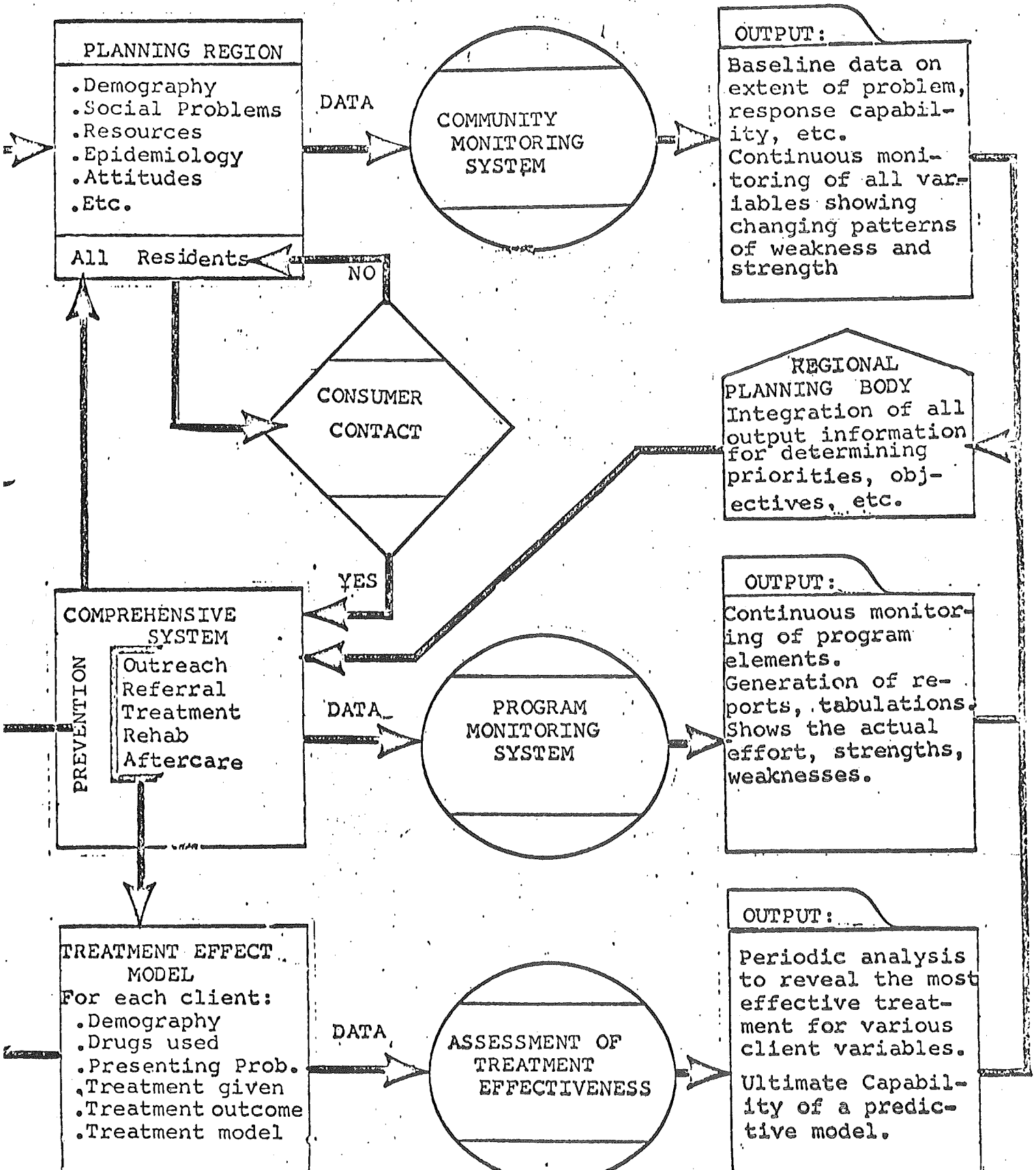
3. Collection capability: Data from each facility will be sent to the evaluation office of the Office of Alcoholism and Drug Abuse Prevention on a quarterly basis.

4. Storage and retrieval: Data will be processed onto punched cards.

5. Generation of reports: Computer programs for quarterly frequency distributions and crosstabulations of the selected data will be developed.

6. Statistical analysis: Same as for Community Monitoring System.

FUNCTIONAL RELATIONSHIPS OF THE TRIPARTITE DATA SYSTEM



C. Management Control

As mentioned in part A of this section, the single state agency will rely upon the fiscal unit of the Bureau of Rehabilitation for assurance as to conformity to all regulations applicable to the fiscal administration of the drug abuse formula grant. The experience and capability of this fiscal unit is proven by its similar responsibility for the alcoholism formula grant, for the various sections of the Vocational Rehabilitation Act, and for various state and federal project grants. The fiscal unit is fully in compliance with DHEW standards, mandates, and requirements.

With respect to sub-grantees, appendix contains a copy of the Office of Alcoholism and Drug Abuse Prevention's grant guidelines. These guidelines are in conformity with State of Maine"s fiscal procedures and with the federal guidelines for the administration of the drug abuse formula grants.

In detail the single state agency requires of subgrantees provide accurate, current, and complete disclosure of the financial results of expenditures of funds from the state's allotment through a quarterly expenditure report and an annual financial status report. Further funding is contingent upon the adequacy of these reports. The state agency itself will comply with those additional requirements prescribed by the Secretary.

The quarterly expenditure reports and annual financial status reports provide effective control over and accountability for funds and property and other assets acquired with funds from the state's allotment. With respect to subgrantees periodic checks will be made on site by a budget analyst assigned to the fiscal unit to insure adequate safeguard for all assets and assure that they are used solely for authorized purposes.

Appropriate records are maintained to assure comparison of actual with budgeted amounts for costs incurred in the preparation of the state plan, costs of projects funded by the formula grant, and costs of expenses incurred in plan administration. The relation of financial information with performance or productivity data, including production of unit cost information is easily determined with respect to projects funded by the formula grant. Specifity of goals and objectives and definition of units of service which we require of subgrantees lends itself easily to performance evaluation. Although potentially available with respect to plan preparation and administration, such performance evaluation would be more difficult.

The fiscal unit's procedures are consistent with the requirement of minimizing time lapsing between the transfer of funds from the U.S. Treasury and their dispursement by the state. This procedure is adhered to with respect to all applicable federal funding handled by the fiscal unit. With respect to sub-grantees allotments will be made to them on a quarterly basis from the state agency. (Pertinent sections of the State's Financial Procedures Manual are contained in appendix)

Procedures for determining the allowability and allocability of cost principles set forth in chapter 5-60 of the DHEW Grants Administration Manual are pending federal approval of a formal agreement of procedure and policy by the Office of Grants Administration Policy. This agreement will, when approved, provide

consistent policy and procedure for all Maine's state government operations. In the absence of such policy agreement, a figure equal to 10% of the grant amount will be used for costs incurred in the preparation and administration of the State Plan and costs incurred in carrying out the project grant mechanism and otherwise implementing an approved State Plan and evaluating the results of such plan as implemented.

Assurance is given that the fiscal unit will maintain accounting records supported by source documentation. Federal audits of HEW programs are conducted at reasonable intervals through an agreement with the regional HEW office in Boston. This agreement is sufficient to determine and maintain the fiscal integrity of financial transactions and reports, and compliance with laws, regulations, and administrative requirements applicable to the formula grant as it is with all other federally funded programs operated through the Bureau of Rehabilitation. In using the HEW audit agreement, we will comply with their standard procedures allowing appropriate response and appeal time for final audit reports. Timely and appropriate resolution of audit findings and recommendations under this agreement has been mutually satisfactory.

In addition, the State Treasurer will receive and provide for custody of all funds paid to the State under the Act subject to requisition or disbursement thereof by the State agency for Plan purposes.

The main responsibility for incurring obligations rests with the Director of the Office of Alcoholism and Drug Abuse Prevention. The Program Specialists incur obligations related to their State Plan activities all of which shall be held subject to review and approval before release for payment by the State Controller.

The State Controller maintains a Pre-Audit Division which audits all vouchers and payrolls for accuracy and conformity to State regulations (other than regulations of this agency) before the checks are made, and again before the checks are delivered to the State Treasurer for final review and mailing. The pre-audit function in no way limits the State agency's responsibility for the administration of the drug abuse program in the State.

As provided in Chapter 16, Revised Statutes of 1954, payments for all services rendered on or before June 30 of each year are chargeable to that fiscal year if bills are forwarded for payment by that date. All goods ordered and encumbered by the State Controller on or before June 30 would usually be charged to that fiscal year providing payment is made no later than the end of the following fiscal year and further providing that instructions from the Department of Finance and Administration for that year make it possible.

The Administrative Code of the State of Maine places the Commissioner of Finance, and the Budget Officer, in complete control of all State finances. Through the Bureau of Accounts and Control, the Commissioner of Finance has the authority to maintain a complete system of general accounts embracing all financial transactions of the State Government and appoints a State Controller as his chief to examine and approve all contracts, to audit and approve all bills, to investigate and verify the cost of materials purchased, to make

monthly reports to the Governor and State Auditor on receipts and expenditures, to prescribe forms to be used in the State's accounting system, to prescribe individual control accounts for various State Departments, and to examine the accounts of every State Department. The State Controller's financial controls are maintained through the use of electronic data processing equipment.

The State Controller supplies a copy of daily warrants issued which are reconciled to the Voucher Register. Each month the Controller furnishes two machine reports: (1) Analysis of Income and Expenditures and Ledger Account Balances (which shows an account breakdown for the month and for the year to date); (2) Summary of Appropriation Expenditures and Income for the current month. These reports are reconciled with the Office's records and an annual report of this reconciliation is submitted to the Bureau of Administration, Department of Health and Welfare, for clearance to the State Controller.

The State maintains a Department of Audit, the head of which elected by the Legislature for a four year term. This Department has the authority to make a complete audit each year and to make a partial audit at any time.

The State agency will maintain such accounts, and supporting documents as will serve to permit an accurate and expeditious determination to be made at any time of the status of the Federal grants, including the disposition of all moneys received and the nature and amount of all charges claimed to lie against the respective Federal authorization. Substantiating invoices are in the custody of the Bureau of Accounts and Control, State Department of Finance. Original records of all income are retained by the State Treasurer.

Earnings by the state realized from grant-supported activities including, but not limited to income from service fees, sale of commodities, usage or rental fees, sale of assets purchased with funds from the State's allotment and royalties on patents and copyrights will be retained by the State for purposes which further the objectives of section 409 of the Act or to deduct such income or royalties from total costs for the purpose of determining net costs on which the Federal share of costs will be based.

Tangible personal property having a useful life of more than one year and an acquisition cost of $300 or more per unit will be considered nonexpendable personal property. When nonexpendable personal property is acquired wholly or in part with funds from the State allotment, title shall be vested in the grantee. The grantee shall retain such property in the grant supported activity as long as there is a need for such property to accomplish the purpose of the activity, whether or not the activity continues to be supported by Federal funds. When there is no longer a need for the property to accomplish the purpose of the original activity, the grantee shall use the property, as needed, in connection with other Federal awards it has received in the following order of priority:

1. Other awards under Federal programs administered by NIMH;
2. Awards of other components of the DHEW and other Federal agencies.

When the grantee no longer has need for nonexpendable personal property in any of its Federally financed activities, the property may be used for the grantee's own official activities in accordance with the following standards:

1) If the property had an acquisition cost of less than $500 per unit and has been used for four years or more, the grantee may use the property without reimbursement to the Federal Government or sell the property and retain the proceeds;

2) For all such property not so covered the grantee may retain the property for its own use provided that a fair compensation is made to the Federal Government for the Federal share of the property. Compensation will be based upon the percentage of Federal participation in the total cost of the activity and the current fair market value of the property.

In OADAP's grant guidelines to subgrantees (appendix) the state agency reserves the right to determine final disposition of equipment which is defined as nonexpendable personal property. Disposition of nonexpendable personal property, as required by the state agency, will be in accordance with Federal regulations 42 CFR Part 54b.115b(3).

The state agency will maintain property management standards to be applied to subgrantees which require that they:

Maintain accurate property records containing a description of the property; manufacturer's serial or identification number; acquisition dates and costs; source of the property; percentage of Federal funds used in the acquisition of the property; location use and condition of the property; and ultimate disposition data including sales price or the method used to determine current fair market value.

Grantees are further required to maintain property in good condition and will follow sales procedures which will result in the highest possible return when property is sold. Grantees will also verify the existence, current utilization, and continued need of property through a physical inventory at least every two years. (Specific policies and procedures are in the State's Manual of Financial Procedures in appendix).

The State agency has not specifically included the following items in its subgranting procedures:

1) Provision for compliance with "Equal Employment Opportunity" for subgrants in excess of $10,000;

2) Provision for compliance with the Copeland "Anti-Kick Back" Act for subgrants for remodeling, alteration or repairs;

3) Provision for having subgrants for research or development governed by DHEW Patent Regulations (45CFR, Parts 6 and 8); and,

4) Provisions for compliance with applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970.

A provision in the State agency's grant guidelines (appendix) states that the grantee agrees to administer any grant awarded by the State in accordance with governing State and Federal regulations and policies in effect at the time the award is made. This statement covers the specific omissions above which will be explained to grantees who apply for funds. A new printing of the guidelines in January 1974 will contain such provisions as were omitted in the first edition.

These grant guidelines fully outline the policies and procedures developed by the Office of Alcoholism and Drug Abuse Prevention for all subgrantees. They explicate the criteria of eligibility of applicants for subgrants, describe the methods of submittal, evaluation and approval of applications, and explain upon what basis the state agency will evaluate projects to insure compliance with requirements, standards, and criteria.

In general, the grant guidelines assure both fiscal and program accountability and adherence to State and Federal regulations. Any public or private agency is eligible for funding provided they meet the specific and detailed requirements of the guidelines. Specificity in terms of goals and objectives and definition of services to be provided assure that subgrantee activities are of no lower quality than those activities which the state undertakes to conduct. Quality will be monitored through the reporting requirements outlined in the guidelines and by direct involvement with the agencies by the Drug Program Specialist in OADAP.

Procurement procedures and policies governing the State of Maine's operating agencies will continue to be used by the Office of Alcoholism and Drug Abuse Prevention. These procedures and policies are consistent with the standards set forth in the drug abuse guidelines 42CFR 54b.117. (appendix)

With respect to contract procurement the state specifically requires contracts to be reviewed by committee at the level of the State Budget Office. IFB's and RFP's are based upon a clear and accurate description of the product, material, or service to be produced which do not unduly restrict competition. Cost-plus-a-percentage-of-cost method of contracting will not be used.

Positive effort will be made to utilize small business and minority owned business sources of supplies and services.

Federal regulations pertaining to advertising, sealed bids, public openings, awards, invitation for bids, and requests for proposals will be adhered to and can be seen in the State's contract guidelines contained in appendix . A sentence to the effect that the state may reject all bids or proposals is included in the advertised RFP or IFB.

The state agency will engage in negotiated procurement only if one or more of the following conditions prevail:

1. The public exigency will not permit the delay incident to advertising;

2. The material or service to be provided is available from only one person or firm; provided that all contemplated sole source

procurements where the aggregate expenditure is expected to exceed $5,000 shall be referred to the granting agency for prior approach;

3. The aggregate amount involved does not exceed $2,500;

4. The contract is for personal or professional services, or for any service to be rendered by a university, college, or other educational institution;

5. The material or services are to be procured outside the limits of the United States and its possessions;

6. No acceptable bids have been received after formal advertising;

7. The purchases are for highly perishable items, medical supplies, or other items specified in the regulations;

8. Negotiation is otherwise authorized by law, rules, or regulations.

The state agency only contracts with responsible contractors who possess the ability to perform successfully under the terms and conditions of a proposed procurement. Considerations are given to such matters as contractor integrity, record of past performance, financial and technical resources, or accessability to other necessary resources.

The state agency's procurement records or files for purchases in amounts of $2,500 provide at least justification for the use of negotiation in lieu of advertising, contractor selection, and the basis for the cost or price negotiated.

The contract administrator named in each state contract is responsible for assuring contractor conformance with terms, conditions, and specifications of the contract. Contract provisions for the State (appendix) are consistent with those prescribed in the federal regulations with four exceptions:

1. Contracts for remodeling, alteration, or repairs shall include a provision for compliance with the Copeland "Anti-Kick Back" Act and related regulations;

2. Research and development grants are to be governed by DHEW Patent Regulations;

3. Contracts awarded in excess of $2,500 shall provide for compliance with applicable regulations and standards of the Cost of Living Council;

4. Contracts in excess of $100,000 shall contain a provision which requires compliance with applicable standards, orders, or regulations pursuant to the Clean Air Act of 1970.

In instances where these excluded provisions are applicable, however, the state agency will add them to the contract.

A code of conduct is maintained with respect to the performance of state officers, employees, or agents in contracting with and expending Federal grant funds. The State's officers, employees, or agents shall neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or potential contractors. State law (appendix) provides for the sanctions to be applied for malfeasance in office, extortion, and conflict of interest.

