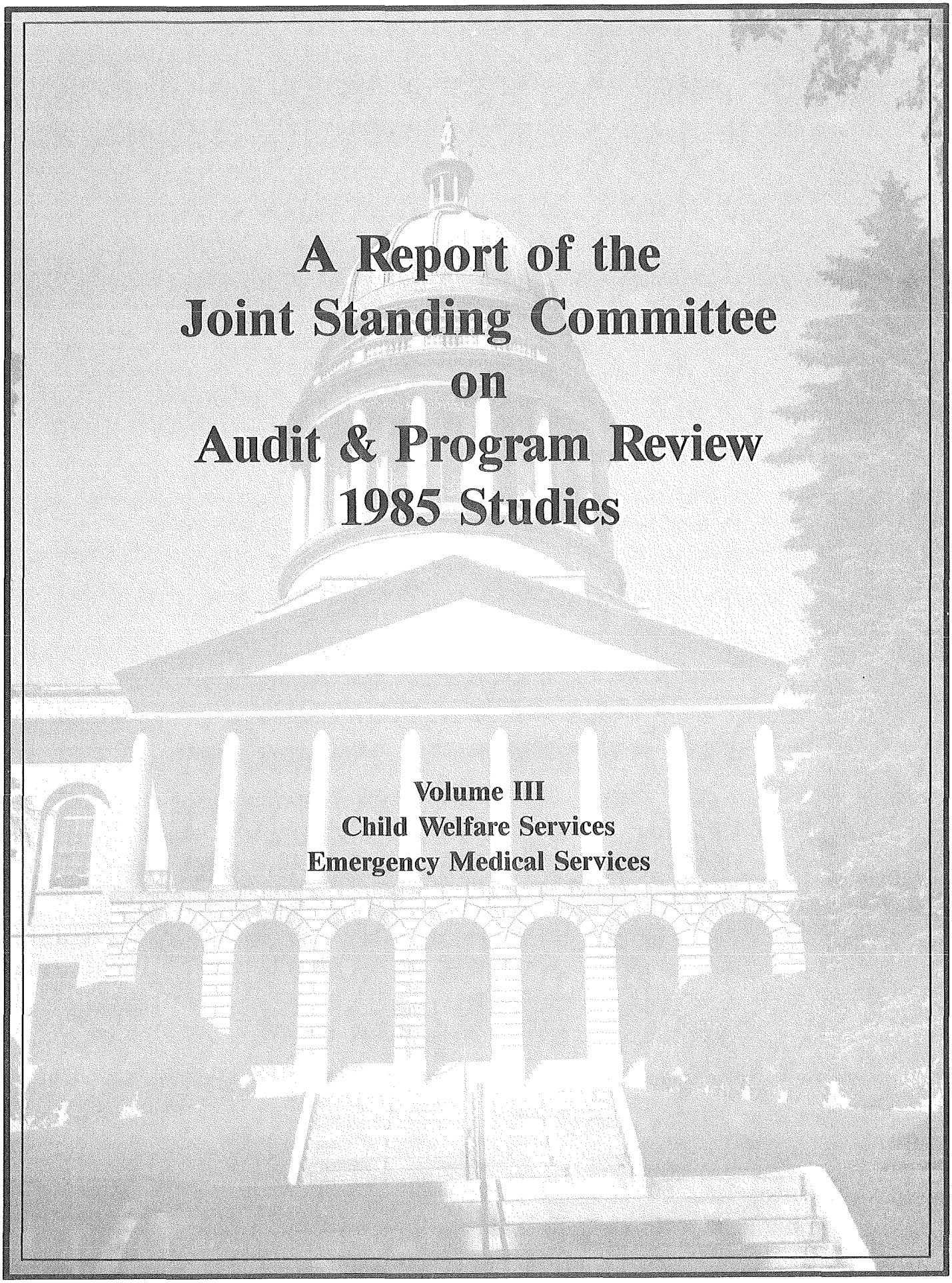

A Report of the Joint Standing Committee on Audit & Program Review 1985 Studies

Volume III
Child Welfare Services
Emergency Medical Services

JOINT STANDING COMMITTEE ON AUDIT & PROGRAM REVIEW

1985-86 Committee Members

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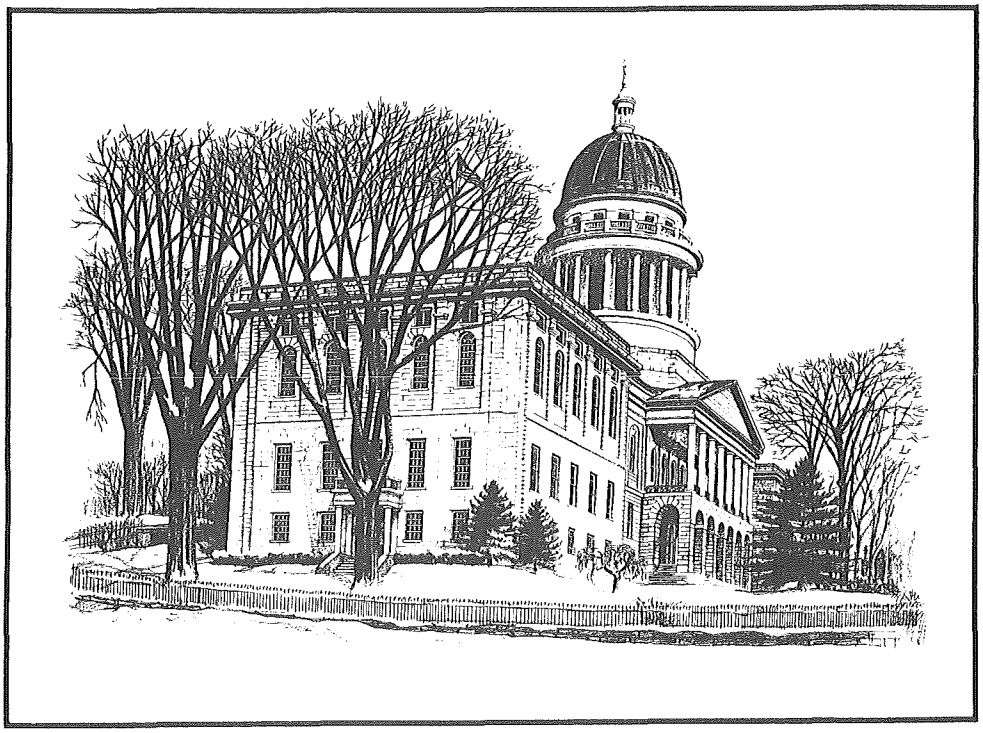

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STATE OF MAINE
ONE HUNDERED AND TWELFTH LEGISLATURE
COMMITTEE ON AUDIT AND PROGRAM REVIEW

June 1986

Members of the Legislative Council;

It is our distinct pleasure to transmit to you Volume III of the seventh annual report of the Joint Standing Committee on Audit & Program Review. Volumes I and II containing our recommendations regarding the Department of Business, Occupational and Professional Regulation (now the Department of Professional and Financial Regulation), a financial and statistical history of Professional Licensing Boards in the state, as well as other agencies, has been transmitted to you earlier. This third and final volume is the formal compilation of the Committee's work and the Legislature's response regarding the topics of **Child Welfare Services**, Part I, and **Emergency Medical Services**, Part II.

Child Welfare Services and Emergency Medical Services have both been challenging topics for the Committee. We have spent many rigorous hours reviewing material, considering testimony, and discussing issues. Throughout the entire process, our objectives have been to make state government more efficient and less costly while ensuring quality service to the people of Maine and improving legislative oversight of the Executive Branch.

We wish to particularly thank the adjunct members who served on our subcommittees from other joint standing committees. Their expertise was invaluable to our process.

Finally, the Committee intends to continue our review of Child Welfare Services this year and to be available to assist, as needed, in the implementation of the Emergency Medical Services recommendations.

Sincerely,

Bill

G. William Diamond
Senate Chair

Neil

Neil Rolde
House Chair

STATE HOUSE STATION 5, AUGUSTA, MAINE 04333 TELEPHONE 207-289-1635

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Joint Standing Committee on Education

Summary of Recommendations

The Committee categorizes its changes into Statutory and Administrative Recommendations. The Committee's bill consists of the Statutory Recommendations. Administrative recommendations are implemented by the Agencies under review without statutory changes. In some instances, the Committee includes a finding which requires no further action but which highlights a particular situation. Recommendations include, where possible, the proposed change and the reason for this change. For more specific detail, refer to the narrative of the recommendations.

CATEGORY		RECOMMENDATION
PART I		
Child Welfare Services		
STATUTORY	1.	Include "emotional injury or impairment" in the definition of **abuse or neglect** to indicate that emotional injury or impairment is a serious threat to a child's health or welfare.
STATUTORY	2.	Include "emotional injury or impairment" in the definition of **serious harm** and augment the list of disorders which indicate when emotional injury is evident. Furthermore, clarify that the court may consider emotional injury which is currently evident or which is likely to be evident in the future.
STATUTORY	3.	Retain family rehabilitation and reunification as a priority for protecting the welfare of children but clarify that in certain circumstances rehabilitation and reunification is not possible and should not be undertaken.

STATUTORY	4.	Authorize the court to declare that in certain cases the Department has no further responsibility to conduct rehabilitation and reunification efforts and that the Department shall develop permanent plans for such children in their custody .
STATUTORY	5.	Provide that the court may not order physical placement of a child with a parent when the Department retains custody.
STATUTORY	6.	Recommend that biennial judicial reviews will not be required if a child is ordered into the custody of a person who is neither the parent nor the Department, unless any party specifically requests that a review be done.
STATUTORY	7.	Authorize the child's guardian ad litem to move for judicial review.
STATUTORY	8.	Broaden the scope of evidence that the court must consider during a judicial hearing regarding the future of an abused child to ensure that the most accurate and relevant information is used as the basis for the court's decision.
STATUTORY	9.	Require the court to make one of three determinations within 18 months for children entering foster care to eliminate unnecessary lingering of these children in the foster care system.
STATUTORY	10.	Require that before the court may restore custody of a child to the parent who had previously lost custody to the department, the burden of proof shall be on the parent to show that he or she can protect the child from further jeopardy.

STATUTORY	11.	Augment the Department's current authority to discontinue rehabilitation efforts by authorizing the Department to not begin rehabilitation efforts under specified circumstances. Furthermore, authorize the court to order that reunification efforts need not begin or may be discontinued under these circumstances.
STATUTORY	12.	Add two circumstances upon which the Department or court may base a decision to not begin or to discontinue reunification efforts.
STATUTORY	13.	Establish two additional circumstances upon which the court may make a rebuttable presumption to terminate parental rights.
STATUTORY	14.	Add state fire inspectors, municipal code enforcement officials, and municipal fire inspectors to the list of those mandated to report child abuse or neglect.
STATUTORY	15.	Clarify that current limitations regarding disclosure to the courts of certain departmental information applies equally to both records and reports.
ADMINISTRATIVE	16.	Require the Department to retain unsubstantiated child protective services case records for no more than 18 months and then expunge these records from all departmental files or archives unless a new referral has been received within the retention period.
STATUTORY	17.	Establish the present position of Institutional Abuse Program Specialist as a full-time position.

ADMINISTRATIVE	18.	Recommend that the department use the same staff personnel to interact with parents whose children are involved in an institutional abuse investigation to provide more consistent contact with these parents.
ADMINISTRATIVE	19.	Direct the Department of Human Services to inform referents at least once about the status of their referrals.
ADMINISTRATIVE	20.	Recommend that the chair of the Advisory Committee on Caseworker Functions not be the Director of the Bureau of Social Services since the Committee's function is to advise the Director of the Bureau of Social Services.
ADMINISTRATIVE	21.	Recommend that the Advisory Committee on Caseworker Functions review the increasing paperwork requirements for caseworkers and report to the Audit Committee with recommendations on improving paperwork efficiences by September 1986.
FINDING	22.	The Committee finds that the Interdepartmental Coordinating Committee has made progress in integrating and coordinating its efforts to provide child welfare services and encourages the Interdepartmental Coordinating Committee to continue to explore additional methods for integrating the child welfare services offered by member state agencies.
ADMINISTRATIVE	23.	Recommend that an independent study be undertaken by the Child Welfare Advisory Committee to review and analyze referrals screened-out by the Department and report on the implications of these screen-outs to the Committee on Audit & Program Review by October 1986.

FINDING	24.	The Committee finds that the department should continue its exploration of the issues involved in making Children's Organized Camps subject to licensing requirements as Child Care Facilities and report on its progress and recommendations to the Committee on Audit & Program Review by September 1986.
ADMINISTRATIVE	25.	Direct the Department to increase its communication, coordination, and cooperative efforts with agencies and individuals concerned with child abuse and neglect on the local and regional community levels. Report to the Committee on Audit & Program Review on the impact of these efforts by September 1986.
ADMINISTRATIVE	26.	Require the Department to communicate clearly with foster parents at the outset regarding departmental policies on foster parent adoption of foster children in order to clarify apparent misunderstanding.
ADMINISTRATIVE	27.	Direct the Department to improve the process by which foster parents may claim damages done by foster children in order to hasten reimbursement.
FINDING	28.	The Committee on Audit & Program Review supports the Commission on Family Matters in the Court in their recommendation and legislation to create a Family Division of the District Court System.
FINDING	29.	The Committee finds that the Court Appointed Special Advocate Program (CASA) holds promise for providing children with the kind of advocacy they deserve in the court system. Therefore, the Committee on Audit & Program Review commends the program and looks forward to its anticipated accomplishments.

FINDING	30.	The Committee finds the development of a statewide Child Abuse and Neglect Prevention Plan to be vitally important and supports the development of regional and local child abuse and neglect prevention plans, now in progress, by the Department of Human Services and the Maine Association of Child Abuse and Neglect Councils.
FINDING	31.	The Committee finds that a Task Force should be appointed to assess the need to establish a separate Department of Child & Family Services to incorporate all child and family service programs now administered by the Departments of Human Services, Educational and Cultural Services, Corrections, and Mental Health and Mental Retardation.
ADMINISTRATIVE	32.	Recommend that the Department use prudent and sensitive discretion regarding its authority to remove children from their homes so that this authority is not used as an unwarranted threat against a parent or other person responsible for the child.
FINDING	33.	The Committee finds that the quality and relevance of placement resources and services currently available to children in substitute care should be assessed.
ADMINISTRATIVE	34.	Extend the review of child welfare services in Maine for one year to allow the Committee to complete work now in progress.

PART II

EMERGENCY MEDICAL SERVICES

STATUTORY	1.	Place the authority for the final adoption of rules with the Board of Emergency Medical Services to strengthen the Board's governance of the EMS program.
STATUTORY	2.	Remove the mandatory requirement for conducting 12 evening hearings for rule making to provide the Board with increased flexibility, minimize cost and maximize efficiency.
STATUTORY	3.	Place the licensing authority with the Board to strengthen the Board's regulatory responsibility.
STATUTORY	4.	Provide that a licensee may appeal the revocation, suspension, or refusal to issue or renew a license to the Commissioner prior to action by the Administrative Court to provide an additional safeguard for both the Board and the licensee.
STATUTORY	5.	Increase the disciplinary options available to the Board to ensure appropriate safeguards, provide more flexibility and clarify the complaint investigation process.
STATUTORY	6.	Place the authority to appoint or dismiss the Director with the Board and provide for approval of the Commissioner, to properly reflect the Board's increased responsibilities.
STATUTORY	7.	Enable the Director to hire other staff as required, subject to personnel law, to reflect the Director's responsibility for the administration of the EMS program.

STATUTORY	8.	Ensure that OEMS employees are maintained within the new organization with the same compensation, benefits and rights to provide job security for present employees.
STATUTORY	9.	Place the authority for the designation of regions and regional councils with the Board to provide a consistent organizational charge.
STATUTORY	10.	Place the responsibility for establishing goals for the Emergency Medical Services program with the Board to facilitate the involvement of the EMS community.
STATUTORY	11.	Place the responsibility for approving the delivery of educational programming and testing with the Board to complete the proposed organizational change.
STATUTORY	12.	Maintain the Board of Emergency Medical Services as an administrative unit within the Department of Human Services to maximize coordination between health programs.
STATUTORY	13.	Remove the word "advisory" from the name of the Emergency Medical Services Advisory Board to reflect its newly revised mandate.
STATUTORY	14.	Provide a transition clause to ensure proper transfer of authority and powers from the Department to the Board on the effective date of implementation, September 1, 1986.

STATUTORY	15.	Provide for an orderly appointment process of Board members and establish the authority of the Board to appoint subcommittees.
STATUTORY	16.	Stagger Board membership so that only one third of the membership terms expire each year.
STATUTORY	17.	Provide that the State Medical Director serve as a non-voting ex-officio member of the EMS Board to strengthen the coordination between the EMS Board and the Medical Control Advisory Committee.
STATUTORY	18.	Provide that the Chair of the Board shall be elected for a two year term by the full membership of the Board to facilitate continuity.
STATUTORY	19.	Establish that a majority of the Board constitutes a quorum for the conduct of board business and that a two-thirds vote of those present is necessary for the suspension or revocation of a license.
STATUTORY	20.	Increase the duration of a Basic Emergency Medical Technician license from one to three years, while maintaining quality standards, to streamline licensure/certification, to improve licensee morale, recognize expertise gained through practice, and increase retention.
STATUTORY	21.	Eliminate the renewal requirement for a Basic license as a condition of continued licensure at the Advanced Level but provide that a combination of criteria be established by the Board to ensure quality care while eliminating unnecessary administrative procedure.

STATUTORY	22.	Review the operations of the EMS program in three years under the provisions of the Maine Sunset law to assess the implementation of the reorganization.
STATUTORY	23.	Include a statement of purpose in the EMS law to indicate legislative intent and affirm the importance of emergency medical services to the public health, safety and welfare.
ADMINISTRATIVE	24.	Recommend that the DHS Office of Public Relations work with the EMS program to develop and implement a public education plan to increase the public's awareness of EMS. Report to the Committee on Audit & Program Review with this plan by September 1, 1986.
ADMINISTRATIVE	25.	Develop orientation packets for new Board members and other interested individuals to include: • a brief history of EMS; • a copy of the laws governing EMS; • a copy of the EMS rules; • a copy of the Board philosophy; • a description of responsibility as a Board member; and • an overview of EMS, goals, program, and budget.
ADMINISTRATIVE	26.	Recommend that the Board ensure that regulations are clearly written to encourage consistent interpretation.
ADMINISTRATIVE	27.	Inform individuals who request interpretation of regulation of their right to request an advisory ruling. Include the procedure in the EMS rules to provide for consistency in interpretation.

ADMINISTRATIVE	28.	Recommend that the Medical Control Advisory Committee develop a statewide procedure governing boundary protocol to resolve potential problem areas. Report to the Committee on Audit & Program Review by February 1, 1987.
ADMINISTRATIVE	29.	Recommend that the Medical Control Advisory Committee review the feasibility of establishing **minimum** statewide protocols. Report to the Committee on Audit & Program Review by February 1, 1987.
ADMINISTRATIVE	30.	Distribute the minutes of the Medical Control Advisory Committee to members of the Emergency Medical Services Board to facilitate communication.
ADMINISTRATIVE	31.	Maintain updated mailing lists of individuals, services and organizations involved or interested in EMS and ensure that copies of regional protocols are available in the central office to strengthen communication.
ADMINISTRATIVE	32.	Recommend that the Board review the data system to determine if the process and information are responsive to the needs of the EMS program. Report to the Committee on Audit & Program Review by February 1, 1987 with any findings.
FINDING	33.	The Committee finds that a state recognition day should be established for emergency medical services personnel to provide recognition for their efforts at protecting the public health, safety and welfare.

ADMINISTRATIVE	34.	Provide technical assistance to the Regional Councils in the development of educational and training programs to improve coordination and maximize limited staff resources.
ADMINISTRATIVE	35.	Provide staff assistance to Washington and Hancock Counties in their efforts to strengthen the delivery of educational programs. Report to the Committees on Audit & Program Review and Human Resources by February 1, 1987.
STATUTORY	36.	Reallocate the Preventive Health Block grant for EMS for FY 1987 to ensure the availability of services.
STATUTORY	37.	Reallocate $12,000 for FY 1986 to provide $2,000 in grant monies for each of the six regions.
STATUTORY	38.	Request an annual appropriation of $210,000 from the General Fund to cover the cost of regional operations to ensure that each Regional Council receives a total of $60,000 in FY 1987.
ADMINISTRATIVE	39.	Expedite the contractual process to ensure that regions receive funds in a timely manner.

Report Overview

The Committee's recommendations reflect many hours spent digesting extensive background information, reviewing statutes and relevant data and statistics, hearing comment and testimony from many individuals with direct experience in these issues, soliciting written comment from over 1200 people and agencies involved in child welfare, job-shadowing substitute care, family services, and child protective caseworkers, and making on-site visits to regional DHS offices.

From the start, the Committee's intention has been to examine Maine's child welfare system closely and make recommendations designed to:

- improve communication between DHS staff and the child welfare community;
- improve the system by which both civil and criminal investigations are conducted;
- increase public education about child abuse and neglect;
- reduce the pressures on caseworkers so they can devote more quality time to each case;
- increase agency accountability;
- clarify certain definitions in the statute;
- clarify and improve the statute regarding rehabilitation and reunification for families;
- determine a more humane and reasonable way to conduct investigations in institutions;
- support modifications in programs focused on juveniles;
- provide caseworkers with more technical support;
- increase the number of placement resources for children;
- take definite, concrete steps to prevent child abuse and neglect from occuring in the first place;
- improve the difficult task of foster parenting;
- provide more therapeutic resources for victims of child abuse, their families, and offenders; and
- require more intensive training for those involved in the child welfare system.

Due to the complexity of its task, the Committee recommends that the review be extended for one year to enable the Committee to complete its work (#34). Thus, this report constitutes Phase I of the Committee's review.

A major portion of the Phase I work focused on family rehabilitation and reunification. The Committee reviewed many case histories and interviewed dozens of people in the child welfare community regarding rehabilitation and reunification. It found that the current law dealing with family rehabilitation and reunification needed clarification as to legislative intent as well as an injection of common sense.

As a result, the Committee recommends that family rehabilitation and reunification be retained as a priority for protecting the welfare of children but clarify that in certain circumstances rehabilitation and reunification is not possible and should not be undertaken. The Committee accomplishes this goal by:

- clarifying and augmenting definitions;
- providing the court with options which enable it to choose a disposition for a child that best suits the child's needs;
- minimizing the probability that a child will linger in foster care "limbo" over unreasonably long periods of time;
- requiring that parents demonstrate to the court that they have resolved problems that led to removal of a child and that the child can now be returned safely; and
- clarifying that rehabilitation efforts need not commence or may be discontinued if the parent commits a heinous or abhorrent act against the child or commits one of eleven crimes against the child including aggravated assault, rape, gross sexual misconduct, sexual abuse of minors, and incest.

During Phase II, the Committee will devote its efforts to completing its review of:

- caseworker retention;
- the court system;
- institutional abuse;
- establishing an ombudsman for child welfare services;
- prevention;
- substitute care; and
- training.

INTRODUCTION

I. Statistical Overview:

A. Child Protective Services (CPS)

The American Association for Protecting Children collected 1,727,000 documented reports of abused and neglected children for 1984 from across the nation. This is a 17% increase over reports received in 1983 and a 158% increase over 1976. (See Appendix 1) These reports fall into the following categories:

Type of Maltreatment Nationally CY 1984	% of Children Reported
Neglect	54.6
Other Physical Injury	21.3
Sexual Maltreatment	13.3
Emotional Maltreatment	11.2
Other	9.6
Major Physical Injury	3.3

In Maine, the Department of Human Services' compilation of statistics for Calendar Year (CY) 1985 shows the results of child protective services cases (CPS) opened for investigation as follows:

Type of Maltreatment in Maine CY 1985	# of CPS Cases Investigated*	% of Children Reported
No Maltreatment Found	2,269	39%
Neglect	1,052	18%
Sexual Maltreatment	990	17%
Minor Physical Injury	780	13%
Potential Abuse or Neglect	699	12%
Major Physical Injury	56	1%
	5,846	100%

* One case generally includes 2.1 children

The Department also reports an increase in the total number of referrals of child abuse and neglect over time. In 1982, the Department received 7,456 referrals; in 1983, 8,465; and in 1984, the Department received 10,541 referrals.

Looking at the particular types of cases handled at selected points in time can provide another perspective to child abuse and neglect in Maine. The following data show the increase in referrals over time for specific types of maltreatment.

CASE TYPE AS OF SELECTED DATES

CASE TYPE	7/5/84	10/3/84	1/1/85	3/8/85
Sexual Abuse	352	420	464	510
Physical Abuse	349	375	420	428
Neglect	575	614	690	684
Potential Abuse and Neglect	83	102	89	91
No Specific Harm	29	29	26	27
Under Investigation	1,358	1,324	1,526	1,529
Total	2,746	2,864	3,215	3,269

Source: DHS

B. Substitute Care

Children in Maine who are removed from a situation of jeopardy are placed in substitute care when provided with a placement that substitutes for parental supervision. Substitute care alternatives include family foster care, relative care, therapeutic foster care, long-term foster care, adoption, emergency shelters, group homes, residential treatment centers, and semi-independent living situations.

The number of children in Maine who are placed in substitute care shows a decline since FY 1982 as follows:

Fiscal Year	# Children Placed in Substitute Care
1982	3,127
1983	3,043
1984	3,012
1985	2,917

Source: DHS' Geographic Distribution Report

The number of adoptions finalized in Maine since Calendar Year 1980 show an upward trend as follows:

Calendar Year	Adoption Finalizations
1980	44
1981	59
1982	79
1993	149
1994	102
1985	115

Source: Adoption Progress Report
DHS 1984 and 1985

II. State Law:

With the passage of Maine's Child and Family Services and Child Protection Act (22 MRSA, Chapter 1071) in 1980, the Legislature recodified the child welfare laws to authorize the Department of Human Services to protect and assist abused and neglected children, children in circumstances which present a substantial risk of abuse and neglect, and their families (22 MRSA §4003). The Act also:

- articulates a set of legal standards to guide state intervention in family life, for removal of a child from home, and for family reunification or termination of parental rights;

- describes the powers and duties of the Department of Human Services to protect children, work toward the reunification of families, and provide permanancy planning;

- includes a set of principles to govern court disposition of child protection proceedings; and

- mandates judicial review of children in departmental custody, coincident with federal law.

III. Maine's Service Delivery System

The State of Maine provides a number of services to promote the welfare of children. These services:

- span four major state agencies;

- include programs designed to protect children from abuse and neglect, substitute for parental supervision when necessary, provide physical and mental health services, license child care institutions, address the needs of troubled adolescents, prevent abuse and neglect, facilitate adoption, promote permanence, disseminate information on all aspects of child welfare; and

- cost millions of state, federal, and dedicated funds annually.

The lead agency in administering child welfare services in Maine is the Department of Human Services. The Department's Division of Child and Family Services within the Bureau of Social Services administered over $24,000,000 in FY 1985 to provide or purchase services to improve the welfare of Maine's children (see appendices 2 and 3 for organizational charts and a breakdown of expenditures and allocations in FY 1985).

The Departments of Mental Health and Mental Retardation, Corrections, and Educational and Cultural Services also provide child welfare services totaling up to 4,000,000 state and federal dollars annually.

The Department's child welfare services system is coordinated from a central office in Augusta and implemented from five Regions which serve the entire state. (see Appendix 4 for a map of the Regions). The chart below indicates the area included in each Region with its assigned caseworker staff for CY 1985 (as described below).

REGION	OFFICES	COUNTIES INCLUDED	CPS STAFF	SUBSTITUTE CARE STAFF	FAMILY SERVICES STAFF
I	Portland-Headquarters Biddeford	York & Cumberland	41	27.5	4
II	Lewiston	Androscoggin Franklin & Oxford	25	16	2
III	Augusta-Headquarters Rockland Skowhegan	Kennebec, Somerset, Waldo, Knox, Lincoln and Sagadahoc	31	27	2
IV	Bangor-Headquarters Ellsworth Machias Dover-Foxcroft	Penobscot, Piscataquis, Hancock and Washington	28.6	22	3
V	Houlton-Headquarters Caribou Fort Kent	Aroostook	13	8	1
			138.6	100.5	12

IV. Child Welfare Professional Staff

Professionals within the Department of Human Services who participate in the delivery of child welfare services include the Commissioner, the Director of the Bureau of Social Services, the Bureau Fiscal Manager and Deputy Director, Division Directors, Unit Managers, and their staff.

In each of the five Regions, the Regional Program Managers, their clerical and administrative staff, and the child welfare caseworkers work together to deliver the needed services.

Child welfare caseworkers within the Department of Human Services fall into one of three categories:

	# Caseworkers	# Supervisors
o CHILD PROTECTIVE SERVICES	138.6	21.5

A Child Protective Services Caseworker assesses and treats reports of neglect, abuse, or exploitation of children. This position includes the following responsibilities:

- o intake screening and assessment;
- o intake study;
- o development of case plan;
- o treatment and service provisions;
- o monitoring and evaluation of case plans;
- o petitioning for protective orders;
- o short term emergency services; and
- o administrative responsibilities.

o SUBSTITUTE CARE CASEWORKER	100.5	18.25

A Substitute Care Caseworker provides services primarily for children who have been removed by the court from a situation of jeopardy in his or her household. The goal of a substitute care caseworker is to develop a permanent plan for the child's well-being. When the child is placed in DHS custody, the caseworker designs a rehabilitation and reunification plan with the child's parent(s). The intent of the plan is to reduce jeopardy to the child by facilitating changes in family life.

