the REPORT OF THE MAINE COMMISSION TO EXAMINE THE AVAILABILITY, QUALITY AND DELIVERY OF SERVICES PROVIDED TO CHILDREN WITH SPECIAL NEEDS

January 1985

Maine Department of

Mental Health and Mental Retardation

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January 11, 1985

Dear Maine Citizen:

It is my pleasure to present to you the Final Report of the COMMISSION TO EXAMINE THE AVAILABIITY, QUALITY AND DELIVERY OF SERVICES PROVIDED TO CHILDREN WITH SPECIAL NEEDS.

Although much has changed in Maine since the time that Malcolm Robbins was a child in Rockland, the Commission's findings reflect the fact that problems continue to impede the availability, quality and delivery of services to children. Some of the Commission's recommendations will be costly to implement; others will require either statutory or administrative changes that may not cost additional money. But the cost in human suffering will continue to be felt unless these problems are addressed now.

Money is not the primary message, however. Implementation of any of these recommendations simply will not happen unless all of us, from State departments, to parents, to private providers, work together to serve the best interests of Maine's children.

The system that failed Malcolm Robbins in the '60's is not the same one that exists in the '80's. But neither are the problems the same. Sexual abuse has increased. Drug and alcohol abuse has increased. More children are growing up in single parent families. More families are living below poverty level than ever before.

What does the future hold for the children of the '80's? They have no powerful voice that can be heard; they must look to us to advocate for them. We must not let them down. Implementation of the recommendations in the Commission's report is a step in the right direction.

Sincerely,

Kevin W Concannon

Kevin W. Concannon, Chair
COMMISSION TO EXAMINE THE AVAILABILITY, QUALITY AND
DELIVERY OF SERVICES PROVIDED TO CHILDREN WITH SPECIAL NEEDS

KWC/smb

MAINE COMMISSION TO EXAMINE THE AVAILABILITY, QUALITY AND DELIVERY OF SERVICES PROVIDED TO CHILDREN WITH SPECIAL NEEDS

FINAL REPORT

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MAINE COMMISSION TO EXAMINE THE AVAILABILITY, QUALITY AND DELIVERY OF SERVICES PROVIDED TO CHILDREN WITH SPECIAL NEEDS

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ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

The ability of Maine's social service and mental health agencies to care for troubled children and their families was called into question last year by a Maine Sunday Telegram article that profiled the tragic life of Malcolm Robbins.

As a child, Robbins was sexually assaulted. In the 1960's and 1970's Maine agencies acknowledged his plight, but Robbins fell through the safety net of the Maine social service system. He grew up to perpetuate the abuse he had experienced as a child.

To make sure that Maine social service agencies could better handle the Malcolm Robbins of today, State Representative Sharon Benoit and others persuaded the Maine Legislature to establish the Commission to Examine the Availability, Quality and Delivery of Services Provided to Children with Special Needs. Governor Joseph E. Brennan supported the initiative.

The Legislature appointed 31 members, including lawmakers, judges, physicians, classroom and special education teachers, a police chief, social workers, counselors, psychologists and commissioners or representatives from the Departments of Corrections, Educational and Cultural Services, Human Services and Mental Health and Mental Retardation to the Commission.

In its search for problem areas or gaps in the system, the Commission invited comment from parents, educators, child welfare officials and mental health experts. The Commission conducted public hearings and invited written recommendations, state agency proposals and professional association critiques.

After more than a year of study, the Commission has found that many positive changes have been made in Maine's social service delivery system since the years when Malcolm Robbins was a child. However, the Commission also acknowledges that numerous problems continue to hamper crucial services and treatment to children with mental, emotional or behavioral problems.

Since the days of Malcolm Robbins' sexual abuse, reports of sexual abuse in Maine have increased dramatically. Substantiated reports of sexual abuse of children in Maine increased by more than 100 per cent in 1983.

While services in Maine have increased in recent years, there are still too few services available on a state and local level to meet the needs of sexually abused children and other children with special needs.

The type and quality of social and mental health services vary throughout Maine. There is no coordinated network of social service personnel, police, prosecutors and judges to guarantee immediate intervention and follow-up when abuse is reported and substantiated.

The judicial system often victimizes abused children again as a result of its lengthy court process. There is also no designated official on a state or regional basis to coordinate services by the various state agencies involved in a child's case.

The Commission has identified problems in coordination, administration and funding of children's services. Because of a fragmented social service delivery system, some youths continue to fall through the cracks. These are children with multiple problems who are involved with several state agencies.

Sometimes there is confusion as to which agency has primary responsibility for a child. Other children have problems that do not fit within established agency guidelines.

The Commission has found limited options for children and adolescents who are placed outside their homes in residential programs. Maine lacks a wide spectrum of treatment programs, including therapeutic foster and group homes.

Other gaps that are particularly troublesome are the lack of services for a child who is too disturbed for a therapeutic foster home or group home, but not disturbed enough for a residential treatment center.

A second Catch 22 is the lack of services for children who are too disturbed for a residential treatment center but who do not meet the legal criteria for admission to the Augusta Mental Health Institute.

The Commission also found that more resources and treatment exist for children who are wards of the State than for children who remain in the custody of their parents. In some instances, there may be pressure on families to give up custody of children to obtain necessary treatment services.

The Commission has found that while there has been a substantial increase in demand for mental health services to children due to increased reporting of abuse, available revenues have not been able to keep pace with this growing demand. As a result, in some cases there is a six week delay before a community mental health center can provide mental health services for low income families receiving State assistance.

The Commission wants the State Legislature to adjust Medicaid reimbursements to cover mental health treatment to children and families with special needs.

The State's contribution to every Medicaid dollar is 35 cents. Greater use of the State's $5.5 million General Fund for mental health as Medicaid seed money would result in a dramatic increase in mental health services available to Maine's low-income residents.

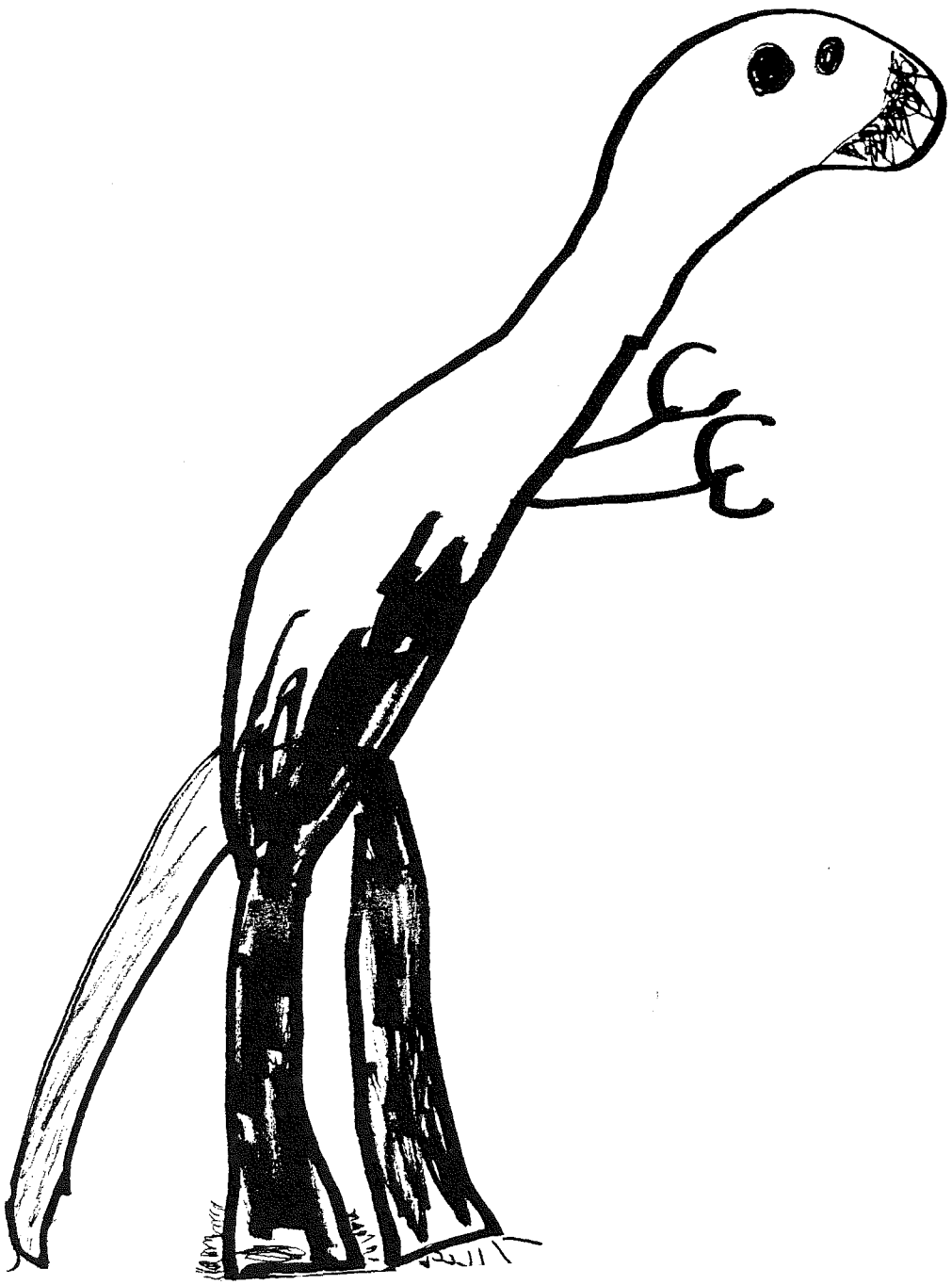
The Commission has identified a critical need for secure treatment facilities for youths who are violent and sex offenders, resources to treat emotionally disturbed offenders and personnel who can provide court-ordered evaluations of juveniles. The Maine Youth Center currently performs most of the court-ordered evaluations. However, its evaluatory services are being curtailed by new State and Federal regulations. Meanwhile, the demand for these services is steadily increasing.

The Federal government has recently mandated that no juveniles can be housed in county jails without the loss of juvenile justice funding. If implemented, the Maine Youth Center would be the only facility available to detain youths in Maine. This would result in a strain on that institution's resources to the point that it will not be able to meet treatment standards set in Maine's Juvenile Code.

Local mental health centers should expand their services to provide treatment and evaluations of juvenile offenders. Judges and other professionals involved with juveniles should be trained in the areas of juvenile treatment and placement.

To address the problem of abuse before it occurs, the Commission proposes a statewide prevention and intervention program for high-risk families, including young parents and families with handicapped children. A preventive program implemented by state agencies, hospitals and public schools could guarantee Maine children a better start in life and save the State money in special education, health care and corrections costs.

The Commission recognizes that many of these recommendations will be costly to implement. However, it firmly believes that to fail to improve these services will be even more expensive - in financial and human costs - to the people of Maine.



INDEX OF RECOMMENDATIONS

The following recommendations are presented in the order that they appear in the report. The Commission strongly encourages implementation of all the recommendations as a total strategy to improve services for special needs children. The Commission highlighted twelve recommendations for priority attention as an initial step in this process. The cost would be approximately $9,000,000. These twelve recommendations appear in dark type.

RECOMMENDATION 1

A statewide prevention and intervention program for high-risk or handicapped infants and their families should be established. This program would identify high-risk children, guarantee them a better start in life and save the State money in special education, health care and corrections costs. The program would be implemented by the Departments of Mental Health and Mental Retardation, Human Services and Educational and Cultural Services in conjunction with the Interdepartmental Coordinating Committee for Pre-school Handicapped Children. (pg. 27)

RECOMMENDATION 2

The Department of Educational and Cultural Services should continue its development of materials for a comprehensive school health curriculum. This curriculum should cover mental health issues, including family living, sexual abuse and decision-making. (pg. 33)

RECOMMENDATION 3

Funding should be made available as soon as possible to set up pilot projects to help families and children who have minor behavioral problems or who are receiving services from several agencies to coordinate treatment available to these families. These projects should be a joint effort by the Departments of Human Services, Educational and Cultural Services, Mental Health and Mental Retardation and Corrections. (pg. 39)

RECOMMENDATION 4

The Departments of Human Services, Mental Health and Mental Retardation, Corrections and Educational and Cultural Services should investigate establishing a centralized referral and ombudsman system, administered by the Interdepartmental Committee, to coordinate case management and treatment when more than one social service department is involved. The Commission also advocates strongly for victim advocates in every district attorney's office. (pg. 39)

RECOMMENDATION 5

The Commission recommends legislative reform of the funding formula for placements in residential programs to guarantee equal access to treatment services. The Interdepartmental Committee, which includes the Departments of Human Services, Mental Health and Mental Retardation, Corrections and Educational and Cultural Services, should develop recommendations for legislative and administrative action.

An interdepartmental agreement should be developed to establish funding and placing responsibilities for placement of children outside their homes in order to improve equal access to services for all children. Procedural responsibilities for referral, placement and follow-up should also be established among departments. (pg. 47)

RECOMMENDATION 6

The Medicaid Review Committee convened by the Department of Human Services, or another interdepartmental group with the Department of Human Services as lead agency, should adjust Medicaid reimbursement requirements to allow counseling services in the most appropriate setting. A more creative use of Medicaid could increase the availability and range of mental health services to children and families with special needs. This group should consider:

a. Medicaid reimbursement to finance services in the most appropriate setting, including home-based care and counseling;
b. Medicaid reimbursement for alcoholism treatment services provided in rehabilitation settings other than hospitals. Currently, such services are covered by Medicaid only if they are offered in hospitals;
c. Increased Medicaid reimbursement rates for mental health services;
d. Medicaid reimbursement for mental health services provided by all certified social workers;
e. Medicaid reimbursement for services provided by teams who treat and evaluate special needs children. (pg. 55)

RECOMMENDATION 7

The Bureau of Mental Health should carry out its planned review of licensing requirements for mental health facilities. It should assess whether different licenses are needed for facilities designated as "Comprehensive Mental Health Centers" or whether the designation itself is unnecessary. (pg. 55)

RECOMMENDATION 8

The Department of Mental Health and Mental Retardation should make sure that community mental health centers tell their clients in a simple format that they can appeal fees charged by the centers. Centers should also take additional steps to let clients know about outside agencies that can assist them when counseling fees are appealed. (pg. 63)

RECOMMENDATION 9

The Department of Human Services should undertake an extensive educational campaign to teach professionals who are required to report suspected child abuse to the State about a loophole in the state's reporting law. The loophole does not require professionals, such as therapists, to report abuse if the information comes from someone they are treating. However, even if a child is out of danger, he or she may still require treatment for the emotional trauma caused by past abuse. (pg. 65)

RECOMMENDATION 10

The Department of Human Services, through extensive discussions with all agencies involved, should review whether or not to modify laws requiring confidentiality between agencies. The Department should determine if full disclosure and better communication among social service agencies could promote better treatment of victims of abuse. (pg. 65)

RECOMMENDATION 11

The Department of Human Services should consider changing the job structure of child protective workers. Currently these workers are expected to investigate as well as treat families where abuse has occurred. The treatment and assessment functions should be separated. (pg. 65)

RECOMMENDATION 12

The Interdepartmental Committee, utilizing state and local mental health and social service agencies, should identify what is needed for a statewide network of residential programs and follow-up for Maine's youth. A plan should be presented to the legislative Human Resources Committee during 1985. (pg. 71)

RECOMMENDATION 13

The Department of Mental Health and Mental Retardation should be assigned responsibility to identify gaps in mental health services for children and families. Consideration should be given to the expanded role that the Augusta Mental Health Institute should play in a network of mental health services. An action plan should be presented to the legislative Human Resources Committee during 1985. (pg. 71)

RECOMMENDATION 14

The Interdepartmental Committee should identify problems in working relationships among agencies serving youth in each region. It should develop recommendations to improve the working relationships and report to the legislative Human Resources Committee during 1985. (pg. 71)

RECOMMENDATION 15

Specific agreements and procedures should be developed to ensure aftercare, follow-up and transition from one social service agency to another. Each of the major state agencies serving youth should require documentation to make sure that proper referrals and communication among departments exist for all children. (pg. 71)

RECOMMENDATION 16

The Commission recommends development of a network of sexual abuse treatment programs. Legislation to develop this network should be developed by the Departments of Human Services, Mental Health and Mental Retardation, Corrections and Educational and Cultural Services and presented to the Legislature during 1985. The network of programs should include:

a. Regional and community response teams, designed along Maine's eight prosecutorial districts, to oversee crisis intervention and long-term care of sex abuse victims and their families.

   i. The response team should be made up of representatives from the Department of Human Services, the local District Attorney's office, law enforcement officials and other professionals as needed. There should be written agreements and procedures to follow by team members.

   ii. The team should identify gaps in the services available, manpower and training needs and resource development.

   iii. A community coordinator should coordinate treatment, ensure communication between the members and their agencies and develop a team approach toward intervention, investigation and treatment of sexual abuse.

   iv. A mental health treatment team capable of providing crisis intervention should be established.

   v. A case manager should be selected to supervise treatment of the victim and family on a case-by-case basis.

   vi. An advisory group of community people should be established to oversee development of the community response team and evaluate current action on child abuse cases.

b. Regional coordinators in community service settings.

c. A new position at the central office of the Department of Human Services specifically to coordinate services to sexual abuse victims.

d. Joint training for all social service workers who work with sexual abuse vicitms, including social workers and law enforcement personnel.

e. Development of a comprehensive treatment program for abusers and victims.

f. Provision of transportation to ensure that victims and their families have access to treatment.

g. Increased funding for all social service agencies providing sexual abuse treatment services. (pg. 79)

RECOMMENDATION 17

The Commission recommends that community mental health centers develop services to deal with sexual abuse. Because of the need for immediate intervention, victims of sexual abuse should receive immediate services from the mental health centers. (pg. 79)

RECOMMENDATION 18

The Interdepartmental Committee should request funds to investigate whether to set up behavior stabilization or secure treatment services for adolescents. Behavior stabilization services are short-term evaluation services designed to bring out-of-control behavior under control in order to provide treatment. There are no such facilities now in Maine. (pg. 85)

RECOMMENDATION 19

The Commission should request funds for an in-depth study of how severely disturbed pre-adolescent children are treated by the state's social services. There is currently no program in Maine to help severely troubled children in this age group. (pg. 89)

RECOMMENDATION 20

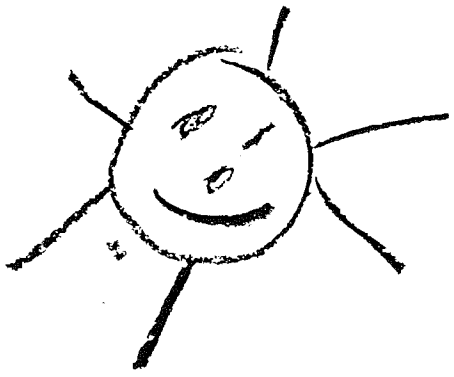
The Department of Mental Health and Mental Retardation should identify resources in each region that can provide both diagnostic and treatment services for children. The Department should report back with its findings to the legislative Human Resources Committee during 1985. (pg. 89)

RECOMMENDATION 21

The Department of Corrections and the Maine Youth Center should develop a plan for a secure treatment program for violent and sexual offenders. Because of the nature of the offense and the offender's potential for violence, the program shoud be housed at the Maine Youth Center, not at a mental health facility. (pg. 93)

RECOMMENDATION 22

The Department of Corrections should request additional funds to staff adequately the Hayden Treatment Unit at the Maine Youth Center so it can realistically serve the needs of female and male offenders at the Center. Currently, no females are served by the Unit, which offers treatment for psychological, emotional and behavioral problems. A proper staffing level should be established and maintained at the Hayden Unit, given the growing population of Maine Youth Center youths who need these services. (pg. 97)



RECOMMENDATION 23

The Department of Corrections and the Office of Court Administrators should develop a plan to provide court-ordered evaluations of juveniles. The Maine Youth Center performs the bulk of these evaluations and its services in this area are being curtailed by new Federal requirements. Meanwhile, the demand for these evaluations is increasing. These evaluation services should be available at the Maine Youth Center and in the community. The plan should be ready for implementation in fiscal year 1986 and should be presented to the Juvenile Justice Advisory Group for review before implementation. It should include:

a. Criteria for determining when evaluations should be performed at the Maine Youth Center and when they should be performed in the community;
b. Identification of community resources and funding for the assessments.
c. Estimated funding requirements;
d. Development of a regional service for te evaluations (this should include Juvenile Justice Advisory Group recommendations.); and
e. Training for evaluators in the community. (pg. 101)

RECOMMENDATION 24

The Department of Corrections and the Division of Special Education in the Department of Educational and Cultural Services has made recommendations to improve the special education program at the Maine Youth Center. The program, which now complies with state standards, should receive permanent funding. The program is now funded with discretionary grants. (pg. 103)

RECOMMENDATION 25

The Interdepartmental Committee, made up of officials from the Departments of Human Services, Mental Health and Mental Retardation, Corrections and Educational and Cultural Services, with the Office of Court Administrators should require training of District and Superior Court judges in the area of children's care, treatment and placement. (pg. 105)

RECOMMENDATION 26

The court record of any juvenile should include pertinent diagnostic, medical, psychological and educational information. This record should accompany the child to a future placement, if one is made. (pg. 105)

RECOMMENDATION 27

Officials from the Departments of Human Services, Educational and Cultural Services, Mental Health and Mental Retardation and Corrections should meet with the Chief Judge of the District Court to develop working agreements to ensure that appropriate information is given to judges before juvenile court hearings and sentencing. (pg. 105)

RECOMMENDATION 28

Funds should be made available and procedures developed so that private agencies can provide services to juvenile offenders involved in the judicial system. Currently, many of these youth are referred to the Maine Youth Center for evaluation before sentencing, which places an excessive burden on that facility, and disrupts the youth and family's life. (pg. 111)

RECOMMENDATION 29

The Department of Corrections should implement a plan to assess continually the needs of the juvenile justice system. Recommendations for funding should be sought from regional juvenile caseworkers and Maine Youth Center officials. A report should be issued to the Juvenile Justice Advisory Group during 1985. (pg. 113)

INTRODUCTION

The story of Malcolm Robbins is the story of a deeply disturbed child. It is also a telling tale of a society that recognized his troubled condition and failed to provide the help he needed in any consistent fashion. It is the saga of social institutions and systems in Maine that did not operate in a coordinated fashion and failed to meet his needs.

Malcolm Robbins, born in 1960, spent his first eleven years in Rockland, Maine. He was slow to learn to walk, for which he was ridiculed, and he was frequently beaten by household members and relatives. He experienced his first of countless forced sexual contacts and rapes when he was only six years old. He was assaulted by one of the many violent males in his mother's life. No effective action was taken to treat him after this experience or to protect him from future abuse.

Schools and social service agencies were not unaware that this was a troubled youngster. He was expelled from kindergarten when he was five and was frequently truant from elementary school in the years to follow. Local police also knew him for he often used a pocket knife to threaten younger children. He was evaluated by a psychologist when he was only nine. Little was done to improve his situation, however. Looking back, one State Child Welfare official said, " we certainly were aware of those children, but never to the point where we took an active part in their lives."

When he was eleven, Malcolm moved to Portland with his family. Because he rarely attended school, a school social worker made an effort to work with Malcolm, but to no avail. Finally, in August of that year, he was committed to the Boy's Training Center in South Portland for pouring Lysol into his three-year-old cousin's Koolaid bottle. That institution in turn sent him to the now-defunct Children's Psychiatric Hospital at Pineland Center in Pownal.

An initial evaluation recommended "supportive counseling on a regular and frequent basis", but little more than structured custodial care and schooling apparently was provided by that institution during the next nine months. Nor did the Boy's Training Center do much more for him during the year that followed, and he was released on entrustment in June, 1973.

Within a year he was returned to the South Portland institution, this time for threatening one boy with a knife and allegedly sexually assaulting another. He attempted to hang himself within a few days after his return to the Training Center. His only treatment for this and a later suicide attempt was medication, together with seven interviews with a psychiatrist over a nine month period. He was sent home on entrustment again in April, 1975. Within another five months he was back again in Juvenile Court, this time for sodomizing a three-year-old boy.

On this occasion, Malcolm Robbins asked to be sent to the Bangor or the Augusta Mental Health Institute, because he felt he could have his problem addressed there. Instead, he was again sent to the Boy's Training Center, now known as the Maine Youth Center. Efforts to be admitted to the intensive Hayden Treatment Unit at the Training Center were also refused. Instead, he was placed in the general population at the Boy's Training Center until his release on "therapeutic leave" in June, 1976.

By November of that year, he was again charged with sodomy on a six-year-old boy. This time the court continued the case and released Malcolm Robbins to the custody of an uncle. He started receiving weekly therapy, but by the following June (1977), the treating psychologist found he had "an ongoing need for structured residential placement where limits and controls are clearly defined and consistently enforced." He recommended a return to the Boy's Training Center. Instead, the court placed him once again on entrustment status, and a little more than a year later, in October, 1978, he was discharged.

Within the next two years, Malcolm Robbins had killed a six-year-old boy, sodomized and killed a nine-year-old boy, and killed a 17-year-old male acquaintance, all by the time he was 23 years old. He currently is serving a life-plus-thirty year sentence in the State of New Jersey.

RECENT CHANGES

Many changes have occurred during the years since Malcolm Robbins grew up in Maine. During the 1970's and early 80's a number of social, educational, health and legal improvements or reforms were initiated. These changes, enactments and evolutions have generally resulted in improved services to special needs children and their families.

Among the most far-reaching of these changes were the educational reforms initiated through the refinancing of the State's education system, as well as by the enactment of the Right to Education Law, which benefits all children regardless of handicap. More than 20,000 Maine children now benefit from some form of special education intervention during the course of any school year. Many commentators point to the educational reforms as being the principal reason for a reduction in the number of institutionalized children.

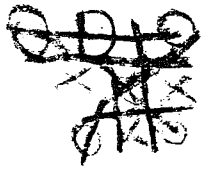
Coupled with the educational reforms, the 70's in Maine was also a period of reform of the criminal and correctional laws relating to children. Some of these reforms decriminalized the so-called status offenses, which included truancy and running away from home. Other reforms established the legal and financial foundation for community corrections. Through the resources and planning of the Law Enforcement Assistance Agency, a number of juvenile service programs came into existence. A range of other social services oriented towards children and families evolved, through such programs as Title IV and Title XX of the Social Security Act at the State and Federal levels.

The interdependence of Maine's service systems as they relate to children and adolescents became very apparent in the latter part of the 70's. In 1976, Maine became the first state in the country to address legislatively the need for interagency service to children. These modest beginnings, initially limited to interagency efforts involving residential treatment services, have since expanded to include other service areas. The Interdepartmental Coordinating Committee, which includes the Commissioners of the four major youth-serving departments, now is staffed professionally by an Executive Director and a full time staff assistant, both positions contributed by State agencies.

A number of home-based service initiatives have been fostered on an interagency basis during the early 80's. Although this has been a time of somewhat limited growth due to reduced Federal funds, the State of Maine has made a significant commitment to improving the capacity of the State Child Welfare system. For example, the Governor and Legislature have funded additional child protective, substitute care and family service workers in the Department of Human Services. Other legislative changes have promoted permanency planning for children, earlier intervention in cases of abuse and neglect, and strong legal sanctions in cases of child and family abuse.

EFFECTS OF INCREASED REPORTS OF ABUSE

Unfortunately, many of the above gains have been counterbalanced by a growth in the number of low income children in the state. There is an all too common relationship between poverty and a variety of social, economic and educational ills; this has been repeatedly demonstrated both individually and collectively in Maine during this era.



On May 8, 1983, an article by John Lovell describing the Malcolm Robbins story appeared on the front page of the Maine Sunday Telegram. Legislator Sharon Benoit and others quickly began asking whether such a saga could take place today. Within only a few weeks, the Maine Legislature established the Commission to Examine the Availability, Quality and Delivery of Services Provided to Children with Special Needs. The purpose of the Commission was to "examine the current mechanisms for identifying and following children with special psychological, emotional and behavioral needs; to identify major gaps in the provision of services to these children; and to examine the current mechanisms used by the Department of Human Services, the Department of Corrections and the Department of Mental Health and Mental Retardation to plan for and provide services to these children...." Thirty-one members representing both the public and private sectors in the area of services to children with special needs were appointed by the Legislative leadership. Kevin W. Concannon, Commissioner of the Department of Mental Health and Mental Retardation, was selected by the Speaker of the House and President of the Senate to chair the Commission.

Following an initial meeting in August, 1983, the Commission sponsored a series of public meetings throughout the state in order to identify problems with the current service delivery system for children. The issues identified at the public hearings were grouped into three major areas: prevention and early intervention, administrative and legal problems, and specialized services. These areas became the focus of the Commission's three committees. Problems were identified and researched, possible solutions were suggested and an Interim Report with tentative recommendations was published in July, 1984. Not all areas identified at the public hearings were able to be addressed in depth by the committees because of limitations of time and resources. An effort was made to address what each committee perceived as the most pressing issues. Copies of the Interim Report were given to the principal departments that serve children, to interested citizens and to the major newspapers in the state. Responses to the Interim Report from the four principal youth serving departments and from private agencies and individuals were reviewed by the Commission during the summer and fall, and are reflected in this report.

The Commission found that despite many changes and improvements in the range of services and in coordination between agencies over the last ten years, numerous problems affecting the care and treatment of many children remain. It found that efforts at prevention and early intervention were often inadequate. The Commission has made a number of recommendations to address these gaps in the system. Some are relatively costly while others require little or no expenditure of funds. It is the belief of the Commission that a failure to address these recommendations would not only cost far more dollars, but would cause more suffering and prevent many children from reaching their full potential.

RECOMMENDATIONS

Research has uncovered biological and environmental risks at the time of birth that can predict later developmental, emotional, social and academic difficulties. Maine does not have a statewide system for identifying these high risk children and intervening effectively during infancy. Maine is also falling short of providing adequate health education to children and parents. Family living, parenting and decision-making, are all skills that can be learned. The Commission recommendations include suggestions derived from the Prevention and Early Intervention Committee for funneling this growing field of knowledge into a plan for action.

The Commission found that problems in coordination, administration and funding of children's services often impair effective service delivery. All children in need of services must have effective advocates who will ensure that they receive these services. This is particularly necessary for children with multiple difficulties. In many cases the parent can fill this role, but in many others a designated "case manager" must be provided by someone outside of the family to make sure those services are sought after and provided.

A morass of funding issues was found to interfere with effective delivery of these services. The Commission found that those children who had access to certain departmental funding sources, such as those available to children in the custody of the Department of Human Services, were eligible for some services that were not available to other children with similar needs. At times, this has led some parents to give up custody of their children to the State to make sure their children are placed in a residential treatment facility.

Medicaid funding was also found to be inadequate, often paying only a portion of the cost of treatment. This has resulted in inadequate resource development and unacceptable waiting lists for services. It has also resulted in a failure to maximize Federal money for children's services since the Federal government's share of Medicaid billing is approximately 65%. Payment for services has also been restricted generally to those services within an office, thus inhibiting the development of effective home-based treatment. Proposed changes in these areas may actually save the State money while increasing services.

TREATMENT PROGRAM SHORTAGES

The Commission found that a number of specific services for children were either inadequate or entirely lacking. Services to children and families dealing with the problem of sexual abuse have increased rapidly over the last several years. Nonetheless, most areas of the state still do not have a full range of sexual abuse intervention services, which provide a treatment program for victims of sexual abuse, their families and abusers. In no area of the state is the service delivery system able to meet the demand. Furthermore, there is a need to ensure coordination among the Department of Human Services, the police and criminal justice system, and the mental health system. The Commission has proposed a comprehensive plan for the development of a coordinated statewide system of services.

At times, despite the efforts of all involved, placement outside the home becomes necessary. A full range of out-of-home services should be available and accessible to children in need. This includes both foster homes without treatment services, and group homes and foster homes with integrated treatment services (therapeutic group homes and therapeutic foster homes). These services are currently inadequate, in part due to a history of poor pay to foster parents and a lack of training opportunities provided to them. The State has recently taken steps to rectify this situation; it needs to proceed rapidly to increase and upgrade these resources.