The state agency will keep intact and accessible in accordance with the provisions of the regulations all records required by Section 409 of the Act. Specific policies and procedures for retention of records are contained in appendix . Furthermore, the state agency will comply with the Secretary's request for transfer of certain records to his custody when he determines that the records possess long term retention value.

Access to any books, documents, papers and records of the State or its subgrantees which are pertinent to the State Plan and expenditures thereunder will be available to the Secretary and the Comtroller General or any duly authorized representatives for the purpose of making audit, examination, exerpts and transcripts. Further, all records required by regulations of this subpart shall be available and accessible to the public except when the records must remain confidential.

The Department of Health & Welfare will maintain such written personnel policies, records, and other data as are necessary to permit an evaluation of the operations of the system of personnel administration in relation to the standards of the agency.

Nominations for appointment to positions on the staff shall be made by the Director of the Bureau of Rehabilitation subject to the approval of the Commissioner, Department of Health & Welfare, and in accord with the State Personnel Laws and Rules. Selection of applicants shall be based upon adequate training, experience and personal qualifications for the job under consideration. There will be no discrimination on the basis of race, color, sex, creed, or national origin.

The State agency operates under provisions of a State Merity System approved by the United States Department of Health, Education, and Welfare, and conducted under the Personnel Law and Rules of the State Personnel Board, Department of Personnel, State of Maine.

The State agency will also use the professional standards of the State Merit System as evaluative criteria in determining the appropriateness of individuals being hired for activities relating to the implementation of the State Plan.

D. Licensing and Accreditation

Two recently enacted laws, Public Laws of 1973, chapters 566 and 164, control the certification and licensing of residential drug treatment facilities.

§7106(11) of Chapter 566 states that the Office of Alcoholism and Drug Abuse Prevention shall have the power and duty to "issue a certificate of approval for any drug abuse treatment facility or program..." In conjunction with §7106, §7115(1) of Chapter 566 states that "the department shall establish standards for approved treatment facilities, that must be met for a facility to be approved as a public or private treatment facility."

These standards (a copy of which are attached) must be adopted in strict compliance with the Maine Administrative Code. Generally, the Administrative Code provides for procedural due process and insures that all parties affected by the standards have recourse to an administrative and judicial hearing and appeals procedure.

After a facility is approved under C.566 it may obtain a license by complying with the provisions of C.164. Under C.164 any residential drug treatment center operating in Maine would be required to annually submit to two inspecions as a pre-condition of operation.

The first inspection will be conducted by the Department of Public Safety or a properly designated municipal official. This inspection will be conducted solely for the purpose of determining whether the physical premises meets the fire safetly standards now in effect for structures of a similar design, construction and use. Similar fire safety inspections would be conducted on an annual basis.

The second inspection will be conducted by the Department of Health and Welfare to determine if the applicant is in compliance with departmental rules and regulations (standards) pertaining to residential drug treatment centers. Upon completion of this inspection, the Department could take any of the following actions:

1. Upon payment of a $25 fee, the department may issue a temporary license for a specified time period not to exceed 90 days. During the temporary issuance period, the applicant would be afforded an opportunity to remedy any stated deficiencies and thereby qualify to apply for a regular license.

2. Upon payment of a $25 fee, the department may issue a conditional license for any reasonable length of time. During the conditional issuance period, the applicant would again have an opportunity to remedy the stated deficiencies that prevented the issuance of a regular license. The principle difference between a temporary license and a conditional license is that the conditional license is not limited in time. Thus, a facility can be licensed while major deficiencies that require significant expenditures of time and money are being made. Also, a conditional license does not expire upon a set day as does the temporary license, rather a conditional license expires upon licensees failure to make stated corrections within a reasonable time. Upon expiration of either a temporary or conditional license, however, applicant must submit a new application for a regular license.

3. Upon payment of a $25 fee, the department may issue a regular license for a period of one year. Upon expiration of the one-year period, applicant must reapply and must again submit to the two inspections outlined above.

4. Upon payment of a $25 fee, the department may refuse to issue any license. Upon such refusal, applicant may bring his complaint before the Administrative Hearing Commissioner.

Any license issued under C.164 may be suspended or revoked through two different procedures. Under the normal procedure, a complaint is filed with the Administrative Hearing Commissioner, the complaint is argued before a hearing officer with both sides presenting evidence, a decision is rendered, and the appropriate action is taken. Under the emergency procedure, a license may be immediately suspended or revoked without waiting for a decison from the Hearing Officer. This emergency suspension or revocation can take place only if the Commissioner of Health and Welfare reasonably believe that undesirable conditions exist so as to create a health and/or safety emergency. While the emergency suspension or revocation is in effect, the Department must submit their complaint to the Administrative Hearing Commissioner and obtain a ruling as to the validity of the emergency suspension or revocation.

Any time a facility is found to be operating without a temporary, conditional, or regular license, a criminal prosecution may be commenced and, upon conviction, a fine of not more than $500 or imprisonment for not more than 60 days may be imposed.

In addition, C.566 authorizes the District Courts to restrain any violation of the requirement that a facility comply with established standards before and during operation.

REGULATIONS FOR LICENSING AND CERTIFICATION OF DRUG TREATMENT FACILITIES

1. Statement of purpose

The purpose of these regulations is to provide standards which shall govern to a reasonable degree the operation of all drug treatment facilities within the State of Maine.

2. Definitions

Drug Treatment Facility (DTF)

Any establishment, facility or institution, public or private, whether operated for profit or not, which offers, or purports to offer, maintain, or operate facilities for the diagnosis, care, treatment or rehabilitation of two or more non-related individuals who are suffering physically or mentally from the use of narcotic or dangerous drugs.

Residential Drug Treatment Facility (RDTF)

Any establishment, facility or institution, public or private, whether operated for profit or not, which offers, or purports to offer, maintain, or operate facilities for the diagnosis, care, treatment or rehabilitation of two or more non-related individuals who are suffering physically or mentally from the use of narcotic or dangerous drugs and which includes as part of its treatment a requirement that persons physically reside on the premises.

Office: Office of Alcoholism and Drug Abuse Prevention (OADAP)

Explanation of Words "Shall" and "Should"

a. Where the word "Shall" is used, it means compliance is mandatory.

b. Where the word "Should" is used, it means a suggestion or recommendation.

3. Procedure for Licensure and Certification

3-1 Application:

Application for licensure and certification as a residential drug abuse treatment facility shall be made on forms provided on request by the OADAP. Such application shall provide the following essential information:

3-12 Name of the facility and location.

3-13 Name of person or legal entity owning the facility, and, where applicable, a copy of the document of incorporation.

3-14 The names and qualifications of the operating directors.

3-15 The geographic area and the number of people to be served.

3-16 A full description of the rehabilitative program.

3-17 A full description of the applicants' self-evaluating procedures that are utilized to evaluate results of the proposed program.

3-18 A financial statement indicating source of support and expenditures for the current year.

3-2 Notice of Application or Renewal

Upon receipt of an initial or renewal application, the OADAP shall notify the Town or Municipality in which the RDTF or DTF is located that such a renewal application has been submitted. Upon the request of the governing authority, whether an individual or group of individuals, of the said Town or Municipality, the OADAP shall conduct a public hearing regarding the application. The said public hearing shall be held in the Town or Municipality so requesting the public hearing.

3-3 Inspection: Each applicant or licensee agrees as a condition of said license to permit properly designated representatives of the OADAP to enter upon and inspect any and all premises for which a license has been either applied for or issued. The purpose of an inspection shall be to verify information contained in the application and to assure compliance with all laws, rules and regulations relating thereto. An inspection may be conducted at any reasonable hour.

3-4 License Review Board: The Director of OADAP shall appoint a board of not less than three (3) or more than five (5) members to review all license applications as appropriate to assure compliance with the State Plan and to make recommendations to the Director concerning issuance or denial of licenses. Also, at other intervals, this board may make recommendations to the Director concerning suspension or revocation of previously issued licenses.

3-5 License Non-transferable: A license issued by the Department for the operation of a DTF applies both to the applicant and the premises upon which the DTF center or program is to be operated. Any person or other legal entity acquiring a licensed facility shall make an application as provided herein for a new license. Similarly, any person or legal entity having acquired a license and desiring to operate another DTF in any other Town or Municipality or transfer to a separate premises must make application for a new license.

3-6 Renewal: Every license issued pursuant to M.R.S.A. 22 §5-A shall be good for a term of one year. Renewal applications shall be submitted ninety (90) days prior to the expiration date of the license.

3-7 Notification of Closure: A licensee shall, if possible, notify the OADAP of impending closure of the licensed facility at least 30 days prior to such closure. The licensee shall be responsible for removal and placement of patients or clients engaged in rehabilitation or treatment program and for the preservation of all records. Upon closure, the license shall be immediately returned to the Department.

3-8 Denial, Revocation or Suspension: Denial, revocation and suspension of any license to operate a DTF shall be in accordance with the procedures set forth in M.R.S.A. 5 §2301 et. seq. The OADAP may deny, revoke or suspend a license if in the opinion of the Office the applicant or licensee (1) has not presented a program designed to rehabilitate drug abusers; (2) has engaged in activities deemed detrimental to the clients; (3) has deviated from the program for which a license was issued; (4) is engaged in activity deemed detrimental to the public health and safety or has violated any provision of Maine law including M.R.S.A. 17, Chapter 91 (Nuisances); (5) has been in violation of any local or state health, safety, sanitation, building or zoning code and failed to correct the same.

4. Staff

4-1 All staff position shall be identified as to title, function, authority and responsibility and minimal educational and/or experience requirements.

4-2 A clearly stated body of rules shall be made available to all staff and participants. Such rules will govern the conduct of all staff and participants. In all cases the rules shall prohibit the use of physical violence, overt sexual behavior and the possession, use or sale of illegal drugs.

4-3 One individual shall be identified as having primary responsibility for the overall operation of the program.

4-4 Any paraprofessional or professional treatment personnel employed shall be fully qualified according to the standards set by each profession, including licensing, if required by Maine law. Paraprofessional treatment personnel shall be experienced and trained in the drug rehabilitation field. Professional staff must be available for support of and consultation with paraprofessional and non-professional staff.

4-5 In-service training and staff development shall be available on a regularly scheduled basis for all staff.

4-6 Volunteer staff shall be well qualified, trained and supervised.

4-7 Personnel policies must be available to all staff and must provide for adequate vacation time and a reasonable number of hours per week.

4-8 An annual evaluation of all members of the staff must be conducted and documented in the personnel files. All staff shall be assisted in any areas of weakness discovered via the evaluations. If performance does not improve, they shall be dismissed from the program.

4-9 Any person who has been a client in any drug abuse rehabilitation facility should be engaged in gainful employment or other productive activity (housewife, student) for a period of six months before accepting a staff or volunteer position with any Drug Abuse Treatment facility.

4-10 Any prior arrest and/or conviction for a drug offense or any former drug use shall not be a barrier to the hiring or upgrading of staff, provided such persons remain drug free and are otherwise qualified and suitable for the position.

5. Program Requirements

5-1 Goals: Programs must have demonstrable goals that include, but are not limited to:

improvement of the client's internal adjustment
improvement of the client's adjustment to others
development of a pattern of abstinence from drug misuse
improvement of the client's vocational educational and social performance.

5-2 Intake

1. Initial contact: sufficient information shall be collected to clearly identify the client, the source of referral, and what disposition was made, i.e., appointment for initial interview, referral to another program, dismissal from the program, etc.

5-3 Orientation

5-31 Client, referral agency or legal guardian shall be given sufficient information about the program to enable him to make a decision regarding admission.

5-32 Prospective clients shall be informed of their rights and responsibilities as program participants.

5-33 Orientation must include a social history and medical examination and may also include urinalysis where appropriate. Admission into the program shall be made in consultation with the Director and an Admissions committee.

5-34 Detoxification, where appropriate, shall take place in a setting that includes medical supervision.

5-4 Direct Services

5-41 The program should not consist of more than 60 clients living in an environment designed to insure, particularly during the early phases of treatment, maximum control of client activity.

5-42 Both individual and group interaction should be provided regularly to stimulate motivation and aid the client in establishing an acceptable pattern of daily living.

5-43 The program shall include regular evaluation, with the client, of his productivity as a member of the group and his participation in the program.

5-44 The program shall include regularly scheduled free time and regularly scheduled recreational and leisure time activities. Recreational and leisure time activities, conducted off the premises of DTF, shall be supervised by appropriate personnel, preferably a qualified staff member.

5-45 An educational program shall be provided. This shall include:

(1) Informational components such as lectures, films, classes, tutoring, etc.
(2) Experiential components such as sensitivity training, marathons, encounter groups and other therapeutic techniques.
(3) As appropriate, arrangements for clients to undertake vocational and/or educational counseling.
(4) As appropriate, arrangements for clients to advance their educational and vocational training.

5-46 Personal needs shall be provided as required for the client's health, comfort, and well-being.

5-47 Programs shall demonstrate an established procedure for handling client complaints. No retribution may be taken against a client who files a complaint.

5-48 Procedures for storage and dispensing of medication shall be in compliance with all applicable state and federal laws and regulations.

5-5 Supportive Services

5-51 In addition to direct services, the clients shall have access to the following supportive services: medical, dental, psychiatric, laboratory, legal, social.

5-52 Individual and group counseling for spouses, parents and other individuals with whom the clients retain significant relationships should be made available when appropriate.

5-6 Program Completion Criteria

5-61 The program shall provide within its structure the means for ongoing review of the degree to which each client is meeting his individual treatment goals. When it becomes evident to key staff that the client has received optimum benefit from treatment and that further progress requires a return to functioning in the community, joint planning for the client's discharge shall be undertaken in consultation with the client.

5-62 Criteria for successful completion of the program must include:

(a) The client shall no longer be dependent for social activity upon those who abuse drugs or upon the DTF and his avocational interests and behavior must have become established in socially acceptable recreational and social pursuits.

(b) The client must have assumed responsibility for himself and must have completed his treatment goals.

5-63 Criteria for successful completion of the program should also include:

(a) The client should have developed the capacity to be as economically self-sufficient as possible.

(b) The client should have demonstrated either job stability or responsibility in seeking employment.

5-64 The client's meeting of criteria for discharge shall be documented in the final case review.

5-7 Aftercare

5-71 The agency should provide appropriate assistance to the client in such matters as job placement, living arrangements, and resumption of education.

5-72 Any needed individual and group services should be provided to parents and relatives on a continuing basis.

5-73 Upon termination of these aftercare services, periodic contact should be maintained with the client for purposes of evaluation.

5-8 Referral

1. The agency must document the various types and levels of services available in the community, and this list, complete with telephone numbers and names of the persons to contact, must be in the files of all staff. It is particularly important that those engaged in-take be aware of alternate resources for help and that in every case in which the agency is unable to accept a client for services an attempt be made to meet his needs by referral.

6. Community Relations

6-1 Programs shall make every effort to involve all levels of community resources including parents, civic groups, law enforcement, youth groups, judiciary, school officials and other professional groups.

6-2 When initiating a program in a community, appropriate groundwork and consideration for established residents shall be observed. This may include a presentation to the local governing body or appropriate agency, newspaper announcements and home or business visits in the immediate area. The goals, the structure and the responsibilities of the program to the community should be presented to insure understanding and cooperativeness.

6-3 Any person may file with OADAP a complaint detailing alleged violations of these regulations. A copy of the allegations must be filed with RDTF against whom the complaint is made. RDTF shall have 15 days to respond to the allegations. OADAP may request a private hearing to determine the validity of the allegations and any appropriate response as provided for in Regulations 3-8.

7. Records

7-1 Records shall be maintained in such a manner as to permit adequate client evaluation at the time of admission, periodic client progress reports, follow-up or termination for any reason.

7-2 Records shall indicate number of contacts with client, nature of problem dealt with, what action was taken and be initialed by the staff person handling the contact.

7-3 All client records are privileged and confidential and shall be kept in a locked file and shall not be disclosed publicly in such a manner as to identify individuals except in a proceeding involving the question of licensure. Confidentiality of records shall otherwise strictly comply with applicable state and federal laws.

7-4 Records should be kept long enough to permit follow-up of clients and adequate evaluation of the program.

7-5 Programs shall participate in the OADAP management information system, where appropriate.

8. Control of Deviant or Criminal Behavior

8-1 Every facility shall take all reasonable measures necessary to insure that no client is exposed to or instigates any behavior that may cause serious physical or emotional injury to any person.

8-2 Any incident resulting in serious physical injury or death shall be investigated by the director of the facility and reported to local authorities when appropriate or when required by law. A written report of the incident shall be made and kept on file at the facility. This report shall be available for review by the OADAP and other authorized authorities.

9. Discrimination Prohibited

9-1 No facility or service shall discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religion, sex or natural origin in any manner prohibited by the laws of the United States or the State of Maine.