The responsibilities of a substitute care caseworker include:

- o assessment;
- o case planning;
- o treatment and service provisions;
- o monitoring and evaluation of case plans;
- o placement;
- o financial services;
- o court/legal activities;
- o foster/adoptive parenting or orientation; and
- o administrative responsibilities

o FAMILY SERVICES CASEWORKER	12	2

A Family Services Caseworker provides early intervention services to the segment of the AFDC population whose head of household is under age 20. The program's goal is to strengthen these high risk families internally while assisting them in accessing helpful and supportive services. Responsibilities associated with this position include:

- o assessment;
- o monitoring and evaluation;
- o caseplanning and coordination;
- o crisis intervention; and
- o counseling.

TOTAL	251.10	39.75

The Bureau of Social Services also has five paralegals and 19 case aides statewide to work in child welfare services as well as 21 Community Care workers (with 3 1/2 Community Care Supervisors) who license, recruit, train, and conduct home studies for foster parents. (See Appendix 5 for flow charts describing the CPS and Substitute Care investigatory process)

STATUTORY	1.	Include "emotional injury or impairment" in the definition of **abuse or neglect** to indicate that emotional injury or impairment is a serious threat to a child's health or welfare.

The American Association for Protecting Children reports that in 1983, 10.1% of the children for whom data was available suffered emotional maltreatment and that this figure rose to 11.2% in 1984.

The complete distribution of maltreatments of these two groups of children is as follows:

TYPE OF MALTREATMENT	FOR 397,785 CHILDREN IN 1983 (%)	FOR 255,312 CHILDREN IN 1984 (%)
Major Physical Injury	3.2	3.3
Other Physical Injury	23.7	21.3
Sexual Maltreatment	8.5	13.3
Deprivation of Necessities	58.4	54.6
Emotional Maltreatment	**10.1**	**11.2**
Other	8.3	9.6

An examination of data available in Maine show that, out of 1,211 males and 2,542 females reported to DHS in the fall of 1984 as suffering some type of abuse and neglect, 15.4% of the boys and 6.4% of the girls had suffered emotional abuse or neglect. The figures are as follows:

ME.CHILDREN REPORTED TO HAVE SUFFERED EMOTIONAL ABUSE OR NEGLECT
September through November 1984

	No. of Boys	No. of Girls	TOTAL
0-4 years	45	37	82
5-8 years	61	34	95
9-12 years	40	26	66
13-15 years	25	37	62
16-17 years	15	28	43
Totals	186	162	348

SOURCE: Department of Human Services. 1984.

Maine's Child & Family Services and Child Protection Act (Title 22, Ch. 1071) currently defines child abuse and neglect as "a threat to a child's health or welfare by physical or mental injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these, by a person responsible for the child."

The Committee finds a subtle and important difference in the connotation of "mental" vs. "emotional" injury. "Mental" connotes injury or impairment suffered by the child's mind, intellect, mental powers, or cognitive ability. "Emotional" maltreatment includes a persistent lack of concern by the caretaker for the child's welfare and such behavior on the part of the child's caretaker as blaming, belittling, rejecting, or constantly treating siblings unequally.

The Committee has reviewed many cases in which emotional abuse and neglect has clearly had a detrimental impact on the child. Therefore, the Committee recommends that emotional injury or impairment be included in the definition of abuse or neglect to indicate that this type of injury is a serious threat to a child's health or welfare and should be recognized as such by the law.

STATUTORY	2.	Include "emotional injury or impairment" in the definition of **serious harm** and augment the list of disorders which indicate when emotional injury is evident. Furthermore, clarify that the court may consider emotional injury which is currently evident or which is likely to be evident in the future.

Since the court must first find a child to be in legal "jeopardy" before it can order a course of protection for the child, the Committee closely examined the definition of jeopardy found in Title 22, §4002, sub§ 6. (See Appendix 6 for a description of the petitions and court hearings that occur when a child is found to be in "jeopardy") The current definition states that jeopardy means "serious abuse or neglect, as evidenced by:

A. serious harm or threat of serious harm;

B. deprivation of adequate food, clothing, shelter, supervision or care, including health care when that deprivation causes a threat of serious harm;

C. abandonment of the child or absence of any person responsible for the child, which creates a threat of serious harm; or

D. the end of voluntary placement, when the imminent return of the child to his or her custodian causes a threat of serious harm."

As the definition of jeopardy includes serious harm (see A above), the Committee turned its attention to the law's definition of "serious harm" finding that it means:

"A. serious injury;

B. serious mental injury or impairment, evidenced by severe anxiety, depression or withdrawal, untoward aggressive behavior or similar serious dysfunctional behavior; or

C. sexual abuse or exploitation." (Title 22, §4002, sub §10)

In reviewing this language in the context of actual case histories, the Committee has determined that the current definition of serious harm is inadequate in its reference to "mental injury or impairment". The Committee finds that:

- the phrase "mental injury or impairment" accounts only for the cognitive abilities of a child and excludes injury or impairment that would more accurately be considered "emotional";

- the phrase "evidenced by" implies "at the present time" and hampers the court in considering mental or emotional injury that a child may experience in the future.

As one example, the Committee reviewed a case history in which a child had been removed from his parent's home and placed in foster care at a young age. At a subsequent judicial review to determine the final disposition of the child, the child did not exhibit serious mental or emotional injury or impairment. Despite substantial testimony that the child would likely experience mental or emotional harm if returned to his parents, the court ordered the child returned to his parents. This order was in part due to the court's inability to consider the future harm that is likely to befall the child due to a particular placement.

The Committee also finds that the law does not provide a full array of legal circumstances by which the court may assess serious mental injury or impairment.

Accordingly, the Committee recommends including "emotional injury or impairment" in the definition of serious harm and augmenting the list of disorders which indicate when emotional injury is evident. Furthermore, clarify that the court may consider emotional injury which is currently evident or which is likely to be evident in the future.

STATUTORY	3.	Retain family rehabilitation and reunification as a priority for protecting the welfare of children but clarify that in certain circumstances rehabilitation and reunification is not possible and should not be undertaken.

When the court determines that a child is in legal jeopardy, the court may order that the child be removed from the custodian and placed in the custody of the department (Title 22, §§4035 & 4036).

In this event, the law requires the department to work with the parents in developing a plan to rehabilitate and reunify the family. (See Appendix 6 for a description of the petitions and court hearings that occur when a child is found to be in "jeopardy") The responsibility for carrying out the plan is shared equally by the Department and the parents. The Department develops a rehabilitation and reunification plan which details the changes that must occur within the family and arranges services to assist the parents in making these changes. The parents are responsible for making the changes specified in the plan so that the child may be returned safely home.

The Committee clearly agrees with the Legislature's original intent that family rehabilitation and reunification be given priority as a means of protecting the welfare of children.

However, the Committee is aware of a number of cases where rehabilitation and reunification of a dysfunctional family was neither in the best interests of the child nor the best interests of society.

As so clearly demonstrated by these actual cases, the Committee finds that the dysfunction in some families is so pervasive that:

- the family cannot and will not be able to provide a secure, stable, nurturing, safe home for the child;
- efforts needed to transform the family will be massive and unsuccessful; and
- the child will not profit by long and rigorous efforts to reunify the family.

Accordingly, the Committee recommends that the legislative intent of the Child & Family Services and Child Protection Act be amended to retain family rehabilitation and reunification as a priority for protecting the welfare of children but clarify that in certain circumstances rehabilitation and reunification is not possible and should not be undertaken.

STATUTORY	4.	Authorize the court to declare that in certain cases the Department has no further responsibility to conduct rehabilitation and reunification efforts and that the Department shall develop permanent plans for such children in their custody .

After the court determines that a child is in circumstances of jeopardy to his or her health and welfare, the court chooses a custodial disposition or arrangement for the child from nine alternatives. These nine alternatives include not changing the custodial arrangement, arranging for Departmental supervision of the child and family in the child's home, and removing the child from his or her custodian and the circumstances causing the jeopardy.

When the court orders the child into the custody of the department, the law now requires the department and the parent(s) to undertake appropriate rehabilitation and reunification efforts in every case.

However, the Committee is aware that in some circumstances family rehabilitation and reunification efforts do not serve a useful purpose. In these cases, the Committee finds that rehabilitation efforts create additional and unwarranted burdens on departmental resources and do not serve the best interest of the child.

Currently, when the court considers families in this category, it does not have the option of relieving the Department of any further responsibility to rehabilitate and reunify the family and to move forward in a timely fashion to make other types of permanent plans for a child in its custody.

To ensure that the court can base its decisions on the best interest of the child in every case, the Committee recommends that the court be authorized to declare that in certain cases the Department has no further responsibility to conduct rehabilitation and reunification efforts and that the Department shall develop permanent plans for such children who are in their custody.

STATUTORY	5.	Provide that the court may not order physical placement of a child with a parent when the Department retains custody.

In arranging the future disposition of a child who has been found to be in jeopardy, the court may order any one of nine alternatives.

Generally, the intent behind choosing an alternative is to meet the best interest of the child and family and enable the Department to marshall its resources to bring about needed change and improvement in family functioning.

On a few occasions, the court has ordered custody of the child to the Department, yet has physically placed the child with the parents. The Committee finds that this type of arrangement creates serious difficulties and confusion for both the custodial Department and the sheltering parents in regard to parenting the child. The Department has difficulty providing resources and adequate custodial supervision to the child, and the parents are unsure about the extent of their responsibilities and obligations toward the child living under their roof but not in their custody.

Therefore, in order to continue to meet the best interests of the child and family and enable the Department to focus its resources to bring about needed change and improvement in family functioning, the Committee recommends that the court may not order physical placement of a child with a parent when the Department retains custody.

STATUTORY	6.	Recommend that biennial judicial reviews will not be required if a child is ordered into the custody of a person who is neither the parent nor the Department, unless any party specifically requests that a review be done.

Federal and state law require the court to review the placement of children who are in some type of substitute care every two years. The statutory purpose of these judicial reviews is for the court to determine whether custody must now be granted to a parent if appropriate conditions are met, whether the disposition continues to be in the best interests of the child, and, if the child is in the department's custody, whether departmental custody should be terminated. These periodic judicial reviews continue until the child's 18th birthday unless the child is adopted, emancipated, or the case is closed because jeopardy no longer exists.

The Committee finds that these judicial reviews continue to be essential when the child is placed either in the department's custody or the custody of a parent. However, the Committee further finds that these reviews are not automatically necessary in cases where the court has placed the child with someone else such as a relative, friend, or other suitably reliable and responsible person. The Committee finds that these placements frequently serve the child well; the child is safe, nurtured, and happy with the placement, the custodial family is able and willing to meet the child's physical and emotional needs, and the biological parents are often able to live nearby and engage in a relationship with the child and custodians which all find mutually satisfactory.

The Committee finds that mandating an automatic judicial review in these cases can be counter-productive for the following reasons:

- First, stable families in whose custody a child has been placed are capable of raising the child without periodic intervention by the Department, and in fact may well resent unnecessary routine intervention. The Committee finds that it is desirable to allow capable custodial parents to raise children without forced involvement with the Department;

- Second, preparing for biennial judicial reviews requires departmental resources to keep track of the custodial parents, the biological parents, the child, and any other relevant parties. The Committee finds that allowing the Department to attend to clients who are in real need of their services is a better use of its limited resources; and

- Third, due to the intent of the biennial judicial review, a child currently placed in the custody of a capable friend or relative is constantly disrupted with the possibility of return to the biological parents regardless of the feasibility of reunification, length of the child's placement with the new custodians, or how well the custodial arrangement is working.

For these reasons, the Committee recommends that biennial judicial reviews not be required if a child is ordered into the custody of a person who is neither the parent nor the Department, unless any party specifically requests that a review be done.

STATUTORY	7.	Authorize the child's guardian ad litem to move for judicial review.

Section 4005 of Title 22 requires that the court appoint a guardian ad litem for children involved in most types of civil proceedings. The guardians ad litem appointed at this time are generally lawyers who are willing to act in "pursuit of the best interests of the child" through all phases of the court process (Title 22, §4005). (The Latin phrase, "ad litem" indicates that the guardian is appointed to the client "for the purposes of the suit".) To carry out their role in the court process, the guardians have access to all reports and reviews relevant to a case and the right to interview all persons involved in caring for or treating the child. They may also subpoena, examine, and cross-examine witnesses and make recommendations to the court.

In reviewing the manner in which children are treated by the court system, the Committee finds that the role of the guardian ad litem is important in ensuring humane and adequate representation of the child. However, the Committee finds that the guardian ad litem's ability to successfully carry out his or her role may be impaired by the lack of one important authorization; that is, the right to move for judicial review of the child for whom he or she serves as guardian.

Currently, the law provides authority to move for judicial review to the court, the child's parent or custodian, or a party to the proceeding (except a parent whose rights have been terminated) (22MRSA.§4038). This provision ensures that the court can be petitioned at any time, in addition to the regularly scheduled judicial reviews, to examine a child's placement and determine if changes need to occur. The Committee finds that adding the guardian ad litem to those who are authorized to move for judicial review would provide the guardian with a full complement of tools with which to protect the best interests of the child.

Therefore, the Committee recommends that the child's guardian ad litem be authorized to move for judicial review.

STATUTORY	8.	Broaden the scope of evidence that the court must consider during a judicial hearing regarding the future of an abused child to ensure that the most accurate and relevant information is used as the basis for the court's decision.

When the court places a child in care designed to substitute for the biological parents, it must review the placement at least once within 18 months and at least every two years thereafter, unless the child has been emancipated or adopted.

At these periodic judicial hearings, the judge reviews the placement and determines whether a change is needed by applying the following dispositional principals in sequence. The court must:

> First, determine that the placement protects the child from jeopardy;
>
> Second, give custody to a parent if appropriate conditions can be applied;
>
> Third, determine that the placement is in the best interests of the child; and
>
> Fourth, terminate department custody at the earliest possible time.

The Committee has reviewed the procedures and outcomes of a number of judicial hearings and finds that a hearing is an important event in the life of a child; it is the time in which the court must consider questions relative to the child's safety, best interests, and custodial disposition.

Furthermore, the Committee finds that the court must consider all information that could help to illuminate the best interests of the child to ensure that the court is able to make the best and most informed decision regarding these issues. In particular, the Committee's review highlights that the court must broaden the scope of evidence it considers regarding:

- the child's present disposition;
- the reason the child was originally found to be in jeopardy and placed in a substitute care arrangement;
- relevant events that have occurred since the original finding of jeopardy and placement of the child; and
- the efforts made by the parents and the department to successfully execute the rehabilitation and reunification plan.

In making this recommendation, the Committee intends the court to consider the present circumstances of the child and the parent(s) as well as past behavior in order to determine patterns of behavior or events that have a bearing on the custodial question for the child.

Therefore, the Committee recommends broadening the scope of evidence that the court must consider during a judicial hearing regarding the future of an abused child to ensure that the most accurate and relevant information is used as the basis for the court's decision.

STATUTORY	9.	Require the court to make one of three determinations within 18 months for children entering foster care to eliminate unnecessary lingering of these children in the foster care system.

When the court has found a child to be in jeopardy and has made a dispositional order, federal and state law require that the case be reviewed at least once within 18 months of the order. The purpose of the review is to consider the child's ongoing safety, best interests, and custodial disposition. If the child is neither adopted nor emancipated and remains in the department's custody, the court is required to continue to review the child's case every two years.

The Committee finds that this current system of judicial review can contribute to what is known as "foster care drift"; that is, children drifting along in substitute care without receiving permanency, resolution, and stability in their living situation.

For example, data shown in the table below indicate that, even though the largest group (275) experienced only one placement during their time in substitute care, a cumulative total of 627 children experienced four or more placements during their time in substitute care. Sixty-eight children experienced 16 or more placements. The Committee finds that these figures indicate that some children in Maine's foster care system are not receiving permanency and instead are experiencing "foster care drift".

SUBSTITUTE CARE REPORT
LENGTH OF TIME IN CARE BY NUMBER OF PLACEMENTS[1]
(Excludes Sub Care Clients 18 Years or Older)
April, 1985

Length of Time in Care	Total Children	Not Reported	NUMBER OF PLACEMENTS 1	2	3	4	5	6-10	11-15	16-20	21-2	Over 25
Less than 1 Year	283	36	86	57	31	24	18	25	4	1	1	0
One to Two Years	431	83	59	75	54	35	25	70	16	11	1	2
Two to Three Years	230	56	26	25	29	17	15	39	12	7	3	1
Three to Five Years	242	63	20	18	21	32	24	34	19	6	1	4
Five Years or More	487	143	84	50	30	24	24	71	31	19	6	5
TOTAL	1,673	381	275	225	165	132	106	239	82	44	12	12

627 children — 68 children

[1]A placement is:

a) Any change of a child's residence which is intended to last more than 7 days, except

(1) A move with foster parents
(2) A move to the residence of parent(s)
(3) A hospitalization, camp stay, or visit, unless it is extended in the absence of another placement
(4) A placement which follows less than 8 days of whereabouts unknown (less than 15 days if the child returns to the group home or residential treatment center from which he left)

b) Whereabouts unknown when return to the foster home from which the child ran is not possible.

Source: Department of Human Services

The Committee reaffirms the Legislature's original recognition in the statute that "uncertainty and instability are possible in extended foster home or institutional living" and that "early establishment of permanent plans for the care and custody of children who cannot be returned to their family should be promoted." (22 MRSA §4003).

As a result of the Committee's review of Maine's foster care system, the Committee finds that some children spend longer time in foster care than is necessary to ensure their protection from jeopardy. Therefore, the Committee finds that the court should decide one of three courses of action for the child within 18 months of the child's entering foster care; the court must either:

- return the child to his or her parent(s); or
- continue efforts to rehabilitate and reunify the family for a specific limited time not to exceed six months and to judicially review the matter within the time specified; or
- declare that the department has no further responsibility to rehabilitate and reunify the family and move forward in a timely fashion to make permanent plans for the child.

In making this clarification, the Committee intends to reduce or eliminate the possibility of "foster care drift" for new children entering the substitute care system.

Accordingly, the Committee recommends that the court make one of three determinations within 18 months for children entering foster care to eliminate unnecessary lingering of these children in the foster care system.

STATUTORY	10.	Require that before the court may restore custody of a child to the parent who had previously lost custody to the Department, the burden of proof shall be on the parent to show that he or she can protect the child from further jeopardy.

As previously stated, the court must conduct periodic reviews of children who have been placed in substitute care. The Committee finds that these reviews are critical in assessing the future of the child and in determining the child's best interests. This is particularly true in instances where the court is considering returning the child to the parents following a period of custody with the Department.

Currently, when the court is considering restoring the custody of a child to the parent, the parent has no responsibility to demonstrate to the court that he or she has in fact carried out his or her responsibilities to rehabilitate and ensure the health and welfare of the child. The entire burden rests on the caseworker and guardian ad litem to demonstrate to the court that harm may befall the child if the child were to be returned; the parents do not have to positively demonstrate that no harm would befall the child if a return order were to be made. The Committee finds that this situation encourages passive participation by the parents in the court process and may contribute to the court's inadequate consideration of the efforts and attitudes of the parents to successfully rehabilitate and provide a safe, nurturing home for the child.

Accordingly, the Committee recommends that before the court may restore custody of a child to the parent who had previously lost custody to the Department, the burden of proof shall be shifted to the parent(s) to make three showings:

- First, that he or she has carried out the assigned responsibilities set forth in the rehabilitation and reunification plan;

- Second, that he or she has rectified or resolved the problems which caused the removal of the child as well as any subsequent problems which would interfere with his or her ability to care for and protect the child; and

- Third, that he or she can protect the child from jeopardy.

In making this recommendation, the Committee intends to strengthen the court's assurance that a child will not be harmed by restoring custody to his or her parents.

STATUTORY	11.	Augment the Department's current authority to discontinue rehabilitation efforts by authorizing the Department to not begin rehabilitation efforts under specified circumstances. Furthermore, authorize the court to order that reunification efforts need not begin or may be discontinued under these circumstances.

In recommendation #4 of this report, the Committee recommends that the court be authorized to declare that in certain cases the Department has no further responsibility to conduct rehabilitation and reunification efforts and that the Department shall develop permanent plans for such children in their custody.

Currently, section 4041 of Title 22 authorizes the department to decide to discontinue rehabilitation/reunification efforts that are already underway. This departmental decision is subject to judicial review and can be made by the department only under specific circumstances as follows:

1. the parent is willing to consent to termination of his or her parental rights;

2. the parent cannot be located; or

3. the parent is unwilling or unable to rehabilitate and reunify with the child.

If the Department discontinues efforts to return the child to a parent, the law requires the department to give written notice of this decision to the parent. This notice must include the specific reasons for the Department's decision, the efforts the Department has made to work with the parent and child, and a statement of the parent's rights to request a judicial review of the Department's decision.

The Committee finds that the current "discontinuation" language in this section presupposes that the Department has already been carrying on rehabilitation and reunification efforts. This presupposition unacceptably restricts the Department in its efforts to act within the best interest of the child.

In cases where reunification is not in the child's best interests, the Department does not have the option of not undertaking reunification; by law, it must always begin good faith reunification efforts. As a consequence, the Committee finds that in a number of actual cases, the Department has been obligated by law to proceed with rehabilitation/reunification efforts that are unnecessary, unwarranted, and that clearly do not serve the best interests of the child. The Department may discontinue these efforts only after a statutorily imposed three-month time period has passed.

Furthermore, to parallel the Department's authority, the Committee has determined that the courts should also be enabled to order that rehabilitation and reunification efforts need not begin or may be discontinued with either parent.

In making this recommendation, the Committee intends to strengthen the state's ability to respond in the best interest of the child and enable the Department to more effectively apply its limited resources.

To parallel the intent stated in recommendation 4, here too the Committee recommends that the Department's current authority to discontinue rehabilitation efforts be augmented by authorizing the Department to not begin rehabilitation efforts under specified circumstances. Furthermore, authorize the court to order that reunification efforts need not begin or may be discontinued under these circumstances .

STATUTORY	12.	Add two circumstances upon which the Department or court may base a decision to not begin or to discontinue reunification efforts.

As previously noted, the Department now has the authority, subject to judicial review, to discontinue reunification efforts with either parent under any of the following circumstances:

1. the parent is willing to consent to termination of his or her parental rights;

2. the parent cannot be located; or

3. the parent is unwilling or unable to rehabilitate and reunify with the child.

The Committee has made a related recommendation (#11) to authorize the Department to not only discontinue reunification efforts under these circumstances, but to decide not to begin reunification efforts based upon these circumstances.

The Committee has carefully reviewed a number of actual case histories in which the parent(s) have committed acts against the child, or failed to protect the child, in ways in which the Committee and society consider to be heinous and abhorrent. These acts, or, in some cases, failures to act, involve murder, aggravated assault, rape, gross sexual misconduct, sexual abuse of minors, and incest - all directed against a child(ren) for whom the parent is responsible.

Even in these cases, the law now requires the Department to develop a reunification plan for the child-victim or his or her siblings and implement the plan to the best of its ability. As documented by these actual case histories, the Committee finds that the department should have the authority to not begin reunification efforts when the parent commits, or fails to protect against, heinous or abhorrent acts directed against a child for whom the parent is responsible. Accordingly, the Committee recommends that the following two circumstances be added to those for which the Department may decide not to begin or to discontinue reunification efforts with either parent:

1. The parent has acted toward a child in a manner which is heinous or abhorrent to society or has failed to protect a child in a manner which is heinous or abhorrent to society, without regard to the intent of the parent; or

2. If the victim of the following crimes was a child for whom the parent was responsible, or the victim was a child who was a member of a household lived in or frequented by the parent and the parent has been convicted of:

   (a) murder;
   (b) felony murder;
   (c) manslaughter;
   (d) aiding or soliciting suicide;
   (e) aggravated assault;
   (f) rape;
   (g) gross sexual misconduct;
   (h) sexual abuse of minors;
   (i) incest;
   (j) kidnapping;
   (k) promotion of prostitution; or
   (l) a comparable crime in another jurisdiction.

In adding the first circumstance, the Committee intends the court to determine the specific circumstances which constitute a heinous or abhorrent parental act or failure to act.

The Committee intends the court to use its best judgement in making this determination according to generally accepted standards in this culture; particularly in regard to the performance, behavior, and responsibility of parents toward their children. The Committee does not intend the court to base its judgment in any way on the intent of the parent. The Committee finds that a parental action or failure to act can be considered heinous or abhorrent without any conscious or unconscious malevolent, evil, wicked, or abominable intention on the part of the parent(s).

STATUTORY	13.	Establish two additional circumstances upon which the court may make a rebuttable presumption to terminate parental rights.

Section 4055 in Title 22 authorizes the court to order termination of parental rights if:

1. The parent consents to the termination, or

2. The court finds, based on clear and convincing evidence, that:

   (A) termination is in the best interests of the child; **AND**

   (B) At least one of the following is true:

      (i) The parent is unwilling or unable to protect the child from jeopardy or take responsibility for the child;

      (ii) The child has been abandoned; or

      (iii) The parent has failed to make a good faith effort to rehabilitate and reunify with the child.

The issue of terminating parental rights brings with it consideration of a number of important Constitutional questions.

The pivotal Constitutional question was raised by the U.S. Supreme Court in Santosky v. Kramer, decided March 24, 1982. In this decision, the Law Court said that, "We have little doubt that the Due Process Clause would be offended '(i)f a state were to attempt to force the breakup of a natural family, over the objections of the parents and their children, without some **showing of unfitness** and for the sole reason that to do so was thought to be in the children's best interest.'" (Santosky v. Kramer, 1982, 102 Supreme Court Reporter, 455 U.S. 745, 71 L. Ed. 2d 599, pg. 1398)

In making this statement, the Law Court has proclaimed that the state must show parental unfitness as the basis for a petition to terminate parental rights. Thus, the Court has provided guidance to the states regarding how to draft statutes that will withstand Constitutional challenge.

Maine's statute rests on a finding of legal "jeopardy" which clearly indicates a form of parental unfitness, upon which termination can be based.

The Committee recommends that the following two circumstances be included as grounds upon which a court may determine a child to be in jeopardy due to parental unfitness, thereby allowing the court to make a rebuttable presumption to terminate parental rights:

1. The parent has acted toward a child in a manner which is heinous or abhorrent to society or has failed to protect a child in a manner which is heinous or abhorrent to society, without regard to the intent of the parent; or

2. If the victim of the following crimes was a child for whom the parent was responsible, or the victim was a child who was a member of a household lived in or frequented by the parent and the parent has been convicted of:

   (a) murder;
   (b) felony murder;
   (c) manslaughter;
   (d) aiding or soliciting suicide;
   (e) aggravated assault;
   (f) rape;
   (g) gross sexual misconduct;
   (h) sexual abuse of minors;
   (i) incest;
   (j) kidnapping;
   (k) promotion of prostitution; or
   (l) a comparable crime in another jurisdiction.

By recommending that these circumstances be established as additional grounds which may lead to termination of parental rights, the Committee is indicating that it intends the Court to consider the occurrence of either one as adequate evidence of parental unfitness, thereby meeting the criteria for a Constitutional finding of unfitness.

To reinforce this intent, the Committee has prefaced these two circumstances with a **presumption** which indicates the Committee's determination that if "A" is true (one of the two circumstances), then the Court may presume that "B" is also true (parental unfitness leading to termination).

To further clarify legislative intent, the Committee has made the presumption rebuttable, to indicate to the Court that it may presume "B" to be true if "A" is true, but that, if the Court is convinced otherwise by evidence presented to it, that the Court need not necessarily presume that "B" is true; the evidence presented could effectively rebut the presumption.

In making this recommendation, the Committee intends the "rebuttable presumption" concept to accomplish two objectives. First, it will allow the court to link a single act (i.e one of the two recommended circumstances) to a finding of parental unfitness, thereby establishing a constitutional base for granting a petition for termination of parental rights. Second, however, the rebuttable nature of the presumption allows the court latitude to not terminate parental rights, even if one of the two circumstances is proven, due to evidence that may be presented. In this way, the recommendation will strengthen the court's ability to protect the best interest of the child.

STATUTORY	14.	Add state fire inspectors, municipal code enforcement officials, and municipal fire inspectors to the list of those mandated to report child abuse or neglect.

Section 4011 of the Child & Family Services and Child Protection Act requires people in 24 professional categories to report cases of child abuse or neglect or suspected abuse and neglect to the Department of Human Services while acting in their professional capacity.

These professional categories include: medical or osteopathic physician, resident, intern, emergency medical technician, medical examiner, physician's assistant, dentist, dental hygienist, dental assistant, chiropractor, podiatrist, registered or licensed practical nurse, Christian Science practitioner, teacher, guidance counselor, school official, social worker, homemaker, home health aide, medical or social service worker, psychologist, child care personnel, mental health professional or law enforcement official.