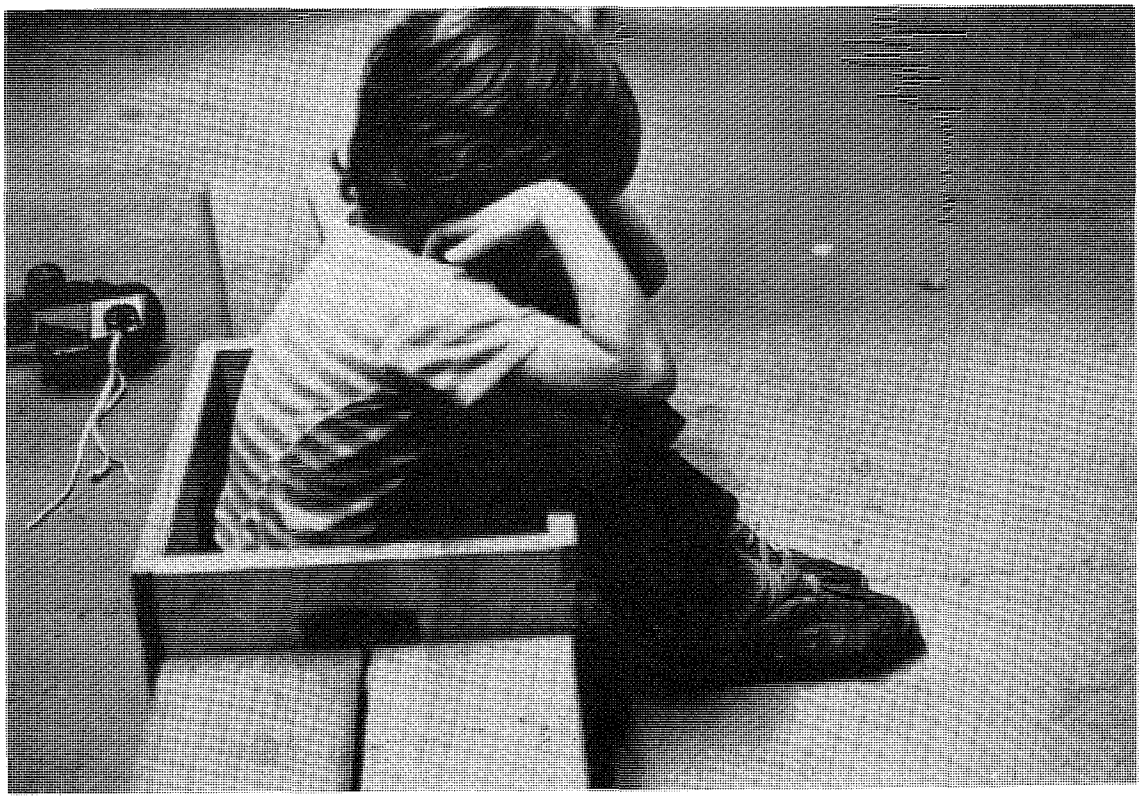
FILLING THE GAPS

An even more comprehensive treatment environment is the treatment of choice for some children. Adequate access to residential treatment centers must be provided, and no child should be deemed "too disturbed" for a therapeutic foster home or group home if he or she is deemed "not disturbed enough" for a residential treatment center. A similar gap between the residential treatment centers and the Adolescent Unit at the Augusta Mental Health Institute must be eliminated. The development of behavior stabilization services for adolescents and a statewide network of similar services for younger children would help make the current treatment system more comprehensive.

MAINE YOUTH CENTER NEEDS

Treatment services at the Maine Youth Center are woefully inadequate. Maine has not kept pace with the demand for treatment of the increasingly disturbed population at that institution. The Commission has made a number of specific proposals to address the many needs of this group. The State should take full advantage of this last opportunity to administer effective therapy and modify the destructive behaviors of all adjudicated youth. Specific recommendations relate not only to the need for increased treatment resources for emotionally disturbed juvenile offenders, but also to the need for special education resources for these youth.

PROBLEM STATEMENTS AND RECOMMENDATIONS FOR PREVENTION AND EARLY INTERVENTION ISSUES




Sad Ness
the Dragon

Currently, no comprehensive process exists throughout Maine to identify children who are handicapped or at high risk at birth for developmental disabilities or delays.

While public health nurses, hospital nursing staff, physicians, early childhood specialists, social service agencies and others recognize the high potential and high likelihood of problems for children born with biological or established handicaps, or into situations of environmental risk, the absence of a comprehensive system for diagnosis and treatment results in insufficient early preventive intervention services.

The Departments of Human Services, Educational and Cultural Services, Mental Health and Mental Retardation and private agencies are making a serious effort to provide and coordinate services for three to five year old handicapped children. Sixteen coordination projects provide services to children in most areas of the state. These projects, together with private agency and State workers, are identifying and providing some services to a large percentage of the three to five year old children at "established" risk. There is now a need for improved and increased efforts not only for children at "established" risk but also for infants and children at "biological" and "environmental" risk. These terms are defined as follows:

Biological risk involves infants and children presenting a history of prenatal, perinatal and early developmental events suggestive of biological insult(s) to the developing central nervous system, such as prematurity, abnormalities of tone, delay in achieving gross or fine motor milestones, abnormal neurological exams, unusual behaviors, feeding difficulties, etc.

Environmental risk involves the potential for delayed development because of limiting early environmental experiences or family situations, such as parental age, parental stress, developmental disability of father or mother, paternal or maternal substance dependence, known history of parental child abuse or neglect, chronic unemployment, single or separated parent, etc.

> Established risk conditions include, but are not limited to, the following kinds of disorders: Down's Syndrome, hydrocephaly, spina bifida, cerebral palsy, orthopedic problems, medical concerns expected to impinge on developmental progression, congenital abnormalities and hearing and vision impairments.

Early identification and referral (prenatally if possible or at birth) of all infants and their families who fall into any of the three risk categories is needed. Attention needs to be paid to infants and families in the environmentally high-risk category who are in need of intensive intervention. The Commission focused on these infants and families.

The needs of such multi-problem families are very great and the long-term costs to society are very high, as highlighted by Stanley Greenspan, M.D., a noted professional in the field of early intervention:

> Estimates vary regarding the use of health, social services, and welfare systems by these families. However, the significance of the challenge that they present is indicated by a study conducted some time ago, in which 6% of the study population was found to be using 45% of all public health resources and 55% of all social, psychiatric, and other auxiliary services. It has been estimated that this 6% use approximately 70% of all public expenditures for health, social, and auxiliary services (Report of the congressionally-authorized Joint Commission on the Mental Health of Children, 1965). Moreover, the problem may be much greater.

There are approximately 16,000 births in Maine per year. Using the 6% incidence figure cited in the quotation above, we can assume there are between 950-1,000 infants and families in Maine who require intensive intervention services.

The evidence that many of the 950-1,000 infants will require continued services as they get older is abundant. The needed services will be in the areas of health, special education, mental health, foster homes, residential placements, correctional facilities, unemployment and other economic payments (food stamps, Aid to Families with Dependent Children, etc.).

The following are approximate costs for placements outside the home; these costs are rising at about 10% annually:

- $5,000 for foster care;

- $10,000 - $12,000 for group home placement;

- $25,000 - $30,000 for residential treatment center placement;

- $30,000 - $40,000 for institutional placement.

Estimates are that the cost of early identification and intensive treatment would vary from $1,000 to $5,000 per year per infant and family depending on the severity of the risk factors.

There is increasing evidence that prenatal and early postnatal identification of high-risk infants or problems in infant-mother relationships can lead to positive treatment. Identification of high-risk infants and families at the time of a child's birth or soon after would be beneficial for at least two reasons:

1. Treatment services would be starting in the early weeks or months of attachment between the infant and parent(s). Positive attachment will benefit the family. If the parent(s) is/are young, additional children are possible. The knowledge and skills gained by the parent(s) should carryover to future children.

2. Identification and early services, utilizing existing staff for the most part, are less costly than later treatment services.

Preventive education on the dangers of alcohol consumption and cigarette smoking during pregnancy and the need for adequate nutrition is important. This public awareness can be accomplished at relatively low cost through public service campaigns and the coordinated efforts of various non-profit groups. Fetal alcohol syndrome, a condition caused by a pregnant mother's drinking of alcoholic beverages, can cause mental retardation in infants. It is completely preventable.

The benefits, therefore, for identifying and serving these infants and their families can be seen from both a service quality and a fiscal perspective. The children will be guaranteed a better start in life while their parents are receiving needed child development and medical information, parenting support and guidance. Successfully serving infant and parent can be of enormous benefit to society by providing productive citizens who will be less likely to require additional costly services for special education, health, foster care, out of home placements or correctional services.

Recommendation 1: The Department of Mental Health and Mental Retardation, the Department of Human Services and the Department of Educational and Cultural Services should jointly implement a statewide program of preventive intervention for high-risk or handicapped infants and their families. Such a program should be based in hospitals and communities, with regional family service teams established from among all socialservice providers to ensure the coordination of diagnosis, intervention, support and treatment.

The program model being recommended (Appendix B) has three components:

1. Case Finding including gross screening, assessment, evaluation and engagement;

2. Intervention; and

3. Training/Supervision/Consultation.

To develop the program on a statewide basis will take four years, with the first year devoted to a major planning effort and commitment by the three departments involved. The one-time cost of this planning (and related training) effort would be approximately $10,000, primarily for technical assistance, support staff and consultation/education activities.

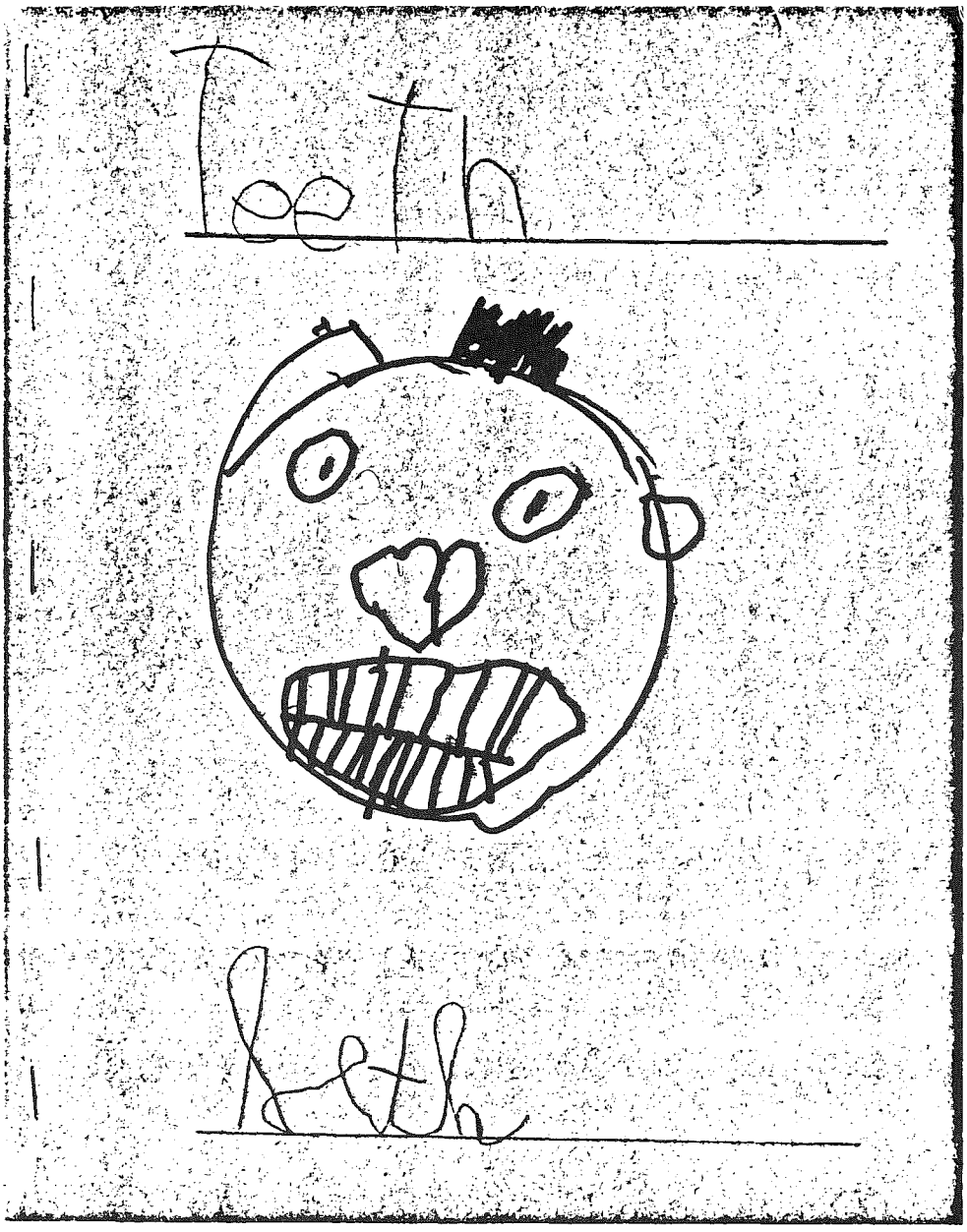
In Year II, six projects (each serving the catchment area of a hospital or hospitals reporting approximately 600 live births annually) would be started, at a unit cost of $117,200. In Year III, ten additional projects would be started, and the six initial ones continued; in Year IV, twenty-six projects would be in operation at an annual, on-going cost of approximately $3,000,000.

The above figures are based on current Maine statistics of 16,000 live births annually. The cost of a single project that could provide service to an infant population of 600 live births (an estimated 12% of which are estimated to be at risk or handicapped) is as follows:

1 Assessment Coordinator @ $20,000 + 20% fringe	$ 24,000
1 Service Coordinator @ $20,000 + 20% fringe	$ 24,000
2 New Intervention Team members @ $18,000 + 20% fringe	$ 43,200
Travel Expenses	$ 8,000
Clinical supervision, consultation and training	$ 8,000
Administration/Contingencies	$ 10,000
TOTAL	$117,200

Departmental Responses: All four departments supported the concept of a statewide program for identification and early intervention on behalf of high-risk and handicapped infants and their families. The Departments of Mental Health and Mental Retardation, Human Services and Educational and Cultural Services all participate on the 0-3 Subcommittee of the Interdepartmental Coordinating Committee for Pre-School Handicapped Children. The Department of Mental Health and Mental Retardation indicated it would be requesting additional funds for the expansion of early intervention programs. Both the Department of Human Services and the Department of Educational and Cultural Services urged that future development efforts be coordinated with the 0-3 Subcommittee's planning efforts.

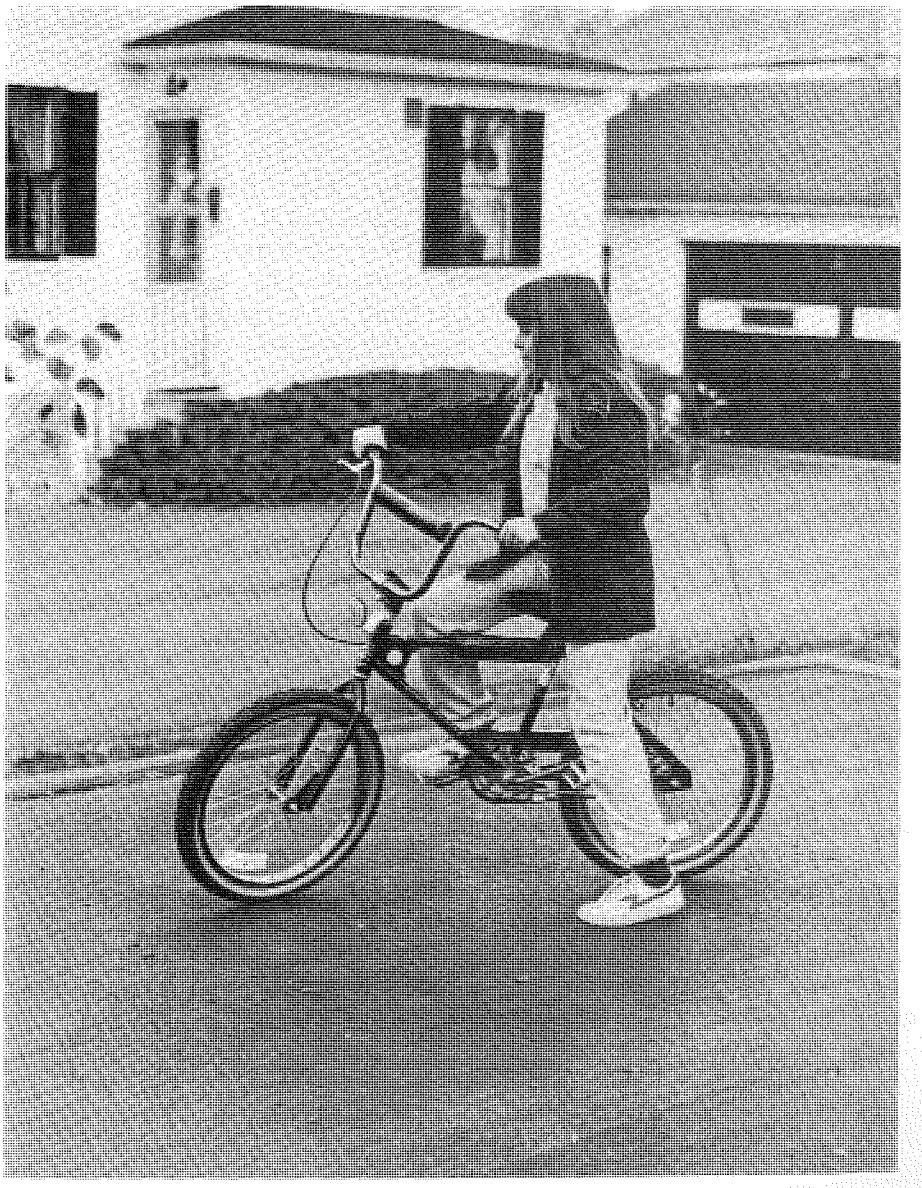
Final Disposition: The Commission urges the departments to implement a statewide program as outlined in the original recommendation, and to coordinate implementation with the efforts of the Interdepartmental Coordinating Committee for Pre-School Children and/or its 0-3 Subcommittee.


teeth

Maine schools provide limited, if any, education to children in a number of critical areas of their day-to-day life.

Some of these areas are mental health issues, family living, substance abuse, sexual abuse, decision-making and parenting, all of which are included in the term "health".

There is at present no unified curriculum available to school systems. Useful and effective models for the development of such a curriculum exist in the areas of dental health, physical fitness, nutrition, drug and alcohol abuse and family life. The Commission looked at a mental health curriculum unit used in Aroostook County, developed by Aroostook Mental Health Center. Members also reviewed curriculum segments used at various grade levels in several areas of the state.



The Department of Educational and Cultural Services has surveyed all schools for information on general curriculum and is still processing the results. However, preliminary information corroborates the view that public schools provide limited instruction in the above areas. There is a Nurse Consultant within the Department who works with the Bureau of Health, and the Department now has two Health Educators who will continue to work with the School Health Education Project (SHEP) to develop model curricula and make them available to schools.

The Commission recognizes the difficulties in developing the content and materials for a mental health related curriculum. Among them are a strong commitment to local control rather than state mandates, a feeling of some parents that these topics should not be taught by schools, a reluctance of regular classroom teachers to add this area to their teaching responsibilities and a lack of commitment of resources to provide appropriate teacher training and/or other personnel to implement such a health curriculum. The societal problems of teenage pregnancy and parenthood, teenage (and younger) suicide, children living with alcoholic parents and physically and mentally abused children require that we address these difficulties.

As a result of the deliberations of the Governor's Commission on the Status of Education in Maine, the Department is also preparing recommendations for changes in the school approval process, by which the current requirements for a health component would be expanded to include such topics as family life education, mental health and substance abuse. In addition, the Department is considering recommending that as a requirement for initial certification, teachers have course work in child development and mental health, so they may be able to assist in the intervention process.

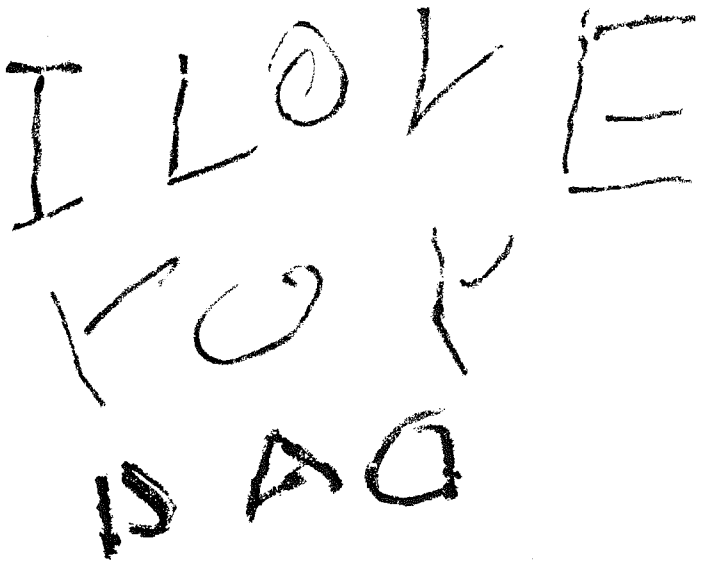
Recommendation 2: The Department of Educational and Cultural Services should be encouraged to continue with its development of materials for a comprehensive school health curriculum.

In addition, the issue should be brought to the attention of the Governor's Commission on the Status of Education, including the Commission's concerns as to who should teach the material in the curriculum, the teachers' use of available outside resources, the need for continuing education programs to familiarize teachers with these issues, etc. (This recommendation was made to the Education Commission, who included it in their Report of June 1, 1984.)

Departmental Responses: All four departments supported this recommendation. The Department of Human Services and the Department of Corrections both emphasized the importance of on-going training of teachers and awareness of community resources for a comprehensive health curriculum. The Department of Educational and Cultural Services

indicated its intent to define specifically health and safety to include such topics as substance use and abuse, family education and mental health. The Department of Mental Health and Mental Retardation indicated its willingness to collaborate with the Department of Educational and Cultural Services in relevant areas.

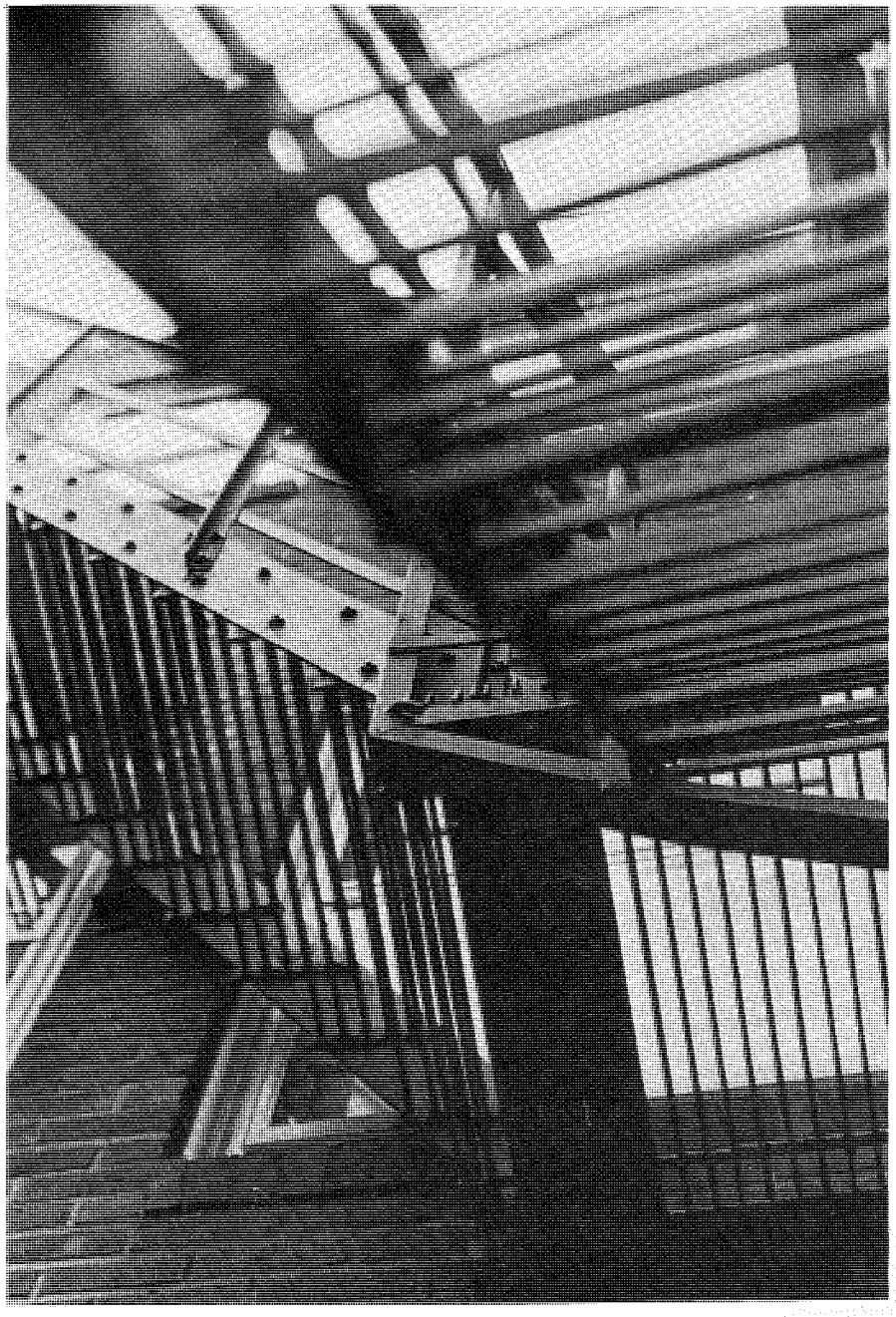
Final Disposition: The Commission encourages the Department of Educational and Cultural Services to implement a comprehensive school health curriculum, in conjunction with other departments, as appropriate.

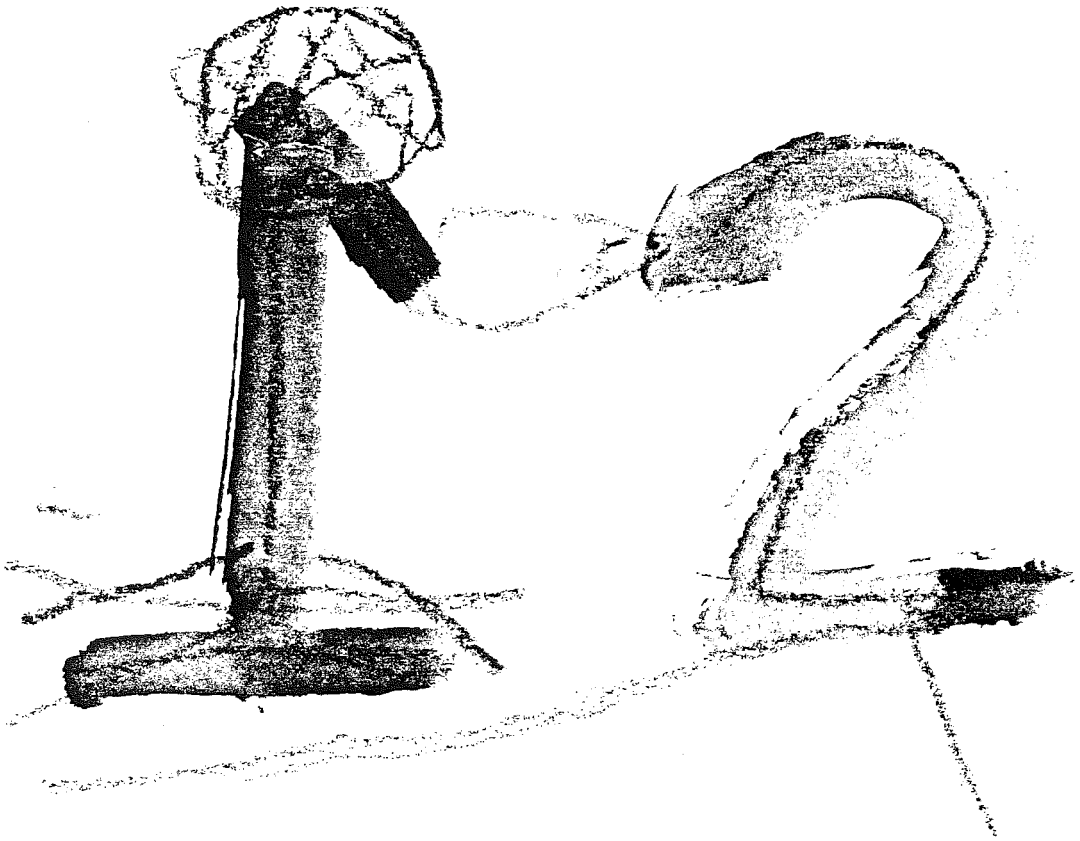


Nathan

Nathan

PROBLEM STATEMENTS AND RECOMMENDATIONS FOR ADMINISTRATIVE AND LEGAL ISSUES





Many children in need do not have access to a case management system.

The following four vignettes describe the representative cases presented to the Commission that typify youth who "fall through the cracks" of a fragmented service delivery system. They are multiple-problem children with multiple agency involvement or children whose presenting problem does not fit within the responsibilities of any existing case management system.

Sam is 14 years old and has had a history of aggressive, uncooperative behavior since entering school and has been in a number of special educational settings and placements. An ongoing specialized treatment program for Sam was interrupted and Sam returned to his family. He continually has been a behavior problem for his parents, school and community. He has recently been adjudicated for motorcycle theft. His psychological evaluator indicates that a correctionally oriented program would be not be in Sam's best interests and recommends a treatment program. Because of Sam's involvement with the criminal justice system, and the judge's order for the various state agencies to assist in identifying and placing Sam in an appropriate treatment setting, there is confusion about who (which state agency or the school) should assume lead responsibility for planning for Sam. With no program identified at present, Sam is currently (but temporarily) committed to the Maine Youth Center.

Tammy is 16 years old and her home situation is in such conflict that she has asked her guidance counselor to find her a place to stay outside of the home. Although the family is a client of Child Protective Services, there is little evidence of abuse or neglect that would justify petitioning the court for custody. When in school, Tammy is an above-average student; this semester, however, she has been truant all but 15 days. It is suspected that she may now turn to prostitution to earn enough money to get an apartment.

Tommy is 14 years old and a patient at the Augusta Mental Health Institute's Adolescent Unit. He is not mentally ill, but is marginally retarded and responds to stress by acting out and assaulting others. He has now had five institutional-type placements in 5 years, primarily for lack of more appropriate environments. A major problem in dealing with Tommy's case is fixing legal responsibility for case management for Tommy. While Tommy has significant needs for specialized services, he does not fit into any of the existing case management systems.

Sue, age 16, was referred to Augusta Mental Health Institute on an Emergency Involuntary basis because of a violent outburst at school in which she threatened a fellow student and actually struck that student. There had been a prior history of mental health treatment, but poor follow-through. When she was evaluated at Augusta Mental Health Institute, it was felt that although there had been some dangerous behavior, she did not meet the criteria for an Emergency Involuntary admission because she did not meet the criteria for mental illness. Her parents had accompanied her to Augusta Mental Health Institute and Voluntary admission had been recommended to both Sue and her parents. Her parents were unsuccessful in convincing her to stay in the hospital for treatment. They appeared very frustrated that they could not keep her at Augusta Mental Health Institute for treatment although they wanted treatment. The family did say that they planned to follow through on out-patient treatment in their community. Due to the poor compliance in the past, it was questionable as to whether or not the family would seek the treatment that appeared necessary. This family had no contact with the Department of Human Services, nor had the child's behavior warranted her involvement in the criminal justice system. A case manager could have assisted the family in assuring follow-through on a course of treatment for Sue.

Case management is a method of assuring that individuals receive appropriate service by coordinating and assigning responsibility for assessment, case plan development, identification of and access to resources and establishment of a process for monitoring progress and reassessing case plans. To implement a case management system, a skilled advocate is assigned to each case that exceeds a certain threshold. The threshold is defined by statute or administrative action incorporating any number of criteria. Appendix C outlines the criteria and other descriptive information for case management systems currently in place in Maine, e.g., the Bureau of Mental Retardation, the Department of Human Services, the Juvenile Services Unit within the Department of Corrections. Most of the time, case management works sufficiently well for youth under the jurisdiction of these agencies. The situations where case management works less well, or not at all, generally fall into two categories:

1. The child is identified as a client of several agencies whose case management responsibilities overlap, creating interagency confusion over roles and responsibilities.

Tommy's vignette demonstrates this problem. Tommy's need for service intervention is not in question; however, the responsibility to manage Tommy's case is not clearly defined. In addition, since Tommy's needs are specialized there will be a significant funding responsibility attached to the provision of service. Five major state agencies have been involved to some extent with Tommy's case for several months. Tommy has received transitional interim services although a long range plan for services has not as yet been developed and the responsibility to develop that plan has not been assigned. Admittedly Tommy's needs are specialized and cannot be met easily by the existing service system. However an assigned case manager could ease the "turf issues" and allow the professional time to be devoted to creative development of an appropriate service for Tommy.

Sam's case demonstrates a slightly different aspect of the same problem. A case manager for Sam might have been able to maintain continuity of treatment services for him when his treatment program closed, possibly preventing further deterioration of Sam's behavior. The case manager also could have provided linkages as Sam moved between the systems, ensuring some continuity of services.