10. Adoption, Amendment or Repeal of Regulations

10-1 Any person may petition the Office of Alcoholism and Drug Abuse Prevention to request the adoption, amendment or repeal of any regulation. Any such petition shall be brought or mailed to the OADAP and shall state specifically what modification is desired. The OADAP shall acknowledge receipt of any petition within five days of the date of receipt. A disposition of the petition shall be made within thirty-five days after receipt of the petition, and the OADAP shall notify the petitioner in writing of their action.

VI. Program Management

E. Evaluation

The single state agency will comply with regulation 54b.112 (42 CFR Part 54b) which requires monitoring and reporting the performance of all programs funded from appropriations under Section 409 of the Drug Abuse Office and Treatment Act of 1972 (86 Stat. 80, 21 USC 1176). The single state agency will also be responsible for evaluation of all drug abuse prevention programs which are funded directly by the single state agency or whose funds are channeled through the single state agency.

Program review will employ both process and outcome evaluation. Process evaluation will include administrative monitoring of fiscal and recordkeeping procedures and progress reports from program administrators. The program's internal data system can also supply useful information. Outcome evaluation, the comparison of program costs to program outcomes, is essential to continued financial support of any program. Outcome evaluation will attempt to answer the following questions:

1. Does the program establish reasonable and measurable goals?

In measuring the effects of a drug abuse program on the participants we should establish specific social, vocational, recidivist or educational goals rather than talk in vague terms of "increased social adjustment." Failure to ask rigorous questions about proposed objectives can compromise the projects potential from the outset. We should not rely on the program administrator and/or clients alone for a measure of whether the program is attaining or falling short of its goals.

2. What is the cost of the program? How does the cost compare to the benefits?

In this instance, we might compare the annual cost per client in a treatment program with the cost of maintaining the same client in jail or on public assistance.

3. What difference did the program make?

This question attempts to compare the characteristics of program participants and non-participants. An example would be to compare arrest rates of program participants and a group of non-participants with similar characterisitics.

The management information system will provide the basic data and process for the evaluation effort.

F. Planning Next Year's Program

The Office of Alcoholism and Drug Abuse will be responsible for planning next year's program. Timetable responsibilities and activities to be followed will be determined by the Director of the Office.

The present single state agency hopes that a revised Action Plan and progress report can be submitted by June 30, 1974.

VII. ASSURANCES

STATE OF MAINE
DRUG ABUSE TREATMENT AND PREVENTION PLAN
ASSURANCES FORM

The following assurances required by DHEW regulations have either already been given in our application for the Sec. 409 grant (1-3) or are written into the State Plan (4-13) on the referenced pages.

The certificate completed at the end of these assurances indicates our intention to comply with them.

1. Grant funds requested for the preparation of the State Plan will be used as intended to meet the requirements of Section 409(e), PL 92-255. Regs. Sec. 54b.105. Contained in Application for Section 409 Plan.(Attached)

2. Grant funds for the preparation of a State plan will be used to supplement State, local and other Federal funds but will not supplant such funds. Regs. 54(b)105(b)(4). Contained in Application for Section(Attached) 409 Plan.

3. The views of representatives of State and local governments, public and private agencies or organizations concerned with drug abuse problems and the views of the general public will be sought and considered in the development of the State plan. Regs. 54(b)105(b)(5). Contained in Application for Section 409 Plan. (attached)

4. Equal Employment Opportunity will be assured in the State Merit System. Discrimination in any aspect of personnel administration because of political or religious opinions or affiliations, or discrimination because of age, sex, or physical disability will be prohibited except where age, sex, or physical requirements constitute a bona fide occupational qualification. Regs. 54(b)113(b)(2).

5. The single State agency will establish safeguards to prohibit employees from using their positions for private gain to themselves or others. The State Statute covering conflict of interest is M.R.S.A. T.17 §3104 Regs. 54(b)(3)(i).

6. No qualified applicant will be denied employment in a position wholly or partly supported by funds authorized by Sec. 409, PL 92-255, solely on the basis of a prior history of drug abuse or drug dependence. Regs. 54(b)113(b)(3)(ii).

7. All records required by Sec. 409, PL 92-255 and the regulations of this subpart (42CFR 54(b)) will be kept intact and accessible in accordance with the provisions of Section 54(b)118,42 CFR54(b). Regs. 54(b)118(a) through (h).

8. The State Agency will make reports as required by the regulations of this subpart, (42 CFR 54(b), and any additional reports as the Secretary may require from time to time. Regs. 54(b) 119(a) and 54(b) 119(b)(1)(2)(3).

9. Federal funds for the maintenance of effort under Section 409, PL 92-255, and the regulations of this subpart, (42 CFR 54(b), will be used to supplement State, local and other non-Federal funds but not to supplant such funds. Regs. 54(b) 120(a)(1)(2).

10. Federal funds available to the State under Section 409, PL 92-255, and the regulations of this subpart, (42 CFR 54(b), will not be available to hospitals that refuse admission or treatment to drug abusers suffering from emergency medical conditions solely because of their drug abuse or drug dependence. Regs. 54(b) 120(c).

11. Facilities, programs and services supported in whole or in part with Federal funds will be so located as to be readily accessible, available and responsive to the needs of the population to be served without discrimination because of sex, creed, or duration of residence and that their services for drug abuse prevention or treatment be publicized so as to be generally known to the populat to be served. Regs. 54(b) 120(b)(1)(2)(3)(4).

12. The State Agency will comply with the Uniform Relocation Assistance and Real Property Acquisition Act of 1970, PL 91-464, which provides for fair and equitable treatment of persons displaced as a result of Federal and Federally assisted programs and applicable regulations issued there under (45 CFR 15); (36 FR 18838), 9/22/71. Regs. 54(b) 120(d).

13. The requirements of Civil Rights Act, 1964, on nondiscrimination because of race, color, or national origin will be fully observed under programs or activitie receiving Federal financial assistance (42 USC 2000(d); 78 Stat. 252; 45 CFR 80).

I do hereby certify that these assurances are made in good faith and will be maintained by the SSA as a condition of continuing funding.

Richard H. Carbonneau — 8/7/1973

Director, SSA, or other authorized official — Date

Marilyn L. McConnell — 11/6/73

Director, Office of Alcoholism & Drug Abuse Prevention — Date

ADDITIONAL ASSURANCES

The State Agency, the Maine Commission on Drug Abuse, responsible for the administration of this State plan assures that:

1. Federal funds made available to the State under this plan will be used to make a significant contribution toward strengthening drug abuse prevention/treatment services in the various political subdivisions of the State in order to improve the quality, scope and extent of such services.

2. Resources, state and Federal will be made available to public or nonprofit private agencies and organizations in accordance with the provisions established in this plan.

3. Federal formula grant funds will be used to supplement and, to the extent practicable to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds were provided and not to supplant non-Federal funds. There will be reasonable State financial participation in the cost of carrying out this State plan in accordance with applicable Federal regulations.

4. Financial procedures for properly charging the costs of activities under the plan will be established and maintained in accordance with Federal Formula grant administrative requirements. Financial reports will be submitted on a timely basis to the Secretary, Department of Health, Education, and Welfare.

5. In accordance with Title VI of the Civil Rights of 1964 (42 U.S.C.2000d et.seq.) and the Regulations issued therunder by the Secretary, Department of Health, Education, and Welfare, no individual shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefit of, or be otherwise subjected to discrimination under this plan. The Single State agency will utilize the State's methods of personnel administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with applicable Federal Civil Rights regulations.

6. **Confidentiality of patient records.** (Sec. 408, P.L. 92-255):

(a) Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function authorized or assisted under any provision of this Act or any Act amended by this Act shall be confidential and may be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b)(1) If the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed

(A) to medical personnel for the purpose of diagnosis or treatment of the patient, and

(B) to governmental personnel for the purpose of obtaining benefits to which the patient is entitled.

(2) If the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, does not give his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management or financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

Penalty.

(e) Except as authorized under subsection (b) of this section, any person who discloses the contents of any record referred to in subsection (a) shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

7. Methods of program administration will be established and maintained as are necessary for the proper and efficient implementation of this State Plan.

8. The single State agency will utilize the state government's methods of personnel administration which are wholly in accord with Federal regulations.

9. The single state agency will insure that no full-time officer or employee of the State agency or any firm, organization, corporation or partnership which such officer owns, controls or directs, shall receive funds from an applicant under this legislation, directly or indirectly, in payment for any services rendered in connection with any activity intended for Federal funding under this program.

10. Policies and procedures will be developed and implemented by the single state agency for the expenditure of funds under this State plan to assure effective and continuing State planning, evaluation, and delivery of services (under both public and private programs).

11. The single State agency is developing methods to assess this State's effectiveness and accomplishments in meeting drug abuse service needs in accordance with the Special Action Office for Drug Abuse Prevention requirements.

12. The single State agency, will make reports, keep records, and afford access thereto, in accordance with applicable Federal regulations.

13. Financial and technical assistance shall be furnished to public and nonprofit private agencies and organizations engaged in providing services and facilities serving persons with drug abuse problems on a statewide basis.

14. Every applicant for a service project will have an opportunity for a fair hearing before the single state agency if the applicant is dissatisfied with any action of the State agency regarding funding applications or program administrative matters.

15. The single state agency will provide the Secretary of Health, Education and Welfare from time to time, but not less than annually, an up-date of the State plan for Federal approval.

16. The single state agency has solicited from the general public through the newspaper media advising also that a copy of this plan is available for public inspection. Advertising attesting to the foregoing has been accomplished through the Kennebec Journal which is circulated throughout the State. Review of this plan and comments from the public sector has been accomplished during the normal State business hours at the State Office Building in the office of the single state agency.

17. The single state agency will report on the methods (evaluation approach, system, process, and evaluative design and analysis) used to assess the effectibeness and accomplishments of the State in meeting the needs of persons at risk or those having drug abuse problems; preparignspecial reports, additional information and assurances that the Secretary of the Department of Health, Education, and Welfare may find necessary to carry out the provisions and purposes of P.L. 92-255.

DIRECTOR, OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

Definition

This is a highly responsible position in the administration, planning, coordinating and integration of all alcoholism and drug abuse services.

An employee in this class is responsible for the overall planning and development of alcoholism and drug abuse services which includes designing and implementing policies governing the dispensation of state and federal money to the private service community; establishment and maintenance of public accountability procedures for alcoholism and drug abuse programs; development and execution of an overall strategy for the treatment, rehabilitation, and prevention of alcohol and drug abuse; insuring intergovernmental cooperation in the area of alcohol and drug abuse; and fostering coordination and integration of treatment services in local communities. Work includes administration of the Office of Alcoholism and Drug Abuse Prevention; management of state and federal funds; negotiation at the state, local, and federal levels; organization of effective systems for planning and programming a wide range of services; and coordinating a multiplicity of related, though competing, public and private agencies. Direct supervision will be exercised over program and staff specialists within the Office and over new projects developed within the Office. Employee has broad latitude for independent decision-making and automomy in innovation and change. Work is performed under the direction of the Director, Bureau of Rehabilitation, and is reviewed through reports, conferences, and assessment of goal achievement.

Examples of Work Performed

The Director, Office of Alcoholism and Drug Abuse Prevention, is responsible to the Director, Bureau of Rehabilitation, for the efficient administration of the programs and projects under the Office of Alcohol and Drug Abuse Prevention.

1. Encourages and assists the development of effective, coordinated, and efficient administration of resources and services available for alcoholics and drug abusers.

2. Establishes operating policy for the Office and interprets state and federal regulations.

3. Controls and allocates resources to meet established goals for the systems established within the Office.

4. Supervises through a review process the preparation and administration of any portion of any state plan relating to alcohol and drug abuse prevention prepared and administrated by any agency of state government for submission to the federal government to obtain federal funding under federal legislation.

5. Enters into agreements necessary or incidental to the performance of the duties of the Office of Alcoholism and Drug Abuse Prevention.

6. Coordinates all state government efforts related to alcohol and drug abuse.

7. Maintains working relationships with the public, governmental officials, planning bodies, and other alcohol and drug abuse oriented agencies.

8. Sets the limits of responsibility and authority for program specialists within the Office.

9. Makes management decisions regarding the implementation and operation of the Office and its sub-systems (components).

10. Establishes office-wide guidelines for planning; establishes or approves goals or program objectives.

11. Insures the appropriate staffing of all councils and committees attendant to the Office.

12. Performs related work as required.

Required Knowledge, Skill, and Ability

Considerable knowledge of the laws and regulations pertaining to provisions of the State/Federal programs in Alcoholism and drug abuse. Considerable knowledge of modern management and administrative practices.

Some general knowledge of alcoholism and drug abuse and their attendant problems.

Some knowledge of the planning process.

Ability to plan and coordinate the activities of all alcoholism and drug abuse programming.

Ability to objectively make decisions under pressure.

Ability to establish and maintain effective working relationships with public and private agencies and the general public.

Desirable Experience and Training

Considerable experience in supervisory, consultative, or administrative positions, and a thorough knowledge of program administration and planning; and, a master's degree in the Human Services or related area.

DRUG ABUSE PROGRAM SPECIALIST

Definition

This is a responsible position of consultation in the area of drug abuse, treatment, rehabilitation, and prevention.

An employee in this class is responsible for cooperatively planning new or expanded drug abuse service programs; fostering public education and awareness of drug abuse issues; formulating recommendations for statewide drug abuse prevention strategy; stimulating agencies and organizations to provide appropriate services for the drug abusing population; and, interpreting and enforcing the drug abuse strategy for the state. Work includes synthesizing statistical reports into a basis for sound planning; consultation and technical assistance to public and private drug abuse service agencies; use of workshops, conferences, or written material for public education; preparation of plans and recommendations consistent with the drug abuse strategy; and, monitoring the efficient use of public resources. Direct supervision will be exercised over staff specialists related to drug abuse. Employee has considerable latitude for independent judgment in his areas of responsibility.

Examples of Work Performed

Work is performed under the general supervision of the Director, Office of Alcoholism and Drug Abuse Prevention, and is reviewed through reports, conferences and assessment of goal achievement.

1. Encourages and assists the development of effective, coordinated, and efficient administration of resources and services available for drug abuse.

2. Provides such technical assistance as may be required by public and private service agencies for drug abuse services and planning.

3. Organizes activities at the community and regional levels to stimulate coordination of existing services available to the drug abuser and to create new services as needed.

4. Plans and develops new or expanded drug abuse service programs on a statewide level, based upon assessments of community needs.

5. Formulates and conducts public education programs to make the public aware of agency services, and to illuminate program gaps and needs.

6. Reviews, evaluates, and recommends improvements in and additions to programs of services for the drug abusing population.

7. Represents the drug abuse program interests of the Office with other relevant agencies and organizations at the state and federal levels, when delegated by the Director, Office of Alcoholism and Drug Abuse Prevention.

8. Provides such staff assistance to advisory bodies as may be necessary, and as the Director, Office of Alcoholism and Drug Abuse Prevention, directs.

9. Prepares budget requests based upon community needs and projected goals and submits recommendations to the Director, Office of Alcoholism and Drug Abuse Prevention. Carries responsibility for the preparation of the narrative description of Program needs to accompany the budget and appropriation proposals relating to his assigned program area.

10. Provides interpretation, clarification, and consultation to Bureau of Rehabilitation regional staff concerning drug abuse program objectives, policies, and procedures.

11. Performs related work as required.

Required Knowledge, Skill, and Ability

Knowledge of laws and regulations pertaining to the provision of services to drug abusers.

Knowledge of drug abuse, its problems and services needed.

Ability to organize and participate in workshops, conferences, and meetings concerning drug abuse issues.

Ability to establish effective working relationships with public and private agencies.

Skill in consultation and technical assistnce activities.

Desirable Experience and Training

Five years of experience in human service or administration field with a master's degree in human service or in administration.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-THREE

S. P. 635 — L. D. 2008

AN ACT Reconstituting and More Effectively Coordinating the Maine Commission on Drug Abuse and the Division of Alcoholism and Providing an Alternative Sentencing for Violators of Drug Laws.

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

Sec. 1. R. S., T. 22, Subtitle 4, Part 3, additional. Subtitle 4 of Title 22 of the Revised Statutes is amended by adding a new Part 3 to read as follows:

PART 3

DRUG ABUSE

CHAPTER 1601

ALCOHOLISM, INTOXICATION AND DRUG ABUSE PREVENTION, TREATMENT AND REHABILITATION

SUBCHAPTER I

GENERAL PROVISIONS

§ 7101. Short title

This Part may be cited as the 1973 Alcoholism and Drug Abuse Act.

§ 7102. Declaration of objectives

1. The serious problem of drug abuse, including the use of alcohol which results in chronic intoxication or alcoholism, must be confronted with the immediate objective of significantly reducing the incidence of such abuse in the State within the shortest possible period of time.

2. In order to efficiently and effectively accomplish this objective, it is essential to adopt an integrated approach to the problem and to focus all the varied resources of the State on developing a comprehensive range of drug abuse prevention and treatment services, conducted by one administrative unit.