In calendar year 1984, the Department opened new cases from referrals received from the following sources:

SOURCE	NUMBER	% OF TOTAL
School Personnel *	824	15
Social Service Personnel *	687	13
Neighbor/Friend	656	12
Medical Personnel *	608	11
Relative	561	10
Law Enforcement *	556	10
Self/Family	542	10
Other	326	06
Mental Health Personnel *	294	06
Anonymous	277	05
Child Care Personnel *	90	02
Statewide Total	5,421	100

* = Mandated Reporter

An analysis of these figures shows that 3,059 or 56% of the referrals were from those mandated to report and 2,362 or 44% were from non-mandated reporters. Based on these results, mandated reporters are an important source of information to the Department regarding child abuse and neglect.

The Committee finds that state fire inspectors, municipal code enforcement officials, and municipal fire inspectors represent potentially valuable reporting sources since these professionals have regular opportunities to observe child abuse and neglect or suspected child abuse and neglect during the course of normal duties. For example:

- State Fire Inspectors inspect all licensed child care facilities at least once per year by law. Furthermore, the State Fire Marshall has occasion to visit buildings and premises within his/her jurisdiction to prevent fires, suppress arson, handle explosives, install and maintain fire alarms and escapes, and ensure proper egress.

- The Code Enforcement Officer is responsible for inspecting each building during the process of construction or repair within his or her jurisdiction.

- The Municipal Fire Inspector carries out many of the same duties required of state fire inspectors.

Accordingly, the Committee recommends adding state fire inspectors, municipal code enforcement officials, and municipal fire inspectors to the list of those officials mandated to report child abuse or neglect to the Department of Human Services to ensure that the Department has another significant source of information regarding these occurances.

STATUTORY	15.	Clarify that current limitations regarding disclosure to the courts of certain departmental information applies equally to both records and reports.

Current Maine law specifies that all department records which contain personally identifying information regarding the Department's child protective or substitute care activities are confidential. Within the Department, these records are only available for use by authorized departmental personnel and legal counsel.

In all other circumstances, the law specifies when the Department may choose to disclose confidential information and when it must disclose confidential information.

Title 22 §4008 indicates that the Department has the **option** of disclosing relevant information in its records to:

- An agency investigating a report of child abuse or neglect under certain circumstances;

- A physician treating a child whom he or she reasonably suspects may be abused or neglected;

- A child named in a record who is reported to be abused or neglected;

- A person having the legal responsibility or authorization to educate, care for, evaluate, treat or supervise a child, parent or custodian who is the subject of a record;

- Any person engaged in bona fide research, provided that no personally identifying information is made available; and

- Any agency involved in approving homes for the placement of children.

The Department **must** disclose relevant information in the records to:

- The child's guardian ad litem;

- A court under certain circumstances;

- A grand jury;

- A state executive or legislative official with responsibility for child protection services;

- The Protection and Advocacy Agency for the Developmentally Disabled in Maine; and

- The Commissioner of Educational and Cultural Services, under certain circumstances.

The Committee notes a subtle but important oversight regarding the Department's mandatory disclosure of information to the court as listed above. The full text of the law reveals an inconsistency in the limitations it imposes on reports vs. records; the law now imposes some access limitations to reports, while others apply to records.

The Committee finds that these limitations are important to ensure that confidential information provided to the court is not shared with individuals not intended by the Legislature. However, the Committee is concerned that the limitation applies only to reports in one case, and records in others. Rather, the Committee finds that these access limitations should clearly be imposed equally on both Departmental records and reports.

Accordingly, the Committee recommends that current limitations regarding disclosure to the courts of certain departmental information apply equally to both records and reports.

ADMINISTRATIVE	16.	Require the Department to retain unsubstantiated child protective services case records for no more than 18 months and then expunge these records from all departmental files or archives unless a new referral has been received within the retention period.

The Department's current policy on records retention directs that unsubstantiated child protective services records be microfiched after two years unless a new referral is received; the policy is silent on the actual destruction or expungement of unsubstantiated records. "Unsubstantiated" cases are those for which a Departmental case study could find no evidence of abuse or neglect to substantiate the original referral.

Although Maine's law currently does not specify time frames for destruction of unsubstantiated child protective services case records, other New England statutes contain language regarding retention and destruction of unsubstantiated case records as follows:

STATE	TIME FRAME FOR CPS RECORDS RETENTION
MASSACHUSETTS	Retain for 1 year then expunge
NEW HAMPSHIRE	Retain for a minimum of 3 years
VERMONT	Files expunged from computer and paper record shredded within 60 days of unsubstantiated finding. Keep an unsubstantiated case open only if family voluntarily receives DHS services of some kind.
CONNECTICUT	If referral invalid: • Computer expunges its records immediately; and • Paper record maintained for 1 year in one of the 13 regional offices, then sent to Central Information Office.

	When Central Information Office receives the records from the Regions, it: • microfilms all records, whether founded or unfounded, and retains the microfim indefinitely; and • retains the paper records for 3 additional years at which time the paper is shredded.
RHODE ISLAND	Retained for 3 years and if no further referral, then expunged.

DHS data indicate that the number of unsubstantiated child protective services case records in Maine varies with time. For instance, for the 1984 fall quarter, the Department documented 695 unsubstantiated cases out of 2542, or 27%. For a three month period in 1985, the Department documented 526 unsubstantiated cases out of 1608, (32.7%) with 186 referrals (11.6%) listed as "potential abuse or neglect" for the same period.

The Committee has spent considerable time reviewing actual cases and has received in-depth testimony from a number of individuals who were themselves subjects of child protective services investigations that were later unsubstantiated. As a result of these discussions, the Committee finds that retaining unsubstantiated child protective case records for 18 months is reasonable and provides the Department with an adequate time period in which to reference the record if needed. However, the Committee finds that the department's current practice of retaining unsubstantiated child protective services case records for an indeterminate time period is unwarranted. The Committee concludes that for individuals who are the subjects of an unsubstantiated case study, indeterminate retention of these records provides no useful public benefit and may:

1. cast a pall over the subjects' reputation;

2. constitute unreasonable state oversight;

3. create unnecessary anxiety and concern; and

4. result in victimization.

Therefore, the Committee recommends that the Department retain unsubstantiated child protective services case records for no more than 18 months and then expunge these records from all departmental files or archives unless a new referral has been received within the retention period.

STATUTORY	17.	Establish the present position of Institutional Abuse Program Specialist as a full-time position.

Currently, the Department coordinates the investigation of institutional abuse referrals with one part-time Institutional Abuse Program Specialist located in Augusta. The investigations of abuse in institutions are actually conducted by caseworkers and supervisors in the relevant Region with the Augusta part-time position providing central coordination of these efforts since April 1984. Duties of the Coordinator include:

- logging all institutional cases and compiling statistics;
- consulting with caseworkers in the field;
- reviewing and editing all reports prepared by caseworkers on institutional abuse and soliciting more information or clarification if needed;
- coordinating with the Licensing Division if the institution is licensed by DHS;
- informing the Department of Educational and Cultural Services in the case of an educational institution;
- dealing with parents; and
- reviewing policies and procedures.

The Protective Services Unit in the Division of Child and Family Services within the Bureau of Social Services received 175 referrals statewide in calendar year 1985 alleging abuse and neglect of children in various types of institutions, up from 72 referrals in 1984.

In response to the increasing amount of time needed to repond to institutional abuse referrals, the Department has paid the Institutional Abuse Program Specialist as a full-time position since March 1985, using salary savings, a funding source that is variable and cannot be guaranteed. In addition, under this arrangement, the Program Specialist continues to be ineligible for full-time benefits.

The Committee finds that institutional abuse referrals are increasing in frequency and severity, necessitating a vigorous and coordinated reponse on the part of the Department. As a first step in improving the management of institutional abuse cases, the Committee supports the establishment of the Institutional Abuse Program Specialist as a full-time position. According to Department of Personnel salary schedules, the Instutitutional Abuse Program Specialist is compensated at Range 22 at a full-time salary ranging from $18,075.20 to $24,648. The department estimates that the cost of increasing this position to full-time status will require funds totalling $14,771 as follows:

$11,773	Balance of salary
2,002	Retirement
944	Medical Insurance
28	Life Insurance
24	Dental Insurance
$14,771	TOTAL

Furthermore, the Committee finds that federal funds are currently available for this purpose and that increasing the position to full-time status will require no increase in General Fund expenditures.

Therefore, the Committee recommends establishing the present position of Institutional Abuse Program Specialist as a full-time position.

ADMINISTRATIVE	18.	Recommend that the Department use the same staff personnel to interact with parents whose children are involved in an institutional abuse investigation to provide more consistent contact with these parents.

Many institutions in Maine provide some type of parenting guidance to children each day. Institutions which are licensed by the Department of Human Services as providing some type of child care services include family foster homes, relative foster homes, child placing agencies, specialized childrens' homes, day care homes, day care centers, nursery schools, home babysitting service providers, group homes, emergency shelters, and residential treatment centers. Other types of institutions which often work with children but which are not licensed as child care facilities by the Department of Human Services include mental health residential care facilities, the Bath Children's Home, substance abuse treatment centers, public and private day or residential schools, correctional facilities, hospitals, skilled nursing facilities, intermediate care facilities, and residential or day organized children's camps.

The Department of Human Services received 72 referrals in 1984 and 175 referrals in 1985 alleging sexual, physical, or emotional abuse or neglect in institutions.

The Department's policy on handling suspected child abuse and neglect in a facility or institution is to work cooperatively with facilities "to enhance their abilities to provide safe care for children" (pg. 2 DHS Policy. Suspected Child Abuse/Neglect in a Facility/Institution. 8/27/85).

The policy makes clear that screening and assessment of institutional abuse referrals are done by caseworkers and the supervisor in the Regions. The Regions are expected to promptly notify the Institutional Abuse Program Specialist in the Central Office who will provide coordination and other assistance as time and the complexity of the investigation dictates.

The Committee finds that conducting an institutional abuse investigation demands a substantial amount of the caseworker's and supervisor's time. A single referral requires dealing with large numbers of people including the alleged victim(s), other children, their parents and caretakers, institutional staff and Board members, law enforcement personnel, medical personnel, mental health professionals, attorneys, guardians ad litem and and any other people involved. A recent referral involving a children's organized camp required interviewing 233 children and their 466 parents, all handled by caseworkers within the Region who also carry regular caseloads.

The Committee has received considerable testimony regarding problems and issues relevant to the present system of handling institutional abuse investigations. One of the identified problems is the complicated DHS communication network into which parents and children are thrust when they are involved in an institutional abuse investigation. Comments received from parents who have been involved in an institutional abuse investigation indicate that:

- for one investigation, three sets of parents were each assigned three different caseworkers during the course of the investigation with little communication or orientation occurring between the outgoing and incoming caseworker;

- parents did not receive information regarding the status of the investigation on a regular basis;

- children were not adequately informed about the status of their participation in the case; and

- lines of communication and authority were unclear and difficult for parents to understand and access.

The Committee finds that these problems indicate:

- a need for the Department of Human Services to establish more effective communication mechanisms with parents;

- that the caseworker serves as the primary link between parents and the Department; and

- communication with parents is hampered by turnover and reassignment of department staff.

The Committee recognizes that some degree of routine turnover of staff is to be expected during institutional abuse investigations, especially if these investigations continue over a relatively long period of time. However, the Committee finds that communication with parents would be enhanced by providing parents with consistent contact with the same department personnel.

Therefore, the Committee recommends that the Department use the same staff personnel in interaction with parents whose children are involved in an institutional abuse investigation to provide more consistent contact with these parents.

ADMINISTRATIVE	19.	Direct the Department of Human Services to inform referents at least once about the status of their referrals.

As noted earlier, the Department of Human Services receives reports, or referrals, of alleged child abuse and neglect from a diverse array of individuals and the number of referrals has increased steadily over time. Professionals who deal with children or who have occasion to observe children are required by law to report child abuse and neglect or suspected child abuse and neglect. Others report solely out of concern for the child, in most cases.

The Committee recognizes that the first step in treating instances of child abuse and neglect currently in progress is to report these instances to the Department. Without the report, departmental resources available to intervene in the abuse and neglect cannot be mobilized.

The Committee finds that providing feedback to referents is important to motivate them to make the referral, thereby initiating the sequence of events needed to address the alleged child abuse and neglect. Unfortunately, the Committee has received considerable testimony that many referents have never received any feedback whatsoever regarding their referral from the Department, despite a Departmental policy that such feedback be given.

The Committee finds that this gap in departmental protocol serves as a strong disincentive for referents to continue to report. Although many unwanted consequences may result from the Department's failure to provide feedback, the most dire would be the department not receiving probable referrals due to unmotivated or disgruntled potential referents.

The Committee understands that the Department is in the process of developing a letter to be sent to each referent regarding the status of their referral. To support this effort and ensure that this important follow-through action is implemented, the Committee recommends that the Department of Human Services inform referents at least once about the status of their referrals.

ADMINISTRATIVE	20.	Recommend that the Chair of the Advisory Committee on Caseworker Functions not be the Director of the Bureau of Social Services since the Committee's function is to advise the Director of the Bureau of Social Services.

In 1982, the Human Services Development Institute at the University of Southern Maine was commissioned by the Department of Human Services to conduct a study of the turnover, burnout, and quality of work life for child welfare workers. The resultant HSDI "Burnout Study" identified a number of problem areas regarding inadequate communication among factions within the Department. To help implement the recommendations of the HSDI Burnout Study, the Department launched a one-year Caseworker Retention Project in 1984.

In her report, "Work Plan and Progress Report for Caseworker Retention Project" (no date given), the Project Director reported that, "workers in all regions report a perception of being ignored on issues vital to them" (pg. 12). To respond to their perception, the Department and caseworkers created the Advisory Committee on Caseworker Functions. The Advisory Committee is composed of one Adult Services Caseworker, one Child Protective Services Caseworker, and one Substitute Care Caseworker from each of the five regions plus one Family Services Caseworker for a total of 16 caseworkers. It's first meeting was held in May 1985.

Since its inception, the Advisory Committee has been chaired by the Director of the Bureau of Social Services who has served as an active and interested participant. The purpose of the Committee is to advise the Bureau Director of Social Services, and ultimately, the Commissioner on issues regarding policy, budget, program plans, and current issues as these specifically impact on caseworkers' interests. In an early formative meeting, the group discussed child protective services intake; overload in substitute care; the need for more purchased services; prevention; and relationships with law enforcement personnel, courts, the legal profession, and the education community.

The Committee finds that the Advisory Committee is important in giving caseworkers an opportunity to provide feedback directly to the Bureau Director on operations and policies. Furthermore, participation by the Bureau Director is important in achieving the primary goal of improving communications.

Nevertheless, the Committee is concerned that the important advisory function of the group may be unduly compromised by having the Bureau Director serve as Chair since the purpose of the group is to advise the Bureau Director on caseworker interests.

Accordingly, although the Committee expects the Bureau Director to maintain an active participation in the group, the Committee recommends that the chair of the Advisory Committee on Caseworker Functions not be the Director of the Bureau of Social Services since the Committee's function is to advise the Director of the Bureau of Social Services.

ADMINISTRATIVE	21.	Recommend that the Advisory Committee on Caseworker Functions review the increasing paperwork requirements for caseworkers and report to the Audit Committee with recommendations on improving paperwork efficiences by September 1986.

As mentioned in the previous recommendation, the Advisory Committee on Caseworker Functions was formally created in 1985 to serve as the vehicle by which caseworkers provide comments and feedback regarding Bureau operation and policy directly to the Bureau Director and the Commissioner.

One of the issues of concern to the Audit Committee and a primary topic of interest for the Advisory Committee on Caseworker Functions is that of "Caseworker Burnout" or overload. Although many separate elements combine to create the environment in which workers "burnout", the Committee finds that one of these elements is the "paperwork" demands on the workers, particularly on Substitute Care workers.

The quantity and complexity of paperwork required of all caseworkers, particularly substitute care, has increased tremendously since 1980. Today, many forms and paperwork are required to accomplish the following:

- open cases;
- authorize board and clothing allowances;
- start medical services;
- determine eligibility for AFDC-Foster Care and medical services;
- apply for available benefit payments, e.g., Social Security, SSI, VA;
- refer any parent upon whom a support order was placed for collection of support;
- prepare case record dictation;
- prepare petitions for termination of parental rights;
- conduct family rehabilitation work;
- prepare provision of notice and service agreements;
- develop case plans;
- conduct administrative case reviews;
- prepare for judicial reviews;
- coordinate needed services; and
- accomplish general administrative tasks.

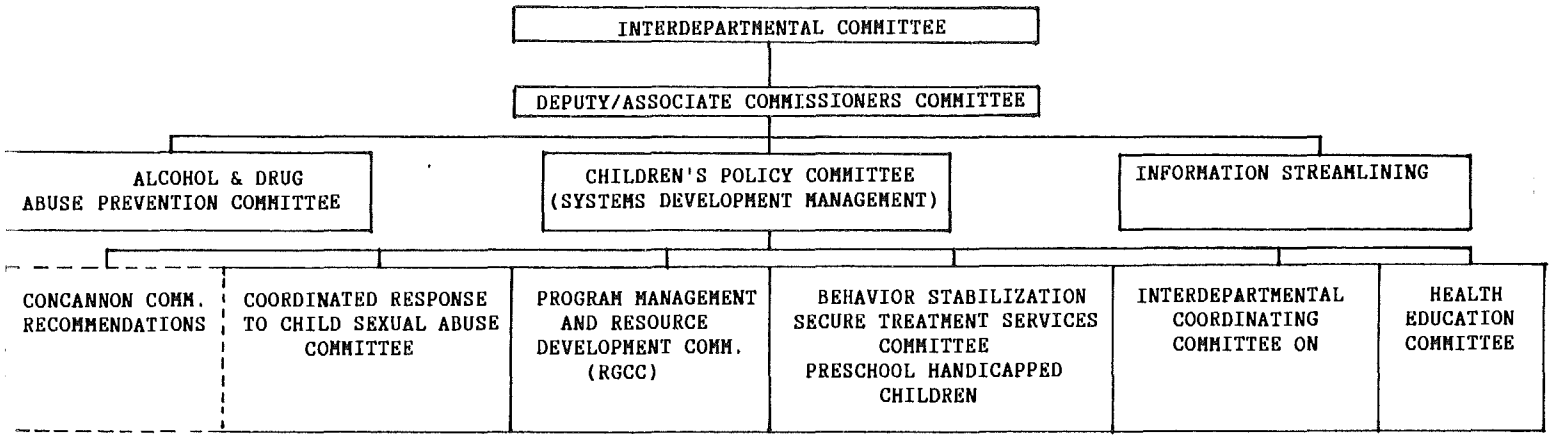
The Committee has received testimony indicating that the complexity of petitions for child protection orders has increased substantially in recent years and that much of the required paperwork is redundant and lacks legitimate purpose.

The Committee finds that an effort should be made to examine this issue and that the scope of the effort to improve paperwork efficiencies should include recommendations to eliminate redundancy, streamline forms, reduce the overall paperwork burden on caseworkers, and explore the possibility of shifting appropriate paperwork to case aides and others. The Committee finds that improvements in these areas could contribute to reducing "burnout", overload, and stress on the caseworkers.

Accordingly, the Committee recommends that the Advisory Committee on Caseworker Functions review the increasing paperwork requirements for caseworkers and report to the Audit Committee with recommendations on improving paperwork efficiences by September 1986.

FINDING	22.	The Committee finds that the Interdepartmental Coordinating Committee has made progress in integrating and coordinating its efforts to provide child welfare services and encourages the Interdepartmental Coordinating Committee to continue to explore additional methods for integrating the child welfare services offered by member state agencies.

In 1980, the Commissioners of the Departments of Human Services, Mental Health and Mental Retardation, Educational and Cultural Services, and Corrections created the Interdepartmental Coordinating Committee (IDC) to discuss, coordinate, and resolve child welfare issues relevant to all four Departments. Since that time, the IDC has developed a number of other interdepartmental committees to work on dozens of issues central to the development of a cohesive, coordinated child welfare system in Maine. The Committee structure is as follows:



The IDC represents a framework to achieve important cross-departmental communication at all staffing levels: Commissioner-to-Commissioner, Bureau Director-to-Bureau Director; Division Head-to-Division Head; and line staff-to-line staff.

The Committee finds that communication and coordination among state departments which deal with child abuse and neglect is essential, and must continue to improve.

Therefore, the Committee commends the IDC for its progress in communicating and coordinating its efforts regarding child welfare services and encourages the IDC to continue to explore additional methods for coordinating the child welfare services offered by these four state agencies.

ADMINISTRATIVE	23.	Recommend that an independent study be undertaken by the Child Welfare Advisory Committee to review and analyze referrals screened-out by the Department and report on the implications of these screen-outs to the Committee on Audit & Program Review by October 1986.

The Child Welfare Advisory Committee was established in 1982 by the Commissioner of Human Services to achieve three purposes:

(1) To advise the Department on the development of policy and programs which affect the well-being of children and their families;

(2) To communicate the activities and goals of the Department to the public; and

(3) To reinforce the Department's awareness of the public's needs and the impact of its activities on Maine's children and their families.

Members serve on the Advisory Committee at the invitation of the Commissioner and presently include 19 members, representing a broad cross-section of the child welfare community. The Advisory Committee is staffed by the half-time services of one position within the Bureau of Social Services.

The Advisory Committee generally meets monthly and makes annual recommendations on various child welfare issues to the Commissioner. In its 1984 report, the group discussed and made recommendations on adolescents, the foster care system, special needs' children, children's rights, the Garianna Quinn case, and the 1983 Prevention of Child Abuse and Neglect Report. The group has continued to focus on adolescents in its 1985 agenda.

The Audit & Program Review Committee finds that the Child Welfare Advisory Committee represents the kind of broad-based, well-informed group needed to explore an issue of interest and concern to the Committee; that of referrals "screened-out", or not accepted, by the Department.

In looking at the "screen-out" issue,, the Committee found that 49% of all referrals received by the Department in Calendar Year 1984 were "screened-out" upon their receipt by the Department and not investigated for validity. This statewide screen-out rate rose to 52% in 1985 as indicated by the following data:

DEPARTMENT OF HUMAN SERVICES
CHILD PROTECTIVE SERVICES
INTAKE-SUMMARY
1/1/85 - 11/30/85

OFFICE	NUMBER REFERRALS RECEIVED	NUMBER REFERRALS SCREENED OUT		NUMBER REFERRALS ACCEPTED		OFFICE % OF TOTAL ACCEPTED REFERRALS
Portland	1,706	44%	748	56%	958	17.0
Biddeford	1,250	46%	577	54%	673	12.0
Lewiston	2,614	68%	1,783	32%	831	15.0
Augusta	1,123	42%	466	58%	657	12.0
Rockland	960	52%	496	48%	464	8.0
Skowhegan	551	59%	323	41%	228	4.0
Bangor	1,846	48%	879	52%	967	17.0
Ellsworth	324	39%	125	61%	199	4.0
Machias	272	33%	89	67%	183	3.0
Houlton	310	69%	215	31%	95	2.0
Caribou	544	55%	300	45%	244	4.0
Fort Kent	108	27%	29	73%	79	2.0
TOTAL	11,608	52%	6,030	48%	5,578	100.0

The Department explains that cases are screened out primarily because they do not meet the statutory definition of abuse or neglect. However, many of these screened-out cases concern children who may not be experiencing statutory abuse or neglect but who live in dysfunctional families having sufficiently serious problems that the child may well suffer physical, mental, or emotional defects later in life.

The Committee reviewed screen-outs for all five regions in the state for an entire quarter of 1985 to acquire a first-hand understanding of the types of cases screened out. On the basis of this review, the Committee finds that although many of the cases appeared to be justifiably placed in the screen-out category, a sizeable percentage of cases appeared to demonstrate significant family dysfunction that would warrant some type of state intervention. The Committee recognizes that the Department has instituted some "fail-safe" measures to intercept initially screened-out cases at a later date, but is concerned that many cases still are not being adequately addressed.

Given time constraints, the Committee was not able to delve into the implications of a large number of screened-out referrals to its satisfaction. The Committee finds that the implications of these screened-out referrals must be studied and further analyzed by a broad-based, well-informed group of representatives from the child welfare community.

The Committee finds that the Child Welfare Advisory Committee meets this criteria and, therefore, recommends that an independent study be undertaken by this Committee to review and analyze referrals screened-out by the Department and report on the implications of these screen-outs to the Committee on Audit & Program Review by October 1986.

FINDING	24.	The Committee finds that the Department should continue its exploration of the issues involved in making Children's Organized Camps subject to licensing requirements as Child Care Facilities and report on its progress and recommendations to the Committee on Audit & Program Review by September 1986.

Currently, the state is responsible for providing oversight to more than 225 Children's Organized Camps in Maine in a number of ways.

First, the Department of Human Services' Bureau of Health, Division of Health Engineering approves site and water supply and inspects each camp to ensure that substantial health and safety regulations are met. The licensing rules define terminology and establish requirements for the camp's premises and buildings, sanitary facilities, health supervision, staffing, swimming facilities, and safety and fire prevention facilities.

Second, standards are also set for primitive camp facilities associated with recreational camps and for the conduct of trip camping. Finally, these camps are subject to rules as eating and lodging places.

However, none of these Children's Organized Camps providing summer recreational opportunities to 70,000 children are licensed as child care facilities and the Department does not now have a statutory mandate to establish such rules. The Department's licensing of child care facilites currently applies only to day care homes and day care centers. The Bureau licenses over 1000 day care centers and day care homes making annual visits and enforcing requirements regarding administration, staff, health, safety, program and transportation facilities. Five licensing workers carry out this licensing program.

In reviewing this situation, the Committee makes a number of findings:

1. Many parents enroll their children in Children's Organized Camps in part to provide a child care function;

2. Children's Organized Camps provide a needed and valuable service to thousands of in-state and out-of-state children;

3. The five Department of Human Services' Licensing workers currently responsible for licensing over 1000 day care facilities are functioning at maximum output;

4. Nine referrals alleging child abuse and neglect have been received by the department in regard to Children's Organized Camps in 1985; and

5. Children's Organized Camps should receive some degree of licensing regulation in their role as a child care facility.

Many of the Children's Organized Camps in Maine are members of the Maine Youth Camping Association. A 1985 Directory published by the Association lists it as "one of the strongest and most active State Camping Associations in the nation ... which fosters safe, healthful, and constructive experiences for all children attending Organized Camps in the State."

Currently, the Department and the Maine Youth Camping Association are seriously exploring the issues involved in making Children's Organized Camps subject to licensing as a child care facility.

The Committee supports this effort and recommends that the Department report to the Committee upon the completion of its collaborative effort to explore the issues involved in making Children's Organized Camps subject to licensing requirements as child care facilities by September 1986.

ADMINISTRATIVE	25.	Direct the Department to increase its communication, coordination, and cooperative efforts with agencies and individuals concerned with child abuse and neglect on the local and regional community levels. Report to the Committee on Audit & Program Review on the impact of these efforts by September 1986.

Growing public knowledge and concern about child abuse and neglect has resulted in a plethora of community responses to the problem ranging from the creation and distribution of educational materials to working together to directly influence public policy and law. Schools, courts, social service agencies, health providers, Child Abuse and Neglect Councils, and the clergy are examples of the diverse array of community resources focusing attention on child abuse and neglect, foster care, adoption, legal questions, placement resources, caseworker issues, and prevention.

A broad overview of child advocacy groups in Maine includes the following representative sampling; each of the agencies listed is generally a composite of a number of organizations or group efforts.

- Androscoggin Community Coordinating Committee, Auburn;
- Bridgton Child Abuse Task Force, Bridgton;
- Brunswick Area SCAN Team, Brunswick;
- Cumberland County Child Abuse and Neglect Council, Portland;
- Franklin County Children's Task Force, Farmington;
- Hancock County Child Protective Council, Ellsworth;
- Kennebec County Children and Family Resources Council, Augusta;
- Knox County Child Sexual Abuse Task Force, Warren;
- Oxford County Child Abuse and Neglect Prevention Council, South Paris;
- Penquis Council CARE, Greenville Jct.;
- Penobscot County Child Abuse Council, Bangor;
- Lincoln County Child Abuse and Neglect Council, Damariscotta;
- South Aroostook County Child Abuse & Neglect Task Force, Houlton;
- Sunrise County Children's Task Force, Pembroke;
- York County Child Abuse and Neglect Council, Biddeford;
- Somerset County Family Resources & Support Council, Skowhegan;
- Maine Association of Child Abuse and Neglect Councils, Portland;
- Advocates for the Developmentally Disabled, Augusta;
- Association for Young Children with Special Needs, Pownal;
- Adoptive Parents Group, Gorham;
- Child Welfare Advisory Committee, Augusta;
- Coalition for Maine's Children, Augusta;
- Day Care Directors' Association, Hallowell;
- Family Planning Association of Maine, Augusta;
- Juvenile Justice Advisory Group, Augusta;
- Maine Committee on Problems of the Mentally Retarded, Ellsworth;
- Maine Consortium of Emergency Youth Shelters, Greene;
- Maine Council of Community Mental Health Services, Augusta;
- Maine Foster Parents Association, Bangor;
- Maine Human Services Council, Augusta;
- Maine School Health Education Coalition, Farmington;

- Maine Coalition for Family Crisis Services, Dover-Foxcroft;
- Community Counseling Center, Portland; and
- Statewide Service Providers' Coalition on Adolescent Pregnancy, Augusta;

The Committee thanks Dorothy Larrabee, Chair, Human Services Council, for compiling the above list.