2. The child is <u>not</u> identified as a client of one of the agencies offering case management, although he/she may be known to many of them. These clients fall into three categories as follows:

<u>Former Status Offenders:</u> The recommendations of Maine's Commission to Revise the Statutes Relating to Juveniles (March 1977) intended to implement the basic philosophy that " children who do not commit criminal offenses but who are 'incorrigible,' truant from school or run away from home should not be referred to juvenile courts but rather should be served by the social and educational agencies better equipped to deal with their behavior than are courts of law." The current social service systems, however, have not formally incorporated the responsibility for serving this population within their current case management systems. Tammy's case is a good example of this type of case. Assistance in obtaining an acceptable living situation, part-time employment and continued education might make the difference for Tammy. While acknowledging that these youth present problems to the system, their behaviors are extraordinarily difficult to define and study. More often than not, they are but one symptom of a child with multiple problems. The Commission is not in any way suggesting that these offenses be recriminalized, thereby substituting incarceration and/or

punishment for services. The Commission, however, identified this group of youth as needing case management services.

Screened Out Protective Service Referrals: The Department of Human Services reported to the Commission that approximately 3600 referrals made to the Protective Services Unit are screened out because these cases do not meet the criteria for abuse and neglect under the current statutes. The type of cases screened out by the Protective Services Unit include (in order of priority):

1. Parent/child conflict which involves acting out and running away by the child but does not involve an allegation of abuse or neglect;

2. Marginal, non-specific allegations such as, "she's not a good mother" or "parents are mean to children";

3. Divorce or custody conflict;

4. Family crisis;

5. Insufficient information;

6. "Throw away" child living with relative;

7. Mental health problems;

8. Truancy and educational neglect where physical/mental/sexual abuse and neglect is not a factor; and

9. Spouse abuse.

While these cases do not qualify for intervention by the Department of Human Services Protective Services Unit, they do represent a source of referrals for multiple-problem, dysfunctional families in need of some level of service. Again, Tammy's case illustrates this target population. In addition, these referrals also may represent another type of child or family - one with a low-level set of problems affecting school behavior, behavior in the community, mental health and family stability. Services provided to these children and families may serve to prevent a situation from deteriorating into a major problem.

Children with Mental Health Problems:

Sue represents a specific client population of emotionally disturbed clients under the age of 18 who require intervention by mental health and allied agencies. These children may be conduct disordered, manifesting long term behavior problems which may include impulsiveness, aggressiveness, anti-social acts, refusal to accept limits, suicide gestures and substance abuse. These children may also be suffering serious discomfort from anxiety, depression, irrational fears and concerns.

The current mental health service system is the least centralized system serving children. This forces families to deal with multiple professionals in a search for resources from many different state agencies. A case manager could assist these families and children by developing case plans and agreements to coordinate educational, residential and therapeutic services.

A coordinated case management system that would assist even some of these youth and their families is an essential first step in seeing that all children with special needs acquire services to address their needs. The Commission strongly supports the development of such a system, using the Family Service Program as the case management model for a pilot project in case management. The Family Service Program model has recently been implemented by the Department of Human Services to serve AFDC families whose head of household is under age 20. The purpose of the program is to strengthen families by identifying high risk families and assisting them in obtaining needed social and health services. While the program is designed to serve all high risk families, resources will initially be targeted on a pilot basis to serve the children and their families identified above.

The program is of a voluntary nature. Families are asked if they wish to discuss their problems and needs with a Family Service Caseworker. If they wish to participate, a case plan is developed tailored to the client's individual needs and goals. Services are provided by the worker, the Departments and existing community agencies. Services provided include continuation of education, acquisition of job skills, improved health, acquisition of life management skills and coordination of existing services. Whenever a case qualifies for case management services, one individual has the authority and responsibility to bring about cooperative action among service providers from different disciplines, departments and agencies, including client and family where appropriate, and to acquire additional services to assist the child who is in need of help. Some situations will require short term intervention and others demand long term solutions.

Recommendation 3: Funding should be sought as soon as possible to set up pilot projects in case management. These projects should be joint efforts among the Departments of Human Services, Educational and Cultural Services, Mental Health and Mental Retardation and Corrections. The pilot projects should be patterned after various models including but not limited to a school based model and the Department of Human Services Family Services Model described in the text. Either the Department of Human Services or the Interdepartmental Committee should be assigned lead responsibility.

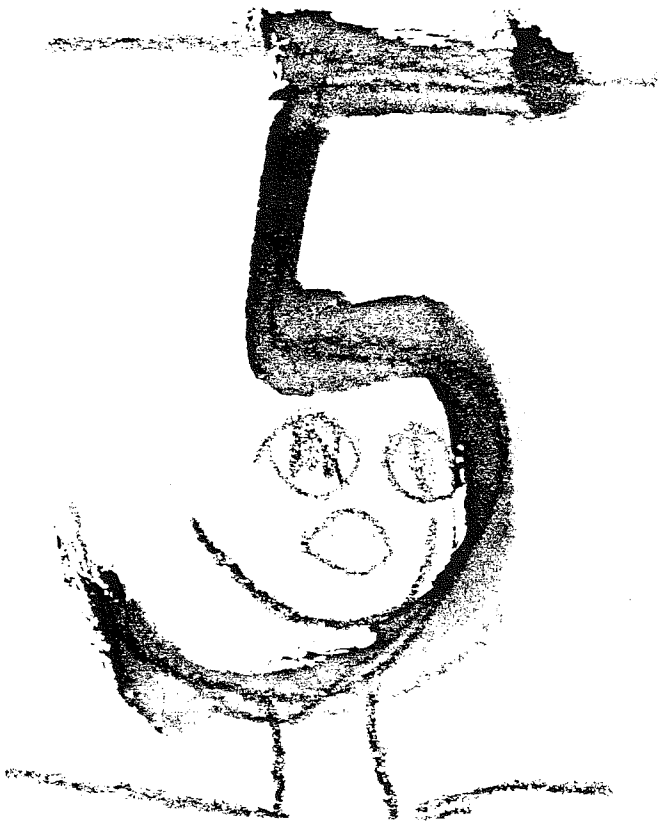
Departmental Responses: All four departments concurred as to the need for statewide case management services; however, they differed as to lead agency and the need for pilot projects. The Departments of Corrections, Educational and Cultural Services and Human Services all saw the Department of Human Services as the lead agency with case management folding into the existing service system. The Department of Mental Health and Mental Retardation saw the Children and Adolescent Service Systems Project (CASSP) as an opportunity to test out and refine a pilot case management system. Additionally, that department supported oversight responsibility being assigned to the Interdepartmental Committee.

Final Disposition: Both approaches should be tried before any final decision is made. However, the Commission felt that a third case management approach, linking case management to the Pupil Evaluation Team process, should also be considered. Whatever the approach, however, the need remains for case management to be available to all children in need.

Recommendation 4: The four departments should also explore the idea of a centralized referral/ombudsman system to be administered by the Interdepartmental Committee which will coordinate existing case management systems and serve as a clearinghouse for those children for whom coordination of services is problematic.

Departmental Responses: The Departments of Educational and Cultural Services and Mental Health and Mental Retardation both supported a centralized referral/ombudsman to coordinate existing case management/clearinghouse systems assigned to the Interdepartmental Committee.

Final Disposition: The Commission concurs with the position that the Interdepartmental Committee take responsibility. The Commission also advocates strongly for the availability of victim advocates in every District Attorney's Office statewide.




DAD
LOVE U!

Administrative and legal regulations impede equal access to services.

A large number of students require placement outside of their home in therapeutic foster homes, therapeutic group homes, residential treatment centers or temporarily in emergency shelters. For example, circumstances involving the community or the family may make it impossible for the student to reside at home, despite the fact that he has been doing well in school.

Chris, age 14, has asked his school guidance counselor to find a place for him to live out of the home because of constant conflict. The conflict, however, does not constitute an abusive or neglectful situation. Therefore, Chris is not eligible for services from the Department of Human Services. Chris has been truant from school but returned upon the urging of his guidance counselor. He is again truant and states that he is looking for a place to live. Chris will miss most of his second semester of school and will not return. His parents most likely will sign him out of school.

Mark, age 15, started doing noticeably poorly in school and acting out in the community, resulting in an arrest. It was discovered that his family was going through a temporary crisis because of unemployment, resulting in family financial problems and unrest. The school provided an alternate program for Mark and linked the family with a home-based services program. Mark's school performance has improved as well as his behavior in the community. As a result, Mark was given probation as opposed to being committed to the Maine Youth Center.

Martha is a 13-year-old girl who has been in a special education program at her school for the past two years. Martha has progressed well educationally according to her evaluations; however, she is not getting along with her family and has become a behavior problem in the community after school hours. Her family, while aware of the problem, has been unable to obtain outside supportive services for their daughter. The family has broken several appointments with the mental health center with no explanation. The school district cites Martha's progress in her school program as proof that her educational needs are being met. She does not qualify for services from either the Department of Corrections or Department of Human Services.

Access to services for children and youth depend upon the child's classification, status and ability to fit within defined program criteria. A broad outline of the criteria for each of the State Departments is defined below:

The Special Education Process serves a specific population of children in need of special education and related services who are visually impaired, hearing impaired, learning disabled, physically impaired, acute health impaired, mentally retarded (maturationally delayed), multiply handicapped, behaviorally/emotionally disturbed and/or suffering from a temporary traumatic illness or injury. Students are referred for services through the Pupil Evaluation Team (PET) process.

The Pupil Evaluation Team is composed of parents, a school administrator, regular and special educators and other appropriate individuals (evaluator, other agency professionals involved with the child, etc.), and is responsible for determining the special education needs of students. The major responsibilities of the Pupil Evaluation Team are to determine whether or not referred students actually need special education and/or supportive assistance, develop an appropriate Individual Education Program (IEP) for each student whose exceptionality has been identified and recommend this program to the district superintendent for approval.

Children in the care and/or custody of the Department of Human Services. Major priority groups served under the Child Welfare Program are children in the care or custody of the Department of Human Services and children who are or may become abused, neglected and/or exploited and their families. A wide range of services is available to this client population, such as substitute care, advocacy, therapeutic services, etc. Additionally, services are provided through the Aid to Families with Dependent Children Program which provides financial assistance to needy families deprived of parental support. The goal of the Office of Maternal and Child Health is to assure that all mothers in Maine receive access to quality maternal and child health services.

The Department of Mental Health and Mental Retardation provides services to children through three distinct channels. The mental health institutions have the direct responsibility to provide in-patient services to adolescents who are mentally ill per legal criteria and dangerous to self or others. In addition to this mandated population, the Augusta Mental Health Institute's Adolescent Unit is able to treat disturbed adolescents who do not meet the criteria for commitment, provided they are admitted on a voluntary basis and there is a plan for discharge that includes establishing parental authority and a place for the youngster to live. The Bureau of Mental Health administers funding to eight community mental health centers to provide emergency, out-patient, in-patient, consultation-and-education and community support services to clients, including children. Five of the Community Mental Health Centers identify specific children's services units. The Office of Children's Services within the Department is responsible for assisting in the planning, coordination and development of mental health services for children, ages 0-20 years. The Office also works closely with the Bureau of Mental Retardation in order to ensure that services are provided in the least restrictive setting appropriate to the child's needs. The Bureau of Mental Retardation provides services for birth to five year old children who are developmentally delayed and case management and other support services for 5 to 20 year old children who are mentally retarded. Emphasis is placed on maintaining each child in his natural home or in a substitute care placement within the community whenever possible.

The Department of Corrections is responsible for the administration of three programs serving youth who are either adjudicated or who have been diverted from adjudication through the juvenile intake process. The Department purchases out of home living services for youthful offenders as an alternative to or diversion from institutionalization. Secondly, the Juvenile Services Unit within the Department of Corrections is responsible for Juvenile Intake which determines which cases referred by law enforcement agencies for formal adjudication proceedings are appropriate for informal adjustment rather than involvement in the court system. Also, the Unit is legislated to provide a continuum of pre- and post-adjudication services including diversion, probation, supervision, institutional support services, aftercare and parole services. Thirdly, the Department of Corrections, through the Maine Youth Center, provides secure detention for juvenile offenders in Maine committed by the courts.

There are a group of children whose problems do not fit within the responsibilities of the state agencies described. Generally speaking, these children with special needs are still in the custody of their parents, have not committed an offense, do not respond well to the clinical approach of the community mental health center, and do not require institutionalization. These children also generally require a combination of intervention services.

The Department of Mental Health and Mental Retardation provides the funding for services most easily available to this population; however, availability is limited by funding levels and community intake. Many times these children require additional residential services provided only on a very limited basis by this Department. The problems experienced by these children and their families could be alleviated through a more coordinated service delivery system coupled with an expanded case management system and provision of additional resources. (Case management is discussed further on pgs. 39-44).

Educational issues are inextricably linked to most issues relating to children's services since a child spends a major part of his day in an educational setting. There are special issues relating to the funding of services and educational programming.

Residential Treatment: Under the current statutes, a local school district is responsible for the full cost (Board/Care, Treatment and Special Education Tuition) for any student not in the care/custody of the Department of Human Services placed in a residential treatment center program through the Pupil Evaluation Team process (State subsidy occurs two years after the fact). Through administrative agreement, subject to existing funding, the Department of Mental Health and Mental Retardation pays the treatment costs for a child not in the custody of the Department of Human Services in the four in-state residential treatment centers. However, for children in the custody of the Department of Human Services, that Department pays the board/care and treatment costs and the Department of Education pays for tuition. The following matrix depicts these funding responsibilities.

	Board/Care	Treatment	Special Education Tuition
Children in Custody of DHS	DHS	DHS	DECS
Children in Custody of Parents	School District	DMHMR (in state facilities)	School District

Concern has been expressed that the entire cost of a residential treatment center (RTC) placement is paid by the State for a child in the care or custody of the Department of Human Services. This leads to more accessible treatment for these children than for children remaining in the custody of their parents. In some instances there may be pressure on the family to give up custody of the child in order to obtain funding for this type of service.

From an educational perspective, however, local school districts are willing to pay the residential treatment costs for students requiring these services for educational reasons. However, the district may be very reluctant to pay these costs if it has an appropriate special education program for the student who needs out of home placement for other reasons. School districts do not feel that it is their responsibility to pay for non-educational placements even though pressured to do so by State agency representatives or others concerned about the mental health or residential needs of the child.

Community-Based Services: In general, in order to have access to other residential services such as group homes, therapeutic group homes and therapeutic foster homes, the child must be a client of either the Department of Human Services or the Department of Corrections. Special arrangements are made only under extenuating circumstances to provide substitute care arrangements for other children in need of these services for non-educational reasons.

The case of Mark illustrates that the intervention of an alternative school program and home-based services were helpful. But a majority of public schools do not operate alternative school programs and only five home-based services programs exist throughout the state. (See pgs. 56-57 for further elaboration of home-based services.) Clearly, access to this service is limited by the availability of these services statewide.

Historically, less emphasis has been placed on preventing family break-up than on providing alternative placements for children in dysfunctional families. Students who are in a caring, loving family but nevertheless are having emotional difficulties or students with mildly dysfunctional families where the child is not in jeopardy do not have the same access to needed services as those young people who have come into state custody because of more serious individual or family behavior.

A final problem impeding equal access to services is created by the current special education reimbursement process. Availability of good special education programming sometimes becomes a consideration in the recruiting and/or development of foster homes, group homes and other residential placements. Many facilities have been established in communities for some time. In these instances, the constant flow of different children with different special needs who require varying levels of special educational programming may create further problems for the school. Any influx of out-of-district students to take advantage of a specialized program can create a burden on a school district. Special education programming can be expensive. State subsidy may not totally offset the expense. The result is a disincentive to school districts to develop quality special education programs.

Recommendation 5: The Commission strongly supports current legislative efforts to modify the funding formula for out-of-home placements and recommends that the Interdepartmental Committee, either through an existing or a specially appointed subcommittee, develop comprehensive recommendations for legislative and administrative action to address the problems defined herein.

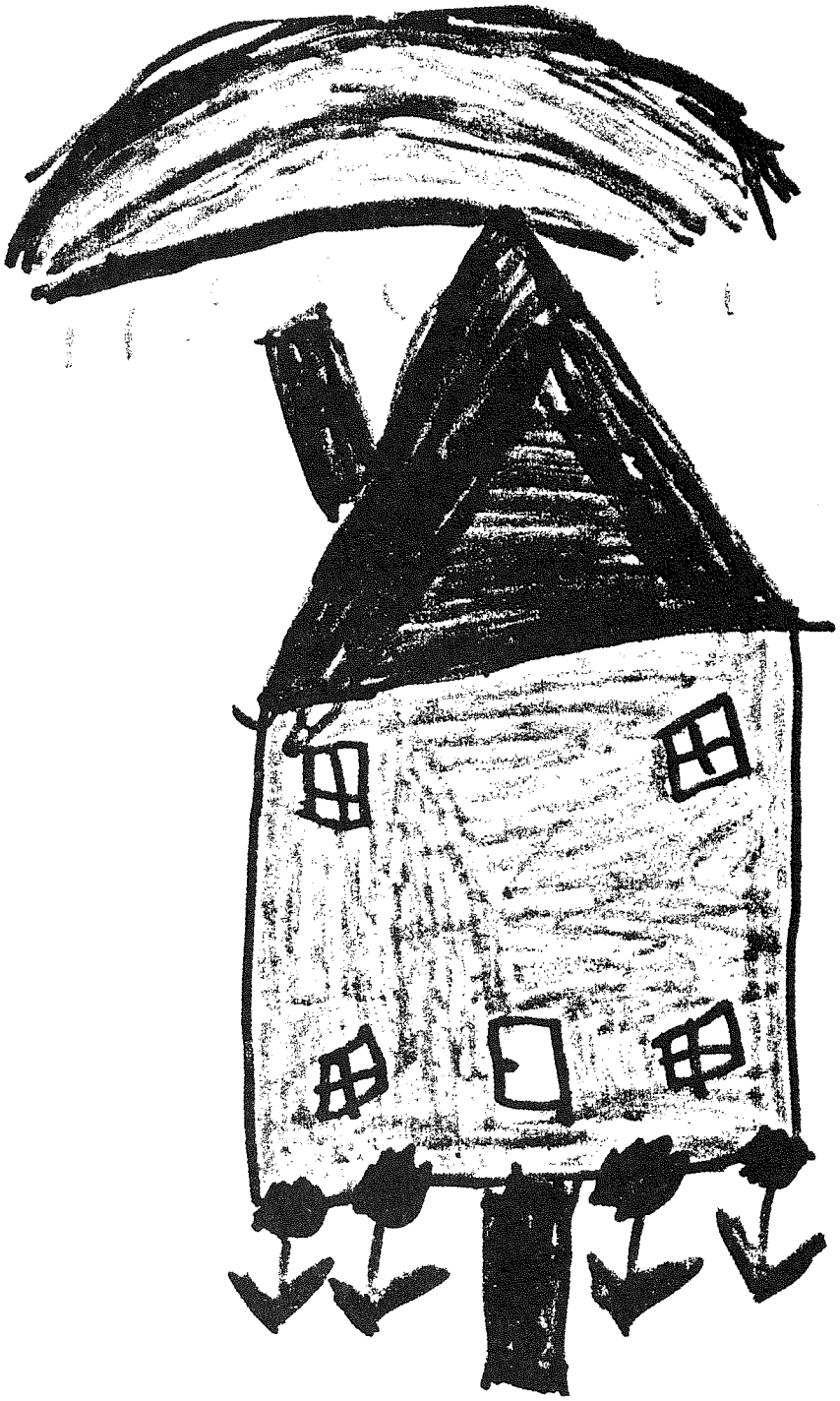
An interdepartmental agreement should be developed to outline and establish:

1. funding responsibilities for out-of-home placements in such a way as to improve equal access to services; and

2. individual protocol and programmatic responsibilities in the referral, placement and follow-up process of such placements.

Departmental Responses: All four departments supported the Interdepartmental Committee's role to re-examine funding responsibilities for equal access and programmatic/protocol responsibilities for referrals, placements and follow-up of clients.

Final Disposition: During the 1984 Special Session, the Legislature passed a bill which accomplished the basic ideas embodied in this recommendation, but the measure died on the Appropriations Table for lack of financial resources. A rewording of that measure is being developed for reintroduction during 1985. The Commission supports the role of the Interdepartmental Committee in this re-examination and urges the departments to support clarification and modification of the funding approach for residential placements.



Limitations of Medicaid reimbursement affect the availability of some needed services.

Maine's Medicaid program provides free medical services to lowincome residents receiving state assistance. Medical services provided under Medicaid include health care and a broad range of related services for children with special needs. A health care provider, such as a doctor, is reimbursed by Medicaid at about the same rate charged by others in his or her field. The Medicaid Program is funded by the State and Federal government, with the State currently providing approximately thirty-five cents out of each Medicaid dollar spent, and the Federal government paying sixty-five cents.

The vast majority of Medicaid dollars spent in this state go directly to hospitals, nursing homes, physicians and similar traditional medical treatment providers. In the past little attention has been given to studying the expansion of Medicaid reimbursement in the area of mental health and related services to children and troubled youth. After a preliminary examination of the matter, the Commission has determined that a number of areas should be studied in greater depth, with an eye towards expansion of Medicaid reimbursement.

While Maine's Medical Assistance Program currently pays for a range of mental health services provided by community mental health clinics and private psychiatrists and psychologists, there is no question that State-controlled dollars continue to be the major source of funds for community mental health services. For example, in FY 83, net Medicaid revenues ($944,000) represented only 6% of the total revenues ($124,981,000) of the agencies funded by the Bureau of Mental Health, while State funds represented 54% of total program revenues. Other funds represented Federal, local, public and other fee-for-service revenues. Also, community mental health services, which may provide 'optional' services under current Federal guidelines, represent only $2 million in the Medicaid Program.

The result is that while there has been a substantial increase in the demand for mental health services to children due to the increase in the reported cases of child abuse and other factors, available revenues to pay for these services have been unable to keep pace with this demand. As a result, in all but emergency cases there is a six week delay across the state in providing needed mental health services for low income families receiving State assistance.

There is no question that more creative use of the Medicaid Program could increase the availability and range of mental health services to children with special needs. For example, the State's seed share of every Medicaid dollar is about thirty-five cents. Greater use of existing State General Fund dollars ($5,500,000) for mental health as Medicaid seed would result in a dramatic increase in the availability of needed mental health services, such as those outlined on the following pages.

Services Provided in a School Setting:

Reimbursable services are normally limited to those rendered at the provider's office. However, in many instances mental health or other services can be rendered most effectively to an individual in that client's home. In some cases that may even be the only setting where the client is willing to receive help. In many other instances a school, neighborhood center, or similar setting offers the best opportunity to connect a service provider with a client in need of services. For example, schools are often the place where certain children's mental health problems are first diagnosed, and are a logical place to render treatment for those problems. Schools are required to provide special education to all exceptional children between the ages of 5 and 20 years old who need special services in the area of visual impairment, hearing impairment, learning disability, physical impairment, behavioral/ emotional disturbance, mental retardation (maturationally delayed), multiple handicaps, and/or chronic/acute health impairment. However, Medicaid generally does not reimburse for services provided at a school site.

Currently, Medicaid reimbursement extends only to services provided by hospitals, certain private mental health professionals and Comprehensive Mental Health Centers. Medicaid reimbursement site restrictions act as a barrier that prevent more children from receiving needed speech and language therapy, occupational therapy, physical therapy, psychological services or other similar treatment. These site restrictions are artificial barriers to the rendering of effective services to troubled children and family members and should be removed. Substituting some of the state dollars currently being spent by school districts with Federal Medicaid funds could provide an expanded capability to provide needed services. Many more children could be served for the same expenditure of funds.

Home-based Services:

Home-based care programs in Maine and elsewhere have successfully kept children out of residential care and offer a constructive alternative mode of treatment to many children and families in need of services. Experience with several projects currently funded in Maine prove clearly that dedicated management, strong community support and specially trained staff can provide more effective services to troubled youths in home settings than is possible in any other program. This has proven to be particularly true in the case of substance abusing families, families who normally function adequately but are temporarily in crisis and multi-problem families who are chronically in crisis.

In its first year, the Bath-Brunswick Homebuilders Program reported that 83% of families they served remained intact. Day One Homebuilders Project in Portland has had similar success rates with substance abusing families, as has Community Counseling Center working with children in foster homes and in marginally abusive families. National statistics for similar projects show that as high as 93% of families can be helped to remain intact. Along with being more desirable socially, this result is also far less expensive than alternative, out-of-home placements.

This success in keeping families "intact" is of particular importance regarding the cost-effective care of this population. In the evaluation of the Day One population, 80% of these clients were in jeopardy of being removed to a more restrictive setting. Approximately half of these clients would have been detained in the juvenile justice system (Maine Youth Center) and the other half in the child protective/foster home system. The cost of these alternatives can be as high as $20,000 per year per child. The cost of the homebuilders intervention is on the average between $3,000 and $4,000 per family.

At the present time, Medicaid does not provide adequate reimbursement to mental health services provided in homes. Even where special reimbursement is made available, no mechanism exists to reimburse for travel time by agency personnel. While one may wish to retain some incentive for clients to go to mental health providers' offices whenever possible, the current severe disincentives to home-based care need to be altered.

From the standpoint of the effectiveness of therapeutic family/child interventions, particularly at the early stages of child/family development, home-based provision of services appears more therapeutically beneficial than does provision in the more traditional office/clinic-based settings.

In dysfunctional families, the combination of intensive home-based services with ongoing, out-patient services through the mental health center appears the most effective, long-lasting approach. If the entire home-based therapy model cannot be Medicaid reimbursable, then components of that model may be reimbursable with minimum changes such as the activities/staff resources in order to conduct initial diagnosis, clinical case review, medication monitoring, ongoing clinical assessments, etc.

Alcoholism Services:

Maine law requires private insurance companies to cover the costs of alcoholism services that are provided in residential and out-patient settings whether in a free-standing or hospital-based program. However, Medicaid does not presently reimburse for those residential and out-patient services which are provided in free-standing, non-hospital-based rehabilitation settings. Many residential and out-patient programs that are not available in a hospital setting are preferable to many individuals. Increased access to treatment services in a non-hospital rehabilitation setting may also help people avoid the need for later hospitalization at a higher cost to the State. It would appear that expanding Medicaid coverage to include residential and out-patient services in non-hospital-based rehabilitation centers removes a barrier which sometimes prevents troubled young people from acquiring needed services.

The Commission supported L.D. 2207, An Act to Provide Medicaid Reimbursement for Substance Abuse Services, which was enacted as PL 1983, c.752. (See Appendix D.) As of January 1, 1985, this law requires the Department of Human Services to provide reimbursement for treatment for alcoholism and drug dependency. The Commission supports the Department seeking a waiver from the Federal government for Medicaid reimbursement for out-patient and residential, non-hospital-based treatment.

The Department of Human Services has indicated to the Commission that Federal statutory authority will allow for the expansion of Medicaid reimbursement in the three ways which have been outlined. The Department of Human Services has also expressed a willingness to pursue these changes, in conjunction with the other appropriate departments. The Commission believes that the time is at hand for the development of proposals which could be presented for approval to the Federal government when necessary and which would accomplish the goals set forth here.

Per Hour Reimbursement Rate:

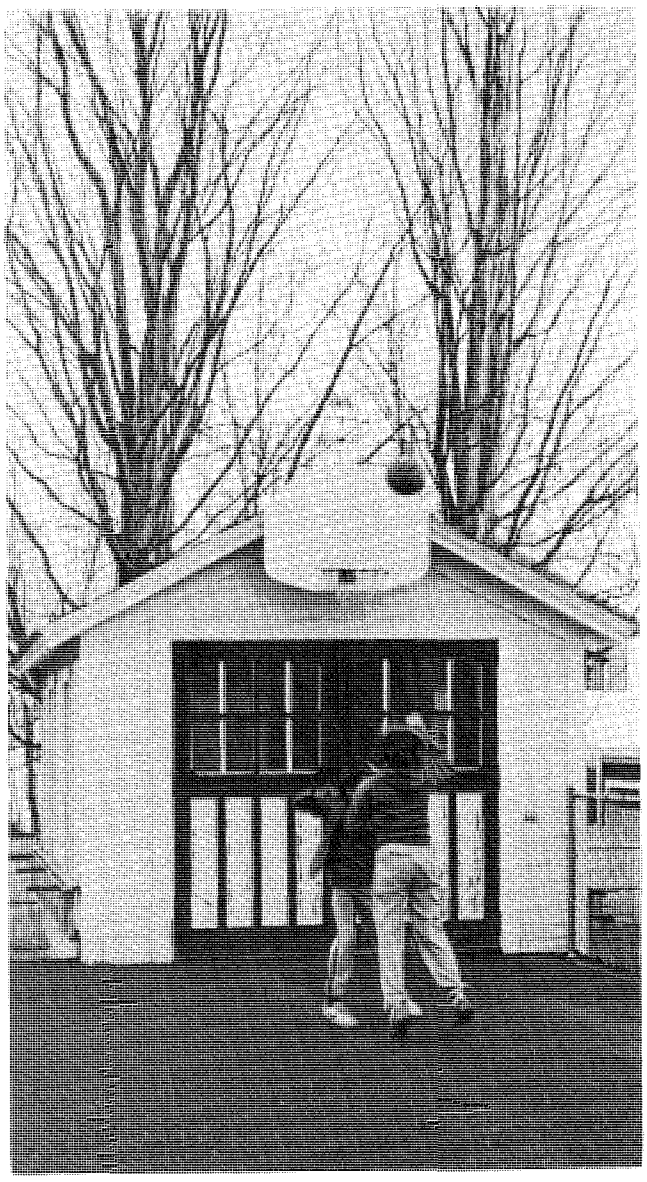
An additional concern brought to the attention of the Commission is the per-hour reimbursement rate for Medicaid-eligible services. Community Mental Health Centers are funded principally by direct grants through the Bureau of Mental Health budget. Most centers supplement those funds with United Way and other grants which they can acquire in their own communities. Private insurance dollars contribute toward the Community Mental Health Centers management as well, as do the fees that centers charge on a sliding scale to clients. The Medicaid program also reimburses for some services rendered. The Commission received testimony that the Medicaid rate does not accurately reflect the actual cost of rendering the service; therefore, State dollars and other funding sources must make up the difference. The Commission believes that effective administrative management of State dollars requires that an effort be made to raise the level of Medicaid reimbursement rates, to maximize the usage of State dollars dedicated to mental health services. This would free up money for additional units of service, which could then be given to serve the population with whom the Commission is concerned.

Reimbursable Providers:

In the mid-1960's, Congress authorized Federal funding for the development and maintenance of a system of regional Comprehensive Mental Health Centers. Over the past several years, the Federal direct grant program has been gradually reduced, until it was terminated entirely in 1983. However, the distinction between Comprehensive Mental Health Centers and other types of mental health facilities has been maintained by the Department of Mental Health and Mental Retardation, by maintaining two separate categories of licensure.

During this same time period, the Medicaid program was established within the State of Maine Department of Human Services, and reimbursement was made available in the state for certain mental health services. It was decided that Medicaid reimbursement would extend only to those services provided by general hospitals, certain private mental health practitioners and Comprehensive Mental Health Centers (but not other mental health facilities). Because of that policy there are some facilities with a general mental health facility license that are not eligible for Medicaid reimbursement, but can provide valuable mental health services to the community.

The Bureau of Mental Health is currently considering changing its licensing structure so that it more accurately reflects the demands and diversity of the mental health services system. Since licensing is closely interrelated to Medicaid reimbursement policies, such a review should be done (at least in part) on an interdepartmental basis.



Recommendation 6: The Medicaid Review Committee currently in existence or such other group as might be developed through interdepartmental cooperation, with the Department of Human Services serving as lead agency, should:

1. develop a proposal for Medicaid reimbursement allowing all service providers to render Medicaid-eligible services in the most appropriate setting, rather than only in their own facilities. Caution should be exercised to ensure that non-hospital-based services such as speech and language therapy, occupational therapy, physical therapy and psychological services which are provided in clients' homes or in school settings are made reimbursable;

2. develop a proposal for Medicaid reimbursement allowing home-based care and counseling efforts to be reimbursed. The definition of eligible services under this approach should be made broad enough to include the many activities that home-based counseling workers engage in with clients in their homes. In addition, such a proposal could provide for the reimbursement of home-based services at a higher rate, to allow reimbursement for travel time. Financial disincentives to rendering home-based services should be reduced;

3. develop a comprehensive reimbursement proposal covering alcoholism services provided in free-standing, non-hospital-based rehabilitation settings;

4. provide for increased reimbursement rates of Medicaid services rendered by Community Mental Health Centers and other mental health providers;

5. research the issue of Medicaid reimbursement for mental health services provided by all Certified Social Workers (CSWs); and

6. encourage a team approach to evaluation and treatment of special needs children by allowing for Medicaid reimbursement for services provided as part of an interdisciplinary consultation.