3. It is, therefore, the objective of this Act to establish one office to coordinate the planning and operation of all state drug abuse services, including those related to the abuse of alcohol, and excepting those relating to the prevention of drug traffic, and to provide support and guidance to individuals, public and private organizations and especially local governments, in their drug abuse prevention activities.

§ 7103. Definitions

As used in this Act, unless the context otherwise indicates, the following words shall have the following meanings.

1. Administrative activities. "Administrative activities" means an activity related to guidelines, criteria, regulations, requirements or procedures for operations related to drug abuse prevention.

2. Agreement. "Agreement" means a legally binding document between 2 parties including such documents as are commonly referred to as accepted proposal, contract, grant, joint or cooperative agreement, or purchase of services.

3. Alcoholic. "Alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted.

4. Approved treatment facility. "Approved treatment facility" means a public or private nonprofit agency meeting the standards promulgated by the office pursuant to section 7115, subsection 1, and approved under section 7115, subsection 3 and licensed pursuant to section 5-A or pursuant to other applicable provisions of Maine law. An approved public treatment facility is a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under section 7114, subsection 6.

5. Commissioner. "Commissioner" means the Commissioner of Health and Welfare.

6. Department. "Department" means the Department of Health and Welfare.

7. Dependency related drug. "Dependency related drug" means alcohol or any substance controlled under chapter 551, subchapter II, and chapters 557 and 558.

8. Director. "Director" means the Director, Office of Alcohol and Drug Abuse Prevention.

9. Drug abuser. "Drug abuser" means a person who uses any drugs, dependency related drugs, or hallucinogens in violation of any law of the State of Maine.

10. Drug abuse prevention. "Drug abuse prevention" means all facilities, programs or services relating to drug abuse control, education, rehabilitation, research, training and treatment, and includes these functions as related to alcoholics and intoxicated persons. The term includes such functions even when performed by an organization whose primary mission is in the field of prevention of drug traffic or is unrelated to drugs. This term does not include any function defined under section 7103, subsection 18 as prevention of drug traffic.

11. Drug addict. "Drug addict" means a drug dependent person who, due to the use of a dependency related drug has developed such a tolerance thereto that abrupt termination of the use thereof would produce withdrawal symptoms.

12. Drug dependent person. "Drug dependent person" means any person who is unable to function effectively and whose inability to do so causes or results from the use of a dependency related drug.

13. Emergency service patrol. "Emergency service patrol" means a patrol established under section 7123.

14. Incapacitated by alcohol. "Incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment.

15. Incompetent person. "Incompetent person" means a person who has been adjudged incompetent by a court.

16. Intoxicated person. "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol.

17. Office. "Office" means the Office of Alcoholism and Drug Abuse Prevention in the department established under section 7104.

18. Prevention of drug traffic. "Prevention of drug traffic" means any functions conducted for the purpose of preventing drug traffic, such as law enforcement and judicial activities or proceedings;

A. Investigation, arrest, prosecution. The investigation, arrest and prosecution of drug offenders and offenses; or

B. Detection and suppression. The detection and suppression of illicit drug supplies.

19. Standards. "Standards" means criteria, rules and regulations of the department that are to be met before and during operation of any treatment facility or treatment program.

20. Treatment. "Treatment" means the broad range of emergency, outpatient, intermediate and in-patient services and care including career counseling, diagnostic evaluation, employment, health, medical, psychiatric, psychological, recreational, rehabilitative, social service care, treatment and vocational services, which may be extended to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person or to a person in need of assistance due to use of a dependency related drug.

21. Treatment program. "Treatment program" means any program or service, or portion thereof, sponsored under the auspices of a public or private nonprofit agency providing services especially designed for the treatment of those persons listed in subsection 20.

SUBCHAPTER II

ORGANIZATION

§ 7104. Office of Alcoholism and Drug Abuse Prevention

There is created within the Bureau of Rehabilitation of the Department of Health and Welfare the Office of Alcoholism and Drug Abuse Prevention. The office shall be under the immediate and full supervision of the Director, Bureau of Rehabilitation. The office shall be the sole agency of State Government responsible for administration of this chapter. It shall be a separate, distinct administrative unit, which shall not be in any way integrated as a part or function of any other administrative unit of the department.

The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the Division of Alcoholism Services hereto-

fore established in the Department shall, by this Act and implementation of it, be reconstituted and unified into a single administrative unit, functioning as an integrated agency of State Government.

§ 7105. Director

The Office of Alcoholism and Drug Abuse Prevention shall be administered by a director, who shall be appointed, subject to the Personnel Law, under the classified service by the commissioner after consultation with the Maine Council on Alcohol and Drug Abuse Prevention and Treatment. The director shall be a person qualified by training and experience with drug abuse, or alcoholism and intoxication, or who has had satisfactory experience of a comparable nature in the direction, organization and administration of prevention or treatment programs for persons affected by drug abuse or drug dependency. He shall be immediately and fully responsible to the Manager, Office of Resource Development and shall not be indirectly responsible to any other official of the department.

The director shall serve full time in a position that is separate from and not in any way integrated with another position in the department. He shall not concurrently hold another title and shall perform duties solely germane to the powers and duties of the office as provided for in this chapter.

The director shall possess full authority and responsibility for administering all the powers and duties of the office provided in section 7106, except as otherwise provided by statute. He shall, with the advice of the Maine Council on Alcohol and Drug Abuse Prevention and Treatment, assume and discharge all responsibilities vested in the office. He shall not in any case assign to another unit of the department which is not responsible to him any powers and duties granted to the office by statute, or by rules, regulations or procedures adopted pursuant to this chapter. He shall make full use of existing support services available in State Government to assist with carrying out the responsibilities set by this chapter.

The director may employ, subject to the Personnel Law and within the limits of funds available, competent professional personnel and other staff necessary to carry out the purposes of this chapter. He shall prescribe the duties of staff and assign a sufficient number of staff full time to the office to achieve its powers and duties. He may arrange to house staff or assign staff who are responsible to him and who are to provide direct service to individuals or small groups of individuals needing drug abuse treatment, to operating units of the department, such as the Bureau of Rehabilitation, which are responsible for similar functions.

§ 7106. Powers and duties

The office shall establish in accord with the purposes and intent of this chapter, and with the advice of the council and the cooperation of the coordinating committee, the overall planning, policy, objectives and priorities for all drug abuse prevention functions, except prevention of drug traffic, which are conducted or supported in the State of Maine. In order to carry out the above, the office shall have the power and duty to:

1. Encourage and assist development of more effective, more coordinated, more efficient administration of resources and services available for drug abuse prevention;

2. Develop and maintain an up-to-date information system related to drugs, drug abuse and drug abuse prevention. The information shall be available for use by the people of Maine, the political subdivisions, public and private nonprofit agencies and the State. Educational materials shall be prepared, published and disseminated. Objective devices and research methodologies shall be continuously developed. Uniform methods of keeping statistical information shall be specified for use by public and private agencies, or-

ganizations and individuals. Existing sources of information shall be used to the fullest extent possible, while maintaining confidentiality safeguards of state and federal law. Information may be requested and shall be received from any state government or public or private agency. To the extent feasible, information shall maintain compatibility with federal information sharing standards.

Functions of the drug information system shall include, but not be limited to:

A. Conducting research on the causes and nature of drugs, drug abuse or people who are dependent on drugs, especially alcoholics and intoxicated persons;

B. Collecting, maintaining and disseminating such knowledge, data and statistics related to drugs, drug abuse and drug abuse prevention as will enable the office to fulfill its responsibilities;

C. Determining through a detailed survey the extent of the drug abuse problem, and the needs and priorities for the prevention of drug abuse and drug dependence in the state and political subdivisions. Included shall be a survey of health facilities needed to provide services for drug abuse and drug dependence, especially alcoholics and intoxicated persons;

D. Maintaining an inventory of the types and quantity of drug abuse prevention facilities, programs and services available or provided under public or private auspices to drug addicts, drug abusers and drug dependent persons, especially alcoholics and intoxicated persons. This function shall include the unduplicated count, location and characteristics of people receiving treatment, as well as their frequency of admission and readmission, and frequency and duration of treatment. The inventory shall include the amount, type and source of resources for drug abuse prevention;

E. Conducting a continuous evaluation of the impact, quality and value of drug abuse prevention facilities, programs and services; including their administrative adequacy and capacity. Activities operated by or with the assistance of the State and Federal Governments shall be evaluated. Included shall be alcohol and drug abuse prevention and treatment services as authorized by this and so much of the several Acts and amendments to them enacted by the People of the State of Maine, and those authorized by the United States Acts and amendments to them as relate to drug abuse prevention:

(1) The Drug Abuse Office and Treatment Act of 1972 (P. L. 92-255);

(2) The Community Mental Health Centers Act (42 USC 2688);

(3) The Public Health Service Act (42 USC);

(4) The Vocational Rehabilitation Act;

(5) The Social Security Act;

(6) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P. L. 91-616) and similar Acts.

3. Assist, with the advice of the council and cooperation of the coordinating committee, the Legislature and executive branches and Judicial Council of State Government, especially the Governor, commissioner, and Bureau of the Budget, to coordinate all state government efforts dealing with drug abuse prevention and control, including alcoholism, by:

A. Submitting to each branch of State Government no later than September 1st of each year an annual report covering its activities for the immedi-

ate past fiscal year and future plans, including recommendations for changes in state and federal laws, and including reports of the council and coordinating committee;

B. Reviewing all proposed legislation, fiscal activities, plans, policies and other administrative functions relating to drug abuse prevention activities made by or requested of all state agencies. The office shall have the authority to submit to these bodies findings, comments and recommendations, which in the case of the Judicial Council, Legislature, Governor and commissioner shall be advisory; and which in the case of other state agencies shall be binding. Such findings, comments and recommendations shall specify what modification in proposals or actions shall be taken to make proposed legislation, fiscal activities and administrative activities consistent with such policies and priorities;

C. Making recommendations to the respective branches of State Government concerning prevention of drug traffic and shall consult with and be consulted by all responsible state agencies regarding the policies, priorities and objectives of functions to prevent drug traffic.

4. Prepare and administer a comprehensive state plan mutually developed by the office, council and coordinating committee, relating to all drug abuse prevention and treatment of alcoholics and intoxicated persons and control of drug abuse. The comprehensive state plan shall be implemented for the purpose of coordinating all drug abuse prevention activities and of assuring compliance with applicable state and federal laws and regulation and with the state plan relating to drug abuse prevention. Implementation of this duty shall mean that the office shall have the authority to supervise through a review process the preparation and administration of any portion of any state plan relating to drug abuse prevention prepared and administered by any agency of State Government for submission to the Federal Government to obtain federal funding under federal legislation. Such state plans, or portions thereof, shall include, but not be limited to, all state plans dealing with education, employment and vocational services, medical, rehabilitation, social services, welfare, drug abuse prevention and treatment of alcoholism and intoxicated persons.

The office shall advise the commissioner and Governor on preparation of and provisions to be included relating to drug abuse prevention and relating to alcoholism and intoxicated persons. Such state plans shall provide for methods of administration which will supplement, compliment and broaden related state plans, including, but not limited to, those developed under the U. S. Public Health Service Act, section 314 (2);

5. Plan, establish and maintain necessary or desirable prevention or treatment programs for individuals or groups of individuals, except that the office and its staff, whether assigned to the office or to operating units, may provide direct service only to a drug dependent individual or groups of such individuals, whose drug dependency is related to alcohol. The office may use the full range of its powers and duties to serve any drug dependent person through indirect services provided for by agreements;

6. Function as the organizational unit of Maine State Government with sole responsibility for conducting and coordinating, with the advice of the council and the cooperation of the coordinating committee, state programs and activities authorized by this chapter, and by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended, and by the Drug Abuse Office and Treatment Act of 1972, as amended; and other programs or Acts of the State of Maine or United States related to drug abuse prevention which are not the specific responsibility of another state agency under federal or state law.

The Office is designated as the single agency of Maine State government solely responsible for administering the state plans required by those Acts;

7. Help communities mobilize their resources to deal with drug abuse. The office shall provide, or coordinate the provision of information, technical assistance and consultation to state, regional and local governments; and to public and private nonprofit agencies, institutions, organizations and individuals. The help shall be for the purpose of encouraging, developing and assisting with the initiation, establishment and administration of any plans, programs or services to prevent drug abuse.

Included in this duty is authority to coordinate the efforts and enlist the assistance of all public and private agencies, organizations and individuals interested in drug abuse prevention, especially alcoholism and treatment of alcoholics and intoxicated persons. The support and assistance of interested persons in the community, particularly recovered alcoholics and abusers of drugs, shall be utilized to encourage alcoholics and drug abusers voluntarily to undergo treatment;

8. Seek and receive funds from Federal Government and private sources to further its activities. Included in this function is authority to solicit, accept, administer, disburse and coordinate for the State in accordance with the intent, objectives and purposes of this chapter; and within any limitation which may apply from the sources of such funds, the efforts to obtain and the use of any funds from any source to treat alcoholism or prevent drug abuse. Any gift of money or property made by will or otherwise, and any grant or other funds appropriated, services or property available from the Federal Government, the State or any political subdivision thereof and from all other sources, public or private, may be accepted and administered. The office may do all things necessary to cooperate with the Federal Government or any of its agencies in making application for any funds. Included in this duty is authority to coordinate the disbursement of all state funds, or funds administered through agencies of State Government, appropriated or made available for drug abuse prevention. No fiscal transaction, including encumbrance or disbursement, shall be made for drug abuse prevention without approval of the office;

9. Enter into agreements necessary or incidental to the performance of its duties. Included is the power to make agreements with qualified community, regional and state level, private nonprofit and public agencies, organizations and individuals in this and other states to develop or provide drug abuse prevention and treatment facilities, programs and services. Such agreements may include provisions to pay for such prevention or treatment rendered or furnished to an alcoholic, intoxicated person, drug abuser, drug addict, drug dependent person or person in need of assistance due to use of a dependency related drug. Such contracts shall be executed only with agencies that meet the standards for treatment promulgated by the office under section 7115, subsection 1, and approved under section 7115, subsection 3, and licensed pursuant to section 5-A or other applicable provisions of law. The office may engage expert advisors and assistants who may serve without compensation, or to the extent funds may be available by appropriation, grant, gift or allocation from a state department, the office may pay for such expert advisors or assistants;

10. Prepare, adopt, amend, rescind and administer policies, priorities, procedures, rules and regulations to govern its affairs and the development and operation of facilities, programs and services. The office may adopt rules to carry out the powers and duties conducted under the authority in accordance with the purpose and objectives of this Act. It shall especially adopt such rules and regulations as may be necessary to define contractual terms, conditions of agreements and all other rules as are necessary for the proper administration of this chapter. Such adoption, amendment and rescission shall be made as provided under Title 5, chapters 301 to 307, Administrative Code;

11. Establish operating and treatment standards, inspect and issue a certificate of approval for any drug abuse treatment facility or program, including residential treatment centers, which meet the standards promulgated un-

der section 7115, subsection 1, and licensed pursuant to section 5-A and other applicable provisions of law. The office shall periodically enter, inspect and examine the treatment facility or program, and examine their books and accounts. It shall fix and collect the fees for such inspection and certificate. Insofar as licensing and certification of drug abuse prevention facilities and programs may also be the responsibility of another administrative unit of the department, the office may assign performance of this responsibility to such a unit or make other mutually agreeable arrangements with such a unit for assisting with performance of this responsibility;

12. Develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons and persons who abuse or are dependent on drugs. Assist in the development of, and cooperation with, alcoholic education and treatment programs for employees of state and local governments and businesses and industries in the State. Convene and conduct conferences of public and private nonprofit organizations concerned with the development and operation of drug abuse prevention programs. Included shall be the power to encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons who abuse or are dependent on drugs and to provide them with adequate and appropriate treatment. Also included is the power to encourage all health and disability insurance programs to include alcoholism as a covered illness;

13. Foster, develop, organize, conduct or provide for the conduct of training programs for all persons in the field of treating alcoholics and intoxicated persons and drug abusers;

14. Coordinate activities and cooperate with drug abuse prevention programs in this and other states for the common advancement of drug abuse prevention and alcoholism programs;

15. Establish and maintain a principal office at the department's general headquarters, and such other offices within the State as it may deem necessary;

16. Do other acts and exercise such other powers necessary or convenient to execute and carry out the purposes and authority expressly granted in this chapter.

SUBCHAPTER III

ADVISORY COUNCIL

§ 7107. Maine Council on Alcohol and Drug Abuse Prevention and Treatment

The Maine Council on Alcohol and Drug Abuse Prevention and Treatment, hereinafter in this chapter referred to as the "council," is created. The council may appoint from its membership subcommittees relating to particular problem areas or to other matters, provided that by January 1, 1975 the council shall function as an integrated committee. The office shall provide the council any administrative or financial assistance that from time to time may be reasonably required to carry out its activities. Any reasonable and proper expenses of the council shall be borne by the office out of currently available state or federal funds. The Maine Commission on Drug Abuse, as heretofore established by Title 5, chapter 317, as amended, and the advisory councils on alcoholism heretofore established in the department and by section 1352, as amended, shall, by this Act and implementation of it, be reconstituted and unified into a single unit.