The Committee recognizes that these community resources are a critical component in waging effective campaigns against child abuse and neglect. Insofar as child abuse and neglect is a problem of the community-at-large, the Committee finds that the community itself must consciously choose to rally and organize its resources in a concerted effort to put an end to child abuse and neglect.

On its own initiative, the Department currently engages in various communication and coordination efforts with public and private sector providers and the local community.

These efforts include departmental participation on various committees, associations, teams, and consortiums involved in child welfare; holding conferences and meetings (covering both topic areas of general interest and specific case plans) with service providers, law enforcement personnel, multidisciplinary teams, educational personnel, and medical personnel; participation in the development of special programs and projects such as the Court Appointed Special Advocate's Project; and provision of information and speakers for the radio and television media and groups. Responsibility for implementing these communication and coordination efforts is shared by central and regional office staff.

Notwithstanding these documented efforts, the Committee has received testimony regarding a lack, or perceived lack, of departmental efforts to work willingly, cooperatively and routinely with the child welfare community. The Committee is concerned about the number of reports indicating a lack of departmental commitment toward mutual cooperation and finds that the Department must play an important role in constantly seeking to build bridges of communication and cooperation with all those involved in the child welfare system .

Therefore, the Committee recommends that the Department increase its efforts to strengthen community relations and reinforce collaboration on all levels to end child abuse and neglect. Renewed departmental efforts shall include but need not be limited to:

1. Regular integration and consultation with community-based multidisciplinary teams on cases of child abuse and neglect in the respective community;

2. Facilitating a process by which incoming caseworkers will meet community service providers and others concerned with child abuse and neglect as part of the orientation session;

3. Hosting a meeting within each Region at least three times a year with agencies and individuals concerned with child welfare to serve a social as well as a business function; and

4. Adopting a general policy of appointing at least one community member to all department task forces and subcommittees.

In these ways, the Department should improve its communication, coordination, and cooperative efforts with agencies and individuals concerned with child abuse and neglect, thereby complementing and empowering these local resources.

Finally, the Department shall report the results of its efforts to the Committee by September 1986. The Committee also takes this opportunity to invite community agencies to report the results of this recommendation from the community agencies' perspective at any time.

ADMINISTRATIVE	26.	Require the Department to communicate clearly with foster parents at the outset regarding departmental policies on foster parent adoption of foster children in order to clarify apparent misunderstanding.

From January 1, 1985, to December 1, 1985, the Department of Human Services had completed 86 adoptions and had 25 adoptions queued pending probate court approval. For the five previous years, the number of adoptions finalized were as follows:

Adoption Finalizations by Calendar Year

Region	1980	1981	1982	1983	1984
I	7	18	23	30	20
II	18	8	15	37	11
III	9	21	19	34	35
IV	7	9	15	38	31
V	3	3	7	10	5
Total	44	59	79	149	102

In 1982, 1983, and 1984, the number of foster children adopted by foster parents ranged between 50% and 60% of all adoptions of foster children and the trends for this year, 1985, appear to be similar.

Foster Parent Adoptions

	1982	1983	1984
Total # of Adoptions	79	149	102
Adoptions by Foster Parents # (%)	46 (58.1%)	90 (60.4%)	49 (48%)

The Department's Policy on Adoption Screenings and Home Studies in Section VIII of the Child and Family Services Policy Manual indicates that foster parents who wish to adopt a foster child are generally treated equally with others who wish to adopt foster children; foster parents, like all prospective adoptive parents, are required to participate in a home study and meet certain eligibility requirements. These eligibility requirements include consideration of residence, age, marital status, family makeup, health, ability to bear children, finances, and work. However, when the prospective adoptive child has a strong relationship with the foster family, the policy allows the Department to give these families special consideration.

The Committee has received compelling testimony from foster parents regarding the need to clarify the policy and procedure for foster parents who wish or may wish in the future to adopt a foster child.

Although the Committee recognizes that the information regarding adoption by foster parents is readily available in the Department Policy Manual in the section on Adoption Screenings, the Committee finds a need to make this information readily available in material focused specifically to foster parents.

Therefore, the Committee recommends that the Department communicate clearly with foster parents at the outset regarding the Department's policies and procedures on foster parent adoption of foster children by including this information in:

- section XIV of the Policy Manual entitled Family Foster Homes for Children, particularly as part of the Pre-Service Training Section;
- the Foster Parent Pre-Service and Orientation Package developed by each region;
- the Foster Parent Training Catalogue compiled by the Department's Staff Education and Training Unit; and
- a phamphlet for general distribution to the child welfare community.

ADMINISTRATIVE	27.	Direct the Department to improve the process by which foster parents may claim damages done by foster children in order to hasten reimbursement.

Currently, the law authorizes the Department to pay claims submitted by foster parents for property damage done by foster children in their care. The current claims process is established by law in Title 5 §1510-A. The Department administers this law using a policy statement developed in 1975.

The law specifies different procedures for claims in two categories. Claims for less than $2000 may be decided unilaterally by the Department; claims for more than $2000 must be submitted via Special Resolve to the Legislature by the claimant's legislator. If claims are denied by the Department or the claimant is dissatisfied with the resolution, he or she may submit the claim to the State Claims Board, an "independent, impartial board composed of five persons well learned in the elements that may be properly considered in the determination of fair market value of property" (23 MRSA §151).

In reviewing the process by which foster parents are reimbursed for damages done by foster children in their care, the Committee finds:

- first, the foster family must submit their damage claim to their assigned caseworker;
- second, the caseworker must review the damage and prepare a descriptive report;
- third, the caseworker must submit the report, together with any itemized bills for damage, to the Department for payment; and
- finally, the Department reviews the submitted material for completeness and clarity and will, after requesting and receiving any additional information needed, pay the claim from the Department's Child Welfare Services account.

The Committee has received testimony that foster parents have experienced considerable and unreasonable delay in receiving remuneration for damages.

The Committee finds that an objective appraisal of the damage claim process reveals the following; that:

- current practice is cumbersome and may contribute to delays in remuneration;
- foster parents are not provided with standardized damage claim forms which clearly specify the documents needed for processing the claim without delay;
- caseworkers may not attend to damage claim reports as speedily as possible in the press of other duties;

- communication among the caseworkers, the claimants, and the Department is not standardized; and

- the Department's 1975 administrative policy is outdated and does not reflect the current process which has evolved considerably since 1975.

Therefore, the Committee recommends that the Department improve the foster parent damage claim process by:

- designing and providing standardized damage claim forms to foster parents, listing all the documents and information that must be submitted to facilitate speedy processing;

- eliminating the caseworker as the middle person and having the foster parent submit the standardized damage claim form directly to the Department;

- designing a standard letter(s) to be sent to the assigned caseworker by central office staff who are processing the claim to advise the caseworker that a claim has been received and requesting the caseworker to corroborate the damage purported by the claimant within a specified period of time; and

- revising the department's administrative policy to reflect current practice.

FINDING	28.	The Committee on Audit & Program Review supports the Commission on Family Matters in the Court in their recommendation and legislation to create a Family Division of the District Court System.

Private and Special Law 1985, Chapter 65 created the Family Matters in the Court Commission. The Commission has been meeting since October 1985 and the membership includes legislators, state agency representatives, court system employees, and judges.

As a result of the Commission's deliberations, legislation has been prepared for the 2nd Regular Session of the Legislature creating a Family Division of the District Court System. The Family Division will have jurisdiction over family matters, with the exception of limited emergency jurisdiction given to other courts in certain family cases.

The proposed legislation assigns the Family Division of the District Court system with jurisdiction over matters involving:

- divorce, annulment, separation, custody and support when parents live apart;
- protection from domestic abuse (temporary order may be sought in any court, further proceedings transferred to family division of district court);
- child protection (temporary order may be sought in any court, further proceedings transferred to family division of district court);
- termination of parental rights, emancipation;
- commitment of mentally ill, sterilizations;
- juvenile offenses; and
- name changes, marriage waivers, and permission for minors to marry.

The anticipated legislation will also:

- create the position of Deputy Chief Judge of the Family Division of the District Court;
- authorize the appointment of Family Division judges from among District, Superior, Probate, and Administrative Court judges to serve two year terms in the Family Division;
- create a uniform docket for family cases;
- order that all courtrooms of the State are to be available for scheduling of family cases; and
- specify what types of family matters will be heard in the Family Division of the District Court.

The Committee has spent considerable time reviewing and discussing the impact of Maine's Court and legal system on the welfare of children involved in child protection or substitute care proceedings. As a result, the Committee finds that:

- the court system plays a prominent and formative role in the child welfare system as a whole;
- current courtroom and legal procedures are often frightening and overwhelming to the child and family; often serving to victimize the child further;
- judges are not always well versed in the intricacies of the complex Child and Family Services and Child Protection law and are themselves swamped with the diversity of cases coming before them;
- court dockets are often over subscribed and often unable to devote the time needed to properly adjudicate these cases;
- the large number of children coming before the courts is a relatively new phenomenon;
- the present system often creates inordinately long delays requiring children to remember the details of their abuse for a year or more which is especially difficult for a young child and which tends to retard their development beyond the incident;
- new, creative, and innovative techniques specific to the special needs of children such as videotaped testimony, separate waiting rooms, and work done in chambers with the child are needed;
- that a major restructuring of the system is necessary to better provide children with equal protection under the law; and
- that the Family Division of the District Court should effectively address many of the identified problems.

Therefore, the Committee supports the Commission on Family Matters in the Court in their recommendation and legislation to create a Family Division of the District Court System.

FINDING	29.	The Committee finds that the Court Appointed Special Advocate Program (CASA) holds promise for providing children with the kind of advocacy they deserve in the court system. Therefore, the Committee on Audit & Program Review commends the program and looks forward to its anticipated accomplishments.

As noted earlier, section 4005 of the "Child and Family Services and Child Protection Law" in Title 22, requires that a guardian ad litem be appointed by the court to represent the child in child abuse civil proceedings. The guardians appointed are virtually always lawyers who serve for a nominal fee. The guardians ad litem not only are required to investigate the child's case and provide recommendations at the initial court hearings, but also to represent the child's interests at administrative case reviews and other proceedings regarding the child's welfare. The strain on professional attorneys who carry regular client loads to perform such functions for the child is substantial. The Committee finds that, although the role of an active advocate for the child in official proceedings is crucial in fashioning a program to meet the child's best interests, attorneys serving as guardians ad litem are often too busy and not compensated competively to devote the time required to optimally carry out this function.

In an attempt to remedy this situation, District Court Chief Judge Bernard M. Devine and Deputy Chief Judge Alan C. Pease worked with a committee in 1985 to begin the process of recruiting lay persons to serve as lay guardians ad litem. Supported by a federal grant from the National Council of Juvenile and Family Court Judges, the Committee established a one-year pilot program called Court Appointed Special Advocate program, or CASA, in Androscoggin, Knox, and Lincoln Counties. A Director was hired whose office is located in the District Court Office in Lewiston. Volunteers from all three counties have been recruited, screened, interviewed, and trained and are now working as lay guardians. In the June/July issue of the "Court Crier", Deputy Chief Judge Alan Pease said, "the program will always need lawyer assistance, but, while lawyers are equipped to defend legally the interests of a person under guardianship, they are not necessarily able to give psychological support, counseling and family-type support which a lay person could offer in a family-type setting.

The lawyers have performed a tremendously valuable service, but a lay advocate will have more time to work with an abused or neglected child." Judge Pease is also working on the idea of locating a single lawyer "willing to serve an entire area in answering questions".

The Governor's Working Group on Child Abuse and Neglect Proceedings has commented, "the use of lay persons as uncompensated guardians ad litem could prove beneficial in many respects, especially doing necessary investigative work and giving support to the child. (The) combined use of volunteer laypersons and attorneys would provide the best legal representation for children."

In summary, the Committee finds a pressing need to provide more consistent advocacy for child victims of abuse and neglect in the Maine Court system and that an expanded Court Appointed Special Advocate program should effectively provide this advocacy. Therefore, the Committee commends this program and looks forward to its anticipated accomplishments.

FINDING	30.	The Committee finds the development of a statewide Child Abuse and Neglect Prevention Plan to be vitally important and supports the development of regional and local child abuse and neglect prevention plans, now in progress, by the Department of Human Services and the Maine Association of Child Abuse and Neglect Councils.

Although the Committee recognizes the absolute necessity of responding to the current crises in child abuse and neglect, it finds that efforts toward preventing child abuse and neglect should be the long-term goal and must be given a high priority if the current epidemic of abuse and neglect is to be arrested. As an important first step toward this goal, the Bureau of Social Services and the Maine Association of Child Abuse and Neglect Councils are beginning the development of regional and local prevention plans with the ultimate goal of integrating these local plans into a statewide Child Abuse and Neglect Prevention Plan.

The local prevention plans to be developed are intended to provide:

1. An overall policy framework for prevention programs and services for the prevention of abuse, neglect, and sexual abuse of children in the local jurisdiction;

2. A listing of specific programs and activities which will be carried out by the appropriate Child and Abuse and Neglect Council and the Department for the upcoming year;

3. An identification of existing prevention activities and services; a description of an ideal prevention service; and a listing of gaps in the prevention and early intervention continuum; and

4. A delineation of the roles and responsibilities of the public and private sector in addressing issues of prevention.

The sixteen Child Abuse and Neglect Councils under the umbrella of the Maine Association have assumed a broad-based responsibility to assemble local and regional resources to address child abuse and neglect. The Councils serve as centers to coordinate resources and ideas, provide information and education on child abuse and neglect, initiate special projects regarding child abuse and neglect in the local area, and advocate for children in various forums. In this capacity, the Child Abuse and Neglect Councils are in contact with virtually every resource within their area having an interest in family and children's services, including schools, courts, social service agencies, health providers, and caseworkers.

The Committee finds that a partnership between the Department and the Maine Association of Child Abuse and Neglect Councils achieves the following important benefits:

- First and most important, direct and effective efforts towards the prevention of child abuse and neglect;

- Departmental communication, coordination and cooperation with the community;

- Involvement of public and private agencies and individuals concerned with child welfare through the local Councils;

- Focusing of scarce resources on the long-term solution of child abuse and neglect in addition to addressing the short-term crisis; and

- Integration of the considerable efforts of the Department and Child Abuse and Neglect Councils towards the acknowledged common goal.

Therefore, the Committee endorses this effort by the Department of Human Services and the Maine Association of Child Abuse and Neglect Councils to develop local and regional Child Abuse and Neglect Prevention Plans toward the ultimate goal of integrating these plans into a Statewide Child Abuse and Neglect Prevention Plan.

FINDING	31.	The Committee finds that a Task Force should be appointed to assess the need to establish a separate Department of Child & Family Services to incorporate all child and family service programs now administered by the Departments of Human Services, Educational and Cultural Services, Corrections, and Mental Health and Mental Retardation.

State programs which serve the child and family are now offered primarily by four state agencies; the Departments of Human Services, Educational and Cultural Services, Corrections, and Mental Health and Mental Retardation. The Department of Human Services alone spends over 24 million dollars annually in the account areas of purchased social services, regional social services, social services administration, child welfare services, AFDC Foster Care, and Aid to Charitable Institutions.

Approximately four million additional dollars are spent annually by other departments in the state on behalf of children and their families. Proper and efficient administration of these programs now requires many staff in a number of different agencies to successfully develop and use interdepartmental communication mechanisms.

The Committee finds that consolidating these programs under one administrative umbrella may benefit the state and its children in the following ways:

- reduced administrative costs;
- improved coordination, cooperation, and communication; and
- improved state services and assistance to Maine's children and families.

Therefore, the Committee finds that a Task Force should be appointed to assess the need to establish a separate Department of Child & Family Services to incorporate all child and family service programs now administered by the Departments of Human Services, Educational and Cultural Services, Corrections, and Mental Health and Mental Retardation.

ADMINISTRATIVE	32	Recommend that the Department use prudent and sensitive discretion regarding its authority to remove children from their homes so that this authority is not used as an unwarranted threat against a parent or other person responsible for the child.

The Child and Family Services & Child Protection Act (22 MRSA Chapter 1071) authorizes the Department of Human Services to remove children from their homes when failure to do so would jeopardize the child's health or welfare or when substituting for parental care of children is necessary (22 MRSA §§ 4003 and 4004).

In taking these actions or providing these services, the Department's duty is to protect abused and neglected children and children at risk of abuse and neglect, prevent further abuse and neglect, enhance the welfare of these children and their families, and preserve family life wherever possible. (22 MRSA §4004 sub §2)

The Committee recognizes the need to protect children from circumstances that jeopardize their health and welfare which may, in some instances, require removal of children from their homes, parents, and caretakers.

As executors of Legislative intent, the Department of Human Services must have the authority, overseen and limited by the Legislature and the courts, to carry out the serious responsibility of removing children from their parents when warranted.

During the review, the Committee received testimony alleging that department caseworkers have periodically used this authority as a threat for the purposes of intimidation.

The Committee finds that any unwarranted use of the Department's authority to remove children does not serve children or families well and is contrary to the intent of the statute.

Therefore, the Committee recommends that the Department use prudent and sensitive discretion when it discusses its authority to remove children from their homes so that this authority is not perceived as an unwarranted threat against a parent or other person responsible for the child.

The Committee intends the Department to implement this recommendation by including discussion of the need for prudence and discretion during caseworkers' initial orientation, subsequent training sessions, and other appropriate forums.

FINDING	33	The Committee finds that the quality and relevance of placement resources and services currently available to children in substitute care should be assessed.

Placement resources currently available to children in substitute care include:

	TYPE	DESCRIPTION	RATE PAID
1.	Family Foster Care	Provides parental care and supervision on a regular, 24 hour/day basis within a family setting in a private dwelling by people serving as substitute parents to children under age 18.	$232 - 337/Month
2.	Relative Care	Provides parental care and supervision on a regular, 24 hour/day basis for a child under age eighteen by a person(s) related to the child by blood, marriage, or adoption.	
3.	Therapeutic Foster Care	A Family Foster Home in which the foster parents serve as a primary agents in addressing and treating identified behavioral and emotional problems.	$400 - 1100/Month
4.	Long Term Foster Care	Substitute parental care provided to a child by a single set of foster parents until the child attains the age of 18. The State retains legal custody of the child and delegates to the foster parents certain responsibilities regarding the life and development of the child.	
5.	Adoptive Placement	Parental rights of the biological parents are terminated and transferred to another person(s) who then serves as the child's legally binding parent(s).	
6.	Emergency Shelter	A facility which serves children needing shelter or assessment for no more than 30 days.	$1410 - 1890/Month
7.	Group Home	A residential facility which provides board and care to the children under age 18. It may also provide education or mental health treatment.	$805 - 1500/Month
8.	Residential Treatment Center; In-State and Out-of-State	A residential facility which provedes board and care, mental health treatment, and education to children under age 18 on either a 24 hour or a daily basis.	$1153 - 5000/month approximately
9.	Semi-Independent Living	A living arrangement which is not licensed as a residential child care facility or family foster home and where no adult, other than the department. has responsibility for the youth's supervision or care.	

As of December 1985, 2,348 children were in substitute care in Maine supported by 100.5 substitute care caseworkers. The Committee has received considerable testimony regarding the limited availability of substitute care placements, particularly in regard to children with severe behavioral and emotional problems. Caseworkers regularly spend long hours seeking a placement for one child for one night only to have to repeat the search the following day. Further, the concept of family foster homes was intended to deal with children whose primary need is a stable nurturing family-type setting. Instead, family foster homes are forced to deal more and more frequently with children whose behavior and emotional problems include fire-setting, damage of self and property, severe acting out and overt and public sexual behavior; few facilities specially equipped to deal with this level of need are available.

The Committee finds that the need to ensure the availability of an adequate number of substitute care facilities designed to deal with the serious problems exhibited by the substitute care population is of critical importance.

As the first step in accomplishing this goal, the Committee finds that placement resources and services currently available to children in substitute care should be examined to determine:

- whether and what types of additional services are needed; and
- the effectiveness of the current array of resources and services at meeting current and anticipated needs of the sub care population.

Therefore, the Committee recommends that the quantity and relevancy of placement resources and services currently available to children in substitute care be assessed.

ADMINISTRATIVE	34	Extend the review of child welfare services in Maine for one year to allow the Committee to complete work now in progress.

The Committee's review of child welfare services in Maine has encompassed a diverse array of programs which are administered by four state agencies, and cost millions of dollars. The Committee entered into this complex subject area because of its great importance to the children of Maine and the need to provide carefully considered legislative oversight as to how best to proceed in the effort to protect children.

In broad terms, the Committee's review has been divided into 27 major topic areas ranging from adoption to turnover/vacancy of caseworkers; each of these 27 areas consist of dozens of constituent issues.

During the past year, the Committee achieved its goal of assaying all targetted areas. This report includes important recommendations dealing with family rehabilitation and reunification, reporting, referrals, disclosure and retention of records, institutional abuse, paperwork redundancy, communication, the court system, prevention, and training. However, due to the complexity and intractability of many of these issues, the Committee was not able to complete its work in time to present all of its recommendations to the Legislature. The balance of the Committee's work includes:

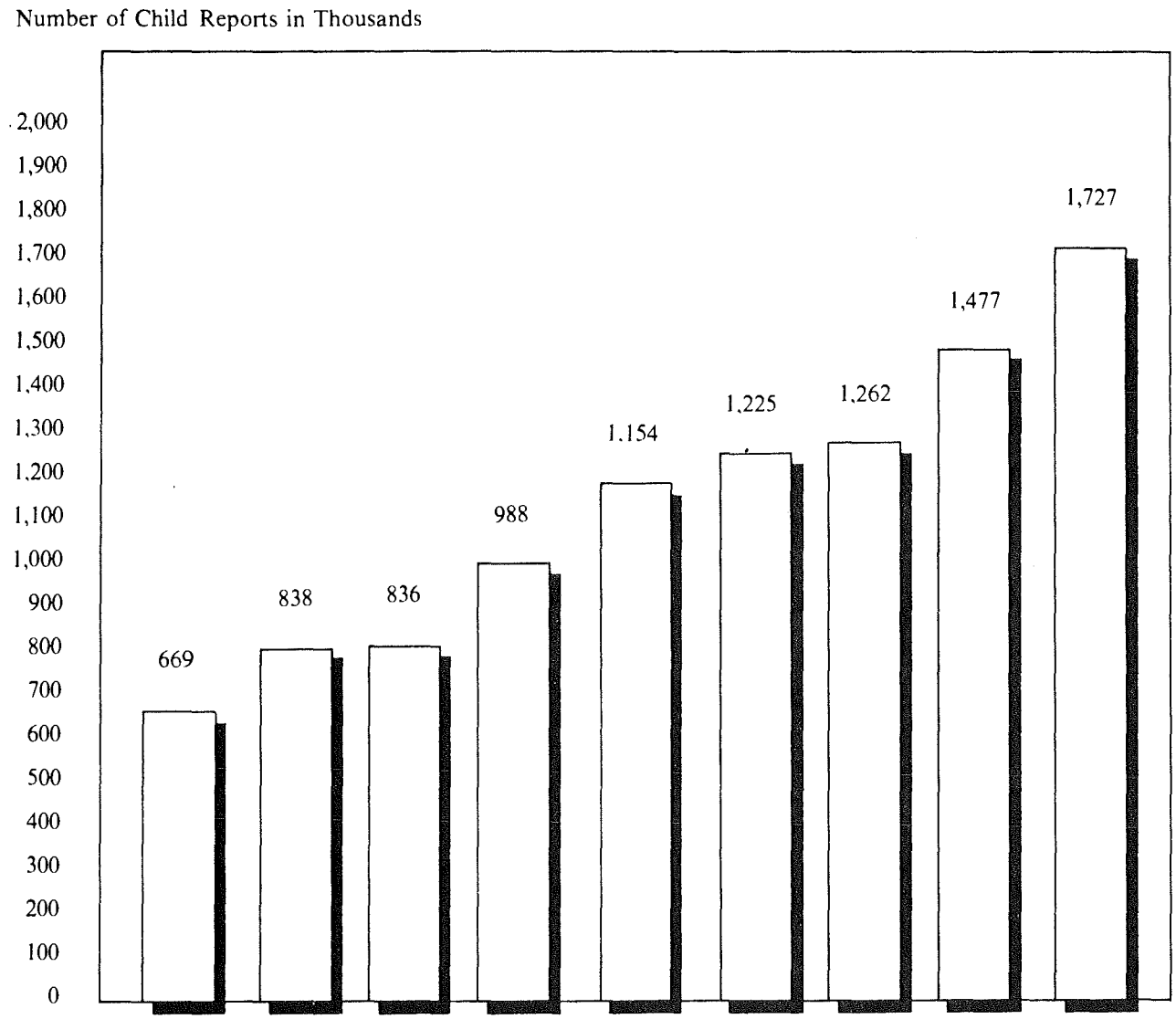
- caseworker retention;
- the court system;
- institutional abuse;
- establishing an ombudsman for child welfare services;
- prevention;
- substitute care; and
- training.

The Committee finds that these issues-in-progress are fundamental to the child welfare system and in particular need of legislative oversight.

Accordingly, the Committee recommends extending its review of child welfare services in Maine for one year to allow the Committee to complete its work.

Appendix 1

National Estimates of Child Abuse and Neglect Reports 1976-1984



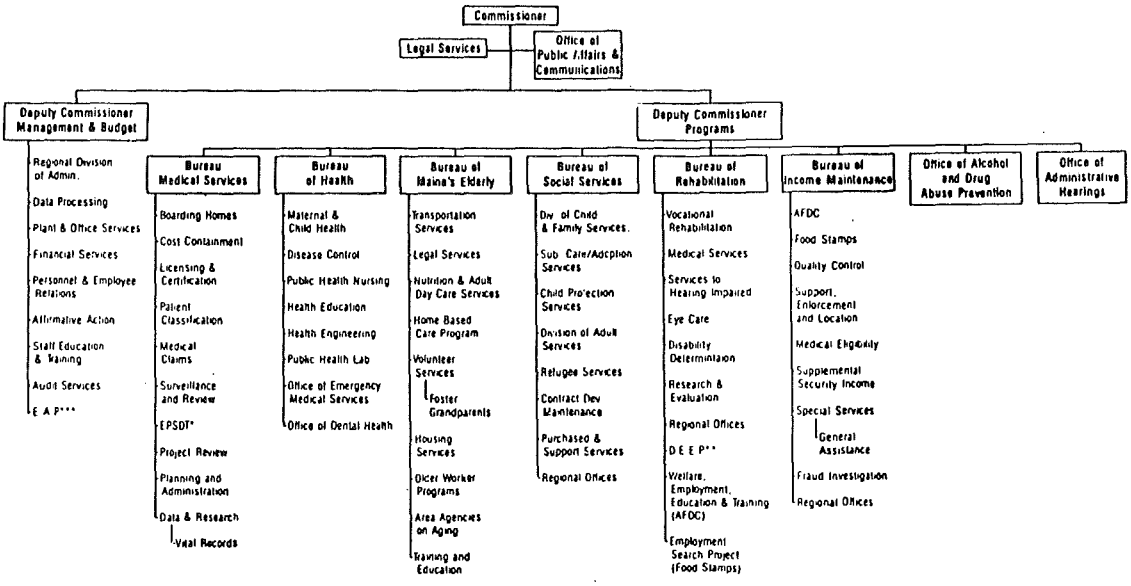
Source:

Highlights of Official Child Neglect and Abuse Reporting
1984

American Association for Protecting Children, Inc.