Departmental Responses: All four departments concurred with the need to adjust Medicaid reimbursement requirements to allow services in the most appropriate setting based upon client needs. This was considered particularly important for home-based care and free-standing alcohol rehabilitation.

Final Disposition: The Commission recommends periodic reviews of Medicaid reimbursement policy and urges that the Department of Human Services give high priority for implementation to proposals that will:

1) remove site restrictions; and

2) expand the categories of professionals who can be reimbursed for service.

Recommendation 7: The Bureau of Mental Health should conduct its planned review of mental health facility licensing requirements and reevaluate whether different licenses should be granted to Comprehensive Mental Health Centers and other mental health facilities. In conducting that review, the Bureau of Mental Health should work closely with the Bureau of Medical Services to integrate the licensing and funding mechanisms for mental health services within the state and explore various methods of increasing Federal financial support for mental health programs to children, such as providing Medicaid reimbursement to a greater number of categories of mental health providers.

Departmental Responses: The Departments of Corrections, Human Services and Mental Health and Mental Retardation all agreed that the licensing requirements for mental health facilities need to be re-examined for continuity, accountability, quality and comprehensiveness. The Department of Human Services suggested the development of a report presenting types and costs of mental health services, numbers of clients and units, and priority, planning and evaluation components utilized. The Department of Mental Health and Mental Retardation suggested convening a broad representative work group to undertake such an effort.

Final Disposition: The Commission recognizes and encourages the continued efforts of all departments.

Consistent notification is a problem in the appeal process for fee setting in Community Mental Health Centers.

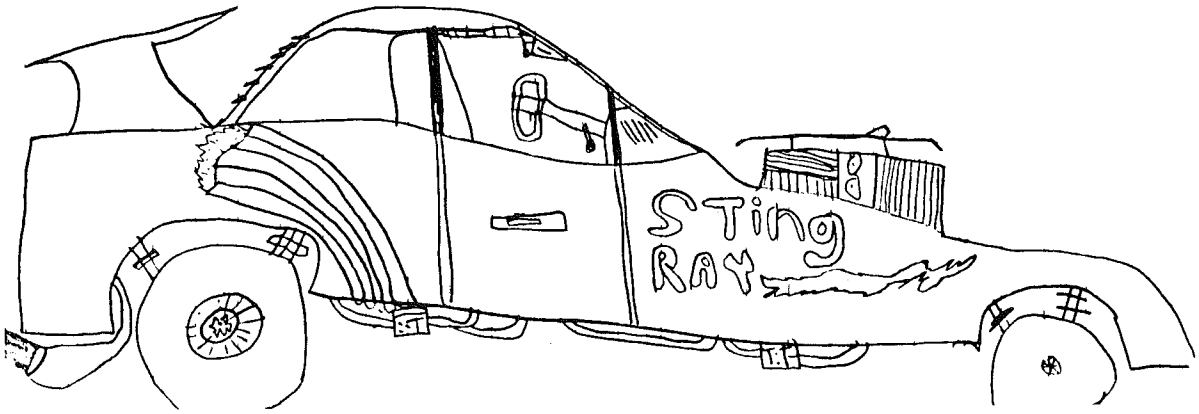
All community mental health centers have sliding-scale fee structures under which services are made available to every client for a fee that each should be able to afford. However, there is no ideal way to set up or administer a fee schedule, and in each community mental health center the fee structure may create an unusual hardship for some individual clients because of peculiar situations that may not easily fit into the formula or schedule applied. For example, in order to encourage effective use of available time, many centers require a client who misses a scheduled appointment without prior notification to be assessed a special extra fee that must be paid before further services are rendered. As another example, some centers may not take into account money which a family sends to a grown child living elsewhere, because there is no obligation to support that other family member. Nevertheless, the family seeking the services may feel unable to pay the fee provided and yet unwilling to cease helping support their grown child.

Because of the difficulties inherent in managing sliding-scale fee structures and the hardships that can result in their application to individual case situations, all community mental health centers ask a second person within the center to review the establishment of the fee. Typically, a person first speaks to a program director, and then to the executive director of the agency. In some cases, the person can then appeal directly to the Board of Directors or to the Bureau of Mental Health. All centers are required to post information regarding this process where clients can have access to it, but some centers are less aggressive in informing all clients about this process than others. In addition, the Commission has heard that most centers do not advertise that clients or prospective clients have the right to seek assistance in appealing fee determinations, despite the fact that these appeal procedures may seem frightening or overwhelming to a client who is going through emotional difficulties. Ineffective notification of the appeal mechanism regarding fees may be a barrier to service in some cases, and ineffective notification of the availability of assistance in appealing fee determinations may also tend to discourage individuals from getting needed mental health services. This seems especially true in the case of children and families in need of mental health services.

Recommendation 8: The Department of Mental Health and Mental Retardation should ensure that Community Mental Health Centers notify all clients of their appeal rights regarding fees in a standardized, easy to understand format and should require that centers take additional steps (written and oral) to inform clients of external sources of assistance in questioning adverse decisions regarding fees.

Departmental Responses: The Department of Mental Health and Mental Retardation supported the need to ensure that all community mental health centers routinely notify their clients of their right to appeal any fees charged for services, and indicated it would develop standardized, easily understood formats for such notification. The Department of Corrections, concurred with the need. Additionally, the Department of Mental Health and Mental Retardation indicated it would work with current staff advocacy networks through such mechanisms as the Patient's Rights Bill and specific contractual agreements to inform clients of their external right to appeal any fees charged.

Final Disposition: The Commission urges the Department of Mental Health and Mental Retardation to continue its efforts to improve communications to clients regarding their rights in fee decisions.



Problems exist with a loophole in reporting child abuse to the Department of Human Services.

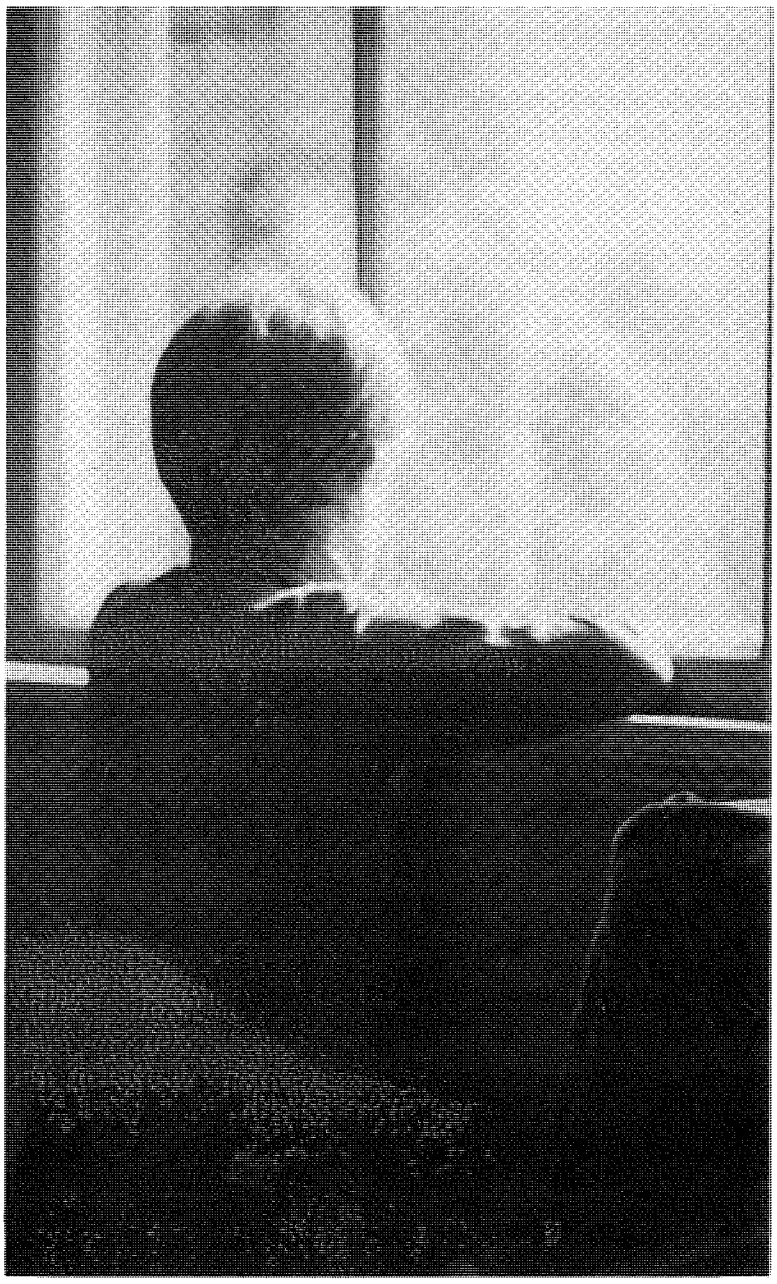
Current law provides that anyone who is included on a broad list of child care and health professionals is mandated to report to the Department of Human Services when he or she "knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected," pursuant to Title 22, Section 4011, subsection 1. However, paragraph C of that law goes on to say:

> A person shall not be required to report when the factual basis for knowing or suspecting abuse or neglect comes from treatment of a person responsible for the child, the treatment was sought by that person for a problem of abuse or neglect and there is little threat of serious harm to the child.

This exception, commonly known as the "treatment loophole" but perhaps more accurately described as a "reporting loophole," was placed in the law when the mandatory reporting law was first enacted by the Legislature. Several therapists argued that the mandatory reporting law would substantially interfere with their efforts to establish a good therapeutic relationship with their clients, because it would tend to inhibit full disclosure of all aspects of a patient's personal life situation.

This loophole in the reporting law is used inappropriately by some therapists. Many do not understand its limitations, or choose to ignore the severe restrictions on its applicability. A child who has been victimized by past physical or sexual abuse but is not in apparent danger of repeated physical or sexual assault, may nevertheless be badly in need of treatment for the emotional trauma caused by what was done to him or her in the past. Because no report to the Department of Human Services is made, and because the therapist sees it as his duty to treat only the perpetrator who has come to him, a child who has been emotionally scarred by past trauma is left without needed treatment. In short, rather than promoting better treatment of abuse and neglect by encouraging free communication between abusers and therapists, as it was designed to do, this provision in the law often prevents the flow of information to those who are in the best situation to help, thereby inhibiting the flow of resources which might either prevent abuse or neglect from continuing or repairing damage done by past abuse or neglect.

Moreover, if the Department of Human Services receives a report of abuse or neglect and opens a child protective case, and the parents are subsequently urged to seek treatment on account of that problem, no information shared with the therapist during treatment in that situation is protected from disclosure to the Department of Human Services protective worker or the courts. The loophole in the reporting law promotes full disclosure only in cases where the abuse or neglect situation is totally unknown to the Department of Human Services. The philosophy underlying the establishment of the reporting loophole, to promote the development of a relationship conducive to effective therapy, has no application to the majority of abuse or neglect cases, i.e., those which have been reported to the Department of Human Services.



Recommendation 9: The Department of Human Services should undertake an extensive educational campaign among mental health professionals and other mandated reporters to educate them about the narrow applicability and many limitations on the reporting loophole.

Departmental Responses: The three departments responding to this recommendation (Corrections, Human Services and Mental Health and Mental Retardation) all supported re-examining and possibly closing the loophole in the Department of Human Services reporting law. A broad-based committee convened by that Department, and including representation from the Department of Mental Health and Mental Retardation, was asked to undertake just such an examination.

Final Disposition: The Commission supports the reactivation of this committee and urges the Department of Human Services to continue with this effort.

Recommendation 10: The Department of Human Services should undertake a review of the laws regarding confidentiality, in light of the need to encourage full disclosure during treatment by perpetrators of all forms of abuse and neglect, to determine if changes in the laws are needed in order to promote effective case management of abuse or neglect cases on the one hand, and to encourage effective treatment of conditions leading to abuse and neglect on the other hand. The Department of Human Services review should include input from a broad range of community providers.

Departmental Responses: The Departments of Corrections, Human Services and Mental Health and Mental Retardation all concurred with the recommendation and supported the Department of Human Services' efforts to re-examine the entire abuse and neglect reporting law specifically as it relates to a need for confidentiality of information, case management and effective treatment. It was suggested that any review be conducted by a broad range of community providers.

Final Disposition: The Commission believes that development of an effective policy in this area can only be done through extensive interdisciplinary discussions by all parties/interests involved. Again, it urges the Department of Human Services to reactivate the committee.

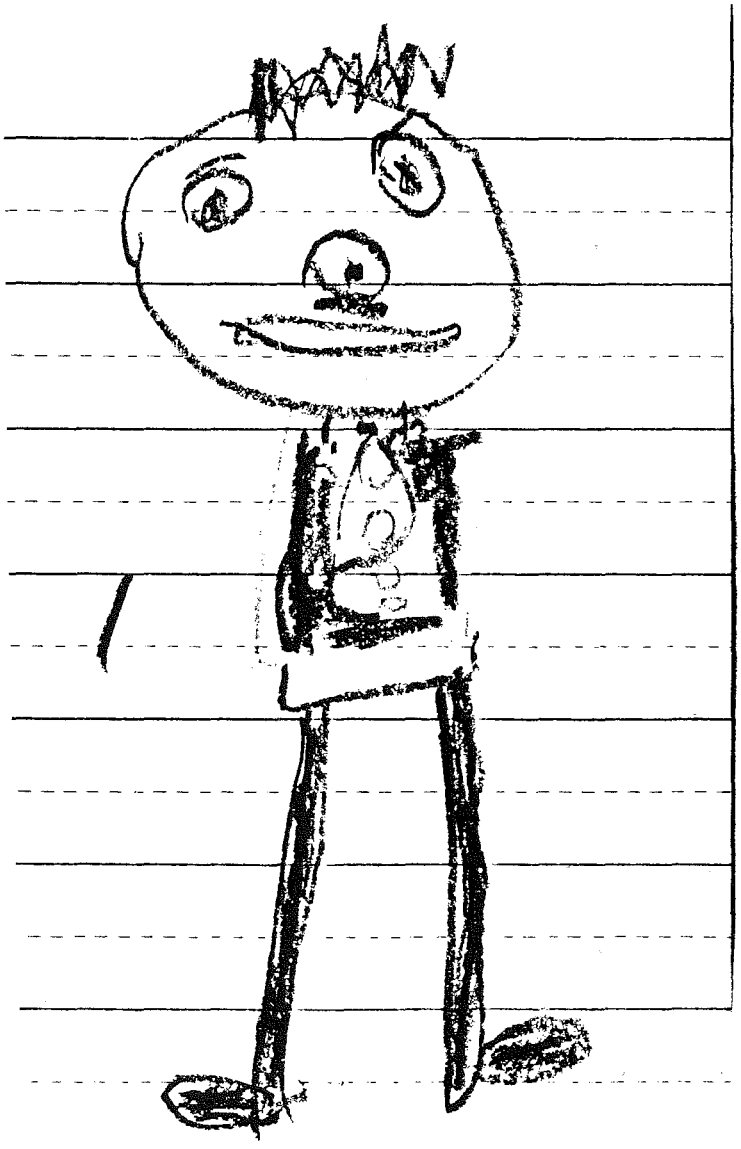
Recommendation 11: The Department of Human Services should explore the separation of the treatment process from the policing function of protective workers.

Departmental Responses: The Departments of Corrections and Human Services both firmly disagreed that any policing/enforcement function should be completely separate from the treatment function. The Department of Mental Health and Mental Retardation, on the other hand, concurred with the separation, citing its needs and willingness to increase the array of treatment resources and options. The Departments of Corrections and Human Services recognized the possible conflict between treatment and enforcement, but saw the examination/resolution within the context of specialized protective worker assignments.

Final Disposition: The Department of Human Services Protective Service Program is currently examining the substantial turn-over in caseworkers, due in part to the recent surge of difficult physical and sexual abuse cases, the lack of adequate pay, fringe benefits and support services, as well as the current structure of that job description. Protective workers are required to assess new cases, prepare some of those cases for court action, line up appropriate treatment resources and provide direct treatment and support to troubled families. It is difficult for families to accept help from the same caseworkers who have earlier referred their situations to court. This blending of functions may exacerbate the job stress for protective workers as well as diminish their effectiveness. Based upon its discussions and recognizing that a complete separation of investigation from case management might not be appropriate, the Commission encourages continued exploration of all options, including those that will alleviate job stress for protective workers and improve their effectiveness. The Commission agreed to revise recommendation 11 to read as follows:

> The Department of Human Services should consider changing the job structure and functions assigned to protective workers and should explore the feasibility of separating the assessment and case management functions.

PROBLEM STATEMENTS AND RECOMMENDATIONS FOR SPECIALIZED SERVICES ISSUES



All children do not have equal access to mental health services.

Over and over again, Commission members have listened to the stories of Maine children (and their families) who need something more than is currently available in Maine.

Tommy is 14 years old and a patient at the Augusta Mental Health Institute's Adolescent Unit. He is not mentally ill, but is marginally retarded and responds to stress by acting out and assaulting others. He has now had five institutional-type placements in 5 years, primarily for lack of more appropriate environments. Indications are that Tommy could benefit from a therapeutic foster home but 1) such a home has not been identified, and 2) appropriate funding source(s) have not been available.

Bobby is also 14 years old and currently lives with his adoptive parents, although the placement, as well as possibly the adoption, are in jeopardy. Adopted at the age of 4, Bobby's placement appears to have proceeded uneventfully until the birth of the parents' natural child, when Bobby was 8 years old. His behavior beyond that point has deteriorated. In a recent incident, Bobby stole the family car and went on a joy ride; his younger brother was captive in the back seat. A therapeutic foster home also appears to be the treatment of choice for Bobby, but again, neither home nor funding source has been identified.

David, age 15, attends an alternative educational program. Recently he was picked up for public drunkenness, a violation of his probation on previous charges. His mother was recently admitted to the psychiatric unit of a local hospital. David, however, continues to live at home with questionable supervision and deteriorating behavior. He needs the structure of a residential treatment center program but can be educated within his school district. Placement has not been recommended because no appropriate funding source has been identified.

The Adolescent Unit at the Augusta Mental Health Institute was originally developed to improve the quality of care for mentally ill youth who were involuntarily committed to the institution. It continues to be the obligation of the Unit to accept and treat adolescents who are mentally ill (per legal criteria) and dangerous to self or others. Criteria for commitment are not, however, clearly spelled out in statute, but reflect the collective standards of the psychiatric community and the court system. The Bureau of Mental Health within the Department of Mental Health and Mental Retardation is currently researching the commitment statutes for juveniles in other states.

In addition to its mandated population, the Adolescent Unit is able to and will treat disturbed adolescents who do not meet the criteria for commitment, provided that there is a plan for discharge that includes establishing parental authority and a place for the youngster to live. This can be done on a voluntary basis, but it must be negotiated with the parents or legal guardians who must agree to the treatment program and sign off on the treatment plan, which always involves family therapy. The focus of the Unit's program for both committed and voluntary patients is a structural/strategic family approach. This stems from a belief that adolescents need to grow up in a family and that the majority of behavior problems can be best treated by helping the parents or parental authority figures gain or regain control over the youngster's behavior. It is also believed that the combination of a structured ward environment and intensive family therapy (which most likely will include out-patient treatment beyond the in-patient stay) should be tried first, before other treatment alternatives are considered.

Residential Treatment Centers provide board and care, mental health treatment and special education to emotionally handicapped children within the confines of a single facility. To be eligible for placement in a residential treatment center, a Pupil Evaluation Team of the child's local school district must recommend such a placement for educational reasons, i.e., the educational needs of the child cannot be met within the local school district. Additionally, a mental health professional from a Community Mental Health Center or consulting to a school district must certify that the child is emotionally disturbed and needs residential treatment.

Therapeutic Group Homes offer a viable short term alternative for adolescents who may need temporary out of home placement but whose educational needs are being adequately addressed within the public school system. Currently there are 8 therapeutic group homes in Maine, with a total system capacity of 51 placement slots. Four of these facilities are coeducational, two serve males only, and two serve females only. Admissions criteria and target populations, however, differ from facility to facility. These programs (with few exceptions) report high occupancy rates and, frequently, waiting lists of several months or more. For youth in crisis and needing immediate placement, time is a critical factor. Too often placements must be made solely on the availability of a vacant bed. In addition, 82% of these placements are funded by the Department of Human Services and 7% by the Department of Corrections. Unless the child is identified by one of these two systems, each of which carries its own personal stigma, access to such a service is not possible.

Transitional/aftercare services are intended to facilitate the return of a youngster to a less restrictive community-based placement from a more restrictive residential placement, e.g., therapeutic group home, residential treatment center, Augusta Mental Health Institute. These latter programs provide time-limited therapeutic services based upon individual case plans and progress toward goals. Any gains made by adolescents completing such programs are difficult to maintain without transitional/aftercare services. Yet with few exceptions, facilities acknowledge that aftercare is the weakest part of their service delivery system. Sufficient resources simply do not exist.

Data obtained in a recent study of adolescents served by group homes, for example, indicated that one-third of the clients discharged from therapeutic group homes were discharged according to case plan, i.e., they had successfully completed the program offered by the facility. However, one-half of these youth again needed placement in a more restrictive setting within 6 months. No single model for transitional/aftercare services is being recommended. There are advantages of course, in utilizing local resources, such as the Community Mental Health Center, for provision of transitional/ aftercare services. This would necessitate additional funding and a closer working relationship between the Centers and group homes. The major disadvantage to relying solely on the Community Mental Health Centers is the fact that for children returning to rural areas of the state, the Community Mental Health Center is not always readily accessible. Other options for transitional/aftercare services include:

1. Home-based care with families of youths discharged from residential care;

2. Therapeutic foster homes as placement options for adolescents needing alternative placements upon discharge from residential care;

3. Specific aftercare worker(s) assigned to specific residential facilities;

4. A network of family support groups specifically for families of youth discharged from residential care.

Regardless of the model(s) chosen, consideration should be given to maximum utilization of available community resources.

Therapeutic Foster Homes likewise offer a less restrictive placement alternative for some children/adolescents who require placement outside their homes. Formal programs currently exist in Bangor (through Community Health and Counseling Services) and in Portland (through Little Brothers Association). The former has a capacity of 9 children; the latter can serve up to 15 adolescents. A third program, Spurwink School in Portland, also provides therapeutic foster home placements, but only as part of its residential treatment center program. Geographic disparity of agencies providing this service, difficulties in recruitment of qualified families and limited availability of state funds all impede access to therapeutic foster home placements. However, it is precisely these problems that make expansion of therapeutic foster care an attractive alternative:

1. individual therapeutic foster homes can be located in a number of communities, increasing the likelihood of the child/adolescent being placed closer to his home community; and

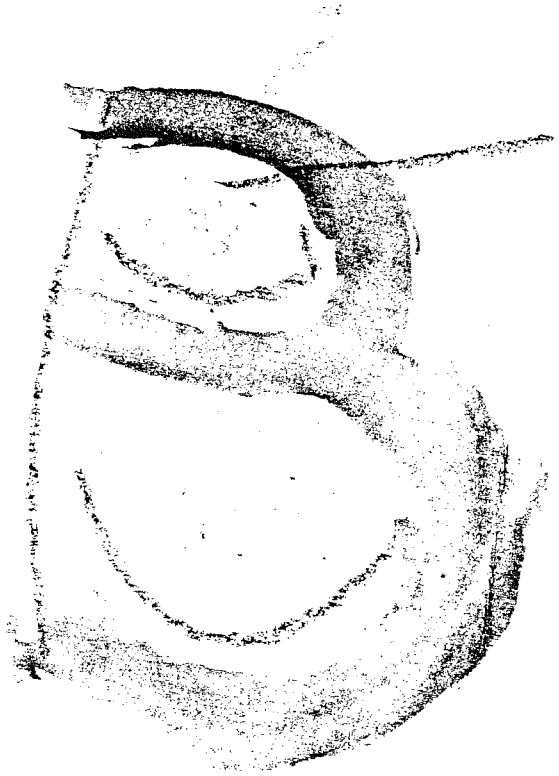
2. the cost of providing such services may be considerably lower than other types of residential care.

The development of additional placement resources is expected to become a critical issue over the next 2 years. Resources are already straining to meet the current demand for services. Maine has elected to comply with the federal initiative to remove all juveniles from county jails as places of secure detention by January 1, 1985. As a result, existing group homes and emergency shelters will no doubt be expected to accommodate some of these juveniles. A coordinated system of emergency foster homes and therapeutic foster homes would allow some of the youngsters now served in residential facilities, i.e., group homes and emergency shelters, to be placed in less restrictive alternatives. This would, in effect, alleviate the pressure on group homes and emergency shelters permitting them to serve a more dysfunctional population. Such a move would also prevent the unnecessary placement of some adolescents in residential facilities.

In other situations, the service is simply not available, or available in very limited scope. The primary source of mental health treatment to families in Maine is the Community Mental Health Center. In a state

such as Maine, it is not at all unusual for a family to live miles away from its community mental health center, or for transportation to the center to be non-existent or for the family to be reluctant, or embarrassed, to walk into such a center. For many of these families, in-home treatment would be preferable. In fact, it may be the only means of engaging such families in therapy. Maine's current Medicaid regulations prohibit reimbursement of in-home services by community mental health centers. Other programs, specifically designed to deliver such services, are relatively new to Maine. Homebuilders-type programs, for example, based on a model developed in Tacoma, Washington, in 1974, use a team approach to working with families in crisis to prevent out of home placement of children. Five such programs currently exist in Maine; however, the demand for the service far outweighs the supply.

Finally, the Commission has heard repeated testimony indicating that treatment of specific children and efforts at program development have been impeded by a lack of understanding, cooperation and trust between mental health service providers and Department of Human Services personnel.



Recommendation 12: The Interdepartmental Committee should be assigned lead responsibility in an interagency effort to identify what is needed for a statewide network of out of home placements. A specific plan should be presented to the legislative Human Resources Committee during 1985. The plan should include consideration of the following points:

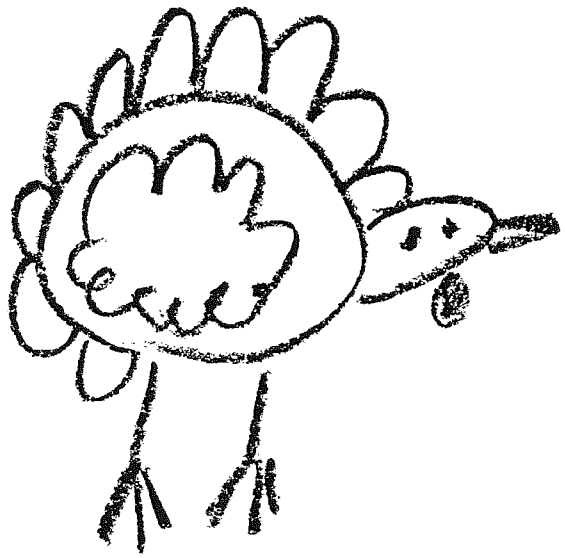
1. Availability of funding to ensure accessibility to therapeutic foster home and therapeutic group home placements for all Maine youth who are in need of such services;

2. Development of one or two pilot projects for provision of transitional/aftercare services and funding identified for implementation;

3. Assurances that for every child placed in a residential facility, an aftercare component is developed and funds made available for implementation.

Departmental Responses: Each of the four departments supported the recommendation.

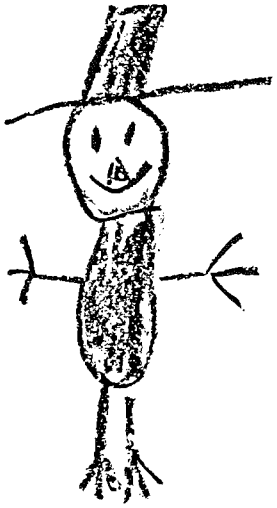
Final Disposition: The Commission was pleased with the philosophical support for this recommendation. The Commission urges the Commissioners or their designees to assign responsibility for the development of a specific plan for out-of-home placements.



Recommendation 13: The Department of Mental Health and Mental Retardation should be assigned lead responsibility in an interagency effort to develop a plan to address the identified gaps in mental health services for children and families. The plan should give particular consideration to the expanded role that the Augusta Mental Health Institute should play in a network of mental health services. An action plan should be presented to the legislative Human Resources Committee during 1985.

Departmental Responses: Two of the departments (Educational and Cultural Services and Mental Health and Mental Retardation) concurred with this recommendation; two departments (Corrections and Human Services) indicated that the Interdepartmental Committee should take lead responsibility. As part of the Department of Mental Health and Mental Retardation's planning process, contact with the other three departments should be maintained. An in-depth look at the role of the Augusta Mental Health Institute in a continuum of care still needs to be done. The Adolescent Unit, whose bed space was recently reduced, is reportedly in the process of contacting children's services coordinators in the community mental health centers regarding this issue.

Final Disposition: The Commission accepts the recommendation by the Departments of Corrections and Human Services that gaps in services should be identified, at least initially, intra-departmentally, and urges the Commissioners or their designees to assign responsibility for this task. Over the longer term, the inter-relatedness of other Interdepartmental Committee activities, such as the development of behavior stabilization/secure treatment services, should not be ignored. The Commission was concerned with the reduction of beds in the Adolescent Unit at the Augusta Mental Health Institute, and urges the Department of Mental Health and Mental Retardation to review this decision.



Recommendation 14: The Interdepartmental Committee should conduct a statewide assessment to identify problems in working relations between youth-serving agencies in each region. Recommendations should be developed for improving relationships that are identified as problematic.

Departmental Responses: All four departments agreed with this recommendation.

Final Disposition: The Commission believes that the following steps should be taken:

1. Individual departments should monitor interdepartmental agreements to ensure effective functioning; and

2. Individual departments should assign responsibility internally for identification of problems in specific regions.

The Interdepartmental Committee should report back to the legislative Human Resources Committee in 1985 with its findings and recommended actions.

Recommendation 15: Specific agreements/protocols should be developed to ensure aftercare, follow-up and transition from one service to another in a way that will continually address and monitor the problems identified herein. Each of the four youth-serving departments, both individually and collectively, should require documentation of working assurances that linkages to services exist for all children.

Departmental Responses: Two of the departments (Corrections and Mental Health and Mental Retardation) concurred with the recommendation.

Final Disposition: The Commission does urge more specificity in protocols and recognizes that the departments have supported recent legislative efforts to alleviate many of these problems.

Substantiated reports of sexual abuse in Maine increased by more than 100% in 1983.

Sexual abuse is an alarming problem nationwide, and in Maine as well.

> William, age 11, was sexually abused by his stepfather since age 8. Abuse consisted of mutual acts of fellatio, fondling and several incidences of sodomy by stepfather. Stepfather told William that "his father was gay and did this to him so it was okay." William and his mother are now in therapy. However, prognosis is poor as a result of severe emotional damage which may well result in the commission of violent sex crimes as William gets older.
>
> Barbara, age 12, started crying at a slumber party and disclosed to the other girls at the party that she had been sexually abused by both her mother's ex-husband and current boyfriend. At one point during the party, Barbara picked up a paring knife and said, "I feel like taking this knife and sticking it in me."
>
> Mary, age 10, and her sister, Annette, age 7, were sexually abused by a 17 year old unrelated boy in the neighborhood. Mother learned of the abuse when Mary had a nightmare and woke up screaming, "no, no, go away, don't touch me." It is suspected that the perpetrator also molested his one year old niece. At the current time, his whereabouts are unknown.

Many adults seeking psychotherapy disclose for the first time that they were sexually abused as children or adolescents. Emotional, personal and social problems are exacerbated by such abuse.

The psychological problems of sexually-abused children are enormous. They experience guilt, shame and a fear of discovery. They often lose their sense of trust in adults and acquire a fear of intimate relationships as a result of their victimization. Male victims, prior to becoming adults, often become sexual offenders. It is not unusual for some female victims to resort to prostitution. In many instances, these victims themselves become abusing parents.

The criminal prosecution system often serves further to victimize children who have already been sexually abused, particularly those who have been victims of incest. The criminal investigation and indictment before a Grand Jury can take as long as 9-12 months. Since it is to their client's benefit to delay the court proceedings, defense attorneys attempt to, and are often successful at, postponing the actual trial for an additional 9-12 months. It would not be unusual, then, for the

victim to remain in limbo, so to speak, for up to 18 months following the initial report of sexual abuse. Effective treatment for the victim, however, is predicated upon immediate crisis intervention. During those 18 months, neither the perpetrator nor the family may engage in treatment since to do so could be construed as an admission of guilt, and anything disclosed in treatment can and would be held against him/her in court. While less common, further victimization may also occur in child protective proceedings. In general, the child is not required to testify at custody hearings, or is questioned in the privacy of the judge's chambers. However, in those instances where the child is called to the witness stand, he/she may be subjected to lengthy, emotionally-draining cross-examination.