§ 7108. Membership

The council shall consist of no more than 17 members who, excepting members representing the Legislature, shall be appointed by the Governor

with the advice and consent of the Executive Council. To be qualified to serve, members shall have education, training, experience, knowledge, expertise and interest in drug abuse prevention and training. Members shall be residents of different geographical areas of the State, who reflect experiential diversity and concern for drug abuse prevention and treatment in the State.

They shall be selected from outstanding people in the fields of education, health, law, law enforcement, manpower, medicine, science, social sciences and related areas. Members shall have an unselfish and dedicated personal interest demonstrated by active participation in drug abuse programs such as prevention, treatment, rehabilitation, training or research into drug abuse and alcohol abuse.

Membership shall include representatives of nongovernmental organizations or groups and of public agencies concerned with prevention and treatment of alcoholism, alcohol abuse, drug abuse and drug dependence. At least 2 members of the council shall be current members of the Legislature, consisting of one member from the House of Representatives appointed by the Speaker of the House to serve at his pleasure and one member from the Senate appointed by the President of the Senate to serve at his pleasure. Two of the private citizen members shall be between the ages of 16 and 21. At least 3 members shall be persons recovered from alcoholism, chronic intoxication, drug abuse or drug dependence. At least 3 members shall be officials of public or private nonprofit community level agencies who are actively engaged in drug abuse prevention or treatment in public or private nonprofit community agencies. Membership may also include, but not be limited to, representatives of professions such as law, law enforcement, medicine, pharmacy and teaching.

Members shall be appointed for a term of 3 years, except that of the members first appointed, 5 shall be appointed for a term of 3 years, 5 shall be appointed for a term of 2 years and 5 shall be appointed for a term of one year, as designated by the Governor at the time of appointment; except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed only for the remainder of such term, and except that members who are members of the current Legislature and who are appointed by the President of the Senate or the Speaker of the House shall serve at their pleasure. Any vacancy in the council shall not affect its powers, but shall be filled in the same manner by which the original appointment was made.

Members shall be eligible for reappointment for not more than one consecutive term and may serve after the expiration of their term until their successors have been appointed, qualified and taken office. The appointing authority may terminate the appointment of any member of the council for good and just cause and the reason for the termination of each appointment shall be communicated to each member so terminated. The appointment of any member of the council shall be terminated if a member is absent from 3 consecutive meetings without good and just cause that is communicated to the chairman. An official, employee, consultant or any other individual employed, retained or otherwise compensated by or representative of the Executive Branch of the Government of the State of Maine shall not be a member of the council; but shall assist the council if so requested. The director of the office or his representative shall attend all meetings of the council.

The Governor shall designate the chairman from among the members appointed to the council. The council may elect such other officers from its members as it deems appropriate.

§ 7109. Meetings, compensation, quorum

The council shall meet at the call of the chairman or at the call of ¼ of the members appointed and currently holding office. The council shall meet at least 5 times a year and at least once every 3 months. The council shall

keep minutes of all meetings, including a list of people in attendance. Minutes of all meetings shall be sent forthwith to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

Members of the council shall serve without compensation, but they may be reimbursed on the same basis as employees of state departments for the actual travel and other necessary expenses incurred in the performance of their duties.

A majority of the council members shall constitute a quorum for the purpose of conducting the business of the council and exercising all the powers of the council. A vote of the majority of the members present shall be sufficient for all actions of the council.

§ 7110. Powers and duties

The council, in cooperation with the office and coordinating committee, shall have the power and duty to:

1. Advise, consult and assist the Executive and Legislative Branches of the State Government and the Judicial Council, especially the Governor, on activities of State Government related to drug abuse prevention and treatment, including alcoholism and intoxication. The council may make recommendations regarding any function intended to prevent drug traffic. If findings, comments or recommendations of the council vary from or are in addition to those of the office or coordinating committee, such statements of the council shall be sent to the respective branches of State Government as attachments to those submitted by the office. Recommendations may take the form of proposed budgetary, legislative or policy actions. The council shall be solely advisory in nature and shall not be delegated any administrative authority or responsibility.

2. Serve as an advocate on alcoholism and drug abuse prevention and treatment, promoting and assisting activities designed to meet at the national, state and community levels the problems of drug abuse and drug dependence. The council shall serve as an ombudsman on behalf of individual citizens and drug dependent people as a class in matters under the jurisdiction of Maine State Government. It shall be a spokesman on behalf of drug abuse prevention to the director, commissioner, Governor, Legislature, public at large and National Government;

3. Serve as the advisory council on behalf of the State of Maine to the state agency as required by the federal regulations governing administration of the United States Drug Abuse Office and Treatment Act of 1972, as amended, and the United States Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended; and such other Acts of the United States as may heretofore or hereafter be enacted. The council shall advise regarding state and federal plans, policies, programs and other activities relating to the drug abuse and drug dependence in Maine. The council shall submit their recommendations and comments on the state plan, and any revisions thereof, and reports to federal or state agencies. Statements at variance or in addition to those of the office or the coordination committee shall be attached to the plan or reports upon submission by the office to agencies of the United States Government and to state agencies;

4. Serve, through a subcommittee of the council consisting of 5 persons including the chairman and 4 other members appointed by the chairman with the advice and consent of the Governor, as the review committee on behalf of the State of Maine responsible for analysis and recommendation to the director concerning the acceptability of proposals requesting award of state administered grant funds for drug abuse prevention and treatment under the United States Comprehensive Alcohol Abuse and Alcoholism Prevention,

Treatment and Rehabilitation Act of 1970 and the United States Drug Abuse Office and Treatment Act of 1972, and in order to insure coordination and prevent duplication of services shall review and comment on, under its own initiative or at the request of any state or federal department or agency, any application from any agency or organization within the State to a state or federal department or agency for financial assistance related to meeting the needs of people who abuse or are dependent on drugs;

5. Review and evaluate on a continuing basis, in cooperation with the office, for the purpose of determining the value and impact on the lives of people who abuse or are dependent on drugs, state and federal policies and programs relating to drug abuse and other activities affecting the people who abuse or are dependent on drugs, conducted or assisted by any state departments or agencies;

6. Inform the public in cooperation with the office, to develop a firm public understanding of the current status of drug abuse and drug dependence among Maine's citizens, including information on effective programs elsewhere in the State or Nation, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports;

7. Provide public forums, including the conduct of public hearings, sponsorship of conferences, workshops and other such meetings to obtain information about, discuss and publicize the need of and solutions to drug abuse and drug dependence. The council may hold a state-wide conference, regional conferences and meetings;

8. Administer in accordance with current fiscal and accounting regulations of the State, and in accordance with the philosophy, objectives and authority of this Act, any funds appropriated for expenditure by the council or any grants or gifts which may become available, accepted and received by the council; and make, to be included in the annual report of the office, an annual report to the director, commissioner, Governor and Legislature not later than September 1st of each year concerning its work, recommendations and interests of the previous fiscal year and future plans; and shall make such interim reports as it deems advisable.

SUBCHAPTER IV

COOPERATING STATE AGENCIES, PROGRAMS AND TREATMENT

§ 7111. State Government Coordinating Committee

1. The State Government Drug Abuse Coordinating Committee is established. It shall, in cooperation with the advisory council and office, recommend policy to be established and implemented by state government agencies. It shall assist with the coordination of, and exchange of information on, all drug abuse prevention and control activities of the State of Maine. It shall act as a permanent liaison among the branches of Maine State Government and their agencies engaged in or expected to engage in activities affecting drug abuse or drug dependent people. The committee shall assist the Legislative and Executive Branches and Judicial Council in formulating and implementing a comprehensive plan, mutually developed by the advisory council, coordinating committee and office, for prevention and control of drug abuse and drug dependence, especially treatment of alcoholics and intoxicated persons. The office shall provide any ordinary administrative and financial assistance to the coordinating committee as may be reasonably required from time to time to carry out its activities. Reasonable and proper expenses of the committee shall be paid from currently available state or federal funds. The committee shall meet at least twice annually at the call of the commissioner, who shall be its chairman.

2. In exercising its coordinating functions, the committee shall assure that:

A. The appropriate agencies of State Government shall provide all necessary career, educational, employment, health, judicial, law enforcement, legal, medical, penal, psychiatric, psychological, rehabilitative, social, treatment and vocational services for drug abusers and drug dependent persons and for prevention and control of drug abuse and drug dependency without unnecessary duplication of services;

B. The agencies of the several branches of State Government cooperate in the use of facilities and in the treatment of drug abuses and drug dependent persons;

C. All agencies of State Government shall adopt policies to control use of drugs, prevent drug abuse and to treat drug abusers and drug dependent persons, especially alcoholics and intoxicated persons in a manner consistent with the policy of this chapter;

D. Minutes of all meetings shall be sent to the Governor and leadership of the Legislature, who shall provide for their appropriate distribution and retention in a place of safekeeping.

3. The committee membership shall consist of not more than 17 members, who shall include, but not be limited to, the following members, who shall serve ex officio, or their designated representatives:

The Attorney General;

The Chief Justice, as Chairman of the Judicial Council;

The Director of Law Enforcement Planning and Assistance;

The Director, Office of Alcohol and Drug Abuse Prevention;

The Commissioner of Educational and Cultural Services;

The Commissioner of Health and Welfare;

The Commissioner of Manpower Affairs;

The Commissioner of Mental Health and Corrections;

The Commissioner of Public Safety;

The Commissioner of Transportation;

The Governor;

The President of the Maine Senate;

The Speaker of the Maine House of Representatives;

The State Youth Coordinator;

and other appropriate officials.

§ 7112. State agencies to cooperate

State agencies proposing to develop, establish, conduct or administer drug abuse prevention programs or to assist with such programs as covered by this chapter shall, prior to carrying out such actions, consult with the office to obtain the approval of the office to conduct such action.

All agencies of State Government shall advise the office of their proposed fiscal activities, especially budget requests and expenditures, concurrently

with their submission to the Budget Office or to the Governor. All agencies of State Government, concurrent with submission to that agency's approval authority, shall advise the office of proposed legislation, fiscal activities and administrative activities relating to drug abuse prevention. No such action shall be taken related to drug abuse prevention without approval of the office. State agencies shall, in the implementation of their activities, keep the office fully informed of their progress and of any proposed changes in fiscal matters and policy.

State agencies shall cooperate fully with the office and council in carrying out this chapter. The office and council are authorized to request such personnel, financial assistance, facilities and data as will assist the office and council to fulfill its powers and duties.

The office shall cooperate with the Department of Mental Health and Corrections and all institutions under its control in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons and for people who abuse or are dependent on drugs in or on parole from penal or special treatment institutions.

The office shall cooperate with the Department of Public Safety and the Department of Transportation in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while under the influence of drugs or intoxicating liquor.

The office shall coordinate all drug abuse education, information and training programs conducted within the State through cooperation with the Department of Educational and Cultural Services, school administrative districts, municipal schools, police departments, courts and other public and private agencies, organizations and individuals. Such coordination may assist with: Establishing educational programs for the prevention of alcoholism and drug abuse; treatment and rehabilitation of alcoholics, intoxicated persons and persons dependent upon or abusing drugs; training in the prevention, treatment and rehabilitation of such persons; and with preparation of curriculum materials thereon for use in all levels of educational programs.

§ 7113. State drug abuse strategy

Immediately upon the day this Act becomes effective, the Governor shall direct the development of a comprehensive, coordinated long-term state strategy for all drug abuse prevention functions and all drug traffic prevention functions conducted, sponsored or supported by any agency of State Government. The strategy shall be initially promulgated by the Governor no later than January 1, 1975.

To develop the strategy, the office, council and coordinating committee shall mutually participate to achieve its preparation. The strategy shall be subject to review and written comment by those state officials participating in its preparation.

The strategy shall contain:

1. An analysis of the nature, character and extent of the drug abuse problem in Maine, including examination of the interrelationships between various approaches to solving the drug abuse problem and their potential for interacting both positively and negatively with one another;

2. A comprehensive plan, with respect to both drug abuse prevention functions and drug traffic prevention functions, which shall specify the objectives of the strategy and how all available resources, funds, programs, services and facilities authorized under relevant law should be used; and

3. An analysis and evaluation of the major programs conducted, expenditures made, results achieved, plans developed and problems encountered in

the operation and coordination of the various drug abuse prevention functions and drug traffic prevention functions.

The strategy shall be reviewed, revised as necessary and promulgated as revised from time to time as the Governor deems appropriate, but not less often than once every 2 years.

§ 7114. Comprehensive program on alcoholism and drug abuse

1. A comprehensive and coordinated program of drug abuse prevention and treatment, especially of alcoholics and intoxicated persons, is established. Nothing in subsequent sections shall be interpreted as preventing the establishment of additional drug abuse prevention and treatment programs, including programs which the office considers necessary or desirable for intoxicated persons and alcoholics.

2. The program shall include:

A. Emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

B. Inpatient treatment;

C. Intermediate treatment; and

D. Outpatient and followup treatment.

3. The office shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 7117 to 7120. Treatment may not be provided at a correctional institution, except for inmates.

4. The office shall maintain, supervise and control all facilities operated by it subject to policies of the department. The administrator of each facility shall make an annual report of its activities to the director in the form and manner the director specifies.

5. All appropriate public and private resources shall be coordinated with and utilized in the program, if possible.

6. The office may contract for the use of any facility as an approved public treatment facility, if the director, subject to the policies of the department, considers this to be an effective and economical course to follow.

§ 7115. Standards for public and private alcohol or drug abuse treatment facilities; enforcement procedures; penalties

1. The department shall establish standards for approved treatment facilities, that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged by the department for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

2. The department periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

3. The department shall maintain a list of approved public and private treatment facilities.

4. Each approved public and private treatment facility shall file with the department on request data, statistics, schedules and information the department reasonably requires. An approved public or private treatment facility

that without good cause fails to furnish any data, statistics, schedules or information as requested, or files fraudulent returns thereof, shall be removed from the list of approved treatment facilities.

5. The District Court may restrain any violation of this section, review any denial, restriction or revocation of approval and grant other relief required to enforce its provisions.

6. The department may at reasonable times enter and inspect and examine the books and accounts of any approved public or private treatment facility refusing to consent to inspection or examination by the department or which the department has reasonable cause to believe is operating in violation of this Act.

§ 7116. Acceptance for treatment of alcoholics and intoxicated persons; rules

The director shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons.

In establishing the rules, the director shall be guided by the following standards.

1. If possible, a patient shall be treated on a voluntary rather than an involuntary basis.

2. A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

3. A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

4. An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

5. Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

§ 7117. Voluntary treatment of alcoholics

1. An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, a legal guardian or other legal representative may make the application.

2. Subject to rules adopted by the director, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to rules adopted by the director, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

3. If a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the office shall arrange for assistance in obtaining supportive services and residential facilities.

4. If a patient leaves an approved public treatment facility, with or against the advice of the administrator in charge of the facility, the office

shall make reasonable provisions for his transportation to another facility or to his home. If he has no home, he shall be assisted in obtaining shelter. If he is a minor or an incompetent person, the request for discharge from an inpatient facility shall be made by a parent, legal guardian or other legal representative or by the minor or incompetent, if the minor or incompetent was the original applicant.

§ 7118. Treatment and services for intoxicated persons and persons incapacitated by alcohol

1. An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility or other health facility by the police or the emergency service patrol.

2. A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and forthwith brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available, he shall be taken to an emergency medical service customarily used for incapacitated persons. The police or the emergency service patrol, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

3. A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician forthwith. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

4. A person, who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility once he is no longer incapacitated by alcohol, or if he remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless he is committed under section 7119. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

5. A person, who is not admitted to an approved public treatment facility, is not referred to another health facility and has no funds, may be taken to his home, if any. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

6. If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.

7. The police or members of the emergency service patrol who act in compliance with this section are acting in the course of their official duty and are not criminally or civilly liable therefor.

8. If the administrator in charge of the approved public treatment facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

§ 7119. Emergency commitment of an incapacitated or intoxicated person

1. An intoxicated person who has threatened, attempted or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not in itself constitute evidence of lack of judgment as to the need for treatment.

2. The spouse, guardian or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within 2 days before the date of the application for admission and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the division is not eligible to be the certifying physician. The certifying physician shall be someone other than the person making the written application for commitment.

3. Upon approval of the application by the administrator in charge of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection 5.

4. The administrator in charge of an approved public treatment facility shall refuse an application if, in the opinion of a physician or physicians employed by a facility, the application and certificate fail to sustain the grounds for commitment.

5. When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than 5 days. If a petition for involuntary commitment under section 7120 has been filed within the 5 days and the adminstrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

6. A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult counsel.

§ 7120. Involuntary commitment of alcoholics or incapacitated persons

1. A person may be committed to the custody of the office by the District Court upon the petition of his spouse or guardian, relative or the administrator in charge of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he has threatened, attempted or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another or is incapacitated by alcohol. A refusal to undergo treatment does not in itself constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within 2 days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact

of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the division is not eligible to be the certifying physician. The certifying physician shall be someone other than the person bringing the petition.