Appendix 2

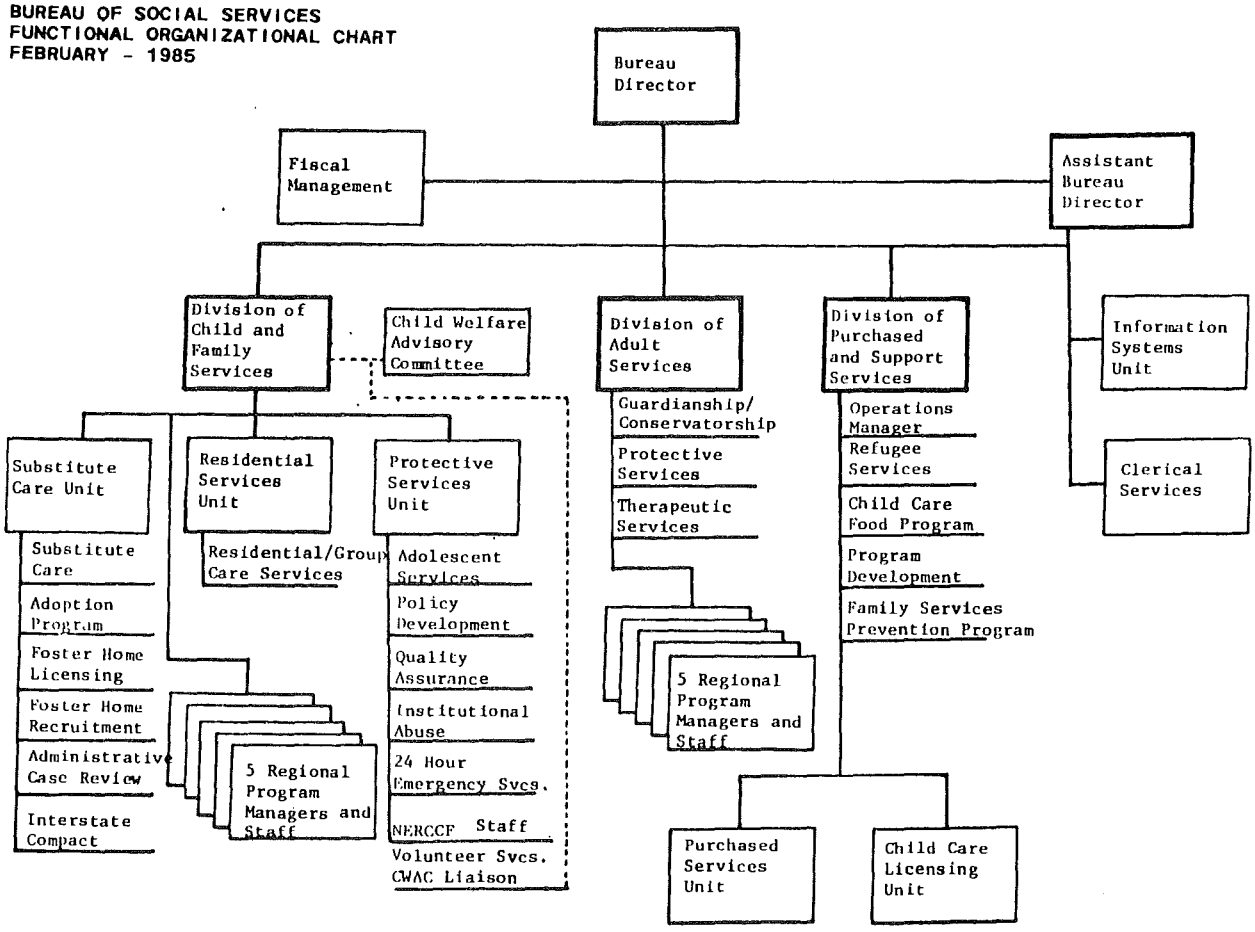
Maine Department of Human Services
Organizational Chart
May, 1984 *



* Early, Periodic Screening, Detection and Treatment ** Driver Evaluation & Education Program *** Employee Assistance Program

* Most recently available

BUREAU OF SOCIAL SERVICES
FUNCTIONAL ORGANIZATIONAL CHART
FEBRUARY - 1985



Appendix 3

Department of Human Services
Child Welfare Services
Summary Total - FY85 Expenditures/Allocations
2245N / 3095N

Child Welfare Expenditures		% of Total in Account
A. Purchased Social Services		
All Other	$3,400,799.00	31%
B. Regional Social Services		
Positions	375.5	87%
Personal Services	$8,192,921.00	
All Other	1,089,468.00	
Capital	59,915.00	
Total	$9,341,584.00	86%
C. Social Services Administration		
Positions	12.5	23%
Personal Services	$405,912.00	
All Other	254,896.00	
Capital	2,296.00	
Total	$663,104.00	37%
D. Child Welfare Services		
Positions	40.00	100%
Personal Services	$933,330.00	
All Other	4,091,368.00	
Total	$5,024,698.00	100%
E. AFDC Foster Care		
All Other	$5,302,388.00	100%
F. Aid to Charitable Institutions		
All Other	$283,872.00	100%
TOTAL ALL ACCOUNTS		
Positions	428.00	81%
Personal Services	$9,532,163.00	
All Other	14,411,791.00	
Capital	61,491.00	
Total	$24,016,445.00	70%

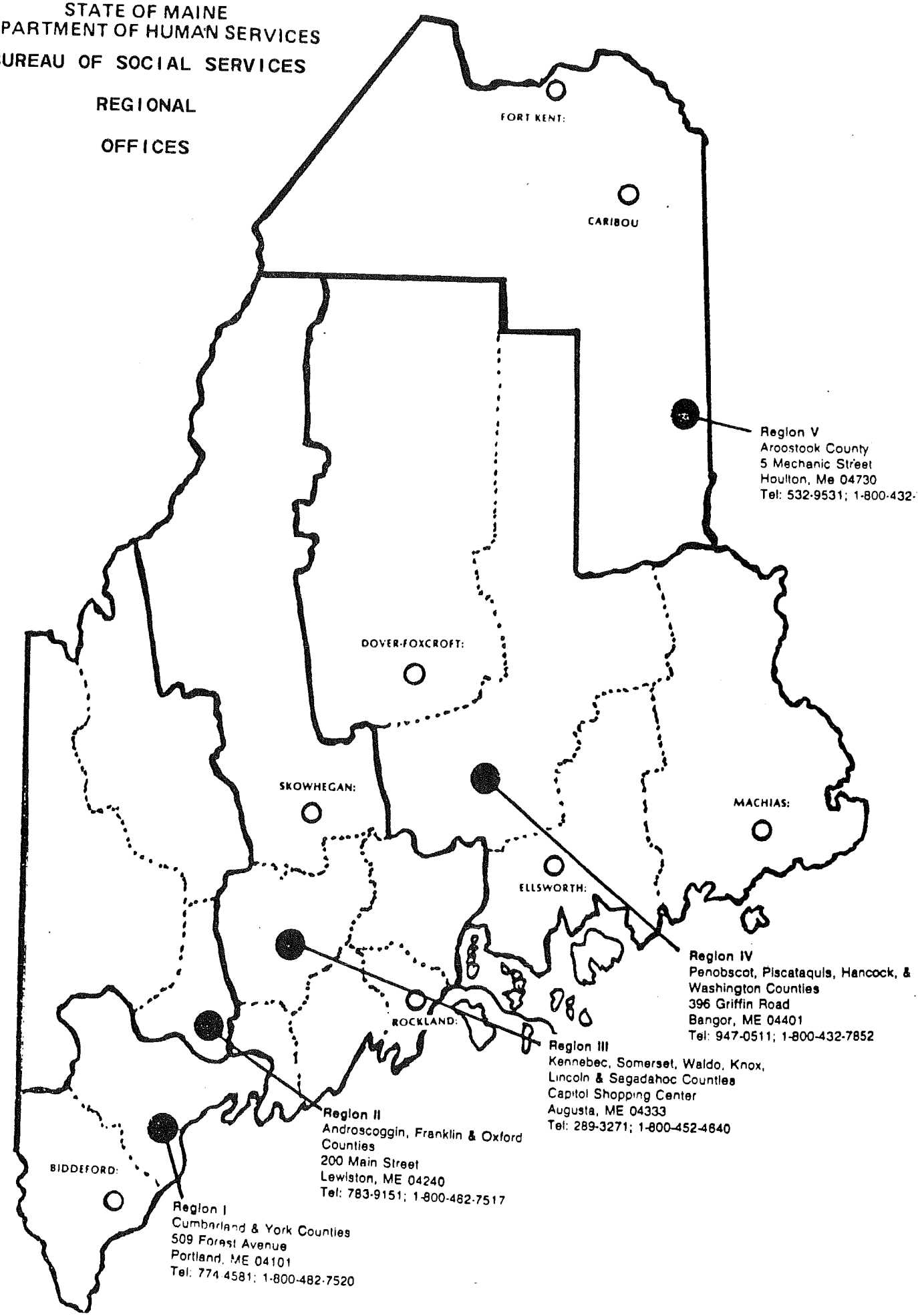
SOURCE: Bureau of Accounts and Control Analysis Sheets
DHS Allocation Information Sheets
DHS Personnel Line Listing

NOTE: Analysis does not include expenditures from the AFDC or Medicaid accounts made on behalf of child welfare services clients. Child welfare services provided by other Departments are also not included here.

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
BUREAU OF SOCIAL SERVICES

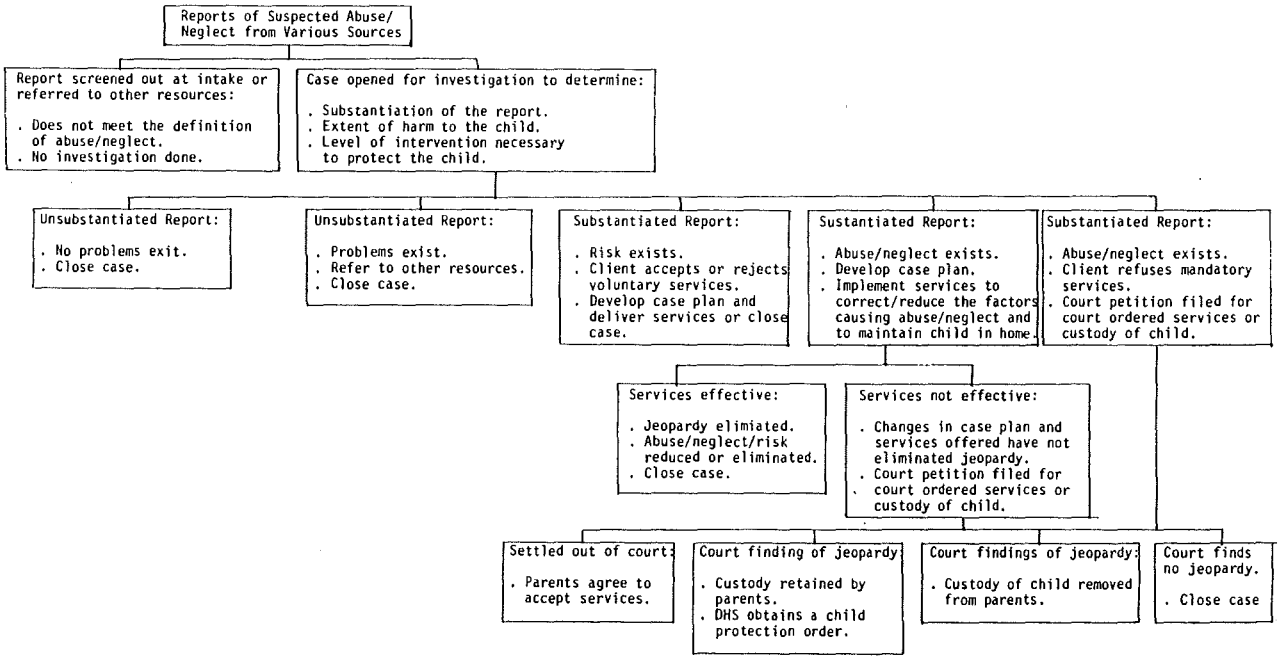
REGIONAL

OFFICES

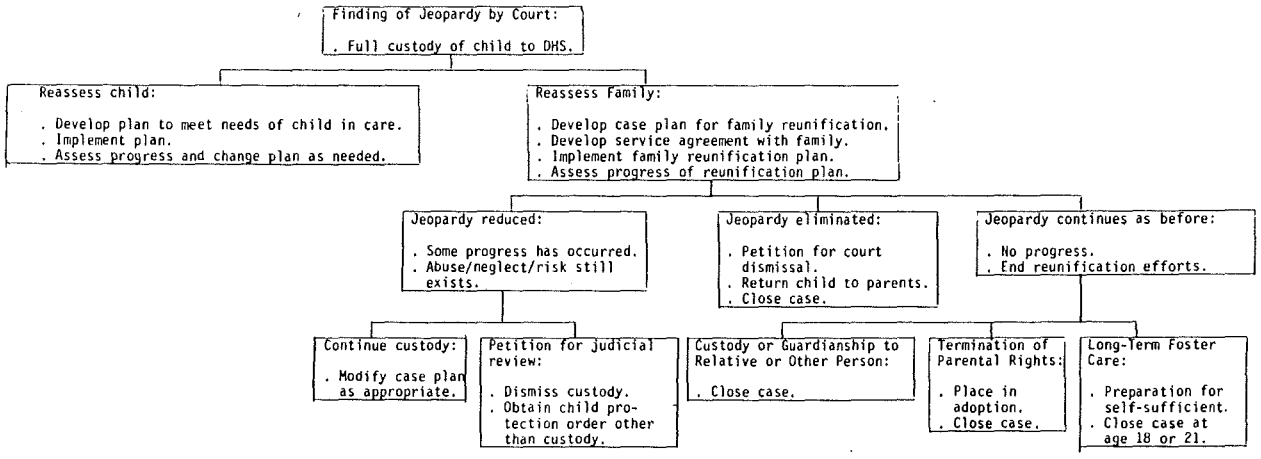


Appendix 5

CHILD PROTECTIVE SERVICES PROCESS



SUBSTITUTE CARE SERVICES PROCESS



APPENDIX 6

LAYPERSON'S GUIDE TO THE

CHILD WELFARE SYSTEM
and
THE COURTS

The following will serve as a guide to the sequence of petitions and court hearings that occur when the the Department of Human Services determines a child to be in "immediate risk of serious harm".

The system involves the following elements:

- Petition for a Child Protection Order;
- Preliminary Protection Hearing and Order;
- Final Protection Hearing and Order;
- Adjudicatory Phase of the Final Protection Hearing; and
- Dispositional Phase of the Final Protection Hearing.

The sequence of events and actions are as follows:

FIRST: The Department staff determine a child to be in "immediate risk of serious harm" in his or her household. (22 MRSA §4034)

SECOND: Department files a **PETITION FOR A CHILD PROTECTION ORDER**, or "**PETITION**" with the Probate, District, or Superior Court to protect the child from serious harm.

This **PETITION** is considered by the court in an ex parte proceeding (one side only represented) and has three major components:

- Details to support the departmental allegation that the child is in immediate risk of serious harm;
- A request for a **HEARING ON THE PRELIMINARY PROTECTION ORDER**; and
- A request for a **HEARING ON THE FINAL PROTECTION ORDER**.

The **PETITION** also contains an affidavit from the caseworker and a sworn summary of the facts of the case.

The **PETITION** can either be signed by a judge at his or her home or at the court during normal working hours.

THIRD: If the court approves the **PRELIMINARY PROTECTION ORDER** requested in the **PETITION**, the department will remove the child from the circumstances which constitute immediate risk of serious harm. It is at this point that substitute care caseworkers step in and rehabilitation/reunification efforts technically begin if custody has been granted to the department.

FOURTH: Within ten days, a **HEARING ON THE PRELIMINARY PROTECTION ORDER** (PPO) must be held, as requested in the original **PETITION**. This hearing is not an ex parte proceeding. At this **PPO HEARING**, the court will either sustain the finding that the child is in immediate risk of serious harm and the department will retain custody or the court will place the child back with his or her parents. Either way, generally the court will move ahead and old a final protection hearing.

FIFTH: At the **HEARING ON THE FINAL PROTECTION ORDER**, the court undertakes a two-pronged or bifurcated process. The first phase is the **ADJUDICATORY PHASE** in which the court will adjudicate, or determine, whether the child is in legal "jeopardy". If the court finds the child to be in legal jeopardy, it will enter into the **DISPOSITIONAL PHASE** and make an order determining the child's future, or disposition. In making this **DISPOSITIONAL ORDER**, the court will consider the department's case plan, the guardian ad litem's report, the attorneys for all parties, and other pertinent information. The court has nine dispositions from which to choose the child's living arrangements.

SIXTH: Rehabilitation and reunification efforts continue if the child is placed in the custody of the department. The court will review the disposition within 18 months and every two years thereafter.

SEQUENCE OF PETITIONS AND COURT HEARINGS
2931N

FIRST: Determine "serious risk of immediate harm."

↓

SECOND: PETITION → 1. Details on "immediate risk of serious harm."

2. Request for a Hearing on the Preliminary Protection Order

3. Request for a Hearing on the Final Protection Order.

↓

THIRD: Child removed from situation of alleged harm 10 days later.

↓

FOURTH: Hold hearing on Preliminary Protection Order

Court will either:

- o sustain the finding that child is in immediate risk of serious harm; or
- o Court will place the child back with his or her parents.

↓

On Date Determined

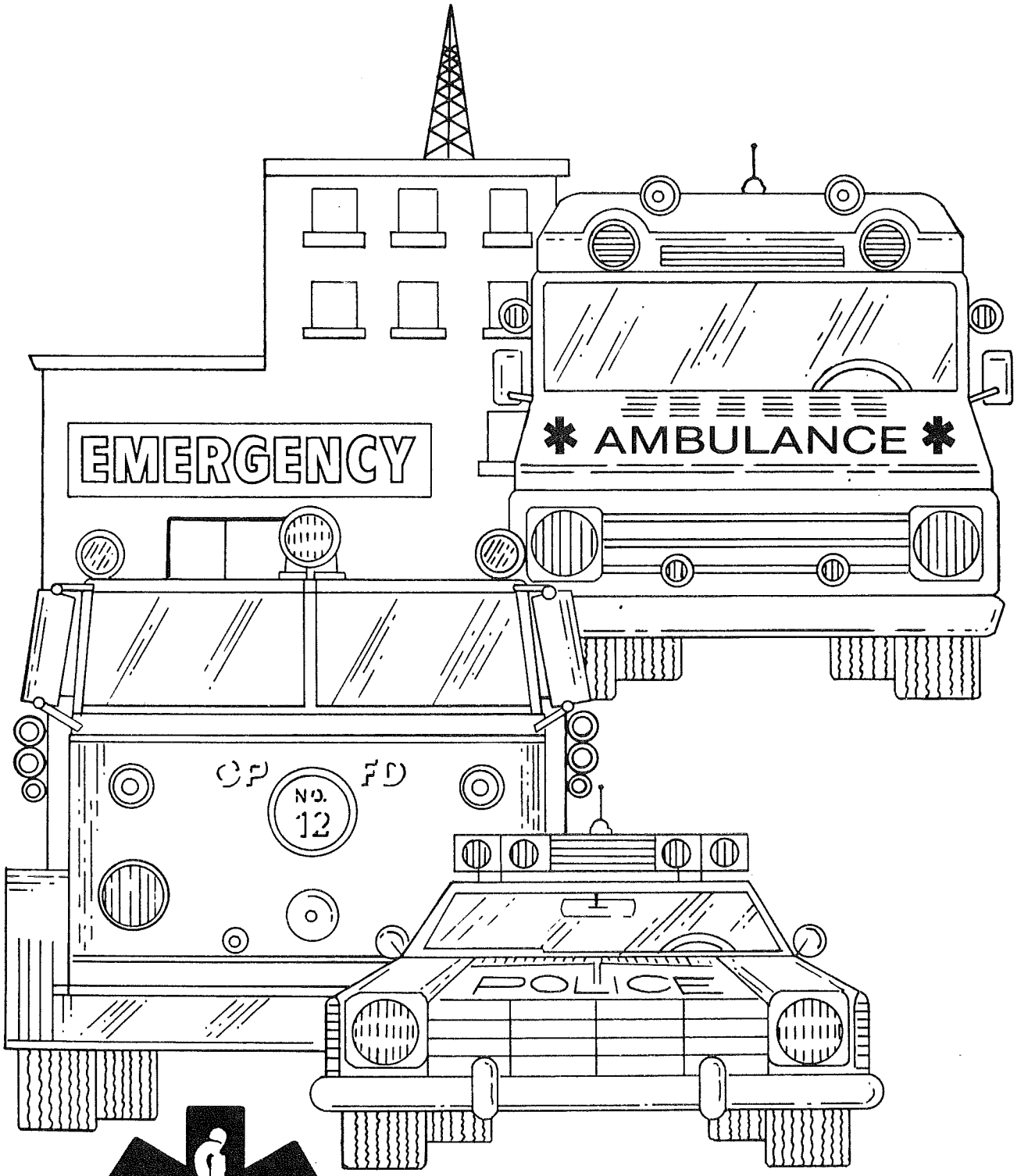
↓

FIFTH: Hold the hearing on the Final Protection Order.

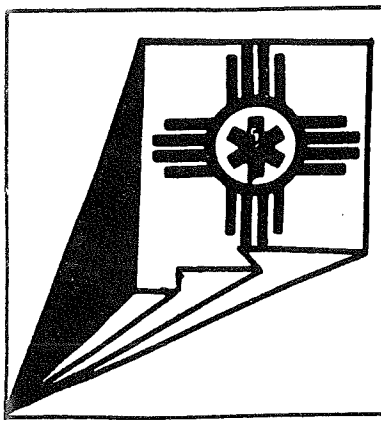
First Court must find legal "jeopardy".

Then, Court makes a dispositional order and determines the future of the child and the expectations of the parents and the department.

EMS Laws, Rules, Regulations



EMS
EMERGENCY
MEDICAL
SERVICES



FOCUS ON

Emergency Medical Services

"A System To Save Lives"

INTRODUCTION

Guidelines provided by the Federal Emergency Medical Services Program define Emergency Medical Services (EMS) as those "services utilized in responding to a perceived individual's need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury."

The American College of Emergency Physicians has estimated that nearly 75,000 deaths could be averted each year in the United States through the provision of prompt emergency medical services to persons experiencing life-threatening emergencies. Further, it is generally accepted that emergency medical services hold great potential for reducing the severity of injury or illness, thus reducing disability and suffering.

The comprehensive and integrated arrangement of personnel, facilities, equipment, services, and organizations which are necessary to provide emergency medical treatment to patients is referred to as an EMS system.

National Historical Development

Much of the legal and programmatic development of emergency medical services in the United States spans less than two decades. In the 1960's, the issue of accidental death, primarily from traffic accidents, began to be examined by medical professionals and organizations. Widespread interest and concern in highway safety led to passage of the National Highway Safety Act of 1966 (P.L. 89-564). Enactment of this law was a major milestone in the early stages of EMS development because it required states to have a highway safety program developed in accordance with uniform standards promulgated by the U.S. Department of Transportation. One of these standards required the development of statewide EMS plans, and provided funding for ambulances, equipment, personnel and communications to upgrade the nationwide response to medical emergencies.

From 1966 through the early 1970's, numerous important EMS activities were undertaken, including:

- development of curricula and certification programs for Emergency Medical Technicians (EMTs);
- formulation of standards for designing and equipping emergency vehicles;
- development of increasingly sophisticated hospital emergency departments; and
- formulation of hospital categorization plans to designate trauma, burn, spinal cord injury, and poison centers on a regional basis.

There was also an emerging recognition in the early 1970's that the coordination of emergency medical services was lacking. In 1972, five emergency medical services demonstration projects, along with other programs, were initiated in various parts of the country. The purpose of these programs was to encourage communities to develop regional emergency medical response systems by establishing that an organized regional and comprehensive systems approach to emergency medical care was both feasible and sound.

The next major milestone was the congressional passage of the Federal Emergency Medical Services. Systems (EMS) Act of 1973 (P.L. 93-154). This law was intended to further promote the development of comprehensive EMS systems. Under this Act, Federal funds were provided as "seed money" for the planning, establishment and expansion of comprehensive regional systems. In order to receive grants, a regional system, administered by a single public or non-profit entity, had to meet certain requirements. These mandatory system requirements included criteria for manpower, training, communications, transportation, record-keeping and the requirement that all components be implemented to the basic life support level by the end of the initial implementation period.

The passage of the Federal EMS Act provided the mechanism and funds for local communities to develop regional EMS systems which encompassed the entire spectrum of emergency medical care from the prehospital to the hospital. Between 1974 and 1981, the U.S. Department of Health and Human Services, the designated "EMS lead agency", helped to identify 303 multi-county regional EMS areas for program development.

In 1981, the Federal role in EMS underwent a significant change as a result of passage of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). Federal EMS funds formerly provided to the states on a categorical basis became a part of the "Preventive Health and Health Services Block Grant".

Accordingly, today, while states continue to receive some categorical funding for EMS through the Highway Safety Program, most Federal funding is through block grants. As a result, state authorities now have an increased degree of discretion in expending EMS funds and in directing EMS program activities.

EMS Development in Maine

The Maine Emergency Medical Services program was initiated in 1967 with the Highway Safety Act of 1966 requirement that each state formulate an emergency medical services program as a condition of receiving the federal funds allocated to the State for highway construction.

The first in-state ambulance personnel training program was initiated in the Rockland area in 1961. The State became involved in training ambulance personnel in 1966 when the Bureau of Civil Defense sponsored a training course for ambulance personnel. The movement mushroomed, and there were more demands upon the Civil Defense training team. In 1968, a hospital-based training program was developed.

Also, in 1968, with the assistance of the Maine Highway Safety Committee, the Maine Extrication and Casualty Handling Team was created. This was the first state-sponsored emergency medical training course of its type in the nation. Members of the Team represented the Maine State Police, Maine Department of Transportation, Civil Emergency Preparedness and the Department of Human Services.

The system itself, up to this point, depended upon funeral directors who provided much of the ambulance services. However, due to the minimum wage law which required that personnel be paid when on call, funeral directors began to cease providing ambulance service given their increased personnel costs. In their place, citizens began creating volunteer ambulance services.

Licensing regulations for ambulance vehicle operation, services and personnel were developed in 1969 by the Governor's Advisory Board to the Department of Human Services (DHS). In 1970, the DHS initiated licensing under the direction of an EMS coordinator. The first year the Department licensed approximately 152 services, 220 vehicles and 1820 personnel. In 1973, a statewide survey was conducted for future EMS planning and in 1974, an EMS plan was submitted to the federal Department of Health Education and Welfare which approved a grant for the City of Portland.

During 1975, a statewide planning grant was approved and the Kennebec Valley Region also received grant approval. The EMS program expanded with the hiring of a Project Director and statewide EMS Physician Director. DHS contracted with Medical Care Development Inc. to administer the Federal Emergency Medical Services Systems grants.

In 1976, EMS regional staff were hired for the five planning regions along with State project staff. Over the next years, various grants were awarded to the Kennebec Valley, Southern Maine, Tri County, Northeast and Aroostook regions to develop emergency medical services. Organizational controversy struck the EMS program and resulted in the enactment of some restrictive legislation in 1979 which was later modified.

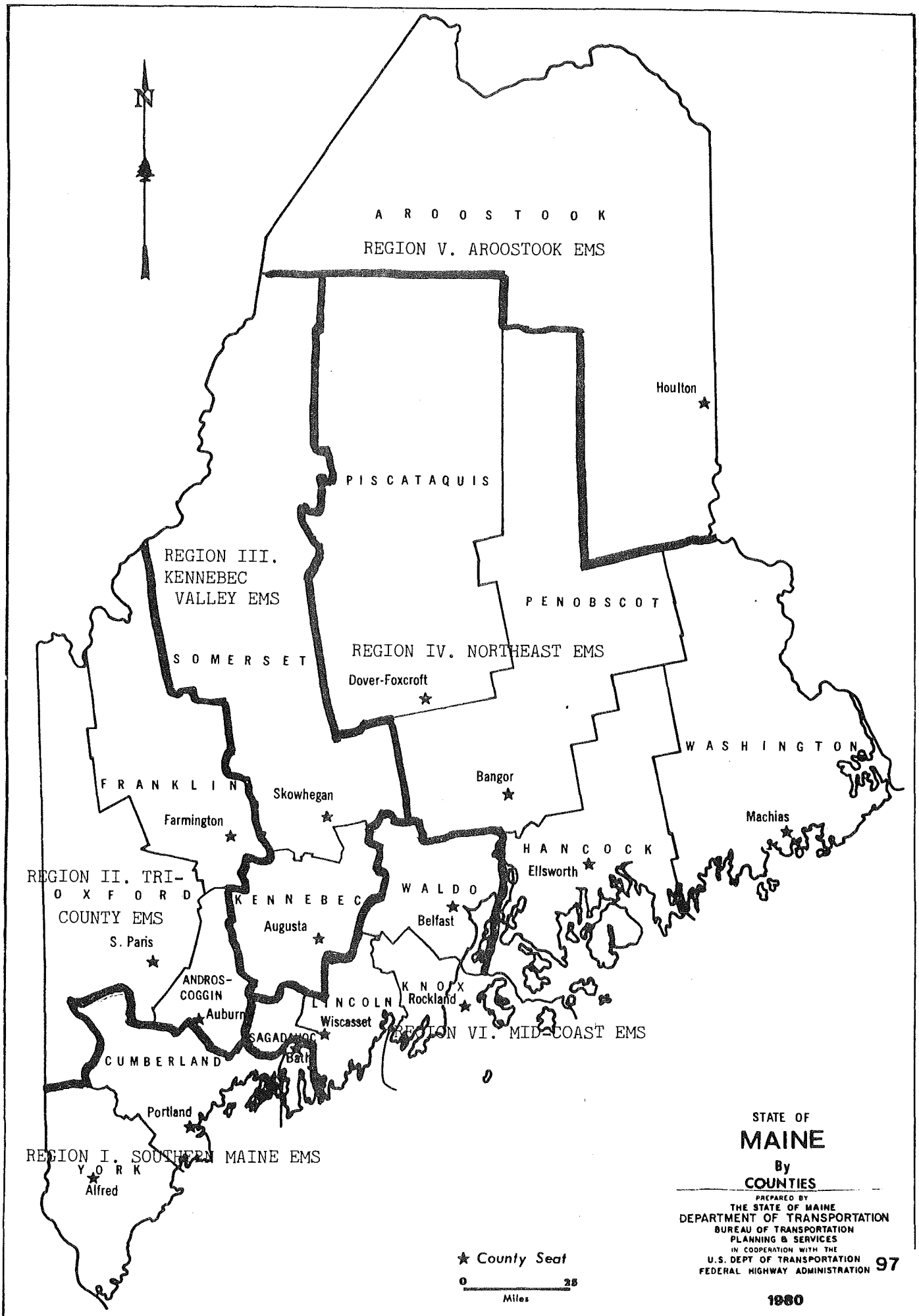
During 1981, the Southern Maine Region was split into two with a division made at the Kennebec River. The new region was referred to as the Mid-Coast Region.