In many ways, the system has changed significantly since the days of Malcolm Robbins' childhood. With increased numbers of caseworkers, better training of multi-disciplinary professionals, and improved responsiveness from many mental health professionals, the system has become more adept at identifying, treating and working cooperatively with law enforcement personnel in cases of sexual abuse. More cases result in prosecution than ever before, as the public and professionals realize the therapeutic value of sentencing. Increased prosecution reinforces society's stance against sexual abuse and recognizes that the offender, not the victim, is to blame.

A number of treatment programs that specifically focus on sexual abuse have been developed throughout the country. The Department of Human Services here in Maine has sponsored training for Department of Human Services caseworkers, law enforcement personnel, District Attorneys and mental health professionals who work with sexual abuse issues.

Training workshops in Maine have been held jointly with the Maine Criminal Justice Academy and the Council of Community Mental Health Centers. Workshops have been held in local school districts for teachers, guidance counselors, school nurses, etc., and prevention programs aimed at letting children know what sexual abuse is and where to go for help have been sponsored jointly by Child Abuse and Neglect Councils and law enforcement personnel. Within the past five years, two sexual abuse treatment programs have been developed in Portland largely through funding by the Office of Children's Services within the Department of Mental Health and Mental Retardation. A sexual abuse treatment team is planned with Aroostook Mental Health Center and treatment programs are pending in Kennebec and York counties.

Some of the most difficult problems to overcome in this area involve certain attitudes still held by many persons, that sexual abuse occurs only in poor or uneducated families, or what happens in the privacy of a family's home is the family's business. Some professionals, likewise, are still reluctant to report offenders of sexual abuse. These people fail to recognize or acknowledge the devastating effect that sexual abuse has and that it is harmful, unacceptable and hurtful. The Commission was particularly concerned to hear the account of an offender who received a suspended sentence after being found guilty of molesting a child for 9 to 10 years.

The advent of mandatory reporting laws, coupled with better training of professionals in the identification of sexual abuse, has served to highlight the lack of resources, specifically for initial crisis intervention, follow-up, long-term treatment and ability to prosecute. The number of reported cases is staggering. Department of Human Services staff are unable to utilize existing expertise in resource development because they are constantly responding to referrals. The capability of community mental health agencies to respond to sexual abuse cases varies from region to region. A lack of response, or a delayed response, as victims of sexual abuse compete with other populations for service, may result in the unnecessary break-up of some families because the Department of Human Services is left with no alternative but to remove the child from the home. At least as critical is the fact that some professionals still lack the expertise to differentiate between a "fixated" and a "non-fixated" offender. A fixated abuser is the most uncontrollable offender with a poor prognosis for treatment and is apt to repeat the offense. This, coupled with the ambivalence of some professionals to encourage criminal prosecution and sentencing of sexual offenders, results in some dangerous individuals remaining in the community.

The capacity to provide initial crisis intervention services in all reported cases is really not available anywhere in Maine. Certain areas of the state are reasonably effective in their response; other areas are just beginning to develop expertise. What works in one part of the state is not necessarily appropriate in other areas. Whatever model is utilized within a region, however, should include:

1. the ability to provide an appropriate medical response;

2. a coordinated response by social services and law enforcement personnel;

3. services/resources, particularly those aimed at initial crisis intervention and follow-up.

While Maine has progressed dramatically in its ability to address sexual abuse issues, there is still a need for improvement.

Recommendation 16: An interagency group, chaired by a member of the Specialized Services Committee of the Commission was assigned responsibility for developing a statewide approach to address the problem of sexual abuse in Maine. Representatives of the Department of Human Services, a Community Mental Health Center, one District Attorney's office, one innovative school program, acute health care providers, and existing sexual abuse treatment programs were recruited to participate in this effort.

The group delineated a plan for a network of sexual abuse treatment programs. Other areas addressed by the group included training for mental health professionals and for others not directly involved in treatment who work with victims of sexual abuse, identification of services currently available, services that should ideally be available and recommendations for needed steps and resources to bridge the gap.

The group recommended a network of sexual abuse treatment programs to include the following:

a. Establishment of a coordinated, community response to child sexual abuse organized along the lines of existing prosecutorial districts, and including:
    i. representatives from the Department of Human Services, District Attorneys office, law enforcement officials and others as needed, with written agreements and procedures;
    ii. identification of service needs and gaps, manpower and training needs and resource development;
    iii. a community coordinator to assure coordination and communication among provider members and agencies and development of a team approach for intervention, investigation and ongoing treatment of sexual abuse;
    iv. development of a responsive mental health treatment team capable of providing crisis intervention;
    v. selection of a case manager on a case by case basis;
    vi. an advisory group of community people to oversee the development of the community response and all ongoing activities related to child abuse cases;
b. Addition of regional coordinators located in community service settings;
c. Establishment of a new position at the Central Office of the Department of Human Services specifically to coordinate sexual abuse services;
d. Joint training for all sexual abuse service providers;
e. Development of a comprehensive treatment program for perpetrators and victims;
f. Development of transportation services to assure the availability and access of services to victims of sexual abuse and their families; and
g. Increased funding for all service providers.

The Departments should develop legislation as needed to implement this plan. Such legislation should be presented to the Legislature during 1985.

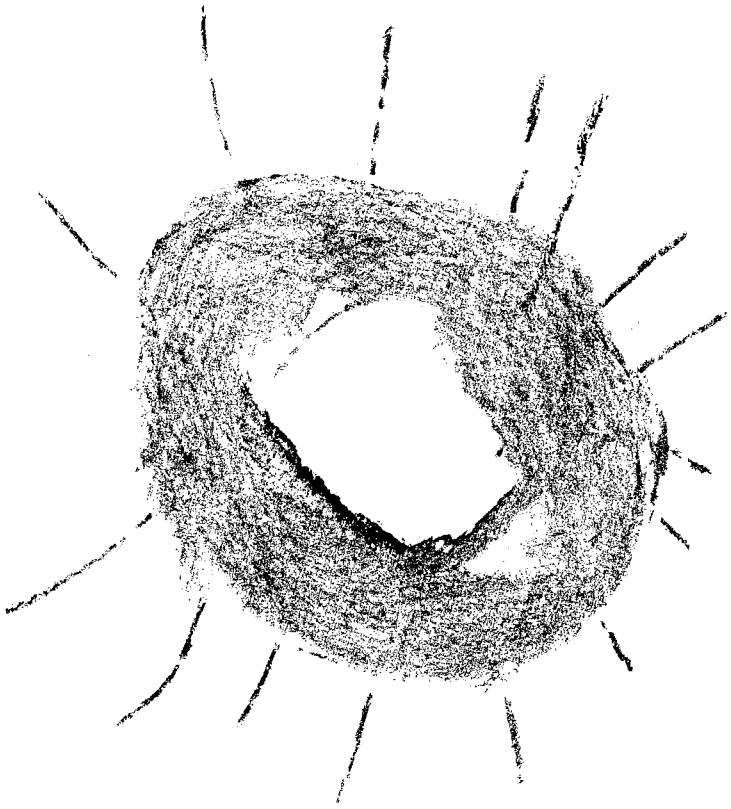
Departmental Responses: The Departments of Educational and Cultural Services and Mental Health and Mental Retardation supported this recommendation. The Departments of Corrections and Human Services emphasized the need for additional resources. Much of the planning activity within the Department of Human Services around the issues of sexual abuse is reflectd in the plan presented to the Commission (Appendix G). The Commission commends the work of the subcommittee that completed this plan in a timely manner. It further recommends that additional funding for treatment programs should not be limited to one department but should be a shared interdepartmental responsibility.

Final Disposition: The Commission supports implementation of the proposed plan. However, concern was raised regarding additional funding solely through the Department of Human Services. Several effective programs were cited that receive joint funding from at least two of the departments. Regardless of the funding arrangements, however, the Commission emphasizes that access to treatment should be available to any victim of sexual abuse. Currently, Department of Human Services funds are limited to victims of incest.

Recommendation 17: Specific services to deal with sexual abuse should be a priority for development in each community mental health center, and because of the nature of the problem and the need for immediate intervention, victims of sexual abuse should constitute priority recipients of services from Community Mental Health Centers.

Departmental Responses: The Department of Mental Health and Mental Retardation indicated it would advocate for additional mental health resources.

Final Disposition: The Commission's original recommendation remains unchanged.



There are no formally identified behavior stabilization/secure treatment services in Maine for the acting out, incorrigible adolescent.

Behavior stabilization services are short-term intervention and evaluation services utilized to bring out-of-control, acting out behavior(s) (such as those described in the following case examples) under control so that a treatment plan can be implemented. In some instances, longer term secure treatment of an involuntary nature is warranted.

Timmy is 14 years old and resides at home with his parents. He has been receiving special education services since he entered school, including several years in a private day treatment program. The program closed; Timmy was returned to the school district. Since that time, his behavior, both in the community and at school, has deteriorated. He is awaiting sentencing following 4 counts of grand theft, property damage and assault on a police officer. He continues to reside in the community.

Terry, age 16, was committed to the custody of the Department of Human Services as a result of ongoing emotional and physical abuse and neglect since birth. There is also evidence that she was sexually abused. Her mother, an alcoholic, abandoned her at age 6. In and out of foster care since age 10, Terry was finally placed in a residential treatment center. She ran from the program, and when picked up by her caseworker, attempted to commit suicide by jumping out of the car. An involuntary commitment to the Augusta Mental Health Institute was changed to voluntary when a foster family was identified to participate in family therapy with her. After 4 months, Terry was discharged. Her behavior at home, in school and in the community is again out of control. Efforts are being made to locate a residential program that can keep her from doing harm to herself or others.

Cindy is 17 years old. When she was in school, she attended special education classes because of hyperactivity and behavior problems. At age 14 she ran away from home. Her behaviors have included prostitution, drug and alcohol abuse and constant running. She was placed in a residential treatment center at age 15, and was discharged at age 16 because they could not control her aggressive and self-abusive behavior. Attempts to place her in several treatment settings over the past year have been unsuccessful because of her inability or unwillingness to engage in treatment. A specialized foster home placement lasted about 2 weeks; Cindy's current whereabouts are unknown.

Every major report on the status of children's services in Maine over the past 7-10 years has stressed the need for behavior stabilization/secure treatment services.

Adolescents requiring such services are not necessarily mentally ill, so placement at either of the mental health institutions may be inappropriate. They are not necessarily juvenile offenders; therefore, a commitment to Maine Youth Center may be inappropriate. They are seldom mentally retarded, making placement at Pineland Center inappropriate. Their behavior is out of control to such an extent that no residential treatment center in Maine can cope with them and continue to ensure a safe environment for other residents. At the same time, there are children's advocates who would argue against involuntary confinement of these youth. Present laws may not permit such action. Even if enabling legislation were enacted, what would treatment programs entail for these adolescents? In a state where placement resources for adolescents are limited, where would they go after stabilization?

Clearly, implementation of behavior stabilization/secure treatment services is a complicated issue that raises as many questions as it answers. The service would no doubt be expensive. Nevertheless, the need is clear. To prolong development of behavior stabilization resources serves only to perpetuate the pain these youngsters are experiencing, the pain that moves them to commit violent acts against themselves or others.

Information regarding two major efforts in this area was presented to the Commission. The first involved a study in progress by the Human Services Development Institute of the University of Southern Maine, through a contract with the Interdepartmental Committee, to research the problem more carefully and to provide concrete data regarding need and implementation.

Of an initial population of 1300 youth identified by social services providers as potential users of a behavior stabilization/secure treatment service, a sample of 308 youth between the ages of 8 and 21 was selected for more in depth data collection. Of the 456 questionnaires sent out (in some instances, more than 1 referral agent was surveyed on the same child), the Human Services Development Institute reported a 60% return. The data was analyzed and a report including a profile of the target population, a description of treatment models being used in other states and a review of legal issues related to behavior stabilization/secure treatment was made available in July, 1984.

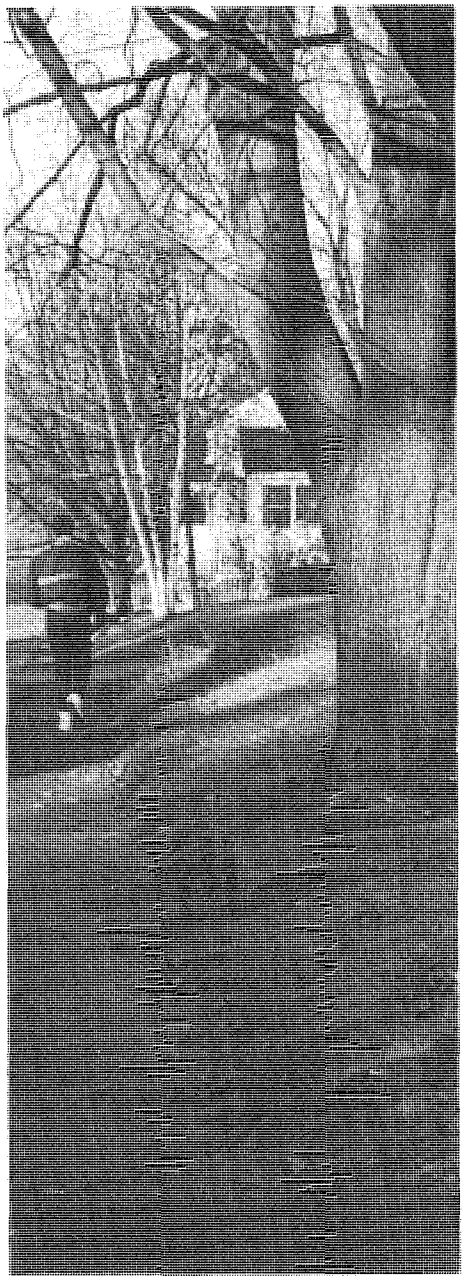
The second effort involved negotiations between the Department of Human Services and the Bureau of Mental Health/Augusta Mental Health Institute to utilize the latter in the development of a therapeutic/psychiatric foster home program to serve some of these youth.

The Commission supports the efforts to move to define clearly the scope of the problem, research the legal implications and develop a proposal for the establishment of behavior stabilization/secure treatment services. It is long overdue. The Commission also encourages the Departments of Human Services and Mental Health and Mental Retardation to utilize the expertise of the Augusta Mental Health Institute in the development of a therapeutic foster home program. It, likewise, is long overdue.

Recommendation 18: Based upon the data summary from the Interdepartmental Committee/Human Services Development Institute's study, the Commission should determine whether to recommend legislation for funding of behavior stabilization/secure treatment services. This decision should be made by August 15, 1984.

If the decision is to recommend legislation, the Commission should work with the Departments to draft any needed enabling legislation by October, 1984, for behavior stabilization/secure treatment services.

Departmental Responses: All four departments supported the concept of behavior stabilization/secure treatment. The Departments of Human Services and Mental Health and Mental Retardation both indicated strong support for the need for such services. The Interdepartmental Committee has been extremely active in developing a legislative request.



The report of the Interdepartmental Committee/Human Services Development Institute was forwarded to Commission members in August. An interdepartmental task group has completed an extensive study of the legal issues involved, the client population to be served, the outline of a treatment program, potential sites for behavior stabilization/secure treatment services, and cost estimates for those services. The process has been a slow one, due to concern regarding the balance between the rights of individuals (in this case, adolescents) with the rights of communities to be protected.

Final Disposition: The Commission supports efforts by the departments to define and deal with this population of youth. The departments should continue exploring the possibility of establishing behavior stabilization/secure treatment services, as well as the possibility of expanding existing capacities within the Departments of Corrections, Human Services and Mental Health and Mental Retardation to serve this population. The Interdepartmental Committee should report back to Judiciary and Human Resources Committees during 1985 with its findings and recommendations.

Specialized in-patient services for pre-adolescents do not currently exist in Maine.

Of the 1300 individuals identified in the initial Interdepartmental Committee survey for behavior stabilization services referred to earlier, approximately 100 were aged 12 and under.

Brian, age 11, was brought to the emergency room of the local hospital after both threatening suicide and making suicidal gestures. At home he was prone to episodes of rage in which he physically attacked other members of his family. Special arrangements were made for Brian to be admitted to the pediatric unit with additional one to one staffing. Subsequent evaluation(s) revealed a malignant tumor of the temporal lobe.

Michael, age 10, was suspended from school after overdosing on medication, setting a fire, and physically striking out at his teacher and fellow students. At home, following the suspension, he threatened to kill himself and tried to smother a younger sibling. Because of a home situation that potentially placed him in jeopardy, an alternative placement was recommended. Through a special funding arrangement with the Office of Children's Services (Department of Mental Health and Mental Retardation), Michael was placed in a residential treatment center. Within a short period of time, however, it became clear that he needed a more secure setting. He was placed at the Augusta Mental Health Institute, and through another special arrangement, again orchestrated by the Office of Children's Services, Michael was able to return home with 24-hour emergency coverage provided by Augusta Mental Health Institute staff. Shortly thereafter, he was sent out of state to live with his father. In all probability, he will resurface in Maine.

Stephen, age 12, had a long history of behavior problems and hyperactivity, for which Ritalin had been prescribed. Problems both at home and at school had precipitated referral to a residential treatment center. Before he could actually be placed, however, Stephen had an episode at home where he threatened other family members with a butcher knife. Fortunately, the local hospital was able to admit Stephen to a "behavior development program" for stabilization prior to return home. In many parts of the state, no immediate placement resource would have been available.

Like their adolescent counterparts, these children are not necessarily psychotic, guilty of juvenile offenses, or mentally retarded. And like the older adolescent, no program currently exists in Maine to provide the specialized in-patient services required by these special needs children.

As the individual child vignettes indicate, such cases are currently handled on an individual, and somewhat haphazard basis. Some are managed (at some risk) on an out-patient basis. Others are placed (often inappropriately) in foster homes, emergency shelters or adult psychiatric units. Even placement in an adolescent program, such as the one at the Augusta Mental Health Institute, poses problems because of the unique programming needs of the younger child. Clearly, placement of a 7 or 8 year old with acting out teenagers is contra-indicated therapeutically.

In general, the children we are talking about fall into one of three categories:

1. the emergent, out of control child, whose behavior(s) need to be stabilized so that out-patient treatment can proceed;

2. the child already in residential care whose psychiatric status deteriorates such that stabilization in a secure setting is necessary; or

3. the behaviorally problematic child who requires brief in-patient hospitalization, including a thorough diagnostic evaluation.

Involvement of the family in treatment is critical. Because of this a single program somewhere in Maine could not possibly be readily accessible to all areas. A more practical solution would be a network of emergency stabilization slots in locations such as hospitals (preferably those with both pediatric and psychiatric supports) or residential treatment centers with the capacity to serve younger children. Because such stabilization services are short-term, other, more permanent placement resources, e.g., family supports, therapeutic foster homes, etc. would need to be readily available. In short, a better and wider range of services are needed that can work together to provide alternatives for children similar to a pre-adolescent Malcolm Robbins.

Recommendation 19: The Commission recommends that funds be identified within existing departmental budgets for a more in-depth study of the pre-adolescent children in the Interdepartmental Committee/Human Services Development Institute's survey population.

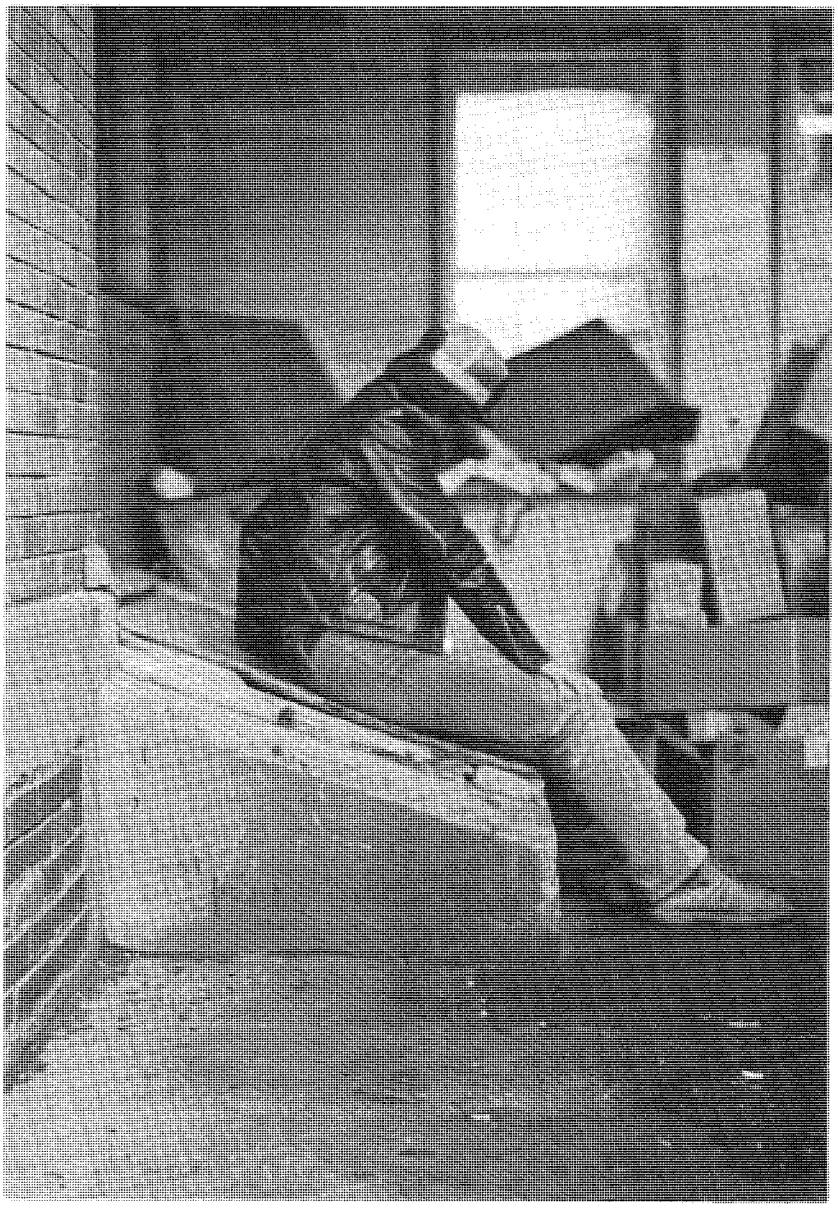
Departmental Responses: Of the three departments responding to this recommendation, the Departments of Educational and Cultural Services and Mental Health and Mental Retardation supported the need for such a study. However, it was unlikely that existing funds could be identified to complete such a study. The Department of Human Services preferred to focus on development of an appropriate service response.

Final Disposition: Funds should be requested from the Legislature for a more in-depth study of the pre-adolescents in the Interdepartmental Committee/Human Services Development Institute population.

Recommendation 20: The Department of Mental Health and Mental Retardation should take lead responsibility with other public and private agency representatives in identifying resources that will accept children for diagnostic/stabilization purposes. At least one facility that provides both types of services should be available in each catchment area. The Department of Mental Health and Mental Retardation should report back to the Human Resources Committee in 1985 with its findings and recommendations.

Departmental Responses: The Department of Mental Health and Mental Retardation mentioned the responsibilities carried out by the Augusta Mental Health Institute, Maine Youth Center and the Department of Human Services and indicated strong support for the development of additional behavior stabilization services.

Final Disposition: The Commission urges the Department of Mental Health and Mental Retardation to re-evaluate its response, focusing on the need for behavior stabilization/secure treatment services for pre-adolescent children.



There is a critical need in Maine for secure treatment services for youth who are violent/sexual offenders.

The following cases are a small sample of the increasing number of violent/sexual offenders at the Maine Youth Center. Many have long standing histories of repetitive violent behavior.

Billy, age 16, is currently at the Maine Youth Center for the brutal murder of a 10-year old girl. This boy simply decided that he wanted to murder somebody and waited until he found the right victim.

Michael, age 16, was involved in the brutal and violent rape of a woman in her 20's, in front of her four year old and five year old children. The incident continued for a one hour period of time with the young children forced to watch the act.

Sam, age 16, is at the Maine Youth Center following the brutal rape of a 7-year old boy. His history includes attempting to murder his mother with a knife and threatening to shoot his father and stepmother.

John, age 15, was convicted of the attempted rape of a 5-year old girl. This boy had a history of committing personal violence toward others, even before entering the criminal justice system.

The Cottage I Treatment Unit houses the majority of violent/sexual offenders committed to the Maine Youth Center. Earlier this year, twenty-two residents of Cottage I were questioned regarding their commission of violent crimes in late childhood and teenage years. The following offenses were reported:

1. Nine boys reported 23 arsons;
2. One boy reported 1 murder;
3. Five boys reported 67 incidents of criminal threatening;
4. Seven boys reported 143 aggravated assaults;
5. Six boys reported 137 assaults with a deadly weapon;

6. Five boys reported 22 rapes;

7. Seven boys reported 32 incidents of threatening with a dangerous weapon;

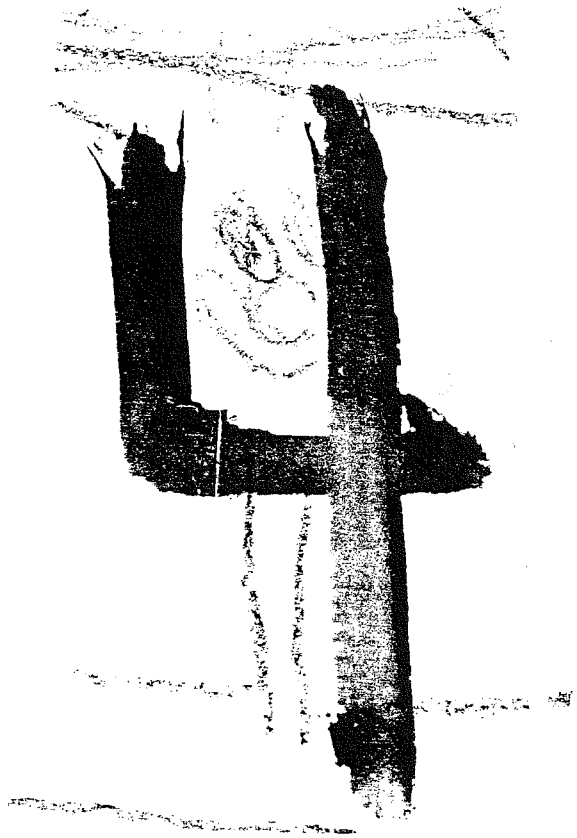
8. Nine boys reported 213 assaults, which were not provoked;

9. Six boys reported 55 incidents of gross sexual misconduct;

10. Six boys reported 72 incidents of extreme cruelty to animals;

11. Seven boys reported approximately 85 incidents of carrying concealed weapons illegally; and

12. Three boys reported 17 incidents in which they fenced dangerous weapons.



Recognizing that such self-reporting procedures may result in an embellished list of offenses, it is still clear that a small percentage of the adolescent population commit the great bulk of violent crimes. These are individuals who, presented with even minimal stress, invoke further disaster upon themselves by resorting to violent, acting-out behavior in an attempt to gain control over their equally disastrous lives.

The problems these individuals present in terms of treatment are enormous and complex. Such violent, incorrigible offenders can have a devastating effect on other correctional programs. Current literature indicates that this type of offender requires highly intensive treatment, in addition to existing correctional treatment programs. Effective treatment for this population can require anywhere from 1-5 years, with 2-3 years the average.

The cost of developing such a program is likely to be expensive, but failure to develop such a program is almost certain to guarantee that these offenders will spend a good part of their lives incarcerated and that they will continue to be dangerous within and outside institutions. The potential for danger is too great to ignore the problem. Resources do exist in other states to address the problem and the body of related knowledge is expanding rapidly. In short, now is the time to address the problem.

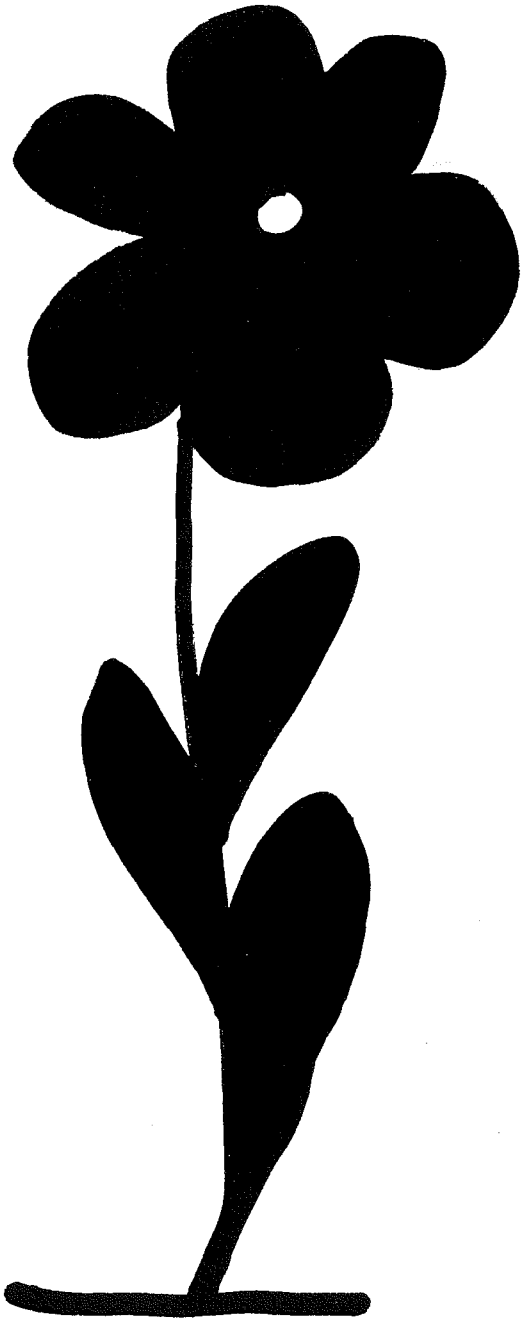
Recommendation 21: The Department of Corrections/Maine Youth Center should take lead responsibility for developing a plan for a secure treatment program for the violent/sexual offender. Because of the nature of the offenses involved, the offender's potential for violence and the need for security, the program should be housed at the Maine Youth Center, not at a mental health facility.

A plan for a secure treatment program for violent/sexual offenders was presented to the Commission in October, 1984. Specific funds will be requested for implementation of the plan.

The Department of Corrections should present a status report on development of a program for violent/sexual offenders to the Juvenile Justice Advisory Group during 1985.

Departmental Responses: The Department of Corrections indicated its intent to comply with this recommendation and to seek funding from appropriate sources. The Department of Mental Health and Mental Retardation supported the efforts of the Department of Corrections to develop such a program.

Final Disposition: The Commission commends the Department of Corrections for completion of the requested plan in a timely manner (Appendix H). Additionally, the Commission suggests that the other departments will need to cooperate with the Department of Corrections to implement effectively such a program.



Resources for treatment of emotionally disturbed offenders in Maine are seriously deficient.

In 1972 the Hayden Treatment Unit at the Maine Youth Center was opened to provide treatment for "problem" adolescents. These adolescents had been identified as needing treatment to address psychiatric and/or emotional behavioral issues. Toward this end, the Hayden Treatment Unit was staffed to provide a full range of professional and para-professional services for up to twelve clients. The following types of disorders were present in the clients:

1. A full range of mental and/or emotional difficulties in all levels of intellectual capacity with the exception of mental retardation. (The Hayden Unit does not deal with persons who have been identified as mentally retarded.)

2. Adolescents suffering from hearing, speech and/or reading disabilities who have potentially normal abilities and performance.

3. Minimally brain-damaged individuals, with or without motor involvement, behavioral deviations or speech problems.

4. Clients with or without current emotional difficulty who have educational difficulties or functional intellectual impairments.

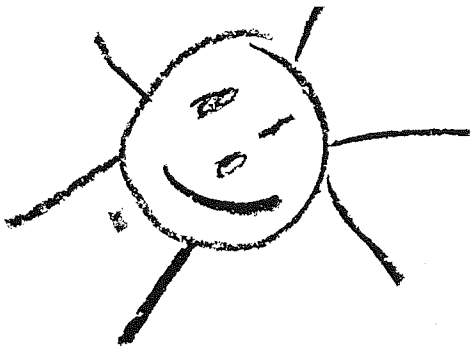
In addition, the Hayden Unit provided out-patient services to other Maine Youth Center residents who were in need - but not sufficiently impaired - to require residency in the Hayden Unit program.

From an historical perspective, it is clear that the Legislature through a special bond issue for building construction and authorization of increased personnel to staff the Hayden Treatment Unit identified a specific need and then provided measures to address this need via appropriate funding. The specialized nature of the Hayden Treatment Unit was further defined through the establishment of the position of Director of the Hayden Treatment Unit. As the only Unit Directorship at the Maine Youth Center, it was targeted to that unit and required special qualifications, experiences and competency.