2. Upon filing the petition, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, a parent or his legal guardian, the administrator in charge of the approved public treatment facility to which he has been committed for emergency care and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

3. At the hearing, the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall be present, unless the court believes that his presence is likely to be injurious to him; in this event, the court shall appoint a guardian ad litem to represent him throughout the proceeding. The court shall examine the person in open court, or if advisable, shall examine the person out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to be examined by a court-appointed licensed physician. If he refuses and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the division for a period of not more than 5 days for purposes of a diagnostic examination.

4. If, after hearing all relevant evidence, including the results of any diagnostic examination by the office, the court finds that grounds for involuntary commitment have been established by clear and convincing proof, it shall make an order of commitment to the office. It may not order commitment of a person, unless it determines that the office is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

5. A person committed under this section shall remain in the custody of the office for treatment for a period of 30 days unless sooner discharged. At the end of the 30-day period, he shall be discharged automatically, unless the office before expiration of the period obtains a court order for his recommitment upon the grounds set forth in subsection 1 for a further period of 90 days, unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment, if after examination it is determined that the likelihood still exists.

6. A person recommitted under subsection 5 who has not been discharged by the office before the end of the 90-day period shall be discharged at the expiration of that period, unless the office before expiration of the period obtains a court order on the grounds set forth in subsection 1 for the recommitment for a further period not to exceed 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists. Only 2 recommitment orders under this subsection and subsection 5 are permitted.

7. Upon the filing of a petition for recommitment under subsection 5 or 6, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, the original petitioner under subsection 1, if different from the petitioner for recommitment, one of his parents or his legal guardian and any other person

the court believes advisable. At the hearing the court shall proceed as provided in subsection 3.

8. The office shall provide for adequate and appropriate treatment of a person committed to its custody. The office may transfer any person committed to its custody from one approved public treatment facility to another, if transfer is medically advisable.

9. A person committed to the custody of the office for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

A. In case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that he is no longer an alcoholic or the likelihood no longer exists; or

B. In case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition or treatment is no longer adequate or appropriate.

10. The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of any proceedings relating to his commitment and recommitment and have counsel appointed by the court or provided by the court, if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

11. If a private or public treatment facility agrees with the request of a competent patient or his parent, sibling, adult child or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

12. A person committed under this chapter may at any time seek to be discharged from commitment by writ of habeas corpus.

13. The venue for proceedings under this section is the place in which the person to be committed resides or is present.

§ 7121. Records

1. The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

2. Notwithstanding subsection 1, the director may make available information from patients' records for purposes of research into the causes and treatment of alcoholism and drug abuse. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

§ 7122. Visitation and communication of patients

1. Subject to reasonable rules regarding hours of visitation which the director may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel and for continuing contact with family and friends consistent with an effective treatment program.

2. Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read or censored. The director may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

3. Except to the extent the director determines that it is necessary for the medical welfare of the patient to impose restrictions, and unless a patient has been restored to legal capacity and except where specifically restricted by other statute or regulation, but not solely because of the fact of admission to a mental hospital, to exercise all civil rights, including, but not limited to, civil service status, the right to vote, rights relating to the granting, renewal, forfeiture or denial of a license, permit, privilege or benefit pursuant to any law, and the right to enter contractual relationships and to manage his property.

§ 7123. Emergency service patrol; establishment; rules

1. The office, counties and municipalities may establish emergency service patrols. A patrol consists of persons trained to give assistance in the streets and in other public places to persons who are intoxicated due to the use of alcohol or dependency related to drugs. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall transport intoxicated persons to their homes and to and from public treatment facilities.

2. The director shall adopt rules for the establishment, training and conduct of emergency service patrols.

§ 7124. Payment for treatment; financial ability of patients

1. If treatment is provided by an approved public treatment facility and the patient has not paid the charge therefor, the office is entitled to any payment received by the patient or to which he may be entitled because of the services rendered, and from any public or private source available to the office because of the treatment provided to the patient.

2. A patient in an approved treatment facility, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability, is liable to the office for cost of maintenance and treatment of the patient therein in accordance with rates established.

3. The director shall adopt rules governing financial ability that take into consideration the income, savings and other personal and real property of the person required to pay, and any support being furnished by him to any person he is required by law to support.

Sec. 2. R. S., T. 5, § 2301, sub-§ 1, ¶ I, additional. Subsection 1 of section 2301 of Title 5 of the Revised Statutes, as amended, is further amended by adding a new paragraph I to read as follows:

I. Approved treatment facilities as defined in Title 22, section 7103.

Sec. 3. R. S., T. 5, c. 317, repealed. Chapter 317 of Title 5 of the Revised Statutes, as enacted by chapter 379 of the public laws of 1971, is repealed.

Sec. 4. R. S., T. 22, §§ 1351 and 1352, repealed. Sections 1351 and 1352 of Title 22 of the Revised Statutes are repealed.

Sec. 5. R. S., T. 34, § 1631, sub-§§ 5 and 5-A, additional. Section 1631 of Title 34 of the Revised Statutes, as amended, is further amended by adding 2 new subsections 5 and 5-A to read as follows:

5. Sentence to drug abuse treatment facility. In any case in which the offense relates to violation of any statutes concerning controlled or illegal

drugs or the sale or possession of drugs or narcotics, the court may impose sentence and place the person on probation. The court may require as a condition of probation that such person shall participate in, as a resident or nonresident, programs at an approved treatment facility as defined under Title 22, chapter 1601, provided the Office of Alcohol and Drug Abuse Prevention certifies to the court that such approved treatment facilities, personnel and programs are available and in compliance with all state licensing and certification laws, standards, rules and regulations.

Any person so sentenced to probation shall be required to participate in programs at the facility for a period not to exceed the period of probation ordered by the court. The professional staff of the facility may determine that the person's participation in treatment should be terminated. The supervisor or professional staff of the treatment facility may make such a determination when in their judgment the person:

A. Has successfully completed treatment or will derive no further significant benefits from such participation, or both, or

B. Will adversely affect the treatment of other participants by his continued participation, or

C. Has not conducted himself in accordance with the provisions of his sentence or probation.

When the professional staff of the treatment facility determines that the person's participation should be terminated, the supervisor of the treatment facility or the probation officer shall make a report to the court, which may thereupon make such provision with respect to the person's probation as the court deems appropriate.

5-A. Definition. For purposes of this section, "drug abuser" shall mean any person convicted of any violation of any statutes relating to controlled or illegal drugs.

Sec. 6. Transitional provisions.

1. Effect of transfer of powers, duties and functions. The Office of Alcoholism and Drug Abuse Prevention of the Department of Health and Welfare shall be the successor in every way to the powers, duties and functions of the former Division of Alcoholism Services and the former Maine Commission on Drug Abuse, or any of their administrative units, except as otherwise provided in this Act. The Director, Office of Alcoholism and Drug Abuse Prevention shall be the successor in every way to the responsibilities of the former Executive Director, Maine Commission on Drug Abuse and the former Director, Division of Alcoholism Services.

2. Rules, regulations and procedures. All existing regulations in effect, in operation or promulgated in or by the Maine Commission on Drug Abuse and the Division of Alcoholism, or in or by any administrative units or officer thereof, are hereby declared in effect and shall continue in effect until rescinded, revised or amended by the proper authority.

3. Contracts, agreements, compacts. All existing contracts, agreements and compacts currently in effect in the Maine Commission on Drug Abuse and the Division of Alcoholism shall continue in effect.

4. Personnel. Any positions, authorized and allocated subject to the Personnel Law, to the former Maine Commission on Drug Abuse and the former Division on Alcoholism are transferred to the Office of Alcoholism and Drug Abuse Prevention and may continue to be authorized to the office. Initial appointments to such positions vacant as of the effective date of this Act shall be made on an open competitive basis. Any employee and official of such former agencies subject to the Personnel Law on the effective date

of this Act may be transferred to the office and continue their employment after the effective date of this Act, without interruption of their state service, unless personnel positions or such office is terminated or abolished or method of appointment or employment is altered or changed by the provisions of this Act. Any positions in the unclassified service allotted to the Maine Commission on Drug Abuse are abolished. The office and title of Executive Director, Maine Commission on Drug Abuse and of Director, Division of Alcoholism are abolished.

5. Records, property and equipment. All records, property and equipment previously belonging to or allocated for the use of the Division of Alcoholism or the Maine Commission on Drug Abuse shall become on the effective day of this Act, part of the property of the Office of Drug Abuse and Prevention, Department of Health and Welfare.

6. Conflicts. All acts or parts of acts and rules inconsistent with this Act are repealed or amended to conform hereto.

7. Funds and equipment transferred. Notwithstanding the Revised Statutes, Title 5, section 1585, all accrued expenditures, assets, liabilities, balances of appropriations, transfers, revenues or other available funds in any account, or subdivision of an account, of any agency to be reallocated to another administrative unit as a result of this Act, shall be transferred to the proper place in an account for the office, by the State Controller, upon recommendation of the department head, the State Budget Officer and upon approval by the Governor and Executive Council. A proper accounting shall be made by activity within the account.

8. Effective date. This Act shall become effective October 1, 1973 in the event the Legislature adjourns on or before July 1, 1973 or otherwise shall become effective January 1, 1974.

IN HOUSE OF REPRESENTATIVES,.....1973

Read twice and passed to be enacted.

.....*Speaker*

IN SENATE,.....1973

Read twice and passed to be enacted.

.....*President*

Approved.....1973

.....*Governor*

32 Winthrop Street
Augusta, Maine 04330
Tel. (207) 289-2141

OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

GRANT GUIDELINES

I. General

1. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and the Drug Abuse Office and Treatment Act of 1972, make by allotment Federal Funds available to this State under a formula grant basis. The State Administrator may provide a portion of these funds to: State, regional and local public and private non-profit agencies and organizations for participation in programs under these Acts. In addition, some State funds are made available for the same purposes.

2. Almost any type of project activity may be fundable, provided that the activity is based upon:

   a. the Alcoholism State Plan or Drug Abuse State Plan.

   b. the development of new or innovative programs to fill gaps in existing services or to expand the reach of existing services.

   c. results in the integration of services and resources of all state, regional, and local public and private agencies assisting alcohol or drug abusers, or high-risk persons as defined in the Drug Abuse State Plan.

   The use of Federal/State funds must not result in a decrease in the effort of providing local alcohol or drug abuse prevention services. To the extent feasible, this program is designed to stimulate an increase in effort.

   The major thrusts of the grant program is for the - (a) delivery of services, (b) ongoing planning and coordination of all alcohol and drug abuse prevention, treatment and rehabilitation efforts.

   d. OADAP will fund 75% of a proposed alcoholism or drug abuse project subject to the availability of funds.

II. Program Guidelines

1. The design of projects, project identification, and justification is basically the same as those in developing any other type of funding proposal.

2. The project documentation features shall include narrative information:

   a. State the project goals and what specific objectives will be accomplished by the project. (goals and objectives should be specific, realistic, and measurable. Avoid general or global statements).

b. Describe how the project objectives will be accomplished. (This should be a description of project activities which clearly relate to achievement of stated goals and objectives. Activities should be defined in clear and specific terms, avoiding generic classifications). In addition, if services of consultants are to be used, explain fully the purpose of consultation, the relationship to goal attainment and the cost.

c. Describe how you intend to measure the effectiveness of the project. Define and estimate productivity factors which are meaningful for the project. (Effectiveness measures will have to be related to the statement of goals and objectives and to the description of project activities).

d. Describe how you integrate your services with those of other agencies in the community. (Be specific).

e. Briefly describe the geographic area and the characteristics of the target population the project intends to serve.

f. Describe how the services which this project will - (a) meet service needs in the community and (b) relate to the service delivery system in the community. (This section must include a definition of the problem(s) addressed by the project and an assessment of the need for the project).

g. Briefly describe the facility to be used in connection with this project. (This section will describe the physical plant and its location. It will also include a description of the organization's capability to fulfill the terms of the project).

3. Delivery of Services:

a. Use of OADAP funds for support of services is designed to fill gaps in the existing service structure in the State and for expansion of services for persons not now receiving services.

4. Proposal Submission

Grant proposals for OADAP funds will be submitted concurrently to regional planning and coordinating agencies and to OADAP central office. Regional review and comment data and OADAP recommendations will then be submitted to OADAP's State Advisory Council for final review and comment. OADAP will then make a final decision as to the disposition of the proposal.

5. Evidence will be submitted that the grant request has been comprehensively planned and that appropriate local and regional agencies coordination has been fully accomplished.

6. The applicant will comply with all the provisions of these guidelines and procedures.

7. Methods of Administration: The public or private agency submitting the project proposal assures that:

   a. Funds paid to the agency under this plan will be used to make a significant contribution toward strengthening alcohol and drug abuse treatment, rehabilitation or prevention services in order to improve the quality, scope and extent of such services.

   b. Funds paid will be further used to suppliment and, to the extent practicable, to increase the level of funds that would otherwise be made available for the purposes for which these funds are provided and will not supplant local funds.

   c. There will be applicant/agency participation in the cost of carrying out the project at the rate of 25% of the project costs.

   d. Methods and procedures for properly charging project costs will be established and maintained. Fiscal procedures will be adequately described in the project grant request submitted to the State for funding the project.

   e. In accordance with Title VI of the Civil Rights Law of 1964 (42 U.S.C. 200d et. seq.) and the regulation issued thereunder by the U.S. Department of Health, Education, and Welfare (45 CFR Part 80) no individual shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under the project submitted.

   f. All information as to personal facts and circumstances obtained by the agencies or other private nonprofit agencies, groups or organizations, to whom funds are paid by the State, will be held confidential and will not be divulged without the individual's consent except as necessary to provide services to him. Any information to be disclosed will be done in summary, statistical or other form which does not identify particular individuals. Each project proponent agency will establish adequate procedures to carry out this provision and to adequately protect the rights of persons with respect to whom confidential information is held.

   g. Applicants for projects shall be in compliance with the U.S. Department of Health, Education, and Welfare policy concerning Human Rights: Copies of HEW Regulations concerning Human Rights are maintained for reference purposes by OADAP at 32 Winthrop Street, Augusta.

   h. Funds will only be made available to such agencies, organizations or institutions which provide the following additional assurances:

      1. The project or facility to be provided funds will furnish a community service, and that consideration will be given to the involvement of residents of the community in management and operation of the project, or if applicable, the facility.

2. The project or the facility will furnish services to persons unable to pay according to ability of grantee.

3. All portions and services of the project, and if applicable, of the entire facility of which, or in connection with which, OADAP funds are sought, will be made available without discrimination on account of sex and creed and no professionally qualified person will be discriminated against on account of sex and creed with respect to the privilege of professional practice in the facility.

4. Resumes detailing the professional qualifications of project staff and key operating personnel, responsible for the operation of service projects or facilities funded under these guidelines will be provided with project applications.

5. All services projects funded will normally be scheduled for termination on September 30. Projects scheduled for a time length of more than 12 months will only be considered for funding by the sole state agency for a specific year. In the event that multi-year projects are submitted, an indication will be provided to project proponents that successive fiscal year funding of continuing projects will be dependent upon Federal/State funding levels and annual approval of OADAP. At the present time there are no provisions for extended time length projects.

   No obligations made before the starting or after the termination date may be charged to a grant.

   Such projects when submitted will be considered for funding subject to these limitations:

   - ..... The annual availability of Federal/State funds
   - ..... Relative success or failure of the project
   - ..... Annual approval of the project by OADAP

6. Any major change in the scope of the project (policy, objectives or goals) for funded projects must receive prior approval of the sole state agency responsible for administration of the program.

   Permissible changes in the approved project shall be limited to minor changes in methodology, approach, or other aspects that would expedite achievement of the project's objectives as long as the original objectives are not changed. Such changes may not result in increasing the cost of the project to OADAP. Whenever the grantee, or program director, are uncertain as to whether any change complies with the above provision, the question shall be referred to the OADAP for resolution.

7. Expenditures will follow the major budgetary categories established in the application. Prior written approval of the grantor is required for the transfer of funds between established budget categories when the amount exceeds 5% of the total grant. Requests for rebudgeting will be submitted to the Director of OADAP outlining the justification for rebudgeting.

The budget categories between which funds are to be transferred will be clearly defined with full justification.

8. Subgranting is not allowable. The grantee may not, in whole or part, delegate or transfer responsibility for the use of project funds to any other institution, organization, or person.

9. Accounting of project funds provided will be in accord with grantee standard accounting practices, based upon generally accepted principles, consistently applied, regardless of the source of these funds. Itemization of all supporting records of fund expenditures must be recorded in sufficient detail to show the exact nature of the expenditures. Where personnel costs apply to two or more activities or projects, such costs involved will be appropriately prorated and explained.