Due to the need for organizational clarity, the Legislature enacted the present EMS law in 1982 (32 MRSA Chapter 2-B). This law defined the role of regional councils, set the statutory basis for some fundamental concepts of EMS, re-established the role of the Emergency Medical Services Advisory Board, and clearly established the Legislature's recognition of emergency medical services and the Department of Human Services' authority and responsibility to conduct both a regulatory and health program. The state ended its contract with Medical Care Development Inc. and established an Office of Emergency Medical Services within DHS which in turn contracted and delegated authority to the six regional councils.

By the end of 1982, the six regional councils were funded through the State and eight professional staff people were in the employment of the Councils. In addition, six staff members worked for the Office of Emergency Medical Services and three for the Maine Health Information Center. The Office also contracted with a part-time medical director. Finally, in 1983, the Governor reconstructed the EMS Advisory Board as authorized by the new law.

This formed the organization presently under review.

(Maine History taken from Mid-Coast Regional Handbook)



STATE OF
MAINE
By
COUNTIES

PREPARED BY
THE STATE OF MAINE
DEPARTMENT OF TRANSPORTATION
BUREAU OF TRANSPORTATION
PLANNING & SERVICES
IN COOPERATION WITH THE
U.S. DEPT OF TRANSPORTATION
FEDERAL HIGHWAY ADMINISTRATION

97

1980

ORGANIZATIONAL OVERVIEW

Program Purpose

The purpose of the regulation of emergency medical services is to develop a strong statewide system which insures quality care for all individuals requiring emergency services.

Organization

As of June 1986, the Maine Emergency Medical Services program has the organizational components which are depicted both in the organizational Chart A and the following descriptions. Changes made as a result of legislation enacted in the 2nd Regular Session of the 112th Legislature will be effective on September 1, 1986. These changes are described in recommendations #1 through #38 and are reflected in organizational Chart B.

The State Office of Emergency Medical Services. This office, located within the Department of Human Services' Bureau of Health, is responsibile for promulgating regulations, licensing, enforcing the provisions of the Emergency Medical Services program, developing educational programs including training and testing programs and monitoring the EMS program. The State Office has a total of six full-time staff which includes a Director, a Training Coordinator, two licensing agents, and two clerical support staff. The expenditures for the statewide EMS program in FY 1985 were approximately $429,000; an amount which included $30,000 for each regional council. In FY 1986, this amount was increased by a one time General Fund appropriation of $180,000 which provided additional funds for each regional council.

Emergency Medical Services Advisory Board. The Emergency Medical Services Advisory Board (EMSAB) advises the Office and Department on the conduct of the emergency medical services program. This includes providing advice on the promulgation of rules and their adoption and the development of regional workplans. The Board has 13 members and meets monthly. The 13 members include one member appointed from each region and seven additional persons: a physician, an attorney, a public representative, a representative of for-profit ambulance services, one representative of a first responder service, a professional nurse, and one representative of a not-for-profit ambulance service. Members serve three year terms.

Regional Councils. The state is divided into six geographical regions for the delivery of emergency medical services. One criteria for this geographical distribution is the location of hospital facilities available to the services in each region. The six regional councils cover the following geographical areas:

Region I. Southern Maine EMS Council, Inc; Cumberland and York Counties areas and a small part of Sagadahoc County;

Region II. Tri-County EMS, Inc; Androscoggin, Oxford and Franklin Counties;

Region III. Kennebec Valley EMS Council, Inc; Somerset and Kennebec Counties;

Region IV. Northeastern Maine EMS Council, Inc; Piscataquis, Penobscot, Hancock, and Washington Counties;

Region V. Aroostook Region EMS Council, Inc; Aroostook County; and

Region VI. Mid-Coast EMS Council, Inc; Waldo, Knox, Lincoln, and Sagadahoc Counties.

Regional councils are responsible for ensuring and monitoring the local delivery of care. In addition to coordinating the courses and programs for ongoing training and retesting, the councils are responsible for developing medical protocols which govern the provision of advanced emergency care.

Medical Control. EMS is a medical program with medical control being an integral element in the delivery of all care, but critical to the application of advanced care. All elements of advanced emergency care are governed by regional protocols which specify the operational and clinical procedures that can be applied by licensed individuals with appropriate physician supervision. The Office of Emergency Medical Services contracts for a State Medical Director who is responsible for overseeing the development of regional protocols and who can provide the necessary medical quidance and direction. Each region, in turn, is required to have a Regional Medical Director who is responsible for ensuring the development and maintenance of that region's protocols. It is only under a physician's authority that advanced care can be delivered. These protocols typically represent the consensus of physicians in the regional area and vary between regions.

The State and Regional Medical Directors form a State Medical Control Advisory Committee which reviews aggregate data to monitor the quality of care and determine the advisability of techniques, procedures and field application. In addition, each region has its own medical control advisory committee or committees which work with the Regional Medical Director to establish the medical protocols governing the delivery of advanced emergency medical services;

Other Agencies:

Maine Health Information Center (MHIC). This is a private, non-profit agency which contracts with the State Office to process the ambulance run reports which are required for each patient transport in the EMS system. In addition to developing, processing and analyzing this data, MHIC compiles, and produces reports for use by individual services, regional and state personnel;

Hospitals. Individual hospitals provide a variety of services to regional EMS councils which include space, administrative support, staffing, funding and training. The cooperative and active inter-relationship between regional councils, emergency room personnel and services is important to patient care;

Vocational Technical Institutes. The VTI's are involved in ensuring the delivery of basic training courses. In addition, the Kennebec Vocational Technical Institute has been instrumental in developing a Paramedic Training Academy. Services provided by technical institutes vary by region and can include the provision of office space and operational support for regional EMS programs;

Bureau of Safety. Housed in the Department of Public Safety, the Bureau contracts with the EMS program to fund special projects;

Attorney General's Office. The Attorney General's Office provides legal consultation and assistance to the State Office and Department of Human Services in the administration of the EMS program; and

Volunteer Efforts. The entire Emergency Medical Services system relies heavily on the dedicated efforts on the part of many individuals including service providers, hospital staff, and other committed and interested persons, too numerous to mention.

Chart A
Present Organization

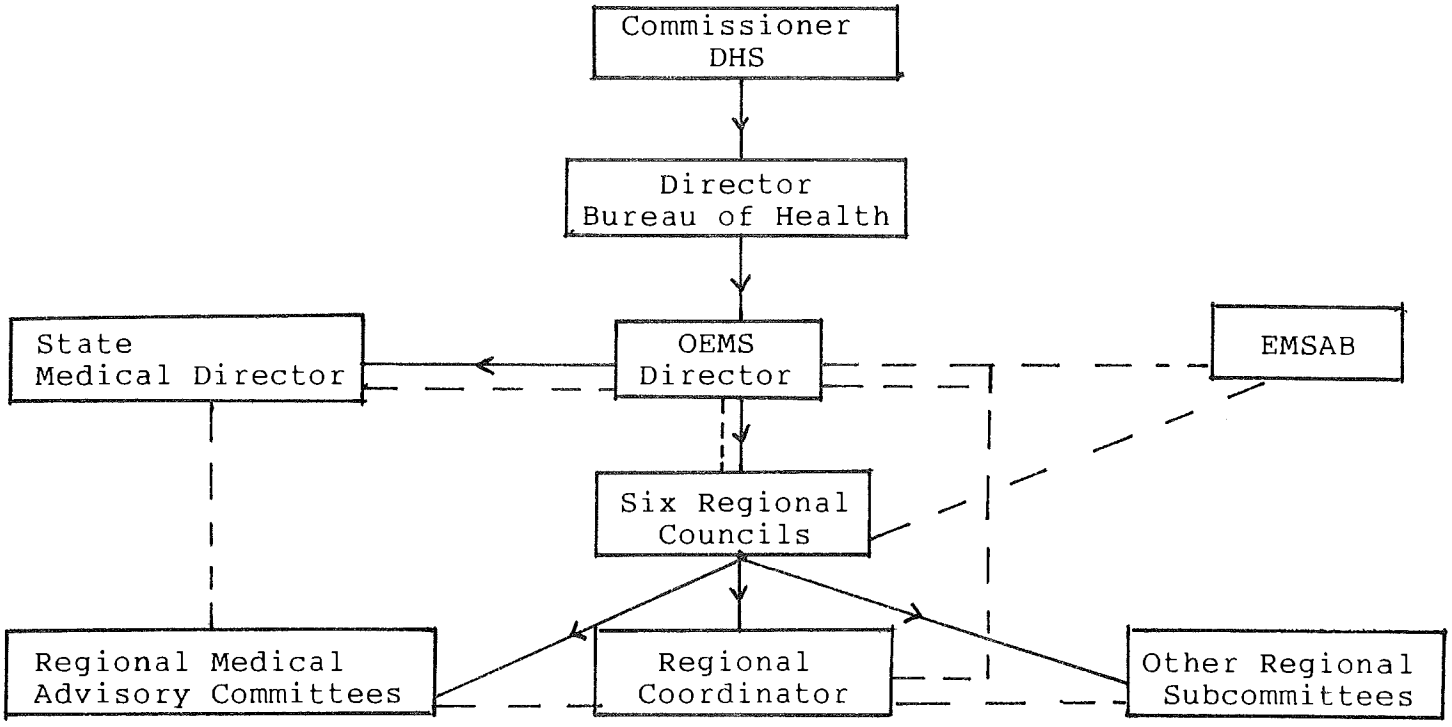
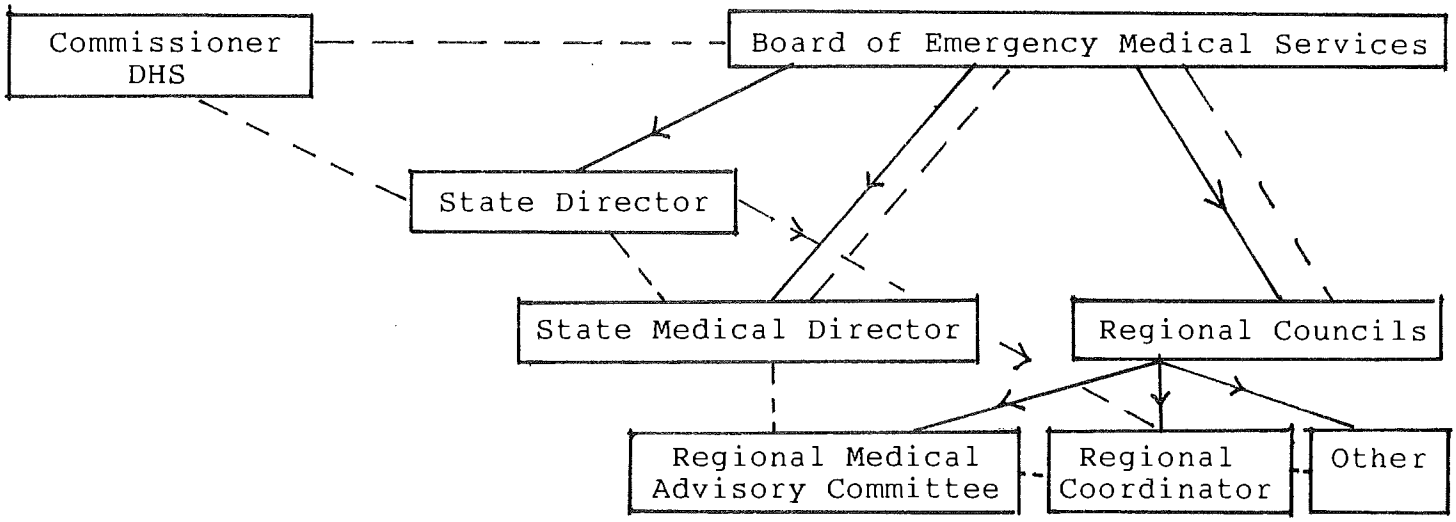


Chart B
Organizational Change



STATUTORY	1.	Place the authority for the final adoption of rules with the Board of Emergency Medical Services to strengthen the Board's governance of the EMS program.
STATUTORY	2.	Remove the mandatory requirement for conducting 12 evening hearings for rule making to provide the Board with increased flexibility, minimize cost and maximize efficiency.

The State Office of Emergency Medical Services (OEMS), located within the Department of Human Services, is charged by statute with the following responsibilities:

- conducting a statewide Emergency Medical Services (EMS) program (32 MRSA §84 sub §1-A);
- administering EMS including the adoption of forms, procedures, testing requirements and records (32 MRSA §84 sub §1-A);
- promulgating regulations and handling appeals in accordance with the Administrative Procedure Act (32 MRSA §84 sub §1-B);
- appointing a state physician to serve as State Medical Director (32 MRSA §84 sub §1-C);
- monitoring of EMS;
- establishing goals which provide a level of minimum requirements for regions;
- contracting with the regional councils; and
- enforcing EMS requirements including license revocation or suspension and formal hearings for personnel, vehicles and services (32 MRSA §84 sub §1).

Additional statutory provisions state that the regulations shall include:

- the composition and designation of regional councils;
- requirements for personnel licensure, at the Basic and Advanced Levels, with the advice and consultation from regional councils, regional medical control committees, the EMS Medical Director to include training and testing;
- requirements for licensure of services and vehicles; and
- the setting of license fees with the exception of personnel licenses (32 MRSA §84 sub §D).

The rule making process involves the Emergency Medical Services Advisory Board and conforms with the notification requirements and provisions of the Administrative Procedure Act with one main exception. This exception requires 12 public hearings to be held in the evening on any proposed rule change; two hearings per region. In addition, at least two board members are required to attend each public hearing (32 MRSA §88 sub §2-B). The 12 hearing requirement was added to ensure visibility and afford maximum opportunity for comment concerning any rule changes.

The Committee's review documented that members of the Board were active in attending the public hearings. The Committee found, however, that although the structure enabled the Board to initiate rule changes, the Board primarily reviewed rules prior to their release for public hearing. At present, the Board, based on a two-thirds vote of all members, determines the recommendations it makes to the Office on the final adoption of rules. The authority for final adoption of rules belongs to the Commissioner.

In 1982, with the Board's involvement, the regulations were re-written and have been updated annually since that time.

During the course of its review, the Committee received extensive testimony concerning the Board's activity regarding the rule-making process. This testimony and results from a survey conducted by the Committee, reflect the Board's limitations concerning the promulgation and adoption of rules. The Board's advisory status was evidenced again within the recent past when the Office of EMS chose not to accept a board recommendation and proceeded with the adoption of a rule with which the Board disagreed.

To address future conflicts of this kind, the Board adopted a policy which provides that:

- to resolve the disagreement, a delegation of board members selected by the Board will meet with OEMS and the Director of the Bureau of Health on the request of the Chair; and

- if there is continued disagreement, the Chair of the Board will request a meeting with the DHS Commissioner for final resolution.

In reviewing the organization of the EMS program, the Committee looked closely at the organizational relationships between the Department and the Board. The Committee also reviewed the structure of other regulatory agencies and boards within Maine and the EMS programs outside of Maine and found a number of organizational structures which place more authority with a board. For example, the Committee noted that the states of Kansas, New Hampshire, North Carolina, North Dakota, Indiana, Iowa, Rhode Island, and Tennessee have policy making boards. The statutes of Kansas state that:

"It shall be the duty of the council after consultation with the Superintendent (Kansas Highway Patrol):

(1) to adopt rules and regulations pursuant to this act;

(2) to review and approve the allocation and expenditure of moneys appropriate for emergency medical services;

(3) to conduct hearings for all emergency medical services regulatory matters;

(4) to submit a budget to the Governor for the operation of the bureau of emergency medical services;

(5) to develop a state plan for the delivery of emergency medical services; and

(6) to enter into contracts as may be necessary to carry out the duties and functions of the council under this act (65-04-316)."

The statutory charge in Tennessee is:

"Powers and duties of board. In addition to any other power, duty or responsibility given to the board by this part, the board shall have the following powers, responsibilities and duties:

(1) to approve schools, to establish and prescribe courses, and to establish and prescribe the curricula and minimum standards for training, as required to prepare persons for certification under this part:

(2) to promulgate regulations governing the issuance of such licenses, permits and certificates for services, vehicles, or personnel as required by this part, and condition such issuance as necessary. These regulations may establish various categories and classifications of licenses, permits and certificates:

(3) to establish minimum standards governing the activities and operations of various categories of services, vehicles or personnel, licensed, permitted, or certified by the board: ....," etc. (68-39-504)

The Committee finds that the Emergency Medical Services Advisory Board can be an important mechanism in providing input and expertise in the development of the EMS program. However, in its present advisory capacity, the Board's role is limited because the promulgation of rules, their enforcement, the establishment of goals and program objectives rest with the Commissioner. The Commissioner, in turn, delegates this authority to the Bureau of Health and the State EMS Director.

The EMS rules encompass all aspects of the program to include criteria for: ambulance service licenses, first responder service licenses, personnel licenses, advanced life support procedures, conduct of EMS training courses, conduct of state licensing examinations, reciprocity, and standards and procedures for refusing a license. Given the fundamental structure which the rule-making process provides to the entire scope of the EMS program, the Committee finds that it is appropriate for the Board to have sole authority over rule adoption. The Committee also finds that the the Board's present advisory level creates unnecessary administrative tension and is disruptive to a cohesive program while making insufficient use of the Board's perspective. Therefore, the Committee recommends that the authority for the final adoption of rules be placed with the Board.

Finally, to facilitate the rule-making process, the Committee recommends that the mandatory requirement for 12 evening hearings be removed from the present law. Although the Committee finds that it is important to provide opportunity for comment on rule-making, the Committee also finds that the practical effect of this requirements is unduly burdensome. The Committee recommends that the Board have the flexibility to determine the number, location and time of hearings within the framework provided by the Administrative Procedure Act.

STATUTORY	3.	Place the licensing authority with the Board to strengthen the Board's regulatory responsibility.

Under the present EMS structure, the Department of Human Services, as charged by statute, has the responsibility for licensure of personnel, services and vehicles. In 1985, the Department licensed over 2,700 individuals, 219 services and 350 vehicles.

There are two categories of care within Maine's Emergency Medical Services System, Basic Life Support (BLS) and Advanced Life Support (ALS). Two levels of licensure fall under the BLS level: Licensed Ambulance Attendant (LAA) and Basic Emergency Medical Services Technician (BEMT). Four levels of licensure fall under the ALS level: Emergency Medical Technician - Esophageal Obturator Airway (EMT-EOA), EMT - Intermediate, EMT Critical Care and EMT Paramedic. In terms of patient care, these licensure levels mentioned above are listed in ascending order of responsibility. In addition to these six licensure levels, there is an apprentice category which serves as an entry level position.

The difference between BLS and ALS is that ALS service levels are physician controlled. At the ALS level, Advanced EMT's may use more "invasive skills" which necessitate physician control and monitoring. The BLS level does not require physician contact. Both BLS and ALS have a fundamental goal of stabilizing the patient from the scene to the hospital. Again, however, at the ALS level, the service provider can begin to apply various definitive care depending upon the level of licensure, skill and regional medical protocol. For example, where a BEMT can **maintain** an ongoing intravenous line, the EMT-Intermediate can **start** an intravenous line. With increasing levels of licensure, there is an increased level of "intrusion" to the body and "critical techniques" brought to the patient care.

Licensure of personnel and services fall into these six licensure levels. The requirements for licensing are set forth in rules with the Office of EMS determining that the licensee meets the criteria for licensure prior to the issuance of the license.

Personnel Licensure/Certification: Personnel licensing is dependent upon obtaining the sponsorship of a service and certification and meeting other requirements. The licensed service must be at least at the same level of licensure as the individual seeking to be licensed. The level of allowable treatment increases with the category of licensure as depicted below.

1. **Licensed Ambulance Attendant (LAA)**

   An LAA may render emergency treatment within the scope of his training to patients who need such treatment, including those who may require extrication, rescue, or ambulance transportation.

2. **Basic Emergency Medical Technician (BEMT)**

   A BEMT may render emergency treatment, within the scope of his training, to patients who require such care. He may give aid to persons entrapped or otherwise in need of extrication or rescue and provide them ambulance transportation where appropriate. A BEMT may use the Medical Anti-Shock Trousers where an LAA cannot.

3. **Advanced EMT- Esophageal Obturator Airway (EOA)**

   An Advanced EMT-EOA has the authority to insert an Esophageal Obturator Airway when:

   - acting under the supervision of the physician who provides medical supervision to the unit to which the EMT-EOA is licensed;
   - following the protocols current in the EMT-EOA's region; and
   - acting as part of an ALS service to which the EMT-EOA belongs, or as part of an ALS service which has a written agreement with the EMT-EOA's service to exchange technicians.

4. **Advanced EMT - Intermediate.**

An Advanced EMT-Intermediate has the authority to deliver external countershock to pulseless, apneic patients whose cardiac rhythms have been monitored by the EMT-Intermediate and determined to be ventricular fibrillation or cardiac standstill, and to begin or discontinue IV therapy within regional protocols. The EMT-Intermediate may be assigned the care of patients with an IV running, provided that any complications of the IV being administered lie within the scope of training, and provided that the EMT-Intermediate receives physician instruction. The EMT-Intermediate practices when acting under the supervision of the physician who provides medical supervision to the unit to which the person is licensed.

5. **Advanced EMT - Critical Care.**

An Advanced EMT-Critical Care has the authority to deliver external counter shock; to take and transmit cardiac rhythm strips, and to interpret them to a limited extent; to store and administer certain medications, and to maintain records of those medications; and to perform endotracheal intubation; when:

- acting under the supervision of the physician who provides medical supervision to the unit to which the person is licensed;
- following the protocols adopted in the region where the person is practicing; and
- acting as part of an ALS service to which the person belongs, or as a part of an ALS service which has a written agreement with his own service to exchange technicians.

6. **Advanced EMT - Paramedic.**

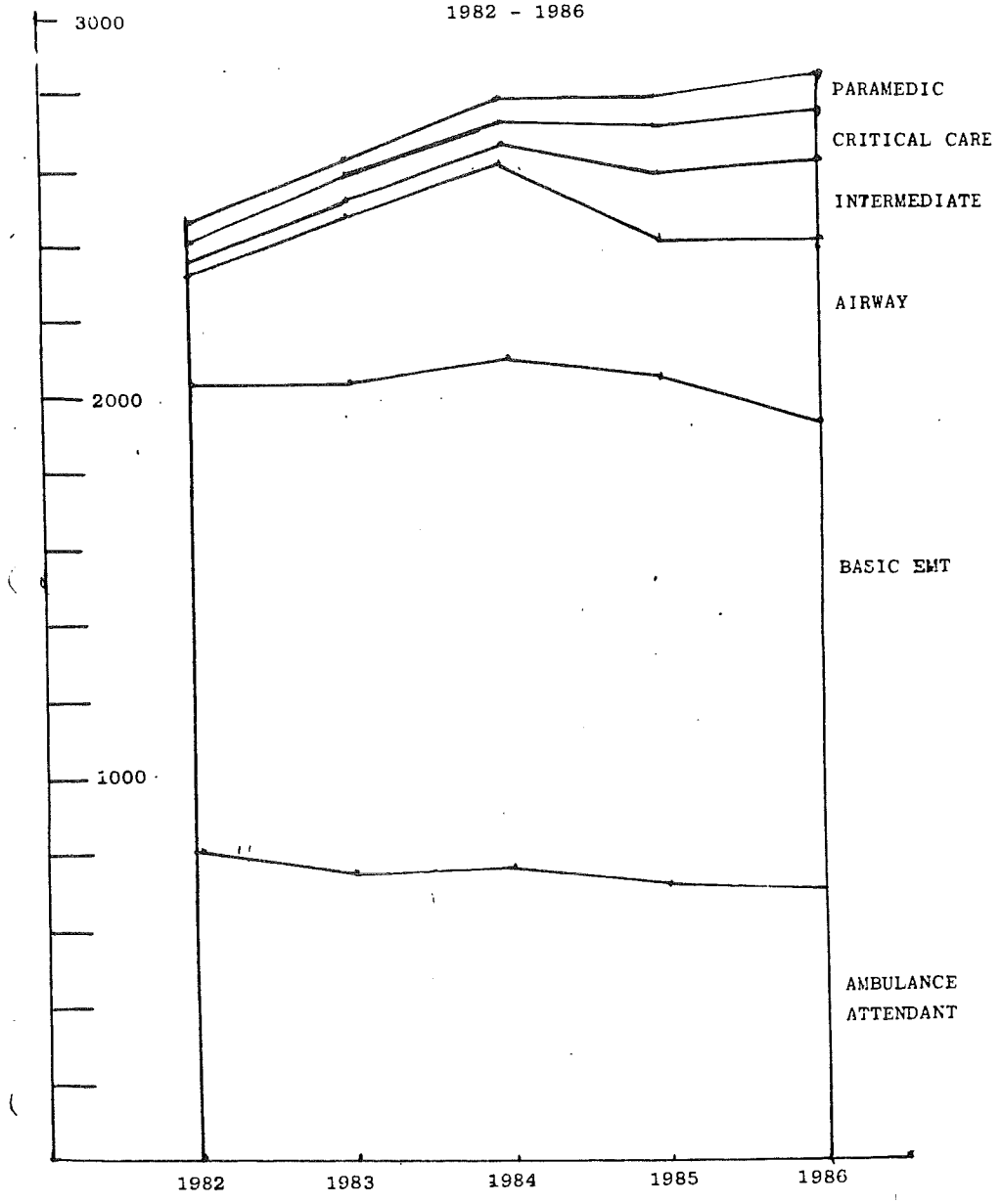
An EMT-Paramedic has the authority to perform chest decompression, transtracheal insuflation, cricothyrotomy, to deliver additional medication and use central approaches for IV therapy, and to administer other treatment included within the approved Paramedic curriculum. A Paramedic may engage in this practice when:

- acting under the supervision of the physician who provides medical supervision to the sponsoring unit;
- following the protocols adopted in the region where practicing; and

- acting as part of an ALS service to which the Paramedic belongs, or as part of an ALS service which has a written agreement with his own service to exchange technicians.

(See Table I for Personnel Licensure Level)

TABLE I
EMS PERSONS, BY LICENSING LEVEL
1982 - 1986



Taken from OEMS

Service Licensure: Services are licensed annually by the Department according to licensure level. There are two broad categories of licensure: Ambulance Services and First Responder Services. The statutory definitions are as follows:

> "**Ambulance Service** means any person, persons, or organization, which holds itself out to be a provider of transportation for ill or injured persons, or which routinely provides transportation for ill or injured persons. For purposes of these regulations, the Maine Army National Guard, Maine Air National Guard and the United States Armed Forces are not considered ambulance services. It does not mean a person, persons, or organization which transports ill or injured persons for reasons not connected with their illness or injury. It does not mean a nursing home licensed under Chapter 405, a boarding home licensed under Chapter 1665, a children's home licensed under Chapter 1669, or similar residential facility when transporting its own residents or those of another similarly licensed facility when those residents do not require emergency medical treatment." (32 MRSA §83 sub §5 and Rules)
>
> **First Responder Services** are defined as meaning "any organization, person or persons who hold themselves out as providers of emergency medical treatment and who do not routinely provide transportation to ill or injured persons and who routinely offer or provide services to the general public beyond the boundaries of a single recreational site, business, school or other facility. For the purposes of this chapter, a physician making house calls as a part of ordinary medical practice is not considered to be a first responder service.
>
> A first responder service must have an agreement with a licensed ambulance service, to ensure continuity of care and adequate transportation for its patients. An ambulance service is not required to approve of or enter into an agreement with a first responder service." (32 MRSA §83 sub §14)

(See Table II for Service Licensure Levels by Region)

TABLE II

Ambulance & First Responder Service Levels by Region

	Basic	MAST/EOA	Intermediate	Critical Care	Paramedic	Totals
Region I	6	10	7	0	4	27
Region II	5	20	19	16	2	62
Region III	5	10	4	4	4	27
Region IV	34	15	4	2	0	55
Region V	5	3	0	5	2	15
Region VI	16	15	5	0	0	36
Totals	71	73	39	27	12	222

Vehicle Licensure: As with personnel and service licenses, vehicles are all licensed and inspected annually by the State Office. Maine statutes provide that:

> "Each ambulance shall be licensed pursuant to this chapter. It shall also meet the design criteria and shall be equipped as specified in regulations adopted under this chapter" (32 MRSA §87).

In FY 1985, the Department licensed and inspected approximately 350 vehicles and air ambulances. These same vehicles are considered "authorized emergency vehicles" under the provision of 29 MRSA §1, sub §1-B and subsequently have various traffic rights including parking, audible signs and speed. In the course of inspection, the Office of Emergency Medical Services staff determine that the vehicle meets Department of Safety standards for vehicle safety, that it contains the proper equipment including medical and communications equipment and meets the necessary sanitation standards. A vehicle license is issued to a particular service for a specific vehicle. The present fee for vehicle licensure is $15 and the vehicle must be assigned to a specific "base" station.