Originally, the Hayden Treatment Unit was staffed adequately to meet program needs. Yet today this staffing has been severely reduced due to financial shortages and other institutional needs. Because of the budget cuts, it is rather ironic that the Courts are being substantially more selective in committing adolescents to the Maine Youth Center. This selectivity is exemplified by the fact that today, a youth is never committed to the Maine Youth Center for status offenses, such as truancy. The Maine Youth Center now serves adolescents committed for a full range of crimes, including murder, rape, arson, incest, burglary, theft or other serious crimes. Commitments in terms of absolute numbers continue to increase. Thus, the residents served by the Hayden Treatment Unit clearly present a high degree of risk to themselves, as well as a thoroughly documented threat to their Maine communities.

The Hayden Treatment Unit historically provided services on an out-patient basis to Maine Youth Center residents, and served about 357 such clients from 1972 to 1980. These out-patients included the female residents in need of therapy available only at the Hayden Program. However, due to the severe staff reductions, the Hayden Treatment Unit no longer provides out-patient services to other Maine Youth Center residents, including the female population. Particular note is made of the female population because their crimes and the threat they pose to the community are equally serious. They are in need of the services previously but no longer available at the Hayden Treatment Unit.

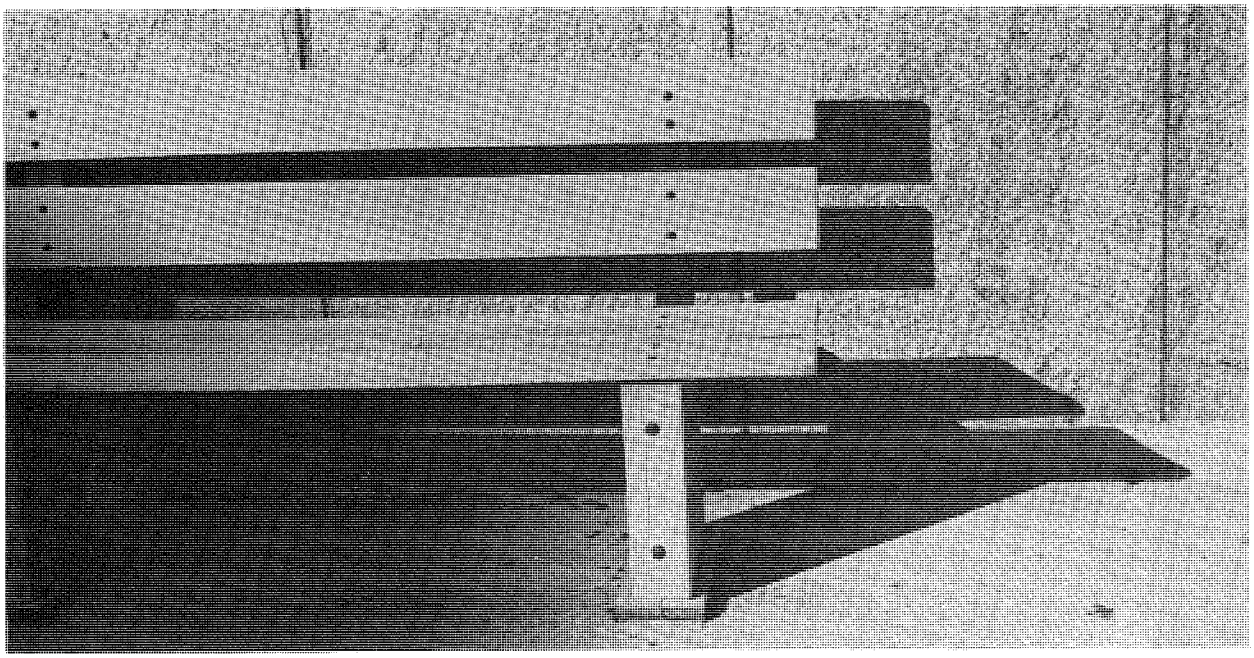
The mission of the Hayden Treatment Unit, namely, to deal with these very special clients, has not changed over time nor has the number of adolescents in need of services decreased. In fact, the direct opposite is true. The clients' needs have escalated and the demand for services has continued to rise while the staffing has continued to decrease.



Recommendation 22: The Department of Corrections should request additional funds specifically to restaff the Hayden Treatment Unit so it can adequately and realistically serve the needs of emotionally disturbed offenders who exhibit a clear need for psychological intervention. Once an adequate staffing level has been established at the Hayden Unit, the Department of Corrections should ensure maintenance of such services. Out-patient services should be made available to other committed youth exhibiting emotional problems

Departmental Responses: The Department of Corrections indicated that it will request additional funds to restaff the Hayden Unit. The Department of Mental Health and Mental Retardation concurred with the recommendation and indicated a willingness to support a legislative request. That department also suggested that once the Hayden Unit was restaffed that resource allocations of several systems, not just the Department of Corrections, would be affected.

Final Disposition: The Commission's original recommendation remains unchanged.



The demand for Hold for Court evaluations exceeds the system's capacity to provide such services.

The Maine Youth Center is the primary agency mandated by the Juvenile Code to perform "Hold for Court" evaluations. These evaluations require a juvenile to reside at the Maine Youth Center until the evaluation is completed for the Court. Over the past seven years, Maine Youth Center's Psychology Department has performed in excess of 1600 evaluations, or an average of approximately 230 evaluations per year. The ability of the department to perform such an enormous volume of work was in large part due to the use of a corps of trained para-professional volunteers.

Recently, the Advocates for the Developmentally Disabled, the Department of Educational and Cultural Services, the Ethics Committees of the Maine Psychological Association (MePA)) and the American Psychological Association (APA) stated that the practice of utilizing such volunteers to administer psychological tests is no longer legal and is in direct violation of the Code of Ethics of the MePA and APA. Therefore, the Maine Youth Center is no longer able to utilize volunteers, who in the past have contributed 20-60 hours per week to the institution. Consequently, the Maine Youth Center's ability to perform the same number of evaluations and fulfill its obligation to the Courts has been seriously impaired.

At the same time, the demand for "Hold for Court" evaluations is increasing. The State of Maine supports the federal initiative which would remove all juveniles from county jails as places of secure detention. In effect, proposed legislation would result in the Maine Youth Center being the only existing facility available for secure detention of juveniles in Maine. Passage of such legislation would further increase the number of secure detentions (Hold for Courts), with a correspondingly larger number of evaluations requested by the Courts.

Qualified estimates indicate that if the requests for evaluations continued to increase at current levels, the Maine Youth Center will be unable to perform approximately 120 evaluations. The jail removal initiative can be expected to substantially increase this number, placing the Maine Youth Center in violation of the rehabilitative mandates of the Juvenile Code.

Recommendation 23: The Department of Corrections in conjunction with the Office of Court Administrators should develop a plan outlining the number of court evaluations estimated to be needed on an annual basis and should make recommendations for developing a regional capacity for secure evaluations. The plan should be developed by September, 1984. Consideration should be given to increasing funds in court budgets to provide specifically for community-based evaluations.

Departmental Responses: The Department of Corrections indicated it would initiate a review of the Maine Youth Center's court evaluation process to include the development of a regional capacity for secure evaluations in conjunction with the Juvenile Justice Advisory Group. The Department of Mental Health and Mental Retardation agreed that a need exists to equalize court access to sound client evaluations and to standardize the information in the evaluations. As a result of additional discussion at the committee level, the recommendation was rewritten to reflect the need for further study.

Final Disposition: The Department of Corrections should be the lead agency to work with the Office of Court Administrators in order to develop a plan for providing court ordered evaluations for juveniles. This plan should address the provision of evaluations both at the Maine Youth Center and in the community and should include, but not necessarily be limited to, the following:

a. Criteria for determining when secure evaluations at the Maine Youth Center are needed, or when evaluations can be performed in the community;

b. How and by whom evaluations should be performed;

c. How and by whom evaluations should be funded;

d. Anticipated level of funding needed;

e. Identification of a requisite component of services;

f. Development of a regional capacity for secure evaluations (should include efforts being explored by the Juvenile Justice Advisory Group); and

g. Training that would be needed by community service providers and a plan to address these training needs.

The plan should be ready for implementation beginning with FY 86 and should be presented to the Juvenile Justice Advisory Group for review prior to implementation.

A majority of juveniles within the various levels of the juvenile justice system require special education services that are not currently available.

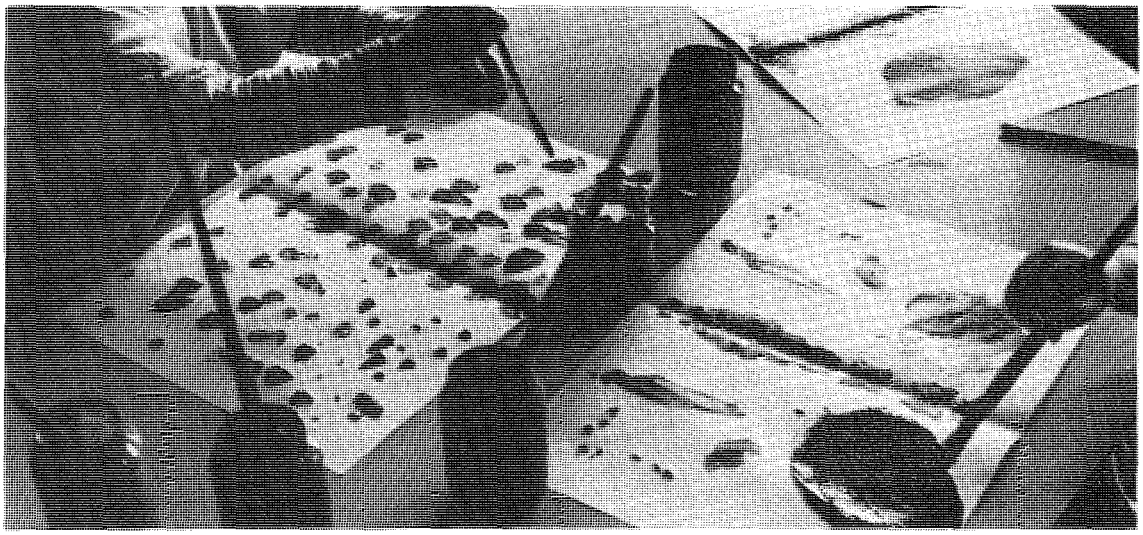
Federal laws and State regulations require that educational facilities identify youth who need special education services and provide appropriate programs for these students. On a national basis, statistics indicate that such youth are disproportionately represented in the juvenile justice system. Experience in Maine parallels that of the nation.

Looking specifically at incarcerated youth, the Maine Youth Center reports that as many as one-third of its committed juveniles (60-80 clients) have been identified as juveniles who require Special Educational/Treatment Programs.

Federal laws and State regulations require that a Pupil Evaluation Team (PET) assessment be performed and an Individual Educational Program (IEP) be developed and implemented for each individual identified as needing special education services. Psychological evaluations are invariably necessary as part of the PET assessment. Psychiatric intervention is also frequently required. Psychological consultations with classroom teachers are required in the course of IEP implementation. In addition, the IEP frequently prescribes individual, group and/or family counseling by a psychologist or psychiatric social worker, as a component of the educational program.

The Maine Youth Center serves as the educational facility for youth on Hold for Court, Hold for Evaluation, and detention statuses, as well as for youth committed there, and as such, must provide the above-mentioned services for the 60-80 youth identified as special education eligible.

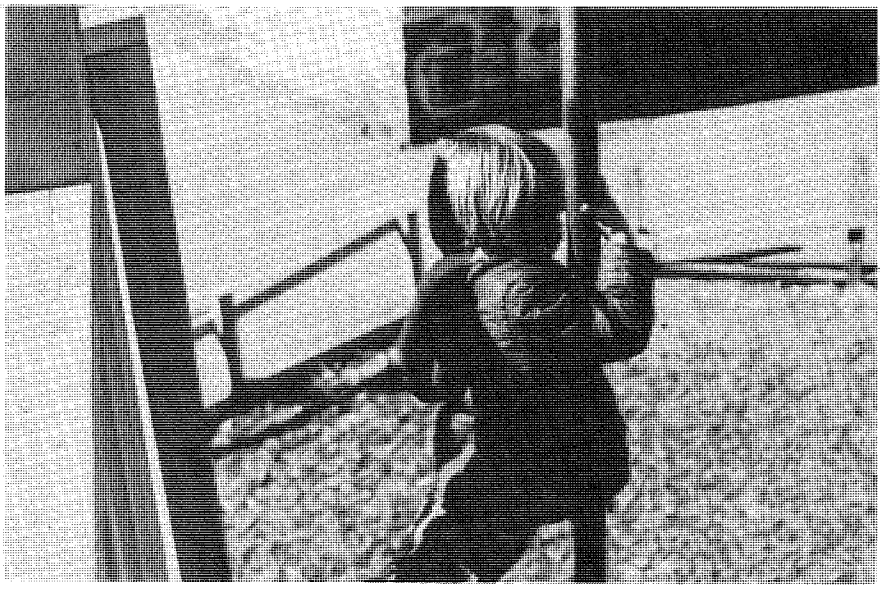
Because the Maine Youth Center does not have adequate psychological resources to participate in educational programming, the institution's compliance with Federal laws and State regulations is jeopardized.



Recommendation 24: The Department of Corrections should work closely with the Division of Special Education within the Department of Educational and Cultural Services to assess and make recommendations on improving and bringing special education programs for adjudicated youth into full compliance, and, where appropriate, should develop a plan for ongoing funding for special education services at the Maine Youth Center.

Departmental Responses: The Department of Corrections indicated that it would work with the Division of Special Education to develop funding requests to address the special education issues at the Maine Youth Center. The Department of Educational and Cultural Services noted that a special education program review at the Maine Youth Center was completed in the spring of 1983, and a corrective action plan was developed with a completion date of July, 1984. Three discretionary grants were applied for and received from the Division of Special Education. These will enable the Maine Youth Center to comply with the corrective action plan. The Department of Mental Health and Mental Retardation indicated support for these efforts. The Commission also supports the efforts of the Departments of Corrections and Educational and Cultural Services. However, continued compliance is dependent upon a more stable funding arrangement.

Final Disposition: The original recommendation remains unchanged but an emphasis is placed on "developing a plan for on-going funding for special education services."



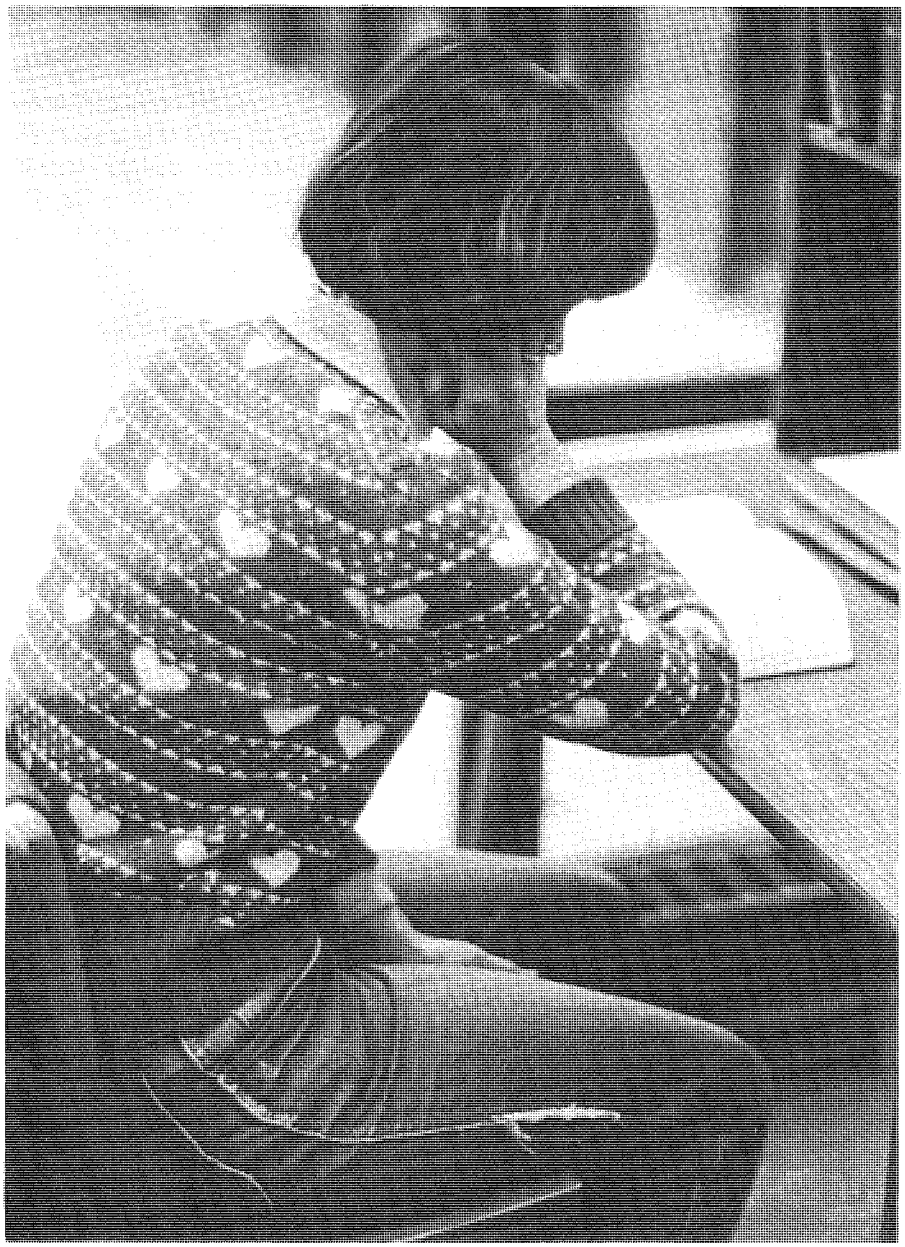
Delivery of appropriate services to adjudicated youth is hampered by inadequate training of persons involved in the placement of these youth as well as a lack of community-based supports, including the availability of evaluation procedures.

Persons involved in the placement of adjudicated youth include judges, attorneys, juvenile caseworkers, law enforcement personnel, educators, and Department of Human Services caseworkers. Knowledge of placement procedures and resources vary considerably from group to group, as well as from individual to individual within each group. While all staff of the various State agencies receive some training in the area of children's placements, no training is currently required for judges.

> Scott, age 16, was a multi-problem juvenile with multi-agency involvement. Problems included substance abuse, an expressed hatred for his mother and aggressive outbursts, one of which involved a charge of alleged sexual assault against his younger brother. Referral to the Community Mental Health Center resulted in a six-week wait for an appointment.
>
> Kevin, age 14, was suspended indefinitely from school for misbehavior. He was well-known to the community at large as a result of his involvement with the criminal justice system. The school agreed at a Pupil Evaluation Team meeting to accept Kevin back into school, but then made his failure there almost certain by imposing a condition of "no swearing."
>
> Bruce, age 16, Richard, age 16 and Peter, age 17, were discharged from the Maine Youth Center on entrustment status and returned to their respective families. Away from the structure/regimentation of the Maine Youth Center program, and without adequate community supports, all three boys resumed their earlier behaviors, which ranged from staying out all night to terrorizing the family.

A juvenile offender's involvement with the juvenile justice system generally begins with an intake process, or somewhat informal contact, during which a child and family may be referred on a voluntary basis to various community agencies, followed by probation, commitment to the Maine Youth Center, absent with leave and entrustment. Treatment for the youth in this system differs from that of other youth in one subtle way - service is involuntary. Failure to participate often results in a court appearance and the next step in the progression described earlier. The therapeutic use of authority/coercion can be effective; a substantial number of Juvenile Services Unit caseloads represent juveniles who never re-enter the system at a more restrictive level.

The actual "treatment" for these juveniles (and their families) is no different than the services that should exist for all children, i.e., home-based support services for families, timely community mental health services, transitional/aftercare services for children returning from residential placements. Unfortunately, by virtue of the stigma attached to involvement with the juvenile justice system, efforts often focus on ostracizing these youth from the very communities into which they could, and should, be reintegrated. Within the limits of due process, and large caseloads, juvenile caseworkers are able to respond quickly to client needs, particularly when protection of the community is paramount. But all too often they lack the resources to resist the community's natural tendency to isolate offenders in those instances where they may possibly profit from treatment services within the community.



There are, of course, instances where temporary placement outside the home, in group homes, therapeutic group homes, etc., is necessary. Despite these persons' well-intentioned efforts, placements are frequently made without regard to State and Federal regulations, resulting in:

1. placements that are made on the basis of expediency, rather than on the basis of the mental health, educational, and correctional needs of the juvenile;

2. failure to adhere to due process concerning Pupil Evaluation Team procedures for making placements; and

3. lack of recognition of departmental policies and procedures regarding appropriate funding.

For example, placement in a residential treatment center (Sweetser Children's Home, Spurwink School, Elan and Homestead), with the expectation of state funding, must originate with a Pupil Evaluation Team recommendation. In the case of children in the custody of the Department of Human Services, a State PET meeting is held; for all other children, the local school district has PET jurisdiction. Based upon a review of the child's special education needs, as well as the results of a current mental health evaluation, the Team may recommend placement outside the district, in one of the facilities previously identified.

Following such a recommendation, a referral would be made to the particular facility thought to be able to meet the child's needs. The facility then conducts its own screening and if the child is thought to be appropriate for placement there, a tentative admissions date is set. The actual placement of the child in the residential treatment center may not occur for several weeks or months, depending upon vacancy. Placements in the residential treatment centers are not intended to occur on an emergency basis. The described process is intentionally deliberate and serves as a safeguard to the child's right to the least restrictive alternative.

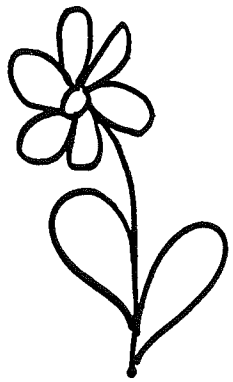
The decision to place a juvenile in another type of residential facility, e.g., group home or therapeutic group home, should always be based upon the individual's needs and the capability of the facility to address those needs. Psychological and educational evaluations are indispensable in effecting appropriate placements of juveniles. Communication among all the systems involved with a particular youth is imperative.

Finally, once the decision has been made that placement outside the home is in the best interests of the youth, the length of placement is sometimes restricted by the relatively arbitrary time limits of informal adjustment, probation, or to a lesser extent, entrustment. Appropriate services should be available to serve needy youth, independent of a particular system's involvement, i.e., juvenile justice or Department of Human Services.

Recommendation 25: The Interdepartmental Committee, in conjunction with the Office of Court Administrators, should ensure that regular formal training in the area of children's care/treatment/placement be required of all District Court judges. Similar training should also be part of the orientation and continuing education of juvenile caseworkers, Department of Human Services workers, Special Education Directors, mental health professionals and other appropriate service providers.

Departmental Responses: All four departments acknowledged the need for training detailed in this recommendation. The Department of Educational and Cultural Services indicated that a representative from the Division of Special Education would be designated to participate in interdepartmental discussions with the Office of Court Administrators. The Department of Corrections suggested, and the Commission agreed, that the training efforts should focus on both District Court judges and Superior Court justices. Each of the departments should continue to provide similar training to staff involved in the placement of adjudicated youth.

Final Disposition: The Interdepartmental Committee, in conjunction with the Office of Court Administrators, should ensure that regular formal training in the area of children's care/treatment/placement be required of all District Court judges and Superior Court justices.



Recommendation 26: The court record of any adjudicated juvenile should include pertinent diagnostic, medical, psychological and educational information. This record should accompany the child to whatever placement is made.

Departmental Responses: The Department of Corrections supported this recommendation "within statutory limits." The Department of Educational and Cultural Services noted that a protocol for accomplishing this recommendation was presented to juvenile caseworkers as part of their orientation in November, 1983. The Department of Mental Health and Mental Retardation indicated a willingness to assist in efforts to develop a standardized format for client data.

Final Disposition: The court record of any adjudicated juvenile (within statutory limits) should include pertinent diagnostic, medical, psychological and educational information. This record should accompany the child to whatever placement is effected.

Recommendation 27: The Commissioners (or their designees) of the four youth-serving departments should meet with the Chief Judge of the District Court to develop working agreements and protocols for assuring the appropriate flow of information to the judge for the dispositional hearing of a juvenile.

Departmental Responses: Both the Department of Corrections and the Department of Human Services agreed with this recommendation. The Department of Educational and Cultural Services indicated that a representative from the Division of Special Education would be designated to participate in interdepartmental discussions with the Chief Judge of the District Court. The Department of Mental Health and Mental Retardation suggested that the Interdepartmental Committee set up a working task group to develop agreements and protocols to serve judicial informational needs while preserving confidentiality.

Final Disposition: The Commission's original recommendation remains unchanged.

Currently, inadequate resources exist to provide for implementation of the 1980 amendments to the Juvenile Justice and Delinquency Prevention Act of 1974 that require Maine to remove all juveniles from county jails or adult lock-ups as places of secure detention.

Maine has elected to comply with the 1980 amendments to the Juvenile Justice and Delinquency Prevention Act of 1974, thereby retaining some $200,000 in federal funds. As a result of this decision, Maine will no longer be able to detain adolescents in county jails or adult lock-ups. In order to address these youngsters' needs appropriately, it will be necessary to develop or expand the availability of the following types of resources for adjudicated youth:

1. Secure detention, including the capability for short-term behavior stabilization and diagnostic evaluation.

2. Non-secure residences, such as emergency shelters, therapeutic group homes, group homes or foster homes.

3. Supervision/support services, such as Homebuilder-type programs, to permit the maintenance of youth within their own homes pending adjudication. Additionally, short-term supervision services within the community will be needed for some youth, pending the arrival of parents/guardians. These services can also be utilized to avoid residential placement when the juvenile's case is heard in Court or to help him or her adjust to a placement after leaving the Maine Youth Center.

4. In-home/community mental health evaluations. The current practice of referring youth in need of these services to the Maine Youth Center not only places an excessive demand on that facility's resources, but is expensive and, in many cases, is needlessly disruptive of the youth's life in his family and community.

Recommendation 28: Adequate funds should be made available and contracts developed to support the initiative of private agencies to provide needed services for juvenile justice clients in a planned, coordinated way. The Commission emphasizes the need for identification of services in a planned coordinated way as well as adequate funding and accountability in the provision of those services.

Departmental Responses: The Department of Corrections noted that for the past ten years funds have been made available on an increasing basis for contracts with community agencies to provide services to juvenile justice clients. Further, the Department indicated its intent to continue joint planning with the other three youth serving departments. The Department of Educational and Cultural Services concurred with the recommendation, noting that recent, unsuccessful legislative proposals provided for additional funds to support this effort. The Department of Mental Health and Mental Retardation was also supportive of interdepartmental planning activities.

Final Disposition: The Commission emphasizes the need for identification of services in a planned, coordinated way and adequate funding and accountability in the provision of those services.

Problems still exist with certain provisions of the Juvenile Code.

Implementation of the Code has proven to vary from region to region within the state, resulting at times in a perceived abuse of the intent of certain provisions and psychological as well as physical abuse to the juveniles involved.

> Matthew, age 14, was accused of stealing an object of minimal value (less than $10). Pending his court appearance, he was housed for 10 days in a county jail with adult inmates, including one who was accused of murder.
>
> John, age 16, was housed in the juvenile section of a county jail, in a cell with other juveniles. During his incarceration, he was raped by three other juveniles, including one who was subsequently sentenced to 20 years at the Maine State Prison for two murders.
>
> Ronnie, age 16, was picked up for being intoxicated, and therefore violating a condition of his probation. He was held for several hours in a cell in the adult section of the county jail, adjacent to an area that was accessible to adult inmates. Other inmates at the time included an adult accused of murder and another accused of robbery, who had been convicted previously of assault.

The Committee to Monitor the Juvenile Code was disbanded in 1981. As a result of recent changes within the juvenile justice system in Maine, as well as a federal initiative to remove juveniles from county jails and adult lock-ups, certain provisions of the Juvenile Code need revision.

The Jail Monitoring Committee of the Juvenile Justice Advisory Group has identified definitional changes that need to be made in the Juvenile Code. The Committee is also developing a plan for removal of juveniles from adult facilities as places of secure detention. This plan, as well as revisions to the Code, will be submitted for consideration by the 112th Legislature.

In some cases, potentially dangerous juveniles are sent to the Maine Youth Center on "Hold for Court" status. This occurs as a result of some judges' interpretation of the bind-over procedures within the Juvenile Code. According to these judges, unless the Maine Youth Center has been tried, they cannot state that all juvenile dispositional alternatives are inappropriate. Yet some juveniles clearly are inappropriate for juvenile facilities. The Chronic and Violent Youthful Offender Committee of the Juvenile Justice Advisory Group is currently investigating this issue.

As noted in an earlier Problem Statement, judges frequently order evaluations of juveniles in order to utilize short-term detention as a deterrent to future criminal activity or to bide time until a placement is secured. If the information resulting from the evaluation is not going to be used, such actions constitute an abuse of the Code.

Judges continue to commit juveniles to particular facilities, rather than to one of the youth-serving departments. The only specific place that a judge may commit juveniles is the Maine Youth Center. Commitment to the Department of Human Services, used solely to secure funding for a residential placement, is inappropriate and a disservice to juveniles and their families. It would be far more beneficial to place the juvenile on probation and have the Department of Corrections provide services to the family.

There is currently no capacity within the Department of Corrections to plan for services for juveniles. i.e., to tie together institutional and community needs and reconcile the differences, or to project from year to year the demand for services in different regions of the state. Efforts have been initiated in the area of data collection, but the Department lacks both the manpower to monitor the data and funding for identified services.

Recommendation 29: An on-going planning process should be instituted within the Department of Corrections to assess formally the needs of the major components of the juvenile justice system. Input should be sought from the regional juvenile caseworkers and the Maine Youth Center and recommendations should be made regarding any additional funding necessary to improve service delivery. A status report should be available for review by the Juvenile Justice Advisory Group in 1985.

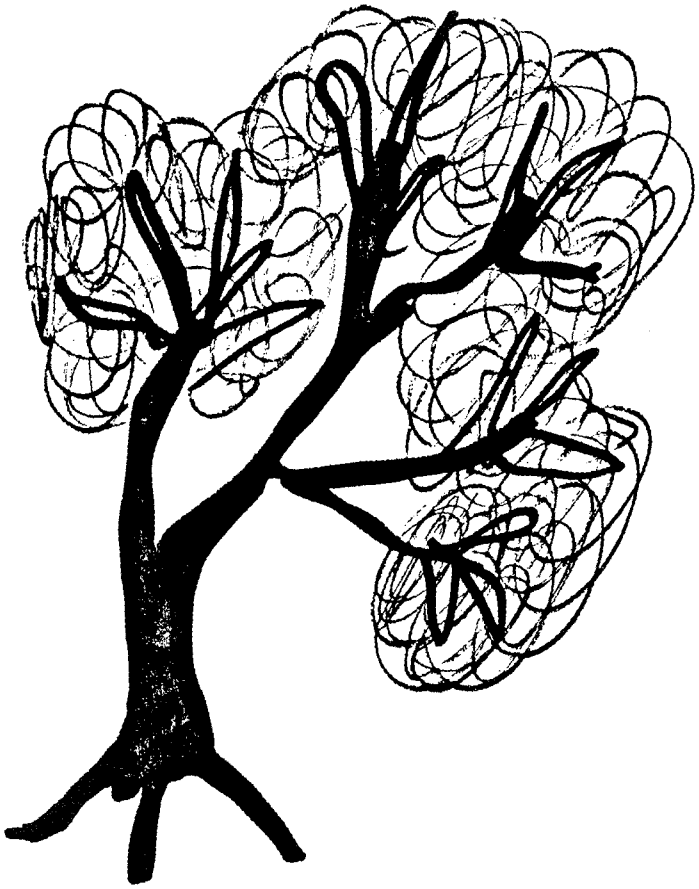
Departmental Responses: The Department of Corrections has initiated a review and assessment of the major components of the juvenile justice system, and will request funds for additional resources, where appropriate, in combination with the other three departments. The Department of Mental Health and Mental Retardation supported the recommendation.

Final Disposition: The Commission's original recommendation remains unchanged.

REFERENCES:

1. S. Greenspan, "Developmental Morbidity in Infants In Multi-Risk-Factor Families: Clinical Perspectives," Public Health Reports, Jan. - Feb., 1982, Vol. 97, No. 1.

2. Stanley Greenspan, 1982; Kathryn Barnard, 1980; Barry Nurcombe,1981; Michael Trout, 1982.



APPENDICES

APPROVED
JUL 5 '83
BY GOVERNOR

CHAPTER
47
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-THREE

H.P. 1251 - L.D. 1664

RESOLVE, to Establish a Maine Commission to Examine the Availability, Quality and Delivery of Services Provided to Children with Special Needs.