10. The retention of essential records is required. Project accounting records are considered to be essential. Records required for retention include all original receipt and expenditure documents that support and substantiate charges to project activity. All recipients of project funds are required to maintain accounting records, as follows:

a. Records may be destroyed three years after the end of the budget period if audit by or on behalf of the state agency has occurred by that time.

b. If audit by or on behalf of the state agency has not occurred by that time, the records must be retained until audit or until five years following the end of the budget period, whichever is earlier.

c. In all cases an overriding requirement exists to retain records until resolution of any audit questions relating to individual grants.

d. Project records are subject to inspection and audit by state and federal representatives:

1. To verify financial transactions and determine whether funds were used in accordance with applicable laws, regulations, and procedures.

2. To ascertain whether policies, plans, and procedures are being followed.

3. To provide management with objective and systematic appraisals of financial and administrative controls and information as to whether operations are carried out effectively, efficiently and economically.

4. To determine reliability of financial records and reports.

e. The audit activity is not intended to review technical aspects of the conduct of the project. The audit is performed in accordance with generally accepted auditing practices in determining that there is a proper accounting for and use of grant funds. If the grantee fails to appeal a proposed audit disallowance within 30 days of receipt of written notification, the disallowance becomes final.

f. Obligations, commitments, encumbrances, or expenditures normally will be made within the budget period indicated on the agreement. (The agreement is a document which will be tendered to grantees upon acceptance of their project application). Project funds may not be used to reimburse obligations, commitments or expenditures made prior to the beginning date of an initial grant for a new or renewal project.

g. Title to equipment purchased with grant funds is vested in the grantee and the equipment must be accounted for during and after the end of the project period. The state agency reserves the right to determine final disposition of equipment.

h. Upon termination of the project, grant, or agreement for any reason, funds issued to the grantee and not expended or obligated will be returned to the grantor.

a. Bonus Payments

Not allowable.

b. Consultant Services

Allowable, subject to the following restrictions:

(a) Consultant fees may not be paid to a State or to a U.S. Government employee.

(b) Consultant fees may be paid to an employee of the grantee institution only under unusual circumstances and with prior approval of the OADAP.

The grantee agency policy prevails as to determination of consultant fees. In the absence of agency policy any questions concerning appropriateness of consultant fees should be referred to the OADAP.

c. Contingency Funds or Reserves

Not allowable.

d. Depreciation or Use Allowance

Not allowable for real or personal property (buildings or equipment).

e. Dues

Not allowable except when incurred because membership in professional organizations or societies is required to obtain publications necessary to the project.

f. Entertainment

Not allowable for costs of amusements, social activities, entertainment, or incidental costs related thereto.

g. Equipment

Allowable. However, prior OADAP approval is required for:

(a) any item of equipment costing in excess of $1,000;

(b) printing equipment;

(c) audio-visual equipment; and

(d) equipment for offices, conference rooms, and similar facilities.

Equipment may be rented but not purchased from funds in support of conferences.

For purposes of charging project grant funds, the cost of a single unit or piece of equipment includes necessary accessories, duty, excise, and sales taxes (unless the institution is exempt from such taxes). If the institutional policy provides that charges for transportation, protective-in-transit insurance, and installation are a part of the cost of equipment, such charges must be included in the equipment costs if they are to be charged to OADAP funds.

h. Equipment Maintenance and Repairs

Allowable on equipment used specifically on the OADAP supported project.

i. Equipment Rental

Allowable provided the equipment is not owned by the grantee. Rental charges to the project must be made in conformance with grantee policies and in the same manner that similar charges are made to any account.

j. Fringe Benefits

Allowable for employer's share to the extent that such payments are made under formally established and consistently applied institution policies, uniformly charged as a direct cost on an actual rather than an estimated basis, and charged in proportion to salary charged to the project. The employee's share is part of the gross salary and included therein. Not allowable for trainees.

k. Honorarium

Not allowable. An honorarium is considered a payment or reward whenever the primary intent is to confer distinction on, or to symbolize respect, esteem, or admiration for the recipient. A consultant fee, on the other hand, is compensation for services rendered an is allowable.

l. Insurance

Allowable for premiums on hazard, malpractice, and other liability insurance to cover personnel directly connected with the project. Not allowable for premiums on equipment.

m. Land

Not allowable for purchase costs.

n. Leave

Allowable when earned on theproject which the grant is supporting and prorated in accordance with the salary charged to the project. Not allowable for trainees.

o. Meals

Allowable for persons receiving service or when an agency or program customarily provides for meals to employees working beyond the normal workday, or as a part of the salary arrangement.

p. Publication Costs

Allowable subject to prior approval for cost of publishing books, monographs, pamphlet, brochures describing project activities.

q. Recruitment Costs

Allowable for full-time employment on OADAP supported projects, including the charges for want ads, transportation for an interview, and other costs, if payment of such costs is normally made by the grantee regardless of the source of funds. Allowable are costs of descriptive brochures or other costs directly related to the recruitment of trainees. Not allowable are

payments to prospective trainees for transportation, per diem, or other related recruiting costs. Not allowable, also, are moving expenses of employees.

r. Rental of Space

Allowable when charges are made in conformance with grantee policies and in the same manner that similar charges are made to any account. Expenses for the alteration of rented facilities will be detailed as a cost item (other). Full cost particulars will be provided and justified for such expenses.

s. Salaries and Wages

Allowable for time or effort spent on a supported project. Rate must be consistent with salaries paid from grantee funds. Salary and wage rates must be in conformity with those permitted by the grantee's wage and salary scales and policies.

t. Supplies

Allowable.

u. Taxes

Allowable only for those taxes which a grantee is required to pay in connection with employment, services, travel, renting, or purchasing for a project.

v. Travel

Allowable for domestic travel when such travel is essential to the successful conduct of the project being supported, including attendance at National or Regional Meetings with prior approval unless authorized in the form of approved application. Travel on grant funds may be allowed for those persons listed in the application who are holding staff positions at least 50% of full time in the conduct of the project (others with prior written approval). Prior approval is required for such travel if the total required for travel exceeds the amount approved by the OADAP. Not allowable for foreign travel. Less than first class air travel must be used when available. Mileage cost and expenses relating to the travel will be applied in accordance with the grantee's policy. State of Maine Travel regulations must be followed when a grantee has no established policy.

w. Tuition and Related Costs

Allowable with prior OADAP approval when specialized training is required for the project. Other tuition costs are not allowable unless treated consistently as a fringe benefit.

x. Indirect costs of a project are those not readily identified with the project itself but nevertheless incurred by a grantee - as in the operation and maintenance of building or in the payment of utilities costs or

administrative salaries - for the joint benefit of the project activity and of other objectives. These costs must be clearly identified in the project application.

12. Reports on Project Accomplishments and Evaluation

Where Regional Coordinators exist, projects will be assigned to them for ongoing consultation. Where they do not exist, consultation will be provided by central office OADAP staff. Program Directors may relate progress or problems either verbally or preferably in writing at any time during the project.

In addition, there are five written reports required to be furnished to OADAP central office and regional coordinators, where they exist.

(1) Quarterly Evaluation Progress Report - (1 copy Regional Coordinator, 1 copy OADAP central office). This report is a narrative report of the Project activities; it will include success or failure assessments based upon criteria in narrative section 3. Problems with goal attainment will also be described in this report.

(2) Report of Expenditures - (1 copy Regional Coordinator and 1 copy OADAP central office). This report will be submitted either monthly or quarterly as deemed by OADAP (Sample forms attached).

(3) Client Reports - (1 copy to OADAP central office). These reports on individual clients will be submitted when services to the client are terminated or as may be required by OADAP.

(4) Final Report - (1 copy to Regional Coordinator, 1 copy to OADAP central office). This report will be submitted within 30 days after the end of the project period. It will consist of a review of the project's activities and accomplishments during the entire project period and a final evaluation of the extent to which the project achieved its objectives.

(5) Annual Financial Status Report - (2 copies OADAP central office). This report submitted within 30 days after the end of the project period (Sample form attached).

III. Grantee Responsibility

1. Grant requirements - The grantee, when applying for a project grant, agrees to administer any grant awarded by the State in accordance with governing State and Federal regulations and policies in effect at the time the award is made. The grantee further agrees to assume responsibility for fiscal and financial administration, public information, program management, integration of services with local public and private agencies, and will comply with the provisions of Human Rights and Civil Rights.

2. Coordination - In order to effectively promote integration of projects in the community and regional system of services, and in order to provide integration of service care provided to the grantee must:

- .....coordinate with appropriate local, regional and state organizations and agencies.

- .....secure letters of endorsement from these organizations, agencies, and others who will participate in proposal. Such letters must be specific in scope and serve as a project commitment.

IV. Complete the project application forms and the project description and forward them to the appropriate regional Coordinator where one exists and to OADAP central office.

OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

QUARTERLY STATEMENT OF EXPENDITURES

Appropriation Number _____

AGENCY _____ GRANT NUMBER _____

ADDRESS _____ OPERATING PERIOD _____

QUARTER FOR WHICH EXPENDITURES ARE REPORTED: From _____ To _____

I. OADAP SPECIAL GRANT FUNDS

A	B	C	D	E
OADAP Special Grant Supported Lines	Approved Annual Grant Amounts	Expenditures Since Start of Operating Period	Expenditures For Indicated Quarter	Requested for Next Quarter
ersonnel				
Consultants				
ICA & Fringe				
pace Costs				
rea/Facility				
Improvements				
Consumable Supplies				
Equipment				
ravel				
Communications & Utilities				
iscellaneous				
OTALS				

II. LOCAL EFFORT

INSTRUCTIONS FOR PREPARING THE FINANCIAL STATUS REPORT

Item 1 – Enter the name of the Federal grantor agency and organizational element to which this report is submitted.

Item 2 – Enter the grant number or other identifying number assigned by the Federal grantor agency.

Item 3 – Enter the name and complete mailing address, including the ZIP code for the grantee organization.

Item 4 – Enter the employer identification number assigned by the U.S. Internal Revenue Service.

Item 5 – This space is reserved for an account number or other identifying numbers which may be assigned by the grantee.

Items 6 and 7 – Mark the appropriate boxes.

Item 8 – Enter the month, day, and year of the beginning and ending of this project period. For formula grants which are not awarded on a project basis, show the grant period.

Item 9 – Enter the month, day, and year of the beginning and ending dates of the period for which this report is prepared. The frequency of the report will be established by the Federal grantor agency.

PLEASE READ BEFORE COMPLETING ITEM 10 – The purpose of vertical Columns (1) through (6) is to provide financial data for each program, function, and activity in the budget as approved by the Federal grantor agency. If additional columns are needed, use as many additional forms as needed and mark *"continuation"* on each form; however, the summary totals of all programs, functions or activities should be shown in the *"total"* Column of the first page.

For grants pertaining to a single Federal grant program (catalog number) or several grant programs which do not require a functional or activity classification, enter under Columns (1) through (6) the title of the program(s). For grants pertaining to multiple programs where one or more programs require a further breakdown by function or activity, use a separate form for each program showing the applicable functions or activities in separate columns. For grants containing several functions or activities which are funded from several programs, prepare a separate form for each activity or function when requested by the Federal grantor agency.

Item 10 – STATUS OF FUNDS

Line a. Enter the total outlays reported on Line 10e of the last report. Show zero, if this is the initial report.

Line b. Enter the total gross program outlays for this report period, including disbursements of cash realized as program income. For reports which are prepared on a cash basis, outlays are the sum of actual cash disbursements for goods and services, the amount of indirect expense charged, the value of in-kind contributions applied, and the amount of cash advances and payments made to contractors and subgrantees. For reports prepared on an accrued expenditure basis, outlays are the sum of actual cash disbursements, the amount of indirect expense incurred, the value of in-kind contributions applied, and the net increase (or decrease) in the amounts owed by the grantee for goods and other property received and for services performed by employees, contractors, subgrantees, and other payees.

Line c. Enter the amount of all program income realized in this period which is to be used in the project or program in accordance with the terms of the grant. For reports prepared on a cash basis, enter the amount of cash income received during the reporting period. For reports prepared on an accrual basis, enter the amount of the net increase (or decrease) in the amount of accrued income since the beginning of the report period.

Line d. This amount should be the difference between amounts shown on Lines b and c.

Line e. Enter the sum of amounts shown on Lines a and d above.

Line f. Enter the amount pertaining to the non-Federal share of program outlays included in the amount on Line e.

Line g. Enter the Federal share of program outlays. The amount should be the difference between Lines e and f.

Line h. When the report is prepared on a cash basis, enter the total amount of unpaid obligations for this project or program including unpaid obligations to subgrantees. If the report is prepared on an accrued expenditure basis, enter the amount of undelivered orders and other outstanding obligations. Do *not* include any amounts that have been included on Lines a through g. On the final report, Line h should have a zero balance.

Line i. Enter the non-Federal share of unpaid obligations shown on Line h.

Line j. Enter the Federal share of unpaid obligations shown on Line h. The amount shown on this line should be the difference between the amounts on Lines h and i.

Line k. Enter the sum of the amounts shown on Lines g and j. If the report is final, the report should not contain any unpaid obligations.

Item l – Enter the total cumulative amount of Federal funds authorized.

Line m. Enter the unobligated balance of Federal funds. This amount should be the difference between Lines k and l.

Item 11 – INDIRECT EXPENSE

a. Type of rate – Mark the appropriate box.

b. Rate – Enter the rate in effect during the reporting period.

c. Base – Enter the amount of the base to which the rate was applied.

d. Total Amount – Enter the total amount of indirect cost charged during the report period.

e. Federal Share – Enter the amount of the Federal share charged during the report period.

If more than one rate was applied during the project period, include a separate schedule which shows the bases against which the indirect cost rates were applied, the respective indirect rates, the month, day, and year the indirect rates were in effect, amounts of indirect expense charged to the project, and the Federal share of indirect expense charged to the project to date. (See Office of Management and Budget Circular No. A-87 which contains principles for determining allowable costs of grants and contracts with State and local governments.)

Item 12 – Space is provided for any explanation deemed necessary by the grantee or for the provision of information required by the Federal grantor agencies in compliance with the governing legislation.

Item 13 – Complete the certification before submitting this report.

OMB NO 80-R0180

FINANCIAL STATUS REPORT

1. Federal Agency and Organizational Element	2. Federal Grant No. or Other Identifying No.

3. Name and Address of Grantee Organization	4. Employer Identification No.	5. Grantee Account No. or Identifying No.	6. Final Report ☐ Yes ☐ No	7. Basis of Report ☐ Cash ☐ Accrued Expenditures

8. Project Period (Month, Day, Year) FROM	TO	9. Report Period (Month, Day, Year) FROM	TO

10. STATUS OF FUNDS	PROGRAMS — FUNCTIONS — ACTIVITIES						
	(1)	(2)	(3)	(4)	(5)	(6)	TOTAL
a. Total outlays previously reported							
b. Total program outlays this period							
c. Less: Program income credits							
d. Net program outlays this period							
e. Total program outlays to date							
f. Less: Non-Federal share of program outlays							
g. Total Federal share of program outlays							
h. Total unpaid obligations							
i. Less Non-Federal share of unpaid obligations							
j. Federal share of unpaid obligations							
k. Total Federal share of outlays and unpard obligations							
l. Total Federal funds authorized							
m. Unobligated balance of Federal funds							

11. Indirect Expense: a. Type of rate (Mark box) ☐ Provisional ☐ Final ☐ Predetermined ☐ Fixed	12. REMARKS (Attach additional sheets if necessary)	13. CERTIFICATION — I certify that to the best of my knowledge and belief this report is correct and complete and that all outlays and unpaid obligations are for the purposes set forth in the grant award documents.
b. Rate / c. Base		Name / Title / TELEPHONE (Area Code, Number, Ext.)
d. Total amount / e. Federal share		Signature of Authorized Official / Date Report is Submitted

HEW-SCIT
11-72

APPLICATION FOR FUNDING

Submit two copies by June 1st

SUBMIT TO:

Office of Alcoholism and Drug Abuse Prevention
Bureau of Rehabilitation
32 Winthrop Street
Augusta, Maine 04330

_____
Date

A. INFORMATION ABOUT THE PROJECT APPLICANT:

1. a.....
(Sponsoring Organization)

b.....
(Name of Project)

c.....
(Address) (Zip Code) (Tel. No.)

2. Administrative Personnel of Organization:

(The Office of Alcoholism and Drug Abuse Prevention should be notified immediately of any change in the slate of officers or responsible officials).

a. Director or Chief Administrator of the agency:

Name: _____ Title: _____

b. Project Director:

Name: _____ Title: _____

Address: _____
(Zip Code) (Tel. No.)

c. Name of person to whom checks should be sent:

Payee: _____

Address: _____
(Zip Code) (Tel. No.)

Is this person bonded? ____ Yes ____ No. If so, amount $ _____

By whom? _____

Signature of Payee: _____

B. INFORMATION ABOUT THE PROJECT:

The major project documentation features shall include narrative information:

1. State the project goals and what specific objectives will be accomplished by the project. (goals and objectives should be specific, realistic, and measurable. Avoid general or global statements).