Again, in reviewing the structure of the EMS program and assessing the organizational relationship between the Board and the Department, the Committee finds that the authority for licensing personnel, services and vehicles should be placed with the Board. This recommendation stems from the Committee's recognition that the Board should be the governing agent for EMS.

It is not because the Department has been remiss in carrying out its licensure functions, but rather because the Committee finds that the structure of EMS as a regulatory program should parallel the structure of other regulatory, licensing boards in the State. In addition, the Committee finds that given the earlier recommendation that the Board have rule-making authority, it follows that the Board should be the licensing agent.

In making this recommendation, the Committee intends that the Board can delegate the mechanics of licensing to the staff. Further, the Committee finds that this change should increase the accountability within the EMS program between services and personnel and work to ensure an appropriate level of flexibility necessary to maintain an effective system without diminishing patient care.

STATUTORY	4.	Provide that a licensee may appeal the revocation, suspension, or refusal to issue or renew a license to the Commissioner prior to action by the Administrative Court to provide an additional safeguard for both the Board and the licensee.

The statutes governing Emergency Medical Services contain an appeals process which provides:

> "§90 Appeals.
>
> Any person or organization, which is aggrieved by the decision of the department in refusing to issue or review a license, may claim a hearing pursuant to the Maine Administrative Procedure Act, Title 5, Chapter 375.
>
> Whenever the department decides to revoke or suspend a license, it shall do so by filing a complaint with the Administrative Court pursuant to the Maine Administrative Procedure Act, Title 5, Chapter 375. The department may seek an emergency suspension, to be in effect for no more than 30 days, from the Administrative Court pursuant to Title 4, section 1153."

Rules adopted in accordance with this section specify the reasons for refusal to issue or renew a license, or for suspension and revocation. These criteria include areas such as: obtaining a license by fraud, violating a lawful order, acting in ways which are dangerous or injurious, and for unprofessional conduct.

In the previous recommendation (#3), the Committee is recommending that the responsibility for licensure be placed with the Board. However, because of the importance of the decision to refuse to issue, renew, to revoke or suspend a license, the Committee finds that an iterim appeal procedure to the Commissioner would be an additional safeguard for both a licensee and the Board. The Commissioner would then hold the power to overturn or sustain the Board's decision.

The Committee does not anticipate extensive activity under this section concerning revocation and suspension because the Administrative Procedure Act gives the Administrative Court exclusive jurisdiction with some emergency exceptions over such revocation or suspension (5 MRSA §10051).

An agency, in this case the Board of Emergency Medical Services, is responsible for filing a complaint with the Administrative Court. Only in specific situations is an agency empowered to revoke, suspend, or refuse to renew any license without proceedings and for only a 30 day period when the health and safety is involved; during which time a complaint must be filed in Administrative Court. These situations are:

- if agency action rests solely upon a finding or conviction in court of any violation which, by statute is grounds for revocation;
- in the case where a reciprocal license has been revoked or suspended by the granting authority; and
- where the health or safety of the public is placed in jeopardy. (5 MRSA §10004)

In FY 1984, the Administrative Court revoked the EMT licenses of two persons and the service license of the company they owned. In FY 1985, the Administrative Court revoked four EMT licenses for incompetence. Two people were suspended for one year for falsifying course records and two other people were advised in the same type of violation that they would be refused licensure.

Accordingly, because of the seriousness concerning the revocation, suspension, refusal to issue or renew a license, the Committee recommends an interim appeals procedure of the Board's action to the Commissioner of the Department of Human Services. It is the Committee's intent that such appeals, although infrequent, will provide licensees additional rights and provide additional support to the Board in its decision making. To clarify that the Board's decision is binding until overturned, the Committee also proposes statutory language be included which clearly indicates the Board's authority to make decisions; authority which will remain in effect until review and decision by the Commissioner.

STATUTORY	5.	Increase the disciplinary options available to the Board to ensure appropriate safeguards, provide more flexibility and clarify the complaint investigation process.

As discussed in the previous recommendation, the Administrative Court has sole jurisdiction, with the exception of specific 30-day emergency provisions, for the revocation and suspension of a license. This statutory provision is stated below:

> "The complaining agency shall retain every other power granted to it by statute or necessarily implied therein, except the power of revoking or suspending licenses issued by it. Such retained powers shall include, but not be limited to, the granting or renewing of the licenses, the investigating and determining grounds for the filing of a complaint under this section, and the prosecution of such complaints." (5 MRSA §10051)

The present EMS law empowers the Department of Human Services (DHS) with the authority subject to the Administrative Procedure Act as specified above and elsewhere, to refuse to issue, renew, suspend or revoke a license (32 MRSA §90). The Committee is recommending that this power be transferred in conjunction with the licensing authority to the Board. An individual has the right to appeal any such agency action to the Administrative Court. The Committee, in Recommendation #4, is providing an interim appeals procedure to the Commissioner of DHS given the Board's increased authority.

The Committee finds that these four basic disciplinary procedures, refusal to issue, to renew, to revoke or suspend a license, are limiting to both the regulatory agency and licensee. Upon reviewing other regulatory licensing laws in the State of Maine, the Committee has found that some licensing boards have disciplinary authority which is broader than these four basic provisions.

These additional disciplinary provisions include such discretionary authority as:

- enabling the agency to enter into a consent agreement with the licensee and the Attorney General's Office to allow for conditional and/or probationary licensing; and
- enabling the agency to accept the voluntary surrender of a license with stipulation again via a consent agreement.

The Committee finds that there may be situations within the EMS program where the alleged violation may not warrant the serious remedies provided in current law but may warrant lesser, more appropriate disciplinary measures. Because of the broad program authority to license personnel, services and vehicles, the Committee finds that there is an increased need to have available disciplinary authority which corresponds to the breadth of EMS's statutory mandate. Therefore, the Committee recommends that the disciplinary options available to the Board be increased.

The Committee finds that by expanding the disciplinary authority, the EMS Board will be able to undertake appropriate disciplinary actions to ensure the public's protection.

In another related area, testimony received by the Committee questioned the consistency of approach in the initial handling of investigations. The Committee finds that it is beneficial to provide statutory clarification, within the EMS law, regarding the uniform handling of a complaint investigation to ensure that proper safeguards and procedures are followed. Because the EMS law presently does not contain such provisions, the Committee recommends that such clarifications be made.

Therefore, the Committee recommends that the complaint investigation process be clarified in statute and that the disciplinary options available to the Board be increased to ensure the continued protection of the public health and welfare.

STATUTORY	6.	Place the authority to appoint or dismiss the Director with the Board and provide for approval of the Commissioner, to properly reflect the Board's increased responsibilities.
STATUTORY	7.	Enable the Director to hire other staff as required, subject to personnel law, to reflect the Director's responsibility for the administration of the EMS program.
STATUTORY	8.	Ensure that OEMS employees are maintained within the new organization with the same compensation, benefits and rights to provide job security for present employees.

When established in 1980, the Office of Emergency Medical Services was housed within DHS as an organizational unit directly under a Deputy Commissioner. This organizational relationship gave OEMS direct access to the Deputy Commissioner and provided a clear working relationship with other organizational components such as medicaid reimbursement and health programming. Further, the Deputy Commissioner served as an advocate for OEMS. This advocacy role was esstential given the Department's increasing priority in providing child welfare services.

In 1984, OEMS was relocated as a unit within the Bureau of Health. The Director of OEMS is now directly responsible to the Director of the Bureau of Health who in turn reports to a Deputy Commissioner.

In FY 1985, the Bureau of Health had a total of approximately 200 authorized positions and expenditures of approximately $15,509,000, with the Office of Emergency Medical Services having a statewide budget of approximately $430,000. The Bureau, in addition to OEMS, contains the following organizational units:

- Central Administration;
- Division of Disease Control;
- Division of Maternal and Child Health;
- Division of Health Engineering;

- Division of Public Health Laboratories;
- Division of Public Health Nursing;
- Board of Certification of Water Treatment Plant Operators;
- Division of Health Education; and
- Office of Dental Health.

The Committee finds that the charge of OEMS makes it both a medical/health and regulatory/licensing program. Because of this and its program responsibilities, the Office does not fall comfortably into any of the main functional areas within the Bureau of Health. In examining other Bureaus within the Department, the Committee did not find other organizational frameworks which would fit to the program requirements of EMS.

Further, the Committee finds that the relocation of this Office to the Bureau of Health reflects a lower priority within the Department of Human Services, an agency with approximately 1800 employees and expenditures of $460,359,000 in FY 1985.

At the present time, the EMS Office has six full-time positions as follows:

- a Director;
- a Training and Education Coordinator;
- two licensing agents; and
- two clerical support staff.

In conjunction with the Advisory Board, medical control, and regional and contract services, the office staff ensures the implementation, development and regulation of emergency medical services. These staff are employees of the Department with the EMS Director hired by the Department.

To provide the Board with the necessary administrative support, the Committee recommends that the Board be empowered to appoint and remove the Director, with the Commissioner's approval. The Committee also recommends that the Director have the authority to hire other staff positions. The intent of this recommendation is to provide the board with the staffing necessary to carry out its new charge as specified by other Committee recommendations. In addition, the Committee finds, to ensure a responsive and organizationally correct structure, OEMS staff should be responsible to the Board.

The Board, under the Committee's recommendation, will remain housed within the Department of Human Services umbrella. Under this new relationship, DHS will provide administrative and budgetary support services to the Board and OEMS. Further, the Committee finds that relocation of the Office and staff, along with the strengthening of board authority within DHS, reflect the priority and attention that should be given to the development and regulation of emergency medical services.

To forge a mutually cooperative working relationship between the Board and Department, the Committee finds that the selection of Director should be achieved through the mutual consent of the Board and Commissioner.

In the course of this organizational change, the Committee is declassifying the position of Director to reflect the policy making status of this position. To provide this individual with job security, the Committee recommends that the statutes clarify that removal be for cause and again, with the Commissioner's approval.

To accurately reflect the responsibilities of the other positions and ensure their job security, the Committee also recommends that these positions remain classified, subject to state personnel requirements, and that the Director be responsible for the hiring of office staff. The Committee finds that the Director should be responsible for the daily operations of the Office.

Finally, to ensure staff continuity, the Committee recommends that statutory language be included which will retain the existing employees in the new organization.

STATUTORY	9.	Place the authority for the designation of regions and regional councils with the Board to provide a consistent organizational charge.

As described earlier, the State is divided into six geographical regions for the purposes of conducting a statewide emergency medical services program, as follows:

Region I. Southern Maine EMS Council, Inc; Cumberland and York Counties areas and a small part of Sagadahoc County;

Region II. Tri-County EMS, Inc; Androscoggin, Oxford and Franklin Counties;

Region III. Kennebec Valley EMS Council, Inc; Somerset and Kennebec Counties;

Region IV. Northeastern Maine EMS Council, Inc; Piscataquis, Penobscot, Hancock, and Washington Counties;

Region V. Aroostook Region EMS Council, Inc; Aroostook County; and

Region VI. Mid-Coast EMS Council, Inc; Waldo, Knox, Lincoln, and Sagadahoc Counties.

The Maine statutes provide for the designation of EMS regions by the Department of Human Services (32 MRSA §84 sub §1-D). These same statutes also define "Regional Council" to mean "those groups recognized by the Department which represent the various regions of the State, as designated by the department....." (32 MRSA §83 sub §20) and state that:

> "a regional council shall, at least, provide adequate representation for ambulance and rescue services, emergency room physicians, and nurses, each hospital and the general public. A regional council shall be structured to adequately represent each major geographical part of its region. Only one regional council shall be recognized in any region." (32 MRSA §89 sub-§1)

The Committee's review of each regional council demonstrated that the councils vary extensively in size, structure, committee organization, and process. All councils, however, have the following characteristics:

- a Regional Coordinator who is responsible for the Council's ongoing operations;
- a Regional Medical Director who oversees the development and application of regional medical operational and clinical protocols;
- the establishment of regional medical control subcommittees and education subcommittees to assist with the development of the emergency medical system at the local level;
- responsibility for ensuring the availability of educational, training and testing programs at the Basic and Advance Levels; and
- responsibility for nominating two or more candidates for a position on the Emergency Medical Services Advisory Board. (32 MRSA §89)

In addition, the Committee noted that the regional council structure facilitates extensive local involvement from the range of individuals and organizations involved in emergency medical services.

Given the extensive delegation of responsibility for emergency medical services to the local level, the Committee finds that the present regional council structure should be maintained but that the Board, as a governing agent, should have the authority to make any future designation or change in the regional structure. Accordingly, the Committee recommends that the authority for the designation of regions and regional councils be placed with the Board.

The Committee finds that such a transfer is important to ensuring the local implementation, development and responsiveness of emergency medical services.

STATUTORY	10.	Place the responsibility for establishing goals for the Emergency Medical Services program with the Board to facilitate the involvement of the EMS community.

As mentioned earlier, there are a number of different organizations and groups within the EMS system. These include:

- the Office of EMS;
- the Advisory Board;
- the Regional Councils;
- the Regional Coordinators;
- the Medical Directors;
- advisory committees; and
- the service providers.

The law requires the Department to establish goals in monitoring the provision of services. In establishing these goals, the EMS Director is required to seek the advice of the Advisory Board.

The final statewide goals are then presented to the regional councils so that they can submit work plans. Work plans are used by the Department when making grants to each council.

Between regions, the Committee finds, there is a wide variance in goal planning. Each region does its own planning, usually within the context of the workplan which is submitted to the State Office.

The Committee further finds that this practice of annual goal determination does not address the long-range planning needs of the system. Priority has not been placed on long-term planning either at a state or regional level. This, in part, is due to limited resources.

The Committee finds that the regionalized nature of EMS, combined with limited fiscal and staff resources, necessitate strong, targeted goal planning. The Committee also finds that the establishment of these goals can be a process which unifies the EMS network by providing a common intent and vision.

Finally, the Committee finds that the Board, by virtue of its expertise and representation, is the appropriate vehicle to establish such program goals. Therefore, the Committee recommends that the responsibility for establishing goals for the emergency medical services program be placed with the Board and that the statutes reflect this change.

STATUTORY	11.	Place the responsibility for approving the delivery of educational programming and testing with the Board to complete the proposed organizational change.

Several other areas of responsibility now held by the Department of Human Services were reviewed by the Audit Committee. These include the Department's authority to determine the delivery of educational courses, the educational requirements for licensure, and the procedures for testing. This authority is established in statute and specified in rules. For example, one regulation which governs the delivery of First Responder courses, EMT courses and refresher courses states "A First Responder course must be sponsored by a Vocational Technical Institute or other educational institution agreed to by the Department and the Department of Educational and Cultural Services." (8.12) At the time of the Committee's review, the Vocational Technical Institutes were the only designated sponsors.

The Committee received testimony from two EMS regions requesting that they be designated sponsors for the delivery of basic educational programs. This would expand sponsorship to agencies other than the Vocational Technical Institutes.

In reviewing these requests, the Committee noted that the relationships and working arrangements between the Vocational Technical Institutes and regional councils vary extensively between regions. In some areas, the Institute provides office space to the regional council such as with Kennebec Valley while in other regions, the relationship is more distant.

In addition, the rules set forth the Conduct of State Licensing Examinations for Licensed Ambulance Attendants, Basic and Advanced EMT's. Again, the Committee received comment concerning the administration of examinations indicating inconsistencies across regions.

The Committee finds that educational requirements, the delivery of courses and testing requirements are a central piece of the EMS system and as such should be placed within the Board's jurisdiction. The Committee finds that the questions raised in these areas are appropriate for deliberation and decision by the Board. Therefore, the Committee recommends that the responsibility for approving the delivery of educational programming and testing be placed with the Board.

STATUTORY	12.	Maintain the Board of Emergency Medical Services as an administrative unit within the Department of Human Services to maximize coordination between health programs.

The present EMS structure places the final authority for decision-making with the Commissioner of DHS. This authority is delegated by the Commissioner to the Bureau of Health and the Office of EMS.

As a result of the Committee's proposed reorganization of EMS, the Board will assume the responsibility for directing and ensuring the operation of the program. The Commissioner's role will be limited to the following areas as set forth in statute:

- to review the function and operation of the Board and regional councils to assure that these organizations are in compliance with their statutory and public service responsibilities;

- to act as a liaison between the Board and other administrative units within the Department, with the Governor and the Legislature;

- to carry out the requirements as set forth in this chapter or as delegated by the Board through rules;

- to provide the staff and administrative support necessary for the Board to carry out its function;

- to approve the Board's appointment of a Director and any subsequent removal; and

- to receive and rule on appeals for any person or organization aggrieved by the decision of the Board in refusing to issue, renew, revoke or suspend a license.

In addition to these provisions, the statutory definition of "Board" proposed by the Committee states:

> **"The board shall be an administrative unit within the Department of Human Services. It shall be a separate, distinct administrative unit, which shall not be integrated in any way as a part or function of any other administrative unit of the department. It shall be equal in organizational level and status with major organizational units within the department or its successors."**

Combined, these recommended provisions place the Board within the DHS umbrella and maintain a direct organizational link to the Commissioner. The Committee finds that this organizational relationship will work to:

- strengthen the coordination between the Board and the Department;

- provide the Board with administrative support;

- place the Commissioner in an oversight capacity; and

- entrust the Board with decision making authority.

Therefore, the Committee recommends that the Board be maintained as an administrative unit within DHS.

STATUTORY	13.	Remove the word "advisory" from the name of the Emergency Medical Services Advisory Board to reflect its newly revised mandate.

The name of the Emergency Medical Services **Advisory** Board properly reflects its present "advisory" function. This advisory role is clearly defined in statute by language in a number of ways:

- **advising** the Director on the preparation of the EMS report ;
- **advising** the Department on the conduct of the EMS program ; and
- reviewing applications for new licenses for ambulance and first responder services - **making recommendations** to the Department concerning the new license applications.....(32 MRSA §88 sub §2A, 2B, and 2C).

The Board's adopted philosophy also reflects this advisory charge.

> **"The Board is here to advise the Department to ensure quality emergency medical care on a statewide basis in a prehospital phase through education, legislation, and licensure."**

Throughout this report, the Committee is making a number of recommendations which change the function and authority of the Board. Instead of serving in an advisory capacity, the Committee is recommending that the Board be the agent responsible for all aspects of the EMS program. Therefore, to reflect this organizational change, the Committee recommends that the word "advisory" be eliminated from the Board's present name to properly reflect its newly revised mandate.

STATUTORY	14.	Provide a transition clause to ensure proper transfer of authority and powers from the Department to the Board on the effective date of implementation, September 1, 1986.

Throughtout this report, the Committee in making many recommendations which will change the organizational authority of the EMS program. To ensure adequate time to facilitate the implementation of these changes, the Committee recommends that an effective date of September 1, 1986, be established. At this time, the Board will assume all responsibility now delegated to the Department of Human Services for the Emergency Medical Services program. This transfer of authority will include funding and program responsibilities. To ensure that this transition takes place as intended, the Committee proposes the adoption of the language which:

- transfers funds and expenditures to the Board's jurisdiction; and

- transfers any corresponding powers and duties now granted to DHS to the Board.

It is the Committee's intent that all funds and associated expenditures such as staff salaries and contract services become the responsibility of the Board. This transfer includes the General Fund appropriations and Preventive Health Block Grant allocations made to the Bureau of Health for the EMS program's operations.

The Committee's intent is also that the Department provide the necessary administrative support to the Board in maintaining proper accounting.

Along with ensuring the smooth transition of funding, the Committee intends to ensure that all regulatory authority is properly transferred to the Board so that it can carry out the responsibilities as assigned under this Chapter.

Therefore, the Committee recommends the inclusion of transition language to ensure an orderly change while providing the Board with the necessary legal authority to carry out its mandate.

STATUTORY	15.	Provide for an orderly appointment process of Board members and establish the authority of the Board to appoint subcommittees.
STATUTORY	16.	Stagger Board membership so that only one third of the membership terms expire each year.

The present EMS law specifies that all 13 Board members shall be appointed by the Governor for three year terms.

> "The members shall serve for three-year terms, and shall be appointed by the Governor." (33 MRSA §88 sub §1-A)

In addition, under the duties of the regional councils, the law states:

> "Specific responsibilities of the councils include, but are not limited to the following:
>
> F. Nominating 2 or more candidates from each council for a position on the Emergency Medical Services' Advisory Board from whom the Governor may select a member." (32 MRSA §89 sub §2-F)

The Committee finds that appointment of board members by the Governor is common to many state boards and should be retained. A gubernatorial appointment process works to ensure an appropriate review of a candidate's qualifications and to maintain a full compliment of Board members.

Upon reviewing the current EMS law governing board composition and appointment, the Committee noted two features which are missing that are customary to this process; the need for language specifying the filling of a vacancy, and the ability of the Governor to remove a member for cause. Although the latter provision is rarely ever used, the Committee finds the addition of such language to be an appropriate safeguard.

In addition, to facilitate the Board's active development of subcommittees, the Committee recommends the insertion of a sentence in the statute empowering the Board to establish subcommittees.

Finally, the Committee noted that the reconstitution of the Board in 1982 under this Chapter created a situation where, at present, eight of the 13 members are up for reappointment this year, 1986. The Committee finds that such a large board turnover (62%) can be disruptive to the continuity of the operation of the EMS program.

The language being recommended by the Committee will begin the correct staggering of terms by the year 1991 as follows:

- four members due for appointment in 1991;
- four members due for appointment in 1992; and
- five members due for appointment in 1993.

This is accomplished by leaving the three year term requirement for all board members with the exception of four of the eight positions due for appointment in 1989. These four board terms will be four years in length at that time.

The Committee recommends that all Board members be appointed by the Governor, vacancies be filled as required and that the Governor be empowered to remove members for cause. Given the increased authority of the Board, the Committee finds that these administrative clarifications are warranted.

In addition, the Committee recommends the adoption of statutory language which will facilitate a more balanced turnover in membership over a three year period.

STATUTORY	17.	Provide that the State Medical Director serve as a non-voting ex-officio member of the EMS Board to strengthen the coordination between the EMS Board and the Medical Control Advisory Committee.

During its review of the EMS system, the Audit Committee examined the present membership criteria for the Board. This was done in view of the many changes the Audit Committee is recommending in this report.

At present the Board membership consists of 13 members as follows: **"One member representing each regional council, and 7 persons in addition. Of the additional persons, one shall be a physician, one an attorney, one a representative of the public, one a representative of for-profit ambulance services, one a professional nurse, one a representative of first responder services and one a representative of not-for-profit ambulance services. The members shall serve for 3-year terms and shall be appointed by the Governor."** (32 MRSA §87 sub §1A)

Upon discussing the criteria for membership and reviewing some suggested changes, the Committee determined that the present composition of the Board with one minor change, provided appropriate representation. Finally, the Committee determined that a Board of 13 voting members is the maximum size for continued efficiency.

The Committee, however, in recognizing the importance of the Medical Control structure, which includes a State Medical Director, Regional Medical Directors, a State Medical Advisory Committee and Regional Medical Control Committees, determined that the representation of this community should be increased at Board meetings to facilitate communications. The Committee also finds that medical control is a central element and governing system for EMS and consequently should have increased input into decision making.

Presently, although the State Medical Director is invited to attend board meetings, there is no formal mechanism to ensure continued participation from that position.

Therefore, the Committee recommends that the State Medical Director serve as an ex-officio member of the Board. However, because the contractual arrangement between the Board and the Medical Director can present a potential area of conflict, and because the Committee finds the Board is at a maximum size for efficiency, the Committee recommends that the status of the Medical Director be as a non-voting member.

STATUTORY	18.	Provide that the Chair of the Board shall be elected for a two year term by the full membership of the Board to facilitate continuity.

The EMS statutes presently provide that "the board shall elect its own chairman" (32 MRSA §88 sub §1A). In reviewing this authority, the Committee noted that the term of the Chair is not specified.

The Committee found, however, that the Board has adopted its own internal policy which provides that the Chair shall be elected at the June annual meeting for a one year term.

Throughout this report, the Committee is recommending many changes which will increase the authority of the Board. This increased authority will, in turn, be reflected in the increased responsibilities of the Chair. Therefore, the Committee recommends that the term of the Chair be for a two year period to provide continuity.

STATUTORY	19.	Establish that a majority of the Board constitutes a quorum for the conduct of board business and that a two-thirds vote of those present is necessary for the suspension or revocation of a license.

During its review of EMS, the Audit Committee assessed the voting procedures of the Board in light of the proposed changes recommended in this report.

A Manual for Licensing Board Members recently published by the Department of Business, Occupational, and Professional Regulation, contains a definition of quorum to mean "**A quorum is the number of board members required to hold a valid board meeting. Each board's quorum is stated in its own statute or, if that is silent, in the general law. A quorum is a majority of the members of a board as that board is constituted by its statute or a specifically stated number.**" This same manual further states that "**A majority is the number of members necessary to exercise the full authority of a board, i.e. to take any official action. A majority is a fraction of a quorum and is always anything over one half the number of members which constitute a quorum.**" The present EMS law does not contain language governing the Board's voting procedure. By default, these procedures are governed by other Maine statutes.

Because of the increased governing authority of the Board, the Committee recommends that the EMS statutes clearly specify that a majority of board members constitute a quorum and that a quorum is necessary for the conduct of official business.

Again, given the increased official nature of the Board's responsibilities, the Committee finds that a quorum should be present for official business. Once a quorum is established, a majority of those present and voting is required for board action.

However, the Committee is also recommending that a two thirds vote of those present and voting is required for any action which results in the suspension or revocation of a license. In making this recommendation, the Committee intends to place emphasis on the importance of any decision to suspend or revoke a license.

Therefore, the Committee recommends that the statutes clarify that a majority of the Board constitutes a quorum for conduct of official board business and that a two-thirds vote of those present is necessary for the suspension or revocation of a license.

STATUTORY	20.	Increase the duration of a Basic Emergency Medical Technician license from one to three years, while maintaining quality standards, to streamline licensure/certification, to improve licensee morale, recognize expertise gained through practice, and increase retention.

The Committee closely reviewed the licensure levels and criteria for emergency medical services personnel. In reviewing these, the Committee received extensive comment, looked at other states' criteria, and reviewed materials provided by the State Office.

The Maine statutes state:

> **"Basic emergency medical technician. "Basic emergency medical technician" means a basic emergency medical services' person who has successfully completed the United States Department of Transportation course for emergency medical treatments and has met the other requirements for licensure at this level." (@83 MRSA sub @6)**

The statutes also set forth the following minimum requirements for licensure at any level:

> "A. The successful completion of the United States Department of Transportation course for first responders or the American Red Cross Advanced First Aid and Emergency Care Course with supplemental training in extrication, oxygen administration and airway care, patient evaluation and taking of vital signs.

B. The person must have successfully completed the American Heart Association basic rescuer course in cardiopulmonary resuscitation or its American Red Cross equivalent.

C. The person must have successfully completed a state written and practical test for basic emergency medical treatment.

D. The person must be sponsored by a Maine licensed ambulance service or first responder service." (32 MRSA §85 sub §3)

The rules adopted by the Department of Human Services regarding the Basic Emergency Medical Technician license set forth the following criteria for initial licensure:

"In order to be licensed for the first time, and EMT must meet four conditions.....These conditions are:

- a candidate must be certified as having successfully completed an emergency treatment course;
- a candidate must be certified in CPR;
- a candidate must have passed the State's written and practical tests;
- a candidate must be sponsored by a licensed ambulance service or First Responder Service or must require licensure as an EMT in order to qualify for a particular job."

For renewal of a license the following is established through rules:

"An EMT license is valid for one year. It is renewed by submitting valid certificates of emergency treatment, training, CPR, State testing, and service sponsorship."

Under this regulatory system, an EMT must:

- annually renew a CPR certification;
- every two years pass a written and practical test and successfully complete the Basic EMT course, or a retraining course approved by the Department, or 30 hours of continuing education; and

- if actively practicing, annually renew licensure.

The Committee received extensive comment which indicated that the present licensure system for BEMTs was discouraging to many licensees because of the extensive time committment, the lack of recognition for the value of experience, the cost and the great distances that many individuals must travel to attend courses, and that the two year period was not necessary to maintaining quality care but rather, counter productive to recruitment efforts and the retention of current licenses.

The Committee recognizes that the intent behind the present licensure/certification process is to ensure high quality emergency medical care. The Committee also recognizes that emergency medical services at the basic licensure level are not physician controlled. At this level of licensure, it is important, as with other levels, to assure basic skill performance.

The Committee finds that the present licensure/certification process in Maine is cumbersome at the Basic Emergency Medical Services Technician level and recommends that the statutes be amended to lengthen the licensure period as follows:

> **"For those individuals who are licensed or who relicense as a basic emergency medical technician after September 1, 1986, and who are not licensed at the advanced level, the basic emergency medical technician license shall be for a 3-year period. Licensure shall include, but not be limited to, annual verification, as determined by the board through rules. In addition, that licensure shall require the successful passage of examinations no more often than once every 3 years. To maintain a valid license, a basic emergency medical technician shall meet the criteria as set out in this subsection. If such criteria are not met, a person shall not hold a valid license and shall reapply for licensure."**

The effect of the Committee's recommended language will be to lengthen the time frame from two to three years in which the licensee is required to take a written and practical test. In addition, the Committee's intent is to encourage the Board to streamline the licensure/certification process while enabling the Board to have the necessary flexibility to set annual requirements within a three year frame.