Commission established. Resolved: That the commission on the Availability, Quality and Delivery of Services Provided to Children with Special Needs is established, consisting of 31 members representing different areas of the State, 25 members appointed by the Speaker of the House of Representatives and the President of the Senate, namely a chairman; a member of the judiciary branch or a designee; a physician; a representative of municipal police; an intake worker; a newspaper editor; a chairman of a pupil evaluation team; a youth member; an elementary school teacher; a junior high school guidance counselor; a superintendent of schools; a representative of a neighborhood group; a case worker or field worker; a representative of a community counseling center; a psychologist specializing in family practice; a psychiatric social worker; a representative from the Bangor Mental Health Institute or the Augusta Mental Health Institute; a representative from the Department of Human Services; a representative from the Department of Mental Health and Mental Retardation; a representative from the Department of Corrections; a representative from the Department of Educational and Cultural Services; a representative from the psychiatric department of a hospital; a member of the clergy; a public representative; a director of an emergency shelter for children and youth; and 6 Legislators, 4 Representatives named by the Speaker of the House of

Representatives and 2 Senators named by the President of the Senate; and be it further

Resolved: That the commission will examine the current mechanisms for identifying and following children with special psychological, emotional and behavioral needs; identify major gaps in the provision of services to these children; examine the current mechanisms used by the Department of Human Services, the Department of Educational and Cultural Services, the Department of Corrections and the Department of Mental Health and Mental Retardation to plan for and provide services to children; and, based on findings, establish priorities for legislative action; and be it further

Resolved: That the commission meet at least 3 times as a committee of the whole, and at such other times in subcommittees, as necessary, to study the problem through examination of data from Maine and other states, to consult with recognized experts in these areas, to conduct public hearings throughout the State and to prepare a report which shall be distributed throughout the State and submitted, together with any accompanying legislation, to the 2nd Regular Session of the 111th Legislature; and be it further

Resolved: That the chairman of the commission be appointed within 10 days after enactment, the other members within 20 days after enactment and that the first meeting of the commission take place within 40 days after enactment.

Resolved: That the commission have sufficient staff assistance and pertinent existing information about problems and services from the Office of Legislative Assistants, the Department of Educational and Cultural Services, Department of Human Services, Department of Mental Health and Mental Retardation, Department of Corrections and the Department of the Attorney General to carry out these duties; and be it further

Resolved: That the legislative members of the commission shall receive a per diem compensation, and all members shall receive compensation for travel and other necessary expenses incurred in the performance

of their duties; and be it further

Resolved: That the sum of $9,000 be appropriated to the Legislative Account to carry out the purpose of this resolve.

APPROVED
APR 30'84
BY GOVERNOR

CHAPTER
86
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-FOUR

H.P. 1739 - L.D. 2304

RESOLVE, Extending the Life of the Commission to Examine the Availability, Quality and Delivery of Services Provided to Children with Special Needs.

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

Whereas, pursuant to Resolve, 1983, chapter 47, a Commission on the Availability, Quality and Delivery of Services Provided to Children with Special Needs was established; and

Whereas, that resolve required that the commission submit a report, together with any legislation, to the Second Regular Session of the 111th Legislature; and

Whereas, while an interim report has been prepared for submission to the 111th Legislature, an extension of the commission into the First Regular Session of the 112th Legislature would allow the commission to complete its report and prepare more comprehensive recommendations; and

Whereas, unless this legislation is enacted as emergency legislation, the commission will expire without having fully completed its very important task; and

Whereas, in the judgment of the Legislature,

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

Commission extended. Resolved: That Resolve, 1983, c. 47, 3rd paragraph, is amended to read:

Resolved: That the commission meet at least 3 times as a committee of the whole, and at such other times in subcommittees, as necessary, to study the problem through examination of data from Maine and other states, to consult with recognized experts in these areas, to conduct public hearings throughout the State and to prepare ~~a~~ an interim report which shall be distributed throughout the State and submitted to the Second Regular Session of the 111th Legislature and a final report which shall be distributed throughout the State and submitted, together with any accompanying legislation, to the ~~2nd~~ First Regular Session of the ~~111th~~ 112th Legislature; and be it further

Resolves 1983, c. 47, amended. Resolved: That Resolve, 1983, c. 47, last paragraph, is amended to read:

Resolved: That the sum of $9,000 for the first 9 months and $7,500 for the second 9 months be appropriated to the Legislative Account to carry out the purpose of this resolve. Any unexpended funds shall remain in the Legislative Account.

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

APPENDIX B

Additional information on the Infant Screening and Intervention model discussed on pgs. 30-31 is given below.

Infant Screening and Intervention Model:

The Infant Screening and Intervention Model is discussed by the Prevention and Early Intervention Committee in their first problem statement. Additional information on the model is as follows:

Underlying Principles of Model

1. Every child should receive preventive health and other supportive services which result in optimal physical and mental wellness for that child.

2. Functional individuals need to be able to develop trusting relationships with others in their family and community. Infants and young children need to develop this capacity within their home environments. In some situations, families need assistance in developing this capacity to trust and build relationships. This assistance may need to come through the combined efforts of individuals and private/public services.

3. Identification and treatment should be carried out to the maximum extent possible by existent public and private sector workers in Maine (physicians, hospital nurses, public health nurses , protective workers, child development workers, infant specialists, private agency staff, etc.) in order to allow for local and regional differences.

4. Implementation should be overseen by a local interagency group and, at the state level, by a state interdepartmental group.

5. Services should be family focused rather than child focused.

6. Services should be home-based rather than center-based to the maximum extent possible.

7. Intervention with 0-3 year olds should be integrated into the current state system for 3-5 year old handicapped children so that a continuum of services is available through school-age.

8. On-going training should be developed and made available to those who will identify and intervene.

9. The delivery system should be interdepartmental in its organizational structure and multi-disciplinary in its intervention design.

Program Model Description

There are two components in the proposed model.

1. Case Finding

The case finding component has four elements as follows:

a. Case Screening

Identification of the at-risk population would come through a network of hospital-based, physician-based and community health-based providers and/or services. This identification would be initiated through broad-based screening of pregnant women and infants routinely in contact with pregnant women and children.

On a prenatal level, this would involve physicians, office nurses, hospital prenatal clinic staffs, family planning workers, WIC workers, public health nurses and others.

If the high-risk mother/family has not been identified during the pregnancy, then the time of delivery within the hospital will be important for casefinding. Important screeners within this setting will be hospital maternity nurses, public health or other maternal and infant care nurses, hospital social workers and physicians.

On a postnatal basis, those involved would be physicians, postpartum nurses, office staff, public health nurses, well baby clinics staff, pediatric clinics, WIC, EPSDT and others.

The screening by this broad spectrum of pregnancy- and infancy-related personnel will of necessity and design be relatively simple and brief. Screening tools are available which meet this criteria; once they are selected, training in their use will be made available to the screening network.

b. Assessment/Evaluation

Those pregnant women, infants or young children (up to age three) who are identified in the gross screening as being high risk will be further assessed. More detailed instruments will be used in the case of infants/toddlers. Careful interviewing of the pregnant or new mother/family will be needed to determine the level of functioning of the adult members of a family.

Both the screening and assessment procedures need to be viewed as the first part of the "engagement" process. A major deficit in the lives of the environmentally high-risk families is the inability to trust other people including those in the "helping" professions. Screeners and assessors will be trained in recognizing this characteristic in coping with the difficulties it presents.

c. Engagement

The engagement process is the first critical step in intervention and begins during casefinding. It is imperative that strong links exist among the screening system, the family's primary health care, the community services system and the intervention system. These linkages need to begin in the initial planning stages and be carefully nurtured at all stages if the program is going to work.

The infant/family in all likelihood will present multiple problems and resistance to support. Screeners, assessors and engagers will need to be prepared for this and prepared to persevere in the face of very difficult circumstances.

d. Summary

A long-term goal of this effort will be the systematic screening of every child, in the state, prenatally and up to age three. Those at environmental risk will require special attention during screening and assessment. These procedures will need to be primarily home-based to a large extent and to focus on family interactional patterns.

2. Intervention

Intervention services to high-risk infants and families will include:

a. Advocacy and linkage to existing services for meeting basic human needs;

b. Emotional support to build trust between family (parents) and helping persons (the engager/intervenor[s]);

c. Developmental guidance for family members (child development, child health knowledge and expectations);

d. Psychotherapy for parents who need this level of intervention.

The "mix" and timing of these separate services will be highly crucial and individualized in each case. Clearly an interdisciplinary mix of knowledge, skills and abilities will make the team most effective.

It is proposed that regional intervention teams be established throughout the state to supplement existing resources in the provision of appropriate intervention services (initially, pilot regions would be selected to test and demonstrate the model). Such teams could basically be formed through the reallocation or reorientation of state positions from a variety of state agencies whose mandates related to high risk infants in some way. The primary focus of the teams would be intervention directed towards families of environmentally-at-risk infants. At the present time, the following agencies are seen as potential participants in the formation of the intervention teams.

Department of Human Services

Protective Services
Public Health Nursing

Department of Mental Health & Mental Retardation

Bureau of Mental Retardation
(Community Mental Health Centers)

Department of Educational & Cultural Services

(Preschool Projects)

Private Community Agencies and Programs

It is proposed that identified state agencies (or contract agencies with a close relationship with the designated state agency) reserve and designate specific positions to work on a full-time basis with the High-Risk Infant/Family Intervention Team. These teams would be interagency in nature with the staff members maintaining agency-of-origin identity while also functioning under the auspices of the interagency, interdisciplinary intervention model. Where community-based programs for high-risk infants exist (Infant Development Programs), a facilitative, support relationship would be regionally developed to maximize the impact of the existing program and integrate it with the interagency teams. Within a given region, the team and cooperating agencies would function with the advice of an existing (or newly established, if necessary) interagency coordinated council or committee whose function is closely related to high-risk infants/families, such as preschool projects or child abuse and neglect councils.

The interagency composition of the team is important for at least two reasons:

1. The four departments with major responsibility for children and/or family services (Human Services, Educational & Cultural Services, Mental Health and Mental Retardation, and Corrections) each have separate and distinct categorical high-risk families and their children;

2. The departments and such private or voluntary agencies as may be included in team composition have different services and resources that will need to be brought to bear in infant-family issues and plans for zero-to-three year olds in high risk families.

It is essential that the representatives of various agencies involved by mandate or service learn each other's potential and limitations, both as individuals and as program representatives. Intervention team training, both initial and continuing, will emphasize interagency and interpersonal team issues as well as substantive content.

CASE MANAGEMENT SYSTEMS - CHILDREN & FAMILY

Descriptive Outline - 1984

	Special Ed.	AMHI	BMR	Family Service Program	Sub.Care	Child Prot.	DOC	Preschool Coordination Sites
Target Population	children requiring residential school placement because of the severity of their handicapping condition	children who are mentally ill by legal definition & those whose "responsible adult" is able to negotiate a contract w/the Adol. Unit	children who are m.r.	AFDC families whose head of household is under age 20	children in foster care	abused/neg. children and families	Juvenile offenders	3-5 y.o. handicapped children. 0-3 for coordination & referral only.
Working Definition	All exceptional child. between ages of 5 & 20 requiring special services in the areas of: 1. Visually Impaired child; 2. Hearing Impaired child; 3. Learning Disabled child; 4. Physically Impaired child; 5. Behavior/ Emotionally disturbed child; 6. Chronic/ Acute Health Impairment	chldren who are in serious jeopardy because of family dysfunction	0-5:developmentally delayed children 5-20:m.r. children who need services not available through education system, i.e., respite, placement case management	AFDC Families whose head of household is under age 20 in the following priority order: 1.Newly granted AFDC families; 2.Referred by another agency including screened out child protective cases; 3.Not referred to the program; 4.Screened out protective service referrals who request assistance.	children who come into care or legal custody of DHS, voluntarily or court com.	chldrn who are or may be in need of protection because of child abuse or neglect,& their families	juveniles who are: chrged by law enfrce ment agencies w/com mitting a juv.offnse & referred to P&P juv casewkrs for court proceedings; placed on 'informal adjustment';placed on probation by the court; committed to MYC preparing for release; on Absent w/ Leave status from MYC;on Entrustment status from MYC.	children: a)who have reached 3 yrs. of age; b) have not reached 5 on or before Oct. 15; c) require special services in the area of: 1.Vision 2.Hearing 3.Speech & Language 4.Cerebral or Perceptual Functions 5.Physical Mobility Functions 6.Behavior, or 7.Mental Development or maturation

	Special Ed.	AMHI	BMR	Family Service Program	Sub.Care	Child Prot.	DOC	Preschool Coordination Sites
Statutory Ref.	20A M.R.S.A.	32 M.R.S.A. 2251,2290 2331,2334	34 M.R.S.A. ch.229 & 186A 2147	22 M.R.S.A. Chapt. 1473 S.5308-10	22 M.R.S.A. 4041-4065	22 M.R.S.A. 4001-4039, 4071		20 MRSA ch.406
Clients/Year	195 NSW in residential placements	150	0-5: 412 5-20: 586	700 unduplicated Families	3043	6496	7000	
Case Management Responsibility	Special Ed. Director or Pupil Eval. Chairman	Psychiatric Nurse III, Psych.S.W.II Psychol.II	0-5:Chld Dev. Worker 5-20:Client Svc.Coord	Family Service Caseworker	Foster Care or Adoption Caseworkers	Child Prot. Caseworkers	Juvenile Casewrker	Varies from site to site, in some cases project staff in others thru cooperating agencies
# Case Managers	91	2-4	approx. 24	N/A	99	122	36	N/A
Average Caseload	N/A	6-8 inpatient 4 outpatient	CDW: 15-20 CSC: 40-60	35-40	24	24.6	50	N/A
Services Provided	residential school placements	family ther. clinical ward management; treatment	In-home train. Case managemnt inc.coord.of svcs.:respite, trans.,medical dental,eval. residential placement;asst in SSI/guard'n	Continuation of education Delay subsequent Pregnancies; Acquisition of employability and job skills;	asst.in family rehab.; activities as legal par ent of chld bd/care,clothing,trans, med.care, case study/	receipt & invest./ eval. of referrals/ reports; intrvent'n to protect child & strengthen	referral to svc.providrs preclient supervision	Coordination of services to preschool handicapped children including: screening, referral, evaluation and direct services as well as mechanism

	Special Ed.	AMHI	BMR	Family Service Program	Sub.Care	Child Prot.	DOC	Preschool Coordination Sites
			ship appl.; family support	Improved maternal and infant health; Acquisition of life management skills; Facilitate the use of existing system; Facilitate the coordination of the existing services by agreements and compacts Prevent child abuse & neglect	supervision counslling, prep./placement;court social svc. advocacy,day care.	family;petition for a court order as necessary to protect child;case study;case managemnt; individual, group & family counselling; advocacy; prep.&placement;court soc. svc.		for interagency collaboration
Needed Services		foster homes ther.f.homes ther.group homes	More resources for teaching parenting skills staff training mechanism to better coord. svc. to multi-agency families	Day Care Serv. Transport. services; Housing; Parenting Classes; Educational Opportunities; Job Opportunities	m.h.svc.both in & outptnt svc. ther.f.homes	intensive in-home ment progs.	job bank or other employ	More direct serv. varying need from site to site

APPENDIX D

APPROVED
APR 13 '84
BY GOVERNOR

CHAPTER
752
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-FOUR

H.P. 1667 - L.D. 2207

AN ACT to Provide Medicaid Reimbursement for Substance Abuse Services.

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

Sec. 1. 22 MRSA §3173-D is enacted to read:

§3173-D. Reimbursement for alcoholism and drug dependency treatment

The department shall provide reimbursement, to the maximum extent allowable, under the United States Social Security Act, Title XIX, for alcoholism and drug dependency treatment. Treatment shall include, but need not be limited to, residential treatment and outpatient care as defined in Title 24-A, section 2842.

Sec. 2. Allocation. The following funds are allocated from the Federal Expenditure Fund to carry out the purposes of this Act.

	1984-85
HUMAN SERVICES, DEPARTMENT OF	
Medical Care, Payments to Providers	
All Other	$42,808

Sec. 3. Effective date. This Act shall take effect on January 1, 1985.

JOSEPH E. BRENNAN, GOVERNOR

DONALD L. ALLEN, COMMISSIONER

STATE OF MAINE

DEPARTMENT OF CORRECTIONS

STATE HOUSE — STATION #111

AUGUSTA, MAINE 04333

(207) 289-2711

November 29, 1984

Kevin Concannon, Chairman
Commission to Examine the Availability, Quality and
Delivery of Services to Children with Special Needs
State House Station #40
Augusta, Maine 04333

Dear Kevin:

The Department of Corrections wishes to commend the members and staff of the Commission to Examine the Availability, Quality and Delivery of Services provided to Children with Special Needs, for its excellent, in-depth Interim Report. The findings and recommendations contained in the report have sparked healthy discussion within both the private and public sector throughout the State. In addition, it has encouraged the Department of Corrections to continue to develop ways to address those "gaps" and "barriers" which hinder the availability, quality, and delivery of its treatment services.

In regards to the recommendations of the Commission's Subcommittee on Prevention and Early Intervention, the Department of Corrections supports the concept of a state-wide program of preventive intervention for high risk or handicapped infants and their families. While the Department has not been directly involved in on-going joint efforts to implement a statewide program, it has indirectly supported such efforts by providing seed money to a number of private contractors with similar objectives. One example is the Mainely Families Project which develops group support networking systems for families in need. Groups have been established in over twelve areas within the State and further expansion is planned. The Department also supports the sub-committee's recommendation regarding the development and implementation of a state-wide comprehensive health education curriculum, because, among other reasons, it recognizes the need for continuing education programs to familiarize teachers and students regarding available community resources.

The issues brought forth by the subcommittee on Administrative and Legal Issues identify many existing difficulties within the current system which hinder the provision of services to children with special needs. The Department of Corrections is very concerned with overcoming these difficulties. One

area of special emphasis is the need to ensure that all youth receive equal accessibility to services, particularly in the area of alternative placements. To that end, the Department is working with the other three major youth-serving departments examining procedures, roles and responsibilities in an effort to improve and streamline services.

The Department of Corrections also supports the expansion of Medicaid services to include the elimination of site restrictions and to allow for reimbursement of in-home care and counseling. Furthermore, the Department of Corrections supports the Department of Human Services in its efforts towards closing the "loophole" in the current child abuse reporting law. It has been the Department's experience that a large number of youths who come into contact with the juvenile justice system have been victims of some form of abuse and/or neglect. The Department of Corrections feels strongly that enforcement is an integral part of treatment from the standpoint of both the victim and perpetrator. it has become very clear that there is a need, not only for more intensified treatment within institutional settings, but for an expansion of treatment within the community sector in order to address this very pressing issue.

The recommendations of the Specialized Services Subcommittee clearly define a number of cogent issues which the Department of Corrections has been studying and attempting to resolve. First, the Department continues to support, through active participation in the Interdepartmental Committee, community initiatives for alternative placement and treatment of correctional clients. The Department also supports, when adequate alternatives are in place, the Juvenile Justice Advisory Group's initiative to remove juveniles from county jails and lockups which also house adults. The Department recently received a grant from the Juvenile Justice Advisory Group for an in-depth study of effective treatment strategies for the chronic/violent juvenile sexual offender. An initial plan has already been submitted to the Commission, and specific funds for implementation have been requested. In addition, budgetary needs have also been requested to restaff the Hayden Treatment Unit; however, staffing patterns must remain flexible in order to provide service to those committed clients who remain outside the Hayden Unit due to its limited capacity.

The Department of Corrections has recently initiated a review of the Maine Youth Center's court evaluation process in order to develop a comprehensive plan for evaluations. The Juvenile Justice Advisory Group has funded a project to test the efficacy of providing evaluations in the community. The project will allow the Department to assess the need for both community-based evaluations and those performed in a secure setting.

The Department of Corrections, in concert with the Division of Special Education is also continuing to evaluate and assess special education programming at the Maine Youth Center in an effort to bring programming into full compliance with State and Federal regulations.

Finally, the Department is continuing to review and assess its juvenile services and will request additional resources, where appropriate, in combination with the other three major youth-serving departments.

In reviewing the various responses to the Interim Report, it appears that all parties are in agreement that the current system can and must be improved. To that end, I recommend that the Commission consider the development of a multidisciplinary and comprehensive state-wide plan which would involve both the private and public sectors in an effort to maximize efficacy within current and anticipated resources.

Again, on behalf of the Department of Corrections, I want to thank the members and staff of the Commission for their service on behalf of youth with special needs.

Sincerely,

Donald L. Allen
Commissioner
Department of Corrections

STATE OF MAINE

Department of

Educational and Cultural Services

STATE HOUSE STATION 23
AUGUSTA, MAINE 04333

November 19, 1984

TO: Susan Bumpus, Interdepartmental Committee
Mental Health & Mental Retardation

FROM: Greg Scott, Commissioner's Office
Educational & Cultural Services

RE: Summary Response to the Interim Report of the Commission to Examine the Availability, Quality and Delivery of Services Provided to Children With Special Needs by the Department of Educational and Cultural Services.

We commend the Commission on the thorough and open manner in which it completed its review. We believe the Commission membership was appropriately representative, and that its public deliberations were carried on in an open, positive atmosphere.

We feel that the recommendations, though far reaching, are reasonable. They address unmet needs with a realistic view of the huge legislative and intergovernmental coordination necessary to accomplish those recommendations.

DECS is, overall, in agreement with, and supportive of, the interim recommendations of the Commission. Obviously, some of the recommendations have more impact on this department than others, and some will take longer to accomplish than others.

For purposes of this summary, we will concentrate on five specific areas of the report:

A. Prevention and Early Intervention
B. Comprehensive School Health Curriculum
C. Eligibility for School Purposes and Interdepartmental Responsibility
D. Sexual Abuse
E. Special Education Programs at the Maine Youth Center

Prevention and Early Intervention

DECS concurs that we, along with DHS and DMHMR, should more closely coordinate our respective statewide efforts in the area of prevention and early intervention. Several vehicles that exist to accomplish that purpose are the 0-3 Subcommittee of the Interdepartmental Coordinating Committee for Pre-School Handicapped Children, the Prevention Intervention Program, the Neo-Natal Intensive Care Center at Maine Medical Center, and the Newborn Intensive Care Nursery at Eastern Maine Medical Center. In terms of direct services, there is currently discussion to coordinate expansion of the existing pre-school handicapped sites, expansion of services for the 0-3 population, increased day care services, and permissive legislation to allow 3-5 year old handicapped children to be served by the public schools.

Comprehensive School Health Curriculum

DECS concurs with the recommendation that we continue the collabortive effort with DHS to promote and make available a comprehensive health education curriculum to publi schools in Maine. We have recently brought DMHMR into that collaborative effort. An ongoing mechanism is in the process of being established to define comprehensive health and look at it in relation to classroom curriculum, teacher training, teacher certification, school approval, graduation requirements, etc. Two health consultants now work within DECS to plan and coordinate these activities with the appropriate staff. As a somewhat side issue specifically relevant to this Commission, recent legislation puts increased emphasis on required K-12 guidance and counseling services in publis schools as part of school approval. Further legislation is being considered to more clearly define these services, to add appropriate staff for DECS to provide technical assistance to the schools, and to assure that financial resources are available to public schools.

Eligibility for School Purposes and Interdeparmtental Responsibility

DECS offers strong support to this recommendation and urges that we, along with DHS, DMHMR, and Department of Corrections, reintroduce legislation that would address interdepartmental planning, coordination and funding responsibilities to provide the types of services to this special group of children that this commission feels are necessary. It should be noted that staff representatives from DECS, DHS, DMHMR and the Department of Corrections have held two meetings to rework legislation to do just that. They will present their product to the Deputy/Associate Commissioners of the IDC. The Deputy/Associate Commissioners will then present their recommendations to the four Commissioners in time for any resulting legislation to be considered by the Governor and the 112th Legislature.

Sexual Abuse

Certainly ongoing collaboration on this issue between DECS and DHS needs to continue. We would suggest that training sessions for people who work with victims of sexual abuse include more school officials. We are also encouraging replication of the Model School Based Child Abuse and Neglect Program in the Lisbon School System. Awareness training for teachers and enforcement of the relatively new law by which a school staff person loses their certification if found guilty of physical or sexual abuse are critical areas as well.

Special Education Programs at the Maine Youth Center

The Division of Special Education did a Special Education Program Review at the Maine Youth Center in 1983. A corrective action plan was developed with a completion date of July, 1984. The Maine Youth Center has met the goals in the corrective action plan as a result of three discretionary grants from DECS which allowed them to add a resource room teacher, a hold for court diagnostic teacher, and a teacher of a self-contained classroom. In addition, they were able to put in place a Comprehensive System of Personnel Development and evaluative and psychiatric services. Continued compliance is contingent on the Department of Corrections obtaining funding in their own budget to continue these initiatives.

DECS is pleased to have been a participant on the Commission and looks forward to working with the Commission and the other three Departments in putting these recommendations in place.

GS:lm

SUMMARY OF DEPARTMENT OF HUMAN SERVICES COMMENTS ON THE RECOMMENDATIONS CONTAINED IN THE CHILDREN'S MENTAL HEALTH SERVICES COMMISSION REPORT

The Department of Human Services supports the purpose of the Commission to Examine the Availability, Quality, and Delivery of Services Provided to Children with Special Needs. The Commission's recommendations are responsive to many of the most serious problems facing Maine's system of services to troubled children. Every effort should be made to implement the recommendations in a quick yet thoughtful manner. Despite this general endorsement, the Department believes that several significant issues have not been directly addressed by the Commission. The Commission was originally created, in large part, in response to concerns about children who "fall through the cracks" between the State's major systems of children's services. While many of the recommendations of the Commission will undoubtedly improve conditions for many children, the report does not focus clearly on the unique responsibilities of those systems. The various State agencies have important legal and traditional roles to fulfill in the areas of treatment, protection, justice, prevention and early intervention. The ability of the collective systems represented by these agencies to provide proper care for children is largely dependent upon their ability to provide complete, complimentary services without substantial duplication of effort. The Department of Human Services believes that the children's services system suffers not only from a lack of resources and specific programs but also from a lack of clear division of responsibility and well defined individual roles for the various departments.

The following represents some of the highlights of the Department's responses to the recommendations of the Children's Mental Health Services Commission. These comments are divided into three areas:

(1) Changes we believe are needed in the mental health service delivery system for services to children and families;
(2) The need for clearer specification and definition of the target groups of children and families which need additional services; and
(3) Our perspective on the issues relating to sexual abuse services.

(1) In various of our earlier responses we said we believed the Commission Report lacks clarity and specificity regarding the services provided to children and their families who are served by the mental health services network. Before any structural changes are made in the mental health services system, we believe that a report should be completed which outlines the types of mental health and counseling services available to children and their families, the amount of funds currently being expended on those services, and the numbers of units of service currently being delivered. In short, we believe that there needs to be developed a comprehensive mental health services system for children and families which is based on a comprehensive and unified set of laws, policies, and procedures; which has a statewide consensus on priority problems and clients to be served; and which has standardized administrative and procedural safeguards as part of the overall system.

It is our very strongly held position that children are dependent on adults in this society for their basic needs and well-being. Therefore, from a child protective perspective, the needs and rights of the child must come before all other considerations including confidentiality issues, or the desire to keep families united. Given this perspective, we believe changes must be made in the laws regarding the relationship between mental health services and child protective services. We believe the so-called "treatment loophole" must be eliminated. Mental health professionals should be

required to provide to child protective caseworkers upon request that information which may be needed as part of the investigatory process of determining whether a child is safe or not. We will be proposing legislation that will enable the child protective program to gain immediate access to relevant portions of the mental health records of alleged perpetrators of child abuse and child sex abuse.

Another component of the mental health services system that has frustrated all of us over the past ten years relates to the need for secure treatment services for children and the need for behavior stabilization programs which can perform emergency assessment and stabilization for children. We are pleased with the progress that is being made towards the establishment of a secure treatment program in Maine. However, even with the establishment of a secure treatment program, there will still be the need for an emergency assessment and stabilization program for children. We believe that the AMHI Adolescent Unit should fill this gap, and that the Department of Mental Health and Mental Retardation should redirect AMHI's programs and services to serve this overwhelming need. Family therapy programs such as that currently operated at AMHI can be and are purchased from a variety of private agencies throughout the State. It is the State's responsibility to provide those services which private agencies cannot or should not sponsor.

(2) While the Department believes that more comprehensive and consistent case management is needed for children and families in Maine, we want to reiterate our feeling that the major problem with existing systems is the lack of a designation of responsibility for children and families who do not fit neatly into predefined groups. In addition to increasing services to already well defined groups, we should also clearly delineate the service needs of those children and their families who do not otherwise fit into those groups. We do not believe the Commission Report specifies clearly enough which under-served children and families should receive services.

In 1984 between 18,000 and 20,000 children will be referred to the child protective services program in the Department of Human Services. Of this number only half will be opened as cases in which the harm to the child is serious enough to warrant the involvement of a child protective worker. The other half of those children will be referred to other agencies, such as mental health centers or day care centers. In the majority of these cases, while the problems are not severe enough to warrant child protective services intervention, there may be significant problems affecting the child and the child's family which, if not treated, may cause deterioration to the point at which protective services involvement would be necessary. The Department of Human Services has contended throughout the life of the Commission that this target group of children is the group toward which new case management services should be directed. If Maine were able to effectively serve these 10,000 children there would be few others who would be "falling through the cracks." In order to serve this population of children, however, more than case managers is needed. There also must be increased community resources funneled to the community agencies to serve these children and their families. There needs to be far greater cooperation and coordination between agencies which serve these children and families, both at the State and community levels, and there may need to be changes in the legal definition of "jeopardy" to include children who are at risk and require services which parents are unwilling or unable to provide. We are currently looking into the implications of lowering the jeopardy standard and will likely be proposing legislation altering this standard in the upcoming legislative session.

It is our strong belief that responsibility for the management of these cases should be assigned to the Department of Human Services as the agency with the most comprehensive

services mandate. We do not make this recommendation out of any desire to merely expand the scope of the Department's services. It is because these referrals now come to the Department. The Department currently has the necessary administrative mechanisms including computer tracking capability, contract and fiscal policies and procedures, existing programs performing similar functions, and the broadest legal mandate to establish and manage social service programs for the citizens of Maine. In other words, rather than creating or duplicating policies, procedures, computer programs or contract policies, the Department has the capacity to integrate new programs and services into its existing administrative infrastructure.

As the report points out, the number of sexual abuse cases served by the Department doubled between 1982 and 1983 and will likely double again between 1983 and 1984. Because of this phenomenal growth the single greatest need is for additional dollars rather than the development of any new organizational structures or mechanisms to address this problem. It is vitally important that any new resources for sexual abuse treatment services be specifically earmarked for the victims, and in some cases the perpetrators, of those cases already known to the existing agencies. At the present time the Department of Human Services contracts for sexual abuse treatment in services with numerous providers, both private therapists and private nonprofit agencies, at a level of several hundred thousand dollars. The Department has plans to expand this amount in the near future. It is because the Department feels that new sexual abuse funds must follow the clients referred to the Department that new sexual abuse treatment funds should be channeled through the Department so as to avoid creating parallel or conflicting treatment programs. If funds are allocated through other agencies, specific contractual mechanisms should be developed to assure that clients being referred through the existing system receive necessary services.

DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION
RESPONSES TO RECOMMENDATIONS OF THE COMMISSION TO EXAMINE THE AVAILABILITY, QUALITY, AND DELIVERY OF SERVICES PROVIDED TO CHILDREN WITH SPECIAL NEEDS.

Kevin W. Concannon, Commissioner

November 12, 1984

The Commission's Report contains well thought out recommendations representing an agenda for action and promise of a better life for troubled children and their families. The Department strongly endorses recommendations supporting the development of home and community-based services directed at prevention and early intervention. Early identification and treatment of children with developmental delays, mentally handicapped citizens, and families needing mental health and other supportive services constitute one of our most effective arsenals in promoting a socially responsible, healthy, and caring environment; a cornerstone in Maine's continuing articulation of public policy towards children and families in need.

A second critical dimension of Commission findings relates to the continuing importance for public, private, and community agencies to develop new strategies and strengthen existing methods of ensuring that services are funded and administered in a complementary fashion fully promoting, rather than detracting from, individual care, treatment, and growth. The Team, interdisciplinary approach pre-eminently effective in working with special needs families must be reflected also in the broader context of inter-agency relationships and development of additional resources. The Department supports this approach as a guiding principle in our joint efforts to meet the needs of troubled children and their families.