2. Describe how the project objectives will be accomplished. (This should be a description of project activities which clearly relate to achievement of stated goals and objectives. Activities should be defined in clear and specific terms, avoiding generic classifications). In addition, if services of consultants are to be used, explain fully the purpose of consultation, the relationship to goal attainment, and the cost..

3. Describe how you intend to measure the effectiveness of the project. Define and estimate productivity factors which are meaningful for the project. (Effectiveness measures will have to be related to the statement of goals and objectives and to the description of project activities).

4. Describe how you integrate your services with those of other agencies in the community. (Be specific).

5. Briefly describe the geographic area and the descriptive characteristics of the target population the project intends to serve.

6. Describe how the services which this project will provide are obtained at the present time in the community (this section must include a definition of the problem(s) addressed by the project and an assessment of the need for the project).

7. Briefly describe the facility to be used in connection with this project. (This section will describe the physical plant and its location. It will also include a description of the organization's capability to fulfill the terms of the project grant.

C.

PROJECT SERVICES BUDGET

ESTIMATED BUDGET FOR: _____
(Name of Project)

Sponsoring Organization _____

For the period from _____ to _____ during fiscal year ending June 30, 19 ____.

Personal Services

Gross salaries - list positions:

_____ $ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Trainees wages ..... _____

Additional Agency Employee Costs:

Social Security .... _____

Health Insurance ... _____

Retirement ..... _____

Other (Explain) .... _____

Total Personal Services: ..... $ _____

Consultant Services

Consultants _____ $ _____

Supplies

Office Supplies ..... $_____

Other (explain) ..... _____

Total Supplies: ..... $_____

Equipment

_____ _____ $_____

_____ _____ _____

Total Equipment: ..... $_____

Contractural Services

Utilities ..... $_____

Rent of Quarters ..... _____

Travel ..... _____

Telephone & Telegraph ..... _____

Postage ..... _____

Other (explain) ..... _____

Total Contractural Services: ..... $_____

Fixed Expenses

Insurance (Building, automobile) ..... $_____

Other (explain) ..... _____

Total Fixed Expenses: ..... $_____

TOTAL ESTIMATED OPERATING EXPENSES: $_____

Less Other Financial Support for the Project ..... _____

PROJECT REQUEST AMOUNT ..... $_____

D. PROJECT INCOME INFORMATION:

List all sources of financial support for this project. Do not include requested OADAP funds.

Source of Funds	Amount
	$
TOTAL INCOME	

E. The grantee acknowledges that he has seen the OADAP grant guidelines and will abide by the conditions stated in those guidelines.

By: _____
Officer authorized to assume contractural obligations

By: _____
Authorized by OADAP

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

_____ (hereinafter called the "Applicant")
(Name of Applicant)

HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health, Education, and Welfare (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

Dated _____

_____
(Applicant)

By _____
(President, Chairman of Board, or comparable authorized official)

_____

_____
(Applicant's mailing address)

HEW-441
(12-64)

GPO 885-128

DIRECTOR, OFFICE OF ALCOHOLISM AND DRUG ABUSE PREVENTION

Definition

This is a highly responsible position in the administration, planning, coordinating and integration of all alcoholism and drug abuse services.

An employee in this class is responsible for the overall planning and development of alcoholism and drug abuse services which includes designing and implementing policies governing the dispensation of state and federal money to the private service community; establishment and maintenance of public accountability procedures for alcoholism and drug abuse programs; development and execution of an overall strategy for the treatment, rehabilitation, and prevention of alcohol and drug abuse; insuring intergovernmental cooperation in the area of alcohol and drug abuse; and fostering coordination and integration of treatment services in local communities. Work includes administration of the Office of Alcoholism and Drug Abuse Prevention; management of state and federal funds; negotiation at the state, local, and federal levels; organization of effective systems for planning and programming a wide range of services; and coordinating a multiplicity of related, though competing, public and private agencies. Direct supervision will be exercised over program and staff specialists within the Office and over new projects developed within the Office. Employee has broad latitude for independent decision-making and automomy in innovation and change. Work is performed under the direction of the Director, Bureau of Rehabilitation, and is reviewed through reports, conferences, and assessment of goal achievement.

Examples of Work Performed

The Director, Office of Alcoholism and Drug Abuse Prevention, is responsible to the Director, Bureau of Rehabilitation, for the efficient administration of the programs and projects under the Office of Alcohol and Drug Abuse Prevention.

1. Encourages and assists the development of effective, coordinated, and efficient administration of resources and services available for alcoholics and drug abusers.

2. Establishes operating policy for the Office and interprets state and federal regulations.

3. Controls and allocates resources to meet established goals for the systems established within the Office.

4. Supervises through a review process the preparation and administration of any portion of any state plan relating to alcohol and drug abuse prevention prepared and administrated by any agency of state government for submission to the federal government to obtain federal funding under federal legislation.

5. Enters into agreements necessary or incidental to the performance of the duties of the Office of Alcoholism and Drug Abuse Prevention.

6. Coordinates all state government efforts related to alcohol and drug abuse.

7. Maintains working relationships with the public, governmental officials, planning bodies, and other alcohol and drug abuse oriented agencies.

8. Sets the limits of responsibility and authority for program specialists within the Office.

9. Makes management decisions regarding the implementation and operation of the Office and its sub-systems (components).

10. Establishes office-wide guidelines for planning; establishes or approves goals or program objectives.

11. Insures the appropriate staffing of all councils and committees attendant to the Office.

12. Performs related work as required.

Required Knowledge, Skill, and Ability

Considerable knowledge of the laws and regulations pertaining to provisions of the State/Federal programs in Alcoholism and drug abuse. Considerable knowledge of modern management and administrative practices.

Some general knowledge of alcoholism and drug abuse and their attendant problems.

Some knowledge of the planning process.

Ability to plan and coordinate the activities of all alcoholism and drug abuse programming.

Ability to objectively make decisions under pressure.

Ability to establish and maintain effective working relationships with public and private agencies and the general public.

Desirable Experience and Training

Considerable experience in supervisory, consultative, or administrative positions, and a thorough knowledge of program administration and planning; and, a master's degree in the Human Services or related area.

DRUG ABUSE PROGRAM SPECIALIST

Definition

This is a responsible position of consultation in the area of drug abuse, treatment, rehabilitation, and prevention.

An employee in this class is responsible for cooperatively planning new or expanded drug abuse service programs; fostering public education and awareness of drug abuse issues; formulating recommendations for statewide drug abuse prevention strategy; stimulating agencies and organizations to provide appropriate services for the drug abusing population; and, interpreting and enforcing the drug abuse strategy for the state. Work includes synthesizing statistical reports into a basis for sound planning; consultation and technical assistance to public and private drug abuse service agencies; use of workshops, conferences, or written material for public education; preparation of plans and recommendations consistent with the drug abuse strategy; and, monitoring the efficient use of public resources. Direct supervision will be exercised over staff specialists related to drug abuse. Employee has considerable latitude for independent judgment in his areas of responsibility.

Examples of Work Performed

Work is performed under the general supervision of the Director, Office of Alcoholism and Drug Abuse Prevention, and is reviewed through reports, conferences and assessment of goal achievement.

1. Encourages and assists the development of effective, coordinated, and efficient administration of resources and services available for drug abuse.

2. Provides such technical assistance as may be required by public and private service agencies for drug abuse services and planning.

3. Organizes activities at the community and regional levels to stimulate coordination of existing services available to the drug abuser and to create new services as needed.

4. Plans and develops new or expanded drug abuse service programs on a statewide level, based upon assessments of community needs.

5. Formulates and conducts public education programs to make the public aware of agency services, and to illuminate program gaps and needs.

6. Reviews, evaluates, and recommends improvements in and additions to programs of services for the drug abusing population.

7. Represents the drug abuse program interests of the Office with other relevant agencies and organizations at the state and federal levels, when delegated by the Director, Office of Alcoholism and Drug Abuse Prevention.

8. Provides such staff assistance to advisory bodies as may be necessary, and as the Director, Office of Alcoholism and Drug Abuse Prevention, directs.

9. Prepares budget requests based upon community needs and projected goals and submits recommendations to the Director, Office of Alcoholism and Drug Abuse Prevention. Carries responsibility for the preparation of the narrative description of Program needs to accompany the budget and appropriation proposals relating to his assigned program area.

10. Provides interpretation, clarification, and consultation to Bureau of Rehabilitation regional staff concerning drug abuse program objectives, policies, and procedures.

11. Performs related work as required.

Required Knowledge, Skill, and Ability

Knowledge of laws and regulations pertaining to the provision of services to drug abusers.

Knowledge of drug abuse, its problems and services needed.

Ability to organize and participate in workshops, conferences, and meetings concerning drug abuse issues.

Ability to establish effective working relationships with public and private agencies.

Skill in consultation and technical assistnce activities.

Desirable Experience and Training

Five years of experience in human service or administration field with a master's degree in human service or in administration.

APPROVED APR 4 '73 BY GOVERNOR

CHAPTER 164 PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-THREE

S. P. 256 — L. D. 753

AN ACT Relating to Inspection and Licensing of Residential Facilities for the Care, Treatment or Rehabilitation of Drug Users.

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

Sec. 1. R. S., T. 5, § 2301, sub-§ 1, ¶ H, additional. Subsection 1 of section 2301 of Title 5 of the Revised Statutes, as amended, is further amended by adding a new paragraph H to read as follows:

H. All facilities licensed under Title 22, section 5-A.

Sec. 2. R. S., T. 22, § 5-A, additional. Title 22 of the Revised Statutes is amended by adding a new section 5-A to read as follows:

§ 5-A. Inspection and licensing of residential facilities for the care, treatment or rehabilitation of drug users

No person, firm, corporation or association shall operate, conduct or maintain in the State any residential facility for the care, treatment or rehabilitation of drug users, not otherwise licensed as a medical care facility, without having in full force, subject to the rules and regulations of the department, a written license therefor from the department. The term of such license shall be for one year and the license may be suspended or revoked for just cause. The annual fee for such license shall be $25. When any such facility, upon inspection by the department, shall be found not to meet all requirements of this section and departmental regulations then the department is authorized to issue either a temporary license for a specified period not to exceed 90 days, during which time corrections specified by the department shall be made by said facility for compliance with this section and departmental regulations thereunder, if in the judgment of the commissioner the best interest of the public will be so served, or a conditional license setting forth conditions which must be met by the facility to the satisfaction of the department or the department may refuse to issue any license. Failure of said facility to meet any of such conditions shall immediately void such conditional license by written notice thereof by the department to the conditional licensee or if the said licensee cannot be reached for personal service by notice thereof left at the licensed premises. The fee for such temporary or conditional license for facilities shall be $25. A new application for a regular license may be considered by the department if, when and after the conditions set forth by the department at the time of issuance of such temporary or conditional license have been met and satisfactory evidence of this fact has been furnished to said department. When the department believes a license should be suspended or revoked, it shall file a statement or complaint with the Administrative Hearing Commissioner designated in Title 5, chapters 301 to 307. Whenever, on inspection by the department, conditions are found to exist which violate this section or departmental regulations issued thereunder which, in the opinion of the commissioner, immediately endanger the health or safety of persons, or both such health or safety, living in such facilities to

such an extent as to create an emergency, the department by its duly authorized agents may suspend said license until such time as the department determines that the emergency no longer exists or until a decision is rendered by the Administrative Hearing Commissioner. The department shall give written notice of such emergency suspension by delivering notice in hand to the licensee. If the licensee cannot be reached for a personal service, the notice may be left at the licensed premises. Whenever a license is suspended by the department under this emergency provision, the department shall file a complaint with the Administrative Hearing Commissioner requesting suspension or revocation of such license. A person aggrieved by the refusal of the department to issue a license may file a statement or complaint with said Administrative Hearing Commissioner. No such license shall be issued until the applicant has furnished the department with a written statement signed by the Commissioner of Public Safety or his duly authorized representative or the proper municipal official designated in Title 25, chapters 311 to 321 to make fire safety inspections that the facility and premises comply with said Title 25, chapters 311 to 321 relating to fire safety. The department shall establish and pay reasonable fees to the municipal official or the Commissioner of Public Safety or his duly authorized representative for such inspection. Said written statement shall be furnished annually thereafter.

Whoever violates this section shall be punished by a fine of not more than $500 or by imprisonment for not more than 60 days.

IN HOUSE OF REPRESENTATIVES,.....1973

Read twice and passed to be enacted

.....*Speaker*

IN SENATE,.....1973

Read twice and passed to be enacted.

.....*President*

Approved.....1973

.....*Governor*

January 3, 1973

MEMO OF UNDERSTANDING BETWEEN
MAINE DEPARTMENT OF MENTAL HEALTH AND CORRECTIONS,
THE NATIONAL INSTITUTE OF MENTAL HEALTH, AND
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, DHEW, REGION I

A. We agree that the overall goal of the SPD demonstration in Maine is to implement a partnership among Maine Department of Mental Health and Corrections, Health Services and Mental Health Administration, Regional Office I, and the National Institute of Mental Health which will (a) facilitate the development of a delivery system of mental health services, training and evaluation as a part of a coordinated human services network making maximum use of existing agency resources and (b) result in a greater relevance and responsiveness of NIMH and the Regional Office in meeting the state mental health needs as defined by the demonstration.

B. We agree with the following jointly developed goals and objectives which are related to the state mental health plan and will be implemented in the achievement of the overall goal:

1. Development and implementation of cooperative relationships in the planning, coordination and delivery of mental health services (a) between state hospitals and community mental health centers and (b) between these mental health agencies and other human service agencies. This will include a procedure, in at least one selected area, whereby patients admitted to a state hospital will first be screened by the CMHC. The CMHC will also involve other agencies in aftercare and follow-up care in collaboration with the state hospital at the time of patients' discharge.

2. Development and implementation of unified services, using the multi-funding mechanisms, in selected geographic areas, combining services such as alcoholism and drug abuse using Federal, State and local resources.

3. Development of a unified state-wide statistics program and evaluation program for State and local mental health services.

4. Development of a State plan for coordinated children's mental health services and implementation in at least one area on a demonstration basis.

5. Development of a State plan for coordinated services for the aged and implementation in at least one demonstration area.

6. Development of mechanisms for insuring maximum collaboration between the Bureau of Rehabilitation and the Bureau of Mental Health in the reformulation and implementation of the State plans for alcoholism and mental health services, and in the initiation and expansion of alcoholism services in selected areas.

7. Development of a collaborative on-going relationship between the Department of Mental Health and Corrections and the Drug Abuse Commission in the formulation of a State plan for the prevention and treatment of drug abuse and for the initiation of needed services in selected areas on a demonstration basis.

8. Development and implementation of a state plan of mental health manpower development and utilization for the service delivery need of the state.

9. Development of mechanisms by which citizens and consumers can be effectively involved in planning, implementation and evaluation of mental health services in State and local levels to improve existing services and to develop new services.

10. Development of a state-wide citizens' mental health constituency.

C. The Maine Department of Mental Health and Corrections will assure the involvement of representative citizens, consumers and State and local human service and training agencies (public and private), in the planning and implementation of SPD Goals and Objectives.

D. NIMH and the Regional Office, with respect to those programs and activities which relate to and facilitate the implementation of SPD Goals and Objectives, will insure priority in the provision of such technical assistance and consultation so as to maximize the potential utilization of Federal and non-Federal resources.

E. The Maine Department of Mental Health and Corrections will give priority to the utilization of its mental health resources in the achievement of SPD Goals and Objectives.

F. NIMH and the Regional Office will identify and assist in mobilizing other Federal agency resources which can be utilized to provide support for the implementation of the SPD Goals and Objectives.

G. NIMH and the Regional Office will inform the Maine Department of Mental Health and Corrections of all grant applications received from Maine by NIMH by forwarding to the Department a copy of those portions of the application that are not privileged communication. Potential applicants will be encouraged to discuss, with the Department, the relevancy of proposals to the goals and objectives of State Program Development.

H. The Maine Department of Mental Health, NIMH and the Regional Office agree to modify their policies and operating procedures, where necessary and when possible so as to facilitate the achievement of SPD Goals and Objectives.

I. NIMH, the Regional Office and the Maine Department of Mental Health and Corrections agree to concentrate their efforts in specific geographic areas for the development, implementation and evaluation of appropriate mental health programs. These areas will be designated by the Commissioner, Maine Department of Mental Health and Corrections.

J. The State Program Development demonstration will continue an additional eighteen months from the date of this signed agreement.

Commissioner, Maine Department of Mental Health and Corrections

William P. Kearns, Jr.

Director, NIMH, HSMHA, DHEW

Bertram S. Brown, M.D.

Director, Maine Bureau of Mental Health

William E. Schumacher, M.D.

Regional Health Director, HSMHA DHEW, Region I

Dr. Gertrude T. Hunter

Associate Regional Health Director for Mental Health, HSMHA, DHEW, Region I

Mrs. Anne L. Twomey