Accordingly, the Committee recommends the inclusion of this language in order to streamline licensure/certification, to improve licensee morale, to enable the Board to assess the expertise gained through practice, and to increase retention.

STATUTORY	21.	Eliminate the renewal requirement for a Basic license as a condition of continued licensure at the Advanced Level but provide that a combination of criteria be established by the Board to ensure quality care while eliminating unnecessary administrative procedure.

As mentioned earlier, there are six levels of licensure; two levels, the Licensed Ambulance Attendant and the Basic EMT are considered Basic Life Support Levels and four levels, the EMT-EOA, EMT-Intermediate, EMT-Critical Care, and EMT-Paramedic constitute Advanced Life Support Services.

The Committee reviewed the requirements for all levels of licensure and found that licensure renewal at the Advanced Level is dependent upon licensure renewal at the Basic EMT level. As mentioned in the preceding recommendation, to hold a valid BEMT license requires bi-annual examinations as well as maintaining other requirements.

The Committee finds that the present structure which requires advanced care providers to renew their Basic license for maintaining their Advanced licenses, in addition to the advanced requirements, is burdensome and can be simplified.

The Committee recognizes that the skills required at the Basic Level differ from those required at the Advanced Level and does not question the need for personnel to demonstrate that these basic skills have been retained. The Committee, however, finds that one license should be given at the Advanced Level which would include licensure at the Basic Level. This type of licensure would parallel to some degree the licensure process for paramedics, where in the course of renewing an Advanced license, the individual refreshes his or her basic skills.

To facilitate this change, the Committee recommends the adoption of the following language:

> **"For those individuals licensed at the advanced level, the board shall establish through rules the criteria for licensure to include the requirements for renewal. Renewal at the advanced level shall not be contingent upon renewal of a basic emergency medical technician license, but may be as a result of demonstrated competence at the basic level and advanced levels. The demonstrated competence at the basic level for advanced license renewal may be any combination of requirements as established by the Board, to include continuing education requirements, passage of a written or practical test, or both, or the successful passage of a refresher course."**

The proposed statutory changes establish that renewal of an Advanced license shall **not** be contingent upon renewing a Basic license but allows the Board to make appropriate substitution in terms of licensure requirements. The statutory provision also specifies that:

> **"A person licensed at the advanced level shall be considered as being licensed at the basic level."**

The inclusion of this last sentence is intended to enable the Board to institute appropriate disciplinary procedures which could result in the removal of an Advanced license but retention of a Basic license.

In making this recommendation, the Committee intends to begin a movement toward licensure simplification while maintaining the standards of quality care.

STATUTORY	22.	Review the operations of the EMS program in three years under the provisions of the Maine Sunset law to assess the implementation of the reorganization.

Throughout this report, the Committee on Audit & Program Review is recommending many changes which will significantly change the present governance of the Emergency Medical Services program.

As part of the ongoing Audit review, the Committee returns to the agency one year after the proposed recommendations are adopted to determine the level of compliance. However, in addition to this process, because of the importance of EMS to the public's health and welfare, the Committee recommends that a formal review be undertaken in three years under the Maine Sunset law. The Committee intends to be available throughout this period to assist with the implementation of this reorganization.

STATUTORY	23.	Include a statement of purpose in the EMS law to indicate legislative intent and affirm the importance of emergency medical services to the public health, safety and welfare.

During the EMS review, the Committee found that present EMS law lacks a statement which identifies the purpose of a statewide EMS program. Given the importance of EMS to the people of Maine and that the EMS law is frequently consulted by EMS providers, the Committee recommends the insertion of a mission statement as follows:

"@81-A. Statement of purpose

It is the purpose of this chapter to promote and provide for a comprehensive and effective emergency medical services system to ensure optimum patient care. The Legislature finds that the provision of medical assistance in an emergency is a matter of vital concern affecting the health, safety and welfare of the public.

It is the intent of the Legislature to designate that a central agency be responsible for the coordination and integration of all state activities concerning emergency medical services and the overall planning, evaluation and regulation of emergency medical services systems. Further, the Legislature finds that the provision of prompt, efficient and effective emergency medical care, effective communication between prehospital care providers and hospitals and the safe handling and transportation of the sick and injured are key elements of an emergency medical services system. This chapter is intended to promote the public health, safety and welfare by providing for the creation of a statewide medical services system with standards for all providers of emergency medical services."

The Committee finds that such a statement of purpose is important in highlighting the value of a coordinated EMS system for Maine citizens. Recognition should be given to the value of a system which has an eight minute average rate of response to emergencies in 1985. The placement of emergency services in Maine makes it possible for 95% of emergency victims to receive care within 20 minutes. These response times are critical to the quality of care for Maine's citizens.

Therefore, to reflect the importance of EMS to the public health and welfare, the Committee recommends the inclusion of a statement of purpose.

ADMINISTRATIVE	24.	Recommend that the DHS Office of Public Relations work with the EMS program to develop and implement a public education plan to increase the public's awareness of EMS. Report to the Committee on Audit & Program Review with this plan by September 1, 1986.

Throughout the Committee's review of the EMS program, it became evident that the general public is relatively unaware of the intent and value of emergency medical services. In addition, the Committee found that providers within the EMS program also have a varying level of understanding concerning the program's operation.

Efforts at increasing the public's awareness are carried out at the regional level. These efforts vary with the availability of resources and may be focused on specific concerns such as encouraging volunteer recruitment. Given other priorities and limited resources at the state level, little attention again has been spent on public education. The Committee finds that the EMS program should have a statewide public education plan. The Committee also finds that the Office of Public Relations within DHS has the resources and expertise to assist in the development of such a plan.

Therefore, the Committee recommends that the Office of Public Relations work with the Board and EMS staff to develop and implement a statewide public education plan to increase the public's awareness.

ADMINISTRATIVE	25.	Develop orientation packets for new Board members and other interested individuals to include: • a brief history of EMS; • a copy of the laws governing EMS; • a copy of the EMS rules; • a copy of the Board philosophy; • a description of responsibility as a Board member; and • an overview of EMS, goals, program, and budget.

Concurrent to the review of the Emergency Medical Services program, the Audit Committee was reviewing the Department of Business, Occupational, and Professional Regulation. The Department of Business Regulation is responsible for providing administrative support to a number of regulatory licensing boards. During its review of Business Regulation, the Committee noted that the Commissioner had developed a manual intended to acquaint board members with the intent and implementation of professional regulation. The Committee found that the completed manual contains useful information on:

- conducting and recording meetings;
- conducting and recording hearings; and
- rule-making.

It also contains information about board mechanics and an orientation for public members. The Committee finds that this type of information and orientation would be of assistance to EMS board members.

The Committee also finds that it would be beneficial to provide EMS board members with a brief history of EMS, a copy of the board's philosophy, and an overview of the EMS goals, program and budget.

Therefore, the Committee recommends that an orientation package be developed for new EMS Board members and other interested individuals to include:

- a brief history of EMS;

- a copy of the laws governing EMS;
- a copy of the EMS rules;
- a copy of the Board philosophy and internal procedure;
- a description of responsibility as a board member; and
- an overview of EMS goals, programs and budget.

These materials will assist new members in becoming oriented to their governance and regulatory responsiblities.

ADMINISTRATIVE	26.	Recommend that the Board ensure that regulations are clearly written to encourage consistent interpretation.
ADMINISTRATIVE	27.	Inform individuals who request interpretation of regulation of their right to request an advisory ruling. Include the procedure in the EMS rules to provide for consistency in interpretation.

Throughout the course of its review, the Joint Standing Committee on Audit & Program Review received many comments concerning the inconsistency of the state office in interpreting regulations. In reviewing these concerns, the Committee found that the need for interpretation of any regulation can stem from unclear regulatory language. Accordingly, the Committee recommends that the Board work to ensure clearly worded regulations.

The Committee noted that the Administrative Procedure Act, 5 MRSA §9001, provides that an individual may request an **advisory ruling** with respect to the applicability of any statute or rule administered by that agency. The Administrative Procedure Act specifies that all rulings shall be in writing and that an advisory ruling shall not be binding upon the agency.

The Committee finds that an advisory ruling can assist in providing written clarification. Further, this same statute directs that:

"4. **Advisory rulings.** Each agency shall prescribe by rule, the procedure for the submission, consideration and disposition of requests for advisory rulings." (5 MRSA §9001)

The Committee also finds that, although the Department of Human Services may have such rules promulgated on a department wide basis, it would be beneficial to include these rules directly in the EMS regulations which are distributed to individuals, services and other providers or organizations to increase the visibility of the process.

The Committee, therefore, recommends that the Board adopt such procedures in rule and notes that the statutory requirement that agencies promulgate the procedure in rules presently exists in the Administrative Procedure Act. The Committee intends that such compliance will assist individuals in obtaining a clearer, more consistent interpretation.

ADMINISTRATIVE	28.	Recommend that the Medical Control Advisory Committee develop a statewide procedure governing boundary protocol to resolve potential problem areas. Report to the Committee on Audit & Program Review by February 1, 1987.
ADMINISTRATIVE	29.	Recommend that the Medical Control Advisory Committee review the feasibility of establishing **minimum** statewide protocols. Report to the Committee on Audit & Program Review by February 1, 1987.
ADMINISTRATIVE	30.	Distribute the minutes of the Medical Control Advisory Committee to members of the Emergency Medical Services Board to facilitate communication.

As previously mentioned, there are two overall categories of care within Maine's Emergency Medical Services system, Basic Life Support (BLS) and Advanced Life Support (ALS). Two levels of licensure fall under the BLS level:

- Licensed Ambulance Attendant (LAA); and
- Basic Emergency Medical Technician (BEMT).

Four levels of licensure fall under the ALS level:

- Emergency Medical Technician - Esophageal Obturator Airway (EMT-EOA);
- EMT Intermediate;
- EMT-Critical Care; and
- EMT-Paramedic.

The difference between BLS and ALS is that the ALS service levels are physician controlled. Medical care is administered at the ALS level under the guidance and authorization of a physician in accordance with a developed set of regional protocols.

The medical control component of the EMS program includes a State Medical Director, six Regional Medical Directors, a State Medical Control Committee, and individual regional medical control committees.

The general functions of each are:

State Medical Director. The State contracts with this individual to provide medical advice concerning overall medical control in the EMS system. The Medical Director serves as final arbitrator on occasion and provides input to the Advisory Board and State Office when appropriate. One main emphasis of this position, at this time, is to review aggregate data figures or special data studies to determine the effect of certain system and medical practices and procedures on the quality of care and patient health;

State Medical Advisory Committee. The membership of this committee is composed of the State Medical Director and six Regional Medical Directors. The Advisory Committee generally meets on a quarterly basis and assists the State Medical Director in reviewing data and developing policy decisions concerning operational and clinical medical procedures as they relate to EMS. These ideas are then brought back to regional medical control committees for review, discussion, and potential implementation. These state Advisory Committee meetings are usually attended by both the State EMS Director and a staff person from the EMS data agency, the Maine Health Information Center (MHIC). The State Medical Control Advisory Committee meeting also serves as an informal forum for discussing regional issues and for the exchange of information;

Regional Medical Director. Each regional council is required to designate a Regional Medical Director. This person is responsible for coordinating the medical aspect of the EMS program at the local level. Coordination involves the establishment of at least one regional medical control committee and the adoption of regional protocols. The Regional Medical Director is often the physician under whose authority advanced care is delivered in the field; and

Regional Medical Control Advisory Committees. These committees are typically comprised of the Regional Medical Director, emergency room physicians, emergency room nurses and in some regions, rescue and ambulance service providers. The Medical Control Committees develop and review specific regional protocols and the requirements for education and training. In addition, these committees may monitor the provision of service and serve as a point of coordination between hospitals and other care providers.

Two areas of disagreement concerning protocols were brought to the Audit Committee's attention during the course of this review: boundary protocols and statewide protocols. Both issues focus on the fact that regional protocols vary between regions; where a practice allowed in one region may not be allowed in another. The effect is some confusion concerning the application of protocols at regional boundary sites and when services transport from one region into another.

The second area, statewide protocols, questions the desirability and practicality of developing a uniform set of statewide protocols.

While the Audit Committee recognizes the importance and necessity in having regional variance in protocol, the Committee also finds that some exploration should be made to determine where common denominators presently exist or could exist between regions.

Therefore, to resolve potential problem areas, while working towards a cohesive system, the Audit Committee recommends that:

- the State Medical Control Advisory Committee develop a statewide procedure governing boundary protocols;
- the State Medical Control Advisory Committee look at the feasibility of establishing minimum statewide protocols; and

- the State Medical Control Advisory Committee report to the Committee on Audit & Program Review by February 1, 1987 with its findings.

In addition, to facilitate communications between the State Medical Control Advisory Committee and the Board of Emergency Medical Services, the Audit Committee recommends that minutes of the Medical Advisory Committee meetings be distributed to Board members. This recommendation along with the addition of the State Medical Director as an ex-officio Board member (see Recommendation #17) are intended to strengthen the working relationships between these policy influencing agents within the EMS program.

ADMINISTRATIVE	31.	Maintain updated mailing lists of individuals, services and organizations involved or interested in EMS and ensure that copies of regional protocols are available in the central office to strengthen communication.

The Office of Emergency Medical Services maintains a list of all individuals and services involved in EMS. During the course of the review, the Committee found instances where the list being maintained was either incomplete or outdated. Because of the importance in disseminating information and the need to strengthen communications, the Committee recommends that some attention be given to maintaining updated mailing lists of individuals and organizations involved in EMS. In addition, the law requires that a copy of the regional medical protocols be filed with the Department.

> "Protocol means the written statement, representing a consensus of the physicians of an emergency medical services' region and filed with the Department, specifying the conditions under which some form of emergency medical care is to be given by emergency medical services persons." (32 MRSA §83)

At the time of the review, the State Office of EMS did not have accessible copies of the regional protocols. Changes proposed by the Committee also include requiring that the protocols be filed with the Board. Given the importance of protocols to the delivery of care, the Committee finds that this statutory provision should be fully implemented. Therefore, the Committee recommends that copies of all regional protocols be available and filed in the central EMS office.

ADMINISTRATIVE	32.	Recommend that the Board review the data system to determine if the process and information are responsive to the needs of the EMS program. Report to the Committee on Audit & Program Review by February 1, 1987 with any findings.

The State Office of Emergency Medical Services presently contracts with the Maine Health Information Center (MHIC) for the on-going development and maintenance of the EMS data system. From 1977 - 1980 this function resided with the Medical Care Development Corporation when the Corporation operated the entire EMS system. In 1980, the contract was shifted to MHIC with the establishment of an EMS Data Research Unit.

The statewide EMS data system has as its base, the run report. A run report is filled out for each patient transported by an emergency service. It serves both as a patient record and legal document. The information collected on the run report is coded and processed by MHIC. The intent of this data system is to:

- promote the efficient and effective transfer of prehospital information to emergency department personnel for the purpose of assuring continuity of care for the patient;
- link prehospital with hospital activities via the emergency department report tearsheet;
- document prehospital events for legal purposes;
- provide management information to each ambulance/first responder service and emergency department;
- provide data to evaluate the functioning and impact of EMS regionally and statewide; and
- provide data to EMS managers and providers for long-term planning purposes.

MHIC's overall agency mission is to develop a statewide integrated health data system. The run report system coordinates the collection of uniform prehospital data with other data such as the linkage to hospital discharge data. In 1980, MHIC received all of the historical hospital discharge data tapes for Maine which amounted to about a million records. MHIC continues to be one repository of hospital discharge data along with other specialized data.

In FY 1986, the funding for the MHIC data system was:

- approximately $69,300;
- a small sum of funds, approximately $4,000 for special runs and analysis when ordered via the State Office;
- an in-house DHS cost for computer key-punching of approximately $3,000 annually;
- an amount charged for special data runs beyond the routine reports; and
- a subsidy which results from reduced costs by the amount of research monies brought in by MHIC.

These funds contracted with MHIC purchase the following :

- the equivalent of 2 1/2 full time staff;
- the ongoing run report system, including any redesign of the run reports with instruction manuals;
- the distribution of run reports to each service; and
- the coding and processing annually of approximately 95,000 individual run reports.

In addition, MHIC issues quarterly routine reports to the State Office, Regional Coordinators, Medical Control, and individual services as follows:

- **Vital Signs Completion Analysis.** This report list for each service out of the total number of emergency runs for the quarter, the percentage of reports which completed information on pulse, respiration and blood pressure. These figures are contrasted against regional totals and state totals;

- **Average Response Times by Types of Run.** This report shows the average response time for each type of run by service, for the quarter. Again, the individual service information is contrasted against the regional total and state total;

- **Sources of Cardiopulmonary Resuscitation Aid.** This report includes the number of run reports which indicated that CPR was administered. Each service is contrasted for that quarter against regional and state totals;

- **Number of Runs per Type Illness/Injury.** This report lists for each service, the total number of runs by the type illness/injury for the quarter. The categories which appear include - trauma, head, spinal, burn, cardiac, poisoning, respiratory, etc. Again, each service can measure its runs against regional and state totals for that period;

- **Total Runs per Type of Run.** This report breaks the total number of runs per service into the categories of Emergency Transport, Routine Transfer, Emergency Transfer, No Transport, and Unknown. Each service can measure itself against regional and statewide totals;

- **Frequency of Treatments Performed by Ambulance Personnel.** This report lists the type of treatments provided by crew members and the total number of runs for each crew member;

- **Peak Activity by Day of Week.** This report lists the day of the week and the time of day each run occurred for the quarter; and

- **Tear Sheet Compliance Analysis.** This report which comes from the emergency room department lists the number of tear sheets submitted to MHIC that match run reports for the time period listed.

All of the above reports are sent to individual services with the State Office, Regional Coordinators, and Medical Control individuals receiving various summary sheets at no additional cost beyond the contracted amount. This information provides a base from which to critique and improve upon the existing system.

The data collection process originates with the development and dissemination of the run reports. These forms have recently been revised as a collaborative effort between MHIC, the State Office, and field personnel.

Ambulance services and First Responder services are required as a condition of licensure to fill out run reports.

Each month, MHIC receives approximately 7-8,000 run reports (95,000 annually). The Emergency Rooms submit the tear sheets which contain additional information on the patients received in the emergency rooms. MHIC reports that service compliance with the run reports is approximately 100%, while emergency room compliance is 50%.

MHIC codes and corrects each run report. These are then sent to DHS for key-punch entry and the tape is returned to MHIC for loading on their computer terminal. MHIC then checks this again to determine any errors and then can issue quarterly reports. Given the other data information collected by MHIC, special projects can be undertaken.

Every six months MHIC gets a copy of the State's data tape and loads it on its system. This enables MHIC to create different fields such as looking at regional accident information and age category of accident victims. MHIC retains present year data plus three years of past data in its current files.

The Committee has received extensive comment both pro and con concerning the use, need and cost for this data system. The Committee finds that the Board of Emergency Medical Services is the appropriate agent to review the data system. Therefore, the Committee recommends that the Board should review the data system to determine if the process and information are responsive to the needs of the EMS program.

FINDING	33.	The Committee finds that a state recognition day should be established for emergency medical services personnel to provide recognition for their efforts at protecting the public health, safety and welfare.

Emergency Medical Services is a coordinated system of trained first responders, rescue squads, ambulance services, and hospital emergency departments that respond to the needs of the sick and injured.

The Committee finds that EMS is rapidly taking its place alongside law enforcement and fire protection as a fundamental basic public service. The services are staffed by volunteers, professionals and others who receive little monetary compensation and give many hours of unselfish, dedicated time to perform their duties at all levels of emergency care.

To duly recognize these efforts, the Committee recommends that the Governor issue a Proclamation designating one day each year to recognize the contributions of emergency medical services personnel.

As part of the recognition of EMS personnel, the Committee also recommends that the Governor recognize outstanding citizens involved in the EMS program with several awards distributed on that day. For example:

Governor's Award - This award would be for an individual who has made an outstanding contribution to the statewide EMS system;

EMS System Excellence Award - This award would be for an EMS system that functions in a consistent and exemplary manner;

EMS Instructor Award - This award would go to an EMS-Instructor who has made a significant contribution to the EMS educational program in Maine;

EMS Medical Director Award - This award would go to a physician who serves or has served the EMS System, and who has performed meritorious service above expectations. This would recognize the special contribution of a physician in such activities as systems development, continuing education, quality assurance and medical community liaison; and

Special Award - This award would be given to medical providers, local officials, members of law enforcement or citizen. It may be for dedicated, long-term service, special advocacy, meritorious or heroic acts, or innovations or new approaches to improve EMS in Maine.

The Committee notes that the President of the United States has designated one week each year to honor the men and women of the country who contribute to the health, safety and welfare of the citizens. Within Maine, various efforts to increase the public's awareness of EMS are made during this week. There exists, however, no statewide recognition of the particular efforts of emergency medical services personnel.

Given the importance of Emergency Medical Services and the tireless commitment of the individuals involved, the Committee recommends that the Governor designate one day per year for special recognition of these efforts.

ADMINISTRATIVE	34.	Provide technical assistance to the Regional Councils in the development of educational and training programs to improve coordination and maximize limited staff resources.

The Regional Councils are responsible for ensuring the availability and quality of training courses both at the Basic and Advanced levels. This can involve the structuring and scheduling of courses, orientation of instructors, and curriculum development. At the Basic Level, curriculum guides include the U.S. Department of Transportation's (DOT) Emergency Medical Services; First Responder Training Course and the U.S. DOT's Emergency Medical Technician - Ambulance National Standard Curriculum.

At the Advanced level, regions are dependent upon their own resources in the development of courses. A Committee review of course materials documented the benefit which could be gained through an increased sharing of course guidelines and evaluation procedures used by regions. Such interaction could assist regions in expanding limited resources, avoiding duplication and increasing statewide consistency.

The Committee finds that the central office of Emergency Medical Services should work to identify educational materials, and disseminate them between regions. In addition, the Committee finds that the central office, with the Board's direction, could be more helpful in providing technical assistance to the regions in the development of educational programs by developing more guidelines, particularly at the Advanced Level, for course content, instructor orientation, and course evaluation. Such assistance would work to maximize limited resources. Therefore, the Committee recommends that the Board provide technical assistance to the Regional Councils in the development of educational and training programs.

ADMINISTRATIVE	35.	Provide staff assistance to Washington and Hancock Counties in their efforts to strengthen the delivery of educational programs. Report to the Committees on Audit & Program Review and Human Resources by February 1, 1987.

Region IV, the Northeastern Maine EMS Council's area of jurisdiction includes Piscataquis, Penobscot, Hancock and Washington Counties. At this time, due to limited financial resources, the Region has one office located in Bangor, staffed by a Regional Coordinator and a Secretary.

The expanse of territory to be covered by this region presents serious logistical problems for the coordination of the emergency medical services program. In addition, the geographic size requires extensive travel on the part of all individuals involved in council activities and the delivery of service.

For a number of years, the Legislature has been asked to divide this large region into two regions; one covering Washington and Hancock Counties; the other region to include the balance. This concern was debated during the 112th 2nd Regular Session by the Joint Standing Committee on Human Resources with the submission of LD 533, AN ACT to Establish a Downeast Emergency Medical Services Regional Office to Serve Hancock and Washington Counties. In its deliberations, the Human Resources Committee decided to withdraw the bill in light of the comprehensive review by the Audit Committee. The Human Resources Committee asked that the Audit Committee look at this area of concern.

The Audit Committee received extensive comment regarding the problems in the Hancock and Washington county areas. These include the lack of accessible training programs and the lack of input emergency medical services personnel in these two counties feel they have in the regional and state decisions.

The Audit Committee finds that prior to establishing a new region, two things should be explored. First, that the Board be given time to assess and address the current problems in the Hancock and Washington area in light of the Audit Committee's recommended organizational changes. Second, the Committee recommends that increased staff assistance should be provided by the State Office to strengthen the delivery of educational programs in this area.

In addition, the Committee recommends that the Board report to the Committees on Audit & Program Review and Human Resources by February 1, 1987, with a summary of the actions taken and attention given to this problem. At that time, the Audit and Human Resources Committees will reassess this area of concern to determine what future action is required.

The Audit Committee also intends that the General Fund should continue to support activities delegated to the Regional Councils by state law as described in Recommendation #38. This continuity of funding should assist all regions in achieving financial stability and strengthening program delivery. The Committee intends that this should positively impact EMS program services to Hancock and Washington Counties.

STATUTORY	36.	Reallocate the Preventive Health Block grant for EMS for FY 1987 to ensure the availability of services.
STATUTORY	37.	Reallocate $12,000 for FY 1986 to provide $2,000 in grant monies for each of the six regions.
STATUTORY	38.	Request an annual appropriation of $210,000 from the General Fund to cover the cost of regional operations to ensure that each Regional Council receives a total of $60,000 in FY 1987.

The Emergency Medical Services program received funding from the following sources in FY 1986:

- **General Fund.** The General Fund appropriation for the Bureau of Health includes approximately $80,000 to fund one staff position in the State EMS Office and to provide for general office operations. In addition, in FY 1986 a one-time appropriation of $180,000 was made to be divided equally between the six regions;

- **Preventive Health Block Grant.** The amount initially allocated in the 112th 1st Regular Session from the Block Grant totals approximately $403,000. Of this amount, $161,000 funds six staff positions, two of which were funded vacant positions;

- **Highway Project Funds.** These are grant funds, which vary annually, distributed through the Department of Public Safety for special projects;

- **Local Funds.** Each regional council, in order to fund operations to a minimal level, is required to raise funds locally. Typically, at least one half of a region's operations is funded through such sources as:

    - course and conference fees;

    - hospital contributions;

    - county and town contributions;

    - service dues; or

    - for Region V, income from their microwave system; and

- **Miscellaneous Funds.** In addition to these other sources of revenues, small amounts of funding from other sources are available for special purposes.

The Committee closely examined the financial viability of the EMS program. Along with receiving extensive testimony, the Committee examined state and regional accounts and balance sheets. It became increasingly evident throughout the review that the Emergency Medical Services program was confronting a serious financial shortfall beginning in FY 1987. Evidence indicated that without the infusion of additional resources, the regional structure of the EMS program would collapse. Indicators included:

- the negative balance being carried by more regions into a new fiscal year;

- the cutbacks regions were potentially facing in services or had already made;

- the increased time spent on regional fund raising which detracted from the provision of services;

- the decrease in hospital contributions;
- the problems with aging equipment in need of replacement;
- the lack of any job security for present staff;
- federal funds which are not keeping up with inflation; and
- the Department's need to withhold $5,000 from each region due to escalating costs at the state level.

The Committee also reviewed the methods of raising revenues for EMS used by other states. Examples of such methods used to fund EMS include:

- dedicating a dollar from each moving violation;
- placing a special fee on registrations; and
- placing a surcharge on emergency room visits.

After many long discussions, the Committee determined that the General Fund is the most appropriate source for funding EMS at this time since Emergency Medical Services are necessary to the health and welfare of all Maine's citizens.

Further, upon reviewing the allocation of the Preventive Health Block Grant, the Committee noted that there were two areas which required Legislative attention:

- First, that a reallocation was required to ensure that funds were available to provide each region with $25,000 in FY 1987 from this source; and
- Second, that a balance of $12,000 would be available at the end of FY 1986 which would be divided into grants for each region.

Therefore, as a result of the review of the program's finances, the Committee is making the following three recommendations:

- that the Block Grant be reallocated to transfer the funding for the two vacant positions and capital into the budget category of "all other" to enable the Department to contract with regional councils at a level of $25,000 from this funding source;

- that the $12,000 balance available in Block Grant funds ending FY 1986, be reallocated to provide $2,000 in grant monies for each of the six regions to assist them with their financial concerns; and

- that the Legislature appropriate $210,000 as an annual General Fund appropriation to provide $35,000 of General Fund support for each region.

The Committee determined that funding each regional council at a level of $60,000 per year was reasonable given their mandated requirements. Regional councils must ensure the proper delivery of courses, ensure the local monitoring of service delivery, and establish the requirements for regional medical control.

However, as it is also the Committee's intent that regions be held accountable for providing the service, the Committee recommends the adoption of the following language:

> **"Funds appropriated or allocated to the Board to be contracted with the regional councils shall be disbursed, according to guidelines established by the Board. Funds shall be expended in accordance with standard state contract or grant procedures and guidelines where appropriate."**

The Committee finds that these changes should result in financial solvency for the EMS system, the continued availability of service and ensure program accountability.

ADMINISTRATIVE	39.	Expedite the contractual process to ensure that regions receive funds in a timely manner.

The Office of Emergency Medical Services contracts with each regional council. In FY 1986, with the addition of those funds provided for in Recommendation #37, each region will receive a total of $57,000. These funds pay for the salaries of a regional coordinator, clerical support and for general office operations.

To receive funds, a region must submit an annual work plan and quarterly reports. Funds are typically contracted for and disseminated on a quarterly basis following the submission of the quarterly report.

The Committee received testimony that the present contractual process was untimely and created cash-flow problems at the regional level. Given time limitations, the Audit Committee was unable to research this problem and look at alternative time schedules for the issuance of contracts and the submission of reports.

Therefore, the Committee recommends that the Board, with staff assistance, review the possibility for expediting the contractual process to ensure that regions receive funds in a more timely manner.