The Department of Mental Health and Mental Retardation has major and ongoing responsibilities for the care, treatment, rehabilitation, and assurance of appropriate community-based services to thousands of mentally handicapped, developmentally disabled, and mentally retarded citizens. Additionally, the Department is in concert with other public and private service providers, a significant treatment and education resource in the provision of mental health and substance abuse services to a wide range of populations needing assistance and support. The continuing implementation of Commission recommendations involving the Department is of highest priority. Specifically, the Department, through a variety of mechanisms and in close cooperation with other state and local agencies, will advocate for:

- Additional resources supporting the establishment of a statewide program of preventive intervention for high-risk or handicapped infants and their families.
- Increased support for community-based services enabling families to maintain their handicapped children at home and in their own communities. Included are physical, occupational, speech, language and psychological therapies; respite care; family support services and networks; therapeutic foster care; specialized medical services, home-based counseling; and others.
- Expanded home-based family treatment programs enabling troubled and dysfunctional families to remain intact.
- Development of an array of community residential treatment and behavior stabilization options for emotionally disturbed youth who are unable to remain with their families.
- Establishing a coherent and focused system of mental health services for severely emotionally disturbed children.
- Additional support for and development of regional programs to evaluate and treat victims and perpetrators of child sexual abuse.
- Specific attention to and resources directed towards the training and vocational needs of children who are "aging out" of their service entitlements in the public school system.
- Ongoing support for the mental health and other service needs of traditionally underserved populations such as juvenile offenders, autistic children and children with mental health and mental retardation service needs.
- Expansion of mental health options and services through effective and increased use of Federal and other funds, with particular emphasis on Medicaid reimbursement.

- Review and strengthening of mental health licensing functions and other protocols to assure appropriate and quality treatment services.
- Increased public awareness and education as to the needs, abilities and potential of mentally handicapped children including proven strategies for community support, treatment, and habilitation.
- Effective strategies, agreements, and procedures for inter-agency cooperation in meeting our collective service obligation to children and families with special needs.

Finally, the Department, in addition to requesting additional resources for children with special needs, has undertaken a critical examination of children's services currently delivered by Departmental staff and through contractual arrangements. Literature surveys, extensive consultation with children's services and mental health professionals across the nation, and analysis of other state children's services systems indicate a pervasive and troublesome theme which is underscored by Commission findings: The vast majority of troubled and handicapped children are not getting the services they need, and few states have developed the necessary procedures and policy focus to effectively address the problem. As a first step, the Department is consolidating its internal administration of and resources for children with special needs. The current Office of Children's Services, legislatively mandated to provide coordination and planning, and already a major funding source for residential treatment, sexual abuse, and homebuilders programs, will be strengthened by transferring the large majority of existing Departmental Children's Services resources currently administered by the Bureaus of Mental Health and Mental Retardation. The advantages of this consolidation and unified programmatic approach are considerable in that it facilitates the development of a comprehensive system of services responding

to needs as against diagnostic labels or categories. Additionally, the reorganization provides for a regionally-based children's services delivery system expanding upon existing funding and cooperative agreements, as well as increased assistance and support to community organizations, service providers, parent groups, and professional organizations.

Appendix F: Summary of Other Responses to Interim Report

Advocates for the Developmentally Disabled - Hallowell

The A.D.D. strongly supported a revision in the statutes governing out of home placements and their funding as well as the need for a centralized ombudsman system. The agency articulated a need to begin effective case management but did not necessarily support the development of pilot projects. It was felt that the A.D.D.'s enabling legislation partially addresses the ombudsman issue.

Cumberland County Children's Mental Health Task Force - Portland

The task force indicated basic support for the recommendations in the Commission's Interim Report, but indicated concern regarding the following points:

1. the need to address the issue of service needs and gaps before considering case management;
2. the lack of equal services that exist for children depending upon the district in which they live;
3. the lack of a clear statement of mission for the Adolescent Unit at the Augusta Mental Health Institute; and
4. the fewer number of resources that exist for females.

Juvenile Justice Advisory Group

The J.J.A.G. generally endorsed the recommendations in the Commission's Interim Report, noting that the following either mirrored or complemented activities in the J.J.A.G.'s 1985-1987 plan:

1. case management;
2. interdepartmental pilot projects in case management;
3. funding for out-of-home placements;
4. a network of out-of-home placements for juveniles;
5. formal agreements to ensure aftercare, follow-up and transition;
6. a statewide approach to deal with the problem of sexual abuse;
7. behavior stabilization services;
8. regional capacities for evaluations; and
9. formal training for judges.

In addition, the J.J.A.G. offered its assistance in implementing the Commission's recommendations and indicated that it would attempt to coordinate its activities with the recommendations in areas of mutual involvement.

Sweetser Children's Home - Saco

Sweetser Children's Home indicated its full support for all the recommendations in the Interim Report and commended the Commission for the quality of the report. In particular, Sweetser indicated support for the following items:

1. equal access to services;
2. continued efforts to revise the funding formula for out-of-home placements;
3. home-based services;
4. narrowing and possibly closing the reporting loophole in cases of physical and/or sexual abuse;
5. aftercare/transitional services;
6. services for younger children; and
7. restaffing the Hayden Unit at the Maine Youth Center.

It was noted that Sweetser, as well as other residential treatment centers, provides services other than residential treatment. The most recent program to be added to Sweetser's services is the Family Preservation Program, made possible by a grant from the Edna McConnell Clark Foundation, with the cooperation of the four major youth-serving departments in Maine.

Sweetser suggested that the following points be considered by the Commission:

1. assignment of specific responsibility through designation of a lead agency and the authority to meet the responsibility in the preventive intervention model proposed;
2. vested authority in case managers;
3. availability of sufficient funding to provide services to children in need;
4. the need for the Adolescent Unit at the Augusta Mental Health Institute to fill some of the gaps in the existing system.

Overall, Sweetser emphasized the need to develop a system to ensure availability of a full range of appropriate services and establishment of funding mechanisms to provide access to those services.

Youth and Family Services - Skowhegan

Youth and Family Services was particularly supportive of the recommendations in the Interim Report pertaining to:

1. development of a statewide system of infancy screening and service teams;
2. changes in the funding formula for out-of-home placements so that special education services are available to all students in residential care;
3. expanded reimbursement for Medicaid;
4. improved service and treatment capabilities at the Maine Youth Center, especially for sexual offenders; and
5. increased regional capacity for evaluations of correctional clients.

APPENDIX G

INTERAGENCY GROUP ON SEXUAL ABUSE SERVICES

REPORT

Submitted to

Specialized Services Subcommittee

September 18, 1984

Interagency Group on Sexual Abuse Services
Specialized Services Subcommittee

Charge

To develop a statewide approach to address the problem of sexual abuse in Maine. The approach should deliniate a plan for a network of sexual abuse treatment programs, including training both to mental health professionals and to others not directly involved in treatment, who work with victims of sexual abuse, identification of services that are currently available, services that should be ideally available and recommendations for needed steps/resources to bridge the gap between the two.

Problem Statement

The committee identified the following problems facing the development of an effective, comprehensive statewide approach to address the problem of sexual abuse in Maine. This comprehensive response includes a timely coordinated effort by the Department of Human Services, law enforcement, District Attorneys, legal, medical, and mental health professionals. The availability of treatment services including services to the victim, the family and perpetrators is a critical part of this comprehensive response. There is recognition that the adequacy of the response to sexual abuse of a child varies from community to community, and this effects the services a child and her family receives in the area of protection and treatment.

1. The overload of existing sexual abuse service providers due to the reporting and discovery of sexual abuse cases. The overload of all providers is the result of the increased numbers, the severity of the cases referred, the time required to effectrively intervene and treat and emotional drain placed on the providers. All these factors lead to a high turnover in all community responders. Department of Human Services statistics show that from 1982 to 1983 there has been a 119% increase in the number of sexual abuse cases served. It is projected that for 1984 another 80% to 100% increase in the number of substantiated cases will occur.

2. The absense of a comprehensive, coordinated community response to child sexual abuse in some areas of the state.

3. The need for close cooperation and coordination among Department of Human Services, law enforcement, mental health, medical and legal professionals and the District Attorneys' offices. These professionals need to be appropriately trained and willing to serve this population.

4. The absence statewide of capacity to provide initial crisis intervention services in all reported cases.

5. Lack of treatment programs within all corrections institutions for sexual abuse offenders and victims of all ages.

6. Lack of systematic, comprehensive prevention programs for children of all ages and parents.

7. Inaccessible or unavailable transportation for victims of sexual abuse and their families resulting in an inability to receive appropriate services.

8. Medicaid reimbursement limitations, rates and negative effect on mental health providers to develop specialized sexual abuse treatment programs.

Interagency Group on Sexual Abuse Services
Specialized Services Subcommittee

Recommendations

1. Increase funding for all service providers with funding coming through the Department of Human Services. Increased funding needs to go to the Department of Human Services, law enforcement, District Attorneys, mental health and medical providers.

   a. Funding should be identified for sexual abuse victims and their families.

   b. This should include all victims and all families - not just incest families.

2. The establishment of a coordinated, community response to child sexual abuse organized along the lines of existing prosecutorial districts.

   a. Each response network shall be composed of representatives from the Department of Human Services, District Attorneys office, law enforcement officials and others as needed. Written agreements and protocols established.

   b. Local community response shall include the identification of service needs and gaps, manpower and training needs and resource development.-------network (DHS, law enforcement, District Attorney)

   c. A community coordinator will be selected to assure coordination and communication among provider members and agencies and to develop a team approach to sexual abuse including intervention, investigation and ongoing treatment.

   d. The coordinator and the network will assure the development of a mental health treatment team capable of providing individual, group and family therapy to victims, families and perpetrators in a coordinated and consistent fashion.

   e. Assure that the sexual abuse treatment team is capable of providing crisis intervention including initial intervention, immediate evaluation assessment and initiation of treatment.

   f. Assure the selection of a case manager to be determined on a case-by-case basis.

   g. An advisory group of community people will oversee the development of the community response and all ongoing activities related to child abuse cases. In order not to duplicate services, Child Abuse and Neglect Councils should be utilized as natural monitoring mechanisms for the development of ongoing activities of the regional coordinated community response network.

      1. Where child abuse and neglect councils exist, attempts should be made to have them develop a standing subcommittee to become the sexual abuse community network advisory board.

2. Where councils do not exist, the advisory group would stand alone or affiliate with an appropriate existing community agency.

3. The advisory board should be broadly based to include not only direct providers but interested community members and leaders.

4. Representatives from each advisory board will make up the state advisory board.

3. The Department of Human Services should fund regional coordinators to be located at community service settings such as the District Attorney's offices, community mental health centers and Department of Human Services offices.

   a. New positions; additional staff

   b. Functions

      1. form networks by community
      2. form advisory board
      3. arrange/facilitate/organize network activities
      4. information sharing locally and statewide
      5. advocacy (for families) with Legislature
      6. mediation among network members
      7. planning/resource development
      8. coordination of investigation, court activities, ongoing services and treatment

4. A new position should be established at the Central Office of the Department of Human Services to coordinate sexual abuse services.

5. Joint training should take place for all sexual abuse service providers including Department of Human Service personnel, mental health providers and law enforcement personnel. Training should cover identification and investigation and treatment of sexual abuse. This training effort should be coordinated through the proposed Department of Human Services, Child Welfare Training Center.

6. The local community coordinator and advisory group in collaboration with the local Child Abuse and Neglect Council should develop a comprehensive prevention program for children of all ages. The program should involve parents, schools, mental health agencies and civic associations. The Department of Human Services in collaboration with allied state agencies should provide technical assistance and training support to local communities.

7. Maine's correctional system must develop a comprehensive specialized treatment program for perpetrators and victims.

8. Transportation services to assure the availability and access of services to victims of sexual abuse and their families must be developed. The responsibility to overcome obstacles to transportation should be assigned to the local community response network, advisory board and/or the local child abuse and neglect council.

Submitted by
Kathleen M. Corey, Chairman
Interagency Group on Sexual Abus Services
Specialized Services Subcommittee

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Summary of Minutes

Interagency Group on Sexual Abuse Services
Specialized Services Subcommittee

Summary of Minutes

Charge: To develop a statewide approach to address the problem of sexual abuse in Maine. The approach should delineate a plan for a network of sexual abuse treatment programs, including training both to mental health professionals and to others not directly involved in treatment, who work with victims of sexual abuse, identification of services that are currently available, services that should ideally be available and recommendations for needed steps/resources to bridge the gap between the two.

May 17, 1984. Location: Full Circle, Brunswick. Present: Sandi Hodge, Jane McCarty, Steve Thomas, and Kaye Corey.

Kaye Corey was asked by the Special Services Subcomittee to chair the interagency group on sexual abuse services.

The group reviewed and discussed its charge. We decided to expand the group and to invite as new members: Pam Lawrason, R. Bruce Boyd, and Michael Harrington.

May 27, 1984. Location: Room 327, State House, Augusta. Present: Kaye Corey, Jane McCarty, Steve Thomas, Pam Lawrason, Bruce Boyd, Michael Harrington. Absent: Sandi Hodge.

Jane McCarty gave a summary of the York County Counseling Services Sexual Abuse Treatment Program, and Steve Thomas gave a summary of the Community Counseling Services' Sexual Abuse Treatment Program. We discussed different ideas on how to plan for a network of Sexual Abuse Treatment services.

We designed a cover letter and questionnaire for a survey of child serving mental health agencies in Maine to gather data on service utilization for sexual abuse treatment, which was distributed in July.

July 10, 1984. Location: State House, Augusta. Present: Kaye Corey Pam Lawrason, Jane McCarty, Sandi Hodge, Mack Dow (for Michael Harrington). Absent: Steve Thomas.

The committee discussed the following issues:

1. The problem of poor access to treatment sources due to inadequate transportation system.

2. The overload of existing treatment resources and the unavailability of any sexual abuse treatment in some areas of the state.

3. The need for treatment providers to train together and share information.

4. The need for close cooperation and coordination among all service providers.

Several recommendation were also made. It was decided that we would go over these recommendations together at the next meeting.

August 15, 1984. Location: State House, Augusta. Present: Kaye Corey, Jane McCarty, Sandi Hodge, Les Swift (Chairman, Specialized Services Subcommittee), and guest from Child Welfare League of America.

We reviewed July 10 recommendations. We concurred that a draft position paper containing all our recommendations would be completed in time for our September 18, 9:00 AM meeting, and we obtained Commissioner Kevin Concannon's agreement to provide our committee with a staff person to draft the position paper.

We discussed and agreed on a set of tentative recommendations: see attached.

September 15, 1984. Location: State House, Augusta. Present: Kaye Corey, Harrington, Hodge, Lawrason, McCarty, Thomas. Absent: Boyd.

We spent the morning reviewing and changing recommendationsto present to Subcommittee at September 18 meeting. Sandi Hodge acted as Secretary at this meeting. Material will be presented to Jim Haddon along with other material for the full Commission.

APPENDIX H

Inter-Departmental Memorandum

Date November 7, 1984

To Commission on Childrens Needs

Dept.

From Francis Cameron, Asst. Supt. of Rehab

Dept. Corrections, Maine Youth Center

Subject Juvenile Violent/Sexual Offenders Program

In response to the Specialized Services Subcommittee of the Commission to Examine the Availability, Quality and Delivery of Services provided to Children with Special Needs, Recommendation which states in part "the Department of Corrections/Maine Youth Center should take lead responsibility for developing a plan for a secure treatment program for the violent/sexual offender", please find attached a conceptual plan for such treatment.

The Department of Corrections has requested, in the Part II Budget for fiscal year '86, staffing to adequately initiate this conceptual plan. Furthermore, the Department has requested funds for renovation of a cottage to accommodate this program.

The Department of Corrections intends to review/evaluate the implemented treatment program on an ongoing basis in an effort to ascertain programmatic (staffing, equipment, building) needs prior to making budgetary considerations for the fiscal year '87, '89 biennium.

It is hoped that this conceptual plan addresses the concerns voiced in the Concannon Commission's Interim Report.

FAC/dk

Attachment

cc:- Donald L. Allen, Commissioner
Michael Molloy, Director Correctional Programs
Richard J. Wyse, Superintendent, MYC

JUVENILE VIOLENT/SEXUAL OFFENDERS PROGRAM
AT THE
MAINE YOUTH CENTER

This proposal is presented as a working document to be refined and molded into a final design for a Juvenile Violent/Sexual Offender Program at the Maine Youth Center. The proposal will be broken down into four areas: 1) introductory remarks, 2) description of treatment modalities, 3) description of treatment phases, and 4) other appropriate considerations.

I. Introductory Remarks

The reader should understand from the outset that this proposal is one part of the ongoing treatment process offered at the Maine Youth Center. Other Maine Youth Center treatment programs are important in terms of support systems and insuring that resources are brought to bear in an effort to address individualized client needs for those clients admitted to the Violent/Sexual Offender Program. Thus, the Juvenile Violent/Sexual Offender Program should be understood within the context of a multidisciplinary treatment approach, eclectically utilizing all resources/services of the Center.

The Juvenile Violent/Sexual Offender Program involves the implementation of an array of cognitive and behavioral procedures, including cognitive restructuring, problem solving and decision-making training approaches and skill deficit training in a confrontive and reality oriented context. Additionally, social assertiveness, empathy skills training and sex education would be involved. The major focus of the treatment program would be to help clients with interpersonal relationships, that is extinguish anti-social behaviors by supplanting such behaviors with pro-social interactions and responses. The Juvenile Violent/Sexual Offender

Program will require an intensive programming structure with an adequate number of staff, in order to deal with each client's behavior, experiences, perceptions, fantasies and thoughts on a daily basis. Treatment interventions will be so designed that each client will be provided with positive reinforcement (feedback) in an effort to bring aggressive behaviors under control and in dealing with individuals' specific problems, e.g. sexually aggressive behaviors, substance abuse, familial issues and the development of skill deficit training. The program would be long term, very highly structured and secure. The estimated length of stay would be between 18 and 36 months.

II. Treatment Modalities

Seven areas of treatment modalities will be utilized in the program. They are as follows:

1. Individualized treatment planning
2. The implementation of Positive Peer Culture
3. A group therapy system, inclusive of structured peer therapy
4. Journal keeping and implementation of written exercises to create and maintain disclosure, honesty, receptivity, self-appraisal and the restructuring of thinking patterns.
5. An Interpersonal Maturity Diagnostic system (I-level)
6. A feedback system on behavior and progress for the purposes of accountability and measurements.
7. Supportive treatment modes and services.

The first modality refers to individual treatment planning, that is the development of the "Problem Oriented Record System". The main feature of this system is a problem list which requires staff to

identify/list in numerical order the youth's problems as discerned from past records, social history, diagnostic work and behavioral observations. This list identifies all known behaviors that require treatment intervention. Such issues as self-worth, value, esteem and image, educational achievement, interpersonal relationships and familial issues to list a few would be found on this list.

The second component of the Problem Oriented Record System refers to a goals/objectives list. Each item on the problem list would have corresponding goals and appropriate objectives. The goals would serve to define the general treatment program, whereas the objectives would refer to specific intervention techniques of treatment with given time frames for accomplishment.

The third component of this treatment system would emphasize plans. This component would define the methods, resources and activities to be implemented in achieving the goals and objectives. Plans serve as prescriptions for action in the treatment of clients. The plan list describes specific treatment activities: when, where and how they will occur, as well as identifying specific treatment staff responsibility for provision of service. All plans will have a built-in review date in order that they might be appropriately modified throughout the treatment process. Treatment team reviews (case review) will be held bi-monthly with the Maine Youth Center's Clinical Services Committee providing oversight reviews on a monthly basis. These reviews will include all treatment unit notes, family therapy sessions, academic and medical reports, as well as the inclusion of the aforementioned treat-

ment components, in order that a multidisciplinary team can effectively evaluate individualized treatment programs and provide ongoing programmatic monitoring.

Secondly, the development of a therapeutic peer mileau (Positive Peer Culture) is an extremely important factor in developing a therapeutic environment in the Juvenile Violent/Sexual Offender Program.

The group therapy system will be described in the next section of this proposal in an effort to aid the reader in understanding the role of the Positive Peer Culture within the treatment environment.

The Positive Peer Culture stresses self-discipline and personal responsibility; thus, enhancing the development of pro-social interaction, a vital element in this form of adolescent treatment intervention. All clients admitted to the Juvenile Violent/Sexual Offenders Program will learn techniques and procedures in order to effectively deal with each other's behavior, maintain a pro-social treatment mileau, and stimulate the development of new thinking patterns and behaviors. The key component of the Positive Peer Culture is the implementation of the "open channel". Simply stated, the open channel refers to open and honest communication between clients and staff members. This approach ensures that most all irresponsible behavior is kept open to the general culture of the unit and treatment staff. By virtue of the open channel, clients would be required to report immediately to staff any incidences of a serious nature, such as: AWOLs, threats and physical assaults. The intention of the open channel in terms of the Positive Peer Culture is to, in effect, co-opt the subcultural code of ethics, which is a negative

reinforcer. The Positive Peer Culture also involves leadership development, peer counseling and teaching, peer orientation and structured peer therapy. Clients will be taught specific counseling techniques, thus, in part become responsible for developing helping relationships with one another on an ongoing basis. When a new client comes into the treatment unit, an orientation committee of peers will be responsible for providing an intensive orientation to the unit and treatment program. Thus, this is one way in which clients become actively responsible for the maintenance of a positive and responsible culture within the treatment environment. The reader should understand that this process will be closely monitored by treatment staff on a moment-to-moment basis. The clients, as a result, will learn to manage their own behaviors while becoming appropriately concerned with the behaviors of their peers.

The intensive implementation of the treatment process in terms of Positive Peer Culture is underscored through intensive group therapy. There will be two major groups in the treatment program. Each client will be assessed and assigned to either the instrumentals or expressive groups. The term "instrumentals" and "expressives" will be dealt with in more detail under the treatment modality of the Interpersonal Maturity Diagnostic System (I-level). Group therapy sessions will be held six days a week for approximately two hours. There would be a weekly business meeting to discuss such issues as: treatment levels, special contracts, peer review and community leaves. In all arenas outside the group, the clients have a continuing responsibility to attain honesty, responsible behaviors, helping each other, to be open about the fulfillment of commitments and other obligations. The basic premise of structured peer

group therapy is that clients need the persistent pro-social involvement of their peers and treatment staff in order to learn responsible behaviors. Clients will be required to run selected group therapy sessions, during which treatment staff will be utilized as positive models or guides for the treatment process.

In the initial phase of treatment, group emphasis will be understanding victim awareness, to include (impact and feelings) implementing a variety of techniques, so that victims become deliberately personalized in an effort to develop remorseful feelings and accurate empathy.

The Interpersonal Maturity Level System (I-level) is a cognitive development theory that describes seven successive stages of interpersonal maturation. The I-level classification system focuses on ways in which the client sees himself and the world. The I-level diagnostic system will be utilized to provide individual treatment to different types of clients in group therapy. Treatment team members will also be divided into these categories based on information relative to their working styles. The expressive staff are more typically mental health staff, offering support and nurturing while a client is developing. They foster introspection in dealing with deep-seated conflicts and emotion. The expressive clients are more in touch with their anxieties and poor self-images, thus, are able to ask for help. They are in most cases more vulnerable, hurting and dependent than the instrumentals. On the other hand, instrumental staff are more typically correctional oriented in the sense that they are concerned with issues of achievement and self-control, which are fostered through setting high expectations and giving encouragement when there is improvement. On the other hand,

instrumental clients have learned to act tough, shield their inner feelings from others and turn many of these feelings into anger; they frequently do not risk themselves by trusting people.

The group therapy system would be divided into two major groups: expressive and instrumental clients to be matched with expressive and instrumental staff.

A hierarchy of treatment levels will be developed in this program to provide a system for clear and prompt behavioral feedback on a daily basis, inclusive of assessing client progress. Via review of the Problem Oriented Record System, privileges and incentives would be integrated at the treatment team level. There will be an entry-level orientation during the initial phase of treatment, focusing on penetrating denial and the development of victim awareness. This system increases client responsibility through a series of levels with increasing privileges to the point of re-entry and reintegration into the community.

Without doubt there will be numerous areas of "overlay" of varying treatment modes and services to augment the work of the basic program; for example, family therapy, substance abuse treatment, sex education and skills deficit training. Furthermore, we recognize the necessity to provide treatment modes that would be necessary to the effective treatment of clients with individual needs that may go beyond the standard treatment program.

The violent/sexual offender would spend approximately six months to one year in the core program. During this period of time, he would be evaluated in terms of demonstrating new behaviors and motivation toward changing his

life style. Through demonstration of new behaviors, the completion of a thorough auto-biography and the mastering of other programmatic skills, he would then advance to the specialized sex offender group.

This group would meet twice a week, combining expressives and instrumentals. Strict confidentiality will be adhered to with treatment staff becoming responsible for creating a climate for honest disclosures. The focus of the sex offender group will be to explore and work on issues relative to sexual aggression, power, control, domination and inadequacies. Furthermore, issues of anger, rejection, abandonment, exploitation of people, victim awareness and the tendency to depersonalize and sexualize other people will be addressed by clients in the sex offender group.

Note:

When the program begins to admit a number of murderers, a specialized group will be developed in order to address the needs of this type of violent offender more directly.

III. Treatment Phases

In its most general terms, phases of treatment in the Juvenile Violent/ Sexual Offender Program are six-fold, inclusive of:

1. Penetrating denial and confronting the offenses the client has committed, emphasizing victim awareness.
2. Developing new thinking structures and patterns to be maintained and expanded throughout the next four phases of treatment.
3. Identifying the client's "cycle" of violent behavior and working with daily manifestations of the cycle.
4. Working with unresolved emotional issues.

5. Retraining in areas of skill deficits.

6. Re-entry into the community.

The first phase refers to the penetrating of denial and confronting the committal offense/s of the client. This initial phase of treatment includes a thorough orientation process. A peer orientation committee with treatment staff assistance will aid the new client in learning the treatment program and the treatment unit's policies and procedures. During this initial phase, immediate, intensive and confrontive treatment intervention would be implemented within structured group therapy in an effort to penetrate the client's denial. As we all know, it is very common for violent and sexual offenders to constantly claim that they did not do what they are accused of. They frequently blame others and externalize responsibility for their actions. The client, in this phase, must learn that negative values must be reversed, that he own up to responsibility for his crimes, that he communicate to those around him that he understands his course of treatment, and that he become integrated into the positive culture of the treatment unit. All treatment processes (written and verbal) will during this phase focus on clients understanding the effects of their behavior on the victim and significant others.

The second phase of treatment will focus on developing new thinking structures and patterns to be maintained and expanded throughout the next four phases of the treatment process. The client's total thinking will become the raw material for change. The clients will learn to report the full content of their thinking, almost as though it was a closed-circuit television recording their actions and thoughts 24 hours a day. This re-

portage will be thoroughly examined in order that errors in their thinking patterns are clearly identified. Clients will be taught cognitive corrective measures to eliminate these errors. Thus, simply put, the client develops cognitive strategies to manage negative thinking. The repetitious, persistent implementation of correctives is the essential process in the restructuring of thinking.

The third phase of treatment refers to identifying each client's cycle of violent behavior and working with daily manifestations of this cycle. The clients learn to identify situations that are likely to become "triggers" for feeling angry and committing violent acts. Clients become aware of the incipient thoughts and behaviors that usually arise prior to the decision to commit a violent act. Violent and sexual offenders are consistently engaged in a series of irrational thoughts that involve catastrophizing, even when presented with minimal stress. The client is taught to analyze his perception of environmental influences and events which lead to an emotional response. This emotional response stimulates an intolerable set of feelings (overwhelming anxiety), which leads to overcompensating through patterns of power and control. These patterns lead to feelings of anger and rage, culminating in a decision to commit a violent act. At this point in the cycle, the client redefines a plan for the violent act, including the selection of a victim, time and place for the act, and ultimately, the act itself. In the final course of the cycle, the internal feelings experienced during the act compensate for the original perception which stimulated the emotion.

The cycle is manifested in the client's daily living in the institutional

setting. Thus, it is very important for the client to examine situations, perceptions and events, while institutionalized, that may lead to behaviors equivalent to the violence committed prior to his involvement in the program. While incarcerated, the client substitutes behaviors that are the outcomes of the same thinking patterns that lead to violent behavior in the community.

The fourth phase of treatment requires the resolution of emotional issues, resulting from the influences that might have had a major impact on the client's anti-social development. Major issues to be addressed include abuse and neglect, sexual victimization, rejection, perceived abandonment, familial conflict, and perceived self-inadequacy. The program will assist each client in identifying problems in these areas in an effort to develop pro-social behaviors. As the client begins resolving these emotional issues, he becomes increasingly confident that he is able to cope more effectively with interpersonal relationships and life in general. As this process continues, the client develops self-respect and is able to accept life (with all its difficulties) and appropriately manage himself in the face of adversity.

The fifth phase of treatment refers to skills deficit training. This type of clientele usually requires training in many areas, to include social skills, such as: assertiveness, developing "fair-fighting rules", and the art of negotiating and compromise. For example, the clients need to learn that it is possible for them to become assertive enough to meet their needs without the necessity for aggressive, violent behavior. Ideally, these skills will help them gain enough confidence in interpersonal relationships so that they no longer perceive themselves as being put down, attacked,

intimidated, controlled or helpless. During this phase of treatment, the client is held accountable for utilizing alternative pro-social behaviors and new skills to better manage difficult situations. Other areas of training include: values clarification, communication skills, how to develop relationships, sex education, courtship skills, job-seeking and vocational skills, and problem-solving and decision-making skills. In the course of skill deficit training, the client learns to eliminate intimidation (power oriented alternatives) while developing a repertoire of pro-social behaviors.

The sixth phase of treatment addresses transition and community re-entry. From the outset the treatment team will be planning for re-entry to the community; thus, it will be very important for treatment staff to gather as much pertinent information as possible relative to the past history of the client, in order to effectively develop future planning. Ongoing contact will be maintained with other service agency providers, in order that they might be active treatment agents throughout the treatment process, e.g. juvenile community services caseworkers, Department of Human Services workers, family members and/or significant others. The Clinical Services Committee of the Maine Youth Center, in conjunction with other appropriate agents of the Department of Corrections, will serve as the liaison and clearinghouse for implementation of placement plans, coordinating efforts between treatment personnel and appropriate service providers. Treatment planning will focus on the client's identified areas of need; for example, job hunting, budgeting personal finances and other "world of work skills".

Transition plans will be designed approximately six months prior to the

anticipated release date. The plan will consist of a series of scheduled therapeutic leaves which would progressively increase in length and decrease in supervision. These leaves will find treatment staff and "responsible others" providing support and guidance for the client while in the community. During the first three to six months after release, the program (proper) will continue involvement with the client. If the client is in the proximity of the program, weekly involvement in program activities will be a consideration. Frequent telephone contacts, plus crisis intervention, will be available depending on need and other geographical considerations. The provision of the aforementioned resources is viewed as imperative to the successful transition of the client from the structured institutional environment to that of the community.

IV. Other Considerations

There are other areas that require serious consideration in the development and implementation of the program design. The following considerations are not intended to be all inclusive, nor are they absolutely necessary in order to initiate the Juvenile Violent/Sexual Offenders Program.

Psychiatric and Psychological consulting services need to be available to the Juvenile Violent/Sexual Offenders Program. It would appear that the most advantageous approach to meeting this need would be to have a consulting psychiatrist work with the treatment staff eight hours per week and a consulting psychiatrist providing services for an additional eight hours per week, providing the program with a total of 16 hours of consulting services weekly to staff and clients.

The Juvenile Violent/Sexual Offenders Program will also require overview and safeguards. The safeguards will take the form of a) the Superintendent

of the Maine Youth Center, b) the Maine Youth Center's Clinical Services Committee (which will be responsible for timely and periodic review of each client's program), and c) the Office of Advocacy of the Department of Corrections. Furthermore, the consulting psychiatrist and psychologist would help in providing individual and programmatic safeguards as well.

Funds should be made available for treatment staff training and network services. Being an active part of a national network and developing professional contacts and exchanges in treatment techniques would aid in the implementation and development of the program. One should remember that the treatment of juvenile violent/sexual offenders is a comparatively new treatment endeavor, requiring openness to innovation and ongoing programmatic refinement.

The reader should keep in mind future considerations, in that as the program develops a gradual increase in resources may be necessary to ensure that full implementation and effectiveness are accomplished.

An initial appropriation of resources for implementation of the Juvenile Violent/Sexual Offenders Program necessitates the addition of the following treatment staff positions.

1. Two (2) psychiatric social workers who will be responsible for planning and social work (primarily intra-institutional) functions.
2. One (1) secretary
3. 20 hours from a recreational therapist per week.
4. One (1) correctional caseworker who will be responsible for planning/liaison with community service providers (networking with families, schools and alternative placements) and significant others.

In addition, 16 hours of consulting services, i.e. psychological and psychiatric, on a weekly basis.

In the scope of functions and the difficulty inherent in working with violent/sexual offenders, the Maine Youth Center's administration anticipates a great deal of wear and tear on treatment staff members. We recognize that one of the keys to success of this program will be attention to staff management, and the development of a genuinely caring, sharing environment for staff, emphasizing creativity, supportiveness and stress reduction. It is extremely important that treatment staff members have the skills and personalities suited for this type of work, in that we are treating a highly dangerous, stressing group of clients who require a persistent, caring, intensive treatment team approach.

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